

# TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

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September 2001



*James E. Zini, D.O.*  
*2001 - 2002 AOA President*

*plus*

Children's Health Issues

pages 6 - 20

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SEPTEMBER 2001

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# INSIDE THIS ISSUE

## *Clinical Focus: Children's Health Issues*

Children's Health Issues .....	6
The Texas Poison Center Network .....	9
by William A. Watson, PharmD, DABAT, FAACCT, FCCP	
ADHD Doesn't Have to Mean Another Doctor Handing out Drugs .....	10
by Mary Ann Block, D.O.	
Kawasaki Disease .....	13
by Fernando Gonzalez, D.O.	
The Vaccination Debate .....	15
by Mary Ann Block, D.O.	
Obesity in Children: Etiological Considerations and Management Strategies for the Primary Care Physician .....	17
by Susan F. Franks, Ph.D and Clifton A. Cagle, D.O.	

James E. Zini, D.O., New President of the American Osteopathic Association .....	21
Guidelines for Comprehensive Risk Reduction for Patients with Coronary and Vascular Disease .....	22
by A.H. O-Yurvat, D.O., FACOS, FICS	
TxACOFP Update .....	24
In Memoriam .....	27
Self's Tips and Tidings .....	28
Opportunities Unlimited .....	30

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# CALENDAR OF EVENTS

## SEPTEMBER 13 - 16

### "OPSO Annual Convention"

*Sponsored by the Osteopathic Physicians and Surgeons of Oregon*

Location: Embassy Suites - Washington Square  
Tigard, Oregon

Contact: 800-533-6776; [www.opso.com](http://www.opso.com)

## SEPTEMBER 14 - 16

### "2001 Mid-year Seminar"

*Sponsored by the Florida Osteopathic Medical Association*

Location: Hyatt Regency Westshore, Tampa, FL

CME: 21 category 1-A hours anticipated

Contact: Florida Osteopathic Medical Association  
The Hull Building, 2007 Apalachee Parkway  
Tallahassee, FL 32301  
800-226-FOMA

## SEPTEMBER 22

### TOMA Board of Trustees Meeting

Location: TOMA State Office, Austin, TX

Contact: Paula Yeamans  
800-444-8662 or 512-708-8662

## OCTOBER 21 - 25

### "106th AOA Annual Convention"

*Sponsored by the American Osteopathic Association*

Location: San Diego Convention Center, San Diego, CA

Contact: Ann Wittner, 800-621-1773

E-mail: [mthompson@aoa-net.org](mailto:mthompson@aoa-net.org)

## NOVEMBER 16 - 18

### "18th Annual Family Practice Update"

*Sponsored by the Oklahoma State University College of Osteopathic Medicine*

Location: Downtown Doubletree Hotel, Tulsa, OK

CME: 25 category 1-A hours anticipated

Contact: Janice L. Giacomo, CME coordinator  
800-274-1972

[gjanice@osu-com.okstate.edu](mailto:gjanice@osu-com.okstate.edu)

[www.osu.com.okstate.edu](http://www.osu.com.okstate.edu)

## DECEMBER 1

### TOMA Board of Trustees Meeting

Location: TOMA State Office, Austin, TX

Contact: Paula Yeamans  
800-444-8662 or 512-708-8662

## 2001-2002 Flu Vaccine Supply and Production

The Centers for Disease Control and Prevention note that this season, the total flu vaccine supply will be greater than in 2000-2001 and comparable to the supply in the 1999-2000 season. Some delays are projected, but they are not expected to be as great as last year's delays. It's anticipated that the total supply by the end of November should be adequate. Vaccine manufacturers project that 77.1 million doses of influenza vaccine will be distributed this season. Because of vaccine delays, however, the Advisory Committee on Immunization Practices recommends the following for the 2001-2002 influenza season:

- Providers should target vaccine available in September and October to persons at increased risk for influenza complications and to health care workers. The optimal time for vaccinating high-risk persons is October through November.
- Beginning in November, providers should offer vaccine to contacts of high-risk persons, healthy persons aged 50-64 years, and any other persons wanting to reduce their risk for influenza.
- Providers should continue vaccinating patients, especially those at high risk and in other target groups in December and should continue as long as there is influenza activity and vaccine is available.

As preparation for the 2001-2002 influenza season proceeds, updates on vaccine supply and other information about vaccination will be available at [www.cdc.gov/nip/flu](http://www.cdc.gov/nip/flu).



**ON THE WEB** is a monthly feature of the *Texas D.O.* announcing headlines and trailers of timely osteopathic news articles, pertinent information on healthcare and education, legislative updates and much more; all of which can be found on our website <www.txosteo.org>.

- **Health Notes**
- **HHS First Guidance on Patient Privacy Protections**
- **TRICARE News and Related Military Issues**
- **News from UNTHSC at Fort Worth**
- **In Brief**
- **Texas FYI**
- **A Statistical Profile of the Osteopathic Medical Profession, July 2001**

## Important Information for Texas Physicians

### Profiles Mandatory on 9/1/01

Texas Physician Profiles, enacted by the Legislature in 1999, became mandatory September 1, 2001. Profile information has been collected on a voluntary basis this past year as a pilot project. Beginning with first quarter renewals mailed in early September for the 11/30/01 deadline, physicians will be required to provide all profile information as specified by the legislation and TSBME rule.

At least 12 other states have passed physician profile legislation with content similar to the Texas profile. Legislation passed by the Texas legislature this spring created profile requirements for other professions including attorneys, chiropractors, podiatrists, optometrists, physical therapists, occupational therapists, dentists, psychologists and pharmacists.

Approximately fifty percent of Texas physicians have already provided all of their profile data during the voluntary pilot period. Beginning in July, pilot participants from the first six months of the year will receive copies of their profiles to review. The first profiles will become available to the public in September as required by the legislation.

Much of the information in the profile is already available to the public through

license verifications. Profiles will provide additional information about education and training along with new information about patient services such as Medicaid acceptance, accessibility for persons with disabilities, hospital privileges and any language translation services offered. The legislation also requires that physicians provide a description of any criminal charges and discipline taken by another state licensing board. Profile reports must also include any disciplinary actions taken by TSBME and the results of any investigations the Board conducted as a result of malpractice claims.

The law requires that the Board collect and update the Profile data at the time of annual renewals of permits. Therefore, size of the permit renewal application has increased to four pages. Beginning with September renewals, the renewal form will also display any profile information voluntarily submitted by the physician in the pilot year as well as any Board restrictions or actions taken.

### A New Renewal Process

The implementation of profiles has meant changes to the renewal process. Physicians and others handling renewal applications should pay close attention to the application and instructions to avoid

delays in receiving permits. Following are some changes that should be noted:

- Data entry is being performed by an outsource vendor and the complete form, along with payment, must be sent to the new address provided. Sending renewals directly to TSBME via overnight carrier can actually delay the renewal process since the application must be re-routed to the vendor for processing.
- Do not separate the payment coupon from the rest of the form. Both parts must be mailed intact along with payment in the same envelope to avoid delays.
- Renewal forms will be "pre-populated" with some of your profile information. A majority of physicians provided at least some of the profile data during this year's pilot project. This information will be printed on your form. Other information already held by TSBME, such as disciplinary actions, will also be displayed so physicians can see what is being reported in their profile. You will need to complete all sections of the form that are not pre-populated as well as review the pre-populated data and make corrections as necessary to any information you previously submitted.

# Children's Health Issues



## Medicines for Children

A new survey by the Pharmaceutical Research and Manufacturers of America (PhRMA) found that 205 medicines are in the pipeline to meet the special needs of children, and that clinical trials on an additional 40 medicines will begin in the near future.

Medicines in development include:

- 32 for cancer, the leading disease killer of children

- 14 for mental illness. According to the National Mental Health Association, one in five children and adolescents may have a mental health problem, but some two-thirds aren't getting the help they need.

- 13 for cystic fibrosis, affecting 30,000 children and young adults in the U.S.

- 13 for asthma, the most common chronic disease of childhood.

- 7 for AIDS and related disorders.

In addition, pharmaceutical companies are working on medicines for children with hypertension, congestive heart failure, high cholesterol, diabetes, epilepsy, eye disorders, gastrointestinal disorders, sickle cell disease, Duchenne's muscular dystrophy, staph infections, ear infections, pneumonia, meningitis, hepatitis, cerebral palsy, Tourette's syndrome, autism, and other diseases.

(Excerpted from "PhRMA Survey finds 205 medicines in the Pipeline for Children." News release, 6-1-2001.)

*In 2000, there were 70.2 million children under age 18 in the United States, or about 26 percent of the population, down from a peak of 36 percent at the end of the baby boom in the mid-60's.*

*Children are projected to remain a stable percentage of the total population, comprising 24 percent of the population in 2020.*

## When Kids Go to the Hospital Major Causes of Hospitalization in Descending Order

### Ages 1-4

Diseases of the respiratory system  
Infectious and parasitic diseases  
Endocrine, nutritional, and metabolic diseases and immunity disorders  
Diseases of the digestive system  
Injury

### Ages 5-9

Diseases of the respiratory system  
Injury  
Diseases of the digestive system  
Infectious and parasitic diseases  
Endocrine, nutritional, and metabolic diseases and immunity disorders

### Ages 10-14

Mental disorders  
Diseases of the respiratory system  
Diseases of the digestive system  
Injury  
Endocrine, nutritional, and metabolic diseases and immunity disorders

### Ages 15-19

Pregnancy/childbirth  
Mental disorders  
Injury  
Diseases of the digestive system  
Diseases of the respiratory system

("Child Health USA 2000." Maternal and Child Health Bureau, Health Resources and Services Administration.)

## Study Suggests Children Could Benefit From Screening For Sleep Disturbances

Sleep disturbances may be more common among school-aged children than previously recognized, according to a study of children in kindergarten through fourth grades.

"Despite increasing evidence of the importance of sleep on children's health and functioning, many sleep disorders in middle childhood still go unrecognized by health care providers," said lead author Judith A. Owens, M.D., MPH, Assistant Professor at Brown University and affiliated with the Hasbro Children's Hospital in Providence.

Owens and colleagues found that 37 percent of 494 school-aged study participants suffered from at least one sleep-related problem. Such problems included bedtime resistance, sleep anxiety, difficulty in falling or remaining asleep, behaviors such as bedwetting or sleepwalking, breathing conditions including snoring or gasping during sleep, and daytime sleepiness.

Data was collected from the children, as well as from their parents and teachers. In general, Owens and colleagues found sleep-related problems – particularly bedtime struggles and night wakings – to be more prevalent among kindergartners through second graders than among third and fourth graders.

According to Dr. Owens, "Primary care providers are generally aware of sleep issues in infants and toddlers but often fail to adequately screen children past the pre-school years for sleep problems in the clinical setting. The results of this study emphasize the importance of screening school-aged children for sleep problems and the need for health care providers to understand the possible consequences of disordered sleep on children's daily lives."

*("School-Aged Children Need Screening for Sleep Disturbances," News release, 2-11-2000, Center for the Advancement of Health, <www.cfh.org>)*

## Children and Cancer

- Approximately 8,500 children were diagnosed with cancer in 1998, and 1,700 children died from the disease during this year. While this makes cancer the leading cause of death by disease among children under age 15, cancer is still relatively rare in this age group with, on average, one to two children developing the disease each year for every 10,000 children in the U.S.
- Among the 12 major types of childhood cancers, leukemias and brain and other central nervous system tumors account for over one-half of the new cases. The most common type of leukemia in children is acute lymphocytic leukemia. The most common solid tumors are brain tumors (e.g., gliomas and medulloblastomas), with other solid tumors (e.g., neuroblastoma, Wilms' tumor, rhabdomyosarcoma) being less common.
- The causes of childhood cancers are largely unknown. A few conditions, such as Down's syndrome, other specific chromosomal and genetic abnormalities, and therapeutic doses of radiation, explain a small percentage of cases. Environmental causes of childhood cancer have long been suspected by many scientists, but have been difficult to pin down,

partly because cancer in children is rare and partly because it is so difficult to estimate past exposure levels in children after they develop cancer.

*("Cancer Facts" fact sheet. National Cancer Institute, National Institutes of Health.)*

## Lead Poisoning in Children

- Lead poisoning is entirely preventable. However, nearly 1 million children living in the U.S. have lead levels in their blood that are high enough to cause irreversible damage to their health.<sup>1</sup>
- The CDC has determined that a level of 10 micrograms or more of lead in a deciliter of blood in children aged 5 years and younger can damage their ability to learn. At levels higher than 10 micrograms per deciliter, lead can cause damage to the kidneys and the reproductive system. At even higher levels, lead can cause convulsions, coma, or death. Unborn children can also be harmed by lead.<sup>2</sup>
- Lead poisoning affects virtually every system in the body, and often occurs with no distinctive symptoms.<sup>1</sup>
- Even low levels of lead are harmful and are associated with decreased intelligence, impaired neurobehavioral development, decreased stature and growth, and impaired hearing acuity.<sup>1</sup>
- According to recent CDC estimates, 890,000 U.S. children age 1-5 have elevated blood lead levels, and more than one-fifth of African-American children living in housing built before 1946 have elevated blood lead levels. These figures reflect the major sources of lead exposure: deteriorated paint in older housing, and dust and soil that are contaminated with lead from old paint and from past emissions of leaded gasoline.<sup>3</sup>
- One of the most important risk factors for lead exposure is the age of housing. Over 80 percent of all homes built before 1978 in the U.S. have lead-based paint in them. The older the house, the more likely it is to contain lead-based paint and a higher concentration of lead in the paint.<sup>3</sup>

<sup>1</sup> Lead Poisoning fact sheet. National Center for Environmental Health, CDC;

<sup>2</sup> "National Report on Human Exposure to Environmental Chemicals." NCEH, CDC; <sup>3</sup> "Lead Poisoning in Children." NCEH, CDC.

## Cigarette, Alcohol and Drug Use

- Cigarette use among adolescents shows indications of decline. Between 1999 and 2000, the rate of daily smoking in the past 30 days decreased from 23 percent to 21 percent among high school seniors and from 16 percent to 14 percent among 10th-graders. Seven percent of 8th-graders reported daily smoking in 2000. These rates for 2000 are significantly below recent peak levels of daily smoking, which occurred in 1997 for 12th-graders (25 percent) and in 1996 for 10th-graders (18 percent) and 8th-graders (10 percent).
- In 2000, rates of heavy drinking remained largely unchanged from 1999, with 30 percent of 12th-graders, 26 percent of 10th-graders, and 14 percent of 8th-graders reporting heavy



drinking, i.e., having at least five drinks in a row at least once in the previous 2 weeks.

- In 2000, 12 percent of 8th-graders, 23 percent of 10th-graders, and 25 percent of 12th-graders reported illicit drug use in the past 30 days, not significantly different from the rates in 1999. Historically, illicit drug use in the past 30 days increased between 1992 and 1996 or 1997. For 12th-graders, it increased from 14 percent in 1992 to 26 percent in 1997. Between 1992 and 1996, rates of use increased from 11 to 23 percent among 10th-graders and from 7 to 15 percent among 8th-graders. Since these recent peaks, illicit drug use has remained stable or declined.

*("America's Children: Key National Indicators of Well-Being, 2001." Federal Interagency Forum on Child and Family Statistics.)*

## Reducing Antibiotic Use

Medical experts have identified antibiotic resistance as an emerging threat to the public health. But a program that simultaneously educates parents and health care providers about appropriate antibiotic use in children can result in a significant reduction in their use, according to a study published in the July issue of "Pediatrics."

Researchers tested an educational outreach program for families and physicians, in children under 6 years old, based on the Centers for Disease Control and Prevention principles of judicious antibiotic use. Twelve pediatric practices caring for approximately 10,000 children took part in the study. For half of the practices, the physicians received a program of two 90-minute antibiotic overuse education sessions. Families in those practices received educational mailings highlighting the growing problem of antibiotic resistance and reinforcing the message that antibiotics do not treat viral illnesses. That information was also provided to families by waiting room materials and by the pediatricians themselves. The practices involved in the program saw a 16 percent decrease in antibiotic use in children ages 3 months to 3 years, and a 12 percent decrease in children ages 3 to 6 years. "Continued focus on patient education and physician behavior change may be the best long-term solution to the problem of antibiotic overuse," the study concluded.

*("Education Program Reduces Antibiotic Use in Children." American Academy of Pediatrics press release. July 2, 2001.)*

## Health Care Products for Children Approved in 2000

Several new products approved last year for pediatric and obstetric use were either specifically designed for the youngest patients or were adult drugs with pediatric indications. The FDA also approved pediatric use for 13 adult medications that were already on the market.

Approved:

- OxiFirst Fetal Oxygen Saturation Monitoring System – represents the first major technological development in fetal monitoring in three decades. The system, which builds on pulse oximetry technology, measures oxygen saturation in



the baby's blood as a sign of fetal health during labor and delivery.

- Prevnar – the first multivalent conjugate pneumococcal vaccine for infants and toddlers under the age of two.
- Pulmicort Respules (budesonide inhalation suspension) – for one- to eight-year old children with asthma. The product is the first anti-inflammatory corticosteroid formulated for inhalation using a nebulizer in this age group. It is considered an important feature because toddlers frequently cannot use metered-dose inhalers.
- Relenza – for the treatment of uncomplicated influenza A and B in patients 7 years and older. Tamiflu oral suspension was approved for prophylaxis of influenza virus in adults and adolescents aged 13 years and older.

Drugs approved with both adult and pediatric indications:

- Kaletra – a protease inhibitor for the treatment of HIV.
- Unithroid – a thyroid replacement drug.
- Protopic – an ointment for patients with moderate or severe eczema.

In addition, FDA added pediatric use to the labeling of 13 adult drugs including ibuprofens Motrin and Advil; Zantac for stomach acid reflux; and Nasalcrom for asthma and hay fever. The agency also approved lowering the age for the Nucleus 24 Cochlear Implant from 18-month-old to 12-month-old infants who are profoundly hearing impaired.

*("FDA's Report on New Health Care Products Approved in 2000." FDA Talk Paper, 1-18-2001.)*

# The Texas Poison Center Network

by William A. Watson, PharmD, DABAT, FAAC, FCCP  
Professor, Department of Surgery, Division Chief, South Texas Poison Center  
University of Texas Health Science Center at San Antonio

Almost 500 times daily, one of the 6 poison control centers in Texas receives a telephone call asking for help or information about a possible poisoning event. These poisonings involve thousands of different substances including household cleaners and products, medications, plants, bites and stings, and almost anything else that we come in contact with. One of the most common calls is about the young child who has spilled or possibly ingested some household bleach. While most telephone calls to the Texas Poison Center Network come from the parents of small children, calls are also received from physicians, nurses, pharmacists, paramedics, employers, child-care providers, the media, law enforcement, and anyone concerned about whether an exposure to something could result in toxicity. This article will provide background about poison control centers and the services and information they provide.

Since 1953 regional poison control centers have been established across the United States to provide state-of-the-art recommendations and case management for toxicity. The American Academy of Pediatrics established the first poison control center based on the need for centralized information resources and expertise in the assessment and management of cases of toxicity. This need is even greater today with the growing number of substances that can produce human toxicity, the increased public awareness of toxicity, and the limited education about toxicity and its management that is in most health care curriculums. As the role of poison control centers in health care grew, the American Association of Poison Control Centers established guidelines for poison control centers, developed certification criteria for regional poison control centers, and created certification examinations for poison information specialists.

*"Help! My 2-year old just tried to drink out of a bottle of bleach.*

*What should I do?"*

In Texas, access to poison information was legislated by Senate Bill 773 in 1993. Six regional poison control centers across the state (Amarillo, Dallas, El Paso, Galveston, San Antonio, Temple) were mandated to provide emergency treatment information as well as public and professional education about poisoning prevention and the treatment of poisonings and toxic exposures. The mission of the Texas Poison Center Network consists of 4 components: 1) to reduce the incidence, morbidity, mortality, and costs of poisonings to the citizens of Texas, 2) to provide toxicology information to health care professionals and to aid in the management of poisoned patients, 3) to provide educational services to health professionals and the citizens of Texas, and 4) to support research in toxicology. The poison control centers are based in hospitals or university health science centers across the state, and are aware of regional and statewide toxicological concerns. Poison control center services are available without charge to the caller 24 hours a day. The funding for poison centers currently is generated by a 0.3% surcharge on intrastate long distance telephone calls.

Approximately 75% of poisoning calls come from parents and other individuals who are taking care of a small child (40% of exposures involve 1 or 2 year old children). Approximately 80% of these cases can be safely and effectively managed by the poison specialist and the parent without taking the child to an emergency department or clinic. By managing cases at home

when it is safe to do so, poison centers prevent between \$6.00 and \$9.00 in unnecessary health care costs for every dollar invested in a poison center, and significantly decrease the unnecessary use of scarce health care resources.

By dialing 1-800-764-7661 Texans are connected to the closest regional poison control center as quickly as possible. A state-of-the-art telephone system will direct the telephone call to the first available poison information specialist. Poison information specialists are extensively trained nurses and pharmacists who focus only on the information and management of poisoning cases. The directors and medical directors of the poison control centers are board-certified in clinical or medical toxicology, and poison control centers also have access to a wide range of consultants with specialized expertise. Information about toxicity caused by drugs and medications, plants, household products, or bites and stings is readily available by calling poison centers in Texas.

The Texas Poison Center Network is also a source of information about the possible toxicity of substances when a poisoning hasn't happened, and information and education about how to prevent poisonings. The Texas Poison Center Network receives more than 300 calls daily with requests for information about the possible toxicity of something even though a poisoning hasn't happened, as well as requests for materials or presentations.

When the poison information specialist receives a call such as the bleach case that started this article, they will ask questions to determine how the child is doing, the specific product and likely amount involved, and circumstances surrounding the event and the center's extensive information resources, the poison information specialist can determine that the exposure is not dangerous. Most bleach ingestions can be



managed at home with dilution and result in no more than mild irritation. Bleach can produce more toxicity with ocular exposures, when the fumes from the mixture of bleach and other cleaning solutions are inhaled, and when the mouth or skin are not quickly rinsed off. When the possibility of significant toxicity is present, the poison center directs the caller to go to the closest emergency department.

All health care professionals can provide an important service to their patients by insuring that they know how to contact the Texas Poison Center Network. The information and experience of the poison center specialists, directors and medical directors can significantly improve the outcome associated with poisonings and decrease health care costs.

Texas Poison Center Network  
800-764-7661 (800-POISON1)

Available 24 hours a day

No cost to caller

Calls are confidential

Spanish and other languages provided

Information will be provided

without caller identification

## Developmental Disabilities

**FACT:** About 17 percent of U.S. children under 18 years of age have a developmental disability.

Developmental disabilities are a diverse group of physical, cognitive, psychological, sensory, and speech impairments that begin anytime during development up to 18 years of age. In most instances, the cause of the disability is not known.

Approximately 2 percent of school-aged children in the U.S. have a serious developmental disability, such as mental retardation or cerebral palsy.

*(National Center on Birth Defects and Developmental Disabilities)*

# ADHD Doesn't Have to Mean Another Doctor Handing out Drugs

by Mary Ann Block, D.O.

In a quick fix, HMO dominated environment, handing out a prescription may seem like the best and most cost-effective way to practice medicine. If your approach to ADHD puts you in a position to be Another Doctor Handing out Drugs, you may be interested in other options. Here are statistics, facts and reports to support you and give you tools for a safer and more successful approach.

## NIH ADHD Consensus Statement

Reading the report from The National Institutes of Health Conference on ADHD in 1998 certainly made me question the appropriateness of the ADHD diagnosis and drug treatment. Experts reported the following:

1. ADHD is a psychiatric diagnosis which has no valid, objective test to support its use.
2. There is no data indicating that ADHD is a brain dysfunction.
3. Drugs do not normalize all behaviors.
4. Children taking drugs still have more behavior problems.
5. Children taking the drugs actually show little improvement in academic and social skills.
6. There is no information available on inattentive type or on the treatment of adolescents and adults.
7. Studies on the drugs were for no more than 3 months yet children are often prescribed the drugs for decades.

## DEA Report on Ritalin

The NIH report only added fuel to the fire already started by the Drug Enforcement Agency when it issued its report on Ritalin in 1995. This is what the DEA had to say:

1. Ritalin is structurally and pharmacologically similar to amphetamines and cocaine.
2. Ritalin has the same dependency profile as cocaine and other stimulants.
3. Ritalin produces cocaine-like reinforcing effects including euphoria and drug liking.
4. Treatment with Ritalin in childhood predisposes takers to cocaine's reinforcing effects.
5. Ritalin substitutes for cocaine in scientific studies.
6. Children medicated with Ritalin reported higher levels of drug dependence.
7. Ritalin abuse is neither benign or rare in occurrence and produces severe dependency.
8. More high school students are abusing Ritalin than those taking it medically.
9. Ritalin is one of the top ten drugs involved in drug thefts and is being abused by health professionals as well as street addicts.

## Serious Adverse Effects Accompany Prescriptions

According to the manufacturers of the drugs commonly used to treat ADHD symptoms, the following nervous system and cardiac adverse effects can occur:

**Ritalin:** Psychotic episodes, depression, chronic abuse can lead to psychic dependency with abnormal behavior, frank psychotic episodes, blood pressure and pulse changes, tachycardia, cardiac arrhythmia, angina.

**Adderal and Dexadrine:** psychotic episodes, can exacerbate behavior disturbances and thought disorders, high potential for abuse, can lead to drug dependency, palpitations, tachycardia, hypertension, cardiomyopathy with chronic use.

**Clonidine:** delirium, mental depression, visual and auditory hallucinations, anxiety, irritability, behavioral changes, adult high blood pressure drug which can cause congestive heart failure, stroke, EKG abnormalities, arrhythmias, chest pain, tachycardia and palpitations

**Prozac and SSRI's:** mania, suicide, agitation, emotional lability, apathy, anxiety, hallucinations, hostility, paranoid reactions, psychosis, personality disorder, hostility, delusions, impaired judgment, confusion, hemorrhage, hypertension, angina, arrhythmias, congestive heart failure, MI, tachycardia, heart block

No wonder school violence and violence in society in general has escalated. Consider that many of the individuals involved in school shootings and other violent acts were taking psychiatric drugs:

- Eric Harris, Littleton, CO, was taking the drug, Luvox, when he killed 12 students and a teacher at Columbine High School.
- Shawn Cooper, Notus, ID, was taking Ritalin when he injured one student and held his school hostage at gunpoint.
- T. J. Soloman, Conyers, GA, wounded six of his classmates while on Ritalin.
- Kip Kinkel, Springfield, OR, was reportedly on Ritalin and Prozac when he murdered his parents and killed two students and injured 22 others.
- Ryan Ehls, Bismark, ND, while on Adderall, went into a psychotic fog and killed his infant daughter. The pharmaceutical company and psychiatrists testified that psychosis is a rare side effect of Adderall.
- Luke Woodham, Pearl, MS, was reported to be taking Prozac when he killed his mother and shot nine at his school, killing two.
- Michael Carneal, KY, killed three and wounded five at his school. Reports say he was on Ritalin.
- Both Andrew Golden and Mitchell Johnson, Jonesboro, AR, were believed to be on Ritalin when they shot 15, killing five.

There have been many other reported connections between psychiatric drugs

## *"Just because a teacher is having difficulty with a student does not mean that child is ADHD..."*

and violence. Now I would include on this list Andrea Yates of Houston, who drowned her five children while taking Effexor and Remeron. We should not ignore the idea that prescribing these drugs does not always have a positive effect and can make the symptoms worse.

Other considerations are the possible cardiac side effects that can occur. When 14-year-old Matthew Smith of Pontiac, Michigan, died of a heart attack the medical examiner said his heart attack was a result of taking Ritalin for 10 years. Though it may not be a common occurrence, I doubt that is any consolation to Matthew's parents.

### **Schools May Be Failing Their Students**

We need to consider whether or not the teachers are actually doing their job before they pressure parents to have you, the physician, prescribe these potentially dangerous drugs to your patients. According to a report from outside consultants, the schools may be one of the problems. This is what these consultants had to say about Special Education within the Fort Worth, Texas Independent School District. Keep in mind that ADHD falls within the scope of Special Education.

1. Schools are spending more time and energy labeling children than helping them.
2. Teachers refer children to Special Ed just to get them out of the classroom.
3. Most tests that are administered are not necessary or legally required.
4. 70% should not have been labeled Special Ed and did not get the help they needed.
5. 40% were referred to Special Ed for behavior problems and little effort was made to deal with them.
6. There was a low tolerance for wiggling.

I see families from all over the United States in my medical center, and from the stories they tell me, the Fort Worth ISD is no different from other schools throughout

the country. Just because a teacher is having difficulty with a student does not mean that child is ADHD and just because a child is quieter in the classroom, does not mean that the child is learning.

There can be incentives for schools to have children labeled as ADHD. The statistics concerning the rise in Ritalin use supports this. Consumption of Ritalin spiked in 1992 along with the application of the ADHD label on children. This huge increase in Ritalin prescriptions coincides with ADHD qualifying as a disability and the beginning of the label falling under the Americans with Disabilities Act (ADA). Since then, each time a child is given the ADHD label, the schools qualify for extra funding.

### **Non-Drug Answers**

If, after reading these facts, you decide to change your approach to attention and behavior problems, here is some information to help.

#### **Remove Sugar from the Diet**

Sugar does affect behavior and removing it from the diet can help attention and behavior. According to studies, sucrose can cause a ten-fold increase in adrenaline levels in normal children resulting in difficulty concentrating, irritability and anxiety. (*Journal of Pediatrics*, 1995) Sugar may cause an increase in inappropriate behavior and decrement in school performance. (*Journal of Abnormal Child Psychology*, 1986). In addition to recommending the avoidance of sugar, I will even write a prescription for children to have a protein snack mid-morning and mid-afternoon to help keep their blood glucose levels stable.

#### **Allergies Affect Learning**

Allergies affect how children feel, think and act. According to *Annals of Allergy*, 1993, poor performance in school may be one of the most serious consequences of allergies. The article goes on to say that children with allergies are described as apathetic, absent-minded

and disinterested and the allergic child was significantly less knowledgeable and performed more poorly than controls. The article ended with the statement that the coincidence of the allergy season with end of year exams discriminates against allergic children and that their exams should be postponed unless the allergies can be successfully treated.

Evaluating and treating children for food and inhalant allergies can be very helpful in controlling attention and behavior problems. In my office, I do allergy skin testing one allergen at a time. This way the parent can observe, not only the skin reaction, but also any changes in attention or behavior.

### Necessary Nutrients

Nutritional deficiencies have an important role in correcting attention and behavior problems. In a double blind, cross-over study, Vitamin B6 was found to be more effective than Ritalin in hyperactive children. (*Biological Psychiatry*, 1979) Magnesium deficiency in children is characterized by psychomotor instability, excessive fidgeting and learning difficulties. (*Magnesium in Health and Disease*, 1980) Zinc deficiencies result in hyperactivity and zinc deficient children are irritable and sullen. (*Biological Psychiatry*, 1996) Lower levels of Omega 3 Fatty Acids were found in children who had temper tantrums and sleep problems (*American Journal of Clinical Nutrition*, 1995) and in children with learning problems (*Clinical Pediatrics*, 1987).

### OMT Can Help

Osteopathic Manipulation (OMT) also appears to be helpful. Dr. Viola Frymann has studied the effects of OMT on the neurological development of children. (*Journal of the AOA*, 1992). In addition, after I developed an OMT treatment for parents to do at home for ear and respiratory infections, the parents reported improved cognitive function in their children after utilizing this treatment. Draining the fluids from the ears and sinuses seemed to make the children more "clear-headed".

### Learning Options

Understanding learning differences is another important step in helping children with behavior and attention problems.

Sometimes the child has a different learning style than the one the teacher is using in the classroom. I remember a time I was sitting in on a colleague's lecture while teaching at the medical school. I was listening acutely as he showed slides along with the delivery of his lecture. At one point, the speaker turned off the slide projector and continued to lecture. Twenty minutes later I realized I had not heard a single word the man had said. As a visual learner, I was able to listen easily while the slides were shown. Without the visual cue, my listening skills were not enough to keep my attention. This same problem often occurs with children who have not adequately developed their listening skills. The good news is there are excellent programs available to help these children develop the skills they need to be good listeners. Sensory Integration programs provided by occupational or physical therapists, Tomatis Listening Centers, Fast Forward, Lindamood-Bell and even developmental optometrists can help improve a child's visual and auditory processing. I often recommend the children listen to Mozart music with headphones on while studying and doing homework. Parents have reported that homework time is often cut in half with the child getting the work done faster and better.

With this information in hand, hopefully many of you will decide that ADHD no longer means Attention Deficit Hyperactivity Disorder. Armed with an effective non-drug approach to treating attention and behavior problems, you can now refer to a young patient as **Another Dynamic, Huggable, Delightful child.**

*Mary Ann Block, D.O., is Medical Director of The Block Center in Hurst, Texas, an international center for the treatment of chronic health problems in adults and children. She is author of the newly released books, No More ADHD, Ten Steps to Help Improve Your Child's Attention and Behavior Without Drugs and Today I Will Not Die, the story of her mother's recovery from metastatic, "terminal" lung cancer. She is also author of the top selling books, No More Ritalin and No More Antibiotics. She is currently a member of The Foundation of Women Legislatures' sub-committee on Special Education and has served as a peer reviewer for the Agency for Health-care Policy and Research and the American Academy of Pediatrics. She is a Texas State Family Practice Preceptor and has served on the faculty of UNTHSCOM. More information is available at Dr. Block's web site <www.blockcenter.com>.*

## Top 10 Drugs Prescribed to Kids Without Pediatric Labeling

These drugs were prescribed more than 5 million times in a single year to children in age groups for which the drugs were not adequately labeled.

**Albuterol** inhalation solution for nebulization – condition: asthma – prescribed 1,626,000 times to children under 12

**Phenergan** – condition: allergic reactions – prescribed 663,000 times to children under 2

**Ampicillin injections** – condition: infection – prescribed 639,000 times to children under 12

**Auralgan** otic solution – condition: ear pain – prescribed 600,000 times to children under 16

**Lotrisone** cream – condition: topical infections – prescribed 325,000 times to children under 12

**Prozac** – condition: depression, obsessive-compulsive disorder – prescribed 349,000 times to children under 16, including 3,000 times to infants under 1

**Intal** – condition: asthma – solution prescribed 109,000 times to children under 2; aerosol prescribed 399,000 times to children under 5

**Zoloft** – condition: depression – prescribed 248,000 times to children under 16

**Ritalin** – condition: Attention deficit disorder, narcolepsy – prescribed 226,000 times to children under 6

**Alupent** syrup – condition: asthma – prescribed 184,000 times to children under 6

("Pediatric Drug Studies: Protecting Pimp-Sized Patients." FDA Consumer magazine, May-June 1999.)



# KAWASAKI DISEASE

by Fernando Gonzalez, D.O.

**Over 80 percent of all cases are under five years of age; with the majority of these being under age two.**

Kawasaki Disease (KD) results from a generalized vasculitis of medium sized arteries and demonstrates a predilection for the coronary arteries. It has become the leading cause of acquired heart disease in children and affects between 2,000 and 3,000 children in this country each year. Males are affected more frequently in a ratio of 1.5:1. Over 80 percent of all cases are under five years of age; the majority of these being under age two. The highest incidence occurs between age 6 months and one year. KD occurs rarely after the age of eight years. The disease was first described in Japan in 1967 and has been reported worldwide. While it is seen mostly in Asians of Japanese ancestry, all races can be affected. It has been recognized that this is not a new disease and most, if not all, cases of infantile polyarteritis nodosa may indeed be manifestations of Kawasaki disease.

Specific clinical criteria must be met in order to establish the diagnosis. In classic Kawasaki disease, fever of five days duration with at least four of five principal clinical features must be present. The fever can reach as high as 40°C and without treatment can persist for over two weeks. Children with prolonged fever have an increased incidence of coronary aneurysms. The five principal features of Kawasaki disease are:

1. Extremity changes – Painful, indurated erythema of the palms and soles is distinctive. Peeling of the fingers and toes follows by 1-3 weeks. Beau's lines of the nails may also appear.
2. Polymorphous rash – 90 percent will develop a generalized rash within 5 days of onset. It tends to be most prominent in the perineal area.
3. Bilateral conjunctivitis – The conjunctivitis, which occurs in 90 percent of affected patients, is non-exudative, primarily affecting the bulbar conjunctiva and may be associated with anterior uveitis.
4. Changes of the oropharynx – The lips are cherry red, dry and may crack and bleed. A strawberry tongue is present and the mouth and throat are intensely erythematous.
5. Cervical adenopathy- At least one node greater than 1.5 cm in diameter. The node is firm, non-fluctuant, tender and usually unilateral. This feature is the least common of the five.

Other physical signs and symptoms may include extreme irritability, vomiting, diarrhea and abdominal pain, hydrops of the gallbladder with or without icterus, urethritis with sterile pyuria, tympanitis, cranial nerve palsies, aseptic meningitis, arthritis of small joints in the acute phase and weight bearing joints during the subacute phase. In the subacute phase, the fever, rash and adenopathy resolve but conjunctivitis may persist. This phase lasts from 3-4 weeks and coincides with desquamation and the appearance of arthralgias and arthritis. It is during this period that cardiovascular complications most commonly appear. The convalescent phase begins when clinical signs resolve and acute phase reactants return to normal.

Patients with fever and less than four of the characteristic features can be diagnosed if coronary aneurysms are detected. Many identify this as atypical Kawasaki disease. Experienced practitioners can establish the diagnosis in the presence of classic features before the fifth day of fever. The differential diagnosis should include scarlet fever, drug eruptions, Stevens-Johnson syndrome, measles and other viral or rickettsial exanthems, staphylococcal scalded skin syndrome and toxic shock, juvenile rheumatoid arthritis, leptospirosis and acrodermatitis.

A leukocytosis with a left shift is typically present in the acute phase. Anemia is an inconsistent finding but marked thrombocytosis is characteristic in the subacute phase. Liver enzymes may be elevated as are acute phase reactants.

Cardiovascular manifestations are prominent and cause long term complications and mortality. Pericardial effusions occur in 30 percent but usually resolve spontaneously. Myocarditis can lead to congestive heart failure and EKG abnormalities in the acute phase. Later onset of congestive heart failure indicates myocardial ischemia or infarction. Coronary aneurysms develop in up to 25 percent of patients, usually within 10 days to 4 weeks of onset. High risk factors include prolonged inflammation (fever after 10 days), male gender, onset before one year of age, any sign or symptom of heart disease, recurrence of fever after being afebrile for over 24 hours or persistence of fever after treatment. All patients in whom KD is suspected or diagnosed should be evaluated by echocardiography in order to establish the presence or absence of coronary artery disease. Children with giant aneurysms (> 8mm) are most susceptible to serious complications such as coronary thrombosis, stenosis or myocardial infarction, the principal cause of death in KD. Valvular insufficiencies, especially of the mitral valve, may also be seen.

While the etiology of Kawasaki disease is unknown, there is a growing body of evidence implicating immune activation in its pathogenesis. During the acute phase of the disease, an inflammatory reaction results in the infiltration of the vascular endothelium by activated CD4 and CD8 T-cells. Serum levels of tissue necrosis factor (TNF), various interleukins (IL), macrophage colony stimulating factor and soluble E-factor are elevated. Cytotoxic antibodies directed against vascular endothelium prestimulated by TNF, IL or interferon also appear in the acute phase. Elevated levels of anticardiac myosin autoantibodies may be involved in producing myocardial damage. The clinical features and immune cell activation significantly overlap those of diseases such as staphylococcal toxic shock syndrome in which bacterial toxins act as superantigens. These superantigens can stimulate T-cell proliferation and hence proinflammatory cytokine production. Studies have demonstrated specific T-cell expansion and the presence of superantigen producing bacteria during the acute phase of KD. Staphylococcal or streptococcal toxins may trigger this immune reaction, with toxic shock syndrome toxin (TSST) being the most likely inciting agent. Several cases of non-menstrual toxic shock have now been

reported showing coronary artery abnormalities similar to those seen in KD. These diseases may actually represent overlapping clinical entities differing only in age and various genetic and environmental factors.

In the acute phase, treatment is directed at reducing inflammation. As soon as the diagnosis is made, aspirin in high doses (80-100 mg/kg/day in 4 divided doses for 10 days) is started with IVIG (2 gm/kg as a single 10-12 hour infusion). Together, both reduce cytokine production and T-cell activation, reducing the risk of developing coronary artery aneurysms. Studies show that less than 3 percent of patients with a normal baseline echocardiogram will develop aneurysms if treatment is begun within 10 days of onset of fever. The dose of aspirin is reduced after 10 days of treatment to 3-5 mg/kg once daily for 6-8 weeks. If no coronary abnormalities develop during this time, the aspirin may be discontinued. Aspirin must be continued indefinitely if coronary artery disease is identified.

In up to 15 percent of cases, fever persists or recurs after therapy. These children are prone to developing coronary artery disease and should receive a second dose of IVIG. Live virus vaccines should be delayed for 5 months after IVIG. All patients should receive the influenza and varicella vaccines given the association of Reye's syndrome with aspirin therapy. Dipyridamole may be substituted for aspirin if exposure to varicella or the flu occurs. The use of steroids is currently not recommended. Steroids may be useful in patients who fail to respond to IVIG but further trials are needed. Superantigen stimulated T-cell activation is resistant to steroid induced immuno-suppression. In contrast, IVIG contains high concentrations of antibodies which neutralize the T-cell response to superantigens. This perhaps explains the efficacy of IVIG. Many patients with aneurysms show spontaneous regression within 6 months to two years. Giant aneurysms are unlikely to resolve and nearly all late deaths occur in this group.

Patients with cardio-vascular disease must be monitored closely on a regular basis by a pediatric cardiologist. Physical activity recommendations must be made on an individual basis after stress testing. Regular monitoring must be initiated and may include x-ray, EKG, echocardiography and, in selective patients, angiography. Anticoagulant therapy may become necessary and other options may include anti-thrombotics, balloon angioplasty, coronary bypass surgery or even cardiac transplantation in the most severe cases.

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# The Vaccination Debate

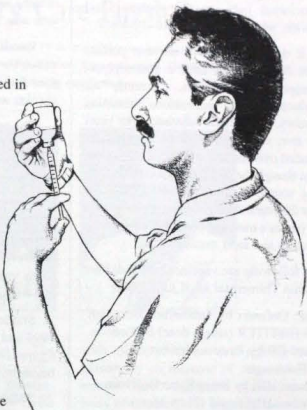
by Mary Ann Block, D.O.

During the past Texas legislative session there was much debate concerning a parent's right to choose to vaccinate their child. All states have some laws allowing vaccination exemptions but states vary as to what is considered an allowable exemption. Medical exemption is the most common and consistent from state to state. Texas currently allows a medical or religious exemption but not a philosophical one. A philosophical exemption is allowed in 17 states. While the debate in Texas was hot and heavy, the choice of philosophical exemption did not pass.

As physicians, we have been taught the importance of every child being vaccinated. However, there has also been a controversy concerning vaccines and Autism. While parents continue to report that their Autistic children were perfectly normal prior to a specific vaccine, the Centers for Disease Control and Prevention and American Academy of Pediatrics contends there is no connection. *Who is right?*

Consider these facts. The increase of children being diagnosed as Autistic has reached epidemic proportions. According to U.S. Congressman Dan Burton's address to the Government Reform Committee, the state of Florida reported a 571% increase in Autism from the years 1993-1998, and Maryland has reported a 513% increase in this same time period. The average across the United States is now that 1 in every 150 children will be labeled as Autistic. The increase of the diagnosis correlates well with the increase in the number of required vaccinations. Mercury, in the form of Thimerosal, has been used in most vaccines, so the total exposure to mercury from vaccines has increased as the number of required vaccinations has increased.

- 1930 Thimerosal was first used in vaccinations
- 1943 Autism first described by Kanner
- Pre 1970 Incidence of Autism was 1 in 2,000
- 1970 Autism incidence was 1 in 1,000
- 1991 Introduction of Hepatitis B and HIB vaccines containing Thimerosal
- 1996 Autism incidence was 1 in 500
- 2000 Autism incidence was 1 in 150



Neal Halsey, M.D., of the Institute for Vaccine Safety at Johns Hopkins, reported in the Journal of the American Medical Association in 1999, that the Environmental Protection Agency (EPA) considers mercury a neuro-toxin which is capable of crossing the placenta and blood brain barrier. It can concentrate in the blood and brain and can affect the immune system, kidneys and lungs. The FDA states that "mercury is toxic when present at relatively low levels" and does not consider any level of mercury-containing compound to be "generally recognized as safe". Thimerosal has been eliminated from paints and many other over-the-counter products because of its toxic side effects.

Mercury toxicity and Autism Spectrum Disorders share at least 20 biochemical traits and over 30 behavioral traits. Although the U.S. Public Health Service and The American Academy of Pediatrics supported the FDA's directive to eliminate mercury from vaccines in July, 1999, the manufacturers are still making vaccines

with Thimerosal and have, in fact, ignored the recommendation by producing a new DtaP vaccine containing Thimerosal, which the FDA approved.

The total amount of mercury a young child would typically receive through recommended vaccinations in the first 15 to 18 months of life is:

- 62.5 mcg at 2 months
- 50 mcg at 4 months
- 62.5 mcg at 6 months
- 50 mcg at 15-18 months
- 225 mcg total mercury by 18 months

The EPA's safe limit for mercury exposure is 0.1 mcg/kg/day. For a 26 pound, 18 month old, the safe limit would be 1.2 mcg. Using the EPA's criteria, no vaccine containing Thimerosal meets the EPA's guidelines as a safe dose. By 1990, children were receiving 33 doses of 10 different viral and bacterial vaccines by the age of five, thereby dramatically increasing their mercury exposure.

*continued on next page*

Many vaccinations are available without mercury. Since that is the case, it makes me wonder why any of the vaccines contain it at all. As physicians, you can order Thimerosal-free vaccines for your patients. Even if there were no association between the vaccines and Autism, why give mercury to children?

It does not surprise me that parents want the option to have a philosophical exemption to vaccines. Currently we produce pediatric vaccinations containing mercury, a very toxic substance. For years the live, oral polio vaccine was recommended over the killed, injectable vaccine, even though the live polio vaccine was the only source of polio in this country for over 20 years. As physicians we must earn the parent's trust and confidence by giving vaccines in a safer manner.

The following are vaccines which did not contain Thimerosal as of June, 2000:

DtaP: Onfanrix by SmithKline Beecham  
Hib:HibTITER (single dose) by Lederle  
Actl IIB by Pasteur Merieux  
Connaught  
Omni Hib by SmithKline Beecham  
PedvaxHIB liquid (2) by Merck  
Hib-Hep B: COMVAX (4) by Merck  
Hep B: Recombivax-HB by Merck  
Hepatitis A: Havrix by SmithKline Beecham  
IPB: IPOL by Pasteur Merieux  
Connaught  
MMR: MMR-II by Merck  
Varicella: Varivax by Merck

(Adapted from the American Academy of Pediatrics and the Institute for Vaccine Safety at Johns Hopkins University)

The National Vaccine Information Center, a national non-profit organization dedicated to preventing vaccine injuries and deaths through public education, has outlined ways to more safely administer vaccinations. For more information, go to <www.909shot.com> or call 703-938-0342.

Mary Ann Block, D.O., is Medical Director of The Block Center in Hurst Texas. Please refer to her bio on page 14.

## Texas Immunization Rates for Young Children Close to 70 Percent in New CDC Survey

A federal survey released August 3 by the U.S. Centers for Disease Control and Prevention (CDC) shows that 69.5 percent of Texas children ages 19 months through 35 months were fully immunized against seven diseases in 2000. The state rate the previous year was 74.7 percent.

Results of the National Immunization Survey (NIS) for 2000 put Texas 50th in the nation for children in this age group to have the 4:3:1 vaccine series. This series includes four doses of diphtheria-tetanus-acellular pertussis (DTaP) vaccine, three doses of polio vaccine and one dose of measles-mumps-rubella (MMR) vaccine.

The telephone survey, covering about 30,000 children, was conducted from January through December 2000 in all 50 states and in 28 specific metropolitan areas. The national immunization rate for 2000 for the 4:3:1 series was 77.6 percent, down from 79.9 percent the previous year.

"We are, of course, concerned that about a third of Texas' young children are not fully protected from vaccine-preventable diseases," said Dr. Sharilyn Stanley, associate commissioner for disease control and prevention at the Texas Department of Health (TDH). "However, this does not mean that 30 percent of Texas children are totally unprotected. Many youngsters have received most of their shots, and we know from previous surveys that a major cause of lower rates is simply that the fourth dose of DTaP is missed."

Stanley said the 2000 NIS covers children born between February 1997 and May 1999 and reflects intervention methods in place two to three years before the survey. The figures include a margin of error for Texas of plus or minus 3.8 percent. The survey began in 1994.

"With the exception of 1995 when Texas reached the U.S. level of 76 percent, this state has ranked below the national average each year," Stanley said.

With that fact in mind, TDH developed a comprehensive state action plan in May 2000 to focus on activities to improve childhood immunization levels. The plan includes enhancing community involvement, improving provider awareness and participation, increasing parent awareness and participation, improving data systems including the statewide immunization registry and providing coordination among programs that deal with children's health issues.

"The 2000 NIS data reflect immunization practices and activities that took place from 1997 to 1999," Stanley said, "long before this plan was put in place. We probably will not see the impact of this state plan on coverage rates until the 2002 NIS, at the earliest."

Four Texas communities are among the 28 metropolitan areas surveyed nationally. Their immunization rates are: El Paso, 71.5 percent, down from 75 percent in 1999; Dallas County, 68.9 percent, down from 76 percent; Bexar County, 68 percent, down from 70.2 percent; and Houston at 65.4 percent, down from 66.5 percent.

"A high immunization level is important in preventing serious and sometimes deadly childhood illnesses," Stanley said. "In general, Texas has not had increased numbers of vaccine-preventable diseases recently. Texas rates for measles, mumps, rubella and pertussis are similar to those for California, New York and Florida."

In 1999, Texas listed seven cases of measles, six of tetanus, nine of rubella and 35 cases of mumps. No cases of diphtheria have been reported in the state since 1982, and the last case of polio occurred in 1977.

"TDH places a high priority on childhood immunizations," Stanley said. "Raising immunizations levels will take a collaborative effort that includes parents, providers, school, businesses, local and state government."

## Abstract

The epidemic of childhood obesity is of great concern from health, economic, and societal perspectives, yet efforts to intervene have not had a large scale impact. Regardless of the complex mechanisms involved in the development of obesity, patients must eventually self-direct changes in lifestyle behaviors to achieve weight loss goals and long-term maintenance.

Comprehensive, multidisciplinary programs have been developed but suffer from cost constraints and equal access. Evaluation of these programs, however, has yielded valuable information about treatment components that may be most effective in managing obesity in children and adolescents. These include active family involvement, use of behavioral contracts, dietary modification, decreased sedentary activity, and prolonged active management under a patient-centered approach. The nature of these individual components is such that they may be translated to efficient physician-based strategies. In doing so, the key foundation of healing, the physician-patient relationship, is restored and can be utilized to effectively manage childhood obesity.

The problem of childhood and adolescent obesity has gone well beyond its portrayal as a major pediatric health problem, having recently reached epidemic proportions in the United States.<sup>1</sup> Despite the identification at least 10 years ago of this increasing trend and the recommendation by the U.S. Department of Health and Human Services to reduce obesity among American youths to 15% or less, attempts to address it have had little large scale impact. Instead, between the years of 1976-1989 and 1989-1991, the National Health and Examination Surveys (NHANES II and III) documented an increased prevalence of overweight and obesity among American youths from approximately 18% to 22%,<sup>2</sup> which further increased to 25% in 1998.<sup>3</sup>

The concern with this trend is heightened due to the recognition that childhood obesity is strongly predictive of adult obesity<sup>4</sup> and its associated health complications including cardiovascular disease, osteoarthritis, Type 2 diabetes, and certain forms of cancer.<sup>5</sup> With these health issues come increased mortality rates as well as

# Obesity in Children: Etiological Considerations and Management Strategies for the Primary Care Physician

by Susan F. Franks, Ph.D. and Clifton A. Cage, D.O.

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increased economic burdens. The economic impact of obesity is often overlooked; yet, in the late 1990s it substantially exceeded that associated with smoking with \$118 billion in costs compared to \$47 billion.<sup>6</sup> Furthermore, enormous social consequences are associated with the societal stigmatization of overweight and obese persons.<sup>7</sup> Indeed, obesity in childhood is often associated with the development of low self-esteem that may lead to childhood behavioral problems and psychiatric conditions such as depression and eating disorders.<sup>8,9</sup>

## Etiological Considerations

As in adult obesity, the nature of obesity in childhood is a complex and multifaceted phenomenon that must take into account genetic, biological, psychological, and social determinants.<sup>1</sup> There is ample data to support the role of genetics in the development of obesity. The inheritability of BMI has been established at 25% to 40%, with a 30% risk of childhood onset obesity with obese parents.<sup>10</sup> Furthermore, recent preliminary studies have identified racial differences in metabolism that appear to impact comparative risks for obesity.<sup>11</sup> However, there is an increasing prevalence of obesity from generation to generation

with obese children outweighing their parents by an increase of about 10 BMI units.<sup>10</sup> There also exists a considerable body of research that supports the role of non-biological factors in this phenomenon. For example, significant correlations have been long observed between spouse's weights,<sup>12</sup> weights of pet owners and their dogs,<sup>13</sup> and between the weights of foster parents and children.<sup>14</sup> As with other chronic diseases and conditions, biological factors explain only a portion of the variance, leaving at issue other factors that may be involved in the development and maintenance of obesity.

The basic understanding of metabolic factors as they relate to obesity, while not incorrect, minimizes its complex nature so that the simple energy-in/energy-out model is insufficient to effectively address the issue at the level of the individual patient. There are many variables involved in caloric intake and caloric expenditure, some of which are not at the level of individual control. For children and adolescents in particular, their family, peers, and the media are greatly influential as determinants of eating attitudes and behaviors.<sup>1</sup> The use of fashion models and popular sports, movie, and television stars in many of the 100,000 television food commercials that are seen by American



# *"...lifestyle behaviors must be altered for an optimal state of health to be achieved that involves weight loss and maintaining that weight loss..."*

youth can encourage consumption of products of low nutritional value without an emphasis on a balance in healthy lifestyle behaviors.<sup>15,16,17</sup>

Naïve and easily influenced children are unable to grasp the contradiction between "slender, attractive people eating in ways that are guaranteed to lead to obesity."<sup>1</sup> Taken in the context of a family system that may not provide the appropriate structure and food choices for healthy eating, children may be placed at further risk from media influence for developing an attitude that normalizes an unhealthy eating repertoire.

The family system is critical in establishing the foundation for healthy food attitudes and preferences so that children may be better prepared to cope successfully with negative peer pressure during the adolescent phase.<sup>18</sup> It is during this time that normative attitudes shift from those of the parent to those of the peer group. Particularly vulnerable are at-risk children whose primary environment is marked by discord where eating habits and food choices may be used as a means to rebel or to deal with internal emotional turmoil.<sup>9,15</sup> Further challenging, especially for the single parent family, is the ability to provide the needed structure of family meals and healthy food choices, and to model the healthy eating behaviors and activity patterns that will prepare a child for the challenges of adolescence.<sup>15</sup> As many as 50% of adolescents eat breakfast less than two times per week while snacking at least five times per day, typically on food considered to be largely calorie rich and non-nutritious.<sup>19</sup> The increasing availability of fast-food makes it even more difficult for adolescents and their families to make healthy choices for snacks and meals.<sup>20</sup>

Changes in the relative distribution of nutrients may be an important factor in the increased prevalence of obesity.<sup>21</sup> Indeed,

the current eating patterns of children and adolescents result in an average fat intake that exceeds U.S. Dietary Guidelines.<sup>22</sup> Despite the changes in eating styles over the past 20 years among children and adolescents, rates of calorie intake have not changed correspondingly to account for the increases in weight.<sup>23,24,25</sup> Shifting the direction of concern toward physical activity. Although little is known about changes in rates of physical activity among youth, a reduction was found in participation in physical education (PE) classes from 60% in 1995 to 49% in 1997.<sup>26,27</sup> Along with reductions in traditional opportunities for physical activity, such as required PE classes, there may be an increase in sedentary activities among youth. Children and adolescents on average watch almost five hours of television per day, and about 1/3 exceed this amount.<sup>28</sup> There is clearly a strong association between obesity and time watching television, with a substantial difference in BMI between children watching two or less versus four or more hours.<sup>29</sup> Furthermore, the effect of rates of television watching on obesity occurs regardless of a child's initial weight status or socioeconomic status.<sup>28</sup>

## **Management Strategies and Issues**

Despite its complex nature, the basic biology of obesity holds true; a positive energy balance must be present for obesity to occur; and correspondingly, a negative energy balance must exist for weight loss to occur.<sup>1</sup> However, getting a patient to achieve and maintain this negative energy balance for a sufficient period of time to reach weight loss goals is a substantial challenge. Regardless of the biological mechanisms of development, lifestyle behaviors must be altered for an optimal state of health to be achieved that involves weight loss and maintaining that weight loss.<sup>30</sup>

The optimal approach to the treatment of obesity in children and adolescents involves the use of a multidisciplinary team so that adequate attention is given to metabolic, nutritional, and psychosocial factors involved in each individual case.<sup>31</sup> However, the inherent limitations to this approach due to insurance restrictions or limited patient finances necessitate the identification of physician-based strategies. In fact, many believe that the key foundation of healing, the physician-patient relationship, has been eroded by the demands of managed care, which has been a driving force in the development of ancillary health services to meet unfulfilled patient needs.<sup>32</sup> The general lack of success of these often costly programs that do not typically afford equal access can be seen in the persistence of high morbidity and mortality rates associated with various chronic diseases. Extensive efforts are underway to provide primary care providers with more efficient and effective physician-based strategies for better management of chronic health conditions. Fortunately, in the area of childhood and adolescent obesity, there have been reports of the efficacy of various treatment components that should enable the individual practitioner to structure an effective intervention that can assist patients in achieving their weight loss goals. The critical elements that appear most important include active family involvement, use of behavioral contracts, dietary modification, decreased sedentary activity, and prolonged active management under a patient-centered approach.<sup>31</sup>

The essential component to any approach to weight management in children or adolescents will be the participation and cooperation of the family, since the family system typically serves as the normative standard to which the child is expected to conform.<sup>31,33</sup> It is incumbent upon the parent(s) to serve as both a model and a director in order to facilitate change. The presence of contradictory behaviors or messages within the family unit can foster a negative attitude that diminishes motivation and cooperation, as will singling out the child by holding him or her to a different standard than other family members. In essence, the behavior of the family unit should be viewed as the target for change.<sup>31</sup> The exact role of the parent

that accounts for their effective involvement is unclear.<sup>33</sup> Assisting the parents in gaining increased mastery over general behavioral management skills appears particularly supportive, and perhaps represents the critical component by providing appropriate and well-placed reinforcement of targeted behavioral changes.<sup>31</sup> Teaching basic behavioral principles of reinforcement is fairly simple, and instructive efforts can be easily supported through the use of educational materials. Another straightforward strategy for optimizing family involvement is to have the parent(s) and each family member formalize their commitment to make positive lifestyle change. The use of a signed "contract" for this purpose may lay the foundation for overall treatment success.<sup>31</sup>

Focus of follow-up visits and monitoring efforts should accordingly be directed toward the family unit rather than strictly focused on the individual child or adolescent, while at the same time giving enough individual attention to provide a sense of an age-appropriate level of autonomy and independence.<sup>31</sup>

The ongoing use of contracts for specific targeted behavioral goals provides a vehicle for continued focus on various aspects of weight management that are under the direct control of the individual. An over-focus on weight and other metabolic indicators as specific targets of change neglects to communicate to the patient that these are only indirectly controlled through lifestyle change. The additional lack of patient awareness regarding the natural variability of weight leads to frustration and resignation when day-to-day weight loss efforts do not appear to produce immediate results. Mutual collaboration appears to be effective in choosing specific behavioral goals and the specific methods for reinforcing success.<sup>31</sup>

At some issue in the literature are the relative contributions of diet therapy versus activity/exercise in weight loss and weight management in children and adolescents.<sup>34</sup> In general, a recent review indicates that diet therapy is best utilized within the context of family participation, exercise/activity, and the principles of behavior modification. When this type of comprehensive approach to weight management is undertaken, treatment

The "Traffic Light" Diet <sup>(34)</sup>		
<b>Green Foods</b>	(GO)	Unrestricted foods May be consumed in unlimited quantities
<b>Yellow Foods</b>	(CAUTION)	Foods of average nutritional value
<b>Red Foods</b>	(STOP)	Foods with high fat or simple carbohydrate content Number of servings should be limited per week

Figure 1

success has been maintained over 5 to 10 years.<sup>33,35,36,37</sup> The "traffic light" approach to diet therapy in the youth appears to be particularly effective for preschool and preadolescent children; promoting marked and enduring changes in food preferences and eating habits. (See Figure 1).<sup>33</sup>

The relatively common use of the protein-sparing modified fast for severely overweight adolescents is no longer recommended due to its failure to demonstrate increased efficacy over less restrictive dietary regimens.<sup>38</sup> Considering the data indicating the eating styles of adolescents, the multiple snacks can provide an opportunity for transforming these into a positive feature of their overall diet.<sup>39</sup> Furthermore, the adolescent is more likely to comply with dietary modifications if goals are mutually agreed-upon; for example limiting rather than eliminating fast-foods and/or making wiser fast-food choices.

Recommendations regarding activity and exercise have been more clearly delineated by the research. Strategies for change should focus on decreasing the rates of sedentary activities (i.e., television viewing) in children and adolescents rather than attempting to increase physical activity. The effectiveness of aerobic activity in the weight management efforts of children and adolescents has not been consistently demonstrated.<sup>40</sup> Limited access to sedentary behaviors, however, consistently improves weight loss efforts beyond that found with attempts to increase activity.<sup>41</sup> Behavioral reinforcement should be used by the parent(s) to positively reward increasing reductions in sedentary activity rather than using restriction and punishment as a means

to force reductions.<sup>34</sup> "Lifestyle exercise" should also be encouraged, involving the use of choices in the way daily activities and routines are carried out (for example, walking or riding a bicycle instead of traveling in the car; taking stairs instead of elevators; using the bathroom that is farther away).<sup>34</sup> The benefits of lifestyle exercise over aerobic exercise for long-term maintenance has been demonstrated.<sup>42, 43</sup>

The frequency and duration of active management is also critical in insuring long-term success. Ongoing monitoring for 8 to 12 months at a frequency of once per week is optimal, although insurance/financial considerations and individual needs must be taken into consideration.<sup>31</sup> It is clear, however, that the use of extended management is most successful if care is given to the provider-patient relationship. The use of a patient-centered approach, where the physician works in collaboration with the patient and their family to facilitate change in mutually agreed upon goals is preferable to the standard physician-directed, autocratic style. This is particularly critical due to the fact that self-directed responsibility for health must eventually take place for long-term success to occur.

While it is clear that the determinants of obesity are complex and multifaceted, it is this reason that it is so difficult to develop effective interventions that will result in long-term maintenance of weight loss. Familiarity with the various factors involved in obesity and behavior change related to weight loss and maintenance plays a key role in understanding the challenges faced by individuals of all ages needing to lose weight, particularly for those who require substantial weight loss.

*continued on next page*



However, in order to facilitate change the physician must take into consideration the individual barriers that a child or adolescent and the family may face in implementing the suggested management plan. Working closely with the family on an ongoing basis and finding a common ground from which to develop goals and strategies will provide a framework for long-term success in the treatment of obesity in children and adolescents.

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# James E. Zini, D.O.

## New President of American Osteopathic Association

The American Osteopathic Association installed James E. Zini, D.O., M.Div., of Mountain View, Arkansas, as its 2001-2002 president during its House of Delegates meeting in Chicago. Dr. Zini will devote the year of his presidency to promoting the Osteopathic Postdoctoral Training Institutions (OPTIs) and to assisting the Osteopathic Graduate Medical Education Development Program in creating and maintaining osteopathic internships and residencies throughout the country.

"I feel extremely honored to be given the opportunity to serve my profession," said Dr. Zini, a board certified family physician and a Christian ordained minister. "Right now, the osteopathic profession is faced with great challenges and also great opportunities, making this time one of the most important in the profession's development. One of our greatest challenges is educating our graduates in an ever-changing health care environment. That is why it's so important to develop our OPTIs to meet that challenge," he explained.

"Another major challenge we're conquering is promoting our profession to the public," Dr. Zini added. "I feel that, in the future, osteopathic physicians will look back at this generation, our generation, as the one that met the greatest challenge of all — educating the public about osteopathic medicine."

Dr. Zini has practiced medicine in Mountain View for 24 years. He works as a family practitioner in private practice and as a medical examiner for the Federal Aviation Administration. He serves as the medical director for the Searcy County Nursing & Rehabilitation Center in Marshall, Arkansas, and the Stone County Skilled Nursing Facility in Mountain View.

In 1990, Dr. Zini joined the AOA's board of trustees. During the past decade, he has chaired committees and departments (such as the Department of Professional Affairs and the Department of Education) in addition to serving on task forces and bureaus. He most recently served as an AOA representative to the Centers for Disease Control and Prevention, where he consulted with the Centers on their vaccine programs. Dr. Zini also served for nine years as an AOA representative to the Commission on Laboratory Accreditation Board, a nation-wide, physician-run accrediting agency that accredits approximately 7,000 office labs.

In addition to devoting his time to the AOA, Dr. Zini has supported osteopathic causes in his home state by helping to found the Arkansas Osteopathic Medical Association. Since its inception, he has served as its president, vice president, as a trustee and now as vice president ex officio.

Dr. Zini made history when he became the first osteopathic physician appointed to the Arkansas State Medical Board in 1990, and he is currently serving a second term on this board. In addition, he has served as a member of the Arkansas Medical Society for 20 years and belongs to the Arkansas Osteopathic Foundation.

Dr. Zini has been honored with numerous awards, including the Flight Safety Award given by the Federal Aviation Administration in 1998; the Distinguished Citizen Award given by the Mountain View Chamber of Commerce in 1997; and the Physician of the Year Award given by the Arkansas Osteopathic Medical Association in 1989.

As an ordained Christian minister, Dr. Zini strives to combine his two professions into a medical ministry. He's had the pleasure of performing the wedding ceremonies of his daughter, Heather, and his son, Brett. He's also performed numerous baptisms for family and friends.

Dr. Zini received his master of divinity from the Eden Theological Seminary, St. Louis, Missouri, in 1972. In 1976, he received his doctorate of osteopathic medicine from the University of Health Sciences, College of Osteopathic Medicine, Kansas City, Missouri. He interned at the now defunct Normandy Osteopathic Hospitals in St. Louis.

Dr. Zini resides in Mountain View with his wife, Judy.



*"...osteopathic physicians  
will look back at this  
generation, our generation,  
as the one that met the  
greatest challenge of all —  
educating the public about  
osteopathic medicine."*

# Guidelines for Comprehensive Risk Reduction for Patients with Coronary and Vascular Disease

by A.H. O-Yurvatli, D.O., FACOS, FICS



*"Our goal to reduce cardiovascular disease and stroke by 25 percent by the year 2010 cannot be done without the help of every osteopathic physician in the state of Texas."*

Osteopathic physicians in the state of Texas have an opportunity to make a major impact on the health and welfare of Texas citizens. The majority of osteopathic physicians in Texas are primary care and reach out to thousands of patients within our state. The American Heart Association (AHA) has presented a goal, begun in the year 2000, to reduce disability from cardiovascular disease and stroke by 25 percent by the year 2010. This is a major project that will require the participation of every medical provider in the state of Texas, as well as patient education and management.

As a board member of the Texas affiliate for the AHA, I recently attended a board meeting in Austin. I was quite dismayed by the statistics that were presented, showing that there is a major lack of following the AHA guidelines for the management of risk reduction for cardiovascular disease. Of patients who have sustained a myocardial infarction, only about 85 percent were placed on aspirin. Only about one-third were placed on a beta blocker. As far as lipid-lowering therapy, one study showed that only 18 percent of physicians had started a patient on this type of an agent. I found these statistics quite staggering. In order to reach the impact goal we would need the assistance of every osteopathic physician in the state.

As you recall, the University of North Texas Health Science Center participated in a cardiovascular reduction study under the direction of Dr. Michael Clearfield. Recommendations came out of the

TexCAPS study that were quite encouraging, in that following these guidelines with lipid-lowering agents the reduction of a second cardiovascular event could be markedly impacted - in some patients by as much as 40 to 60 percent. Therefore, I wanted to bring to the attention of physicians some of the recommendations and guidelines from the AHA.

There have been two projects undertaken: one called "Get with the Guidelines" from the AHA. The other is a health partnership program developed by the TMA committee on cardiovascular disease and the Texas affiliate of the AHA, as well as Merck & Company. This healthcare partnership was started over a year or so ago, and the results are quite impressive as far as improvement. Recently, in the January 2001 issue of *Texas Medicine Rounds*, a short article noted that there are a few facilities that showed marked recognition for improvement in following these guidelines. They included Baylor University Medical Center in Dallas, the Comprehensive Family Healthcare Center in San Antonio, and the Osteopathic Medical Center of Texas in Fort Worth. I think, as osteopathic physicians practicing in the state, we should be quite proud of this accomplishment, as we have taken on this initiative. More information can be found about this partnership at <[www.texmed.org/has/prs/hcp/default.asp](http://www.texmed.org/has/prs/hcp/default.asp)> or by contacting Bridget Butler at 800-880-1300, ext. 1461.

The guidelines program developed by the AHA is available on their Web site at <[www.americanheart.org](http://www.americanheart.org)> and a PDF file

can be downloaded showing these guidelines. The chart shows the "Comprehensive Risk Reduction for Patients With Coronary and Other Vascular Disease." Major risk interventions should be undertaken to include smoking cessation, and recommendations are given for this, blood pressure control, lipid management and defining the current recommendations on lipid-lowering agents. The paper goes on to discuss physical activity and weight management. Further diabetes management with the management to reduce the hemoglobin A1c to less than 7, a second on antiplatelet agent and anticoagulation therapy as indicated, ACE inhibitor, and beta blockers, as well as estrogen management for women to reduce their risk of heart disease.

The second document is a tracking form - "Primary and Secondary CVD Patient Tracking Form," which can be found on the Web at <[www.americanheart.org/cap/pdf/tracking.pdf](http://www.americanheart.org/cap/pdf/tracking.pdf)>. This is a primary and secondary cardiovascular disease tracking form that could be placed in the patient's chart. It is an easy form that could be followed by the medical staff in the office to enter the data, and then it is a simple check-off list as far as patient education. This also would meet many of the requirements from managed care organizations for primary care physicians for following these cardiovascular guidelines.

In reviewing many of the statistics associated with cardiovascular disease, we find that in the state of Texas one in five deaths from cardiovascular disease is



attributed to smoking. Therefore, a reduction of this factor would also improve the management of these patients. We find that 50 percent of patients have cholesterol levels that are over 200, and only 22 percent report any regular physical activity. In 1997, statistics from the AHA showed that cardiovascular disease remained the number one killer in America, with about 953,000 Americans dying of cardiovascular disease, so this accounts for about 41.2 percent of all deaths. Also, data has strongly supported a lack of physical activity as now clearly shown to be a risk factor for heart disease. Recently, there was a possible contributory link between the lack of regular exercise and stroke. Although there was not a direct link, there appeared to be some statistical increase in those patients. It may be related that these patients are also more at risk for other coronary events, and the stroke events are secondary, but we do not know that at this time.

An area that has only recently been studied is the risk of cardiovascular and stroke in women. We know that cardiovascular disease ranks first among all disease categories in hospital discharge for women, and 43.7 percent of all female deaths in America occur from cardiovascular disease. It is interesting to note that risk of dying from a cardiac event is substantially higher in African-American women than in Caucasian women. Cardiac disease claimed over 502,000 lives in 1997, as compared to 258,000 from cancer in women. This statistic also is quite staggering. Also, in patients who have had a primary event, 38 percent of these women, compared with 25 percent of men, will die within one year or after a coronary event. The stroke statistics are somewhat new, but they show that about 15 to 30 percent of stroke survivors are permanently disabled. We do not know the exact stroke incidence at this time in women; however, we know that stroke is a leading cause of serious, long-term disability.

I am encouraging every osteopathic physician in the state of Texas to help us on the American Heart Association to "Get with the Guidelines" so that we can impact on the health of the citizens of Texas. Our goal to reduce cardiovascular disease and stroke by 25 percent by the year 2010 cannot be done without the help of every osteopathic physician in the state of Texas.

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Dr. O-Yurvati is an Associate Professor of Surgery at the University of North Texas Science Center, Fort Worth.



## HealthFind 2001

HealthFind 2001, September 15-16, 2001, is a job fair that matches rural communities with physicians who want to practice in rural areas.

If you are interested in finding out first hand the benefits of rural practice, call the Center for Rural Health Initiatives and request a HealthFind 2001 registration packet.

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# TEXAS ACOFP UPDATE

## 44th Annual Clinical Seminar

The Texas ACOFP 44th Annual Clinical Seminar was a great success. Held at the Radisson Plaza Hotel in Fort Worth, attendees enjoyed an interesting mix of lectures specific to family practice as well as great social events. We were honored by the attendance of several alumni from the Texas College of Osteopathic Medicine as their Alumni Weekend was again held in conjunction with this seminar.

We did our job in initiating ACOFP president-elect Kieren Knapp, D.O., from Pennsylvania as a Texan by presenting him with the official hat and boots. He and his wife Jane attended social events, mixing with our members and answering questions about the ACOFP. We thank him and Jane for spending the weekend with us.



Kieren Knapp, D.O., and Harold Lewis, D.O. (R)



The President's Reception and Dinner, honoring Robert Deluca, D.O., was attended by more than 200 physicians and their families. Dr. Knapp presented Dr. Deluca with the *TxACOFP President's Award*.

Harold Lewis, D.O., was installed by Dr. Knapp as President for the 2001-2002 term. His family joined him for the weekend, making the event a family reunion.



Dr. Lewis then announced the 2001 - 2002 TxACOFP Board of Governors as follows:

President-Elect	Jerry Smola, D.O.
Vice President	Ronda Beene, D.O.
Past President	Robert Deluca, D.O.
Secretary	Tony Hedges, D.O.
Treasurer	Rodney Wiseman, D.O.

### Governors

Richard Erickson, D.O.  
David Garza, D.O.  
Jamie Inman, D.O.  
Bruce Maniet, D.O.  
Donald Peterson, D.O.  
Robert Stark, D.O.

Student Rep	S/D Derek Lang
TCOM Liaison	Samuel T. Coleridge, D.O.
ACOFP Liaison	Greg Maul, D.O.
AOA Liaison	Robert Peters, D.O.
Parliamentarian	T. Eugene Zachary, D.O.
President Emeritus	T. R. Sharp, D.O.

The new TxACOFP president encourages anyone interested in serving on a board committee to call the TxACOFP Office at 888-892-2637.



John Bowling, D.O., (L) was presented with the *A.T. Still Statue* for his work on the board over the past seven years. Eugene Zackery, D.O., did the honors.



The *TxACOF Family Physician of the Year Award* was presented to Hector Lopez, D.O., from El Paso. His dedication to his community in providing free medical services to residents who have no health care as well as his volunteerism among the youth programs was recognized. Also noted was his continued service as a Trustee of the Texas Osteopathic Medical Association and his work with students of the Texas College of Osteopathic Medicine.



T.R. Sharp was honored for his continued contribution to our profession and was presented with a new ABOFP certificate which states the new name of the certification.



The weekend ended Sunday evening with a new event. We hosted a dinner for incoming TCOM 1st year students and presented them with back packs. More than 100 students and guests mingled with TxACOF Board members and were addressed by Dr. Kieren Knapp as well as TCOM Family Practice Club President Derek Lang.



### Primary Care Update To Be Held In Austin

Looking for more CME? The Texas ACOFP and the UNTHSC at Fort Worth will hold a Primary Care Update, October 5 - 7, 2001, at the Austin Renaissance Hotel. This program offers 15 Category 1-A AOA and ACGME credit and will include several procedural workshops as well as office management lectures. TxACOF members, TCOM Alumni and those participating in the TCOM Preceptorship Program will receive reduced registration rates.

In conjunction with this program, we will offer an OMT Board Review Course for those registered to take the ABOFP Certification Test. This is an excellent way to prepare for the OMT portion of the board exam or brush up on your OMT skills if you are already board certified.

Registration materials were mailed mid-August. Please call 888-892-2637 if you did not receive forms and wish to register for either of these programs.

# Independent Investor

A monthly update on money and markets from Dean, Jacobson Financial Services, LLC

September 2001

## "Caveat Emptor" For Those Who Rely on Analysts' Recommendations

Thanks to the explosion of the Internet and the proliferation of financial cable television channels, investors looking for information or advice on stocks have access to a wealth of data.

Analysts, whose ratings are widely quoted in the financial press and featured prominently on television programs that report on the stock market, often provide the most visible evaluation. However, for investors who rely solely on the advice of analysts they believe to be objective sources of information, the Latin phrase "caveat emptor," or buyer beware, best applies.

Confusing classifications, a lack of accountability for their evaluations and inherent conflicts of interest mean analysts' recommendations should at best be examined closely.

To begin with, the classifications used by investment firms when evaluating a stock's prospects vary widely. An online search for investment banks' ratings systems reveals that many employ a unique system of ratings, making it difficult to com-

pare a stock's standing with analysts from one firm to the next. Dozens of different ratings are used, often employing vague classifications such as "accumulate," "hold" and "outperform." One firm's recommendation to "buy" may represent its highest rating, while for another firm the same term ranks below "strong buy" and may even hold a negative connotation. Unless one is familiar with each firm's ratings system, these labels are rendered nearly meaningless.

Another troubling aspect of analysts' ratings is a general lack of accountability. Much time and effort is spent tracking the performance of a particular stock and ranking this data relative to its peers, yet little attention seems to be paid to the accuracy of the analysts who follow these stocks. Websites that champion the cause of individual investors, such as Motley Fool ([www.fool.com](http://www.fool.com)), are rife with examples of how analysts sometimes not only miss the boat on rising or falling stocks, but also often provide recommendations that are effectively the opposite of sound investment advice. One such example tracks an analyst's appearance on television to announce a sell rating for a popular stock. Nine months and a 40 per cent gain later, the analyst finally changed his rating to "buy."

The conflict of interest inherent when brokerage firms issue analyst ratings and perform underwriting business also raises questions. Underwriting

public offerings for companies is lucrative business, and the recommendations from analysts are an effective publicity tool. An analyst that issues a negative rating risks scaring off profits for his or her company, while a positive rating on a stock for which the analyst's firm has an underwriting relationship can mean bigger profits for the investment bank.

One certainty is that following analysts' recommendations should not be the sole basis of a stock investment strategy. Picking a stock on the basis of its short-term potential to rise or fall is a risky practice. A buy-and-hold investment strategy, in which profits are reinvested and allowed to compound over time, eliminates the headache and heartache of guessing where a stock is headed in the short term. This approach allows the benefits of compounding interest to work to the advantage of a portfolio over a long period of time, and perhaps equally important, frees up investors to concern themselves with matters other than deciphering the real meaning of the word "outperform."

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# In Memoriam

## Hyman Kahn, D.O.

Dr. Hyman Kahn of Dallas passed away on July 3. Services were held July 6 at Temple Emanu-El in Dallas, with interment at Temple Emanu-El Cemetery.

Dr. Kahn was born in New York City in 1925. After serving in the U.S. Army during World War II, he graduated from City College of New York. He received his D.O. degree in 1951 from the Kirksville College of Osteopathic Medicine, where he completed an anesthesiology residency.

During his medical career, Dr. Kahn chaired the Departments of Anesthesiology at Steven's Park Hospital, Dallas Family Hospital and Dallas Southwest Medical Center. In addition, he served as chief-of-staff at Steven's Park.

A skilled and dedicated teacher, Dr. Kahn was a clinical associate professor in the Department of Anesthesiology at the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in Fort Worth, where he has been nominated to receive the title of Professor Emeritus. He also taught in the Pharmacology Department at UNTHSC/TCOM.

He was elected president of the American Osteopathic College of Anesthesiologists in 1972, and maintained a leadership role as an active and involved member of the AOCA board for four years. For eight years, he was chairman of the examination committee of the American Osteopathic Board of Anesthesiology.

As a founding member of Dallas Southwest Osteopathic Physicians, Inc., Dr. Kahn regularly contributed his time, ideas and acumen to advance numerous charitable projects assisting social services, educational institutions and cultural organizations.

Dr. Kahn also served his community as a member of the Oak Cliff Chamber of Commerce, the Economic Development Advisory Board to the City of Dallas, and the board of the Jewish Community Center in Dallas.

Survivors include his wife, Anna Lee Kahn; daughters, Lisa Kahn and Isabel Kahn; son-in-law, Jeffrey Smith; grandson, Connor Smith; sister and brother-in-law, Dinah and David Wolkoff; sister-in-law and her husband, Benah and Howard

Golden; nieces and nephews; his close friends, Renee Stanley and her family, and Shirley and Kenneth Bayles.

In lieu of floral tributes, the family suggests that contributions be made in Dr. Kahn's name to Friends of Golden Acres, c/o Dallas Home for the Jewish Aged, 2525 Centerville Road., Dallas, 75228-2693.

## George M. Esselman, D.O.

Dr. George Esselman of Fort Worth passed away on July 17. He was 84. Services were held July 20 at Greenwood Chapel, Fort Worth, with entombment in Greenwood Mausoleum.

Born in 1917, Dr. Esselman grew up in McBride and Perryville, Missouri. Inspired by the local doctor, he graduated from the University of Missouri in Columbia, and received his D.O. degree in 1944 from Kirksville College of Osteopathic Medicine.

Dr. Esselman specialized in Internal Medicine, establishing a long and fruitful practice in Dayton, Ohio. After nearly 20 years in private practice, he returned to Ohio State University to specialize in medical education. In 1972, he took a position with the then-just starting Texas College of Osteopathic Medicine as director of medical education. Dr. Esselman was instrumental in the founding and development of the college and its present relation with the North Texas State University. He graduated the school's first class of doctors from a converted bowling alley.

Dr. Esselman was an active TOMA member and was honored with Life Membership. He instigated the establishment of the TOMA Impaired Physicians Committee (renamed the Physicians Health and Rehabilitation Committee), serving as chair for many years, and assisting many of his colleagues with substance abuse problems. He also wrote and lectured extensively on the subject. He also served on the Fort Worth mayor's commission that developed the homeless shelter in Fort Worth.

Survivors include one daughter, Karen Beth Martin of Benbrook; two sons, George Douglas Esselman, his wife, Debra, of Colleyville, and Gregory Watt Esselman and his wife, Elaine, of Springfield, Missouri; two granddaughters, Angela Beth Christian and Summer Leigh Bartlett; one grandson, Andrew Douglas Esselman.

## San Antonio Hospitals Dedicate Significant Resources in Response to Nursing Shortage

In the face of a nursing crisis that is expected to get significantly worse in the next five to seven years, Methodist Healthcare System is dedicating more than \$6 million for nurse recruitment, while University Health System is dedicating more than \$2.3 million to fill as many of its nursing vacancies as possible. Methodist is directing its recruitment efforts overseas and hopes to recruit 150 to 175 new registered nurses over the next two years from the Middle East, while the University Health System Foundation recently created a nursing scholarship fund for system employees, awarding scholarship recipients up to \$3,000 per year to attend the school of their choice. (*San Antonio Business Journal*, 7-9-01)



# Self's Tips & Tidings



By Don Self

## A Note from Don

Recently, it came to our attention that many of the osteopathic doctors around Texas are under the misconception that we are Medicare consultants only. We not only co-manage six primary care physician offices and increase their income, but we also write magazine columns, assist hundreds of physicians throughout the country with cardiac event monitors, 24 hour holters and sleep apnea, help establish fee schedules, teach physicians on heart rate variability and autonomic nerve diagnostic tests, file claims to all carriers, tech collections, teach seminars, consult on WC cases and fight managed care companies on behalf of physicians. Basically - everything concerning reimbursement and we've been doing it with the TOMA for 13 years.

## Get Used to the 95 & 97 Guidelines

For the past few years, you've been told to expect the 2000 E&M Guidelines to replace the 95 & 97 HCFA guidelines by nearly everyone. I've been saying that if it happened, don't expect it before 2002 (and I wasn't sure it would even happen). The latest news from Tommy Thompson (HHS Secretary) is that the new guidelines have been scrapped and we will continue to use the 95 and 97 guidelines indefinitely. So, make sure you're using one or the other and stick to them. Oh yeah, one more thing - I was in an office in North Texas a couple of weeks back and they were still using S.O.A.P. - which doesn't meet either the 95 or 97 guidelines. If you're still using the S.O.A.P. method - and you get audited - look out. Your fines will probably exceed your income this year.

## Patients' Confidentiality

Instead of "blackout" the information that does not apply to the patient on

each EOB, try folding and copying the EOMB's so that only the pertinent patient information is visible to the secondary carrier. This process saves time over "blackout" all other information before sending a copy of the EOB to the secondary insurance.

## I Don't Remember Going to the Doctor That Day...

In an attempt to catch physicians billing for services not rendered, some Medicare carriers are starting to call the patient at home and ask them if they were in the doctor's office last month. It may go something like this:

Carrier: "Mr. Stubblehoffer, this is Medicare calling. Can I ask you a couple of questions?"

Patient: "About what?"

Carrier: "About your recent visit to your doctor. Did you see Dr. Adams last month on the 13th?"

Patient: "Okay - ask me anything and I'll try to help you"

Carrier: "Okay, sir - do you remember seeing Dr. Adams last month on the 13th?"

Patient: "So what do you wish to ask me?"

Carrier: "Uh, sir - I'm wondering if you saw Dr. Adams last month."

Patient: "Sure I did. I sit right behind him in church listening to that new preacher."

Carrier: "Sir, I need to know if you went to his office last month."

Patient: "Of course I did. I'm a deacon and I have a meeting with the preacher every month."

Carrier: "No, sir. I mean the doctor."

Patient: "I have no idea if the doctor went into the preacher's office last month. Do

you pray to the Lord?"

Carrier: "Yes, sir. I am praying right now. Thank you sir - no more questions."

Folks, it looks like the carriers are trying to catch doctors fabricating office notes, so it would be a good idea to have every patient sign every superbill while they're in the office, unless you keep the sign-in log or check-in sheets. Either way, protect yourself.

## New Versus Established Revisited

In 2001, new language was added to the CPT code book which further restricts the definition of a NEW patient.

"Solely for the purposes of distinguishing between new and established patients, \*professional services\* are those face-to-face services rendered by a physician and reported by a specific CPT code(s)."

What may be confusing the matter is that Medicare would appear to have a slightly different definition from the CPT definition. Here is the content from Section 15502 of the Medicare Carrier Manual:

"Definition of New Patient For Selection Of Visit Code--Interpret the phrase 'new patient' to mean a patient who has not received any professional services from the physician within the previous 3 years. (See definition of physicians in group practice in Section 15501H.) If no evaluation and management service is performed, the patient may continue to be treated as a new patient."

So, the key question with Medicare is whether or not an E&M has been billed on the patient within the previous 3 years. For non-Medicare, the question is whether ANY professional service has been rendered. For Medicare, it narrows down to E&M services.

## **Sending Patients Out for Sleep Apnea Tests**

From what I understand, most of the sleep apnea testing centers are running from 3 to 6 weeks behind right now, so if you want to schedule a patient for a test, they're in for a wait. You've heard me talk about Health Monitoring Services before when it comes to them providing your office with free Cardiac Event and 24 hour Holter with ABP monitors - but now I'm talking about sleep apnea. They can usually have a sleep apnea monitor to your office in less than a week, no charge to you, and your staff can make \$125 hooking up the patient in the patient's home and you get paid for the interpretation. They even do the pre-authorization for you. If you want more information on this, call me at 800 256-7045 or email me at <donself@donself.com>. Don't wait, contact me today.

## **Multiple Visits or Multiple Physicians – Same Patient**

How do you handle it when two physicians of the same specialty in your group see the same patient on the same day? It's pretty simple: Two Hospital Visits Same Day--Pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not. Advise physicians that they may not report two hospital visits on the same day to the same patient. The inpatient hospital visit descriptors contain the phrase "per day" which means that the code and the payment established for the code represent all services provided on that date. The physician should select a code that reflects all services provided during the date of the service.

## **Enlist the Patient's Assistance**

You've filed the claim and waited 30 days and the private or managed care plan hasn't paid or contacted you. What do you do? It's really simple. Get the following rubber stamp made and put it on the patient statement in RED ink:

Your carrier has NOT responded to the claim we filed. Under our agreement with you, the full balance is now YOUR RESPONSIBILITY. Please pay.

You'll find that the patient quickly calls you and their insurance carrier to find out where the claim is and why the carrier hasn't paid. Remember, the patient, their family member, or employer chose their insurance in EVERY instance - so enlist their help this way. It works.

## **How to Bill for Nutritionists**

Many private carriers have adopted Medicare's rules on services rendered by Nutritionists. In some instances you can negotiate a better deal with one carrier or another. Medicare's rule is simple. The Nutritionist is treated like any other employee of the physician under "incident-to" rules and the only code that can be billed for their service is 99211 (brief established office visit). The \$30 or less that is usually paid for 99211 doesn't usually compensate you or the nutritionist for the time spent, so consider this before hiring one for your practice.

## **If You Didn't Pay for It, Don't Bill It**

I just heard of another case where a doctor was charging for the "samples" he was giving to the patient. Not only is this illegal in most instances, but it's also just plain unethical. If the sample didn't cost you anything, then don't bill for it. You also cannot charge for the band aid you put on the patient when you give them an injection, the pen the patient uses to fill out the new patient form or the paper you put on the exam table. Those are the costs of doing business. Now - you want a tip on how to get many of your supplies for free? Set up a "SHOPPING LIST" on the wall for the pharmaceutical reps to bring into your office and list the calendars, floor fans, wall clocks, thermometers, etc., you're wanting. You'll be surprised at how fast these are taken care of.

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**FP, BC, D.O., Desires full-time primary care position** in South Texas. CV & references available on request. E-mail: akicora@indy.net or call 312-257-4477 & leave message. (19)

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