TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

Volume LIX, No. 5

May 2002

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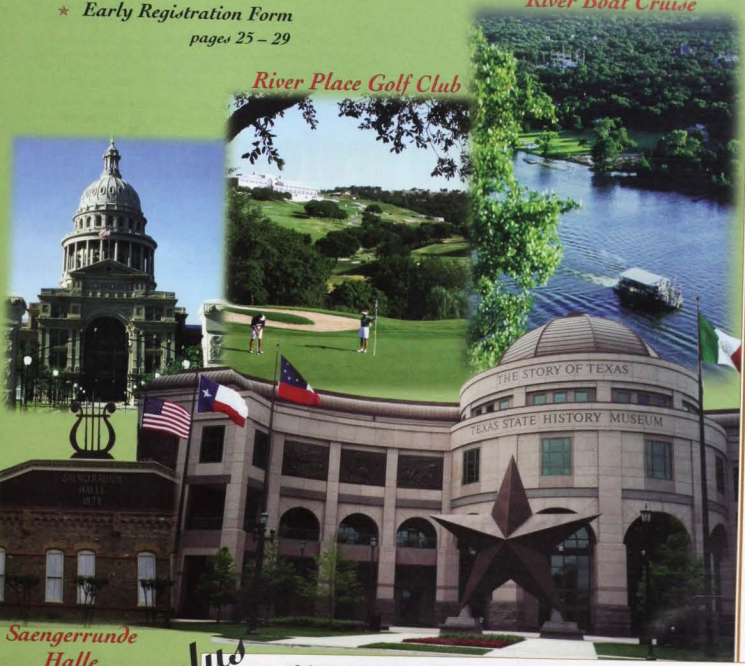
River Place Golf Club



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TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association

MAY 2002

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INSIDE THIS ISSUE

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CALENDAR OF EVENTS

JUNE 12 – 16

"TOMA 103rd Annual Convention and Scientific Seminar"

Sponsored by the Texas Osteopathic Medical Association

Location: Reniassance Austin Hotel, Austin, TX
CME: 26.5 hours category 1-A credits anticipated
Contact: TOMA, 800-444-8662 or 512-708-8662

JUNE 15 – 19

"June Basic Course"

Sponsored by The Cranial Academy

Location: DMU/OMC, Des Moines, Iowa
CME: 40 hours category 1-A credits anticipated
Contact: The Cranial Academy
8202 Clearvista Parkway, #9-D
Indianapolis, IN 46256; 317-594-0411
FAX 317-594-9299

JUNE 26 – 30

"22nd Annual Stanley E. Weiss, D.O. Primary Care Update"

Sponsored by the University of North Texas Health Science Center at Fort Worth

Location: Sheraton South Padre Island Resort
South Padre Island, Texas
CME: 24 hours category 1-A credits anticipated
Contact: UNTHSC Office of CME at 817-735-2539
or 800-987-2CME; or <www.hsc.unt.edu>

JULY 19 – 21

"AOA House of Delegates Meeting"

Location: Fairmont Hotel, Chicago, IL
Contact: Ann M. Wittner, AOA
800-621-1773, ext. 8013; 312-202-8013
awittner@aoa-net.org

AUGUST 1 – 4

"TxACOFP 45th Annual Clinical Seminar"

Sponsored by the Texas Society of the American College of Osteopathic Family Physicians

Location: Wyndham Arlington Hotel, Arlington, TX
Contact: TxACOFP, 888-892-2637

AUGUST 17 – 18

"OMT – Ligamentous Articular Strain Techniques for Treating the Rest of the Body Based on Sutherland's Methods"

Presented by the Dallas Osteopathic Study Group

Location: Doubletree Hotel Campbell Centre, Dallas, TX
CME: 16 hours category 1-A credits anticipated
Contact: Conrad Speece, D.O., Course Director
214-321-2673

SEPTEMBER 14 – 15

"HealthFind 2002"

Sponsored by the Office of Rural Community Affairs, Texas State Office of Rural Health

Location: Hyatt Regency Hotel, Town Lake, Austin, TX
Contact: Robin Wright, Office of Rural Community Affairs
P.O. Box 12877, Austin, TX 78711-2877
512-936-6701 or 877-839-2744
FAX 512-479-8898
E-mail: rwright@crhi.state.tx.us
www.orca.state.tx.us

OCTOBER 7 – 11

"107th Annual Convention and Scientific Seminar"

Sponsored by the American Osteopathic Association

Location: Las Vegas Convention Center, Las Vegas, NV
Contact: Ann Wittner, AOA
800-621-1773, ext. 8256; or 312-202-8014

Note: Advance registration will begin in the summer of 2002.

CME CORRESPONDENCE COURSE

"Medical Ethics: Applying Theories and Principles to the Patient Encounter"

Sponsored by the University of Pennsylvania School of Medicine, the University of Pennsylvania Center for Bioethics and Clinical Consultation Services

CME: 60 hours category 2-B credits
Tuition: $1,200
Contact: 800-480-5542

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TOMA's 103rd Annual Convention & Scientific Seminar Program Chair, Bobby Howard, D.O. Welcomes Attendees, Families and Guests

As we approach the summer vacation time I would like remind everyone to mark their calenders for June 12-16 for the Texas Osteopathic Medical Association's 103rd Annual Convention and Scientific Seminar – *"D.O. Roundup – Osteopathic Medicine in Texas"*. This is an excellent opportunity to attend some timely CME sessions, network with new colleagues, renew old acquaintances, learn about new technologies and just have loads of fun, especially since we have already taken care of the "serious business" of the TOMA House of Delegates in April.

This year's educational program covers a broad range of topics from Men's Preventative Health to End of Life Care. We have top notch speakers and many of them will be new to this meeting. And of course, being in our state capital, we will also address the political and legislative issues affecting our profession. Addressing these issues will be Joe Gagen, J.D., a legislative trainer and Keynote Speaker at our Saturday luncheon. He will also be conducting a Grassroots Lobbying Workshop for CME credit as well.

But it won't be all work. We also have plenty of fun activities for attendees and their families. To liven things up in the Exhibit Hall we are going to have some Trick Roping Performers. Sustainers Night will be a relaxing river boat cruise on beautiful Lake Austin. The Family Fun Day will consist of visiting the Bob Bullock Texas State History Museum. This museum is unlike any you've ever visited and will excite and interest kids of all ages! Then we head over to an Austin favorite for decades, Saengerrunde Halle, for eats, drinks, more entertainment and fun for the whole family. And as always, ATOMA is sponsoring its Annual Fund Raising Golf Tournament. This year it takes place at the spectacular and challenging River Place Golf Course with dinner and awards to follow in the club house.

So "head 'em up and move 'em out" to the D.O. ROUNDUP. See y'all in Austin!

President of the American Osteopathic Association Guest Speaker at Convention's AOA Update Luncheon

In 1990, James E. Zini, D.O., current AOA president, joined the AOA's board of trustees. During the past decade, he has served in various capacities, including chair of the Department of Professional Affairs and member of the Accreditation Program Task Force, Bureau of Finance and the Program Task Force. He serves as an AOA representative to the Centers for Disease Control and Prevention, where he consults with the Centers on their vaccine programs. He also serves as an AOA representative to the Commission on Laboratory Accreditation Board.

In addition to AOA activities, 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 currently as an ex-officio member. 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.

Dr. Zini has worked as a family practitioner in private practice in Mountain View, Arkansas, for over 24 years. He also 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, and is a medical examiner for the Federal Aviation Administration.

Dr. Zini received his master of divinity from the Eden Theological Seminary, St. Louis, Missouri, in 1972. In 1976, he received his D.O. degree from the University of Health Sciences, College of Osteopathic Medicine, in Kansas City, Missouri.

He resides in Mountain View with his wife, Judy.

See pages 25 – 29 for convention, hotel and special events information, golf tournament sponsorship, CME sessions, breakout workshops and discounted early registration form.

Are You Asleep?
Sleep Disturbance and Psychiatric Symptoms

by Laura L. McClintock, D.O.

"Sleep that knits up the raveled sleeve of care,
The death of each day's life, sore labor's bath,
Balm of hurt minds, great nature's second course,
Chief nourisher in life's feast."
From Macbeth by William Shakespeare

Sleep disturbances are now recognized as a significant health hazard, which if left untreated, can cause serious consequences in the quality of anyone's life. There is an overlap in some situations in the area of sleep medicine where the skills and experience of the psychiatrist are needed in developing the optimum plan of care. Insomnia and the behaviors associated with the sleep disturbance have long been part of the psychiatric assessment. Psychotropic agents are a part of the sleep specialists' formulary. So what is it that the psychiatrist is looking for in this area? First let's look at the most common types of insomnia.

Transient insomnia is something that most people have experienced at one time or another. It lasts no more than a few days. This type of sleep "disruption" occurs during time of stress, excitement or anticipation like getting ready for board exams, starting a new job, getting married. It can occur during an illness, after going to high altitudes or changing sleep times. These types of sleep disturbances are very responsive to short half-life hypnotic agents for a brief interval (usually no more than seven days) with restoration of normal sleep patterns.

Short-term insomnia is up to three weeks in duration. These are sleep disturbances that are caused by severe, persistent stress like serious illness, major surgical interventions with protracted recovery, major loss or bereavement, and serious interpersonal stress. There is normally a very clear relationship between the stressor and the onset of insomnia. This form of insomnia is best treated by both pharmacological intervention using short-term hypnotics, and behaviorally with sleep hygiene techniques and stress management. Short-term insomnia due to bereavement responds best to intervention with sedating antidepressants (trazadone or mirtazepine). If left untreated, short-term insomnia places the individual at risk for developing a more intractable insomnia, a depressive syndrome or an anxiety disorder.

Chronic insomnia is a sleep disturbance that is greater than three weeks in duration and rarely is there an identifiable primary cause. There is generally more than one factor contributing to the difficulty. Often the complaint of insomnia is laid at the physician's feet, however, complaints of chronic fatigue, excessive daytime sleepiness, impaired daytime performance are the presenting complaints. With complaints of chronic insomnia or impaired quality of life due to an apparent disturbance in sleep, in-depth investigation is warranted and possibly an assessment by a sleep specialist is needed.

The psychiatric diagnoses that are often associated with insomnia are those that present with short-term and chronic insomnia. The most serious psychiatric condition associated with sleep disturbance is Major Depression. This insomnia is characterized by early morning awakening or awakening during sleep and being unable to resume sleep (middle and terminal insomnia). Hypersomnia can also be a symptom. Whether there is insomnia or hypersomnia, there is no sense of being refreshed after sleep. There are other symptoms in the complex which includes anhedonia, depressed mood everyday or almost every day for two weeks, thoughts of death or suicidal ideation, impaired attention and faulty concentration. Weight gain or loss that cannot be attributed to dieting or a loss or increase in appetite are part of the symptom complex. There can be a delusional component associated. In diagnosing Major Depression there must be five of the nine criteria present every day or almost every day for two weeks. Patients with Major Depression require pharmacological and supportive interventions. If there is minimal to no response after an effective trial of medications, a referral to a psychiatrist can be life saving. Depression of this nature is like any other chronic medical illness. If there is effective early intervention, the long-term sequella are diminished.

Adjustment disorders with depressed mood, mixed emotional features, and anxious mood are frequently associated with insomnia that is best described as difficulty going to sleep but, once asleep, being able to sustain sleep. There is usually a sense of refreshment after sleep. There is a stressor associated and the duration of symptoms has been ongoing for two months. There is generally a preoccupation associated with the stressor. There is a change in mood that is unsustained and there is no indication of a Major Depression, Anxiety Disorder or psychotic illness. The symptom of insomnia is easily treated with sedative-hypnotic agents, but the psychiatric illness requires intervention as well. Supportive psychotherapy, stress

"When sleep disturbance is the chief complaint, thinking clearly is often lost by the wayside, so getting that 'third history' is essential in making an accurate diagnosis."

management techniques, and cognitive behavioral therapies are often used to speed recovery. The course of the disturbance lasts no longer than six months after the stressor or its consequences have ceased.

Substance abuse is one of the most often overlooked causes of insomnia. Alcohol use is frequently one of the major contributors to sleep disturbances and is often unaddressed. An individual does not have to be diagnosed as chemically dependent to experience sleep disturbance stemming from substance use or abuse. Alcohol, benzodiazepines, psycho stimulants and marijuana all disrupt the natural rhythms of sleep whether used habitually or sporadically. After cessation of use of a substance like nicotine or alcohol, there can be an insomnia associated with the stabilization of the CNS as the receptor sites "reset". The use of any pharmacological agents to stabilize sleep or induce sleep when someone is using recreational psychoactive agents is futile in most cases. It just adds more to the mix.

Anxiety disorders are often found in association with depressive illness and substance abuse. This category of diagnoses is characterized by a state of heightened arousal with an autonomic response during manifestations of the disorder most commonly seen in panic attacks and flash backs. (There is an anxious response to the relative decrease of psychoactive agent as the natural process of withdrawal occurs in substance abuse disorders.) In depressive illness the negative self-absorption of the patient can generate an anxious response. True anxiety disorders have intermediate insomnia as well an initial insomnia associated with the symptom complex. Anxiety disorders are now treated with antidepressants (SSRI's and SSRI/NERI's). Psychotherapy is very beneficial in facilitating the development of increased mastery over the stressors associated with the anxiety response. It is essential in the treatment of Post Traumatic Stress Disorder, Obsessive-Compulsive Disorder, and Phobias.

The psychotic disturbances are well-known for the sleeplessness of the patient. This is associated with bizarre behaviors, delusions and hallucinations. Sometimes in severe Major Depression there will be psychotic symptoms that manifest which can become life-threatening. There is always information in the history of the disorder that can reveal the severity of the delusional syndrome. This presentation requires the use of antipsychotic agents and often hospitalization of the patient is essential to get the symptoms addressed in a safe environment. If left untreated or under-treated, the outcome can be disastrous for the patient and family.

The history of the sleep disturbance is the primary factor. When did it start? Are there any stressors-physical, emotional, interpersonal, environmental-associated with the onset of the sleep disturbance? What have you attempted to do to facilitate sleep induction? Have you gained weight recently? How many "Cokes" or how much coffee do you drink each day? How much alcohol do you drink? Have you increased the amount you drink recently? When? What was going on at that time? Do you smoke cigarettes or use tobacco products? Have you increased or decreased your use recently? Do you smoke Marijuana? Do you snore? How is your mood? Have there been any changes in your routine at work, at home? Do you do shift work? Then the basic review of systems and the physical exam.

In medical school, the faculty repeatedly stressed, "95% of the diagnosis is in the history." When I was on rotations, one of my faculty demonstrated to me his maxim that "The third history is the most inclusive." Sometimes we just have to ask over and over to get the complete history. When sleep disturbance is the chief complaint, thinking clearly is often lost by the wayside, so getting that "third history" is essential in making an accurate diagnosis. Not all insomnia is a sleep disorder; sometimes it is a symptom of a different "dis-ease".

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1. Diagnostic and Statistical Manual of Mental Disorders, *Fourth Edition, 1994; American Psychiatric Association.*
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3. *Psychiatric Times'* Monograph, Pharmacological Management of Insomnia, *May, 1999, CME, Inc., Irvine, CA.*
4. *Reite, Martin, M.D., Ruddy, M.D., Nagel, M.D.,* Evaluation and Management of Sleep Disorders, *Second Edition, 1997, American Psychiatric Press, Washington, D.C.*

Dr. McClintock received her D.O. at OSU-COM in 1988 and her post- doctoral training in Psychiatry at LSU-Shreveport and University of South Alabama Medical Center. She is currently in private practice in Fort Worth, Texas as a consultation-liaison psychiatrist engaged in the palliation of psychiatric symptoms presenting in medically ill patients. She was formerly with UNTHSC/TCOM as assistant professor of Psychiatry.

Let's Sleep On It

What Should We Know About Sleep?

The Dangers of Sleep Deprivation

The need for sleep varies among individuals and is dependent upon various factors, including age. Generally speaking, infants require about 16 hours a day, while teenagers need about 9 hours on average. When adults are allowed to sleep without restriction, the average time slept is 8 to 8.5 hours.

Experts say that if you feel drowsy during the day, you haven't had enough sleep. If you routinely fall asleep within 5 minutes of lying down, you probably have severe sleep deprivation, possibly even a sleep disorder. Microsleeps, or very brief episodes of sleep in an otherwise awake person, are another mark of sleep deprivation. In many cases, people are not aware that they are experiencing microsleeps.

Sleep deprivation can have dangerous consequences. Sleep-deprived people who are tested by using a driving simulator or by performing a hand-eye coordination task perform as badly as or worse than those who are intoxicated. Sleep deprivation also magnifies alcohol's effects on the body, so a fatigued person who drinks will become much more impaired than someone who is well-rested. According to the National Highway Traffic Safety Administration, driver fatigue is responsible for an estimated 100,000 motor vehicle accidents and 1500 deaths each year.

Sleep deprivation contributes to performance errors and increases the risk of accidents in the work place. It can also impair learning, perceptual skills, and memory in young people, thus leading to poor school performance.

(Excerpts from Problem Sleepiness in Your Patient, NIH Publication No. 97-4073, <www.nhlbi.nih.gov>; and Understanding Sleep: Brain Basics, National Institute of Neurological Disorders and Stroke, <www.ninds.nih.gov>.)

Sleep Disorders

At least 40 million Americans each year suffer from chronic, long-term sleep disorders, and an additional 20 million experience occasional sleeping problems. These disorders and the resulting sleep deprivation interfere with work, driving, and social activities. They also account for an estimated $16 billion in medical costs annually, while the indirect costs due to lost productivity and other factors are probably much greater.

Because the prevalence of sleep disorders appears to increase with advancing age, the graying of the U.S. population suggests that we will encounter an increasing public health burden in the years to come.

Sleep disorders and disturbances of sleep comprise a broad range of problems. Doctors have described more than 70 sleep disorders, most of which can be managed effectively once they are correctly diagnosed. The most common sleep disorders include insomnia, sleep apnea, restless legs syndrome, and narcolepsy.

Insomnia

Insomnia is the most prevalent sleep-related complaint. Approximately 30 percent of American adults report occasional insomnia, and nearly 10 percent report chronic insomnia. Women report insomnia more frequently than do men, and insomnia complaints increase with age.

Insomnia is the perception or complaint of inadequate or poor-quality sleep because of one or more of the following:

- difficulty falling asleep
- waking up frequently during the night with difficulty returning to sleep
- waking up too early in the morning
- nonrefreshing sleep.

Insomnia is not defined by the number of hours of sleep a person gets or how long it takes to fall asleep. Individuals vary normally in their need for, and their satisfaction with, sleep.

Periods of sleep difficulty lasting between one night and a few weeks are referred to as acute insomnia, which is often caused by emotional or physical discomfort. Examples include stressful life events, acute illness, and environmental disturbances such as noise, light and temperature.

Chronic insomnia refers to sleep difficulty at least three nights per week for one month or more. It is more complex and often results from a combination of factors, including underlying phys-

ical or mental disorders. One of the most common causes of chronic insomnia is depression. Other underlying causes include arthritis, kidney disease, heart failure, asthma, sleep apnea, narcolepsy, restless legs syndrome, Parkinson's disease, and hyperthyroidism. However, chronic insomnia may also be due to behavioral factors, including the misuse of caffeine, alcohol, or other substances; disrupted sleep/wake cycles as may occur with shift work or other nighttime activity schedules; and chronic stress.

Certain conditions seem to make individuals more likely to experience insomnia. Examples of these conditions include: advanced age (insomnia occurs more frequently in those over age 60); female gender; and a history of depression.

In addition, the following behaviors have been shown to perpetuate insomnia in some people: expecting to have difficulty sleeping and worrying about it; ingesting excessive amounts of caffeine; drinking alcohol before bedtime; smoking cigarettes before bedtime; excessive napping in the afternoon or evening; and irregular or continually disrupted sleep/wake schedules. These behaviors may prolong existing insomnia, and they can also be responsible for causing the sleeping problem in the first place. Stopping these behaviors may eliminate the insomnia altogether.

Patients with insomnia are evaluated with the help of a medical history and a sleep history. The sleep history may be obtained from a sleep diary filled out by the patient or by an interview with the patient's bed partner concerning the quantity and quality of the patient's sleep. Specialized sleep studies may be recommended, but only if there is suspicion that the patient may have a primary sleep disorder such as sleep apnea or narcolepsy.

A treatment plan for insomnia may include behavioral therapies alone or a combination of behavioral and pharmacological treatments. Short-term use of short-acting hypnotics has been shown to be effective in reducing problem sleepiness associated with acute insomnia. Lower doses of short-acting agents should be prescribed for older patients.

Sleep Apnea

First described in 1965, sleep apnea is a breathing disorder characterized by brief interruptions of breathing during sleep. It owes its name to a Greek word, apnea, meaning "want of breath." The hallmark of the disorder is excessive daytime sleepiness and compromised quality of life.

There are two types of sleep apnea: central and obstructive. Central sleep apnea, which is less common, occurs when the brain fails to send the appropriate signals to the breathing muscles to initiate respirations. Obstructive sleep apnea is far more common and occurs when air cannot flow into or out of the person's nose or mouth although efforts to breathe continue. In a given night, the number of involuntary breathing pauses or "apneic events" may be as high as 20 to 30 or more per hour. These breathing pauses are almost always accompanied by snoring between apnea episodes, although not everyone who snores has this condition.

Seep apnea occurs in all age groups and both sexes but is more common in men (it may be underdiagnosed in women). It has been

"The [sleep apnea] patient often does not know he or she has a problem and may not believe it when told."

estimated that as many as 18 million Americans have sleep apnea. People most likely to have or develop sleep apnea include those who snore loudly and also are overweight, or have high blood pressure, or have some physical abnormality in the nose, throat, or other parts of the upper airway. Sleep apnea seems to run in some families, suggesting a possible genetic basis.

Symptoms of obstructive sleep apnea include chronic, loud snoring; gasping or choking episodes during sleep; and excessive daytime sleepiness; morning headaches; loss of energy; trouble concentrating, irritability; forgetfulness; mood or behavior changes; anxiety or depression; obesity; and decreased interest in sex. Early recognition and treatment of sleep apnea is important because problems associated with untreated sleep apnea include hypertension, coronary artery disease, myocardial infarction, stroke, psychiatric problems, impotence, cognitive dysfunction, memory loss, and death.

For many sleep apnea patients, their spouses are the first ones to suspect that something is wrong, usually from their heavy snoring and apparent struggle to breathe. Coworkers or friends of the sleep apnea victim may notice that the individual falls asleep during the day at inappropriate times (such as while driving a car, working, or talking). The patient often does not know he or she has a problem and may not believe it when told.

In addition to the primary care physician, pulmonologists, neurologists, or other physicians with specialty training in sleep disorders may be involved in making a definitive diagnosis and initiating treatment. Diagnosis of sleep apnea is not simple because there can be many different reasons for disturbed sleep. Several tests are available for evaluating a person for sleep apnea, such as polysomnography and the Multiple Sleep Latency Test. Diagnostic tests usually are performed in a sleep center, but new technology may allow some sleep studies to be conducted in the patient's home.

Treatment options range from behavioral therapies to oral/dental appliances to surgical interventions. Many patients are treated with nasal continuous positive airway pressure (CPAP).

Note: The American Academy of Pediatrics has just released new clinical practice guidelines recommending that all children be screened for snoring, which is often a symptom of obstructive sleep apnea syndrome. The guidelines can be found at <www.aap.org>.

Restless Legs Syndrome

Restless legs syndrome (RSL) is a neurological disorder characterized by unpleasant sensations in the legs and an uncon-

trollable urge to move when at rest in an effort to relieve these feelings. RLS sensations are often described by people as burning, creeping, tugging, or like insects crawling inside the legs. The sensations range in severity from uncomfortable to irritating to painful. The most distinctive or unusual aspect of the condition is that lying down and trying to relax activates the symptoms. As a result, most people with RLS have difficulty falling asleep and staying asleep.

Some researchers estimate that RLS affects as many as 12 million Americans. However, others estimate a much higher occurrence because RLS is thought to be underdiagnosed and, in some cases, misdiagnosed. Some physicians wrongly attribute the symptoms to nervousness, insomnia, stress, arthritis, muscle cramps, or aging.

RLS occurs in both genders, although the incidence may be slightly higher in women. Although the syndrome may begin at any age, most patients who are severely affected are middle-aged or older. The severity of the disorder appears to increase with age.

More than 80 percent of people with RLS also experience a more common condition known as periodic limb movement disorder (PLMD). PLMD is characterized by involuntary leg twitching or jerking movements during sleep that typically occur every 10 to 60 seconds, sometimes throughout the night. The symptoms cause repeated awakening and severely disrupted sleep. Unlike RLS, the movements caused by PLMD are involuntary. In one study, RLS and PLMD accounted for a third of the insomnia seen in patients older than age 60.

The symptoms of RLS vary in severity and duration from person to person. Mild RLS occurs episodically, with only mild disruption of sleep onset, and causes little distress. In moderately severe cases, symptoms occur only once or twice a week but result in significant delay of sleep onset, with some disruption of daytime function. In severe cases, the symptoms occur more than twice a week and result in burdensome interruption of sleep and impairment of daytime function.

In most cases, the cause of RLS is unknown. A family history of the condition

is seen in approximately 50 percent of such cases, suggesting a genetic form of the disorder. People with familial RLS tend to be younger when symptoms start and have a slower progression of the condition.

Researchers have found that caffeine, alcohol, and tobacco may aggravate or trigger symptoms in patients who are predisposed to develop RLS. Some studies have shown that a reduction or complete elimination of such substances may relieve symptoms, although it remains unclear whether elimination of such substances can prevent RLS symptoms from occurring at all.

Currently, there is no single diagnostic test for RLS. It is diagnosed clinically by evaluating the patient's history and symptoms. Despite a clear description of clinical features, the condition is often misdiagnosed or underdiagnosed. In 1995, the International Restless Legs Syndrome Study Group identified four basic criteria for diagnosing RLS: 1) a desire to move the limbs, often associated with paresthesias or dysesthesias, 2) symptoms that are worse or present only during rest and are partially or temporarily relieved by activity, 3) motor restlessness, and 4) nocturnal worsening of symptoms.

Physicians must rely largely on patients' descriptions of symptoms and information from their medical history. Patients may be asked about frequency, duration, and intensity of symptoms as well as their tendency toward daytime sleep patterns and sleepiness, disturbance of sleep, or daytime function. In some cases, sleep studies such as polysomnography are undertaken to identify the presence of PLMD. The diagnosis of RLS is especially difficult with children as the symptoms can be difficult for a child to describe. The syndrome can sometimes be misdiagnosed as "growing pains" or attention deficit disorder.

Treatment for RLS and PLMD may include benzodiazepines, dopaminergic agents, or opioids. For mild cases of RLS, symptoms may be relieved by massaging the legs, exercising, and eliminating caffeine and alcohol.

Narcolepsy

Narcolepsy is a disabling neurological disorder of sleep regulation that affects the control of sleep and wakefulness. The four classic symptoms of the disorder are excessive daytime sleepiness; cataplexy (sudden, brief episodes of muscle weakness or paralysis brought on by strong emotions such as laughter, anger, surprise or anticipation); sleep paralysis (paralysis upon falling asleep or waking up); and hypnagogic hallucinations (vivid dream-like images that occur at sleep onset). Disturbed nighttime sleep, including tossing and turning in bed, leg jerks, nightmares, and frequent awakenings, may also occur.

The development, number and severity of symptoms vary widely among individuals with the disorder. Unrelenting excessive sleepiness is usually the first and most prominent symptom of narcolepsy. Patients with the disorder experience irresistible sleep attacks, throughout the day, which can last for 30 seconds to more than 30 minutes, regardless of the amount or quality of prior nighttime sleep. These attacks result in episodes of sleep at work and social events, while eating, talking and driving, and in other similarly inappropriate occasions. Although narcolepsy is not a rare disorder, it is often misdiagnosed or diagnosed only years after symptoms first appear.

In most cases, the first symptom to appear is excessive and overwhelming daytime sleepiness. The other symptoms may begin alone or in combination months or years after the onset of the daytime sleep attacks. Only about 20 to 25 percent of people with narcolepsy

experience all four symptoms. The excessive daytime sleepiness generally persists throughout life, but sleep paralysis and hypnagogic hallucinations may not.

Narcolepsy affects an estimated 250,000 Americans. It is often misdiagnosed as depression, epilepsy, or the side effects of medications. It can occur in both men and woman at any age, although its symptoms are usually first noticed during adolescence and young adulthood, commonly before the third decade of life. Narcolepsy can also occur in children. A definitive diagnosis of narcolepsy usually requires objective testing and evaluation by a sleep specialist.

Treatment of narcolepsy includes central nervous system stimulants for excessive daytime sleepiness, as well as anticholinergics and antidepressant agents for cataplexy. Basic lifestyle adjustments such as regulating sleep schedules and scheduled daytime naps are an important adjunct to drug therapy.

In 1999, a research team working with canine models identified a gene that causes narcolepsy – a breakthrough that brings a cure within reach.

(Excerpts from "Problem Sleepiness In Your Patient," NIH Pub. No. 97-4073; "Insomnia: Assessment and Management In Primary Care," NIH Pub. No. 98-4088; "Facts About Insomnia," NIH Pub. No. 95-3801; "Facts About Narcolepsy," NIH Pub. No. 96-3649; "Facts About Sleep Apnea," NIH Pub. No. 95-3798; from National Heart, Lung, and Blood Institute at <www.nhlbi.nih.gov> and "Understanding Sleep: Brain Basics"; "NINDS Sleep Apnea Information Page"; "Restless Legs Syndrome Fact Sheet"; NINDS Narcolepsy Information Page"; from National Institute of Neurological Disorders and Stroke at <www.ninds.nih.gov>.)

Children and Sleep Disturbances Study

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., M.P.H., 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. These sleep-related 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.

The researchers collected data from the children, as well as from their parents and teachers. Collecting data from parents alone may give an incomplete picture of childhood sleep behavior, according to Owens. Teachers, for example, noted higher levels of daytime sleepiness in younger children than in older, while parents did not. "This finding underscores the potential importance of obtaining teacher observations when assessing children for daytime repercussions of disordered sleep," said Owens.

"Teachers are routinely observing children in a different environment and under a different level of stimulation than are parents," she added.

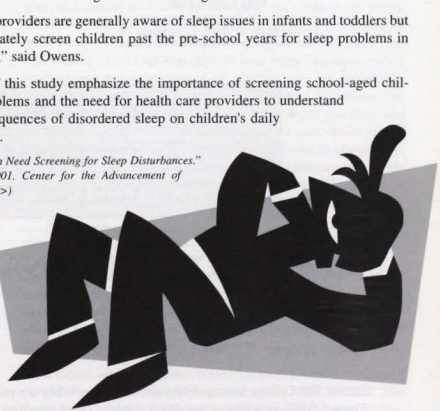
The reports of children themselves are equally important, according to the researchers, who noted discrepancies between parents and children's reports. Children reported higher levels of certain sleep problems, like difficulty falling asleep and waking in the night, than did their parents, the researchers found.

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.

"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," said Owens.

"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," said Owens.

("School-Aged Children Need Screening for Sleep Disturbances." News release. 2-11-2001. Center for the Advancement of Health, <www.cfah.org>)



The folks at the IRS must have kids too.

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WHY REFER TO CLINICAL TRIALS?

by Clifton Cage, D.O., P.I. and Debbie Lewis, RN, Clinical Trials Coordinator

The number of family physicians involved in clinical trials has significantly increased in recent years. For the pharmaceutical companies, the cost of initiating additional investigative sites is insignificant in comparison with the dollars saved by expediting the approval process. Data from more sites in less time translates to the marketing of their drug sooner, the recovery of their research costs, and profit.

The reasons a busy osteopathic family physician might choose to become involved in clinical trials are varied. One benefit is continued learning. Trial-related training broadens the investigator's examination and diagnostic skills, enriching the scope of their practice. Involvement in trials equips the investigator with first-hand experience with the efficacy and tolerability of new drugs. Prescriptions based on such knowledge are made with confidence that is lacking when relying on the presentation of those with a vested interest in the sale of the product. Additionally, clinical trials offer an avenue of providing care for patients without health insurance or means to pay for services and medications. Finally, clinical trials also provide an additional source of income.

Subjects who choose to participate in clinical trials enjoy the satisfaction of contributing to medicine for themselves and future generations; the opportunity to receive a variety of diagnostic tests, cutting-edge treatment for their medical condition; and the close and frequent monitoring by the investigative staff. Drug accountability and frequent laboratory assessments often result in greater patient compliance, accountability, and ultimate control of their disease.

The benefits to the sponsor, investigator, and subject are clear. Why a treating physician might choose to refer patients to a clinical trial is the question. The reasons NOT to refer patients seem glaring. After all, don't those investigators use clinical trials as a way of building their practice patient population? Once a patient gets into one of those trials, the treating physician loses control and has no knowledge of what effect the study is having on their patients, do they?

Quite the opposite is true of clinical trials conducted in the Family Medicine department of the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in Fort Worth, Texas. Our goal as an investigative site is to further the science of medicine, and support rather than assume the care provided by the primary physician and other treating physicians. Subjects' health and well-being are the primary concern of the investigative staff.

The informed consent document is provided for review by the primary care physician. Copies of all lab results and procedure reports are forwarded for inclusion in the patient's medical record. Referring physicians who choose not to do clinical research themselves, may actually achieve better outcomes of difficult to manage patients through referrals to clinical trials. Reimbursement issues and time constraints brought on by managed care have all but eliminated the hand holding that some patients need. Patients are the first to admit that they are more compliant when involved in a clinical trial because they are seen more frequently and monitored so closely. Patients without insurance, or other means of reimbursement, benefit greatly from participation in clinical trials. Because all visits, exams, and trial-related labs and procedures are done at no cost to the patient, data that might otherwise be unavailable provide a basis for treatment by the patient's primary care physician. In many cases, the clinical investigator is able to provide samples for patients who need assistance to comply with their medication regimen.

In summary, clinical trials can be a win-win-win-win proposition for the sponsoring company, the investigative site, referring physician, and study subject through the advancement of medicine, treatment of disease, furthering education and enhancing practice, and improved medical management for those unable to afford proper care. The subjects benefit from the satisfaction of contributing to medicine; a variety of diagnostic tests and the potential for cutting-edge treatment for their medical condition; and the close and frequent monitoring by the investigative staff. The fact that they frequently achieve improved management of their disease as a result of increased compliance is, perhaps, the biggest benefit of all. The principle investigator enriches the scope of their practice while contributing to the advancement of medicine, and obtains first-hand knowledge of the efficacy and tolerability of new drugs. Clinical trials provide an additional avenue of continuing education while supplementing income. Primary care and treating physicians who refer patients often find these collaborations enhance management of patients who are difficult to manage due to compliance and/or reimbursement limitations. The close and frequent monitoring augment needed teaching and emotional support that is limited by managed care. Study related labs and procedure results, data that may otherwise be unavailable, provide the basis for treatment by the subject's primary care physician. The collaboration of all involved benefit untold numbers of patients with common diagnoses for generations to come.

For information regarding clinical trials in the department of Family Medicine at UNTHSC/TCOM, call 817-735-0432.

Dr. Cage is the Director of Clinical Trials for the Family Medicine Department of the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in Fort Worth, Texas. He has over 30 years experience as a family medicine provider and over 5 years experience in clinical trials.

Mrs. Lewis, an R.N., is the Senior Clinical Trials Coordinator for the Family Medicine Department of UNTHSC/TCOM. She has a background in cardiology and intermediate care nursing, and over 5 years clinical trial research experience as well.

CASE REPORT

Multiple Myeloma

by Mark A. Sanders, D.O.
University of North Texas Health Science Center at Fort Worth
Department of Family Medicine

Agent Orange exposure may be a link in this patient in his development of MM.

The United States military should continue to invest resources into discovering diseases possibly linked to Agent Orange exposure.

General

Multiple Myeloma (MM) occurs when an inciting event causes malproliferation of the B-cell lineage in the bone marrow. The etiology is essentially unknown except there seems to be an increase incident of MM in those exposed to nuclear radiation during World War II. MM affects men slightly more than women. It occurs in blacks at twice the rate of whites and has a median age at diagnosis of 68. The most commonly presenting complaint is pain worsened by movement affecting the back or ribs.[1,2,3] This case report details a patient diagnosed with MM with an accompanying review.

Case Report

Presentation

The patient is a 61-year-old Caucasian male with past medical history of non-insulin dependent diabetes mellitus, benign prostatic hypertrophy, coronary artery disease with prior myocardial infarction, essential hypertension presenting to an emergency department complaining of 3-month history of intermittent midline lower thoracic pain after moving a refrigerator. He was placed on an anti-inflammatory, muscle relaxant and narcotic pain medicine by his internist. These pains progressively worsen and the day of admission he began having diffuse abdominal pain. His past history was pertinent for tobacco abuse (1 pack per day for 10 years), Agent Orange exposure in Vietnam 27 years ago, and a weightlifting champion. His family history included mother with ovarian cancer, father with a pulmonary embolus, otherwise unremarkable.

Physical Exam

His vitals sign were stable except pain was rated 5 out 5 on the Wang pain scale. He appeared his stated age in moderate distress secondary to pain. Heart was regular rate and rhythm without murmur, rub or gallop. His lungs were clear to auscultation bilaterally. His abdomen was soft, distended, and diffusely tender, bowel sounds were present in all four quadrants, no masses, scars or hepatosplenomegaly were appreciated. Neurological exam was nonfocal. Musculoskeletal exam revealed exquisite tenderness over the midline of the back at T6-T10 exacerbated with any movement, paraspinal muscles were tight at the corresponding levels, and strength was 5/5 in all extremities. Rectal exam was unremarkable and he was guaic negative.

Laboratory Data (normals in parenthesis)

A metabolic panel revealed elevation of calcium at 12.1 (8.4-10.2 mg/dL), BUN at 22 (9-20 mg/dL), creatinine at 1.8 (0.8-1.5 mg/dL), total protein at 8.8 (6.3-8.2 g/dL) and alkaline phosphate at 164 (50-136 u/L). Complete blood count and parathyroid hormone were normal. Urine immunoelectrophoresis revealed total protein elevated at 3478 (10-140 mg/24hour); albumin, alpha 1, alpha 2, and gamma were detected (nondetected), Bence-Jones-QL positive (negative), Bence-Jones-QT was 3438.8 mg/24hour. Serum immunoelectrophoresis revealed elevation of total protein at 8.50 (6.00-8.30 g/dL), gamma at 2.42 (0.72-1.46 g/dL), Immunoglobulin A (IgA) at 2050 (68-378 mg/dL) with an M spike in the gamma region of the monoclonal peak accounted for 1.89 g/dL of the total 2.42 g/dL. IgM and IgG were low. Protein electrophoresis revealed elevation of total protein at 8.60 (6.00-8.30 g/dL), gamma at 2.47 (0.72-1.45 g/dL), IgA at 1930 (68-378 Mg/DL), and beta2-microglobulin at 4.6 (1.1-2.4 µg/mL).

Studies

Radiographs: An MRI without contrast revealed pathological fracture of the vertebral body of T10. Plain films of the hip, femur and skull revealed enumerable lytic lesion consistent with multiple myeloma. A whole body bone scan revealed multiple abnormal foci of increased activity in cervical and lower thoracic spine, posterior ribs, left skull and anterior costochondral junctions consistent with metastatic disease process. A bone marrow biopsy revealed a plasmacytosis of greater 10%. A MUGA scan was performed prior to beginning chemotherapy and was within normal limits.

Diagnosis and Staging

The patient was diagnosed with IgA Multiple Myeloma. The patient was staged as Stage IIIA (high burden) disease using the Durie-Salmon staging system (see Table 1) for MM. The patient met two of the four criteria for Stage III disease (calcium level greater

TABLE 1[3]
Durie-Salmon Staging System for Multipe Myeloma

Stage	Criteria	Estimated Tumor, x1012 cells/m2
I	All of the following: 1. Hemoglobin>10g/dL 2. Calcium <12 mg/d 3. Normal bone x-rays or solitary lesion 4. Low M-component production a. IgG level <5g/dl b. IgA level <3g/dl c. Urine light chain<4g/24 hour	<0.6 (low burden)
II	Fitting neither I nor III	0.6-1.20 (intermediate burden)
III	One or more of the following: 1. Hemoglobin <8.5 g/dL 2. Calcium >12 mg/dl 3. Advanced lytic bone lesions 4. High M-component production a. IgG level >7 g/dl b. IgA level >5 g/dl c. Urine light chain >12 g/24 hour	1.20 (high burden)

TABLE 2[1]
Subclassification Based on Serum Creatinine and Survivalship

Level	Serum Creatinine	Stage	Median Survival (Months)
A	<2mg/dL	IA	61
B	>2mg/dL	IIA, B	55
		IIIA	30
		IIIB	15

than 12 (12.1 mg/dL) and advanced lytic bone lesions (plain bone radiographs revealed enumerable amount). He was further categorized as IIIA because his creatinine level was less than 2 (1.8 mg/dL) (see Table 2). This would place his median survival expectancy at 30 months. However, staging based on beta2-microglobulin (see Table 3) is the most powerful predictor of survival and for this reason is often used in place of staging to determine median survival. This patient had a beta 2-microglobulin level of greater than 4 (4.6 µg/mL). Thus his expected survival rate is approximately 12 months.

Hospital Course

The patient was admitted to the oncology floor and was placed on scheduled and as needed narcotic pain medications. He was given Aredia® to normalize his calcium. He developed a fever of 101˚F on day 4 and was placed on Fortaz®. No specific infectious cause was identified. Sputum, urine and blood cultures

TABLE 3
Serum Beta 2 – Microglobulin Level Staging and Survivalship

Level	Stage	Median Survival (Months)
<4µg/mL	I	43
>4µg/mL	II	12

were negative, a 2-view chest X-ray was unremarkable, CBC was normal and the fever resolved after 24 hours and Fortaz® was discontinued. The patient remained afebrile throughout the rest of the hospitalization. Prior to discharge from the hospital, he was given a chemotherapeutical regimen consisting of Cytoxan®, vinicristine, melphalan and prednisone. He tolerated this regimen without complications. The patient was tolerating a regular diet, ambulating without difficulty and his pain was controlled with non-narcotic pain medications. He was to follow-up in 1 week with his oncologist.

Discusion

General

MM is a malignant proliferation of plasma cell generally derived from a single clone.[1,2,3] This tumor cell proliferation can result in multiple organ system involvement. MM median age of onset is 68 with an annual incidence of 4 per 100,000 persons.[3] Males are more often affected than females with blacks developing MM twice the rate of whites.[4,5,6]

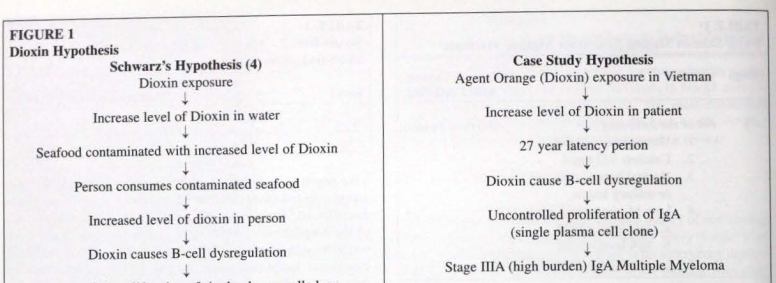
Clinical Presentation

The most common presenting symptom in MM is bone pain, which commonly occurs in the back or ribs. Movement usually precipitates this pain and if the pain is persistent and localized it usually represents a pathological fracture.[1] Patients are more prone to develop infections because MM produces functional hypogammaglobulinemia (not producing enough normal Ig and increase catabolic rate of Ig destruction).[2,3] This causes poor overall function of the antibodies thus raising the risk of infections. MM also may present as kidney failure. This is usually from the hypocalcaemia (from bone resorption) but may also be secondary to the light chain toxicity or direct renal infiltration by the myeloma cells (myeloma kidney).[1,2,3] Anemia can also result from MM. It is usually normocytic normochromic and is due to tumor cells replacing normal bone marrow.[1] Neurological symptoms usually occur because of the hypocalcaemia (abdominal pain, lethargy, irritability) or symptoms of cord compression secondary to pathological fractures.[1,2]

Etiology

The cause of MM is unknown. There has been an increase frequency noted in people exposed to nuclear warhead radiation after a 20-year latency period. Recently there has been a proposal that exposure to dioxins increases the risk for developing MM.[4,5] One such dioxin is Agent Orange (TCDD) that was commonly used in the Vietnam War. Agent Orange, a dioxin, has been used in animal studies and is shown to be carcinogenic.[4,6] Their immune systems have been shown to be highly sensitive to doses that do not produce overt signs of toxicity. TCDD affects both the T-cell and B-cell mediated immunity.[4] The hematopoetic tissue is

FIGURE 1
Dioxin Hypothesis



one target for the actions of dioxin. Links between MM and dioxin were first proposed in the late 1970s and 1980s.[4] Elevated relative risks were found for MM in those exposed to TCDD.[6]

Dioxin Hypothesis: In 1997, TCDD was classified as a group 1 human carcinogen by the International Agency for Research on Cancer.[7] Since dioxins are immunotoxic, target hematopoetic tissue and inhibit the B-cell lineage proliferation, they are conceivably myelomagens.[4] The hypothesis is simply that one is exposed to dioxin in a significant amount which accumulates in their body, then causes B-cell dysregulation, thus increases the risk of MM.[4] In this case report the hypothesis would be: patient exposed to TCDD during the Vietnam War in significant amounts to elevate levels in his body significantly enough to cause B-cell dysregulation thus increasing his risk for developing MM. After a greater than 20 year latency phase he indeed developed MM (see Figure 1). Currently there is not enough data to determine the latency phase of a TCDD exposure and development of MM.[5]

Schwartz's dioxin hypothesis was based on elevated levels of dioxin in water and increased rates of MM around these bodies of water. The hypothesis that flowed was the contaminated water accumulated in fish and seafood. Those that consumed higher levels of contaminated seafood would achieve elevated levels of dioxins in their body. This would lead to B-cell dysregulation and thus increase risk of MM (see Figure 1). Further studies, however, have possible increased incidence. In a Seveso study, which involved a dioxin chemical leak in Italy, the population was exposed to high levels of dioxins. The area was divided into zones depending on their proximity to the dioxin spill. This study found a weak correlation between dioxin exposure and MM.[6] Currently, Agent Orange is classified as a compound that is limited/suggestive of being correlated with MM. The limited/suggestive category means that there appears to be a link between MM but the association may be because of chance or bias.[5] However, there are studies to support a link. The United States military has been studying those exposed to Agent Orange in Vietnam but have found no conclusive data to support the theory that these exposures have definitely increased the incidence of MM.[5]

Conclusion

Agent Orange exposure may be a link in this patient in his development of MM. Current studies are underway on veterans exposed to Agent Orange and they may find that this was indeed a cause of developing MM, thus providing us with a better understanding of the pathogenesis in the early stages of B-cell dysregulation in MM. This understanding should also provide us with better treatment options, thus better survivalship. The United States military should continue to invest resources into discovering diseases possibly linked to Agent Orange exposure.

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Mark A. Sanders, D.O. is a 1998 graduate of UNTHSC/TCOM and is currently a Geriatric Medical Fellow at UNTHSC at Fort Worth. He was the recipient of the 2001 Phillip P. Saperstein Award for Outstanding Resident.

NEWS

from the University of North Texas Health Science Center at Fort Worth

U.S. News & World Report Ranks UNT Health Science Center Among Top Primary Care Medical Schools

The University of North Texas Health Science Center at Fort Worth has been ranked as one of the country's top medical schools in primary care by *U.S. News & World Report*. The magazine published its annual rankings of America's best graduate schools in its April 15 issue.

The Texas College of Osteopathic Medicine (TCOM) at UNT Health Science Center tied for 39 on the list with Brown University, Wake Forest, and University of Nebraska. This is the first time this survey has ranked the health science center in the top 50 medical schools. However, the magazine has ranked the community health degree program at the center's School of Public Health since 2000. That specialty survey was not updated this year.

These rankings of the medical schools are based on the results of surveys sent to deans and senior faculty of the 144 medical schools in the United States and to residency program directors, as well as other criteria such as student selectivity and faculty resources.

A complete copy of the survey results is available online at <www.usnews.com>.

UNTHSC Physician to Lead American Osteopathic Academy of Sports Medicine

Fort Worth physician Alan Stockard, D.O., FAOASM, will assume the presidency of the American Osteopathic Academy of Sports Medicine at its annual meeting April 10-14 in Washington, DC.

Dr. Stockard is sports medicine director at Sports Medicine and Rehabilitation of Texas (SMART) and associate professor of family medicine at the University of North Texas Health Science Center. He is actively involved in the athletic community in several capacities. Locally, Dr. Stockard volunteers as the team physician for 10 local high schools and one of several physicians for the Fort Worth Stock Show and Rodeo. He is also the medical director of the Cowtown Marathon.

Dr. Stockard is also a charter member of Texas' University Interscholastic League's Medical Advisory Committee. He has served as team physician for a variety of statewide organizations, including the Texas State Golden Glove Championships. Nationally, Dr. Stockard serves on the national Sports Medicine Subcommittee of the U.S.A. Judo team. He has also been a part of the U.S. Olympic Committee's drug control team.

He received his undergraduate degree from The University of Texas at Arlington and his medical degree from the health science center's Texas College of Osteopathic Medicine (TCOM). Dr. Stockard is board certified in both family practice and sports medicine.

The American Osteopathic Academy of Sports Medicine is dedicated to treating athletes involved a variety of sports, emphasizing the use of osteopathic manipulative medicine in treating the complete athlete.

TCOM Dean to Lead American Academy of Pain Medicine

Marc B. Hahn, D.O., dean of the Texas College of Osteopathic Medicine (TCOM) at the University of North Texas Health Science Center, is now the 2002 president of the American Academy of Pain Medicine. He assumed the presidency of the organization at its annual meeting February 26 through March 3 in San Francisco.

Dr. Hahn obtained his undergraduate degree from Syracuse University and his medical degree from Des Moines University. He completed his internship and residency in anesthesiology at Walter Reed Army Medical Center. He then completed a fellowship in pain management through both Georgetown University and the Clinical Center of the National Institutes of Health. He is board certified in anesthesiology with sub-specialty certification in pain management.

Dr. Hahn was a 1998-1999 Robert Wood Johnson Health Policy Fellow at the Institute of Medicine of the National Academy of Sciences in Washington, D.C. In that capacity, he served as a Health Advisor to the U.S. Senate Committee on Finance. He served for 12 years in the U.S. Army, prior to an honorable discharge at the rank of Major. While in the army, Dr. Hahn was stationed at the Walter Reed Army Medical Center and the Uniformed Services University. He also served as an anesthesiologist for two U.S. Presidents.

Prior to joining the health science center last September, Dr. Hahn was a professor of anesthesiology and director of the Pain Medicine Fellowship Program at the Pennsylvania State University College of Medicine and was also the chief of the Pain Medicine Division at the Milton S. Hershey Medical Center.

Dr. Hahn is active in clinical research, having published multiple abstracts, book chapters, book reviews, editorials, and scientific papers. His textbook, *Regional Anesthesia: An Atlas of Anatomy and Technique*, was recognized as the Best New Textbook in Clinical Medicine by the Association of American Publishers. The second edition of this text is in progress. He also served as an associate editor for the 3rd edition of the preeminent and authoritative textbook, *Practical Management of Pain*.

The American Academy of Pain Medicine is the multi-specialty physician organization for practice of pain medicine. Its mission is to promote quality care of patients with pain as a symptom of disease and primary pain disease. AAPM is the only pain organization with representation in the American Medical Association (AMA) House of Delegates. The organization was founded in 1983 and now has 1,300 physician members.

UNTHSC Receives $1.5 Million Endowment for Clinical Research

Osteopathic Heritage Foundations, of Columbus, Ohio, have established an endowed Distinguished Chair of clinical

research at the University of North Texas Health Science Center at Fort Worth.

The $1.5 million endowment supports a growing clinical research team that conducts patient-based clinical research. Funds from the endowment will also provide stipends for students who are simultaneously earning medical degrees and doctorates in biomedical sciences as they conduct clinical research projects in their final years of medical school.

The clinical research team consists of physician researchers, basic scientists, epidemiologists, statisticians, and medical students, including those who are earning combined D.O. and Ph.D. degrees.

In addition to increasing its clinical research, the health science center will use the funding to train more physician scientists capable of conducting their own clinical research programs.

The health science center now plans to conduct a nationwide search for a physician with an established record in clinical research for the Distinguished Chair.

"The endowed chair in clinical research brings a new dimension of coordination to our expanding quest for discovery, leading to preventive measures, early diagnosis, and enhanced treatment for cancer, Alzheimer's disease, tuberculosis, and cardiovascular disease, to name a few research areas," said Benjamin Cohen, D.O., health science center provost and senior vice president for health affairs.

This is the first gift from the Osteopathic Heritage Foundations to the health science center. The Ohio-based foundation supports osteopathic medical education and research, as well as programs that improve health and quality of life in central and southeastern Ohio.

"The foundation's decision to establish the endowment was based upon the Texas College of Osteopathic Medicine's distinguished history and high quality programs," said Rick Vincent, Foundation president. "We are proud to support TCOM in this way and to recognize the excellent students, staff, faculty and administration, noting especially Dr. Cohen, provost and Dr. David Richards, former UNTHSC President."

NOM WEEK 2002 to be Held in Conjunction with AOA Convention

The celebration of National Osteopathic Medicine Week will be held in conjunction with the AOA 107th Annual Convention and Scientific Seminar. The AOA notes that the decision to link the two events represents a great opportunity to recognize the achievements of the profession, both internally within the family of osteopathic medicine and externally with the general public.

A theme will be developed for NOM Week that incorporates the convention theme "Osteopathic Medicine: Leading the Way in Comprehensive Care". Stay tuned for more details in the coming weeks.

The official dates for this year's NOM Week are October 6-12, 2002. The convention dates are October 7-11, 2002, in Las Vegas, Nevada.

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Do you refer the patient to the cardiologist? If so – how much time passes and how many events are missed in that one week, two weeks, or five weeks until they get in to the cardiologist? Instead of sending the patient to the cardiologist for a "suspected" condition, why not do the holter – with ambulatory blood pressure monitoring or 30 day patient activated event monitor in your office and YOU get paid for it by the insurance carrier? There are (4) four very good reasons why you should:

* **You can put the monitor on the patient today or tomorrow – no long waiting times, so events are not missed while waiting for an appointment with a cardiologist.**
* **Early detection can save patient lives!**
* **Reimbursement from private insurance is Excellent!**
* **Neither one costs you or your practice even a penny!**

We're doing this in thousands of offices. Call **DON SELF** at 800 256-7045 TODAY for information. This can and does save patient lives! If you call us today, you can be using these free monitors by next Monday.

You've trusted **DON SELF & ASSOCIATES** for 14 years to bring you coding, reimbursement and collection information. Trust us now and let us explain how and why this will help your patients without costing you money.

YOU HAVE PATIENTS WITH MIGRAINE HEADACHES AND/OR I.B.S. & NOTHING SEEMS TO BE HELPING SOME OF THEM. DON SELF HAS A SUGGESTION WORTH LISTENING TO.

I personally did not know that food allergies usually result in a reaction (skin or pulmonary) within 4 hours, but food sensitivities may take 4 days to show a non specific reaction – such as **DIARRHEA** or **MIGRAINE HEADACHES**. You knew that certain TRIGGER FOODS" are known to spark migraines – but I didn't realize that **as many as 75% of migraines** may be caused by food sensitivities to other foods or chemicals.

Many of the patients suffering from **diarrhea predominant Irritable Bowel Syndrome** may also be suffering from food sensitivities and if you identify what those particular foods are and take them out of the diet – more than 7 out of 10 may have those episodes of diarrhea either reduced or eliminated.

I was amazed to find just how many of your patients are probably suffering from Irritable Bowel Syndrome. What a surprise it was to learn there is a test that will help identify the sensitivities that cause so many to suffer and is reimbursed by most carriers. Some of your colleagues are participating and helping manage the problems of their patients. If you would like more information, give us a call today.

The important thing is that many patients are being helped by the FDA approved **LEAP** lab test & subsequent diet changes and, again, insurance carriers are paying quite well for it too – which is never a bad thing.

Help some of the patients with **Migraines** & **IBS** that are not getting help otherwise with the **LEAP** test.

DON SELF & ASSOCIATES, INC. **Call Don today - 1 800 256-7045**

Self's Tips & Tidings

By Don Self

Patient Requests Code Changes

You coded the services you provided and submitted the claim, yet the patient's insurance didn't pay as much as they might have. The patient gets a bill for the remainder of the balance and complains that you didn't use the right codes on the claim. The patient continues to ask you to re-code the claim so the carrier will pay more, and no matter how many times you tell them "NO", they persist. Try sending the following letter:

"Your insurance claim has been coded by professionals so as to abide by local, state and national coding guidelines and documentation rules. We have already told you that we cannot change the codes on the claim to reflect anything other than what we have already coded. To do so would put us and yourself into danger of violating Federal False Claims laws. Are you asking us to violate federal laws? It is our responsibility to report any such requests to the Office of the Investigator General."

Digital Rectal Exams

Per Medicare Carrier's Manual 4182.6 "Billing and payment for a Digital Rectal Exam (DRE) (G0102) is to be bundled into the payment for a covered E/M service (99201-99456 and 99499) when the two services are furnished to a patient on the same day. If the DRE is the only service or is provided as part of an otherwise noncovered service, HCPCS code G0102 would be payable separately if all other coverage requirements are met."

Diagnostic Coding Tips

Here are seven tips that should help you make sure you're doing the best job of coding that you can. Doctor, the primary responsibility for coding is yours and not your staff, since it will be you who will be fined or even possibly jailed if the coding isn't done correctly.

1. Code the confirmed diagnosis whenever possible. If you have confirmed a diagnosis based on the results of the diagnostic test, you should code that diagnosis.
2. If there's no confirmed diagnosis or the results are normal, code the signs and symptoms that prompted you to order the rest. Let's say you see a patient in your office for chest pain and do an EKG (93000). The EKG is normal, and the final diagnosis is chest pain due to suspected gastroesophageal reflux disease (GERD). You would NOT use the GERD as the diagnosis for the EKG. The primary diagnosis code for the EKG should be chest pain, because the EKG was normal and you did not determine a definitive cause for the chest pain
3. Never list incidental findings as primary diagnoses. You should report incidental findings as secondary diagnoses only. For example, a patient presents to you because of wheezing, and you do a chest X-ray. The X-ray is normal except for scoliosis and degenerative joint disease of the spine. In this case, you report wheezing as the primary diagnosis since it was the reason for the patient's visit, and you may report scoliosis and degenerative joint disease of the spine as secondary diagnoses.
4. Report unrelated and co-existing conditions/diagnoses as secondary diagnoses. For example, an established patient presents with a cough, and the result of the ensuing chest X-ray indicates the patient has pneumonia. The patient also has chronic hypertension and diabetes mellitus. In this case, you report a primary diagnosis of pneumonia. You may also report the hypertension and diabetes mellitus as secondary diagnoses.
5. Code to the highest degree of specificity. In the context of ICD-9 coding, the "highest degree of specificity" refers to the code that most fully explains the narrative description of the symptom or diagnosis. For example, if a chest X-ray reveals a primary lung cancer in the left lower lobe, you should report the ICD-9 code 162.5 for malignancy of the left "lower lobe, bronchus or lung," not the code for a malignancy of "other parts of bronchus or lung" (162.8) or the code for "bronchus and lung, unspecified" (162.9).
6. Code to the correct number of digits. Remember that ICD-9 diagnosis codes have three, four or five digits. Assign three-digit codes only if there are no four-digit codes within that code category. Assign four-digit codes only if there are no five-digit codes for that category. Assign five-digit codes where they exist. As an example, if you see a patient with diabetes, it would be incorrect to assign code 250 since all codes in this series have five digits. The fourth and fifth digits of the code vary depending on the patient's condition. If the type of diabetes is not specified and there is no indication that the patient has a complication or that the diabetes is not under control, the correct ICD-9 code would be 250.00.
7. If you order a diagnostic test in the absence of signs/symptoms or other evidence of illness or injury, use the appropriate "screening" diagnosis code. The primary ICD-9 diagnosis code should reflect that it is a screening test (e.g., V76.11, "Screening mammogram for high-risk patient"). The results of the test, if reported, may be recorded as additional diagnoses.

Free Vaccinations Must Also Be Extended to Medicare

MCM §4480.5
No Legal Obligation to Pay

"Nongovernmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. (See §§2306 and 309.4.) Thus, for example, Medicare may not pay for flu Vaccinations administered

to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees. Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients. (See §1128 (b)(6)(A) of the Act.)".

You Can Call Patients by Their Name

Beware of those companies trying to sell you this or that latest gimmick so "you will be compliant with HIPAA." One thing that many seminar leaders are teaching is that effective April 2003, you will no longer be allowed to call patients by their names in the reception area, as that would be a violation of the patient's privacy. That smells like pooh-pooh to me because it is! Here is something from CMS (formerly HCFA) in black and white, from the July 14th CMS clarification of HIPAA Privacy guidelines:

"Provisions of this rule requiring covered entities to implement reasonable safeguards that reflect their particular circumstances and exempting treatment disclosures from certain requirements are intended to ensure that providers primary consideration is the appropriate treatment of their patients... We will propose regulatory language to reinforce and clarify that these and similar oral communications (such as calling out patient names in a waiting room) are permissible."

Also – keep in mind that if you are a small office with less than 25 employees, you can request and get an automatic extension on HIPAA compliance that extends until April 2004, so don't panic yet. Remember that there are a lot of people teaching about HIPAA today – but a lot of what you're hearing may be intended to help sell you on buying their product or getting you to spend $50,000 on an attorney to write you a HIPAA compliance plan.

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TDH Awards Unclaimed Lottery Winnings to Hospitals

The Texas Department of Health (TDH) has awarded $16.4 million in unclaimed Texas Lottery winnings to 132 hospitals in 102 Texas cities to reimburse them for some of the cost of providing certain types of medical care to patients whose bills have not been paid.

The reimbursement program was established by the Texas Legislature in 1999 and directs TDH to provide the money to Texas hospitals for providing tertiary, stabilization and extraordinary emergency care services to patients from outside the hospitals' designated service areas whose bills have not been paid.

During the 2000-2001 state biennium, which ended August 31, some $57.2 million in unclaimed prizes from on-line drawings and instant games was available from the Texas Lottery Commission.

By law, the first $40 million in unclaimed winnings each biennium is earmarked for the University of Texas Medical Branch at Galveston (UTMB). Of the remaining funds, state law specifies that 90 percent ($15.6 million for the 2000-2001 biennium) be awarded to hospitals for tertiary and stabilization care and 5 percent ($.8 million) for extraordinary emergency care. The remaining 5 percent ($.8 million) is to be transferred to the state's County Indigent Health Care Program, which also benefits hospitals and local governments.

The 132 hospitals applying for the tertiary, stabilization and extraordinary emergency care funds reported $556 million in unpaid billings. TDH applied a Medicare cost-to-charge ratio, or rate, to arrive at a cost figure for providing the services and then reimbursed the hospitals a pro rata share of funds available. The total calculated cost of providing the services was $260 million.

Peggy Belcher, who administers the program for TDH, said the money received by the hospitals was 6 percent of the computed cost of providing the tertiary and stabilization services and 31 percent of the calculated cost to provide the extraordinary emergency care. Hospitals receiving funds in the extraordinary emergency care category treated victims of Tropical Storm Allison, which struck the Houston area in June 2001.

TDH mailed an application package to qualified hospitals in August. Hospitals had until December 31 to apply for the funds.

The next disbursement, for the 2002-2003 state biennium, will be done in early 2004. UTMB will continue to receive periodic payments during the biennium based on unpaid billings submitted.

Lottery winnings are considered forfeited if not claimed within 180 days of an on-line drawing or the close of an instant game.

The 57th Meeting of the TOMA House of Delegates

April 20, 2002
Round Rock, Texas

Final actions of the TOMA House of Delegates will be reported in the June issue of the *Texas D.O.*


TEXAS OSTEOPATHIC
MEDICAL ASSOCIATION


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TEXAS OSTEOPATHIC
MEDICAL ASSOCIATION

ATOMA News

The ATOMA House of Delegates Meeting
April 20, 2002, Round Rock, Texas

Share With Those In Real Need

Austin's Women's Shelter
SAFE PLACE

ATOMA will be collecting the following items at the TOMA Annual Convention, in Austin, June 12 – 16, to donate to SAFE PLACE

Diapers–Preferably sizes 5 and 6.

Women's and children's summer clothes – New or gently used T-shirts, shorts, cotton blouses, skirts and summer dresses.

Women's and children's *new* underwear and socks.

Check their web site <www.austin-safeplace.org> for other "Wish List" items.

LOOK FOR THE ATOMA COLLECTION BOX AT THE TOMA REGISTRATION DESK.

***REMEMBER:** Most women and their children arrive at the shelter with only the clothes on their backs, leaving behind everything to escape their violent environment.*

Texas Osteopathic Medical Association

103rd Annual Convention & Scientific Seminar

Renaissance Austin Hotel • Austin, Texas

June 12 – 16, 2002

Whether you serve in osteopathic, allopathic or integrated communities as a physician, physician's assistant, nurse or other healthcare provider, you will benefit from this educational and networking opportunity. The program includes educational sessions on a wide variety of health topics, instructed by leading health care professionals, along with specialty breakout workshops. In addition to the educational value, you can visit over 75 exhibitors, enjoy great social events and network with your peers all in the thriving capitol city of Austin, Texas.

Hotel Information

The host hotel for the 103rd Annual Convention is the Renaissance Austin Hotel
9721 Arboretum Blvd. • Austin, Texas 78759

Please call the hotel directly to make your room reservations at 800-228-9290 or 512-343-2626. Be sure to say you are with "Texas Osteopathic Medical Association" to receive the group rate of $139.00 single, double or triple per night. **Reservations must be made no later than Monday, May 20, 2002 to receive the discounted rate.**

SuperShuttle provides shuttle service to and from the airport to the Renaissance Hotel. The fare is $26 round-trip or $15 one-way. You can contact SuperShuttle directly at 512-929-5508. Another option is to take a taxi for $34 one-way. The taxis can take up to four people.

Physician Registration

The Physician's Registration Fee includes admission to all CME lecture sessions, workshops and the exhibit hall, plus 26.5 available hours of category 1-A credits, including two hours of ethics education and four hours of Risk Management CME. Also included are all lecture handouts, Wednesday Night Grand Opening Reception, Breakfast Thursday through Sunday and one admission ticket for each of the following: Thursday Keynote Luncheon, Saturday AOA Luncheon and Saturday Night President's Reception and Banquet. For additional tickets, please see registration form.

Spouse Registration

The Spouse Registration Fee includes exhibit hall admission and one admission ticket for each of the following: Breakfast Thursday through Sunday, Wednesday Night Grand Opening Reception, Thursday Keynote Luncheon, Saturday AOA Luncheon, ATOMA President's Installation Breakfast and Saturday Night President's Reception and Banquet. For additional tickets, please see registration form. Contact numbers for childcare services will be available during the convention. Look for more information in your registration packet.

Tickets for individual events, *with the exception of the President's Reception and Banquet and the ATOMA President's Installation Breakfast*, can not be purchased separately. You may purchase a "meal tickets package" for individuals wanting to attend any meals. See registration form for details.

Refund/Cancellation Policy

To receive a registration refund, less 25% for administrative handling fee, all registration and special event refund requests must be IN WRITING and postmarked no later than May 20, 2002. No refunds will be given to requests postmarked after May 20, 2002.

Special Requests

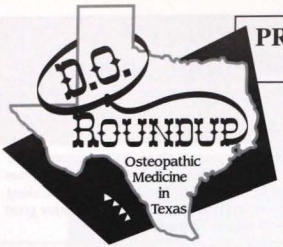
TOMA wants your convention experience to be everything you want it to be. If you have any special requests* (such as vegetarian meals) please contact the TOMA office prior to May 20th at 800-444-8662 or 512-708-8662. All TOMA Annual Convention functions, including off-site activities and bus transportation, are ADA compliant.

Optional Activities

In addition to our planned Family Fun Day, Sustainers Party and the Annual ATOMA Golf Tournament, TOMA will provide information on other optional activities for the entire family all within close proximity to the hotel. Austin and the surrounding Hill Country provide many family activities such as the Lady Bird Johnson Wildflower Center, the Texas Capitol, Governor's Mansion and several surrounding lakes for boating and water activities plus extensive shopping, museums and restaurants. Look for flyers in your registration packet and a special "Austin Information Table" near the Registration Area at the hotel.

Convention Attire and Gear

Daytime convention functions are "Business Casual to Vacation Casual." Family Fun Day will be "Summer Casual". The President's Banquet, Saturday night, June 15th, at the Renaissance Austin Hotel, is black tie optional.



PRELIMINARY PROGRAM SCHEDULE

– 26.5 Category 1-A CME Hours Anticipated –

Wednesday, June 12

4:00pm – 7:00pm	Registration Open
5:00pm – 7:00pm	Exhibits Open
5:30pm – 6:30pm	Reception with Exhibitors

Thursday, June 13

7:00am – 5:00pm	Registration Open
7:30am – 8:30am	Breakfast with Exhibitors
8:30am – 10:30am	*Men's Preventive Health* Ronald Martin, D.O. Sponsored by Bayer
10:30am – 11:00am	Pharmaceutical Update
11:00am – Noon	*Rheumatology Arthritis: "Nuts & Bolts"* Scott Stein, D.O. Sponsored by Wyeth
Noon – 1:30pm	AOA Luncheon
1:30pm – 2:30pm	*"Who's a Bully...And What Does It Matter To You"* Deborah Blackwell, D.O.
2:30pm – 3:30pm	*Systems, Quality Improvement and Chronic Disease Care* David R. Wood, D.O. Sponsored by Texas Medical Foundation
3:30pm – 4:00pm	Pharmaceutical Update
4:00pm – 5:00pm	*Dermatological Procedures for Skin Care Patients* Daniel Ladd, D.O. Sponsored by Dermik Laboratories
6:00pm – 10:00pm	Sustainer's Party

Friday, June 14

7:00am – 1:00pm	Registration Open
7:30am – 8:30am	Breakfast with Exhibitors
8:00am – 9:00am	**Texas State Board of Medical Examiners Update* David Garza, D.O.
9:00am – 10:00am	*Pediatrics in the Family Care Practice* Jim Marshall, D.O.
10:00am – 10:30am	Pharmaceutical Update
10:30am – 12:30pm	*4 Breakout Workshops* (Workshops 1, 2, & 3 repeat on Saturday afternoon) Workshop 1 – *Handheld PC's* Daniel Saylak, D.O.
Friday, 10:30 am – 12:30pm continued	Workshop 2 – *OMT* Anthony Wright, D.O. Workshop 3 – *HIPPA* Janet Horan, J.D. Sponsored by the American Osteopathic Association Workshop 4 – *Knee Injections* Alan R. Stockard, D.O. Sponsored by Wyeth-Ayerst
1:00pm	Family Fun Day and Golf Tournament
1:30pm – 3:30pm	OPTIONAL CME LECTURE *End of Life Care* Karen Nichols, D.O. Sponsored by the American Osteopathic Association

Saturday, June 15

7:00am – 4:00pm	Registration Open
7:30am – 8:30am	Breakfast Buffet
8:30am – 10:30am	*Bioterrorism* Ronald Blanck, D.O.
10:30am – 10:45am	Break
10:45am – 11:45am	*Legal & Regulatory Issues Concerning Chronic Pain Management* Kristi Dover, Pharm.D
Noon – 1:15pm	Keynote Luncheon Joe Gagen, J.D. Legislative Grassroots Trainer Sponsored by Pfizer
1:30pm – 2:30pm	*HeartSaver CT Scanning* George Rogers, M.D.
2:30pm – 2:45pm	Break
2:45pm – 4:45pm	*4 Breakout Workshops* Workshops 1, 2, & 3 repeat of Friday morning Workshop 4 – *Grassroots Lobbying* Joe Gagen, J.D. Sponsored by Pfizer
6:30pm – Midnight	President's Banquet

Sunday, June 16

7:30am – 10:30am	Registration Open
7:30am – 8:00am	Breakfast Buffet
8:00am – 12:15pm	**Risk Management Program* Sponsored by Dean, Jacobson Financial Services, LLC Texas Medical Foundation TMLT/TMIC

* This course designated by the Texas Osteopathic Medical Association for one (1) hour of education in medical ethics and/or professional responsibility.

SPECIAL EVENTS

"TOMA has created a unique "bring the family" environment as an important part of their annual convention. Family Fun Day, the ATOMA Golf Tournament; these and other special activities have made this a conference not to be missed. There seems to be something for everyone plus, as always, quality CME. Will I be there in Austin? You bet!"

Ray Morrison, D.O.

Wednesday, June 12

5:30pm – 6:30pm
Convention Grand Opening Reception with Exhibitors
"D.O. Roundup – A Gathering of Friends"
The attire is "Business Casual."
This a No Charge Event open to all registrants, their families (all children must be accompanied by an adult) and registered convention exhibitors.

Join us as we gather together for the spectacular TOMA 103rd Annual Convention and Scientific Seminar in the Exhibit Hall. An hour of mixing and mingling with exhibitors and colleagues plus entertainment, food and beverages.

Thursday, June 13

6:30pm – 10:00pm
Sustainers *"Boat Cruise"* Party
Commodore River Boat
The dress for the evening is "Evening Casual."
This is a No Charge Event for sustaining members and one adult guest only.

You will be whisked away on the Commodore River Boat that will take you up the Colorado River along the beautiful Austin skyline and luscious hill country scenery. Your boat cruise will be complete with a singing mariachi band, margaritas and appetizers. We will then dock at the beautifully landscaped Green Shores picnic area for a culinary extravaganza. This evening will truly be an Austintacious experience!

Friday, June 14

2:00pm – 8:00pm
ATOMA's Annual Golf Tournament
River Place Golf Club
4207 River Place Blvd., Austin, Texas
The dress is golf attire (as comfortable as you can get in the hot Texas sun!).
This is a Ticketed Event open to everyone over the age of 18. $75 per person.

Ready for a day of fun and sun out on the links? Then you won't want to miss the ATOMA Annual Golf Tournament sponsored by Dean, Jacobson Financial Services. River Place Golf Club is the location for this year's tournament and promises to be a fun time for all golfers from novice to pro. After the tournament, relax and enjoy dinner at the club house while tournament trophies and prizes are shared.

Friday, June 14

3:00pm – 9:00pm
Family Fun Day
"Celebrate Texas History"
The dress for this afternoon is summer casual.
We will be inside for both the museum tour and dinner afterwards.
This is a Ticketed Event, $20 per person.

We will be going to the new Bob Bullock Texas History Museum for an afternoon of exploring and fun. The new museum has something for everyone – two IMAX theaters, Texas Spirit Theater, Hands-On Exhibits for the kids and 63,000 square feet of exhibit galleries. Step back in time and learn the exciting history of Texas.

After the museum we will go to the historic Sanguerunde Hall for dinner and a western "hoe down" complete with games and entertainment.

Saturday, June 15

6:00pm – 7:00pm
President's Reception
7:00pm – Midnight
President's Banquet
The attire for this special occasion is "Elegant Evening" with Black Tie optional.
Your registration fee includes one ticket. Additional tickets are $75 per person.

The President's Reception will take place in the Foyer of the Grand Ballroom at the Renaissance Austin Hotel. The start of this elegant evening will be the reception where you can gather with your colleagues and friends to enjoy drinks, entertainment and lively conversation.

Following the reception is a full course extravagant dinner in the Renaissance Austin Ballroom. Current President, Dr. Mark A. Baker will pass the gavel to Dr. James E. Froelich, III and TOMA award presentations will be made.

Then you will really get the party going as you enjoy great music and all your favorite tunes to dance the night away.

? ? QUESTIONS ?? Call the TOMA office at 800-444-8662 or 512-708-8662

TOMA's 103rd Annual Convention & Scientific Seminar • June 12 – 16, 2002

REGISTRATION

PRINT CLEARLY or TYPE

Name_____

First Name for Name Badge (if different from above)_____

Mailing Address_____

City_____ **State**_____ **Zip**_____-_____

Phone ( )_____ **FAX ( )**_____ **E-mail**_____

D.O. College_____ **Year Graduated**_____ **AOA#**_____

Specialty_____ **TOMA District**_____

Spouse or Guest (if Name Badge is requested)_____

☐ Please check here if you have a disability, require a special diet or accommodations. You will be contacted to discuss your needs.

REGISTRATION FEES

	EARLY Registration (Postmarked by 5/20)	Registration (Postmarked after 5/20)	
TOMA Members*	$450**	$550**	$_____
• 1st or 2nd Year in Practice**	$275	$375	$_____
• Retired/Life Members**	$200	$300	$_____
• Guests**	$200	$300	$_____
Non-Members**	$600	$700	$_____
Other Healthcare Professionals** (such as P.A.'s, Nurses)	$300	$400	$_____
Students/Interns/Residents***	$0	$0	$_____ 0

* Includes members of other state osteopathic associations.
** Registration includes one ticket to all meal functions and one ticket to President's Banquet.
*** Registration does **NOT** include tickets to any meal function or special activities listed below. Meal tickets can be purchased by package only. See "Meal Ticket Package" below.

REGISTRATION FEES SUBTOTAL $_____

SPECIAL EVENTS

Family Day*. . . . . $20 x # _____ tickets $_____

YES __I/We will ride the TOMA Shuttle. # of riders in your group____

NO __I/We will NOT ride the TOMA shuttle.

* Tickets are limited to 175 people on a "First-Come First-Served" basis.

ATOMA Golf Tournament . . . . . $75 x # _____ tickets $_____

Name: Player #1_____ Handicap_____

Player #2_____ Handicap_____

YES __I/We will ride the TOMA bus. # of riders in your group____

NO __I/We will NOT ride the TOMA bus.

YES __I want to sponsor a Tee Sign with my name for $100 (per sign) $_____

Sustainers Party (*Open to Sustaining Members - Adults Only*)

Number of tickets (circle one) 1 2 N/C

YES __I/We will ride the TOMA bus. # of riders____

NO __I/We will NOT ride the TOMA bus.

SPECIAL EVENTS SUBTOTAL $_____

ADDITIONAL TICKETS/MEAL TICKET PACKAGE

Convention Meal Package*. . . . . $140 per person x # _____ packages $_____

Includes Breakfast-Thurs., Fri., Sat., Sun.; Keynote Luncheon; AOA Luncheon

TOMA President's Banquet . . . . $75 x # _____ tickets $_____

ATOMA President's Installation Breakfast

. . . . . $30 x #_____ tickets $_____

* Convention Meal Packages can be purchased on-site. A ticket must be presented for each meal. Meal tickets **CAN NOT** be purchased separately or at the meal function.

ADDITIONAL TICKETS/ TICKET PACKAGES SUBTOTAL $_____

PAYMENT SUMMARY

Convention Registration Fee(s) $_____
Special Events $_____
Additional Tickets/Packages $_____
TOTAL $_____

FORM OF PAYMENT

☐ Check in the amount of $_____

OR

Credit Card in the amount of $_____

☐ Visa ☐ MasterCard ☐ AmExpress

Card Number

_____

Expiration Date_____

Please **TYPE** or **PRINT** name as it appears on the card:

_____

Authorized Signature

_____

MAIL COMPLETED FORM WITH CHECK PAYABLE TO TOMA
1415 Lavaca Street, Austin, TX 78701
OR
***ONLY* if paying by credit card**
FAX: 512-708-1415

FOR OFFICE USE ONLY

Date Received_____

Amount $_____

Check Number_____

Fifth Annual ATOMA Golf Tournament

Join in support of the Auxiliary to the
Texas Osteopathic Medical Association's golf tournament

Proceeds received from the golf tournament will be used by the Auxiliary to fund

Yellow Ribbon Youth Suicide Prevention Program
→Scholarships to The University of North Texas Health Science Center Students
→The Educational Endowment Fund
→The Osteopathic Health Foundation
→The National Ad Campaign

The Golf Tournament will be held **Friday, June 14, 2002 at the River Place Country Club** in Austin, in conjunction with the Texas Osteopathic Medical Association's Annual Convention. As in the past, the tournament will be coordinated and sponsored by:

Dean, Jacobson Financial Services

All exhibitors may play golf at the TOMA Member rate of $75 instead of $150, if they are a Tee Sponsor at the Silver, Gold, or Platinum Level.

Sponsorship Benefit Incentives:

ATOMA Platinum - $1,000.00

Entitles the sponsor to have:
- A **Sponsorship Large Sign**, visible on the golf course
- **A complimentary player** to play in the tournament
- **Full page** advertisement in golf program
- **Verbal recognition** at awards ceremony
- Recognition in the **Texas DO Magazine**

ATOMA Gold - $500.00

Entitles the sponsor to have:
- A **Sponsorship Sign,** visible on the golf course
- **1/2 page** advertisement in golf program
- **Verbal recognition** at awards ceremony
- Recognition in the **Texas DO Magazine**

ATOMA Silver - $250.00

Entitles the sponsor to have:
- A **Sponsorship Sign**, visible on the golf course
- Recognition in the **Texas DO Magazine**
- **1/4 page advertisement** in golf program

ATOMA Bronze - $100.00

Entitles the sponsor to have:
- A **Sponsorship Sign,** visible on the golf course
- **Recognition** in the golf program

_____ ***Yes, I would like to be a sponsor*** _____ ***Amount***
_____ ***Golf Fee***

Recognition to read: _____

_____

Signed: _____ Email _____

Name of person authorizing sponsorship _____

Check or
Credit Card # _____ Expiration Date _____

Signed _____ Name on card _____

Billing address: _____

_____

Mail to: ATOMA Golf - 1415 Lavaca St. • Austin, TX 78701 - Attn: Paula Yeamans

Golf Registration Information

Name _____ Handicap _____
Name _____ Handicap _____

Sponsor forms also available at www.txosteo.org

Opportunities Unlimited

PHYSICIANS WANTED

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NEW BRAUNFELS, TEXAS: HELP NEEDED, flexible hours, low level practice for a physician. Let's talk. Call Trisha at 800-444-8662. (06)

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BOARD CERTIFIED FAMILY PHYSI-CIAN (No OB). Desires to relocate to Texas. Enjoys OMT. Looking for permanent full time position, preferably close to my family in DFW area. Please contact me at home at 847-662-6196; Cell: 847-971-6855. (02)

BOARD CERTIFIED FP for outpatient full time, part time or locum tenens, prefer 60 miles radius of Dallas/Fort Worth area. $65.00 per hour. Excellent references will be furnished. Call Eric M. Concors, D.O., at 214-365-9013. Leave message. (13)

PRACTICE FOR SALE/RENT

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