TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

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June 2000

Summertime Allergies

As the sounds of sneezing, wheezing, coughing, and nose blowing fill waiting rooms everywhere, new advances in treatments are emerging to help the 20 to 40 million Americans suffering from summertime allergies.

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TOMA's 101st Annual Convention & Scientific Seminar – The Speakers and The Topics

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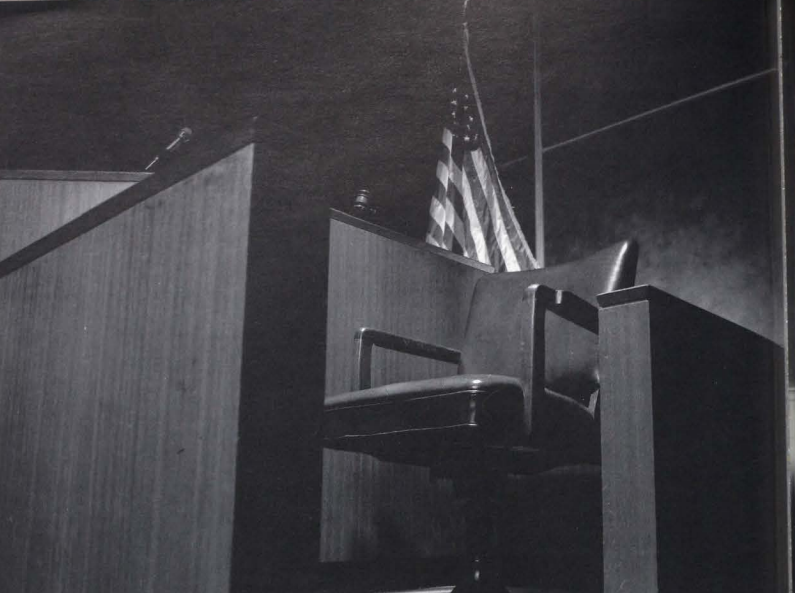

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CALENDAR OF EVENTS

JUNE 28 – JULY 2

"20th Annual Primary Care Update"

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

Location: Radisson Resort, South Padre Island, TX
CME: 24 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
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JUNE 29 – JULY 2

"98th Annual CME Convention & Scientific Exhibition"

Sponsored by the Georgia Osteopathic Medical Association

Location: Hyatt Regency, Hilton Head Island South Carolina
Contact: Holly Barnwell, Executive Director
2160 Idlewood Road, Tucker, GA 30084
770-493-9278
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JULY 27 – 30

"TxACOFP Annual Clinical Seminar"

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

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CME: 27 hours category 1-A credits
Contact: Janet Dunkle, TxACOFP Executive Director
888-892-2637

AUGUST 11 – 13

"25th Annual Convention"

Sponsored by the Pennsylvania Osteopathic Family Physicians Society

Location: Hotel Hershey, Hershey, PA
CME: 16 hours category 1-A credits
Contact: Mario Lanni, POFPS Executive Director
1330 Eisenhower Blvd., Harrisburg, PA 17111
717-939-9318; in PA 800-544-7662
FAX: 717-939-7255
E-mail: poma@poma.org

AUGUST 19 – 20

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

Sponsored by Dallas Osteopathic Study Group

Location: Holiday Inn Select LBJ Northeast
11350 LBJ Fwy., Dallas, TX
CME: 16 hours category 1-A credits anticipated
Contact: Conrad Speece, D.O., Course Director
10622 Garland Road, Dallas, TX 75218
214-321-2673

AUGUST 25 – 27

"A Nutritional Approach to Osteopathic Medicine"

Sponsored by Indiana Academy of Osteopathy

Location: Embassy Suites Hotel North
Indianapolis, IN
CME: 20 hours category 1-A anticipated
Contact: Indiana Academy of Osteopathy
317-926-3009

SEPTEMBER 22 – 24

"The Successful Osteopathic Practice: Wine Country Revelations"

Sponsored by the Osteopathic Physicians and Surgeons of California

Location: Embassy Suites, Napa Valley, CA
CME: 20 hours category 1-A credits
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NOVEMBER 8 – 12

"Fall CME Conference & Scientific Exhibition"

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TOMA's 101st Annual Convention and Scientific Seminar Information Packet and Registration Form

10 Years Ago in the *Texas D.O.*

Washington Update

TRICARE News and Other Military Issues

Health Notes

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A Listing.

People who have made pledges or have contributed to TOMA's Building Fund Campaign are known to TOMA as "Texas Stars" due to their commitment to the osteopathic profession.

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A Listing.

Thank you to "Texas Stars" who have contributed above the $1,000 donation level to TOMA's Building Fund Campaign.

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A Listing.

Phone numbers of Federal agencies, osteopathic agencies and state agencies useful to the osteopathic healthcare community.

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What's Up with Allergies

by John A. Fling, M.D.

As the sounds of sneezing, coughing and constant blowing of the nose fill cli waiting rooms, new advances in the treatment of allergies are emerging. Indeed, over past few years a tremendous expansion of our knowledge regarding the pathophysiol of the allergic response in humans has occurred. Research has demonstrated t allergen-reactive lymphocytes play a critical role in the induction and maintenance of allergic inflammatory cascade. Cytokines and chemokines produced by TH2 lymp cytes (GM-CSF, IL-4, IL-5, IL-6, IL-9, IL-10, IL-13) and those produced by other c types accounts for most of the pathophysiologic aspects of allergic disorders (product of IgE; recruitment and activation of mast cells, basophils and eosinophils; mucus hyp secretion; subepithelial fibrosis; and tissue remodeling). This TH2 hypothesis provi insights at the cellular level and offers opportunities for the development of no immunotherapeutic strategies.

The evaluation of patients with allergies involves a detailed characterization of syn toms, when they occur, known triggers and responses to prior treatment modaliti Comorbid conditions such as asthma, frequent ear and sinus infections should be cons ered. Seasonal symptoms are best explained with sensitivity to airborne pollens such tree pollen which typically pollinate in the spring, grasses in the late spring and weed the fall. A major exception to the above is Mountain Cedar. Mountain Cedar are uniq trees found primarily in the hill country area of Texas and are a major pollinating sou found in the winter months, usually late December through January. Perennial symptor occur in highly sensitive individuals and can be secondary to common indoor allerge such as dust mites, molds and animal dander. A strong family history of allergies usually present and we now know that several genes are involved in the development a regulation of TH2 cells, which helps explain the genetic linkage with allergic rhinit asthma and atopic dermatitis.

One of the critical steps in the diagnosis of allergic rhinitis is determining the pre ence of allergen specific IgE. This can be accomplished by either allergy skin testing by a blood test such as RAST. Significant improvements in the quality of allergy extrac has improved testing specificity but clinical correlation with the patient's history imperative before making a definitive diagnosis. Assessment for the presence of nas eosinophils is an easily performed office procedure and can provide additional inform tion that can assist in the formulation of a treatment plan.

Management of allergic rhinitis involves education, avoidance, medications ar allergy immunotherapy. Education is very important in providing patients with an expl nation of the disease process and the rationale to avoid any and all trigger Environmental control measures to decrease dust mites and animal allergens is critic and the adverse effects of cigarette smoke on already inflamed airways should b addressed. Over the past few years, new and more selective medications have been deve oped. Newer longer-acting antihistamines with a much safer profile have been recentl introduced, providing excellent anti-histamine activity with few side effects. A uniqu nasal spray antihistamine is now available with a faster onset of action. Topical nas steroids continue to be highly effective in relieving nasal allergy symptoms and now ca be used down to 3 years of age. Newer preparations can be used on a once-a-da schedule, a finer mist spray and little scent. Allergy desensitization continues to be highly effective form of treatment. Recent studies demonstrated continued sympto relief in grass sensitive patients 3 years after stopping allergy injections. Standardize extracts with many of the allergens are now available and more are on the way. This stan dardization allows for more specific immunotherapy and greater immunologic response Newer modalities currently being tested include the use of leukotriene modulator specific cytokine inhibitors and monoclonal antibody directed against IgE. Exciting ne advances in treatment will continue to emerge as we become more knowledgeable of th basic cellular activities in allergic disease.

Dr. Fling serves as Associate Professor of the Department of Allergy/Immunology at th University of North Texas Health Science Center.

Allergic Rhinitis & Allergic Conjunctivitis
Diagnosis and Treatment

by Brian Terry Miller, D.O.

"Perennial indoor allergens include certain molds, dust mite fecal particles, cat and dog dander, and cockroaches."

Allergic rhinitis is an IgE mediated reaction to an airborne allergen which results in inflammation of the nasal mucosa. It is characterized by nasal congestion, episodic rhinorrhea, paroxysmal sneezing, nasal itching and itchy, watery eyes. It has a profound impact in that it affects 20 to 40 million Americans, 10% to 20% of the population, and is the 5th most common chronic disease for all ages. In children, it is the most chronic illness.

Allergic rhinitis has a deleterious effect on quality of life in that it reduces physical functioning, social functioning, energy and mental health as compared to otherwise healthy subjects. It is a disease that affects people in the prime of life – young adults up to 55 years.

Allergic rhinitis is a type I allergic reaction in which IgE molecules bind to mast cells, resulting in release of chemical mediators which cause a local reaction in the mucosa. Allergic rhinitis is a two-phase reaction. With continued stimulation or a more intense stimulation, a late phase occurs about 3 to 10 hours after exposure. This is characterized by an influx of mast cells, eosinophils and basophils.

In Central Texas, approximately three weeks after the first hard freeze, Mountain Cedar begins its winter mating ritual with the release of pollen grains into the atmosphere. These counts can reach as high as 40,000 pollen grains per cubic meter. In comparison, Ragweed usually peaks out around 1,800 pollen grains per cubic meter. As the weather gets warmer in late February or early March, Mountain Cedar stops and trees begin pollinating from February through June. Grasses start in May and continue through October, depending on rainfall and daytime temperatures. The fall allergy season is generally the worst as grasses, weeds and Cedar Elm pollinate simultaneously.

Perennial indoor allergens include certain molds, dust mite fecal particles, cat and dog dander, and cockroaches. These tend to be year round, but are more prevalent during periods of higher humidity. Avoidance can be practiced with these indoor allergens by making the bedroom a dust free environment and exterminating mites or at least controlling them by encasing mattresses and pillows.

Allergic rhinitis presents with symptoms of stuffy nose, sneezing, posterior nasal drainage, clear, sometimes yellowish rhinorrhea, stuffy head and itchy eyes. Nasal congestion is the most common complaint. Physical exam include eyes, looking for conjunctivitis; sinuses, looking for tenderness; nasal mucosa, looking for a pale bluish membrane with discharge; oral cavity, looking for tonsillar enlargement, posterior nasal drip; ears, looking for evidence of otitis media, with effusion, bubbles behind the tympanic membrane and serious otitis media; skin, looking for atopic dermatitis; and lungs, looking for any evidence of asthma.

Conditions associated with allergic rhinitis include asthma, chronic sinusitis, allergic conjunctivitis, otitis media with effusion, nasal polyposis, and atopic dermatitis. The differential diagnosis of rhinitis includes basomotor rhinitis, infectious rhinitis (sinusitis), rhinitis medimentosa, non-allergic rhinitis with eosinophilia (NARES), hormonal rhinitis and atrophic rhinitis in the elderly.

The pharmacotherapy of allergic rhinitis and conjunctivitis consists of antihistamines, decongestants, combinations of antihistamine/decongestants, nasal corticosteroids, nasal Cromolyn Sodium and Ipratropium Bromide. The second generation oral antihistamines have the advantage of being either non-sedative or less sedative than the first general medications. There is no evidence of anti-cholinergic activity so they cause no drying effects in the lungs and may be used in asthma. Tolerance has not been reported with newer antihistamines but has been reported with classical antihistamines. The non-sedating drugs include Fexofenadine, Astemizole, Loratadine, and Cetirizine. Sedation is possible with both Loratadine and Cetirizine only at higher doses. One of the newer advances recently has been release of the internasal antihistamine Astelin. Astelin is a first generation antihistamine however, because of the mode of delivery, sedation is rarely a problem. In addition, the drug has an extremely rapid onset of action as it is applied directly to the mucosa and its actions are similar to that of the oral drugs. Oral decongestants include Pseudoephedrine, Phenylpropanolamine, and Phenylephrine. Intranasal Cromolyn is more effective as a

prophylactic drug. Topical steroids are effective in chronic management and offer relief of nasal pruritis, sneezing, rhinorrhea, and nasal congestion. Ipratropium bromide is an anti-cholinergic. These drugs treat secretions, whether thick or thin.

To summarize, antihistamines work for sneezing, itching and clear drainage. They do not treat congestion. Decongestants only decongest. Cromolyn Sodium works for allergic rhinitis. If successful, it is an excellent drug because of the safety profile. Topical steroids work for allergic rhinitis, non-allergic rhinitis with eosinophilia, rhinitis medimentosa, nasal polyposis and rhinosinusitis. Systemic steroids may be used briefly, usually 5 to 7 days. There is no need for a tapering schedule if used less than 10 days. Antibiotics are useful with infections which would be the case in an infectious sinusitis. Immunotherapy could be considered when symptoms are not adequately controlled by avoidance and/or pharmacotherapy; when symptoms are severe and persist more than 4 to 6 weeks in the given pollen season; in patients who are intolerant of or non-adherent with pharmacotherapy; or in patients whose treatment will be somewhat compromised secondary to other diseases, such as diabetes, hypertension or heart disease. Immunotherapy works for hay fever 70 to 85% of the time, and asthma 60 to 70% of the time.

When should you consider referral to an allergy subspecialist for evaluation? If the disease or its treatment interferes with patient performance; if the disease interferes with school, work or causes significant absences; if quality of life is significantly affected and not improved by drug therapy; if persistent complications such as sinusitis, otitis, hearing loss or asthma, recurrent use of systemic steroids are required; if medications are required on a daily basis; or if the patient demands evaluation.

Dr. Miller, who is certified in Allergy & Immunology, is owner of the Allergy and Asthma Clinic, 4204 Stan Schlueter Loop, in Killeen, Texas. He is a 1979 graduate of the University of North Texas Health Science Center/Texas College of Osteopathic Medicine.

Rethinking Respiratory Infections

by A. H. "Lon" Jones, D.O.

Summary

Respiratory Infections (RI's) are the most frequent presenting complaint to primar care physicians. Their medical costs are in the billions of dollars annually and the cos from time lost at work are comparable. We tend to think of them as simple to deal wit and mostly innocuous, but at the far end of the curve, the Centers for Disease Control an Prevention estimates 40,000 people in this country die annually from infection wit Streptococcus Pneumoniae, a bacterium that lives only in the nasopharynx. That figure i much higher in developing countries. RI's range from the common cold to acute otiti media in infants and children and to acute sinusitis in adults. Upper airway irritants, bot allergens and pathogens, play a major role in triggering asthma. The common ground fc all this is the nose. The physiologic response to upper airway irritants is examined. Th common use of antihistamines and decongestants is known to block the effects of hista mine and to constrict the vascular bed. What is not commonly told is that these effect essentially block the effort of the immune system to wash out the irritant. Current recom mendations, that uncomplicated respiratory infections be treated with observation attempts to reduce the problem of antibiotic resistance. Suggestions are made for a mor helpful response that assists the immune system in clearing the irritant.

Physiology

Any irritant in the airway elicits an inflammatory response, consisting basically o histamine release that triggers increase in capillary permeability and the efflux of plasma that bathes the cells in the area and winds up in the airway lumen. In the nose we sense this increased flow as rhinitis, nasal congestion, or post nasal drip. The degree of flow is probably a reflection of the person's hydration. If we pause to think about it, this attempt at washing appears as the body's first response to any irritant. Insults to the stomach lea to vomiting and diarrhea from the rest of the bowel. Urinary frequency is associated with bladder irritation and cough with irritants in the bronchi. The immune system's first line of defense is washing away the irritant. And, the nature of the irritant is not identified. The same response happens in the nose if the irritant is a virus, bacteria or pollen.

Customary Treatment

The most common first response to these nasal symptoms is to take an antihistamine o a decongestant, mostly done without medical control or advice. While these medications may make us a bit more comfortable, there are no data showing their efficacy as treatment

r RI's. What they do is block the washing
y interfering with the histamine or by
onstricting the capillary bed that has been
ade more permeable by the inflamma-
ory response. My own experience with
current sinus infections correlates well
ith most of my patients and tells me that
ese complications are more common
ter taking cold pills. The overwhelming
ccess at treating cholera and other diar-
eal diseases with oral rehydration, that
cilitates this washing, shows clearly the
alue of helping the immune system. If self
eatment of the RI doesn't work and the
atient seeks medical help, many of the
mptoms are complicated by fever,
ough, or pain. The most common bacteria
volved in RI's are Streptococcus
neumoniae, Haemophilus Influenzae and
loraxella Catarrhalis. These bacteria live
the nasopharynx. A wide variety of your
vorite antibiotic is available for treatment
f these complicated URI's and therein lies
nother problem.

Antibiotic Resistance

Those working on the problem of
ntibiotic resistance are currently
ocusing on ways to prevent it. They
ecognize that many of antibiotics
rescribed for uncomplicated RI's are
ken sporadically. This leads to a greater
me under the curve of suboptimal expo-
re that allows the bacteria to adapt to
e antibiotic. The recommendation now
to not be so liberal in our use of antibi-
tics. While this is wise and admirable
om the viewpoint of antibiotic resist-
nce, it is problematic in the logistics of
eating a patient. For a patient who is
oncerned enough to come to the office
ecause they have a problem, saying,
Let's watch it", is going to have a mixed
ception at best.

Alternatives

Saline nasal sprays and other means of
rigation have been used for decades as
djuncts for alleviating chronic nasal prob-
ms. There is no question of their useful-
ss in reducing problems when used regularly.[1,2] Their use reduces inflammatory mediators in nasal secretions. [3]

Hypertonic saline has been shown to enhance saccharin clearance from the nose more than the isotonic or hypotonic saline that is commonly available.[4] An hypertonic solution is available over the Internet as ENTsol. Studies in animal models using more concentrated solutions temporarily paralyze ciliary activity (7%) and stop it permanently (14%), so care should be used.[5]

Xylitol saline nasal spray is available also over the Internet and at health food stores. An example may help to understand the use of xylitol. Most people, especially women who are affected more often, know that drinking cranberry juice helps prevent urinary tract infections. We used to think this effect was because it made the urine more acid. Recently, we have found that this assistance is because the mannose in the cranberry prevents the attachment of E Coli to the bladder wall.[6] Mannose is a sugar and is a natural chemical found in the body. Xylitol also shares these properties. It is the polyol of xylose, wood sugar. It is a natural sweet substance found in many fruits and vegetables and made by the human body in amounts of about ten grams daily. Finnish researchers found that taking 8 grams orally every day reduces the incidence of ear infections by about 40%.[7] They also show, in vitro, that a 5% solution of xylitol reduces the adherence of S. Pneumoniae and H. Influenzae to nasal epithelial cells by 68% and 50% respectively, an effect very much like that of cranberry juice or mannose, in the bladder.[8] The difference is that there is an opening in the nose into which we can spray some of this sugar. I have been using this spray in my practice for the past two years and have seen more than a 90% reduction in ear infections when used regularly. Sinus infections are similarly reduced.

Besides its specific effect on these bacteria, this solution is hyperosmolar. This type of solution greatly enhances the immune systems washing.[9] This cleansing significantly reduces allergies and asthma, where the triggers are irritants in the nose. More information on this combination is on the Internet at <www.nasal-xylitol.com> or ask at your local health food store.

These alternatives should be actively promoted by the medical profession as ways to facilitate the immune system in its attempts at washing the nasopharynx.

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Dr. A. H. "Lon" Jones is Assistant Clinical Professor of Family Medicine at Texas Tech University School of Medicine.

Asthma

Etiology, Pathophysiology, Assessment and Intervention

by Brian Terry Miller, D.O.

The classic definition of asthma is reactive obstructive airway disease characterized by increased sensitivity (an airway hyper-responsiveness) to various stimuli resulting in bronchial constriction that is variable over time. The incidence is about 6.6% of the American population. Asthma accounts for more lost school and work days than any other disease entity in the United States. The mortality is significant. For people in status asthmaticus, the mortality is 1% to 2%. In status requiring intubation, these numbers rise to 10% to 20%. For all asthma, the death rate is 1-50/100,000 per year. The death rate is increased in children under five years of age and in blacks. Others terms used for asthma include ROAD (reversible obstructive airway disease), RAD (reactive airway disease), VOID (variable obstructive intrabronchial disease), DEB (desquamative eosinophilic bronchitis), and DERB (desquamative eosinophilic reversible bronchitis).

The pathopsysiologic features of asthma include bronchospasm (smooth muscle contraction), mucous secretion, mucosal edema, cellular infiltration and desquamation. The first two changes, bronchospasm and mucous secretion, occur acutely. With chronicity, the mucous becomes more viscous and tenacious, and mucosal edema, cellular infiltration and desquamation occur. It is clear that the mast cell governs the mast soper of the pathophysiologic features of allergic forms of asthma. When the mast cell degranulates, it releases a number of mediators. Bronchospasm is modulated by leukotrienes, prostaglandins, thromboxanes, histamine, platelet activity factor, acetylcholine and the bradykinins. The first five mediators listed are primarily mast cell mediators released during mast cell degranulation. In addition, mucous secretion is governed by the leukotrienes, prostaglandins, histamine (via H2 receptors, not the H1 receptor), acetylcholine, platelet activity factor, HETES, alpha adrenergic agonists, and beta adrenergic antagonists. The intense cellular infiltration which occurs in the late phase of the bronchial response is secondary to the presence of eosinophil chemotactic factor, neutrophil chemotactic factors, HETES and LTB4. The desquamation that occurs is secondary to peroxides, hydroxyl radicals and superoxides which are produced by polymorphonuclear cell and eosinophils.

In 1968, Andor Sventivanyi advanced the beta adrenergic theory of asthma which states that asthma is a consequence of diminished beta2 receptor responsiveness. Kaliner at the National Institutes of Health later showed that asthmatics are not only beta2 hypo-responsive, but also exhibit an alpha hyper-responsiveness and cholinergic hyper-responsiveness as well. Therefore, an updated definition of asthma is that asthma is an inflammatory process response induced by mediator response with imbalances of the autonomic nervous system resulting in bronchospasm, increased mucous production, mucosal edema, cellular infiltration and desquamation, all of which are variable in intensity over time or in response to treatment.

...Pulmonary function remains the single best test in the treatment of asthma.

Precipitating factors in asthma include allergens consisting of pollens, house dust mite fecal particles, animal danders; mold spores; infections which are virtually all viral, irritants such as ozone, TDI, formaldehyde, trimellitic anhydride, and sulphur dioxide, drugs and preservatives, gastroesophageal reflux, and a number of miscellaneous triggers such as stress, positive ions, weather changes, cold dry air, temperature changes and exercise.

In the clinical evaluation of asthma, t primary symptoms are chest tightnes cough, dyspnea, wheeze and fatigue. T most common complaints are chest tigh ness and dyspnea. Cough may be the on symptom (the so-called cough varia asthma), which occurs in both adults ar children. Fatigue is a common symptom the patient has chronic obstructio Therefore, any patient with chest tightne and dyspnea should be evaluated for asthm whether or not the wheezing is present.

The clinical history should be brief an focused on the acute setting and shoul include the severity of asthma, the percep tion of asthma, the liability of the patient asthma, the response to therapy an whether or not the patient has a history c subsensitivity to the therapy. Severity ca be tracked by asking about seizures, intu bations and long use of steroids. Som patients poorly perceive the severity o their asthma. These people do not know they have severe asthma and are therefor at high risk for poor outcome. Liability implies that there are wide swings i pulmonary functions during the course o the day. These patients are commonly called morning dippers since thei pulmonary functions are usually much worse in the early morning hours. In terms of response to therapy, the patient should be asked about the length of previous hospitalizations. Subsensitivity is classically seen in the setting of viral infection, status asthmaticus or prolonged use of beta agonist therapy. The clinical syndrome of subsensitivity is marked by a decrease in the duration of response to beta2 drugs, as well as a decrease in the amplitude of the response. In the 1980 *American Journal of Medicine*, 35 patients estimated their peak expiratory flow rate, and it was then plotted against their measured peak flow. Of those, 63% could guess within 20% of the measured peak flow. Six fully trained pulmonologists, following their standard physical exam and history, then estimated peak flow. Only 44% of the estimates were within 20% of the measured peak flow.

This implies that physicians are not as good as the patient in determining the severity of asthma. Rubenfield, however, in 1976, published a study in *Lancet* looking at 61 hospitalized asthmatics. Six of the 61 had no symptoms, despite an initial FEV1 (forced expiratory volume in one second) of less than 50% of predicted, implying these people were imperceptive at baseline despite having an FEV1 of less than 50%. Four of the 61 had no symptoms during the height of an attack; these people were imperceptive despite FEV1's as low as 25% of predicted. This implies that approximately 16.4% of asthmatics are imperceptive as to the severity of their disease.

In 1976, Commey, in the *Journal of Pediatrics*, looked at 62 children with asthma and compared pulmonary function (FEV1, FVC and MEFR) to dyspnea, subjective wheezing, rhonchi, scalene and muscle retraction (SCMR). Only SCMR correlated well with pulmonary functions, and it was commonly seen when the pulmonary functions were less than 50% of predicted. Another useful parameter is the pulsus parodoxus, which was studied by Knowles in 1973 and Galant in 1978. They found that pulsus paradoxus of less than 10 is normal, and levels above 22 correlate well with abnormalities in blood gases and peak flows of less than 25%. Banner, in 1976, and Kelson, in 1978, looked at the use of peak expiratory flow rate to determine the need for admission in the setting of asthma. Banner found that the patient had a poor outcome if the initial peak flow was less than 60 liters per minute or if in post-treatment they had less than a 15% increase in their peak flow. Kelson looked at 127 visits to the emergency room for asthma and found that, if the change in FEV1 was less than 0.4 liters, 50% had a relapse. He also showed that the duration of emergency room therapy and the improvement of the FEV1 was directly related to the outcome. Nowak in 1979 looked at 85 episodes of asthma and divided these patients into three groups (group 1 based on admission, group 2 on relapse and group 3 on successful treatment). At 48 hours, in group 1 patients it was noted that 88% had had an initial FEV1 of less than 0.6 liters and/or a post-treatment FEV1 of less than 1.6 liters. In group 2, 68% had post-treatment FEV1's of less than 1.6 liters.

Conclusions regarding clinical status:

1. Most patients are better than physicians in judging clinical status.
2. Patients aren't that good and the imperceptive patient may represent a frequent (16.4%) dangerous subset.
3. Significant abnormalities in lung function persist well beyond the disappearance of both symptoms and signs, as all symptoms disappear at approximately 50% of predicted FEV1 and signs are gone at around 60%.
4. The best signs are sternocleidomastoid muscle retraction and pulsus paradoxus, with heart rate and respiratory rate being helpful.
5. Pulmonary function remains the single best test in the treatment of asthma. FEV1 is the gold standard. Peak expiratory flow is useful in the younger patients.

In terms of laboratory evaluation in asthma, laboratory data are often ordered which have no influence on the outcome of the asthma, e.g., chest x-rays. Gerschel in the *New England Journal of Medicine* in 1983 looked at 371 children having their first episode of asthma. Of those, 350 had x-rays consistent with asthma. Of the 21 abnormal x-rays, 20 could be identified on the basis of a respiratory rate greater than 60, a heart rate of greater than 160, fever, and focalized lung findings. Therefore, in the initial presentation of a pediatric asthmatic, the chest x-ray is useful in only 1 out of 371 serial cases. This data has also shown to be true in adult asthma as well. In terms of arterial blood gases, Nowak, in 1983 in the *Journal of the American Medical Association*, looked at pre and post arterial blood gases in an attempt to predict patient outcomes, i.e., discharges or admission. Neither p02, pC02 or pH were predictive. In addition, all patients who had blood gas abnormalities also had an FEV1 less than 2 liters and a peak expiratory flow rate of less than 200 liters per minute. Their conclusion was that arterial blood gases add discomfort and cost without benefit. A CBC is not useful to diagnose infection as the patient often will have a high white count secondary to the sympathomimetic drugs used for treatment. Theophylline levels are not mandatory to begin treatment. An electrocardiogram should be done in older patients, and a monitor should be used in patients with intense therapy.

We will now examine the treatment of the ambulatory asthmatic. It is interesting to note that from 1965 to 1975 the death rate from asthma decreased about 60% to 70%. However, despite the fact that there is now better emergency room equipment, better training, and newer drugs, the death rate in asthma rose from 1975 to 1985 despite a decrease in deaths from all other causes, especially in children. It is further interesting to note that the deaths from asthma have risen almost as a reciprocal of the referrals to allergists by other physicians.

The key concepts to the treatment of ambulatory asthma are:

- Asthma is a chronic inflammatory condition, and the inflammatory component is approximately 70% of the disease as compared to the bronchospasm, which accounts for about 30% of the pathophysiologic process.
- There are only three regimens which affect inflammation – these are corticosteroids, disodium cromoglycate, and allergy immunotherapy.
- The death rate is rising and for inner city blacks has increased 57% over the last several years.
- In 1983, asthma alone accounted for almost two and one-half million hospitals days for 434,000 asthmatics.
- Only allergy immunotherapy alters the natural course of the disease.
- Although some children have a tendency to resolve their asthma in childhood, a fourth of these children redevelop adult asthma, which in general has a more severe prognosis.
- When possible, aerosol therapy should be utilized to avoid drug interactions and potential side effects.

The typical stepped care regimen in the United States is 1) oral Theophylline; 2) more oral Theophylline; 3) an oral beta2 agonist; 4) an inhaled beta2 agonist; and 5) oral Prednisone with some groups using atropine-like compounds or inhaled steroids. It is interesting to note that in Europe, the initial agent is usually an

inhaled beta2 agonist, followed by either inhaled Cromolyn or an inhaled steroid, followed by inhaled ipratropium Br. In Europe, the fifth drug is ketotifen, followed by oral Prednisone with number seven being oral Theophylline. In treating chronic ambulatory asthma, there is a choice of basically five drugs: the methylxanthines, cromolyn, steroids, sympathomimetics, and anticholinergics. Other useful therapies have included injected or oral gold, acupuncture, moxibustin, azathioprine, arsenic, iodineguaifensin, methatrexate, alpha blocking agents, and calcium channel blockers. The sympathomimetics or the beta2 agonists are the most potent bronchodilators available. They decrease the mast cell mediator release, increase mucociliary clearance and increase bronchial secretion of free water. Reported untoward effects include paradoxical bronchospasm, increased hypoxemia, arrhythmias, CNS disturbances to include convulsion and subsensitivity. Again, subsensitivity is defined as to a diminished response to the beta2 agonists, manifested by decreased duration of action (which is the hallmark) and also a decreased peak response. The ideal beta2 agonist drug is effective topically (inhaled), long-acting, produces no systemic side effects, contains no preservatives (metabisulfite), does not produce paradoxical bronchospasm or hypoxemia, is easy to use and is widely available. Two drugs which best meet this classification are Albuterol, either by metered dose inhaler or multidose vials; and Terbutaline, either as a metered dose inhaler or 1cc./1mg. ampules. Neither of these drugs has been reported at this time to produce paradoxical bronchospasm or hypoxemia, and via the inhaled route, arrhythmias and hypokalemia in general are not seen. It has been shown that the aerosolized route is equivalent in efficiency to the oral route. The advantages of aerosol versus oral administration include lower doses, rapid onset of action, less systemic side effects, and direct delivery to the airways. A number of "spacing devices" can be utilized to facilitate drug delivery to the lung and decrease the need for coordinated effort with these metered dose inhalers. They include the Breathancer, produced by Ciba-Geigy; the Azmacort spacer, produced by Rorer; the InspirEase or Inhalaid, produced by Key Pharmaceuticals; and the aerochamber, produced by Mohahans. In

...Subsensitivity to the anticholinergics does occur, but the clinical impact is at present unknown.

has been clearly shown by Tobin in the *American Review of Respiratory Disease*, 1982, that with metaproterenol via the InspirEase, there is a further increase in pulmonary function over the use of metaproterenol via the metered dose inhaler without a spacer.

The second drug of interest is cromolyn. Cromolyn is an extremely safe drug for long-term asthma. It prevents asthmatic events caused by allergens, exercise, cold air, pollutants and industrial exposures. Cromolyn decreases bronchial hyper-reactivity. Cromolyn inhibits mast cell mediator release from sensitized mast cells to following antigen challenge, as well as inhibits mediator release from nonsensitized mast cells which can release mediators by non-specific or non-immune mechanisms.

The third drug useful in chronic asthma is the corticosteroid. It may be given either orally or by inhalation. The inhaled route is safer in terms of side effects. If the PO route is chosen, alternate day therapy is always better than daily therapy, if tolerated. Morris in Denver ascertained that the dose equivalent to 2.5 daily is approximately 80 mg. every other day in terms of adrenal suppression. The outstanding feature about steroids is that they treat every aspect of the inflammatory response in asthma. They also, at least by the oral route, can eliminate the subsensitivity previously discussed. Steroids have been shown to reduce the frequency of hospitalizations, the number of emergency room visits, the number of relapses in acute flares, and probably significantly alter mortality. Steroids are the only drugs which prevent mucous plugging, which is the cause of death in severe asthma. Their action is modulated by the fact that they stimulate production of macrocortin, a membrane protein which inhibits arachidonic acid release from the cell membrane. Steroids also relocate the eosinophils basophils and (increase) beta adrene responsiveness.

The fourth category of drugs is methylxanthines or theophylline drugs. They are bronchodilators with a therapeutic index. They may act suppressor cell induction, altered muc secretion, prostaglandin inhibiti changes in cAMP, and increased diaphr matic contractility, but not phospho esterase inhibition. Start at low doses select a slow-release drug with 10 availability. Less than 100% bioavailabil implies widely fluctuating peak to trou levels as well as frequent excursions i the toxic or nontherapeutic range. Wh switching from brand to brand or generi you must monitor theophylline levels there are major differences in metaboli and absorption from patient to patie Start low in children – 16 mg./kg./day a increase slowly to about 24mg./kg./day divided dosages. In adults, 200 mg. b.i. to start, with an increase to 300 mg. b.i. after four days. Starting low will minimi initial side effects. The major problem the theophylline like drugs is the numb of drug interactions and side effec Increased levels of theophylline are seen the drug is used in conjunction with allo urinal, citetidine, erythromycin, propr nolol, troleandomycin, and lincomyci Decreased levels will occur if the drug used with isoproterenol, phenobarbit dilantin, marijuana, and cigarettes. There increased toxicity of alcohol and ephedri if the patient is on theophylline product In addition, there are numerous sic effects, including headache, seizures, in tability, tremor, nausea, vomiting, diarrhe gastrophageal reflex, delayed gastr emptying and urinary retention. Cardi effects include arrhythmias and cardi arrest in the toxic state. Pulmonary compl cations include hypoxemia. Hypokalem and hypercalcemia can also occu Anaphylaxis has been reported to t ethylendiamine component of amin phylline. In addition, there is altered clea ance of the theophylline by numerou drugs, age, smoking, disease of the live and heart, as well as bacterial or vir pneumonias and even vaccinations. In chil dren, theophylline compounds can hav adverse effects in psychometric testing an related parameters, to include quality o sleep as determined by the electroen

ephalogram and teachers' school behavior erformance ratings.

The final category of drugs utilized ommonly in the outpatient setting for the eatment of ambulatory asthma is the anti-holinergics. These compounds seem to xert a bronchodilatory effect independent f beta agonist action and, therefore, may e additive when added to the beta agonist egimen. Side effects are extremely infre-uent via the inhaled route, but do poten-ally include blurred vision, dry mouth nd flushing. Subsensitivity to the anti-holinergics does occur, but the clinical npact is at present unknown. Indications or use seem to include a prominent omponent of bronchorrhoea, adolescent sthmatics, gastroesophageal reflux, cough nd a poor response to a beta agonist alone. he brand name is Atrovent, and the dose n general is two puffs four times a day by netered dose inhaler.

In the treatment of outpatient asthma, if he patient has intermittent symptoms with ormal pulmonary functions between pisodes, then the most proper drug would e a PRN inhaled beta2 agonist with a pacing device. If the patient has chronic ymptoms, then an inhaled beta2 agonist, wo puffs four times a day. If that is not dequate for coverage, then inhaled romolyn should be the second drug in hildren, atopic patients, patients with an xercise component and patients with a old air or occupational component. nhaled steroids in general should be used n the adult patients with more severe sthma and especially in those patients ho are currently requiring oral steroids or ad been on steroids in the past. The third tep then would be to add cromolyn or nhaled corticosteroids if that was not done n step two. Drug four would be iprat-opium Br or oral theophylline. The fifth rug would be prednisone.

In conclusion, the current goal of herapy is to maintain the patient in a well ondition, that is, normal pulmonary func-on and no visits to the emergency room or ospitalizations. Subacute illness, that is, bnormal pulmonary function but asymp-omatic, should be identified. Overt illness status asthmaticus) should not be allowed.

Letter to the Editor

Dear Editor:

I applaud you on the March issue of the *Texas D.O.* for its focus on organ and tissue donation awareness.

As you may know, the Travis County Medical Society's tissue bank, an operating division of the Blood and Tissue Center of Central Texas, is a fully accredited nationally recognized tissue recovery and processing organization. Like every agency in the transplantation community, we support efforts such as yours to raise awareness of the need.

I particularly enjoyed the article by Dr. Phil Berry, a dear personal friend from my early days in Dallas. Phil is an avid golfer and one of the other neat things he would have missed but for his second chance at life, (but didn't include in his article), was a hole in one!

I had one concern related to the article on page 8, "Do You Have What it Takes to be an Organ Donor?" My concern is that the reader of this article is left with the impression that Southwest Transplant Alliance (STA), is the only organ procurement organization (OPO) to call for organ donation information in Texas.

STA covers only one of three federally designated OPO territories in Texas, along with LifeGift of Houston and the Texas Organ Sharing Alliance (TOSA) of San Antonio, all OPOs with excellent records, Incidentally, TOSA is the designated OPO for Central and South Texas. In addition to Dallas, there are nationally recognized transplant programs in Houston, San Antonio and Austin.

That said, I again want to thank and applaud you for embracing this vital topic so visibly in your March publication.

Sincerely,

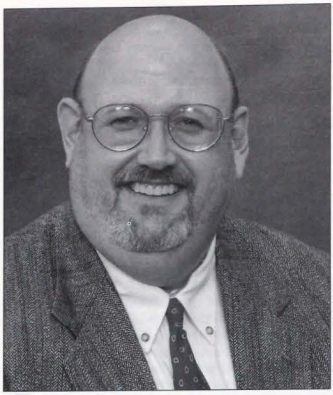
Marshall G. Cothran
Executive Vice President/CEO
Travis County Medical Society

ATTENTION GRADUATING SENIORS!

Please let the TOMA office know where you will serving your internship. You are very important to us and we don't want to lose track of you.

ATTENTION ALL STUDENTS!

To continue receiving the *Texas D.O.*, please call the TOMA office at 800-444-8662 with any change in your mailing address.



Ray Morrison, D.O., Program Chair

Bobby Howard, D.O., Secretary
Host District 8

Welcome to the Sparkling City by the Sea

TOMA District 8 would like to wish a warm and sunny welcome to all physicians, their families and the exhibitors attending the 101st Annual Convention & Scientific Seminar in Corpus Christi, June 15-18, 2000. The Convention Program Committee, chaired by Ray Morrison, D.O. and the TOMA staff have worked hard to put together an excellent combination of continuing medical education, social events and lots of fun family events. Since the TOMA House of Delegates has already been held (April 8, 2000 in Austin), we can all relax and focus on the medical lectures and other events of the convention.

On the CME side, we will have many talented speakers presenting important information on current medical topics such as Hepatitis C and Managing Migraines with numerous topics in between including several OMT demonstrations and workshops. We even have "Residents' Paper" being presented by the TCOM-Bay Area Medical Center family practice residents. I am especially anticipating the workshops which will include CLIA waived office lab testing, exercise stress-testing and Synvisc injection training on "real patients" as well as a workshop which will provide 2 hours of ethics CME. And, of course, the Risk Management session on Sudany will be very informative and useful as always.

On the fun side, Corpus Christi is a great place to come to spend relaxing family time. Enjoy our beautiful bay front with attractions such as the USS Lexington, Texas State Aquarium, Discovery Museum, all sorts of water sports and miles and miles of dazzling beaches and coastal scenery. You may even want to add a day or two to your stay and get in some great charter fishing or just work on your tan while loafing on Padre Island.

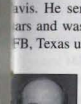
If you are looking for oustanding CME, fun for the entire family or simply renewing ties with osteopathic colleagues (or perhaps all the above), come on down and experience why Corpus Christi is hailed as the "Sparkling City by the Sea".

Bobby Howard, D.O.
Secretary, TOMA District 8

TOMA's 101st Annual Convention and Scientific Seminar
June 14 - 18, 2000
Bayfront Plaza Convention Center and Omni Bayfront Hotel
SPEAKERS AND TOPICS

rank B. Adams, D.O.
Screening for Hepetitis C"
Dr. Adams practices gastroenterology in Austin, Texas where s has been in private practice since 1993. He is board certified both Gastroenterology and Internal Medicine.

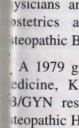
He earned his B.S. degree from the U.S. Military Academy in est Point, NY, in 1969 and his M.S. degree in Operations esearch from the University of Arkansas in 1973. He went on to ceive his D.O. degree from UNTHSC in 1980. In 1983, he terned and completed his residency in Internal Medicine at the avid Grant USAF Medical Center/University of California at avis. He served in the Air Force Medical Corps for over 15 ars and was on staff at Bergstom USAF Hospital, Bergstrom FB, Texas until 1993.



Robert C. Adams, D.O., FACOOG
"A New Look at Pelvic Pain"

Dr. Adams began his professional career in 1984 with the Texas College of Osteopathic Medicine as an Assistant Professor in the Department of OB/GYN. He became an Associate Professor in 88 and chair of the department in 1990. He remains active in e didactic course, the clinical clerkship and the residency ining programs. In 1997, Dr. Adams was appointed Assistant ean for Medical Practice and Medical Director of the ysicians and Surgeons Medical Group. He is certified in stetrics and Gynecologic Surgery by the American teopathic Board of Obstetricians and Gynecologists.

A 1979 graduate of the Kirksville College of Osteopathic edicine, Kirksville, Missouri, Dr. Adams completed an 3/GYN residency program in 1984 at the Grand Rapids teopathic Hospital in Grand Rapids, Michigan.



Shahid Aziz, D.O., FACOI
"Non-Ulcer Dyspepsia"

Dr. Aziz is an Assistant Professor of Medicine in the UNTHSC Department of Internal Medicine, where he teaches and performs patient care in the Division of Gastroenterology.

Originally from Pakistan, he completed his undergraduate udies in Molecular Biology at the University of Texas at Dallas 1979. He received his D.O. degree in 1986 from the University North Texas Health Science Center/Texas College of teopathic Medicine. Dr. Aziz completed an internal medicine idency at Osteopathic Medical Center of Texas, Fort Worth, l completed a gastroenterology fellowship at Botsford General spital in Farmington Hills, Michigan. He was in private prac- e from 1991-96.

Daniel A. Boudreau, D.O.
"Non-Surgical Treatment for Painful Herniated, Degenerated and Bulging Lumbar Disks"

Dr. Boudreau has held the position of Chief of Surgery at Tri-City Hospital in Dallas, at Rutherford Hospital in Mesquite, and at Mesquite Community Hospital, Mesquite. He practiced orthopedic surgery in Mesquite until 1999, and is currently the Medical Director for Texas Centers for Vax-D in Dallas. Dr. Boudreau is certified in Orthopedic Surgery.

He attended Central State College in Edmond, Oklahoma, after completing a four-year enlistment in the U. S. Navy. Graduating with a B. S. in Science, he then attended the Kansas City College of Osteopathic Medicine and Surgery (now the University of Health Sciences College of Osteopathic Medicine), Kansas City, Missouri, earning his D.O. degree in 1968. He interned at Stevens Park Hospital in Dallas, and did an orthopedic surgery residency at Lansing General Hospital, Lansing, Michigan.

Jamie L. Claypool
"False Claims: Is your Practice at Risk?"

Ms. Claypool is a Practice Management Consultant whose career spans over 20 years with consulting service to Houston, Austin and other Texas communities. She began her work with the Methodist Hospital Healthcare Network in Houston, providing consulting services to their affiliate physicians and hospitals. She has managed both small and large practices.

From 1993-96, she served as an adjunct faculty member at the University of Houston Clear Lake in the School of Business and Public Administration. At the University, she taught Group Practice Management and Medical Reimbursement. Currently, she serves on the University's advisory board for the undergraduate program in Healthcare Administration.

Ms. Claypool is a member of the American College of Healthcare Executives, a member of the Medical Group Management Association and Texas Medical Group Management Association. She is an endorsed consultant to the American Academy of Family Practice Physicians. Ms. Claypool has authored numerous articles on practice management and reimbursement and was an endorsed consultant with the TMA endorsed consulting program from 1996-1999.

E. Scott Ferree, D.O.
"Hands-On OMT Demonstrations"

Dr. Ferree, a board-eligible Internist, is currently finishing a manipulative medicine residency at the Osteopathic Medical

Center of Texas, Fort Worth. Beginning in September, 2000, his plans are to practice pain management, osteopathic manipulation and acupuncture research at Forest Park Institute in Fort Worth.

Dr. Feree earned his D.O. degree in 1996 from the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine. His internal medicine training was at Saint Vincent Hospital in Worcester, Maine. Additionally, he trained as a Medical Acupuncturist in Joseph Helms' course at UCLA.

Russell G. Gamber, D.O.
OMT Workshop

Dr. Gamber is Associate Professor of the Department of Manipulative Medicine at the University of North Texas Health Science Center/Texas College of Osteopathic Medicine. Additionally, he serves as Clinic Division Director, Two-Year Residency Director, and Research Division Director of the Department of Manipulative Medicine at UNTHSC/TCOM.

He earned his B. S. degree in 1965 from West Virginia University, and his D.O. degree in 1969 from the Kirksville College of Osteopathic Medicine, Kirksville, Missouri.

Bill N. Griffin, M.D., FACOG
"The ABC's of Osteoporosis"

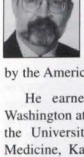
Dr. Griffin is a managing partner of Obstetrical & Gynecological Associates of Corpus Christi, and serves as Medical Director and Certified Clinical Densitometrist of The Bone Center. In addition, his work activities include president of the Nueces County Medical Society for 1999-2000; member of the Texas Osteoporosis Advisory Committee to the Texas Legislature; member of Eli Lilly Women's Health Advisory Panel; and investigator for a new drug study for Lipha Pharmaceuticals. He is certified by the American Board of Obstetrics & Gynecology.

He earned his M. D. degree in 1972 from the University of Texas Southwestern Medical School in Dallas, and served an OB/GYN internship at Parkland Memorial Hospital, also in Dallas. He then served as Ship's Physician and Head of the Medical Department on the U.S.S. Simon Lake, Rota, Spain, followed by an OB/GYN residency at Parkland Memorial Hospital.

Richard C. Grossman, D.O.
"Liposuction and Obesity"

Dr. Grossman is in private practice at Metropolitan Surgical Specialties in Colleyville, where his practice is limited to medical and surgical treatment of the bones and soft tissue of the ear, nose, throat, head, face, neck and sinuses, including facial plastic surgery. He also performs tumescent liposuction of the face and body. Dr. Grossman is board certified in otorhinolaryngology and maxillofacial plastic surgery.

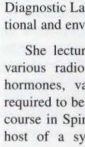
He received his undergraduate premedical training at Ripon College, Ripon, Wisconsin, and his master's degree in chemistry from Drake University, Des Moines, Iowa. He received his D.O. degree in 1978 from the University of Osteopathic Medicine a Health Sciences/College of Osteopathic Medicine, also in D Moines. He completed a five-year residency in ear, nose, thro and facial plastic surgery at Oakland General Hospital Madison Heights, Michigan, and post-residency training in lip suction of the face and body



A. H. "Lon" Jones, D.O.
"Xylitol – the Sweet Treat(ment)"

Dr. Jones has a family practice at Hi-Plain Hospital and Clinic in Hale Center, and als serves as Professor of Family Medicine at Texa Tech University Medical School. He is certifie by the American Osteopathic Board of Family Physicians.

He earned his M.A. degree from the University Washington at Seattle in 1965, and his D.O. degree in 1973 fro the University of Health Sciences College of Osteopathi Medicine, Kansas City, Missouri. He served an internship Hillcrest Osteopathic Hospital in Oklahoma City, Oklahoma.



Alison Levitt, M. D.
"Women's Health Naturally: A Functional Medicine Approach to Endocrinology"

Dr. Levitt is a board-certified family practitione currently living in Asheville, North Carolina. She works as the medical and laboratory consultant fo the Department of Medical Sciences at the Great Smokie Diagnostic Lab, a Functional Medicine Lab specializing in nutritional and environmental medicine.

She lectures nationwide and has been a guest feature o various radio and television shows talking about nutrition hormones, various diseases and lifestyle changes that are required to be made for optimal health. Dr. Levitt also teaches course in Spirituality and Medicine and is co-producer and the host of a syndicated television show called "The Healing Doctor," now airing on WLOS and The Wisdom Channel. On her show, she focuses on preventive medicine as well as a blend of complementary as traditional treatments for acute and chronic illnesses. Dr. Levitt is also in the process of developing an innovative and interactive corporate wellness program.

David A. McFarling, M. D.
"Diagnosis and Treatment of Migraines"

Dr. McFarling served in the U. S. Army for 23 years, retiring as a Colonel in 1995. Since then, he has been in private practice with The Neurological Clinic in Corpus Christi. In additional to his general neurological practice, he serves as Medical Director of the Muscular Dystrophy Clinical and as chairman of the Ethics Committee at Christus Spohn Shoreline Hospital. He is board certified in Neurology and is a Fellow of the American Academy of Neurology.

He received his M. D. degree in 1972 from Tulane Medical School. He served an internship at Gorgas Hospital and neurology residency training at Walter Reed Army Medical Center in Washington, D.C. Additionally, he served a fellowship

behavioral neurology at the University of Florida at Gainesville.

Susan G. Moster, D.O.
"The Latest on Irritable Bowl Syndrome"

Dr. Moster is currently in practice in Fort Worth, Texas, where she is a physician partner with Gastroenterology Associates of North Texas.

She graduated from Southwestern Oklahoma State University in 1981 with a degree in Pharmacy and Chemistry and received her D.O. degree from Oklahoma State University, College of Osteopathic Medicine and Surgery in 1986. Her gastroenterology fellwoship was completed at Midwestern University in Chicago in 1986. In 1995, Dr. Moster returned to Texas to begin clinical research and private practice.

Bradley Reiner
"Ten Tips for Dealing with Managed Care and Government Regulated Plans – A Meat and Potatoes Approach"

Mr. Reiner has been a healthcare consultant for the Texas Medical Association (TMA) for the past 10 years. He recently left the TMA to be an independent practice management consultant with J. Claypool Associates, specializing in reimbursement issues.

He has extensive experience with billing, coding and reimbursement in both the public and private sector. Mr. Reiner has counseled individual physicians and group practices regarding maximization of revenue and billing to ensure compliance with all types of payers. During his tenure at TMA, he conducted educational seminars on downcoding of evaluation and management services and the bundling and unbundling of procedures. One such program was the Min-consult program for county medical societies dealing with reimbursement for Medicare, Medicaid, Champus, Workers' Compensation as well as managed care issues. Another program presented by Mr. Reiner was the TMA "Hassle Factor" program that helped physicians and their staffs deal with all types of insurance problems. In 80% of the cases, he was able to resolve the problems with a positive outcome for the physician. Additionally, he assisted with the development of legislative policies to assist physicians throughout the state.

Mr. Reiner received a Bachelor of Business Administration in Marketing from Texas A&M University in College Station. His is frequently published author in such publications as American Medical News, Texas Medicine, Cardiac Coding Alert and TMA's Action Newsletter.

Duane Selman, D.O.
"Fermentation: Friend, Friendly, Friendlier"

Dr. Selman practices emergency medicine at North Hills Hospital in North Richland Hills, Texas. Credentialed in Emergency Medicine at nine hospitals in Texas, he is currently EMS Director for two fire departments' ambulance services and one private service.

He served as a field paramedic for 11 years, and is a former Fire Chief who operated the first paramedic ambulance service in Tarrant County in 1976. He holds degrees in Fire Protection Technology and Law Enforcement, with advanced certification as a peace officer.

A 1987 graduate of the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine, Dr. Selman served his internship at Osteopathic Medical Center of Texas, also in Fort Worth.

Alan R. Stockard, D.O., FAOASM
"Joint Injection with Viscosupplementation Agents"

Dr. Stockard is an Assistant Professor and Division Chief of Primary Care Sports Medicine in the Department of Family Medicine at the University of North Texas Health Science Center in Fort Worth, Texas. He is a board certified family physician and is also board certified in Sports Medicine by the American Osteopathic Academy of Sports Medicine, in which he serves as secretary-treasurer for the AOASM Board of Directors.

Dr. Stockard also serves as team physician for USA Judo, USA Weightlifting, 10 area Fort Worth High Schools and as primary care team physician for Texas Wesleyan University in Fort Worth. Additionally, he serves as medical director for the annual Cowtown Marathon in Fort Worth. He is very involved in the Olympic movement, both as a volunteer physician and as Crew Chief for the United States Olympic Drug Control Program.

He is a 1976 graduate of the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine.

Bridget T. Walsh, D.O.
"Current Concepts – Management of Acute and Chronic Pain"

Dr. Walsh serves as Assistant Professor of Clinical Medicine at Southern Arizona VA Health Care System, and as Staff Internist and Rheumatologist in the Department of Internal Medicine, Tucson.

She received a B.S. in nursing from Indiana University School of Nursing in 1980, and her D.O. degree in 1985 from Chicago College of Osteopathic Medicine. She interned at the University of South Alabama and at USAF Medical Center Keesler, Keesler AFB, Mississippi. Dr. Walsh served an internal medicine residency at Keesler AFB and a fellowship at the University of Arizona Health Sciences Center, Rheumatology Section.

Be sure to attend the **Keynote Luncheon**, **Thursday, June 15** to hear **Billy Riggs**, nationally recognized speaker, illusionist and entertainer deliver his powerful motivational presentation, ***"How to Drive Yourself without Driving Yourself Crazy"***. He will have you listening, laughing and learning with his special blend of inspiration, humor and personal insight.

Thank You

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ATOMA News

President's Report
by Lewis Isenberg
1999-2000 ATOMA President

The 1999-2000 officers were installed at the TOMA Annual Convention by the AAOA president–elect, our own Rita Baker. The golf tournament was again a huge success due to the efforts of past president Linda Cole and her great staff of volunteers. Thank you all for your help. I can attest that if everyone that participated didn't enjoy himself or herself, they only had themselves to blame.

Thanks, also, to Dean, Jacobson Financial Services and Healthcare Insurance Services for letting us be a part of this great event and, of course, all the monetary benefits we receive. A special thanks, also, to the SAA - you are an inspiration to us all with your enthusiasm and dedication.

My first visit was to Santa Fe, New Mexico, for the district 10 meeting in September. I had a wonderful visit but didn't win the golf tournament this year. The weather, as well as the families who make that journey, help to make that meeting one of the highlights of the year.

The AOA meeting in San Francisco was a blast! I attended as your president as well as a member of the national AAOA board. The Women's Health Symposium that was presented in conjunction with the convention was a big success, with over 600 local women attending. The Emmas were again in attendance and, as always, gave a heart-rending presentation on the yellow ribbon program and their son's suicide that precipitated the program. This year, the AAOA unveiled the new video, which tells the story of how the program got started and just exactly what the program is designed to do. This is a very moving video. I have shown it numerous times in conjunction with my district visits and am always impressed because I get something new and emotional from it each time I see it.

The highlight of San Francisco was the inaugural luncheon for the president of AAOA for the year 1999-2000. As you all are aware, that person is our own Rita Baker. Let me tell you, it was the biggest thing to happen in the AAOA in a long time, maybe even in the entire history of the AAOA. I overheard some longtime members of the AAOA saying that they had never been present at an installation luncheon that compared with this one. We can be "Texas proud" of everyone who participated. Each district had a special drive to raise funds for this event - a great big thanks to TOMA and all of the districts, especially districts 2 and 5.

We held our fall meeting in Austin at the TOMA building. We had a great time. Thanks to the executive director and all the staff for making the meeting a success.

The mid-winter meeting was held in Dallas and I was absent. I was in Chicago attending the mid-winter meeting of the AAOA board. Tami Prangle presided at this meeting and, from all reports, it was successful and well attended. Thank you, Tami!

Throughout the year, I have attended the regular board meetings of TOMA. I must say that the board members are very interested in what the auxiliary is "working on." They are very attentive to our reports and ever helpful with monies and other support. Just recently, I spoke at the House of Delegates meeting in Austin and immediately after I finished, one of the delegates from Tyler came forth with a check to defray costs of having more yellow ribbons cards printed.

The month of May marks one of the really fun things that the president gets to do - present scholarships at the Honors Day celebration at the University of North Texas Health Science Center/Texas College of Osteopathic Medicine. Jan Bowling, scholarship chair, and I presented two scholarships to very deserving third year students. Thanks, Jan, and also your husband, John, for a job well done.

And last, but nowhere the least, thanks to Terry, Paula, Sherry, Mary and the entire TOMA staff. You really make this a breeze and, above all, enjoyable! Also, a very humble thank you to all the officers and board members this year. I know that I have not mentioned special people like Susan, Shirley, Karen, Ruby, Barbara, Joan, Cindy, Pam, Kathy, Beth, Linda G, Ann, Joyce, Peggy, Darlene, Patty and others I have, inadvertently, overlooked. Thank you, each and every one!

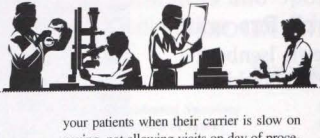
ATOMA Announces New Board

Nominations for the 2000-2001 A.T.O.M.A. Board are as follows

President:	Tami Prangle
President-Elect:	Susan Selman
Vice-President:	Pamela Adams
Recording Secretary:	Barbara Galarneau

Respectfully Submitted,
Nominating Committee, A.T.O.M.A.
Linda Cole, Shirley Bayles, Linda Garza

Self's Tips & Tidings



By Don Self

Charging a Collection Surcharge

More and more offices that take managed care patients are starting to apply a $5 or $10 surcharge if the patient does not pay the co-pay on the day the service is rendered. Some offices apply the surcharge if the co-pay is not paid at the time of service, and others apply it if the co-pay is not paid by 5 p.m. on the day of service. Check with your managed care contract to make sure that you are not prohibited from applying this surcharge before adopting this policy. We also recommend that you post notices in your office that state the surcharge policy will begin on a certain date, in order to give the patients plenty of warning.

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1 part continuous - 15.95 p/1000
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Managed Care Gets Warning

The largest employers in Central Florida revealed a warning to managed care:

"Change or we will abandon you!"

Apparently, enough physicians and hospitals have made the patients aware of problems, so that the employers have decided to set a precedent. This is the first time that a combined group of employers have thrown the gauntlet to the managed care carriers.

It's uncertain how Aetna, United Healthcare, Prudential and others will respond but it's obvious they will have to improve or lose their business.

When will the employers in the land of the Alamo take the same stand? The only way it will happen is if you start notifying your patients when their carrier is slow on paying, not allowing visits on day of procedures, not recognizing modifiers, etc.

Use the 1995 or 1997 HCFA Guidelines

Some offices are under the misconception that they have to use the 1995 guidelines while others may think they are restricted to only the 1997 guidelines. A letter from Nancy Min DeParle, Administrator of HCFA, says "I am directing carriers to continue to use both the 1995 and 1997 guidelines, whichever is more advantageous to the physician, until the revisions have been completed and there has been adequate time for testing and education."

You may use the 95 guidelines on one patient encounter and the 97 on another. The auditors are required to use whichever is most favorable to you, the provider.

Withdrawing from Plans

If you drop a managed care plan, we recommend you notify the patients on that plan of your intention and why. Here is a sample letter:

Dear Patient:

Due to the selfish habits and wants of my wife and children, it is with regret that we must withdraw from the wonderful managed care program to which you belong. While I've tried to convince my wife that it IS fashionable to wash clothes using a washboard, and it is good for her health to walk to the grocery market that is two miles away, she will not believe me. I explained to her that the managed care plan that some of my patients belong to are striving to assist in attempts to reduce overall medical care spending, but she says there is only so many ways to cook Spam and she's tired of it. I tried explaining to my children that it is good for the environment to reuse gunny sacks as clothes as buying new ones at Walmart is wasteful - but they seem to think their peers will make fun of them. I explained to them that being the butt of jokes build character in them and they said they didn't want to be "dished" or dissed" o something like that. I can never under stand their new words. On top of that, explained to our excellent staff that they should welcome the cut in salary we've had to institute since it should lower their taxes, and living on smaller income with less distractions would help build char acter. Unfortunately, they too, seem selfish and wish to keep the same salary they've had for the past 5 years.

I've even found that I'm starting to enjoy meeting all of the strange people at the convenience store where I work as a clerk during the midnight hours and on weekends. I also get a discount on the Big Gulp.

So, it is with regret that we must with draw from the managed care plan to which you belong. It is not my wish to do this. Personally, I know that I am helping the economy by providing care to the plan's members while the CEO of the plan has a salary exceeding $10 million per year, but I have to give in to my family and staff's wishes.

Should circumstances change (I win the lottery, your managed plan starts paying what it costs us to deliver services or my children join the Peace Corps), we will reconsider re-enrolling with your plan.

You May Bill that Visit When Patient Not Present

Section 35-14 from the Medicare Coverage Issues Manual (CIM) – the section entitled "Consultations With a Beneficiary's Family and Associates" explains quite clearly those situations where consultations with a patient's family member without the patient being present are covered by Medicare. It all boils down to whether the patient is withdrawn and uncommunicative due to a mental disorder

comatose. If so, the physician may ntact relatives and close associates to ure background information to assist in agnosis and treatment planning. When a ysician contacts his patient's relatives or sociates for this purpose, expenses of ich interviews are properly chargeable as ysician's services to the patient on hose behalf the information was secured. the visit is solely due to the fact that the mily wishes to know more about andpa's condition, then you need to let e family know that Medicare will not pay r educational visits with the family like is. There has to be a medical necessity r the visit, such as educating them how to edically handle grandpa, educating the ysician on grandpa's condition, making oices about treatment options for andpa, etc.

For Physicians Only

Through a joint arrangement between on Self and Wayne Clark, JD, we will be fering a special workshop to physicians ly, starting in July. Wayne Clark is one the foremost healthcare practice attor-ys in the country and works with OMA. This workshop will be geared ecifically to Family/General Practice d will have a guarantee you've never en before. If at the end of the seminar, ou do not agree that you can increase ur net income by at least $5,000 per onth by using the practice management os you will learn in the seminar, you will ceive a full 100% refund on the tuition the seminar. Attendees will be required sign a non-disclosure statement stating ey will not disclose any information arned at the seminar to any other physi-an office. Each seminar will be limited the first 10 prepaid & registered.

If you want further information, check www.donself.com/toma.html> or call 0-256-7045. There are no links to this e, so do not lose it. We are initially anning on one seminar per month. The st will be in Dallas at the end of July, e next in Houston in August, etc.

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Recommended Childhood Immunization Schedule – United States, 2000

A revised year 2000 immunization schedule was issued by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAF). This schedule should be implemented in WIC clinics and all public health clinics.

Copies of the immunization schedule can be downloaded from the Centers for Disease Control and Prevention website <www.cdc.gov/nip/pdf/child-schedule.pdf> or the Texas Department of Health (TDH) website <tdh.state.tx.us/immunize/2000schd.htm>.

If you want an electronic copy, please contact Ms. Veronica Primeaux by phone at 512-458-7283 or e-mail at: veronica.primeaux@tdh.state.tx.us.

Several significant changes have been made since the publication of the 1999 immunization schedule. These changes include:

- ✓ Removal of rotavirus vaccine from the schedule;
- ✓ Inactivated polio virus vaccine is recommended for all four doses;
- ✓ Hepatitis A vaccine is added to the schedule for selected states and geographical areas.

For additional information concerning the above statements, please read the footnotes to the immunization schedule. Please refer to the package inserts for each vaccine/toxoid. The inserts contain critical information such as dosage, number of doses needed, dosing intervals, and the minimum/maximum age for administration of the vaccine/toxoid.

FDA Considers Making Drugs Available to Consumers Without Physician's Prescription

The FDA plans hearings in late June to launch an extensive review of its over-the-counter drug policy, the last of which was in 1972 and led to more than 600 prescription drugs being moved over the counter. The review will focus on drugs for chronic conditions such as high cholesterol, high blood pressure, diabetes and osteoporosis.

(USA Today, 4-28-2000)

$250,000 Up for Grabs

The Center for Rural Health Initiatives (CRHI), the Texas State Office of Rural Health, is looking for applicants to take advantage of its $250,000 Medically Underserved Community-State Matching Incentive Program (MUC-SMIP). The purpose of the program is to enhance the abilities of underserved communities to attract and retain primary care physicians by providing matching funds to cover certain costs of establishing a primary care physician's practice site. Rural communities struggling with losses of access to health care providers are encouraged to take advantage of the invaluable MUC-SMIP program. "It's a very unique opportunity for rural folks to attract and keep health care providers in their communities," said Sam Tessen, Executive Director of CRHI.

The state grants funds from $15,000 to $25,000 per applicant. The community must provide matching funds of the same amount, and the contracted physician must agree to practice in the community for at least two years.

The matching grant is available to communities located in rural Texas counties that are designated as either a Medically Underserved Community (MUA) or a Health Professional Shortage Area (HPSA). To determine the status of your county, contact the Health Professions Resource Center at 512-458-7261 or email them at <hprc@tdh.state.tx.us>.

If you have questions or would like an application, contact Marty Darnell at CRHI at 512-479-8891, toll free at 877-839-2744, or by email at <darnell@crhi.state.tx.us>. Applications for this year's funding must be received by July 31, 2000.

The Center for Rural Health Initiatives is the State Office of Rural Health. Established in 1989, it provides leadership in encouraging innovative responses to rural health care needs. The Center advocates a number of programs and services designed to help rural health providers and communities proactively address the health care needs of rural Texans.

National Academies of Practice Inducts Samuel Ganz, D.O.

The National Academies of Practice is pleased to announ the election of Samuel Ganz, D.O., of Corpus Christi, Texas, a distinguished practitioner-member of the NAP. Dr. Ganz w installed at a gala membership banquet on April 28 in Bethesd Maryland, at which time the National Academies of Practi inducted new members from ten professions, including oste pathic medicine.

Extremely active in TOMA affairs, Dr. Ganz served as pre dent from 1977-78. He is certified in Family Practice and Addictive Diseases, and is a Diplomat of the National Board Examiners for Osteopathic Physicians and Surgeons. Dr. Ga serves as a member of the Physicians Health and Rehabilitatio Committee and is a member of the TOMA House of Delegate recently receiving a certificate for 24 years of service.

The National Academies of Practice was founded in 1981 i recognition of the need for interdisciplinary collaboration i health care. It is comprised of distinguished practitioners an scholars from all of the primary health professions, no including ten disciplines: Dentistry, Nursing, Optometry Osteopathic Medicine, Medicine, Psychology, Podiatri Medicine, Social Work, Veterinary Medicine, and Pharmacy Only 100 distinguished members can be elected to membership so selection is indeed an honor. Each year, the NAP sponsors forum on aspects of interdisciplinary collaboration. This year' Forum charted requirements to advance the field of interdisciplin nary practice, research and teaching in the 21st century throug a consensus development process culminating with a conferenc held at NIH on April 28.

For further information about nominating potential member to the NAP or about the work of the organization in interdisciplin nary care and public policy, call the NAP office at 410-676-339 or visit the Web site at: http://views.vcu.edu/nap.

TCOM Class of 2000

would like to extend its deepest thanks to the following sponsors for their contribution to our senior activities and class gifts.

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TEXAS FYI

Texas Board of Medical Examiners Suspends License of United HealthCare Medical Director for Denying Medical Care to a Child with a Critical Respiratory Condition

United's medical director denied the commendation of a treating physician at a 13-year-old boy be provided with me nursing care from providers trained both cardiopulmonary resuscitation d ventilator care, while admitting that had no experience in home ventilator re and that he consulted no medical terature in reaching his decision. United s gone into court to block the suspen-on, contending that because its medical rector made a benefit determination, not medical decision, he and the company e protected by federal law and that nited was acting on behalf of Allstate, e employer through which the boy's surance was obtained. The board said it ould put its suspension on hold if the edical director agreed to two years' robation, 12 hours of medical courses, a 5,000 fine and other provisions.

Dallas Morning News, 4-16-2000)

Texas Employee Retirement System Drops Four HMOs State's Health Insurance Program Effective September 1

Employee Retirement System offi-als said the health plans, including etna U.S. Healthcare, Humana Health lans of Texas, AmCare Health Plans of exas and Firstcare, asked for unaccept-bly high rate increases. Their exclusion om the state's health insurance program ill require 115,000 state employees in exas to change health plans.

ustin American-Statesman, 4-20-2000)

AOA News

Executive Director Declares Patients' Rights Top Priority at White House Meeting

(Washington, DC) - In a top-level White House meeting, American Osteopathic Association (AOA) Executive Director, John Crosby, JD, declared the AOA's commitment to meaningful patients' rights legislation with a plan to launch a unified and full-force grassroots campaign in support of the Norwood-Dingell Patients' Bill of Rights.

"Enactment of the Patients' Bill of Rights is the highest priority in our Washington Office. A right without a remedy is not a right - it is a request. And, when it comes to managed care, our patients are demanding more," says AOA Executive Director John Crosby, JD. "The health professions need to unite behind one issue - at this time it is the Patients' Bill of Rights. We have pledged to help the Clinton Administration and the majority in Congress to employ all of our grassroots and other resources to accomplish this goal."

The AOA committed to mobilizing the 44,000 osteopathic physicians and hundreds of thousands of patients it represents through legislative hotline recordings (800/560-6229), grassroots action alerts and web-based patients' rights updates at <www.aoa-net.org>. Meeting participants White House Chief of Staff John Podesta, Health and Human Services Secretary Donna Shalala and Labor Secretary Alexis Herman welcomed this commitment. Crosby also told White House senior advisors Chris Jennings and Barbara Woolley the AOA would closely work with the other patient advocates attending the meeting.

At the meeting, advisors revealed that leading conferees would be invited to a White House meeting to discuss the progress of patients' rights negotiations. The AOA believes the conference committee's slow progress needs to accelerate, as patients' deserve a Patients' Bill of Rights now, not next year.

According to the AOA, a meaningful patients' bill of rights allows physicians to determine medical necessity, holds health plans accountable for their actions, provides a fair and independent appeals process to patients, and ensures these basic protections apply to all Americans. While patients' rights conferees have agreed on legislative concepts of access to emergency room services and pediatricians, prohibition of discrimination against providers and external review, they have not reached an agreement on the scope of patient care or health plan liability. AOA firmly believes meaningful patients' rights legislation must provide patient protections to all Americans and hold all health plans accountable for medical decisions that harm or injure a patient.

"This meeting was a major milestone for the osteopathic profession," says Crosby. "Without the leadership of our Council on Federal Health Programs, the Unity campaign and our grassroots operations, it would have never happened. As John Podesta, President Clinton's Chief of Staff said. The next time AOA and other meeting participants are invited to the White House, it will be to witness the signing of the Patients' Bill of Rights into law."

Under the direction of the Council on Federal Health Programs, the AOA embarked on a nationwide effort to involve osteopathic physicians in the patients' rights debate. Aside from regular action alerts and an orchestrated effort to unify state, affiliate and non-practice osteopathic medical group advocacy, the AOA organized a Capitol Hill day to lobby Members of Congress on patients' rights in April. The Unity Campaign, AOA's public relations campaign dedicated to making D.O.s a household word, ran ads in USA Today, CQ Weekly and Roll Call.

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Traditional vs. Roth IRA: Which is Best for Your Portfolio?

The past several years have seen a dramatic increase in investors' interest in the stock market. The comparison has been drawn that investors now check the performance of certain stock indices much the same way that fans follow the scores of their favorite sports teams.

Certainly a sustained bull market is part of the reason for this interest. The economy has enjoyed an unprecedented period of prosperity. However, another reason for the increased interest in stock performance is the popularity of self-directed retirement plans such as the Individual Retirement Account (IRA). Investors in an IRA have a wide array of choices, not only in the investments that are held in the account, but in which account works best for their particular financial situation. In this article, we'll examine two of the most popular retirement accounts, the traditional IRA and the Roth IRA.

The Roth IRA, introduced on January 1, 1998, caught the fancy of investors as soon as it was introduced. After just two years of existence, more than seven million American households own a Roth IRA. Its primary appeal is tax-free retirement withdrawals, provided certain conditions are met. With a traditional IRA, your contributions may not be deductible, and distributions are subject to federal tax.

Get the Facts Before Making a Move

Understanding the key differences between Roth IRAs and their traditional counterparts will help you decide which fits best in your retirement program.

Traditional IRAs

The Basics: IRAs allow individuals with earned income to make tax-deductible contributions of up to $2,000 per year. The earnings in the account grow on a tax-deferred basis. All contributions and earnings are taxed as ordinary income when they are withdrawn. However, withdrawals prior to age 59 ½ are subject to a 10 percent income tax penalty.

The Limitations: Individuals who are active participants in an employer-sponsored retirement plan and who have adjusted gross incomes above $40,000 for singles or $60,000 for married couples are not allowed to deduct their contributions. IRA participants must begin taking minimum withdrawals by April of the year they reach age 70 ½.

Roth IRAs

The Basics: You contribute to a Roth IRA with after-tax dollars, thus avoiding any eligibility conflicts with employer-sponsored plans. After five years, you may take tax-free, penalty-free withdrawals if you're 59 ½ , or as a result of death, disability, or a first-time home purchase.

The Limitations: Eligibility to contribute to a Roth IRA phases out between $95,000 and $110,000 for single filers and between $150,000 and $160,000 for married couples. Unlike traditional IRAs, Roth IRAs do not require participants to begin taking minimum withdrawals after reaching age 70 ½.

Things to Think About Before Converting to a Roth IRA

What are the key factors that determine whether you should convert to a Roth IRA? Answering the following questions may help you arrive at your decision.

How old are you and when do yo to retire? If you have time on you you may benefit by converting to a IRA. You'll pay income taxes on value rather than on a more appre value. If you are close to retireme you'll have to carefully weigh you options and income needs.

Do you currently qualify for tax-deductible contributions to an IR so, it's actually cheaper to use a traditional IRA to put away $2,000 because of the tax deduction.

What is your income tax bracket and what do you expect it be in retirement? If you are beginning career and are in a lower tax brack may be more favorable to convert a pay the taxes now.

How much money is in your IRA? the figure is relatively low but you anticipate making future contributi and foresee growth over time, you c pay the taxes and thereby eliminate income taxes on any future earning received as part of a qualified distribution. Whichever you choose IRAs can play an important role in retirement savings. Your decision v ultimately depend on your own uniq financial situation – your time horiz income level and goals.

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Review of the Agreement Between AETNA and Texas Attorney General

by Janet Horan, JD,
AOA Assistant Director, Socioeconomic Affairs

Introduction

The agreement between the state of Texas and Aetna, called n "Assurance of Voluntary Compliance" (AVC), is the settle- ient for a lawsuit initiated by the Texas Attorney General lleging that Aetna established financial incentives to encourage ysicians to limit care. Many of the provisions of the AVC are rrently required by Texas statute.

Improving the Quality and Integrity of Determinations of Medical Necessity and Covered Benefits

Aetna agrees that the determination of covered services is inde- endent of whether the services are medically necessary. A deter- ination of medical necessity will be made on a case-by-case asis by "qualified professionals who have the appropriate aining, education, and experience and who possess the clinical dgement and case specific information to make these decisions".

"Medically necessary" care is defined as the care and services at under the applicable standard of care are appropriate:

> To improve or preserve health, life, or function; or
> To slow the deterioration of health, life, or function; or
> For the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness, or injury.

Determinations of whether care is medically necessary shall so include determinations of whether services are cost effective, mely, and sufficient in quality, quantity, and frequency consistent ith the applicable standard of care. A treatment is cost effective if is the least expensive medically necessary treatment selected om two or more treatments that equally effective in achieving a sired health outcome for that particular patient.

Aetna agrees that any non-case specific guidelines or policies sed by Aetna in determinations of covered services or medical ecessity will be available to the public via the internet and avail- ble for peer review if allowed by copyright, trademark or other censing agreements.

Aetna agrees to conduct audits every 180 days of utilization view personnel to determine the incidence of erroneous adverse terminations. Any adverse determination will be ultimately ecided only by a physician licensed to practice medicine in Texas.

Aetna agrees to maintain or apply for National Committee for uality Assurance accreditation for Aetna's commercial HMO perations in Texas.

Any member, or provider upon written consent of a member, ay appeal denials or reductions through the Aetna internal ppeal process. If this appeal is denied, the parties may seek an external review if at least $500 is at issue. The external review will be arranged and provided by Aetna and conducted by a neutral and independent licensed physician with the appropriate expertise. The denials subject to this process are:

- any denial or reduction of payment for emergency care based on failure to meet the "prudent layperson" standard;
- any denial or reduction of payment because the services are deemed experimental or investigational;
- any denial of payment for drugs for covered health care services sought by a member whose plan includes a prescription drug rider for any reason not subject to review under Texas statute; and
- any denial of a written request for a standing referral to a specialist for reasons other than medical necessity.

Capitation and Other Financial Incentive Arrangements

Aetna agrees not to use any financial incentives that provides physicians additional compensation for not exceeding budgets, for not incurring expenses for services that medically necessary or for limiting medically necessary health care services. Aetna also agrees not to use any financial incentive arrangement that is not actuarially sound.

Aetna agrees not to enter into any financial incentive arrangement with a risk bearing network provider unless the arrangement includes a means such as stop loss insurance or reinsurance to protect the members from any inducement to limited medically necessary services resulting from extraordinary costs.

If after six months under a capitated agreement, a primary care physician who has less than 100 Aetna members will be offered the option to be paid a set amount per office visit. The set amount per office visit will be no less than the average fee paid for an intermediate office visit by a primary care physician under Aetna's usual and customary HMO fee for service schedule for the relevant geographic area.

Aetna agrees to provide financial incentives to encourage physician to provide the following preventive care to members:

- prescribing ACE inhibitors for members with congestive heart failure;
- prescribing anti-inflammatory drugs for members with asthma;
- performing skin biopsies;
- providing immunizations;
- providing allergy desensitization injections;
- seeing members at least once every twelve months;
- providing asthma treatment;
- referring members with complex asthma to specialists;

- providing members with cardiac disease an influenza vaccine;
- encouraging members with hypertension or congestive heart failure to take medications;
- providing annual retinal eye examinations for members with diabetes; and
- encouraging members with diabetes to take medications.

Aetna agrees that all services to be provided in exchange for a financial incentive arrangement will be clearly disclosed in all physician contracts. Physicians will have 30 days to evaluate the information to determine if they wish to sign the agreement.

The methods by which physicians are compensated will be disclosed to Aetna members.

The Physician-Patient Relationship

Aetna agrees not to terminate or penalize a physician who provides or proposes to provide medically necessary care that is more than that which is –

- projected;
- the statistical norm;
- provided or proposed to be provided by peers; or
- established as a goal.

Aetna agrees that profiling of providers will be the product of qualified and objective peer review, utilizing criteria directly related to the quality of patient care. Aetna will not use economic profiling to discourage providers from providing medically necessary care.

If utilization review meetings are held, Aetna agrees to provide the physician with 72 hours advanced notice of which treatment requests and decisions of that physician will be evaluated. Aetna will also disclose all information used in these meetings 72 hours prior to the meetings. Results of the meetings will be provided to the physicians within ten days after a decision has been reached.

Aetna agrees not to discriminate against a member based on the member's acute, chronic, disabling, or life threatening illness or condition.

Aetna agrees to provide physicians with copies of contracts, policies, guidelines or criteria that physicians are contractually obligated to comply with within ten business days of a receipt of a written request for such information. Amendments to such contracts, policies, guidelines or criteria will require 90 days notice and provide physicians an opportunity to comment.

Participation by Physicians in Aetna Health Care Products

Aetna agrees to allow individual physicians, primary care physician groups of ten or less and non-primary care physician groups of 25 or less the option of participating in either HMO or non-HMO based products. Whichever product line physicians select, they must participate in all of the Aetna products in that particular line that are in effect at the time of the contract.

Individual physicians and small physician groups may al limit their patient population of Aetna members to 25%. Thi need to provide Aetna with 60 days notice and also limit th patient base for other payors to 25%.

Aetna may use a different capitation rate or fee schedule f physicians based on the physicians' choice to accept all Aet products than for those physicians accepting only the HMO non-HMO product lines.

Physicians currently subject to the Aetna "all product provision can choose not to participate in all products by givi Aetna 90 days notice of such a decision.

Aetna agrees to provide 90 days notice of contract change including fee schedules or capitation rates. Physicians have days to evaluate the change and terminate the contract if th change is unacceptable. Aetna further agrees not to implemen retroactive changes to the contract.

Patient Protection from Provider Inability to Pay Physicians

Aetna agrees to directly contract with providers of a ris bearing network if the network is unable to make timely paymen to the providers for medically necessary covered benefits.

Improving Member Choice of and Access to Quality Health Care

Health Care Providers

Aetna agrees to publish a physician and provider directory o the Internet and will update it weekly. Aetna agrees to allow members to either choose new physicians or continue to receiv care through to the end of plan year from physicians who termi nate their Aetna contract as long as the termination was not du to poor quality of care, loss of license, fraud or failure to b credentialed.

Aetna will compensate the physician at the contract rate unti the end of member's plan year or the expiration date of the physi cian's contract – whichever is earlier. If the physician's contrac expires before the end of the member's plan year, the compensa tion will be Aetna's usual and customary HMO fee for the service

Aetna agrees to notify members no later than 30 days before a physician's termination date, unless immediate termination i justified to protect the member's health.

Aetna agrees that if medically necessary covered benefits are not available within the limited provider network to which the member's primary care physician belongs, but is available within Aetna's network, upon request Aetna will authorize payment for a referral within five business days after receipt of request.

Aetna agrees to have the referral reviewed by a specialist of the same or similar specialty as the referred physician before denying the referral.

Aetna agrees that if a member is admitted to an in-patient facility, Aetna will not assign a physician other than the member's primary care physician to direct and oversee the members care if the member objects to the Aetna assignment.

Aetna agrees to approve a request for a standing referral to a rticipating specialist for a member with a chronic, disabling, or e-threatening illness or condition if the referral is medically cessary. Aetna may place reasonable limits on the duration and ope of the standing referral.

Once Aetna communicated approval of payment for a partic-ar procedure, service, product, or supply then Aetna will pay.

Aetna will implement programs to encourage physician to ovide members with preventive health care services such as the llowing:

financial incentive arrangements to primary care physicians to provide preventive and quality care;
retinal eye examination reminders to members with diabetes;
identification of members with asthma and providing asthma educational materials and peak flow meters to members;
contraindication programs with pharmacies to prevent members from taking contrary medications;
reminders to female members age 40 and older to have mammograms and perform breast self-examinations;
reminders to female members age 18 and over to have pap screening;
reminders to parents of infants to get appropriate immunizations;
reminders to members age 65 and older to get influenza and pneumococcal vaccines; and
reminders and screening kits to members age 50 and older for early detection of colorectal cancer.

escription Drugs

Aetna agrees to provide notice of any modification or dele-n of coverage for prescription drugs in the member's next plan ar. Aetna also agrees not modify (e.g., increase the copayment ligation of the member) or delete coverage of any prescription ig during the last 90 days of the member's plan year. Aetna ll give 90 days notice to physicians and other providers of any odifications or deletions of prescription drug coverage.

Aetna will make the drug formularies available to consumers d providers through the Internet, which will be updated as soon changes in the formularies occur.

Aetna agrees that a determination of whether a drug repre-nts an important therapeutic advance will be done without gard to cost, price, volume discount arrangements, rebates, or ier agreements or financial arrangements between Aetna and armaceutical companies or drug manufacturers.

Aetna agrees that if a physician determines that it medically cessary to treat a member with a prescription drug excluded from the member's formulary, and Aetna determines that it is medically necessary to treat the member with the excluded drug, the excluded drug will be covered.

Aetna agrees that any pharmacy, pharmacist or pharmaceutical benefit manager involved in the delivery of prescription drugs to Aetna members shall not have any financial incentive to encourage the substitution of any particular Aetna formulary drug in place of the drug prescribed by the treating physician.

However, there can be financial incentives for alerting a treating physician of any hazards posed by the prescribed drug or for a drug more effective than the prescribed drug or for encouraging the substitution of an equivalent generic drug for the brand name drug prescribed by the treating physician.

Experimental and Investigational Therapies and Clinical Trials

Aetna will cover experimental or investigational therapies and clinical trials if the member has a current diagnosis that has a probability of causing death within two years and standard therapies have not been effective or medically appropriate.

A physician requesting this treatment on behalf of a member must put the request in writing and include two documents from the medical and scientific evidence that Aetna finds acceptable indicating that the requested therapy is likely to be more beneficial than the standard therapy.

Emergency Care

Aetna agrees to pay for emergency department screening and stabilization services, in and out of Network, without prior authorization by Aetna or the member's primary care physician in accordance with the prudent layperson standard.

Aetna encourages emergency department physicians to exercise their own independent professional judgement in providing medically necessary care.

Ambulance services participating in Aetna's network will be required to deliver the patient who requires emergency medical care to the nearest medical facility where emergency medical care can be provided in a timely fashion. This requirement may be modified by specific instructions from the member, the member's family or the member's physician.

The Office of Ombudsman

Aetna agrees to establish an ombudsman office by June 1, 2000 to educate Aetna's members and advocate on behalf of these members in obtaining medically necessary care through the internal appeal, independent review organization proceedings and external review processes.

News
from the University of North Texas Health Science Center

UNT Health Science Center Opens Patient Care Clinic in Azle

The University of North Texas Health Science Center's Physicians & Surgeons Medical Group has opened a patient care clinic in Azle, located at 232 Park Place.

The following board-certified physicians – Dr. Burke DeLange, general and vascular surgeon, Dr. Adam B. Smith, general surgeon, and Dr. Shahid Aziz, gastroenterologist – will be on staff at the health science center Azle Clinic, seeing patients by appointment only.

According to Dr. Sam Buchanan, chief of the department of surgery at the UNT Health Science Center, an increasing patient base from Azle supported the need for such a clinic.

"Many of our patients are coming from Azle, so our clinic services can be closer to the patient's home, adding to the clinic's accessibility and convenience," said Dr. Buchanan.

Doctors at the UNT Health Science Center Azle Clinic will work closely with Harris Methodist Northwest Hospital for referring patients who need additional care not available in a clinic setting. Dr. Aziz has been providing patient care services in the Azle community since 1992.

"We will continue to explore other medical needs of the Azle community which may increase the demand to bring other specialty physicians from the UNT Health Science Center to this clinic," said Dr. Buchanan.

To contact the UNT Health Science Center Azle Clinic, all (817) 270-5511 or (817) 735-2518 for surgery appointments or (817) 270-5510 or (817) 735-2660 for internal medicine.

IN BRIEF

The Federation of State Medical Boards and the National Board of Medical Examiners Opened a National Center to Evaluate Competence of Physicians Suspected of Substandard Care

State medical licensing boards estimated that they could refer up to 1,000 physicians each year to such a center to receive assessment and potential retraining following licensure sanctioning, and plan to refer 200 physicians over the next 12 months to the new Institute for Physician Evaluation located in the Denver area, while three to four additional regional assessment centers are projected to open as board referrals increase. Competency assessment at the institute includes written tests, examination by peers on hypothetical cases to evaluate decision-making and documentation, and videotaped interactions with simulated patients, as well as a remediation plan when indicated.

(American Medical News, 5-1-2000)

HCFA Considering Boosting Medicare Payments to Nursing Homes by 5.8 Percent

Published for public comment, HCFA's proposed payment rate increase would start October 1 and amount to a $1.00 million increase over the current year's allocations, for an estimated total of $15.5 billion for nursing homes in fiscal 2001. The rate increase would make more funds available for nursing home patients with complex medical needs requiring intensive care and treatment.

(Associated Press, 4-8-2000)

HCFA Offered Clarifications of Medicaid Emergency Department Payment Policy

HCFA instructed all state Medicaid directors to pay hospitals and physicians for services rendered to Medicaid managed care enrollees in their emergency departments, clarifying a Balanced Budged Act provision that requires coverage under the "prudent layperson" standard, regardless of whether the enrollee received prior authorization. HCFA also said that Medicaid managed care plans must use presenting symptoms, not a discharge diagnosis, to determine whether the prudent layperson standard is met.

(Massachusetts Hospital Association Monday Report, 5-1-2000)

The U. S. Justice Department and State Attorneys General Allege Pricing Practices by the Pharmaceutical Industry Could Result in $1 Billion in Medicare and Medicaid Overpayments Each Year

An investigation by the regulators alleges that the drug industry inflates wholesale drug prices to attract physicians, clinics and other medical providers to their products by enabling them to bill Medicare and Medicaid at the inflated price while obtaining the drugs at a substantially lower rate. The Justice Department has asked a private California firm that provides drug price information to the states to change the way it reports prices for 50 drugs, substituting prices determined by state Medicaid fraud investigators for wholesale prices set by drug manufacturers.

(USA Today, 4-6-2000)

A U.S. Senate Panel Approved Compromise Bill - Nation's Organ Allocation Policy

The bill's approval followed a House veto that replaced the government's new national priority system for organ recipients with the previous allocation system that gave patients who live near a donor first priority for newly available organs. The Senate Health Committee unanimously approved a bill that, if passed by the Senate, would allow broader sharing of organs while creating a committee of medical professionals to determine transplant policy. The Senate bill was endorsed by the Clinton administration and the United Network for Organ Sharing.

(Houston Chronicle, 4-13-2000)

The Percentage of Low-Income Children with Health Insurance Unchanged Over the Last Few Years Despite Expansions in Public Coverage Through Medicaid and State CHIP Programs

The percentage of low-income children with public coverage recently increased from 29 to 33 percent, while the percentage of private coverage fell from 47 to 42 percent, resulting in no net change in their overall uninsurance rate, according to a study by the Center for Studying Health System Change. The study, based on two surveys from 1996-97 and 1998-99, also found that the uninsurance rate for low-income parents increased from 31 to 35 percent during this time period.

(Center for Studying Health System Change, 4-24-2000)

Thirty-nine Percent of Physicians Deceive Health Insurers to Help Patients Get Needed Care Not Covered Under their Plan, According to a Study Published in the Journal of the American Medical Association

A survey of 1,124 practicing U.S. physicians in 1998 found that 39 percent of respondents used at least one of the following tactics "sometimes" or more often within the preceding year: exaggerated the severity of an illness to circumvent early hospital discharge of a patient, listed an inaccurate diagnosis on bills, or reported nonexistent symptoms to secure insurance coverage. Thirty-seven percent of physicians said their patients "sometimes" or more often asked them to deceive insurers, while 28.5 percent of physicians said it is necessary to game the system to provide high quality care.

(Journal of the American Medical Association, 4-12-2000; Boston Globe, 4-12-2000)

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PART-TIME Physician Wanted – The Davisson Clinic. Dallas, Texas. 214-546-7266. (06)

SPINE SURGEON NEEDED – Orthopedic Management Co. needing a PT spine surgeon for workers comp injuries. Flexible hours, 2 convenient locations within the DFW area. 817-652-4666. (07)

DALLAS - Physician needed at walk-in GP clinic. Flexible hours or part-time. 214-330-7777. (11)

PHYSICIAN WANTED (FORT WORTH, TX) – Full/Part time physician wanted to work in Occupational Medicine Clinic. Preferably with experience working in high volume Occupational Medicine or Family Practice clinic. Call 817-735-8131 or fax CV to 817-763-5577. (12)

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FOR SALE – FAMILY PRACTICE, AUSTIN, TEXAS. Net $200,000/no hospital. Will finance. Will work with new associate/owner during transition period. Contact TOMA at 800-444-8662. (09)

MEDICAL PRACTICE, EQUIPMENT AND BUILDING – FOR SALE. Established 1982, no HMO, 50% cash. Good location. Call TOMA 800-444-8662. (18)

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FOR SALE – Family Practice, Dallas, Texas. No hospital. Will work with new owner during transition period. Established practice 40 years-plus. Call TOMA 800-444-8662. (23)

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WANTED: P.T. equipment, hydroc lator heater and packs, step stools, Upp Body Exerciser, ultrasound for P privacy curtains or dividers, lifting b and sled, Total Gym. Also need a cabin Contact: 830-MAX-CARE (629-2273) FAX 830-MAY-WORK (629-9675). (0

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FOR SALE – Late model MA X-ra and processor with view box and acces sories; hydraulic stretcher; transpo stretchers; Coulter counter and dilute storage cabinets; office desk; assorte other items - very good condition Contact: Dr. Glen Dow or Offic Manager, 817-485-4711. (48)

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