

TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

Volume LIX, No. 10

November 2002



It comes in all shapes, sizes and colors.



It is the largest organ of the human body.

It is made up of approximately
19,000,000 cells per every square inch
of the human body.

It grows faster than any other organ
and continues to repair and renew itself
for the entire life of the body.



It is tough, elastic, flexible
AND waterproof.



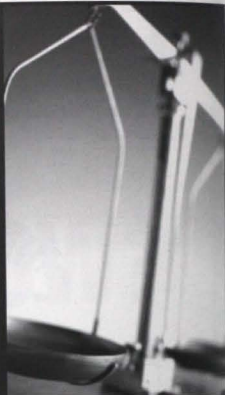
SKIN

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plus

TOMA's 47th MidWinter Conference
& Legislative Symposium
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CALENDAR OF EVENTS

DECEMBER 6 - 8

"21st Annual Winter Update"

Sponsored by the Indiana Osteopathic Association

Location: Sheraton Hotel & Suites, Indianapolis, IN

CME: 20 hours category 1-A credits anticipated

Contact: IOA, 800-942-0501 or 317-926-3009

DECEMBER 7

"Infectious Disease Update"

Sponsored by the University of North Texas Health

Science Center/Fort Worth

Location: UNTHSC/Fort Worth

3500 Camp Bowie Blvd., Fort Worth, TX

CME: 8 hours category 1-A credits anticipated

Contact: UNTHSC/Fort Worth Office of Professional &

Continuing Education

817-735-2539

www.hsc.unt.edu

DECEMBER 7

"TOMA Board of Trustees Meeting"

Location: Toma Building, Austin, TX

Contact: Lucy Gibbs, Associate Executive Director

800-444-8662

DECEMBER 9 - 11

"HIPAA Forum"

Sponsored by the American Hospital Association and the

Health Care Compliance Association

Location: San Diego, CA

Contact: www.hccca-info.org

2003

JANUARY 10

"A Day of Pain: Pain Management Update"

Sponsored by the University of North Texas Health

Science Center/Fort Worth

Location: UNTHSC/Fort Worth

3500 Camp Bowie Blvd., Fort Worth, TX

CME: 8 hours category 1-A credits anticipated

Contact: UNTHSC/Fort Worth Office of Professional &

Continuing Education

817-735-2539

www.hsc.unt.edu

FEBRUARY 7 - 9

"TOMA's 47th MidWinter Conference & Legislative Symposium"

Sponsored by the Texas Osteopathic Medical Association

Location: Omni Mandalay Hotel at Las Colinas

Irving, Texas

CME: 16.75 hours category 1-A credits anticipated

Contact: Sherry Dalton

899-444-8662

512-708-8662

FEBRUARY 21 - 23

"13th Annual Update in Clinical Medicine for Primary Care Clinicians"

Sponsored by the University of North Texas Health

Science Center/Fort Worth

Location: Steamboat Grand Hotel, Steamboat Springs, CO

CME: 20+ hours category 1-A credits anticipated

Contact: UNTHSC/Fort Worth Office of Professional &

Continuing Education

817-735-2539

www.hsc.unt.edu

FEBRUARY 26 - March 2

"Midwinter Basic Course"

Sponsored by The Cranial Academy

Location: AZCOM, Phoenix, AZ

CME: 40 hours anticipated

Contact: The Cranial Academy

8202 Clearvista Pkwy, #9-D

Indianapolis, IN 46256

317-594-0411; FAX 317-594-9299

MARCH 19 - 23

"ACOF 40th annual Convention & Exhibition"

Sponsored by the American College of Osteopathic

Family Physicians

Location: The Gaylord Opryland Resort &

Convention Center, Nashville, TN

Contact: ACOFP

www.acofp.org

APRIL 11

"58th Annual Meeting of the TOMA House of Delegates"

Location: Austin Marriott North at Round Rock

Contact: Lucy Gibbs, Associate Executive Director

800-444-8662

TOMA's 47th MidWinter Conference & Legislative Symposium

February 7 – 9, 2003

Omni Mandalay Hotel at Las Colinas
Irving, Texas



John L. Wright, Jr., D.O.
Program Chair



Patrick J. Hanford, D.O.
Program Co-Chair



16.75 CME Hours Category I-A Anticipated

Tentative Program

Friday, February 7

- 5:00p.m. – 6:00p.m. Welcome Reception with Exhibitors
- 6:00p.m. – 7:00p.m. Daniel R. Rouch, D.O.
"More Money-Less Work"
Sponsored by Meditalk
- 7:00p.m. – 8:00p.m. Rod Elliott-Mullins, D.O.
"Sleep Apnea 2003"
- 8:00p.m. – 9:00p.m. Conrad Speece, D.O.
"OMT Workshop"

Saturday, February 8

- 7:30a.m. – 8:30a.m. Breakfast with Exhibitors
- 8:30a.m. – 9:30a.m. Jack Cohen, D.O.
"Dermatitis/Eczema"
Sponsored by Novartis
- 9:30a.m. – 10:30a.m. S. Mark Olmstead, D.O.
"One Airway: Coexistence of Allergic Rhinitis/Asthma & Implication for Treatment"
Sponsored by GlaxoSmithKline
- 10:30a.m. – 11:00a.m. Pharmaceutical Update Break
in Exhibit Hall
- 11:00a.m. – Noon Monte E. Troutman, D.O.
"TAPA Update"
Sponsored by AstraZeneca
- Noon – 1:30p.m. Legislative Update Luncheon
Invited Guest Speaker – Senator Kyle Janek, M.D.
Sponsored by TMLT

Saturday, February 8 continued

- 1:30p.m. – 3:30p.m. Joe Gagen, J.D.
– Legislative Grassroots Trainer –
"Affective Communication with Legislators or Why You Can't See What is Entirely Clear to Me"
Sponsored by Pfizer
- 3:30p.m. – 4:00p.m. Pharmaceutical Update Break
in Exhibit Hall
- 4:00p.m. – 5:00p.m. Irvine Prather, D.O.
"Pressure Ulcers and Common Lower Extremities Ulcers"
- 5:00p.m. – 6:00p.m. Jeffrey Stone, D.O.
"Hyperbaric Treatment of a Diabetic Foot"

Sunday, February 9

- 7:00a.m. – 8:30a.m. Continental Breakfast
- 8:00a.m. – 12:15p.m. Risk Management Program
Sponsored by Dean, Jacobson Financial Services, LLC
Texas Medical Liability Trust

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

**Registration information will be mailed by
Friday, November 22, 2002**

WHAT'S THE SKINNY ON OUR SKIN?

Little Known Facts About a Well-Known Subject

Common Skin Diseases, Disorders and Conditions

PSORIASIS – chronic skin disease characterized by scaling and inflammation. Scaling occurs when cells in the outer layer of the skin reproduce faster than normal and pile up on the skin's surface.

- Currently, psoriasis affects more than 7 million Americans.
- Psoriasis appears to be slightly more prevalent among women than men.
- The average age of onset is 28 years of age, although psoriasis is seen at birth and as late in age as 90.
- Between 10% to 15% of those who get psoriasis are under the age of 10.
- Psoriatic arthritis, a form of arthritis, occurs in approximately 10% to 30% of the people who have psoriasis.
- Between 150,000 and 260,000 new cases of psoriasis occur each year in the U.S.
- Annual outpatient costs for treating psoriasis are currently estimated at \$1.6 to \$3.2 billion.
- An estimated 400 people are granted disability each year by the Social Security Administration because of their psoriasis.
- Approximately 400 people die each year from psoriasis-related causes.

(Psoriasis Statistics reprinted with permission from the National Psoriasis Foundation's Web site, www.psoriasis.org. All rights reserved, © 1995, 1999.)

Symptoms

People with psoriasis may suffer discomfort, including pain and itching, restricted motion in their joints, and emotional distress. In its most typical form, psoriasis results in patches of thick, red skin covered with silvery scales. These patches, which are sometimes referred to as plaques, usually itch and may burn. The skin at the joints may crack. Psoriasis most often occurs on the elbows, knees, scalp, lower back, face, palms, and soles of the feet; but it can affect any skin site. It may also affect the fingernails, toenails, and the soft tissues inside the mouth and genitalia.

Cause

Recent research indicates that psoriasis is likely a disorder of the immune system. This system includes a type of white blood cell, called a T cell that normally helps protect the body against infection and disease. Scientists now believe that in psoriasis an

abnormal immune system causes activity by T cells in the skin. These T cells trigger the inflammation and excessive skin cell reproduction seen in people with psoriasis. In about one-third of the cases psoriasis is inherited, and researchers are studying large families affected by psoriasis to identify a gene or genes that cause the disease.

Diagnosis

Doctors usually diagnose psoriasis after a careful examination of the skin. However, diagnosis may be difficult because psoriasis can look like other skin diseases. A pathologist may assist with diagnosis by examining a small skin sample (biopsy) under a microscope.

There are several forms of psoriasis. The most common form is plaque psoriasis (scientific name is psoriasis vulgaris). In plaque psoriasis, lesions have a reddened base covered by silvery scales. Other forms of psoriasis include:

Guttate psoriasis—Small, drop-like lesions appear on the trunk, limbs, and scalp. Guttate psoriasis is most often triggered by bacterial infections (for example, *Streptococcus*).

Pustular psoriasis—Blisters of noninfectious pus appear on the skin. Attacks of pustular psoriasis may be triggered by medications, infections, emotional stress, or exposure to certain chemicals. Pustular psoriasis may affect either small or large areas of the body.

Inverse psoriasis—Large, dry, smooth, vividly red plaques occur in the folds of the skin near the genitals, under the breasts, or in the armpits. Inverse psoriasis is related to increased sensitivity to friction and sweating and may be painful or itchy.

Erythrodermic psoriasis—Widespread reddening and scaling of the skin is often accompanied by itching or pain. Erythrodermic psoriasis may be precipitated by severe sunburn, use of oral steroids (such as cortisone), or a drug-related rash.

Treatment

Doctors generally treat psoriasis in steps based on the severity of the disease, the extent of the areas involved, the type of psoriasis, or the patient's responsiveness to initial treatments. This is sometimes called the "1-2-3" approach. Step 1 involves topical treatment; Step 2 focuses on phototherapy; and Step 3 involves systemic treatment.

(Fact Sheet: Questions and Answers About Psoriasis" at <www.niams.gov>; National Psoriasis Foundation at <www.psoriasis.org>.)

ACNE – a disorder resulting from the action of hormones on the sebaceous glands, leading to plugged pores and outbreaks of lesions commonly called pimples which usually occur on the face, neck, back, chest, and shoulders.

Incidence

Nearly 17 million people in the U.S. have acne, making it the most common skin disease. Although acne is not a serious health threat, severe acne can lead to disfiguring, permanent scarring. People of all races and ages get acne. It is most common in adolescents and young adults. Nearly 85 percent of people between the ages of 12 and 24 develop the disease. For most people, acne tends to go away by the time they reach their thirties. However, some people in their forties and fifties continue to have this skin problem.

Cause

The exact cause of acne is unknown, but it is believed to result from several related factors. One important factor is an increase in hormones called androgens. These increase in both boys and girls during puberty and cause the sebaceous glands to enlarge and make more sebum. Hormonal changes related to pregnancy or starting or stopping birth control pills can also cause acne. Another factor is heredity or genetics. Researchers believe that the tendency to develop acne can be inherited from parents. For example, studies have shown that many school-age boys with acne have a family history of the disorder. Certain drugs, including androgens and lithium, are known to cause acne. Greasy cosmetics may alter the cells of the follicles and make them stick together, producing a plug and increasing the chances of an occurrence of lesions.

Treatment

The goals of treatment are to heal existing lesions, stop new lesions from forming, prevent scarring, and minimize the psychological stress and embarrassment caused by this disease. Drug treatment is aimed at reducing several problems that play a part in causing acne: abnormal clumping of cells in the follicles, increased oil production, bacteria, and inflammation.

OTC or prescription topical medication for people with mild signs of acne is usually recommended. Patients with moderate to severe inflammatory acne may be treated with prescription topical or oral medicines, alone or in combination. For patients with severe inflammatory acne that does not improve with medicines such as those described above, a doctor may prescribe isotretinoin, a retinoid.

(Questions and Answers About Acne, NIH pub. 01-4998 at <www.niams.nih.gov>.)

SHINGLES – a disease caused by the varicella-zoster virus; the virus that causes chickenpox. Shingles occurs in people who have had chickenpox and represents a reactivation of the dormant varicella-zoster virus. The disease generally affects the elderly, although it occasionally occurs in younger and/or immunodeficient individuals.

Incidence

About 10 percent of normal adults can be expected to get shingles during their lifetimes, usually after age 50. The incidence increases with age so that shingles is 10 times more likely to occur in adults over 60 than in children under 10. Most people who get shingles develop immunity to the virus and will not get the disease again. However, shingles does recur in some individuals. These cases usually involve people with declining or compromised immune systems, such as those infected with HIV or receiving chemotherapy. Youngsters whose mothers had chickenpox late in pregnancy – 5 to 21 days before giving birth – are also vulnerable to shingles. Sometimes these children are born with chickenpox or develop a typical case within a few days.

Symptoms

The first sign of the onset of shingles is usually a tingling feeling, itchiness, or stabbing pain on the skin. After a few days, a rash appears as a band or patch of raised dots on the side of the trunk or face. The rash develops into small, fluid-filled blisters which begin to dry out and crust over within several days. When the rash is at its peak, symptoms can range from mild itching to extreme and intense pain. Contact with a person with shingles may cause chickenpox (but not shingles) in someone who has never had chickenpox.

Treatment

Current treatment for shingles includes antiviral drugs, steroids, antidepressants, anticonvulsants, and topical agents. The severity and duration of an attack of shingles can be significantly reduced by immediate treatment with the antiviral drugs acyclovir, valacyclovir or famcyclovir. These drugs may also help stave off the painful aftereffects of shingles known as postherpetic neuralgia.

Although shingles can be very painful and itchy, it is not generally dangerous to healthy individuals and usually resolves without complications. The rash and pain generally go away within 3 to 5 weeks. Sometimes serious effects including partial facial paralysis (usually temporary), ear damage, or encephalitis (inflammation of the brain) may occur. Persons with shingles on the upper half of the face should seek medical attention immediately as the virus may cause serious damage to the eyes. Most people who have shingles have only one bout with the disease in their lifetime. However, individuals with impaired immune systems, such as those with AIDS or cancer, may suffer repeated episodes.

(“Shingles Information Page,” National Institute of Neurological Disorders and Stroke. “Shingles: Hope Through Research,” National Institutes of Health Pub. No. 00-307, National Institutes of Health “Word on Health,” October 2000.)

ECZEMA – a chronic disease that affects the skin and a general term for the many types of dermatitis.

Types of eczema are:

Contact eczema— localized reaction that includes redness, itching, and burning where the skin has come into contact with an allergen or with an irritant such as an acid, a cleaning agent, or other chemical.

continued on next page

Symptoms

Symptoms of this disease vary. The most common symptoms are dry, itchy skin; cracks behind the ears; and rashes on the cheeks, arms, and legs. The itchy feeling is an important factor in atopic dermatitis, because scratching and rubbing in response to itching worsen the skin inflammation characteristic of the disease.

Skin Features of Atopic Dermatitis

Lichenification—thick, leathery skin resulting from constant scratching and rubbing.

Papules—small raised bumps that may open when scratched, becoming crusty and infected.

Ichthyosis—dry, rectangular scales on the skin.

Keratosis pilaris—small, rough bumps, generally on the face, upper arms, and thighs.

Hyperlinear palms—increased number of skin creases on the palms.

Urticaria—hives (red, raised bumps), often after exposure to an allergen, at the beginning of flares, or after exercise or a hot bath.

Cheilitis—inflammation of the skin on and around the lips.

Atopic pleat (Dennie-Morgan fold)—an extra fold of skin that develops under the eye.

Hyperpigmented eyelids—eyelids that have become darker in color from inflammation or hay fever.

Diagnosis

Currently, there is no test to diagnose atopic dermatitis and no single symptom or feature used to identify the disease. Each patient experiences a unique combination of symptoms, and the symptoms and severity of the disease may vary over time.

Major Features of Atopic Dermatitis

- Intense itching
- Characteristic rash in locations typical of the disease
- Chronic or repeatedly occurring symptoms
- Personal or family history of atopic disorders (eczema, hay fever, asthma)

Some Minor Features of Atopic Dermatitis

- Early age of onset
- Dry, rough skin
- High levels of immunoglobulin E (IgE), an antibody, in the blood
- Ichthyosis
- Hyperlinear palms

Allergic contact eczema (dermatitis)—a red, itchy, weepy reaction where the skin has come into contact with a substance that the immune system recognizes as foreign, such as poison ivy or certain preservatives in creams and lotions.

Seborrheic eczema—yellowish, oily, scaly patches of skin on the scalp, face, and occasionally other parts of the body.

Nummular eczema—coin-shaped patches of irritated skin—most common on the arms, back, buttocks, and lower legs—that may be crusted, scaling, and extremely itchy.

Neurodermatitis—scaly patches of skin on the head, lower legs, wrists, or forearms caused by a localized itch (such as an insect bite) that becomes intensely irritated when scratched.

Stasis dermatitis—a skin irritation on the lower legs, generally related to circulatory problems.

Dyshidrotic eczema—irritation of the skin on the palms of hands and soles of the feet characterized by clear, deep blisters that itch and burn.

ATOPIC DERMATITIS—the most common of the many types of eczema characterized by itchy, inflamed skin.

Cause

The cause of atopic dermatitis is not known, but the disease seems to result from a combination of genetic and environmental factors. Evidence suggests the disease is associated with other so-called atopic disorders such as hay fever and asthma, which many people with atopic dermatitis also have. In addition, many children who outgrow the symptoms of atopic dermatitis go on to develop hay fever or asthma. Although one disorder does not cause another, they may be related, thereby giving researchers clues to understanding atopic dermatitis.

Incidence

Atopic dermatitis affects males and females equally and accounts for 10 to 20 percent of all referrals to dermatologists. It occurs most often in infants and children and its onset decreases substantially with age. Scientists estimate that 65 percent of patients develop symptoms in the first year of life, and 90 percent develop symptoms before the age of 5. Onset after age 30 is less common and often occurs after exposure of skin to harsh conditions. People who live in urban areas and in climates with low humidity seem to be at an increased risk for developing atopic dermatitis. Although it is difficult to identify exactly how many people are affected by atopic dermatitis, an estimated 10 percent of infants and young children experience symptoms of the disease. Roughly 60 percent of these infants continue to have one or more symptoms of atopic dermatitis into adulthood. This means that more than 15 million people in the United States have symptoms of the disease.

- Keratosis pilaris
- Hand or foot dermatitis
- Cheilitis
- Nipple eczema
- Susceptibility to skin infection
- Positive allergy skin tests

Treatment

There are three main goals in treating atopic dermatitis: healing the skin and keeping it healthy, preventing flares, and treating symptoms when they do occur. Much of caring for the skin and preventing flares has to do with developing skin care routines, identifying exacerbating factors, and avoiding circumstances that trigger the skin's immune system and the itch-scratch cycle. If a flare of atopic dermatitis does occur, several methods can be used to treat the symptoms. Corticosteroid creams and ointments are the most frequently used treatment.

Phototherapy that uses ultraviolet A or B light waves, or both together, can be an effective treatment for mild to moderate dermatitis in older children (over 12 years old) and adults. When other treatments are not effective, systemic corticosteroids may be prescribed. Typically, these medications are used only in resistant cases and only given for short periods of time. In adults, immunosuppressive drugs, such as cyclosporine, are also used to treat severe cases of atopic dermatitis that have failed to respond to any other forms of therapy. In rare cases, when no other treatments have been successful, the patient may have to be hospitalized. A 5 to 7-day stay in the hospital allows intensive skin care and reduces the patient's exposure to irritants and allergens and the stresses of day-to-day life. Under these conditions, the symptoms usually clear quickly if environmental factors play a role or if the patient is not able to carry out adequate skin care at home.

("Handout on Health: Atopic Dermatitis," National Institute of Arthritis and Musculoskeletal and Skin Diseases at <www.niams.nih.gov>.)

FYI: Smallpox Vaccination Strategies

One more piece of the evolving Smallpox Response Plan

by Paul McGaha, D.O.

NEW! September 23, 2002 - The Centers for Disease Control (CDC) Smallpox Response Plan and Guidelines now contains a very important addition to our smallpox preparedness efforts, a comprehensive annex titled *Smallpox Vaccination Clinic Guide*. This new section of the upcoming Version 3 of the CDC Smallpox Response Plan and Guidelines describes the operational and logistical considerations associated with implementing a large-scale voluntary vaccination program in response to a confirmed smallpox outbreak. It also provides details on all aspects of immunization clinic operations and staffing and includes an example of a model smallpox vaccination clinic. The document is basically a "how to" manual for initiating mass vaccination clinics. More information can be found at <www.bt.cdc.gov/documents/app/smallpox/rpg/index.asp>

There are still many policy issues outstanding, namely who should be "pre-vaccinated." Per the following quotes from the September 23 *Atlanta Journal Constitution*:

"In October 2002, Tommy Thompson, Secretary of Health and Human Services (HHS) sent recommendations to the White House on how many people should be inoculated in advance. Although a CDC advisory panel has recommended vaccinating about 20,000 medical personnel, several administration sources said President Bush is weighing a proposal on the order of as many as 500,000 people."

"Until a decision is made on pre-vaccination," Jerome Hauer, Assistant Secretary for HHS' Public Health Emergency Preparedness said, "our efforts continue to focus on bioterrorism detection and response."

HELPING TO PREVENT SKIN CANCER

by Bill V. Way, D.O., TOMA Past President
Program Director for the Texas Osteopathic Dermatology Residency Program.
Division of the Kirksville College of Osteopathic Medicine Dermatology Department

"...the osteopathic physician can play a very important role in insuring patients a lifetime of healthier skin."



November marks the launch of the American Academy of Dermatology's "Sixth Annual National Healthy Skin Program: For A Lifetime of Healthier Skin." This national campaign is designed to encourage all people to take better care of their skin and to consult dermatologists for any medical, cosmetic, or surgical treatment of their skin, hair, and nails.

It is important that physicians educate their community about the importance of developing a lifelong relationship with their primary care physician and dermatologist.

I want to remind physicians that there are three basic types of skin cancer: Basal Cell Carcinoma, the most common type of skin cancer; Squamous Cell Carcinoma, the second most common skin cancer; and Melanoma, the deadliest of the three types of skin cancers.

All physicians are strongly encouraged, when examining patients, observe their skin and look for any unusual lesions. Lesions that are atypical or unusual should be considered for possible biopsy to determine if they might represent skin cancer. If a primary care physician is uncomfortable with the diagnosis or biopsy of skin lesions, it is important that the patient be referred to a dermatologist for consultation and possible biopsies as needed.

Remember that Melanoma has four signs representing atypical growth:

- Asymmetry
- Border irregularity
- Color variation
- Diameter greater than 6mm.

If the lesion has two or three of these findings, it is important that the lesion be evaluated and most likely biopsied.

Encourage your patients to apply a Sunscreen and Lip Balm SPF #15 or higher each morning to all sun exposed areas. Use a Sunscreen of #30 or higher if planning to be in the sun over 2.5 hours. Wear sunscreen no matter the color of their skin. Sunscreens protect the skin from photodamage, which can lead to wrinkles, solar elastosis, precancers and skin cancers. Wear protective clothing, a hat and UV protective sunglasses when possible. Educate your patients on how to do a self skin exam from the top of their head to the tip of their toes every three months to look for any abnormal skin lesion which is changing and, if found, to schedule an appointment for further evaluation.

I hope that you, as a primary care physician or other specialist, will join with the Texas Osteopathic Dermatologists of the American Osteopathic College of Dermatology in supporting the American Academy of Dermatology's "National Healthy Skin Program: For a Lifetime of Healthier Skin" during the month of November.

You can run ... But you can't hide from the sun



Sunscreen, Sunglasses, Shirts ...

SMART!

80% of sun damage occurs before age 18
Win the race ... Win the battle
Sun protection beats skin cancer



Safe and Effective Use of Topical Corticosteroids

by Richard N. Rudnicki, D.O.

"A good working knowledge of topical corticosteroids is essential for the safe and effective treatment of responsive dermatosis."

Patients appreciate the prompt resolution of a persistent rash with a topical medication. However, many patients mistakenly believe that topical medications are totally safe to use on any body area, in any age group, as well as for any length of time. Topical corticosteroids offer an effective means of controlling responsive dermatosis and your patients will appreciate your knowledge of their safe use.

Topical corticosteroids achieve their anti-inflammatory activity in a number of ways.

- Inhibition of the arachidonic acid cascade thru inhibition of phospholipase A
- Inhibition of T-cell activation and production of cytokines
- Inhibition of migration and influx of leukocytes to the inflammatory site
- Inhibition of vascular permeability

A number of interrelated factors must be considered when selecting a topical corticosteroid. Patient, disease and product related factors must all be evaluated.

Patient and Disease Related Factors

Patient and/or disease related factors include the distribution of lesions, skin thickness (which is directly related to absorption) as well as the likelihood of local or systemic side effects. Skin thickness is the major determinant of topical corticosteroid absorption. Thicker skin is less absorbent than thinner skin. Increased absorption increases the relative potency as well as the risk of adverse events. In general, choose lower potency agents for thinner-skinned areas, i.e., face, neck, axillae, groin, and scrotum. There are, however, individual variations and the relative risk must always be assessed against the benefit. Thicker skin may require stronger potency agents in areas such as the plantar surface of the feet, elbows, forearms, knees and palms. Additionally, particularly thickened skin may require occlusive dressings to increase absorption and penetration. Keep in mind that generally, children and the elderly have increased absorption.

Local as well as systemic side effects can be seen with topical corticosteroids. The most common local and cutaneous side effects include atrophy, striae, folliculitis and telangiectasia. HPA-axis suppression is a possible systemic side effect related to large dosages over long periods of time. Adverse effects increase with use in skin folds and the face, more potent agents, long

periods of treatment and the use of occlusive dressings. Three of the four highest potency topical corticosteroids come with warnings that recommend no more than 50 grams be used in an average adult over a two-week period of time because of the risk of systemic side effects.

Patients in general prefer creams to ointments and for that reason ointments are usually only chosen over creams for their increased effectiveness. In our current managed care environment, cost is always an issue. Although generics in general are less effective, they can be useful as long as you factor that in.

Product Related Factors

Topical Corticosteroid Vehicle

The vehicle functions to maximize drug absorption at the target. The vehicle suspends the drug in a stable formulation for delivery. The vehicle itself may provide therapeutic benefit of its own, i.e., be it drying or moisturizing. Solutions, foams, gels and lotions (water or alcohol based) tend to be drying. Creams and lotions (oil emulsions) tend to be less drying than solutions. Solutions, lotions and foams are ideal for the scalp and other hair bearing areas. Gels work well in hair bearing areas as well, but can also be used on the hands and feet. Creams are suitable for most body areas except the scalp. Oil emulsion lotions work well for large dry non-scalp lesions. Emollient creams are used for dry lesions to moisturize and are suitable for most body areas except the scalp. Ointments are the most moisturizing of all vehicles and can be used in most body areas except the scalp. Vehicles also influence the potency of topical corticosteroids. In general, solutions are lowest in potency, followed by lotions, creams, gels and finally ointments being the highest. I find it useful to consider a vehicle that can be used in more than one anatomical area. For instance, when treating a patient with psoriasis with scalp, elbow and knee involvement, consider prescribing a foam or lotion formulation that can be used in all three anatomic locations, rather than a cream or ointment for the elbows and knees and a lotion or solution for the scalp.

Topical Corticosteroid Potency – Table I

Topical corticosteroids are categorized by potency with class I being the highest potency and class VII being the lowest potency. Potency and absorption are determined by a vasoconstrictor bioassay test that measures the visible blanching when a compound is applied to the skin. Blanching is directly propor-

tional to the potency and speed of absorption of a given topical corticosteroid. The least potent topical corticosteroid should be used that will safely and effectively treat a patient's condition.

Application: How Much is Needed?

Long et al. developed the "rule of hand" to help determine the amount of drug needed to cover a body area. They determined that one FTU (fingertip unit) is the amount that is needed to cover both sides of one hand. One fingertip unit = .49 g/male = .43 g/female. Table II depicts the necessary amount of drug necessary for various body areas.

TABLE I

CLASS I	Diprolene, Ointment - 0.05%	Highest Potency
CLASS II	Elocon® ointment - 0.1%	
CLASS III	Aristocort®A ointment - 0.1%	
CLASS IV	Elocon® cream - 0.1%	
CLASS V	Westcort® cream - 0.2%	
CLASS VI	Aclovate® cream - 0.05%	
CLASS VII	Hytone® - 1% or 2.5%	Lowest Potency

TABLE I

BODY AREA	AMOUNT DRUG NEEDED	
	MALE	FEMALE
FACE & NECK	1.23 g	1.08 g
TRUNK (FRONT)	3.43 g	3.01 g
TRUNK (BACK)	3.43 g	3.01 g
ONE ARM	1.47 g	1.29 g
HAND (BOTH SIDES)	0.49 g	0.43 g
ONE LEG	2.94 g	2.58 g
ONE FOOT	0.98 g	0.86 g

Dr. Rudnicki is a board certified dermatologist and fellow of the American Society for Mohs' Surgery. He has practiced in the Dallas metroplex for over ten years and has offices in Rockwall and Mesquite, Texas.

ROSACEA

by Rick Lin, D.O., M.P.H. and Dan Ladd, Jr., D.O.

Rosacea is a common skin disorder, which occurs in patients 30 to 60 years of age. It is characterized by recurrent facial flushing with abnormal sebaceous and vascular responses. The full-blown syndrome of active rosacea consists of clusters of papules and pustules on red, swollen telangiectatic skin of the cheeks and forehead. Most patients will have fair skin and light color hair. Rosacea can be exacerbated by many different factors. Alcohol, sun exposure and the drinking of hot or spicy liquids such as coffee or tea can lead to increased facial erythema and flushing.

Rosacea occurs most often in the people of Celtic origin, and has been called "the Curse of the Celts." Actual epidemiological data in the US is not available, but an international study in Sweden revealed an incidence of one in ten middle class individuals between the age of 25-60. It is more likely to affect women than men. This disease is chronic and can remit and relapse for years. The typical pattern of eruption appears on the forehead, cheeks, nose, and around the eyes. The most common presentation is facial erythema (>95%). Other presentations include facial flushing (40%), inflammatory papules, and telangiectasias (50%). Some patients with severe cases also present with hypertrophy of the connective tissue and sebaceous glands of the nose, known as rhinophyma (15%). Rhinophyma is more common in the male population. A familiar figure in American culture who suffered the bulbous nose of rhinophyma was W.C. Fields, who popularized the erroneous association of rosacea with alcoholism.

An abundance of the hair follicle mite *Demodex folliculorum* has been demonstrated in the skin of some patients with rosacea. Therefore, it is postulated that these mites may contribute to the pathogenesis of the disease. There are some postulated mechanisms. It is possible that rosacea is an inflammatory and allergic response to *Demodex folliculorum*. Another proposed mechanism is that these mites cause mechanical blockage of the follicles, which in turn leads to a secondary inflammatory response. Mite counts before the treatment of tetracycline and one month post treatment are exactly the same. Because *Demodex folliculorum* mites are also found in the skin of patients who do not suffer from rosacea, these proposed mechanisms for rosacea remain controversial. There is also an ongoing controversy about its possible association with *Helicobacter pylori* infection.

The differential diagnosis for rosacea includes acne vulgaris, systemic lupus erythematosus, seborrheic dermatitis, perioral dermatitis, steroid induced acne, and cutaneous sarcoidosis. The diagnosis of rosacea is based on clinical presentation and medical history. Bacterial culture may be considered to rule out *Staphylococcus aureus* infection. Acneiform papules and occasionally pustules may be present with rosacea, but comedones are not present.

Oral treatment using the tetracycline family of antibiotics is an effective treatment for rosacea. Therapy can be initiated using tetracycline 250mg four times daily until the symptoms improve.

continued on next page

It is important to inform patients to take this medication one hour before or two hours after meals to maximize absorption of the drug through the GI tract. Oral antibiotics may be tapered as the condition improves. For some patients this improvement may take 2-4 weeks, so patients should be counseled not to expect a rapid resolution of their condition.

Because rosacea is a chronic condition for which no cure exists, patients need to understand that 25% of the patients who experience significant improvement of their rosacea can be expected to re-flare in the future. About 60% of these patients will have a relapse of symptoms within 6 months. For patients who re-flare with the cessation of oral antibiotics, long-term suppression with tetracycline may be required. The dose for long-term maintenance should be titrated according to the patient's response to therapy. Women on

long-term tetracycline therapy should be counseled to eat un-pasteurized yogurt to help rebalance the natural flora.

Alternatives to oral antibiotics are topical metronidazole preparations such as Metro-Gel 0.75%, Metro-Cream 0.75%, Metro-Lotion 0.75% (Galderma) used twice daily and Noritate 1% cream (Dermik) used once a day. These preparations have demonstrated a reduction in papules by 65% in a 9-week period. Topical sodium sulfacetamide preparations such as Klaron 10% Lotion (Dermik) and Ovace 10% Wash (Healthpoint) are also effective. Topical preparations that combine sodium sulfacetamide 10% with sulfur 5% are Plexion Cleanser, Topical Suspension and Plexion SCT (Medicis) are also effective topical therapies. All of these topicals can be used as a maintenance therapy after the disease has been initially controlled by oral tetracyclines or as monotherapy. Patients on

topical monotherapy alone should be followed up after two weeks for evaluation of treatment efficacy.

The treatment of rosacea also involves the control of precipitating factors. If the flushing and erythema are aggravated by consumption of alcohol, soups, coffee, tea or spicy foods, these "trigger" factors should be avoided. Sunscreen use and sun avoidance should be part of this prevention as well. Vasodilating drugs may also exacerbate the flushing symptom of rosacea.

Rhinophyma may be improved by various surgical reduction methods, however, most insurance companies may consider these treatments to be cosmetic and not medically necessary, and may not reimburse cost of these procedures. Lastly, referral to a dermatologist is appropriate for patients who wish to improve their appearance.

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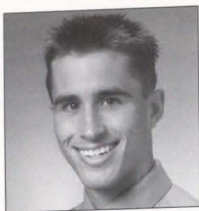
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Chest Pain – An Osteopathic Approach

by S/D Benjamin Dagley

University of North Texas Health Science Center/Texas College of Osteopathic Medicine, Fort Worth, Texas

How many times have you heard it? A patient presents with a chief complaint of chest pain. The squeezing pressure radiates to his left arm, neck, and jaw and lasts about 30 minutes. The nitroglycerin you gave the patient 6 months ago is no longer working. Accompanying the discomfort is shortness of breath, nausea, vomiting, sweating, and lightheadedness. This situation is enough to elevate the neck hairs of even the most inattentive of physicians. As heart disease continues to be the number one American killer and medical technology continues to race to reach the diagnosis before the living heart beats its last, papers like this one will continue to be written in hopes of shedding a new ray of light on the differential for chest pain.

Unfortunately, chest pain is significantly more complicated than blaming the pain on the heart, giving a pill, and going on your merry way. It is an arduous complaint requiring appropriate diagnostic laboratory tests and meticulous history taking in order to discover the true etiology. Experience is worth its weight in gold when approaching these cases. To complicate the matter further, time is often working against the physician as death can ensue within moments of reaching the hospital if certain causes are not identified and respected.

There is, however, more to chest pain than heart disease, and not all chest pain is cardiac. Though most physicians know this, do they know that the number one reason for chest pain is chest wall pain arising from bones, muscles, joints, and nerves found in the chest wall (byu.edu)? That does not even say anything about the other possible etiologies of chest pain. The list is longer than an intern's call shift on New Year's Eve. Some of the culprits are coronary artery disease, angina, anxiety, GERD, costochondritis, pulmonary embolism, myocardial infarction, and muscle strain. Often, more than one problem contributes to a patient's chest pain. However the complaint may present, a careful work up is essential in the evaluation of the ubiquitous issue of chest pain.

Case Report

A 54-year-old white female presented with a chief complaint of chest pain for the past 6 years. The pain was described as pressure that usually radiates to her left shoulder and neck lasting about 15 minutes and occurring 1 time per week. As a result, her arm often feels heavy and has a tingling sensation when these episodes occur. The pain is relieved with sublingual nitroglycerin. She currently rates her overall pain as a 10 on a scale of 0-

10. Notably, the patient had a significant cardiac work up in the past with numerous emergency room visits and hospital admissions. Included in this work up were EKG, echocardiogram, stress test, MRI of the head, chest X-ray, serial cardiac enzymes, and a cardiac catheterization - all of which were negative. She last visited the ER in January or February of 2002 for shortness of breath, weakness, diaphoresis, nausea, slurred speech, and overall disorientation. The work up was negative at that time and included an MRI of her head.

Past medical history is significant for DDD, GERD, hiatal hernia, hypertension, COPD, and CAD. Surgical/hospitalization history includes a right carotid endarterectomy and a disc fusion of C3-C7. In addition, the patient has been admitted into the hospital several times for chest pain.

Family history is positive for diabetes, stroke, atherosclerosis, hypertension, MI, and lung cancer. Social history is remarkable for a pack a day, 40 year smoking history.

The patient is allergic to morphine, cytotec, and plavix. Current medications included: Toprol 100 mg BID, Norvasc 5 mg QD, Nexium 40 mg QD, Paxil 15 mg QD, Zocor 40 mg QD, HCTZ 25 mg QD, and Nitrostat 0.6 mg PRN chest pain.

Physical exam showed a well developed 54-year-old white female weighing 164 pounds. She was completely oriented and in no apparent distress. Her vital signs were as follows: BP = 114/82; HR = 68; Resp = 12. Neurologic exam demonstrated decreased strength in the upper left extremity compared to the right and 5/5 lower extremity strength bilaterally. DTRs measured 2/4 globally with the exception of 1/4 in the left Achilles. In the cervical region, restriction in all planes was palpated at C3-C6 and the OA was rotated right sidebent left. Findings in the thoracic spine included displacement of rib 2 on the left and the following tender points: T4 on the left and T6 on the right with T3-T6 being rotated right sidebent left. No points in the lumbar spine elicited tenderness on palpation but L3-L5 were found to be rotated right sidebent left. The sacral base was anterior and tender to palpation. Also, tender points were noted on the PSIS bilaterally and the left piriformis muscle. Slight crepitus and restriction in motion were palpated in the upper extremities bilaterally. The lower extremities showed good range of motion but some crepitus was present in the left knee.

Assessment of this patient was as follows: 1) cervicalgia, 2) thoracic spine pain, 3) somatic dysfunction of cervicals,

thoracics, lumbar, sacrum, and pelvis, 4) cervical fusion C3-C7, 5) COPD by history, 6) CAD by history, 7) pain level decreased from 10/10 to 7/10 following OMT.

The plan for this patient was OMT performed to the affected areas. The techniques applied were myofascial release, strain counterstrain, indirect, craniosacral, muscle energy, and ligamentous articular strain. The patient was also taught several stretches and information was given to her. Also, the patient was educated on how to treat her own tender points using Jones strain counterstrain techniques.¹ Lastly, the patient was asked to follow up in 1 week.

At the follow up visit, the patient complained of significant pain in her chest and said she had had the pain all morning rating it a 10/10. She described it as feeling like someone was sitting on her chest. The pain radiated to her left arm and shoulder as well as her jaw. She had left arm weakness but no lightheadedness, diaphoresis, nausea, or vomiting.

On physical exam, cervical and thoracic tenderness and motion were restricted like last visit. In addition, a remarkable finding of a left scoliotic curve from T3-T6 was palpated. The patient was questioned extensively about trauma or other inciting events and denied having all such experiences. Ribs 2 and 4 were also displaced on the right. Pelvic tender points were present but less than last visit and the sacrum was nontender. Slight crepitus as before was appreciated in the extremities.

OMT was utilized. After all other areas were addressed, full attention was given to the thoracic spine. Treatment began with an indirect technique followed by muscle energy directed at the left transverse process of the nonneutral T6. The tender point resolved but a new one arose on the right. OMT given to this area resolved the pain, and then a tender point manifested on the right 2nd rib anteriorly. At this point, the patient was in enough distress that she took a nitro tablet. Treatment was continued and a tender point was found on the sternum and one in the corresponding thoracic vertebrae. Myofascial release resolved these tender points. When the chase ended, the patient did not feel any more tender points and said that her pain was now down to an 8/10. She was to return in 2 weeks.

Review of the Literature

Though the list of differentials is extensive for chest pain, only chest wall pain, myocardial infarction, and angina are going to be addressed. As mentioned earlier, chest wall pain is the main reason for chest pain. This pain is often sharp in nature and made worse with motion of the chest wall as with coughing. The complaint is often reproducible meaning the pain is reproduced when tender points are touched on the chest with sufficient pressure.

Myocardial infarction on the other hand is often described as pressure that radiates to the neck, shoulder, jaw, or arm and is typically not reproducible.² Often accompanying the chest pain associated with myocardial infarction are nausea or vomiting, diaphoresis, or shortness of breath. These symptoms last longer than 15 minutes and do not usually respond completely to nitroglycerin. The diagnosis seems straightforward, but statistics indicate that as many as 25% of heart attacks are not bothersome enough to the patient to go to the hospital. Subsequently, many heart attacks are discovered after the event.

Angina feels like substernal pressure that lasts for 5 – 15 minutes and tends to radiate like myocardial infarction. Anginal attacks can be precipitated by exercise or may occur when a patient is at rest. Nitroglycerin usually relieves the pain within 3 minutes. The basic problem is a decreased blood supply to the heart through narrowed coronary arteries leading to inadequate blood supplied to the rest of the body.³

Knowing that one of the foundations of osteopathic medicine is that structure and function are intimately interrelated and interdependent, L.C. Chandler, D.O., made several observations over 50 years ago. One such observation was that "the failure of the body to make adequate responses to the demands placed upon it is tremendously dependent upon the body's being in some way mechanically out-of-order." In other words, he held that the body should be able to supply the demands placed on it unless the structure of the body was compromised somehow. We now refer to these areas of anatomical, palpatory compromise as somatic dysfunction. He also noted that "living forces can operate effectively only through fit structures that are appropriate to the environment".⁴ In short, Dr. Chandler believed that proper bodily function was utterly dependent on body mechanics free of structural compromise.

Another central tenet of osteopathic philosophy is the existence of viscerosomatic reflexes. This term means that disturbances in the internal organs can manifest in the form of "altered musculoskeletal function." The reverse, known as somatovisceral reflexes, is theorized to be true as well: musculoskeletal dysfunction can manifest as visceral disease. How does this apply to heart disease? All sympathetic nerves exit through the foramina of T1 – L2. Of interest to us is the fact that the heart receives its innervation from T1 – T6.⁵ So in terms of viscerosomatic reflexes, a heart problem could theoretically manifest or cause somatic dysfunction in the thoracic spine likely between T1 – T6. The somatovisceral reflex would mean that somatic dysfunction in T1 – T6 could potentially cause or present as a cardiac problem.

According to Dr. Rogers, studies have shown that somatic dysfunction has been found in the upper thoracic spine of patients who have coronary artery disease.⁶ Perrin Wilson, D.O., from Cambridge, Massachusetts, was also convinced that cardiac problems have a structural pattern and he took it a step further. In a study containing 12 cardiac patients, he and his cohorts found that heart patients consistently manifested a specific pattern of flexion, right sidebending, and left rotation of T1 – T5.⁷ Dr. Rogers explained what he and others observed by saying, "A viscerosomatic lesion may occur when visceral afferent nerves interconnect with cell bodies of somatic efferent nerves at segmental levels of the spinal cord to produce a local reaction in the musculoskeletal system, which is characterized by abnormalities of range of motion, soft tissue texture, et cetera".⁸

Edward G. Stiles, D.O., of the Waterville Osteopathic Hospital in Waterville, Maine, was a proponent of somatovisceral reflexes. He asserts that animal studies where dysfunction was introduced into the spine produced ischemia to the viscera innervated by the nerves exiting the sights of dysfunction. In addition, he said, "Atherosclerosis has also been found to develop in organs that are innervated by postganglionic fibers from the chronically stimulated sympathetic ganglion." He

"...I am a believer in the testimonies that first attracted me to this field, and I will continue to listen to my patients and to refine my skills in manipulation..."

believed that proper manipulation to these areas could serve to prevent the pathology from occurring in the heart by "normalizing vasomotor tone." Another thought of Dr. Stiles was that hyperactive sympathetic activity in the heart resulting from thoracic somatic dysfunction could lead to increases in heart rate, blood pressure, and overall work. This would likely lead to fatigue and to angina-like symptoms.⁸

Most practitioners are in agreement in regards to manipulative treatment of patients with cardiac symptoms. Dr. Chandler said it well when he stated, "Our treatment must try to restore structural conditions in the body to as fully normal as possible in all essential parts."⁴ Obviously, the thoracics would be a prime target for manipulative treatment. Though no specific technique is recommended in the literature, the osteopathic approach would support the idea that treatment should be individualized to each patient in order to produce the maximum response.

Besides treating the thoracics, Dr. Stiles highlighted the importance of giving special attention to the rib cage and lymphatics. He noted that proper motion of the ribs and diaphragm would assist the body in ventilation and maximal venous return. This would in turn reduce the workload on the heart. Lastly, Dr. Stiles emphasized the importance of evaluating the rest of the patient's body to detect somatic dysfunction. He supported this by saying, "Studies have indicated that somatic dysfunction in the lower extremities can increase the total energy demands on the whole body by up to 300%." This would create more work for the already overworked heart.⁸

Discussion

The patient discussed in the case study represents a common occurrence in the world of chest pain. She had typical symptoms pointing to a cardiac etiology, but the labs and imaging studies were negative for heart pathology. Out of

desperation, this patient sought out what she thought of as her last option - the osteopathic physician. In her mind, everything else available had been tried, and she still had chest pain. Knowing that the main cause of chest pain claims its origin in the chest wall, the osteopathic physician is uniquely equipped to relieve or eradicate a large degree of chest pain.

However, with this patient, the slippery slope is a bit more slippery and a clear-cut diagnosis is quite elusive. As mentioned previously, the etiology of chest pain is often multifactorial. Our patient's presentation, past medical history, and alleviation of symptoms with nitroglycerin point to a cardiac etiology. In addition, she had several risk factors pointing to a cardiac origin. Despite this, it is our opinion that a cardiac origin is not the sole proprietor of the blame. We draw this conclusion based on the negative results of an exhaustive cardiac work-up and the findings made on palpatory exam. This patient is likely to have the beginnings of coronary artery disease; however, we believe that the somatic dysfunction discovered in her thoracic spine is playing an intricate part in her pathology. So, which came first is the next question: Heart problems or spine problems? We do not know and will likely not know with this patient. Despite that, can anything be done? Should anything be done? A resounding yes!

Osteopathic manipulation has helped to decrease her pain level both times she has received it. That in itself makes it worth while in her case. In all likelihood, it took years for the condition in this patient to present as it does currently, and it is fair to assume that it will take time to facilitate the healing process in this individual using OMT. Treatments to the thoracics have been very effective in producing a change in the tissues and relieving this patient's discomfort; and as we have discovered in the literature, we have every inclination to believe that correcting the somatic dysfunction will provide relief of at least some of her symptomatology.

Conclusion

The field of osteopathic manipulation is an exciting one. The testimonies from innumerable patients increase the thrill of being osteopathic physicians in those of us who are part of or training to be part of this elite profession. We have heard it over and over again. The patient who has gone to every doctor under the sun reluctantly decides to give the osteopathic physician a shot at the problem. With skillful manipulation and genuine compassion, the patient feels better for the first time in days, weeks, months, or years.

Though our profession has stood the test of time, the research aspect of osteopathic manipulation is still in its infancy. It seems that the day of anecdotal evidence is no longer sufficient. The demand for scientifically validated evidence presides in the world of medicine. It would be nice to have hard evidence that somatovisceral reflexes really do occur. It would be nice to know beyond a shadow of a doubt why manipulation to the chronic pain patient's low back spared him the need to go to surgery.

The problem I have observed is that many are getting caught up in the rat race of research and evidence based medicine to such a degree that they forget that not everything in medicine is supported by evidence and many practices probably never will be. The lack of scientific evidence has actually caused some osteopathic physicians to stop using manipulation or feel embarrassed to have this as a part of their training. My question stems from our case study. What happened to listening to the patient and what she says about the effect manipulation had on her? We listened to our patient. She said her pain decreased and that she wanted to continue treatment. In my opinion, this is enough evidence to continue with her therapy.

The second problem is this: How can manipulation be effectively measured in a research setting? It would be difficult. Osteopathic manipulation is an art. The perfect treatment to use on one patient

may do nothing for the next patient you try it on. Furthermore, the skill level of each physician is highly variable and is also difficult to measure.

I am by no means against research being done in manipulation. I believe it should be done. The very nature of science is to research and experiment in order to find out answers to the questions we have. How well manipulation works in controlled settings needs to be answered. However, because osteopathic manipulation is an art, I believe, that no matter how many questions our research answers, there will be those that are left unanswered. Then what will we do? As for me, I am a believer in the testimonies that first attracted me to this field, and I will continue to listen to my patients and to refine my skills in manipulation in order to use it as often as I can.

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S/D Dagley is a fourth-year medical student at the University of North Texas Health Science Center/Texas College of Osteopathic Medicine, Fort Worth, Texas.

Being Involved - A Key for "Access to Care"

By Lane Fairbairn, President, TCOM Class of 2005

I am running, searching for the finish line, and my current cardiologist professor casually runs up beside me. Through the pain, I am trying to think of something clever to say when he leaves me in the dust. Dr. Schaller, without a doubt a true osteopathic cardiologist, went on to win first for his age group.

A true osteopathic physician...what does that mean? With exams looming overhead or with the busy physician lifestyle, it is sometimes difficult to remember why it is that we came here in the first place. Why did we choose an osteopathic school as opposed to any other medical school? National Osteopathic Medicine Week is the perfect chance to consider this choice. We remember why we chose this profession and what makes being an osteopathic doctor unique. The week is about being involved with the profession, with the community, and with the lives around us. Here at TCOM we showed our osteopathic pride in many ways.

The first annual "D.O. Dash" kicked off National Osteopathic Medicine (NOM) Week at the Texas College of Osteopathic Medicine (TCOM). The run was organized by the Class of 2005 and was led by second year medical student Mo Som. It was a beautiful, cool (as cool as it gets in Texas) Saturday morning. People from the community joined students and members of the University of North Texas Health Science Center (UNTHSC) for a great day of fun, food, and discussion of osteopathic medicine and access to care. It was an excellent way to begin a week meant for community awareness, education, and celebration of a profession that we all love so much. There was a booth to promote osteopathic principles using books and pamphlets. Students ran a medical tent to help with the medical needs of race participants, and there were free blood pressure readings. Our very own Dr. Russ Gamber was also there to answer questions and participate in the run. "I am proud of beating the army recruits that came out, but I am amazed at the students that dared to pass me," he joked.

ATOMA and Trilogy sponsored the event along with various community businesses. The run benefited Cook Children's Hospital and the University of North Texas Health Science Center. For all who didn't join us, put your running shoes on and start getting ready for next year. It will only get bigger and better.

Besides putting our hearts to the test, the week was full of informative lunch meetings on access to care. Dr. Monte Troutman spoke about some of the problems with access to care for patients due to professional liability insurance policies. Jaclyn McDonald, a second year student at TCOM, noted, "In better understanding the politics, I have realized the importance of educating family and friends on the issues. In health care today the patients are getting hurt more than any one else, and they also need to understand what health care is facing." As the talk ensued, we realized the importance of being involved within the politics, to not only protect our rights as physicians, but also to allow our patients to have the access to care that they deserve. Matt Jones, first year medical student, feels that he has "...gotten a little more understanding of the medical field's point of view and can better address issues in discussions concerning the politics of medicine." Dr. Troutman's talk was excellent and everyone left with a few more lawyer jokes but, more importantly, with a sense of duty to our political organizations and the importance of voting.

On Wednesday, Troy Alexander of TEXPAC spoke to us about the Texas Medical Association's political action committee. He focused on the importance of voting and being active within the realm of politics, especially with the problems we face today. We reviewed many of the candidates that support our cause. Brandon Zinn, a first year



Monte Troutman, D.O., addresses TCOM students during NOM Week.

medical student claimed, "I usually don't think about the politics because I am studying so hard, but I definitely have a better awareness now of why I should be involved."

The lunch meetings during the rest of the week centered on ways we can increase access to care in our everyday practices as physicians. On Tuesday, Dr. Gulbranson from the Department of Pediatrics of the JPS network joined us to discuss access to care for children. On Thursday, SOMA had an organ donation organization, Life Gift, come and speak about the importance of organ donation to increase access to care for many individuals in need of life saving, healthy organs.

Two health fairs occurred during the week. The first was organized by students Shelley Hamrick and Cedric Pratt from the Class of 2006, and targeted the employees at the health science center. "It was eye opening," said Edgar Reyther, a medical assistant in the health science center. Many people were amazed at how poorly they did on tests like aerobic fitness. It is startling to get a high BMI, high glucose, and high BP when you anticipate being perfectly healthy. Other booths included grip strength, heart rate and pulse, and body composition.

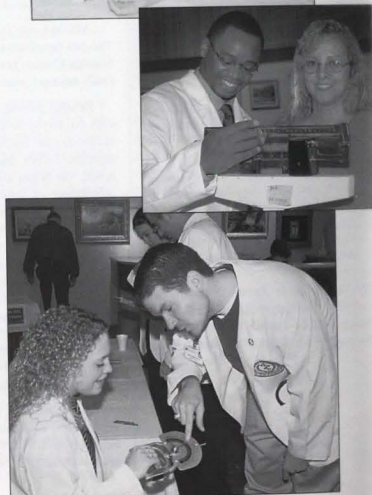
The second health fair was organized by medical student Nina Patel. Northside Health Fair supplied HIV testing, flu shots, free well-woman exams, depression screening, sports safety information, smoking cessation information, blood pressure and glucose screens, along with a variety of other services. Each of the clubs sponsored different booths. It was a true outreach to the community and provided immediate and free access to care for many people who cannot always get to the doctor. This year, as in years past, it was a success and another way that we, as the osteopathic community, have shown our true colors.

Other activities during the week included the citywide proclamation of National Osteopathic Medicine Week. Dr. Michael Martin, along with many of the students, congregated at the court house in downtown Fort Worth to hear the proclamation of this week as the official National Osteopathic Medicine Week. Also, the Class of 2005 visited North Hi-Mount Elementary School to talk to the teachers about osteopathic medicine. An informational booth at Tom Thumb, a local grocer, was set up by LaPonna Irvin-Moore and Heather Volkman, the Class of 2006 TOMA representatives. They took blood pressures and talked to people in the store about osteopathic medicine, our school (TCOM), and issues concerning access to care.

Participation by the students was exceptional during the course of the week. The events of the week were coordinated by second year medical student Janice Thomas and the rest of the Medical School Government Association (MSGA). However, the week was an effort by all the students, especially the classes of 2005 and 2006. All of the clubs and student body organizations added their touch to the issues concerning access to care.

Besides all of the activities here at the school, 12 students also went to the AOA conference in Las Vegas. This participation is imperative for our understanding, as students, of the impact we can make on the national level as future professionals. On behalf of the student body, thank you to all the people that supported this week and made it a success.

As students of the osteopathic profession, we are learning all that it means to be true osteopaths. Chad McCormick, a first year medical student states, "This is our week to shine and let everyone know the great things about osteopathic medicine." Another successful NOM week has ended and we have all been reminded that being an osteopathic physician is about loving medicine, providing a service, and most importantly, being involved. It is about giving patients access to care. As osteopathic physicians, we think about our patients and what their needs are today and tomorrow. We reached the community with the DO Dash, Northside Health Fair, the booth at Tom Thumb, and the North Hi-Mount Elementary Project. We reached the health science center with the employee health fair and all of the educational lunch meetings. Classes move on and our lives are filled with the everyday responsibilities that make us so busy, but at least we have taken this week to think about the road we have chosen and why it makes us different...why it is that we love this profession the way we "DO".



TOMA Welcomes New Members

The Board of Trustees of the Texas Osteopathic Medical Association is pleased to introduce the following new members who were formally accepted at the September 21, 2002, Board meeting.

Cheri L. Andrews, D.O.

1926 SW Green Oaks
Arlington, TX 76017

Dr. Andrews is a first year member and a member of District 15. She graduated from the Texas College of Osteopathic Medicine in 1999, and specializes in Family Practice.

John B. Arkusinski, D.O.

204 E. Main
Italy, TX 76651

Dr. Arkusinski is a first year member and a member of District 5. He graduated from the Texas College of Osteopathic Medicine in 1999, and is Board Certified in Family Practice and Osteopathic Manipulative Medicine.

Eric L. Babb, D.O.

University Medical Center
3601 4th Street
Lubbock, TX 79430

Dr. Babb is a first year member and a member of District 10. He graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery in Des Moines, Iowa, in 1999, and specializes in Family Practice.

Steven L. Casey, D.O.

209 Billings #420
Arlington, TX 76010

Dr. Casey is a member of District 2. He graduated from the Texas College of Osteopathic Medicine in 1992, and specializes in Anesthesiology and Pain Management.

Lois Y. Chu, D.O.

9737 FM 1960 Bypass East #17
Humble, TX 77338

Dr. Chu is a member of District 6. She graduated from The University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri, in 1996, and is Board Certified in Family Practice.

Stevan Cordas, D.O., MPH

1237 South Ridge Court #102
Hurst, TX 76053

Dr. Cordas is a member of District 15. He graduated from the Philadelphia College of Osteopathic Medicine in 1964; and is Board Certified in Internal Medicine, Allergy and Immunology, and Occupational Medicine.

Francis J. Cummins, Jr., D.O.

15410 Fortuna Bay Dr. #3006
Corpus Christi, TX 78418

Dr. Cummins is a first year member and a member of District 8. He graduated from the Western University of Health Sciences in Pomona, California, in 1999, and specializes in Family Practice.

Daralynn Deardorff, D.O.

University of Texas Southwestern
Medical Center

Department of Psychiatry
5323 Harry Hines Blvd.
Dallas, TX 75390-9116

Dr. Deardorff is a first year member and a member of District 5. She graduated from the Texas College of Osteopathic Medicine in 1998, and specializes in Psychiatry.

Paul T. Duncan, D.O.

907 North Loop 4
Buda, TX 78610

Dr. Duncan is a member of District 7. He graduated from the Texas College of Osteopathic Medicine in 1993, and is Board Certified in Family Practice.

Marvin L. Faulkner, D.O.

1788 Highway 157 North
Mansfield, TX 76063

Dr. Faulkner is a member of District 5. He graduated from the Kirksville College of Osteopathic Medicine in 1985, and is Board Certified in Anesthesiology and Pain Management.

Arnold A. Fikkert, D.O.

UNTHSC - Department of Surgery
800 Montgomery Street
Fort Worth, TX 76107

Dr. Fikkert is a first year member and a member of District 2. He graduated from the Texas College of Osteopathic Medicine in 1997, and specializes in General Surgery.

Angela M. Gibson, D.O.

7100 Oakmont Blvd. #202
Fort Worth, TX 76132

Dr. Gibson is a member of District 2. She graduated from the Texas College of Osteopathic Medicine in 1997, and is Board Certified in Family Practice.

Gilson R. Giroto, D.O.

Sheppard Air Force Base
Wichita Falls, TX 76308

Dr. Giroto is a first year member and a member of District 16. He graduated from the Texas College of Osteopathic Medicine in 1999, and specializes in Family Practice.

Catherine Floyd Hampton, D.O.

2200 Danielle Dr.
Colleyville, TX 76034

Dr. Hampton is a first year member and member of District 5. She graduated from the Texas College of Osteopathic Medicine in 1999, and specializes in Pediatrics.

J. Marcus Heim, D.O.

2402 Cornerstone Blvd.
Edinburg, TX 78539

Dr. Heim is a first year member and a member of District 14. He graduated from Oklahoma State University/College of Osteopathic Medicine in 1982, and is Board Certified in Orthopedic Surgery.

John B. Herrick, D.O.

2625 Renwick Way
Troy, OH 43573

Dr. Herrick is a first year Non-Resident Associate Member. He graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 1998, and specializes in Emergency Medicine.

Lisa R. Holloway, D.O.

600 Austin Road
Eagle Lake, TX 77434-0277

Dr. Holloway is a member of District 6. She graduated from The University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri in 1994, and is Board Certified in Family Practice.

David E. Kerek, D.O.

Christus Spohn Memorial
Hospital/Trauma Services
2606 Hospital Dr.
Corpus Christi, TX 78411

Dr. Kerek is a member of District 8. He graduated from the Philadelphia School of Osteopathic Medicine in 1984, and specializes in General Surgery.

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Shirat Ling, D.O.

7121 SPID #101

Corpus Christi, TX 78414

Dr. Ling is a first year member and a member of District 8. She graduated from the Texas College of Osteopathic Medicine in 1999, and specializes in Family Medicine.

John G. Malouf, D.O.

333 N. Rivershire Dr. #160

Conroe, TX 77304

Dr. Malouf is a first year member and a member of District 6. He graduated from the Texas College of Osteopathic Medicine in 1998, and is Board Certified in Ophthalmology.

David S. McElroy, D.O.

201 Main Street

New Boston, TX 75570

Dr. McElroy is a member of District 3. He graduated from the College of Osteopathic Medicine of the Pacific in 1983, and specializes in Family Practice.

Darryl G. Meyer, D.O.

Angelina Surgical Associates

302 Medical Park Dr. #101

Lufkin, TX 75904

Dr. Meyer is a first year member and a member of District 3. He graduated from the Texas College of Osteopathic Medicine in 1997, and specializes in General Surgery.

Steven E. Nowotny, D.O.

601 Texan Trail #100

Corpus Christi, TX 78411

Dr. Nowotny is a first year sustaining member and a member of District 8. He graduated from the University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine in 1998, and is Board Certified in Family Practice.

Leslie H. Parks, D.O.

17030 Nanes #111

Houston, TX 77090

Dr. Parks is a first year member and a member of District 6. She graduated from Oklahoma State University/College of Osteopathic Medicine in 1997, and specializes in Obstetrics and Gynecology.

Kyle D. Phillips, D.O.

1601 Lancaster Dr. #20

Grapevine, TX 76051

Dr. Phillips is a first year member and a member of District 15. He graduated from the Texas College of Osteopathic Medi-

cine in 1999, and is Board Certified in Family Practice.

Toni H. Picerno, D.O.

819 East Main Street

Robstown, TX 78380

Dr. Picerno is a first year member and a member of District 8. She graduated from the University of New England College of Osteopathic Medicine, Biddeford, Maine, in 1999, and specializes in Pediatrics.

Eric D. Reed, D.O.

105 West 20th Street

Mount Pleasant, TX 75455

Dr. Reed is a member of District 3. He graduated from Oklahoma State University/College of Osteopathic Medicine in 1996, and specializes in Otorhinolaryngology.

Alejandro Rocha, D.O.

8269 North Loop

El Paso, TX 79907

Dr. Rocha is a member of District 11. He graduated from the Texas College of Osteopathic Medicine in 1998, and is Board Certified in Family Practice.

Raul Santoscoy, D.O.

7616 Culebra #130

San Antonio, TX 78251

Dr. Santoscoy is a member of District 17. He graduated from the University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine in 1999, and specializes in Family Medicine.

Don J. Sarmiento, D.O.

2418 Widgeon Drive

Clarksville, TN 37042

Dr. Sarmiento is a first year member. He graduated from Oklahoma State University/College of Osteopathic Medicine in 1997, and specializes in Family Medicine.

Cynthia L. Shughrue, D.O.

8220 Walnut Hill Lane #516

Dallas, TX 75231

Dr. Shughrue is a member of District 5. She graduated from Oklahoma State University/College of Osteopathic Medicine in 1987, and is Board Certified in Family Practice.

Geurt L. Tilma, D.O.

P.O. Box 210864

Bedford, TX 76021

Dr. Tilma is a member of District 15. He graduated from the Texas College of Osteopathic Medicine in 1976, and specializes in Radiology.

Norman D. Truitt, D.O.

VA Hospital Kerrville

3600 Memorial Blvd.

Kerrville, TX 78028

Dr. Truitt is a Member of District 17. He graduated from Oklahoma State University/College of Osteopathic Medicine in 1972, and is Board Certified in Family Practice.

Jeff J. Wang, D.O.

12121 Richmond Ave. #325

Houston, TX 77082

Dr. Wang is a first year member and a member of District 6. He graduated from the Texas College of Osteopathic Medicine in 1999, and specializes in Family Practice.

J. Steven Welch, D.O.

111 W. Akard

Weatherford, TX 76086

Dr. Welch is a member of District 15. He graduated from the Texas College of Osteopathic Medicine in 1998, and is Board Certified in Family Practice.

Aimee L. Wright, D.O.

6029 Beltline Rd. #100

Dallas, TX 75240

Dr. Wright is a first year member and a member of District 5. She graduated from the Texas College of Osteopathic Medicine in 1999, and is Board Certified in Family Practice.

New Affiliate Member**Utility Solutions, LLC**

aka Holter Monitors

Bob Wehrmeyer

24165 I-10 West #217

San Antonio, TX 78257

New Intern/Resident Members

Manju Babu, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at the Family Practice Residency Program of Brazos Valley in Bryan.

Tayson DeLengocky, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at Botsford General Hospital in Farmington, MI.

Richard J. Fairboth, D.O., graduated from the Chicago College of Osteopathic Medicine in 2000, and is serving an Internship at UNTHSC in Fort Worth.

Julie A. Gainer, D.O., graduated from the Chicago College of Osteopathic Medicine of Midwestern University in 1998, and is serving a Fellowship in Obstetrics and Gynecology at Parkland Memorial Hospital in Dallas.

Jessica Hals, D.O., graduated from Lake Erie College of Osteopathic Medicine, East Lansing, Michigan, in 1999; and is serving a Fellowship in Oncology at Scott & White Memorial Hospital in Temple.

Verlaine G. Limbo, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at Summa Health System in Akron, OH.

Courtney R. Marburger, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at the Children's Hospital of Austin.

Joseph P. Martin, D.O., graduated from The University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri, in 1999, and is serving a Fellowship in Child and Adolescent Psychiatry and Neurology at the Austin State Hospital.

Jennifer T. McGaughey, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at Texas Tech Medical Center in Amarillo.

Richard S. McPherson, D.O., graduated from the Texas College of Osteopathic Medicine in 2001, and is serving a Residency in Physical Medicine and Rehabilitation at the University of Pittsburgh Medical Center.

Hoang H. Nguyen, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at the University of Mississippi Medical Center in Jackson.

Lynda B. Stafford, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at the Osteopathic Medical Center of Texas in Fort Worth.

Robyn D. Stewart, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at McLennan County Family Practice Residency Program in Waco.

Anita Tharian, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at University Hospital in San Antonio.

Kokila Thirumartiti, D.O., graduated from Nova Southeastern University of Health Sciences-College of Osteopathic Medicine, Fort Lauderdale, Florida, in 2002; and is serving an Internship at the Osteopathic Medical Center of Texas in Fort Worth.

Daisy Thomas-Gobalakrishna, D.O., graduated from New York College of Osteopathic Medicine/New York Institute of Technology in 2002, and is serving an Internship at the Osteopathic Medical Center of Texas in Fort Worth.

Beth Ann Valashinas, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at the Osteopathic Medical Center of Texas in Fort Worth.

Shelly R. Van Scoyk, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at the Osteopathic Medical Center of Texas in Fort Worth.

Chau Paulina Vu, D.O., graduated from Midwestern University Arizona College of Osteopathic Medicine in 2001, and is serving a Residency in Family Practice at the Osteopathic Medical Center of Texas in Fort Worth.

Erin C. Westerholm, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at the Osteopathic Medical Center of Texas in Fort Worth.

Anita C.H. Wood, D.O., graduated from Michigan State University College of Osteopathic Medicine, East Lansing, Michigan, in 2002; and is serving an Internship at the Osteopathic Medical Center of Texas in Fort Worth.

Won Yi, D.O., graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at the University of Florida at Jacksonville.

In Memoriam

George Robert Baylis, II, D.O.

Dr. George Robert Baylis, II, of Pearland, passed away July 30, 2002. He was 38. Services were held August 5 at Sagemont Church, with interment at Forest Lawn Cemetery.

Certified in Family Practice, Dr. Baylis practiced at the Moody Health Center in Pasadena. He was a 1996 graduate of the University of North Texas Health Science Center/Texas College of Osteopathic Medicine, Fort Worth, Texas. Memberships Included Texas Osteopathic Medical Association, Christian Medical and Dental Association, Kappa Alpha Order and Sagemont Church.

He is survived by his wife, Marcy; daughter Abigail; parents, George and Jerra Baylis; sisters, Deborah Lilley and husband Thomas, and Galynn Crow and husband Chris; father- and mother-in-law Ray and Jeanette Willis; brother- and sister-in-law Ken and Holly Wallis; and aunt and uncle Robbye and James Rankin.

Self's Tips & Tidings



By Don Self

Using ERISA to Help You

There are about 288 million Americans living today. About 70 million of them have insurance coverage through some kind of military program and about 40 million through either Medicare or Medicaid. About 18 million do not have any kind of health insurance coverage, leaving the other 160 million or so having coverage of some kind covered through their employer or the employer of a family member. It is the 160 million that gives you a greater reason to learn more about ERISA.

ERISA stands for the Employee Retirement Income Security Act, and if you're wondering how this affects medical insurance claims, you're not alone. Ninety-nine percent of Americans and ninety percent of physician offices have probably never heard of ERISA, yet it is a federal law that protects you. ERISA became law back in 1974. ERISA requires plans to provide participants with important information about plan features and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty.

Even though you may have never heard of ERISA, you have heard of a couple of its amendments, such as COBRA (Consolidated Omnibus Budget Reconciliation Act) and HIPAA (Health Insurance Portability and Accountability Act). Other amendments include the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act.

In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans that are maintained solely to comply with applicable

workers compensation, unemployment, or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

So, how does ERISA affect you (other than the well-known COBRA and HIPAA)? Instead of relying on state laws to mandate coverage and payment issues with the health plans, ERISA brings in the federal government and the federal standards already existing to be applied on the insurance claims. However, there is a correct and incorrect way to use ERISA to help you. We will be covering this in the next couple of months in this article and in my 8-page newsletter sent to subscribers.

HIPAA Questions

CMS now has a toll free number to call with HIPAA privacy questions at 1-866-627-7748, hours: 9 a.m. - 6 p.m., Eastern Standard Time; Web site <www.cms.hhs.gov/hipaa>.

Home Health Certification

This seems to be an area where many PCPs are doing the work, but they are not billing for the service. Codes G0179 and G0180 reimburse very well when billed properly, but they are under-utilized at this time. If your physician completes a CMS-485 form (HOME HEALTH CERTIFICATION AND PLAN OF CARE) form and has documented this in his/her progress notes (most people use a template for this kind of service), you should be billing out G0179 or G0180. Code G0180 is HHA Certification and Code G0179 is HHA re-certification. Medicare's allowed ranges from \$52 to \$65 for G0179 (depending on your locality) and G0180 is between \$68 and \$80. If you're already doing the work, why not bill for it? Make sure the date of service on the claim is the same as the "From" date on the CMS 485 form.

If you do not have a 485 form, you can download it in Acrobat (PDF) format on my free documents page at <www.donself.com>. If you do not have web access, you can call our office and we will fax one to you.

New ABN Required by Medicare

Advance Beneficiary Notices (ABN) advise beneficiaries, before items or services are actually furnished, when Medicare is likely to deny payment. ABNs allow beneficiaries to make informed consumer decisions about receiving items or services for which they may have to pay out-of-pocket and to be more active participants in their own health care treatment decisions.

In June, HHS published revised ABNs, which are designed to be more beneficiary-friendly, more readable and understandable, with patient options more clearly defined.

The CMS-R-131 form is the new ABN approved by Medicare and the OMB (Office of Management and Budget). There are two CMS-R-131 forms: the General Use form ("ABN-G") and the Laboratory Tests form ("ABN-L"). Both CMS-R-131 ABN forms are in English and in Spanish. You can download them on our web site at <www.donself.com> on our documents page.

"Chief Complaint" Can be Anywhere

Someone is teaching in seminars that the CHIEF COMPLAINT has to be separately listed in the progress notes. While there does have to be a chief complaint (CC) shown for any E&M service, it does not have to be a separate statement. The medical necessity of the visit (to include the history that caused the patient to walk in the door) needs to be documented. The docu-

mentation guidelines do clearly state that the CC may be listed separately, usually in the patients' own words, or it may be included in the description of the history of the present illness. We do recommend you use some kind of template that has a space for each element (history, exam, mdm) as it does help remind you of what needs to be done on each visit, however, templates are not required by any third party carriers, including Medicare and Medicaid.

Vaccine Payments to Increase

Medicare has published an increase in the amount they pay for the Flu and Pneumonia vaccines, with the following amounts:

90657

Flu vaccine, 6-35 months, im \$8.02

90658

Flu vaccine, 3 years, im \$8.02

90659

Flu vaccine, whole, im \$8.02

90732

Pneumococcal vaccine, im \$13.10

Don't forget to charge the appropriate vaccine administration code. If the patient is Medicare, the code will be:

G0008

Influenza Vaccine Administration

G0009

Pneumonia Vaccine Administration

G0010

HIB Vaccine Administration

If the patient is not Medicare, use the 90471 and 90472 codes for private and managed care vaccine administration.

Coding Wart Removal

Common warts usually grow on the fingers, around the nails and on the backs of the hands. They are more common where skin has been broken, for example where fingernails are bitten or hangnails picked. These are often called "seed" warts

because the blood vessels to the wart produce black dots that look like seeds.

Flat warts are smaller and smoother than other warts. They tend to grow in large numbers - 20 to 100 at any one time. They can occur anywhere, but in children they are most common on the face. In adults they are often found in the beard area in men, and on the legs in women. Irritation from shaving probably accounts for this.

Flat wart destruction should be coded as 17110 for up to 15; Common and Plantar warts should be coded as 17000 for the first, then 17003 for 2-14, "each", 17004 if there are over 15.

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News from the Texas Department of Insurance

Physician/Provider Fee Disclosure Rules Adopted

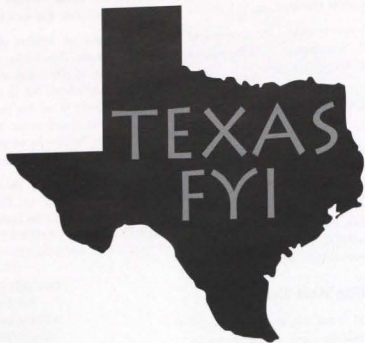
The Texas Department of Insurance has adopted new rules giving physicians and health care providers the right to receive information to help them understand how HMOs and insurance companies calculate their fees, including "bundling" and "downcoding" practices.

Governor Rick Perry directed the Texas Department of Insurance to develop fee disclosure rules in order to benefit physicians and providers under contract with HMOs and insurance company preferred provider plans. The new rules took effect on October 09, 2002.

"These new disclosure rules adopted by the Texas Department of Insurance will shine a light on the practices used by insurance companies to calculate fees," said Insurance Commissioner Jose Montemayor. "Physicians and health care providers should have a right to see and understand the procedures that insurance companies and HMOs use to determine how much they will pay for services."

Under the rules, an HMO or insurance company must furnish fee schedule and coding information when a contracting physician or provider requests it in writing. It must be in sufficient detail that a skilled, reasonable person can determine the payment to be made according to the terms of the physician or provider's contract. Under existing contracts, an HMO or insurer will have 30 days after receiving a request to furnish the information. When negotiating new contracts or renewing old ones, the HMO or insurer must furnish the information, upon request, along with other contractual materials. To allow carriers time to meet these requirements, the earliest date the carriers will have to provide the information is 90 days from the date these rules became effective.

Specifically required are a summary and explanation of all methodologies used to pay claims, including a fee schedule, coding methodologies, bundling processes and downcoding policies. For example, if a fee schedule indicates reimbursement of certain claims at a "usual and customary" rate, then the HMO or insurance company must explain how it determines that rate.



Texans' Ability to Sue Their HMOs Upheld by the 5th Circuit Court of Appeals In a Ruling Welcomed by Patient Advocates

Under the Court's ruling, three cases which were considered can be filed in state court, while a fourth case must remain under federal jurisdiction. Patients prefer to keep HMO lawsuits in Texas courts because state law gives them the right to sue over decisions that cause harm or death, while HMOs usually prefer the cases to be tried in federal courts, which have widely ruled that the Employee Retirement Income Security Act of 1974 bars traditional suits for negligence and medical malpractice.

(Dallas Morning News, 9-20-02)

Texas Chiropractors Continue to Perform Student Athletes Physical Examinations Until Dispute Between Practitioners and the University Interscholastic League is Settled in Court

Visiting Judge Charles Campbell of Austin overturned the UIL's decision in April to discontinue allowing chiropractors to perform the physicals. His order

will not take effect until all parties in the dispute between the UIL and the Texas Chiropractic Association have signed it. Campbell also set a court date for February 3, 2003 to settle the dispute.

In April of this year, the UIL excluded chiropractors from the list of qualified medical professionals allowed to perform the exams needed for students to participate in interscholastic athletics, prompting the chiropractic group to sue the UIL in July, arguing that the removal was discriminatory and illegal.

(Fort Worth Star-Telegram, 9-14-02)

Harris County Cardiologists and Patients Participate in Project to Change Future Process of National Medicare Policies

The program, jointly conducted by the Centers for Medicare & Medicaid Services (CMS) and CorSolutions Medical Inc., is designed to determine the value of disease management for Medicare beneficiaries with acute congestive heart failure; and will involve local cardiologists and 1,750 of their patients, who will pilot the project for the next four years. Patients enrolled in the local program are matched with nurses who remain in frequent contact throughout the four-year period to help manage the

disease as prescribed by attending physicians, while CMS officials say they hope the project will provide the basis for expanding disease management services to all Medicare beneficiaries in the future to bring the program up to par with private Medicare plans.

(Houston Business Journal, 9-16-02)

Houston's Largest Medicare HMO Leaving Area by Year's End

PacifiCare of Texas says it will no longer offer its Medicare HMO, Secure Horizons, in Harris, Fort Bend and Montgomery counties as of January 1, 2003, citing the high cost of providing care in the area as the reason. This will leave more than 25,000 elderly and disabled residents scrambling for coverage. For now, PacifiCare enrollees can go back to standard Medicare or join one of three remaining Medicare HMO plans, including one that doesn't have a drug benefit and another that is struggling financially.

(Houston Chronicle, 9-10-02)

Two Non-Profit Groups Sue Three Texas State Agencies in Federal Court

The lawsuit cites the Texas Departments of Human Services (DHS) and Mental Health and Mental Retardation (MHMR) as well as the Health and Human Services Commission, and claims that more than 18,000 people with mental retardation have been on waiting lists for years for the Medicaid-funded Home and Community-Based Services program operated by MHMR. The suit also claims more than 7,000 Texans with developmental disabilities await services from the DHS Community Living Assistance and Support Services program.

(San Antonio Express-News, 9-6-02)

KOAA ALUMNUS OF THE YEAR 2002

Richard W. Anderson, D.O., FACGP has been named the Kirksville Osteopathic Alumni Association (KOAA) Alumnus of the year 2002. The award was established in 1982 and recognizes graduates who have made outstanding contributions to the College and the osteopathic profession.

For Dr. Anderson, it was always about being an osteopathic family physician, not being merely a family physician. "I have always felt very fortunate and blessed to be an osteopathic physician who could practice family medicine and also use osteopathic manipulation," said Dr. Anderson, who retired from his solo practice in Mesquite, Texas, in 1998.

Dr. Anderson has been an advocate of the osteopathic profession since he was a teenager (an older brother, Esmond G. Anderson, D.O., now deceased, practiced in their hometown of Janesville, Wisconsin). He said Esmond, a 1931 graduate of the Chicago College of Osteopathy, was his earliest role model. There were, however, plenty of other siblings, 10 to be exact, who influenced him while he was growing up on a farm.

He received his undergraduate education from Milton College and Northeast Missouri State Teachers College (now Truman State University). After graduating from Kirksville in 1946, he practiced in Cudahy, Wisconsin and then relocated to Mesquite, Texas in 1968.

Serving on the KOAA Board of Directors for nine years, from 1991 to 2000, allowed him to help support his alma mater and work with colleagues. "I enjoyed coming back to Kirksville for KOAA Board meetings and seeing the progress that has been made since I was in school. And it was great to be around alumni who are dedicated to helping improve the College and the osteopathic profession as a whole. I enjoyed every minute of my time on the Board."

Although retired, he continues to give manipulative treatments to close friends and family members, and regularly participates in meetings of a Dallas osteopathic study group that includes D.O.s and Student Doctors who are dedicated to perpetuating and teaching osteopathic manipulation.

From the Texas Department of Health Cochlear Implants and Meningitis

The Food and Drug Administration (FDA) has received reports of people with cochlear implants contracting bacterial meningitis. In response to this public health concern, the FDA is working with the Centers for Disease Control and Prevention (CDC) and state health departments to investigate the association between cochlear implants and meningitis.

According to an FDA survey of cochlear implant vendors, as of November 2001 an estimated 70,000 people worldwide have received implants; approximately 21,000 of those live in the U.S. Over a 14-year period, 52 cases of meningitis in cochlear implant recipients have been identified worldwide; 24 cases have been in North America. The 52 cases have occurred in children and adults ranging in age from 21 months to 72 years; 12 died from sequelae. The time period for developing symptoms and signs of meningitis ranged from within 24 hours of implantation to 5 years postimplantation. Cerebrospinal fluid results are available from 14 cases: *Streptococcus pneumoniae* was the most common pathogen; but *Hemophilus influenza*, *Escherichia coli*, *Streptococcus viridans* and *enterococcus* species have also been cultured.

To determine risk factors for meningitis associated with cochlear implants, CDC in collaboration with the FDA and state

health departments is planning a case-control study. The target population is children under age 6 who have received cochlear implants. Information regarding the type of implant, medical and surgical history, age, gender, race, and ethnicity will be collected from study participants and analyzed for risk factors.

Potential risk factors are many. Congenital deafness may increase baseline risk even prior to implantation and deafness secondary to meningitis may increase recurrence risk. Prior otitis media or immunodeficiency may also be predisposing factors. Additionally, each of the three U.S. manufacturers of cochlear implants has different implant designs and it is possible that certain design features increase risk for meningitis. Two implant surgeons, Dr. Noel Cohen and Dr. Thomas Balkany, surveyed the North American cases: 9 cases were in patients with the Advanced Bionics Corporation CLARION device, 15 were in patients with the Cochlear Nucleus Corporation device, and none were among patients with the MED-EL Corporation device.

Removal of cochlear implants is not recommended at this time. Vaccination against *Streptococcus pneumoniae* and *Hemophilus influenza* may offer protective benefit for cochlear implant candidates and recipients although 3 of the meningitis cases

developed despite vaccination. The Advisory Committee on Immunization Practices (ACIP) recommends the following schedule for vaccines against *Streptococcus pneumoniae* and *Hemophilus influenzae*. At least one of the cochlear implant manufacturers is offering to reimburse for vaccination.

Vaccination against *Hemophilus influenzae*:

- All children < 5 years old: *Haemophilus influenzae* conjugate vaccine series is recommended

Vaccination against *Streptococcus pneumoniae*:

- All children < 2 years old: Heptavalent pneumococcal conjugate vaccine (Prevnar®) series is recommended
- Children 2 to 4 years old at high risk for invasive disease: both vaccines are recommended—the heptavalent pneumococcal conjugate vaccine (Prevnar®) series followed by a 23-valent pneumococcal polysaccharide vaccine 6-8 weeks later.*
- Children 5 years old through adults at high risk for invasive disease: A 23-valent pneumococcal polysaccharide vaccine is recommended.

Report Texas cases of meningitis in cochlear implant recipients to Swati Avashia, M.D., at Texas Department of Health at 512-458-7676 or e-mail to <swati.avashia@tdh.state.tx.us>.

* For a detailed immunization schedule refer to the American Academy of Pediatrics (AAP) policy statement on recommendations for the prevention of pneumococcal infections in Pediatrics (106) 2:362-366, August 2000 or on the AAP website <www.aap.org/policy/re9960.html>.

Research and SAMHSA Physician Training Combine to Put Care for Opiate Dependence in Hands of Family Doctor

Buprenorphine, a new medication developed through more than a decade of research supported by the National Institute on Drug Abuse (NIDA), will now become available to treat heroin and other opioid dependence through certification and training of physicians to use the medication by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Buprenorphine will be able to be used by physicians in office-based treatment, as long as physicians have the minimum eight hours of training mandated by Congress and obtain a waiver that allows them to prescribe certain controlled substances. Buprenorphine was approved October 8, 2002 for treatment of opioid dependence by the Food and Drug Administration. This medication will not replace methadone therapy, provided through special methadone treatment facilities, but will provide the office-based physician an opportunity to treat patients for addiction to heroin or other opioids, including prescription pain-killers. Physicians will be required to refer patients to full-spectrum care for their social and psychological needs.

"Buprenorphine will allow patients to be treated for addictions in the same manner as they are treated for other chronic illnesses, such as diabetes or hypertension," said SAMHSA Administrator Charles G. Curie. "A qualified physician will be able, for the first time, to prescribe an anti-addiction medication in an office setting and treat opiate addiction as any other chronic disease."

Buprenorphine's unique effects and pharmacology make it an attractive and clinically helpful treatment option. Buprenorphine is related to morphine, but is a partial agonist that functions on the same brain receptors as morphine. It does not produce the same high, dependence or withdrawal syndrome. It is long-lasting, less likely to cause respiratory depression, and well-tolerated by addicts. It will join methadone, naltrexone and LAAM as the fourth medication available for treating heroin and other opiate addictions.

Physicians who are not addiction medicine specialists, but to offer this new option to their patients, must first complete an eight-hour training session to qualify for a waiver from the Controlled Substances Act 21[USC 823(g)], which restricts the use of methadone and other opiate drugs to federally licensed addiction treatment clinics. The waiver permits primary care physicians to provide office-based treatment. To date, approximately 2,000 physicians have received training.

In the next few months, SAMHSA will establish a nationwide registry of physicians holding this waiver to assist health care workers and patients identify qualified treatment professionals for detoxification (weaning off heroin) or maintenance (keeping off heroin) of as many as 30 patients. It is estimated that there were 898,000 chronic heroin users in the United States in 2000.

To encourage physicians to participate in buprenorphine training sessions and to inform the public about this new treatment option, SAMHSA/CSAT will be launching an information campaign in the near future. This campaign will kick-off in Washington, DC and roll-out to cities across the United States including: Baltimore, MD; Boston, MA; Chicago, IL; Dallas, TX; Detroit, MI; Miami, FL; New Orleans, LA; Newark, NJ; New York, NY; Portland, OR; Salt Lake City.

SAMHSA has set up an information website and toll free number. Physicians can get more information at <www.buprenorphine.samhsa.gov> or by calling the SAMHSA Buprenorphine Information Center at 866-BUP-CSAT from 8:30 A.M. to 5:00 P.M., EST.

TRICARE News & Related Military Information

Gulf War Medical Research Library

The Departments of Defense, Health and Human Services, and Veterans Affairs have worked together to create this library of government-sponsored Gulf War-related research. The library was developed to help service members, veterans, families, and the public learn about research efforts into health concerns related to service during the Gulf War. This web site will also provide scientists and medical professionals information about initiatives and findings in Gulf War-related medical research.

"Research Topics" is the section of Medsearch that describes the research projects sponsored by the federal government. This section has been updated to reflect all projects funded through fiscal year 2002.

"Major Focus Areas" is the section of Medsearch that summarizes certain subjects of great interest to people trying to understand the illnesses of Gulf War veterans.

An alternate way to find information about a specific subject is to use the Search feature. The Search tool is at the upper right of every page in Medsearch. The Medsearch web site is available at <www.gulfink.osd.mil/medsearch>.

Blood Transfusions and West Nile Virus

by Kathleen T. Rhem

American Forces Press Service Officials are urging people not to forgo blood transfusions because of concerns about West Nile Virus. "A blood transfusion is usually a life-saving or life-sustaining event," said Army Col. Michael Fitzpatrick, director of the Armed Services Blood Program.

Medical experts have recently reported several cases where individuals are believed to have contracted West Nile Virus through blood transfusions or donated organs. Fitzpatrick said the risk of getting ill from West Nile Virus is so low that he wouldn't want someone to choose not to get a needed blood transfusion.

West Nile Virus is generally spread through bites from infected mosquitoes. It is deadly for some types of birds and horses, but generally doesn't cause illness in humans, according to public-health experts. Fitzpatrick explained that most people who do become ill because of the virus experience only mild cold-like symptoms and never realize they are infected with West Nile. However, in the elderly, very young children or people with weakened immune systems, the virus can cause a deadly form of encephalitis.

Because of the reports of transmissions through blood, the Atlanta-based Centers for Disease Control and Prevention are warning blood donor centers to be especially vigilant in screening potential donors. Fitzpatrick described this process as performing a "mini-physical" on donors - checking such things as temperature, blood pressure and pulse, and asking questions about the donor's general health.

"All collection centers have been doing this routinely for years," Fitzpatrick said. "This is merely a heightened awareness." Fitzpatrick also urged donors who subsequently come down with cold- or flu-like symptoms to call the donor center and report their illness. Any blood or blood products from that donor will be quarantined from use in patients. If the donor then sees a physician and tests negative for West Nile Virus, the blood will be cleared for use. If the donor has not been "cleared" for West Nile Virus, the unexpired blood will be disposed of.

Blood products have varying shelf lives. Red blood cells are stored for up to 42 days, while platelets expire after five days. Fresh-frozen plasma can be kept for up to one year, Fitzpatrick explained. He said the military has an advantage over many civilian communities: an aggressive preventive-medicine program. He said West Nile Virus is a "reportable disease," meaning medical professionals are required to report instances of West Nile infection to the CDC.

If a reportable disease is detected in a military patient, preventive-medicine professionals would follow up to see if that patient had donated blood and make sure the proper authorities were notified, Fitzpatrick explained. The colonel also urged people to continue donating blood. "There's a continual need for blood," he said. "The only caveat, if you've had a minor illness, wait 14 days before donating".

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