TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

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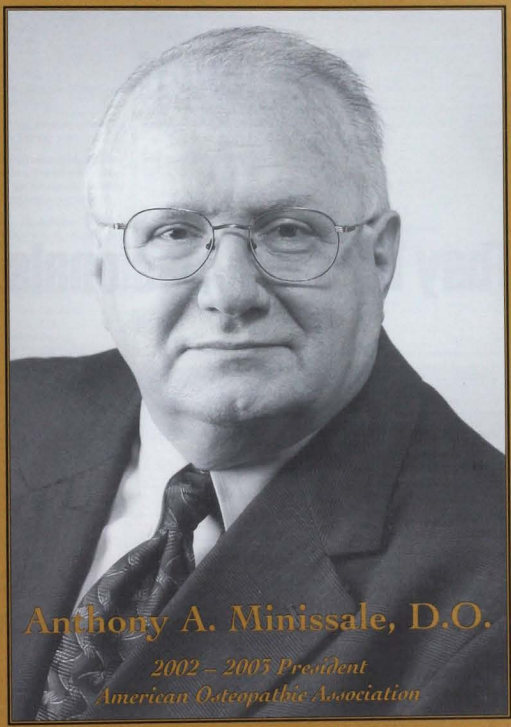

Anthony A. Minissale, D.O.

2002 – 2003 President
American Osteopathic Association

plus

This Month's Clinical Focus:
EAR, NOSE & THROAT
pages 6 – 11

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SEPTEMBER 2002

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INSIDE THIS ISSUE

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CALENDAR OF EVENTS

SEPTEMBER 12 – 14
"13th Annual Osteopathic Medical Education Leadership Conference"
Sponsored by AOA; Cosponsored by AACOM
Location: Wyndham Chicago, Chicago, IL
CME: 14.5 hours Category B credits anticipated
Contact: jratliff@aoa-net.org; 800-621-1773, ext. 8080

SEPTEMBER 14 – 15
"HealthFind 2002"
Sponsored by the Office of Rural Community Affairs, Texas State Office of Rural Health
Location: Hyatt Regency Hotel, Town Lake, Austin, TX
Contact: Robin Wright, Office of Rural Community Affairs
P.O. Box 12877, Austin, TX 78711-2877
512-936-6701 or 877-839-2744
FAX 512-479-8898
rwright@crhi.state.tx.us
www.orca.state.tx.us

SEPTEMBER 19 – 22
"2002 Annual Clinical Assembly of Osteopathic Specialists"
Sponsored by the American College of Osteopathic Surgeons
Location: Disney's Contemporary Resort
Lake Buena Vista, Florida
Contact: 800-888-1312

SEPTEMBER 20 – 22
"FOMA Mid-Year Seminar"
Sponsored by the Florida Osteopathic Medical Association
Location: Hyatt Regency Westshore, Tampa, FL
CME: 23.5 hours category 1-A credits anticipated
Contact: 800-226-3662
FAX 850-942-7538

SEPTEMBER 21
"TOMA Board of Trustees Meeting"
Location: TOMA Office, Austin, TX
Contact: Paula Yeamans, 512-708-8662; 800-444-8662

OCTOBER 6*
"Osteopathic Mangement of Patients with ENT/Respiratory Problems"
Sponsored by the American Academy of Osteopathy
Location: Las Vegas Convention Center, Las Vegas, NV
Contact: AAO, 317-879-1881
www.charlan@academyofosteopathy.org
* This one-day workshop is being held the day prior to the opening of the AOA's Annual Convention

OCTOBER 2 – 6
"62nd Annual Convention and Scientific Session"
Sponsored by the American College of Osteopathic Internists
Location: Camelback Resort & Spa, Scottsdale, AZ
Contact: Brian Donadio, Executive Director
800-327-5183 or bjd@acoi.org

OCTOBER 7 – 11
"AOA 107th Annual Convention and Scientific Seminar"
Sponsored by the American Osteopathic Association
Location: Las Vegas Convention Center, Las Vegas, NV
Contact: Ann Wittner, AOA
800-621-1773, ext. 8256 or 312-202-8014

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

American Osteopathic Association 2002 – 2003 President

Anthony A. Minissale, D.O.

The American Osteopathic Association (AOA) installed Anthony A. Minissale, D.O., of York, Pennsylvania, as its 2002-2003 president during its recent House of Delegates meeting in Chicago. Dr. Minissale will devote his year as president to expressing the importance of the AOA's members and promoting the AOA's Code of Leadership, which pushes for commitment, integrity, competency, and vision among the profession's leaders.

Dr. Minissale earned his doctor of osteopathic medicine degree from the Philadelphia College of Osteopathic Medicine. He completed a rotating internship at Green Cross General Hospital in Cuyanhoga Falls, Ohio, and a residency in general surgery at Parkview Hospital in Philadelphia.

A board-certified surgeon, Dr. Minissale is vice president of medical affairs and director of medical education at Memorial Hospital in York. He is a fellow of the American College of Osteopathic Surgeons. He joined the AOA in 1957 and has served as a member of its Board of Trustees for ten years and as a delegate to its House for over 20 years. He has chaired all departments of the AOA and acts as the AOA's internship inspector, a post he has held since 1973.

In his home state, Dr. Minissale has served the Pennsylvania Osteopathic Medical Association since 1961, in capacities such as vice chair; secretary/treasurer; board member and delegate to the House. Additionally, Dr. Minissale acted as founding member and chairman of the Pennsylvania Osteopathic Surgical Society and belongs to the York County Osteopathic Medical Society.

Dr. Minissale has been honored with a number of awards throughout his career, including the Pennsylvania Osteopathic Medical Association Certificate of Appreciation in 1991, and the 110% Award from KePro in 1994.

Over and above his osteopathic duties, Dr. Minissale has worked for civic organizations such as Leadership York, Coalition for a Healthy York and the Gladwyne Civic Association.

Dr. Minissale resides in York with his wife, Adel. He has two children, Anthony and Angela.

Four of Our Five Senses Rest Squarely on Our Shoulders

So What's Going On Up There?

Hearing Loss

Over 28 million Americans are deaf or hard of hearing, and 30 million more are exposed to dangerous levels of noise. The largest group of Americans suffering from hearing loss is the elderly. Age-related hearing loss affects about one-third of the U.S. population between the ages of 65 and 75, and 40 percent over the age of 75. Hearing loss can be caused by noise, viral or bacterial infections, heart conditions or stroke, head injuries, tumors, certain medicines, heredity, or changes in the ear that occur with aging.

Presbycusis is the loss of hearing that gradually occurs in most individuals as they grow older and is the most common hearing problem in older people. The loss associated with presbycusis is usually greater for high-pitched sounds. Most commonly it arises from changes in the inner ear due to aging, but can also result from changes in the middle ear or from complex changes along the nerve pathways leading to the brain. Presbycusis usually occurs in both ears, affecting them equally. Since the loss occurs gradually, many people do not realize that their hearing is diminishing.

Tinnitus is a symptom associated with a variety of hearing diseases and disorders, however it can also be a symptom of other health problems. The American Tinnitus Association estimates that at least 12 million Americans have tinnitus and of these, at least one million experience it so severely that it interferes with their daily activities. People with tinnitus have a ringing, roaring, or hear other sounds inside the ears. It may result from ear infection, exposure to loud noise, reaction to certain medications, advancing age, allergies, tumors, and problems in the heart and blood vessels, jaws and neck.

Noise-induced hearing loss can be caused by a one-time exposure to loud sound or by repeated exposure over an extended period of time. Examples of sources of noises that cause NIHL are motorcycles, firecrackers and small arms fire, all emitting sounds from 120 decibels to 140 decibels. By contrast, the humming of a refrigerator is 40 decibels, usual conversation is about 60 decibels and city traffic noise can be 80 decibels. Sounds of less than 75 decibels, even after long exposure, are unlikely to cause hearing loss. The effect from impulse sound can be instantaneous and can result in an immediate hearing loss that may be permanent. This kind of hearing loss may be accompanied by tinnitus in one or both ears. The damage that occurs over years of exposure to loud noise also results in hearing loss and tinnitus. Both forms of NIHL can be prevented by the use of ear plugs or ear muffs, or other hearing protective devices.

The most common cause of hearing loss in children is otitis media, or ear infections. Seventy-five percent of children experience at least one episode of otitis media by their third birthday. Almost half of these children will have three or more ear infections during their first 3 years. Otitis media can also affect adults, although it is primarily a disease of infants and young children.

("Hearing and Older People" Age Page, National Institute on Aging, <www.nia.nih.gov>; "Presbycusis" NIH Pub. No. 97-4235; "The Noise In Your Ear – Facts About Tinnitus" NIH Pub. No. 00-4896, "Noise-Induced Hearing Loss" NIH Pub. No. 97-4233, "Otitis Media" NIH Pub. No. 97-4216, National Institute on Deafness and Other Communication Disorders. <www.nidcd.nih.gov>.)

Smell and Taste Disorders (Chemosensory disorders)

Each year, more than 200,000 people visit a physician for help with smell disorders or related problems. Those who experience smell disorders experience either a loss in their ability to smell or changes in the way they perceive odors.

Most people who develop a smell disorder have recently experienced an illness or an injury. Common triggers are upper respiratory infections and head injuries. Other causes of smell disorders are polyps in the nasal cavities, sinus infections, hormonal disturbances, or dental problems. Exposure to certain chemicals and some medicines have also been associated with smell disorders. In addition, people receiving radiation treatment for head and neck cancers may have problems with their sense of smell.

The true loss of taste is rare and oftentimes actually a smell loss. The reduced ability to identify taste sensations (sweet, sour, bitter, etc.) is called hypogeusia while ageusia is the inability to detect any taste at all. Other disorders include distortion of an odor or taste, or detection of a foul taste from something that is usually pleasant tasting.

Hyposmia is the condition in which the ability to detect odor is reduced. Anosmia is the inability to detect any kind of odor. As for changes in the perception of odors, some people notice that familiar odors become distorted or an odor that is normally pleasant smells foul. Others may perceive a smell that is not present.

Although some people are born with such disorders, most are developed after an injury (such as a head injury) or an illness. However, some chemosensory losses are attributed to upper respiratory infections as well. Loss of the ability to taste can also be caused by oral health problems, exposure to certain chemicals and/or some medicines, and by radiation therapy for cancers of the head and neck.

("Smell and Smell Disorders" NIH Pub. No. 01-3231, "Taste and Taste Disorders" NIH. Pub. No. 01-3231A, <www.nidcd.nih.gov>.)

Head and Neck Cancers – Some Facts –

Head and neck cancers account for 3 percent of all cancers in the United States. These cancers are more common in men and in people over age 50. It is estimated that almost 38,000 men and women in the U.S. will develop head and neck cancers this year.

Tobacco (including smokeless tobacco) and alcohol use are the main risk factors for head and neck cancers, especially those of the oral cavity, oropharynx, hypopharynx, and larynx. Eighty-five percent of head and neck cancers are linked to tobacco use.

Why These Cancers Occurr Where They Do

Oral cavity – Sun exposure (lip); HPV infection.

Salivary glands – Radiation exposure to the head and neck.

Paranasal sinuses and nasal cavity – Certain industrial exposures, such as wood or nickel dust inhalation.

Nasopharynx – Epstein-Barr virus infection; occupational exposure to wood dust; and consumption of certain preservatives or salted foods.

Oropharynx – Poor oral hygiene, mechanical irritation such as from poorly fitting dentures, and use of mouthwash that has a high alcohol content.

Hypopharynx – Plummer-Vinson (also called Paterson-Kelly) syndrome, a rare disorder that results from nutritional deficiencies. This syndrome is characterized by severe anemia and leads to difficulty swallowing due to webs of tissue that grow across in the upper part of the esophagus.

Larynx – Exposure to airborne particles of asbestos, especially in the workplace.

A Variety of Symptoms

Symptoms that are common to several head and neck cancer sites include a lump or sore that does not heal, a sore throat that does not go away, difficulty swallowing, and a change or hoarseness in the voice.

Other symptoms may include the following:

Oral cavity – A white or red patch on the gums, tongue, or lining of the mouth; a swelling of the jaw that causes dentures to fit poorly or become uncomfortable; and unusual bleeding or pain in the mouth.

Nasal cavity and sinuses – Sinuses that are blocked and do not clear, chronic sinus infections that do not respond to treatment with antibiotics, bleeding through the nose, frequent headaches, swelling or other trouble with the eyes, pain in the upper teeth, or problems with dentures.

Salivary glands – Swelling under the chin or around the jawbone; numbness or paralysis of the muscles in the face; or pain that does not go away in the face, chin, or neck.

Oropharynx and hypopharynx – Ear pain.

Nasopharynx – Trouble breathing or speaking, frequent headaches, pain or ringing in the ears, or trouble hearing.

Larynx – Pain when swallowing, or ear pain.

Metastatic squamous neck cancer – Pain in the neck or throat that does not go away.

("Head and Neck Cancers: Questions and Answers" Fact Sheet 6.37, National Cancer Institute, <www.cancer.gov>.)

Vocal Cord Disorders

Vocal cord disorders are often caused by vocal abuse or misuse, such as excessive talking, singing, coughing, smoking, screaming or inhaling irritants. They are the most prevalent and preventable of the types of voice disorders. Three of these are:

Laryngitis – This is an inflammation of the vocal folds, and is often characterized by a raspy or hoarse voice. It can be caused by excessive use of the voice, bacterial or viral infections, inhaled irritants, or gastroesophageal reflux.

Vocal nodules – These are benign, callous-like growths on the vocal cords and are among the most common voice disorders directly related to vocal abuse. This condition is often called "singer's nodes" because it is a frequent problem among professional singers. Vocal nodules cause the voice to be hoarse, low-pitched, and breathy.

Vocal polyps – These are benign growths similar to vocal nodules, but are softer and more like blisters. They are often caused by long-term smoking, but may also be linked to hypothyroidism, gastroesophageal reflux, or chronic vocal misuse. Voice polyps cause the voice to be hoarse, breathy and low-pitched.

("Disorders of Vocal Abuse and Misuse" NIH Pub. No. 99-4375, <www.nidcd.nih.org>.)

A Review of Fungal Sinusitis

by Stephen Krzeminski, D.O.

Mycotic paranasal sinus infections are uncommon causes of recurrent or persistent sinusitis despite adequate medical care. Unfortunately they are often overlooked during treatment directed toward more common bacterial etiologies. Fortunately, the diagnosis of fungal sinusitis has advanced with the increasing use of computerized tomography (CT) and sinus endoscopy as well as specific RAST testing for various mycotic pathogens. Symptoms can range from rapid invasion of surrounding bone and tissues to much more insidious, chronic, or even allergic presentations.

Conditions that lower immune resistance, such as diabetes mellitus, malignancy, or immunosuppressive therapy, have been shown to predispose to the development of fungal sinusitis. Warm, dry climate, such as we have in Texas, also appears to be a factor, and there are geographic areas in the Middle East where fungal sinusitis is endemic. Prior chronic bacterial sinus infections and sinus obstruction with impaired ventilation also can play roles in both normal and immunodeficient individuals.

Complicating diagnosis are the many species now known to contribute to causing fungal sinusitis. Aggressive, angioinvasive Mucormycosis, such as Rhizopus species, can present in diabetic and other immunosuppressed patients with rapid tissue necrosis and CNS invasion. This rare infection has a direct correlation between early diagnosis and prompt treatment and more favorable prognosis. Blackened areas along the nasal turbinates may be the first sign with biopsy revealing the classic broad nonseptate hyphae. CT scanning can demonstrate soft tissue invasion and bone erosion. MR imaging is the best way to evaluate intracranial extension. Fortunately, this group of fungi is rarely seen in the United States.

Table 1.

Classification System for Fungal Sinusitis

Modified from Morpeth, et al.

Category	Immune Status	Tissue Invasion	Sinuses Affected	Course	Treatment
Acute Fulminant	Compromised	Yes	One	Acute	Radical debridement, Systemic antifungals
Chronic Indolent	Competent	Yes	Varies	Chronic	Complete excision, Systemic antifungals
Mycetoma/ Fungus Ball	Competent	No	One	Chronic	Debridement, Aeration
Allergic Fungal	Competent	No	Multiple	Chronic	Debridement, Sinusitis Aeration, Steroids

Much more common and more extensively described, are fungal infections due to Aspergillus (septate hyphae). Considerable literature has been published recently reviewing the types of sinusitis associated with this organism. Four primary categories have evolved and have been adapted to other species of fungi, as listed in Table 1.

Acute fulminant or invasive fungal sinusitis is associated with diabetic ketoacidosis and other severe immunodeficiencies. Presentation is similar to the Mucormycosis infection described above. Initial symptoms include fever, lethargy, facial pains, and decreased vision with a serosanguinous nasal discharge and dark crusting on the nasal septum and turbinates. Septal perforation and epistaxis can also be seen. Key to diagnosis is the severity of the illness is disproportionate to the typical picture of acute sinusitis. Decreased mentation and lethargy in the typical immunosuppressed patient who presents with a rhinosinusitis requires cultures or stains (H&E, PAS, GMS) leading to prompt care as acute fulminant fungal sinusitis can progress to death within days.

Indolent or chronic fungal sinusitis conversely is slowly progressive and often affects immunocompetent, nonatopic patients. Tissue invasion does occur and radiographic scanning often shows the classic findings associated with fungal sinusitis, as described in Table 2.

Besides *Aspergillus*, the dematiaceous species are becoming more recognized as a cause of chronic, insidious invasion in otherwise healthy persons. The dematiaceous fungi consist of: Alternaria, Bipolaris, Curvularia, Cladosporium, Exserohilum, and Scedosporium species. Important in Texas, Stachybotrys chartarum, or Texan black mold, is also a dematiaceous species. The darker color in these organisms is due to melanin production, and often appear greasy yellow or brown in the sinuses. Soft peanut butter is a good description of its appearance and consistency within the paranasal sinuses.

It was believed until recently that the dematiaceous fungi were not pathologic in humans, but it is becoming apparent that they are capable of causing invasive disease in otherwise healthy people. It is important to note that S. chartarum has not been shown to be a direct cause of sinusitis, but it can increase the amount of nasal mucosal eosinophils and induce an allergic or inflammatory reaction, in addition to its more studied pulmonary effects.

The physical exam in chronic fungal sinusitis reveals polypoid nasal mucosa

Table 2.

Radiographic Diagnosis of Fungal Sinusitis

CT	Often only one sinus or unilateral disease, hyperdense or nonhomogenous opacifications, evidence of bone destruction or sinus expansion may or may not be present, focal areas of increased attenuation from increased levels of calcium and iron in the fungal mucin.
MRI	As above as well as an isointense, decreased intensity on T1 weighted images, very decreased signal intensity on T2 weighted images (vs. the mild decrease associated with acute hemorrhage and the increased intensity associated with bacterial sinusitis)

"Allergic fungal sinusitis, first described in 1981, has become the most commonly diagnosed form of fungal sinusitis."

that is usually unilateral. Tissue necrosis and bone erosion can be present. H&E stain of nasal tissue biopsy reveals abundant amounts of eosinophilic mucin with polymorphonuclear leukocytes and sometimes Charcot-Leyden crystals, the "allergic mucin." The diagnosis of chronic indolent fungal sinusitis has dropped dramatically since the recognization of allergic fungal sinusitis.

Allergic fungal sinusitis, first described in 1981, has become the most commonly diagnosed form of fungal sinusitis. Pathologic findings are similar to those of patients with allergic bronchopulmonary aspergillosis (ABPA). Clinically, these patients are almost exclusively immunocompetent adolescents or young adults with common histories of recurrent bilateral sinusitis, nasal polyposis, and asthma. Absence of mucosal invasion is essential on pathological examination to exclude invasive fungal sinusitis. Again, members of the dematiaceous fungi groups and *Aspergillosis* are the common pathogens.

It is felt that the allergic fungal sinusitis is due to an immunologic reaction to fungal antigens in the nasal and sinus mucosa rather than being a true fungal infection in soft tissue. Diagnosis is based on an often asymptomatic overall exam except for their presenting complaint such as worsening nasal obstruction or postnasal drainage despite appropriate treatment. Five criteria have been suggested as important to the diagnosis of allergic fungal sinusitis, listed in Table 3.

Finally, a mycetoma or fungus ball is a noninvasive, chronic form of fungal sinusitis. It is often reported after a prior sinus surgery as a slight sensation of pressure and usually affects only a single sinus. The tightly packed hyphae and lack of eosinophils in the mucus differentiates this from allergic fungal sinusitis.

Treatment for fungal sinusitis is usually handled by otolaryngologists as surgical debridement is essential to clear disease and prevents advancement. Systemic oral antifungals seem largely ineffective against sinus based fungal organisms. Amphotericin B is an important component in the treatment of the invasive forms of mycotic sinusitis. Due to the fungistatic nature of the drug, treatment is long term, ranging from weeks to months, with high doses often required. Even with aggressive surgical and medical treatment, mortality rates due to the rare fulminant invasive sinusitis are still significant.

Allergic fungal sinusitis, however, is usually treated conservatively. Systemic steroids can mute the hypersensitivity reaction and have been used successfully. This is the most commonly used therapy at this time. Surgery can consist of ventilation of the involved sinuses only if necessary. Systemic antifungals are usually not advocated. New modalities including nebulized topical antifungal treatments may show promise in the future. Immunotherapy to fungal allergens potentially could provide some benefit. However, regardless of the treatment, the rate of delayed recurrence remains high.

In summary, fungal sinusitis is an uncommon and often overlooked diagnosis with varying symptoms and prognoses. If a chronic sinusitis patient seems especially difficult to treat and physical, hematological, or radiological examination raise the possibility of mycotic involvement, your answer just may be the unexpected.

Table 3.

Characteristics of Allergic Fungal Sinusitis

Type I (IgE mediated) Hypersensitivity	increased total serum IgE levels or positive specific IgE-modified RAST testing for multiple fungal antigens
Nasal Polyposis	
Characteristic Fungal CT Scan	
Eosinophilic mucus	
Positive Fungal Stain	

References

1. *Morpeth JF, Rupp NT, Dolen WK, et al. Fungal Sinusitis: an update. Ann Allergy, Asthma, & Immunology 1996;76:128-139.*
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3. *Blitzer A, Lawson W. Fungal infections of the nose and paranasal sinuses. Otolaryngol Clinics North America 1993;26:1007-31.*
4. *Zieske LA, Kopke RD, Hamill R. Dematiaceous fungal sinusitis. Otolaryngol Head Neck Surg 1991;105:567-76.*

Dr. Krzeminski is a board certified otolaryngologist. He has offices in Granbury, Glen Rose and Weatherford, Texas.

Injection Snoreplasty
A New Treatment for Snoring

by Gunnar West, D.O.

Injection Snoreplasty is a new, safe, and effective treatment for snoring. The procedure is done in the office with topical anesthesia. This procedure appears to be more effective than other more invasive techniques, with less morbidity and complications.

When asked, most people deny snoring; however, household members often give a different story. After all, the person who is snoring is usually the one asleep and keeping the others awake. Because of the annoyance and disruption of sleep, patients and their families often present for the treatment of snoring. We often joke about snoring, however, snoring may be a sign of severe obstructive sleep apnea with cardiac and other medical problems. Sleep apnea needs further evaluation with a physical exam and a diagnostic sleep study. After obstructive sleep apnea has been ruled out or treated, the snoring aspect can then be addressed. Snoring is a sign of sleep disordered breathing that can range from mild respiratory noise to loud obstructive process, which can be heard throughout the house. This can interfere with a restful night of sleep for the patient, spouse or other household members.

Snoring is caused by the vibration or flutter of the soft palate. The vibration is the result of a lax or redundant soft palate that obstructs the airway while asleep, especially in the supine position. A hypertrophic uvula can worsen the snoring; however, the main etiology of snoring is the palatal vibration. A deviated nasal septum and hypertrophic turbinates contribute to the obstruction. Hypertrophic tonsils and adenoids contribute to snoring, especially in children. Use of alcohol, sedatives, fatigue, dehydration, smoking and excess weight may also worsen snoring.

Treatment of snoring can range from lifestyle changes to extensive oral-pharyngeal surgery. Lifestyle changes include weight loss, regular exercise (both cardiac and weight lifting), avoidance of alcohol, sedatives and smoking. Dietary changes include healthy food eating habits, increase in fruits and vegetables, vitamins and intake of antioxidants. Treatment of allergies, use of nasal breathe strips, septoplasty and turbinate reduction lessen the nasal component of obstruction. Oral-pharyngeal surgery such as uvulopalatopharyngoplasty and laser-assisted uvulopalatoplasty may lessen snoring. However, these surgical procedures have a certain amount of morbidity and complications. Radiofrequency ablation of the soft palate may also be used.

Injection Snoreplasty was recently introduced by Eric C. Mair, M.D., and Scott E. Brietzke, M.D., from Walter Reed Army Medical Center. What I know about Injection Snoreplasty was obtained from a course taught by Dr. Brietzke, discussion with other ENTs and personal experience using this technique.

The injection technique is done in the office with the use of topical Benzocaine gel and Cetacaine spray as local. Two ml of 3% sodium tetradecyl sulfate is injected into the soft palate with a 27' gauge needle. The injection is into the submucousal layer at the junction at the base of the uvula and soft palate. As the sclerosis occurs a mucosal ulcer develops, which heals with the formation of scar tissue. This scar tissue results in a stiffening of the soft palate and reduces the palatal flutter, which lessens the snoring. Usually two injections are done about six weeks apart. Some patients have a moderate sore throat for several days, although several patients have reported very little pain. There has not been any reported complications, however, allergic reactions, infection, bleeding and ulceration with perforation are possible complications.

In the study presented by Brietze and Mair, all patients received benefit from the treatment. Twenty-five out of twenty-seven reported that "snoring is no longer a problem." Our results are similar with all patients receiving some benefit. Several patients and their spouses have said "the snoring has stopped" and "he sleeps a lot better at night."

The concept of palatal sclerotherapy was first reported in 1943 by Strauss. Since then, the study by Brietzke and Mair is the first reported using this technique for the treatment of palatal flutter. Sodium tetradecyl sulfate (sotradecyl) was used as the agent because of its record of safety and effectiveness. Sotradecol has been used for head and neck sclerotherapy for over 20 years. The long-term effects of Injection Snoreplasty are not yet known. There are additional studies being done, which I plan to follow closely.

Injection Snoreplasty is intended for the treatment of snoring, not sleep apnea. However, it may have a role in the treatment of sleep apnea in the future. We explain to our patients that we are attempting to treat their snoring and that C-PAP is recommended if they have sleep apnea. Although we are treating snoring, several patients have reported less apnea, less daytime fatigue, and a general overall better night sleep after injection.

We have added Injection Snoreplasty to our practice in an effort to provide a service to our patients who suffer from snoring. Having spent the last fifteen years treating snoring with both conservative and surgical means, Injection Snoreplasty is promising. We are looking forward to further developments in the treatment of sleep disordered breathing.

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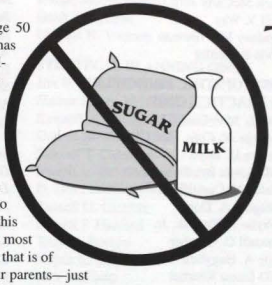
2. *Lee KJ. Essential Otolaryngology. 7th Edition. Sleep Apnea: 859-870.*

Dr. West has been in private practice in Dallas since 1989. He is certified in Otorhinolaryngology and Facial Plastic Surgery.

The Nutritional Approach to Ear Infections in Children

by Harlan O.L. Wright, D.O.



Since I went to osteopathic college 50 years ago, about the only thing that has changed in treating ear infections in children is the addition of tubing of the ears, which started to be done quite routinely several years ago. Otherwise, the treatment is basically the same. Give antibiotics for ten days and possibly use some ear drops to alleviate the pain. Recently it has become a fad to intubate the ears of children who have repeated ear infections. I feel that this is a very poor, but lucrative treatment in most cases. We are overlooking the treatment that is of the most benefit to the children and their parents—just another example of treating the disease but not the patient.

During the past year, the Centers for Disease Control have spent over $20 million dollars to try to educate doctors to the fact that we are using far too many antibiotics. In fact, there is a preponderance of information extant today which emphasizes the fact that most ear infections should not be treated with antibiotics. Antibiotic treatment is probably causing far more problems in these little children than it is curing.

Continued and repeated treatment with antibiotics is not only nonproductive in most cases, but is actually harmful and adds to the suppression of the child's immune system which, in turn, leads to more infections of all kinds, especially systemic candida infections. With repeated use of antibiotics, the normal acidophilus in the bowel is eliminated causing may other health problems—but that is another subject.

We must become more oriented to PREVENTING disease instead of waiting until it happens and then giving medications to combat the disease. Unfortunately, it is much more profitable to TREAT disease than it is to prevent it.

Holistic care (which includes nutrition) will, in my experience, not only get rid of an existing infection but will prevent it from happening again about 90 percent of the time. Let me show you how simple and effective the nutritional approach can be.

I have found over the years that most of the children who have repeated ear infections are allergic to cows' milk. Cows' milk must be stopped. It is simple to substitute Rice Milk. Most of these children are ingesting a lot of sugar foods—candy, cakes, cookies, ice cream, soft drinks, etc. Concentrations of sugar suppress the immune system while at the same time depleting the child's reserves of the vitamins and minerals that are needed to metabolize the sugar and keep them in good health.

My treatment of present ear infections in little children and the prevention of future ear infections is quite simple and very effective:

1. Stop all cows' milk, sugar foods and soft drinks and sugared drinks.
2. Give a dropper full of a good children's vitamin daily.
3. Give the child at least 500 mg. of Vitamin C daily (1000 mg. if the child is over one year of age).
4. Give one dropper full of Cod Liver Oil daily (for the Omega 3 Fatty Acid content).
5. Give 10 mg. of zinc to children under two years of age and 15 mg. if over two years. (Zinc is what I refer to in my book "Letters to my Patients," as the healing mineral). No healing can occur without an adequate amount of zinc.
6. Use Garlic Oil in the ears to ease the pain and help the infection.

It is amazing how quickly little children respond to this treatment. About 90 percent of the children get over their repeated ear infections and rarely have any recurrences as long as they are following the above program. It not only stops the ear infections, but many of the parents volunteer the information that the children are then rarely ill with anything. You may have lost a frequently ill little patient but you will have gained a very grateful and loyal family. So come on, let's do the right thing!

Harlan O.L. Wright, D.O., has been in practice in Lubbock for the past 50 years, and is still actively practicing nutritional and manipulative work. He has authored many articles for nutritional magazines over the years. Additionally, Dr. Wright has a weekly hour radio show called "Letters to My Patients,' during which he talks about alternative medical treatments for common problems and answers questions from the radio audience.

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Fall Date for HIPAA Extension Approaching

Members of TOMA are strongly encouraged to apply for the one-year deadline extension offered by the federal government to extend the compliance date for HIPAA Transaction Code Sets. Deadline extension applications must be filed by October 16, 2002 and will grant applicants one additional year (until October 16, 2003) to meet HIPAA compliance for Transaction Code Sets. Filing for this extension will allow osteopathic physicians to continue to electronically submit transactions in the old format until carriers are prepared to accept HIPAA standard transactions.

To apply for the extension, the Department of Health and Human Services has developed a draft/hypothetical model Transaction Code Sets compliance plan and it is available online. Log on to <www.cms.gov/hipaa/hipaa2/ASCAForm.asp> to file the form electronically. A paper form of the application is available for downloading and printing at this same web address. TOMA recommends that you file the form electronically because you will receive an online confirmation number, which will serve as acknowledgment of your extension. You will not receive a specific approval of your submitted compliance plan.

The AOA Division of Socioeconomic Affairs has created a practical how-to-manual that explains how a physician's office can implement a HIPAA Privacy Compliance Program for their office, ***which must be in place by April 14, 2003***. At this time, the manual covers only the HIPAA privacy regulations, but when the HIPAA security regulations are issued in final form, a security supplement will be issued. The manual is free to AOA members and can be accessed through the AOA web page at www.aoa-net.org . This manual contains a step-by-step plan to review the practice's current privacy procedures for patients' medical records and other patient health information. The plan will allow you to determine what additional procedures need to be implemented to be in compliance. Model forms for patient consent and authorization, forms to track releases of patient information, and a model business associate contract are also included in the manual. Most physicians' offices already know how to handle confidential patient health information. Complying with the HIPAA privacy regulations should not require tremendous changes. Major remodeling or restructuring of your office or practice should not be required.

Questions and Answers about HIPAA Privacy Compliance

On April 14, 2003, your practice must be in compliance with the medical privacy section of the Health Insurance Portability and Accountability Act (HIPAA). As that date draws closer, questions about what the sweeping requirements of the law will mean for medical practices are reflected in the many calls to the TOMA Office. Listed here are ten of the most recurring questions that we continue to hear about what the privacy rule will mean to physician practices. We have attempted to address these questions with the best information we have available at this time.

Question #1
Can patients waiting to be seen by a physician be identified by their names?

Answer
Yes, while some practices are assigning numbers to patients instead of identifying them by name, the rule does not preclude identifying patients by name. The rule states that medical practices can use "patient names to locate them in waiting areas." The rule prohibits the open discussion of patient information in areas where others can overhear.

Question #2
Will every hospital patient have to be seen in a private room?

Answer
While "covered entities" (physicians, hospitals and health plans) have to make every reasonable effort to protect the confidentiality of patient information, hospital rooms can, for the most part, remain as is. The rules point out that private rooms are not mandated.

Question #3
Can your office telephone patients to remind them about future appointments?

Answer
The consent forms that your office staff gives patients to sign on their first visit to your office should include a section allowing you to call about appointments, treatment information, or any other details related to the patient's care and treatment.

Question #4
Can my practice bill patients who revoke their consent?

Answer
While patients are allowed to revoke consent – in writing – the rule states that patients can't suddenly cancel their consent in order to escape payment for services that have been provided. While you don't have to treat a patient who revokes or refuses to sign your consent forms, you are allowed to take action to secure payment for treatment based on forms that were previously signed.

Question #5
Does the federal government intend to cancel all of the HIPAA rules because of the uproar they have caused?

continued on next page

Answer
While the Bush Administration has revised or deleted some of the more onerous regulations, HIPAA and the privacy protections that it brings, is not going away. Even though some aspects of the rules are being modified, their key objective has already been established, thus setting the privacy direction that physicians' practices need to follow. While some covered entities have been granted an extra year to comply if they file details of their compliance plan, HIPAA will become a reality for all medical practices. Don't look for a last minute reprieve.

Question #6
Can my practice purchase a service that makes my practice HIPAA-compliant and relieves me of the regulatory burden?

Answer
Unfortunately, meeting HIPAA requirements requires more than the purchase of a service that handles the transfer of information from your practice to outside groups. HIPAA demands good-faith efforts by you and your staff to protect the confidentiality of medical records. HIPAA also mandates training your staff so that they understand what the rules mean and how to follow them. This will include appointing a privacy officer who oversees daily privacy operations and ensures that the practice is making a reasonable effort to protect the privacy of your patients.

Question #7
Will patients be required to sign a new consent form every time they come to the office?

Answer
No, patients only have to sign a consent form once. Return visits, even for treatment for conditions unrelated to the initial visit, do not necessitate that patients sign additional consent forms. The only time a patient needs to sign another consent form would be if the consent has been revoked between treatments.

Question #8
Will HIPAA regulations prohibit me from selling my practice because the sale constitutes the unauthorized transfer of medical information?

Answer
While this might seem to be a genuine concern, the privacy rules make specific allowances for special situations that require disclosures of information. Medical information, according to the rules, can be transferred "pursuant to the sale of a covered entity's business as a going concern." This also covers acquisitions, mergers, consolidations, and other kinds of transactions in which covered entities take part. In addition, HIPAA allows for corporate restructuring of covered entities and the division of those entities. This applies to entities that are not presently covered, but will become so after a sale or transfer takes place.

Question #9
Does complying with HIPAA's privacy requirements only apply to staff members whose work involves computers?

Answer
No, the rules require that your privacy officer and compliance committee ensure that all staff members understand and comply with the law. Yes, many aspects of the privacy rule discusses how computers handle protected patient information, but the compliance committee must direct and review actions by all staff members to ensure that the law is being followed.

Question #10
Does HIPAA permit practices to share medical records to help with patient billing?

Answer
The new rules do not allow your practice to share health information with another practice for billing purposes. Your practice "may not disclose protected health information for payment activities of a second covered entity." These provisions are more complicated, so carefully review your billing activities and the applicable HIPAA regulations when your billing procedures involve records that both you and another practice have compiled.

INTRAFASCIAL ABDOMINAL HYSTERECTOMY
– REVISITED AND RE-EVALUATED –

by Jeff Hantes, D.O. and Kirkland Grant, M.D.

Objectives

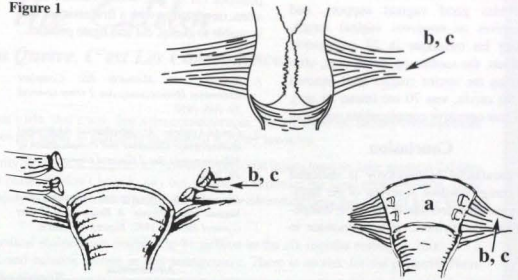
To revisit the benefits of an intrafascial hysterectomy, describe our modified technique, and evaluate the operative time in removing the cervix by this technique.

Material and Methods

Intrafascial abdominal hysterectomies have many advantages including preserving the complex anatomic relationships between the endopelvic fascia and vagina, decreasing morbidity, and possibly decreasing operative time, with our technique, as compared to the extrafascial hysterectomy. The intrafascial technique used in the study is similar to those described by Richardson (1929) and Aldridge and Meredith (1950) with some modifications. After ligating the uterine arteries, traction was placed on the fundus of the uterus and, using Jorgenson scissors, cut into and around the entire pericervical fascia in the same plane until the cervix was "shelled out" (no serial clamping, cutting, and ligating was done). The pericervical fascial and its connections between the vagina and endopelvic fascia remain intact (Figure 1). After the cervix was removed, the angles of the extrafascial layer and vaginal mucosa was closed with figure of eight sutures. The rest of the vaginal cuff was closed with a running suture through the cut edge of the squamous epithelium but not through the full thickness of the vagina. The fascial cuff was closed above the vaginal vault with a running suture (Figure 2).

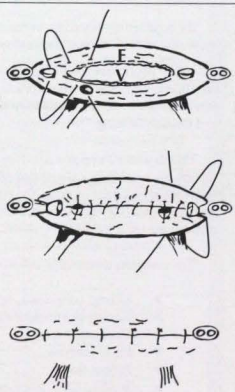
In the study, operative times were evaluated in 24 consecutive patients from April 2000 – October 2000 undergoing abdominal intrafascial hysterectomy for benign conditions. The operative time measured was after the uterine arteries were ligated until removal of the cervix (the main variable between the intrafascial and extrafascial technique).

Figure 1



Note with the intrafascial technique, the pericervical fascia (a) and its connections remain intact, and the cardinal ligaments (b) and the uterosacral ligaments (c) are not cut.

Figure 2



The angles of the fascia (F) and vaginal epithelium (V) are closed with a figure of eight suture.

Next, the vaginal squamous epithelium is closed.

This is followed by the fascial layer, which is closed separately.

Results

Few comparisons have been made of the extrafascial vs intrafascial abdominal hysterectomy. Hinojosa et al compared 150 hysterectomies performed by the extrafascial technique and 150 performed by the intrafascial technique. The overall morbidity rate was 38% for extrafascial and 32% for intrafascial. Bravo-Sandoval et al reported the results of 2816 hysterectomies performed by the intrafascial technique. The rates of injury to adjacent organs, vesicovaginal fistula, operative site infection, and fascial dehiscence were 1.2, 0.5, 7.4, and 0.5% respectively. Although the general incidence of ureteral injury with major gynecologic surgery has not changed in the past 50 years, Neuman et al have reported that the incidence of ureteral injury during abdominal hysterectomy has decreased from 0.7% in

1960 to 0.22% in 1989 when the ureter was dissected out and carefully visualized. In a series of 867 intrafascial abdominal hysterectomies, performed without routine dissection of the ureter, only one case of ureteral injury occurred (0.12%).

Other studies demonstrate that it provides good vaginal support, and preserves or improves vaginal length. Using his technique in 24 consecutive patients, the median operative time, after ligating the uterine arteries until removal of the cervix, was 70 sec (mean 88 sec). No post-operative complications occurred.

Conclusion

Intrafascial hysterectomy is indicated for benign diseases. A review of the literature reveals a decrease in operative complications. Furthermore, with an increase in focus on the prevention of pelvic organ prolapse, the intrafascial hysterectomy appears to be the logical preference. In our study, we demonstrated an extremely short operative time in removing the cervix. This may be of further benefit when operating on a uterus with a long cervix, an obliterated posterior cul de sac, severe bladder adhesions, or operating with a first assistant that is unable to clamp, cut and ligate pedicles.

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Acknowledgments

John Chapman, D.O., and Gary Meyer, D.O., for allowing me to perform the technique at Osteopathic Medical Center of Texas, Fort Worth.

Jeff Hantes, D.O., was a 4th year OB/GYN resident at Osteopathic Medical Center of Texas when he wrote this article. He has recently begun a one-year Minimally Invasive Surgery/Advanced Laparoscopy fellowship at Women's Hospital of Texas in Houston.

Kirkland Grant, M.D., is an OB/GYN physician at Mesquite Community Hospital, Mesquite, Texas.

Letter to the Editor

C'est La Vie, C'est La Querre, C'est Les Consequences

Dear Editor;

The French have a saying, "That's life, that's war, that's the consequences." In life there are usually consequences for every action; however, this does not apply to plaintiffs in medical liability lawsuits.

The plaintiffs have total impunity in medical malpractice lawsuits. Personal injury lawyers take medical liability cases on a contingency basis – the plaintiffs don't have to pay out-of-pocket expenses for legal representation. Only in those cases where a personal injury lawyer obtains a judgment from the defendant does the plaintiff have to pay the lawyer.

The average jury award for medical malpractice doubled to $1 million in the six months ending in 2000. It's a judicial lottery! There is no check-and-balance system in this arrangement. There is no risk for the plaintiff. There are no adverse consequences for the plaintiff.

The cost of obtaining legal representation for the defendant to get a medical liability suit dismissed is $10,000 to $12,000, even when the lawsuit has no merit and is groundless. There are adverse consequences for a defendant even if the defendant is acquitted of all charges, such as double and triple future medical liability insurance premiums.

It is time for the Court of Public Opinion to get involved in medical liability lawsuits because there are real health consequences for the general public when health care facilities close and physicians leave a community. When there is no longer availability of health care in the community, it is too late to act.

No matter how much tort reform occurs in Texas, it will still not result in adverse consequences for people who file frivolous medical liability lawsuits. How can a community protect itself from people who file these frivolous lawsuits so that there will be checks and balances within the legal system? Ostracize them!

Exclude from our society those individuals that exploit the legal system by filing non-meritorious claims for personal financial gain. This worked in the past, and it will work in the future. A hostile environment in which to live (work, shop, worship, play, etc.) usually results in re-location. Don't have any social or professional interaction with these individuals.

It is easier to replace plaintiffs in medical liability lawsuits than it is to replace health care facilities and physicians in our communities. This would be a community non-violent action in order to establish consequences for plaintiffs who file claims that have no merit.

Meritorious claims should be handled in a fair and equitable manner through the creation of special courts to try medical malpractice lawsuits. This medical liability lottery in Texas has to stop. It will take community action!

Joseph Montgomery-Davis, D.O.
Raymondville

Self's Tips & Tidings

By Don Self

LEAP Training

At the TOMA and the TxACOFP annual conventions within the past two months, we had the pleasure of introducing many Texas physicians to the LEAP and the benefits of what it's doing for headache, migraine, irritable bowel, fatigue and GERD patients. As a result, we've had almost 4 dozen Texas osteopathic physicians ask us to come to their office and get them set up. We're running behind as we now have more than 60 offices waiting for us to train them on the LEAP disease management program in Texas, Oklahoma and Kansas. Please be patient and also, you need to notify your office manager that we'll be calling to schedule a date to come to your office. We had one office manager refuse to set an appointment when we called and she called back later and expected me to still have that date open. I did not have it available then. She had to settle for an appointment two months later. If you're one of the 42 D.O.s who told me to come to your office and get you set up, please tell your office manager to expect our call. Also, in these calls to your office managers, I'm still hearing from them that YOU do not give them a copy of this article each month. That is your loss, as your billing personnel need to see it if you wish to benefit from it.

Allergic Rhinitis *Does* Have Different Codes

Be sure to use the proper ICD-9 code when dealing with Allergic Rhinitis. Many carriers have started delaying the claim while they ask for specific code information in this code group.

477.0 Code for allergic rhinitis due to pollen

477.1 Code for allergic rhinitis due to food allergies

477.8 Use as a catch all for allergic rhinitis cause by allergens other than pollen

477.9 Use this code for initial visits when you don't know the cause of the allergic reaction.

Medicare Won't Talk to Dead People

Unlike Kevin Costner or Haley Joel Osmet, Medicare refuses to talk to dead people. A practice in Alabama had the unpleasant task of telling a patient that Medicare had her listed as deceased. A mix-up had occurred at the social security office a short time before that, when the patient's mother had passed away. The patient, while sitting in the doctor's office, was put on the phone with the Medicare representative who refused to talk to her, stating that she "wasn't allowed to talk to her since she is dead." The office staff tried to explain to the rep the fact that the patient was alive, but it wasn't until the patient's husband explained to the rep that his wife was breathing that they believed it. The representative told them how to fix it at the social security office, and it all started again.

Get Patients Involved in Carrier Delay Process

When you get a denial from a managed or private carrier, you need to realize 2 things:

1. Why are you getting that denial? No, I don't mean the reason code they give you (medical necessity or lapse of coverage or paper clip on wrong corner or whatever), but the real reason behind the denial. It has been our experience that more than 50% of offices do not appeal denied claims and this results in the carrier saving money. Too often, the person tasked with appealing claims or following up on improperly paid claims is overworked, underpaid, undermotivated or they just don't care. Hey – it's not their money, or at least that is how they look at it (which is also called tunnel vision and about as stupid as approaching railroad tracks and refusing to look either way). So, the carrier saves money because they are betting you will not appeal it - and they are usually right.

2. Who chose that insurance plan for the patient? This is something you may initially be surprised at, but the answer is the patient or their responsible party. They chose where they would work and in making that choice, they considered the pay, vacation time, work hours, insurance benefits, retirement, etc. Now, that employee would not continue to work at that job if the employer came in and told them they would have to take a 75% reduction in pay, yet many continue to work even though they may change plans on them and drop coverage or raise deductibles. It's the patient's choice. So, Joe Blow goes along his merry way, never knowing that his plan is garbage UNLESS YOU (yes – I said the Y word!) make sure the patient gets a copy of every appeal, every letter and every fight you have with their carrier. You'll be surprised at how much it helps to have the patient involved with their plan.

HIPAA Myths

At the TxACOFP annual convention in Arlington in August, we had a very knowledgeable speaker, Pamela Biffle, teach a workshop on HIPAA (Health Insurance Portability and Accountability Act) and dispel some myths about HIPAA. She did an excellent job. No, you don't have to spend $50,000 on an attorney to come into your practice and write a HIPAA Compliance Plan, unless you just want to. Of course, I have some other suggestions of what you could do with that $50,000 and it doesn't include attorneys either!

Here are just a few points made in the workshop.

1. You don't have to replace all of your patient charts and remove their names from the outside of the charts or folders.

2. You don't have to throw away your patient sign-in sheet.

3. You don't have to go buy locking file folder and chart cabinets.

4. You don't have to make patients wear a paper bag over their head to your office.

5. You are not prohibited from calling your patients by name while in your reception area or any other area of your office.

6. You don't have to redesign your office to have a separate check-in and checkout window.

7. You don't have to put up sound barriers to separate the reception area from the reception desk.

8. You do need to make sure your computer screens are not positioned in such a way as to prevent patients from seeing the screens.

9. You do need to assign someone in your office to be the HIPAA Compliance Officer.

10. You do need to either have a completed Compliance Plan in place by **October 16, 2002** or have filed an extension request no later than **October 15, THIS YEAR**. This can be done on-line at <cms.hhs.gov/hipaa/hipaa2/ASCAForm.asp>.

11. You will either need to get a shredder for your office and start shredding everything (well, almost everything) or hire a disposal company and even then, it has to be done a certain way.

12. You must establish protocols as to what can and cannot be faxed or e-mailed.

13. Patients will have the right to review their own records and request amendments be made to their Protected Health Information.

14. You will have to RE-TRAIN your staff as to what they can and cannot say in the hallway, in the lab, in the office, etc., even to each other (while patients are in the building).

15. You will have to restrict where pharmaceutical reps have access to in your office.

16. You will have to have confidentiality agreements on file for just about anyone that has access to protected patient medical and business records, including your billing service, transcription service, janitorial service, etc.

17. You will comply. This is not something you can shrug off, as certain procedures and steps have to be taken or you will be fined in the tens of thousands of dollar range. This is no joke – you will have to take proactive steps to be in compliance.

This is only a partial list. If you want someone to talk to about this, feel free to call our office at 800-256-7045 or Pamela Biffle, CPC, at 817-485-2484. If you qualify for the extension (less than 25 employees and other qualifications), we recommend you immediately visit the web site in #10 and either submit it electronically or download the form. This is not something you want to procrastinate on or neglect.

Don Self, CSS, BFMA
305 Senter Avenue
Whitehouse, TX 75791
donself@donself.com
www.donself.com/doc
903-839-7045; Fax 903-839-7069

Did You Know?

Hospitals, HMOs and PPOs Now Required to Use Texas Department of Insurance Credentialing Forms

Form available at <www.tdi.state.tx.us/company/hmoqual/crform.html>

The physician credentialing form developed by the Texas Department of Insurance ("TDI") must be used by hospitals, HMOs, PPOs and preferred provider benefit plans for initial credentialing and recredentialing processes that begin on or after August 1, 2002. TDI's final adoption of the rules governing use of the form may be found on TDI's web site at <www.tdi.state.tx.us/commish/rules/credentialing2.html>.

The TDI form is mandatory only for credentialing of physicians, but may be used for other types of providers on a voluntary basis. Hospitals and other entities remain free to obtain information in addition to that required by the TDI form, which reportedly complies with standards issued by the National Committee for Quality Assurance (NCQA). Physicians can save the completed form electronically and update it as needed for recredentialing purposes.

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 June 15, 2002 Board meeting

Ade L. Adedokun, D.O.
1002 Montgomery Street #200
Fort Worth, TX 76107
Dr. Adedokum is a member of District 2. He graduated from Ohio University College of Osteopathic Medicine in 1994. He is an Assistant Professor, Department of Manipulative Medicine at UNTHSC, and is Certified in Physical Medicine and Rehabilitation.

Carla Jean Cole, D.O.
621 Clara Barton #104
Garland, TX 75042
Dr. Cole is a member of District 5. She graduated from the Texas College of Osteopathic Medicine in 1996, and specializes in Pediatrics.

Darrell D. English, D.O.
126 W. Main
Gun Barrell City, TX 75147
Dr. English is a first year member and a member of District 3. He graduated from University of Health Sciences College of Osteopathic Medicine, Kansas City, MO, in 1999, and specializes in Family Practice.

Paula R. Lewis, D.O.
73 Mill Pond Dr.
Frisco, TX 75034
Dr. Lewis is a member of District 5. She graduated from the Texas College of Osteopathic Medicine in 1984, and is Certified in Pain Management.

Melanie L. Marshall, D.O.
Amarillo Veterans Administration
Amarillo, TX 79109
Dr. Marshall is a member of District 1. She graduated from Philadelphia College of Osteopathic Medicine in 1988, and is Certified in Internal Medicine.

Alan L. Podawiltz, D.O.
John Peter Smith Hospital
Department of Psychiatry
1500 S. Main Street
Fort Worth, TX 76104
Dr. Poadwiltz is a member of District 2. He graduated from Oklahoma State University/College of Osteopathic Medicine in 1995, and specializes in Psychiatry.

John B. Share, Jr., D.O.
2929 Carlisle Street #260
Dallas, TX 75204
Dr. Share is a member of District 5. He graduated from the Texas College of Osteopathic Medicine in 1995, and is Certified in Family Practice.

H. Thomas A. Willard, D.O.
117 University Dr.
Fort Worth, TX 76107
Dr. Willard is a member of District 2. He graduated from the Texas College of Osteopathic Medicine in 1985, and is Certified in Family Practice.

Alan W. Young, D.O.
9119 Cinnamon Hill
San Antonio, TX 78240
Dr. Young is a member of District 17. He graduated from University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa in 1980, and specializes in Physical Medicine and Rehabilitation.

NEW INTERN/RESIDENT MEMBERS

Michael C. Ampelas, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Family Practice at John Peter Smith Hospital in Fort Worth.

Bruce Alan Barker, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving a Residency in Family Practice at Christus Spohn Memorial Hospital in Corpus Christi.

Kevin J. Blanton, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Family Medicine at John Peter Smith Hospital in Fort Worth.

Suparna Chakraborty, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Internal Medicine at Methodist Hospitals of Dallas.

Jacquelin D. Dewbre, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Pediatrics at the University of Texas Medical Branch in Galveston.

Mark A. Gamber, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving a Residency in Emergency Medicine at Scott & White Memorial Hospital in Temple.

Sonia R. Garadi, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Family Practice at Parkland Hospital in Dallas.

Hans K. Ghayee, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at Sinai Hospital in Baltimore, Maryland.

Leslie C. Hardick, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Obstetrics and Gynecology at Osteopathic Medical Center of Texas in Fort Worth.

Matthew C. Johnson, D.O. graduated from University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri, in 1997, and is serving a Fellowship in Spine Surgery at Tulsa Regional Medical Center.

Arash Keyhani, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in General Surgery at University of Texas-Houston Health Science Center.

Patti R. King, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Family Practice at Bay Area Medical Center in Corpus Christi.

Elaine K. Miller, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at Plaza Medical Center in Fort Worth.

Nancy Naghavi, D.O. graduated from University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri, in 1999, and is serving a Residency in Family Medicine at University of Texas Medical Branch in Galveston.

Manish P. Patel, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at Hillcrest Medical Center in Waco.

Anthony T. Pham, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at Plaza Medical Center in Fort Worth.

Lori G. Plesa, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Family Medicine at Methodist Medical Center in Dallas.

Minh T. Quach, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Emergency Medicine at Botsford General Hospital in Farmington Hills, Michigan.

Bibas Reddy, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Internal Medicine at Ochsner Clinic Foundation in New Orleans, Louisiana.

David P. Russo, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at John Peter Smith Hospital in Fort Worth. In 2003 he will begin a Residency in Physical Medicine and Rehabilitation at the Mayo Clinic in Rochester, Minnesota.

Justin J. Stewart, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Internal Medicine at Brooke Army Medical Center, Fort Sam Houston, San Antonio.

Eden Temko, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship at the National Naval Medical Center in Bethesda, Maryland.

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

Nguyen X. Tran, D.O. graduated from the Texas College of Osteopathic Medicine in 2002, and is serving an Internship followed by a Residency in Family Medicine at Plaza Medical Center in Fort Worth.

NEW ASSOCIATE MEMBER

Betty B. Ritchie, P.A.
9955 Dyer
El Paso, TX 79924
Ms. Ritchie is an Associate Member who works in the office of Hector Lopez, D.O.

FREE Brochures on Osteoporosis

Osteoporosis impacts the health of thousands of American women. Its prevention is an important goal for women and their health care providers. A woman plays a significant role in successful prevention through her daily decisions about nutrition and physical activity. Education is the key to her success.

The Texas Department of Health (TDH) has developed free materials on Osteoporosis to help educate women. The brochures are available in a generic format as well as customized materials for African American, Asian, Caucasian and Hispanic (English/Spanish) women. You may order quantities at no charge for use within your practice by contacting the Texas Department of Health at 800-422-2956 or TOMA at 800-444-8662. Also, the materials can be viewed on the TDH website at <www.tdh.state.tx.us/osp/osteo/>.

In Memoriam

Herbert L. Chambers, D.O.

Dr. Herbert L. Chambers of Dallas passed away on March 25, 2002. He was 73.

Dr. Chambers earned his D.O. degree at the University of Osteopathic Medicine and Surgery in Des Moines in 1959. In 1960 he opened the Chambers Medical & Surgical Clinic in Oak Cliff. He was in active practice as a family practitioner at the time of his death.

He was an associate clinical professor at the University of North Texas Health Science Center. Dr. Chambers was a member of the American College of Osteopathic Family Physicians and a fellow of the American Academy of Family Physicians.

Survivors include his wife, Dorothy Chambers of Dallas; two daughters, Anita Wright of Dallas and Dr. Carla Hardy of San Diego; sister, Willie Pearl Britt of Dallas; brother, Dr. Miller E. Chambers, Sr., of Compton, California; and six grandchildren.

AOA State Associations Organize Emergency Response

by Jacquie Goetz, Staff Writer

AOA to Oversee Development

Responding to a resolution passed by the AOA House of Delegates in July 2000, the AOA is helping state osteopathic medical associations organize emergency response systems. These systems will allow states to quickly contact and dispatch appropriately trained osteopathic physicians to disaster sites.

Submitted by the Osteopathic Physicians and Surgeons of Oregon (OPSO), the 2000 resolution calls for the AOA to oversee the development of emergency response systems that would be activated after natural disasters and terrorist attacks.

"The idea for this resolution arose after the Oklahoma City bombing," says OPSO President Robin L. Richardson, D.O. "Several Oregon physicians were in Oklahoma City when the bombing occurred, and they offered their medical services at local hospitals. But those D.O.s could not help out right away because the hospitals had to verify their credentials."

"Verifying the credentials of physicians during emergencies can be difficult and time-consuming. Having emergency response systems in place will facilitate that process."

Creating State Databases

The AOA asked the members of the Association of Osteopathic State Executive Directors (AOSED) to help develop the systems.

"Because emergencies are best managed at the local level, it made sense for AOSED to be involved in developing the system," notes Kristen Sokolowski, the director of the AOA Division of State and Specialty Relations.

The AOA created an ad hoc committee for the emergency response systems and appointed Lynette C. McLain as its chairman. Other members of the committee are Jeff Heatherington, OPSO's executive director; Stephen R. Winn, the executive director of the Florida Osteopathic Medical Association; and Valerie Smith, the former executive director of the Alabama Osteopathic Medical Association.

"The goal is for each state association to develop a database that state emergency response offices and the AOA can access quickly in times of emergency," explains McLain, the executive director of the Oklahoma Osteopathic Association.

"The goal is for each state association to develop a database that state emergency response offices and the AOA can access quickly in times of emergency..."

Physicians Needed

"We are passionate about building these emergency response systems," McLain notes. "We hope to compile a list of D.O.s who are willing to put their training to use in desperate times."

To participate in the emergency response systems, D.O.s and osteopathic medical students are asked to fill out a background information form (on page 25).

D.O.s and students can mail or fax the completed forms to their state osteopathic medical associations or their osteopathic specialty colleges. Each association will use the information to create a database of osteopathic physicians and osteopathic medical students willing to volunteer in emergencies.

For additional information on the emergency response systems, D.O.s and students can call 800-631-1773, Ext. 8188, or 312-202-8188; send e-mail to ksokolowski@aoa-net.org; or FAX inquiries to 312-202-8488. They can also write to Kristen Sokolowski, director, Division of State and Specialty Relations, American Osteopathic Association, 142 E. Ontario St., Chicago, IL 60611-2864.

Planning Ahead

Building the emergency response systems is among the steps the AOA has taken to address the threat of terrorist attacks. In December 2001, the AOA and the American Association of Colleges of Osteopathic Medicine (AACOM) created the AOA-AACOM Task Force on Bioterrorism.

The mission of the task force is to educate osteopathic physicians and osteopathic medical students to recognize and respond to biological agents that may be used in terrorist attacks. In addition, the task force plans to assist osteopathic physicians in responding to questions regarding bioterrorism from their patients and the rest of the public.

The task force is compiling two lists with contact information for state and territorial public health laboratories and state health departments.

Readers who would like more information can read the article titled "AOA, AACOM Join Forces to Prepare for Bioterrorist Attacks" in the April issue of *The DO*. The full text of this article is available on the AOA's web site at <www.aoa-net.org>. The article can be accessed by clicking on the "Publications" link on the AOA's home page or by going to <www.aoa-net.org/Publications/DO/domagazine.htm>.

(Reprinted with permission from the American Osteopathic Association, The D.O., volume 43, number 5, May 2002.)

American Osteopathic Association
Osteopathic Emergency Response System

By filling out this form, D.O.s and osteopathic medical students can join the emergency response systems that their state osteopathic medical associations and osteopathic specialty colleges are establishing. After completing the form, D.O.s and students should mail or FAX it to their state associations or specialty colleges.

Personal Information

Name:_____ AOA number:_____

Street address:_____

City and State:_____ ZIP code:_____

Telephone number: (____) _____ FAX number: (____) _____

E-mail address:_____

Name of emergency contact:_____

Emergency contact's telephone: (____) _____

State Medical License Numbers

License number:_____ State:_____

License number:_____ State:_____

License number:_____ State:_____

Specialty Information

Specialty:_____ Board certifications:_____

Specialty skills related to emergency situations, such as forensic pathology experience with crime teams and experience with canine search units:

Osteopathic Medical College

College:_____ Graduation date:_____

Response Time

___ Able to response immediately
___ Able to respond in 24 hours
___ Able to respond in 48 hours

Comments:

Projected Length of Service

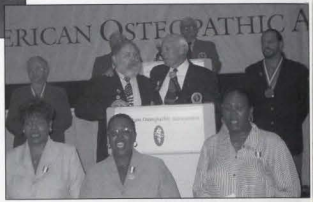
___ One to three days
___ Three days to one week
___ One to two weeks

Comments:

I hereby confirm that the information I provided above is accurate and contains no false statements concerning my personal and professional standing.

Signature_____ Date_____

AOA House of Delegates Meeting
July 19 – 21 • Chicago



TxACOFP 45th Annual Clinical Seminar
August 1 – 4 • Arlington

Health Officials Focusing on Infants as Whooping Cough Surge Continues

The Texas Department of Health (TDH) and local health departments are focusing on protecting infants as they continue to battle a surge in the number of whooping cough cases around the state.

"Parents should keep infants away from people who have coughs or cold-like symptoms and should make sure infants and other young children are vaccinated against whooping cough," said Sharilyn Stanley, M.D., TDH associate commissioner for disease control and prevention.

Some 378 cases of whooping cough, including four infant deaths, have been recorded in 41 Texas counties so far this year. About 30 percent of all the cases have been in children under a year old. Stanley said any infant with a cough or difficulty breathing should be seen by a physician.

Of the state's 378 cases of whooping cough, 86 have been in Burnet County, 54 in Travis County; 41 in Dallas County; 33 in Bexar County; 21 in Tarrant County, 18 in Williamson County, 15 in Hidalgo County, 14 in Cameron County and 13 in Harris County.

In lightly populated Burnet County, with 86 cases in a population of only 40,000, health officials have been battling a continuing outbreak of whooping cough that began in May. The Central Texas county includes Marble Falls and Burnet. No cases were reported in the county last year.

Stanley said the end of the summer vacation period and mid-August start of Texas school sessions could accelerate the spread of the illness. She said older children, teen-agers and adults usually have milder cases of whooping cough but that it's more likely to cause pneumonia, seizures, brain damage and death in infants. The elderly and persons with weakened immune systems also are more likely to have severe complications.

Complete vaccination against pertussis includes a series of four primary doses and a fifth booster dose of DTaP, a combination vaccine that also protects against diphtheria and tetanus. The first dose should be given at 6 weeks to 2 months of age, with subsequent doses at 4 months, 6 months and 15-18 months, and the booster dose at 4 years. Protection increases after each dose. The vaccine is not authorized for people 7 and older.

She said TDH is advising physicians to consider giving antibiotics immediately to patients with whooping cough symptoms and to their family members, instead of waiting for results of lab tests to confirm the illness.

Noting that the vaccine's effectiveness may diminish after a few years, she added that physicians should not rule out whooping cough as a possible diagnosis simply because the patient has been vaccinated.

Whooping cough has three stages. The first is marked by a runny nose, sneezing, low-grade fever and a mild cough and usually lasts for one to two weeks.

The second stage, typically lasting from one to six weeks, includes prolonged spasms of rapid coughs usually accompanied by high-pitched whoops as the person gasps for air. Vomiting often follows the coughing fits. Sometimes apnea, a failure to breathe, occurs. People usually feel fine between coughing bouts.

In the third stage the coughing spells occur less frequently as the patient recovers over a two- to three-week span, but coughing spasms can recur for several months.

"One of the biggest problems in controlling the spread of whooping cough is that it's often not suspected or diagnosed in the first stage when the symptoms are so similar to those of colds and allergies," Stanley said. "It's usually not until the second stage, with the trademark coughing spells and whooping, that diagnosis and treatment occur. But someone with whooping cough can infect others throughout their illness," she said.

The incubation period, or time from exposure to the appearance of symptoms, is typically seven to 10 days but can range from four to 21 days and longer. However, people who have had whooping cough are not likely to have it again.

Last year some 615 cases of whooping cough were reported in 70 Texas counties, the highest number of cases since 1968 when 802 cases were reported.

"Despite advances in early detection and effective treatment, cancer remains one of the most feared diseases, not only because of its association with death but also with diminished quality of life."

Panel Calls for Greater Attention to Cancer Patients' Pain, Depression and Fatigue

Health care professionals, caregivers, and patients all have an important role in symptom management throughout the course of cancer. Evidence suggests that pain is often under treated, despite the availability of effective interventions. Cancer-related depression and fatigue are less clearly defined, but are extremely common and have a profound impact on patients' well-being. In the research community, more resources need to be devoted to studying the occurrence, causes, and impediments to effective treatments of these symptoms.

These findings emerged from an NIH State-of-the-Science conference on Symptom Management in Cancer: Pain, Depression and Fatigue that began Monday, July 15 at the NIH campus in Bethesda, Maryland. The conference brought together national experts to address key questions regarding the occurrence, assessment, and treatment of these symptoms, barriers to their effective treatment, and directions for future research in the area.

"Currently, cancer-related pain, depression, and fatigue are under treated and this situation is simply unacceptable -- there are effective strategies to manage these symptoms and all patients should have optimal symptom control," said panel chair Dr. Donald Patrick, Professor and Director of the Social and Behavioral Research Program in Public Health at the University of Washington in Seattle.

Despite advances in early detection and effective treatment, cancer remains one of the most feared diseases, not only because of its association with death but with diminished quality of life. While research is producing new insights into the causes and cures of cancer, efforts to manage the symptoms of the disease and its treatments have not kept pace. There are nearly 9 million people in the U.S. with a history of cancer. An estimated 1.3 million will be diagnosed with cancer this year and of those, 60% will be alive in 5 years. Addressing the total quality of life of cancer patients, including the effective management of symptoms is an increasingly critical aspect of efforts to reduce the burden of cancer.

The panel members found that the available evidence supports a variety of interventions for treating cancer patients' pain, depression, and fatigue. The panel noted, however, numerous factors that can interfere with adequate symptom management. Among them are: incomplete effectiveness of some treatments; a lack of sufficient knowledge regarding effective treatment strategies; patient reluctance to report symptoms to caregivers; a belief that such symptoms are simply a part of the cancer experience that must be tolerated; and inadequate coverage and reimbursement for some treatments. The panel pointed out the additional difficulty presented by the interactions among these three symptoms for example, a successful treatment for depression might also alleviate fatigue, but conversely, adequate pain management may exacerbate fatigue.

The panel's statement concluded that: clinicians should use brief assessment tools routinely to ask patients about pain, depression, and fatigue and to initiate evidence-based treatments; current evidence to support the concept of cancer symptom clusters is insufficient, and additional theoretically driven research is warranted; research is needed on the definition, occurrence, treatment of pain, depression, and fatigue alone and together in adequately funded prospective studies; all patients with cancer should have optimal symptom control from diagnosis throughout the course of illness, irrespective of personal and cultural characteristics.

Among the evidence considered by the state-of-the-science panel was an evidence report prepared by the New England Medical Center Evidence-based Practice Center (EPC) under contract to the Agency for Healthcare Research and Quality (AHRQ). EPC evidence reports are comprehensive, systematic reviews and analyses of published scientific evidence. A summary of the Evidence Report on Management of Cancer Symptoms: Pain, Depression, and Fatigue is available at <www.ahrq.gov/clinic/epcix.htm>. Copies are also available from the AHRQ Publications Clearinghouse, by calling 800-358-9295. The full report will be available on-line shortly thereafter. In addition, the National Library of Medicine prepared an extensive bibliography on this topic, available at <consensus.nih.gov>.

The full text of the panel's statement is available in draft form at http://consensus.nih.gov. Statements from past conferences are available at the same web site, or by calling 888-NIH-CONSENSUS (888-644-2667).

Opportunities Unlimited

PHYSICIANS WANTED

DALLAS SUBURB – Primary care group seeks BC/BE FP or IM physician on a full or PT basis. Inpatient services for six provider Group plus some office practice. Enjoy lake and country living with immediate access to Dallas. Call 972-733-1758 or Fax CV to 972-250-1413. (04)

POSITIONS FOR EXTENDED FAMILY CLINIC, part-time or locum tenens. 30 minutes from Fort Worth, Texas Metroplex area (Burleson, Texas). References, please, and must carry own insurance. Contact Annette Nelon at 817-269-4726 or 817-447-1208 or FAX 817-447-1106. (05)

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

DALLAS/FORT WORTH – Physician opportunity to work in low stress, office based practice. Regular office hours. Lucrative salary plus benefits. No call and no emergencies. Please call Lisa Gross at 1-888-525-4642 or 972-255-5533 or FAX CV to 214-441-2813. (25)

POSITIONS WANTED

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

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

PRACTICE FOR SALE/RENT

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

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Call Trisha at the TOMA Office • 512-708-8662 or 800-444-8662

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