TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association
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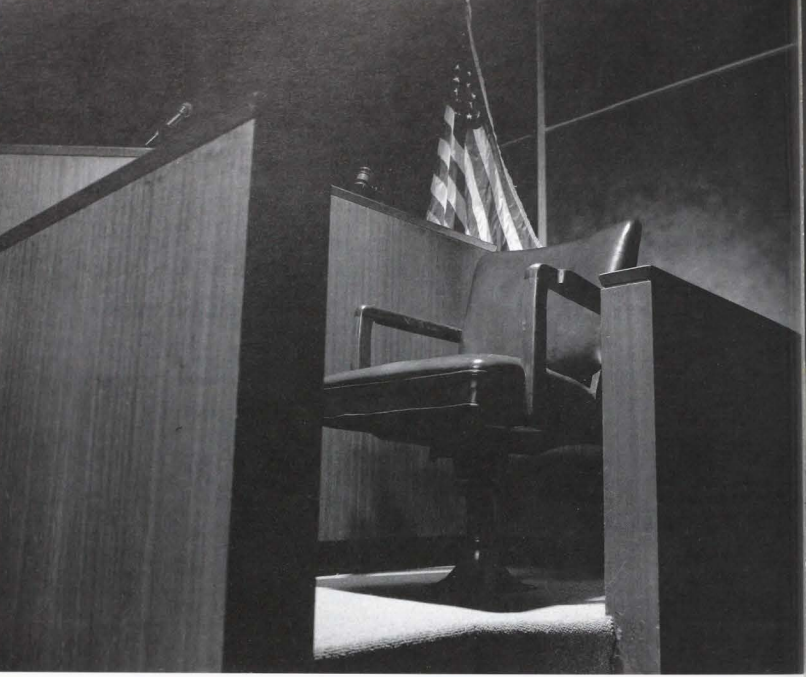
National Breast Cancer Awareness Month



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OCTOBER 1999

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CALENDAR OF EVENTS

OCTOBER

24-28

"AOA Annual Convention"
Sponsored by the American Osteopathic Association
Location: San Francisco, CA
Contact: AOA, 800-621-1773

NOVEMBER

3-7

"Fall CME Conference & Scientific Exhibition"
Sponsored by the Georgia Osteopathic Medical Association
Location: Atlanta Marriott Gwinnett Place, Atlanta, GA
Contact: GOMA, Holly Barnwell, Executive Director
2160 Idlewood Rd., Tucker, GA 30084
770-493-9278
E-mail: GOMA@mindspring.com

DECEMBER

1-3

"Texas' Seventh Minority Health Conference: Reflectling on the Past and Shaping the Future of Minority Health"
Sponsored by the Texas Department of Health
Location: Omni Hotel Galleria, Houston, TX
Contact: Eva Holguin at 512-458-7629

DECEMBER

4

"Family Medicine Update"
Sponsored by the Washington Osteopathic Medical Association
Location: Seattle, WA
CME: 8 hours 1-A
Contact: Washington Osteopathic Medical Association
P.O. Box 16486, Seattle, WA 98116
206-937-5358; FAX 206-933-6529

2000

JANUARY

28-30

"TOMA's 44th MidWinter Conference & Legislative Symposium"
Sponsored by the Texas Osteopathic Medical Association
Location: Renaissance North Dallas Hotel
Dallas, Texas
CME: Approx. 17 hours category 1-A CME credits
Contact: Texas Osteopathic Medical Association
512-708-8662 or 800-444-8662

23-27

"Osteopathic Medicine: A Universal Approach"
Sponsored by the Osteopathic Physicians & Surgeons of California
Location: Sheraton Universal Hotel, Universal City, CA
CME: 40 hours category 1-A CME credits
Contact: 916-561-0224; FAX 916-561-0728

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National Breast Cancer Awareness Month

When breast cancer is detected early and treated promptly, morbidity and mortality can be significantly reduced. Mammography is the single most effective method to detect breast changes that may be cancer. Unfortunately, many women face barriers when it comes to utilizing this medical service. Such obstacles include a lack of information or misinformation about the procedure; little or no health insurance; and transportation problems, especially for those in rural areas. Yet another issue is the fear of discovering breast cancer.

For over 10 years, health care institutions, organizations, associations and individuals have joined forces every October during National Breast Cancer Awareness Month (NBCAM) to help women overcome these barriers.

The Mission and History of NBCAM

The Board of Sponsors of the NBCAM program is dedicated to increasing awareness of the importance of the early detection of breast cancer through a nationwide educational campaign. (See related listing of NBCAM Board of Sponsors.)

The NBCAM mission statement is as follows:

The Board of Sponsors of National Breast Cancer Awareness Month is dedicated to increasing awareness of the importance of early detection of breast cancer. This message is communicated through a nationwide educational campaign to audiences including women in all age and ethnic groups, the general public, state and federal governments, health care professionals, and employers.

In October of 1985, the first NBCAM program took place through the efforts of the two founding members of the NBCAM Board of Sponsors, who distributed information and testified before a U.S. congressional committee about the need for widespread access to mammography. Public interest was further stirred through the assistance of Former First Lady Betty Ford and her daughter, Susan Ford Bales, who made national public service announcements. Ms. Bales has served as National Spokesperson for NBCAM since 1985.

In 1992, President Bill Clinton signed official legislation proclaiming October 19 to be National Mammography Day. Currently, National Mammography Day is celebrated the third Friday in October each year as part of the National Breast Cancer Awareness Month program.

Today, the combined involvement of over 17 national public service organizations, professional association and government agencies ensures that the NBCAM program and message reaches millions of people across the country.

National Mammography Day – Friday, October 15

The adage, "an ounce of prevention is worth a pound of cure" is the reasoning behind National Mammography Day, a day when women across the country will be reminded of the importance of finding a breast cancer before it can be felt.

To encourage this life-saving practice, thousands of accredited radiologists nationwide will be offering reduced fees on screening mammograms during October.

National Mammography Day is spearheaded by AstraZeneca, Inc., a founder and co-sponsor of NBCAM and one of the first U. S. firms to establish a worksite mammography facility. Female employees at AstraZeneca get free mammograms on company time

Breast Cancer **is the leading cancer diagnosed in women in America. This year alone, it is estimated that 175,000 women will be diagnosed with the disease, and that over 43,000 will die from it. In Texas, those figures are 11,300 and 2,800 respectively.**

Epidemiological studies estimate that breast cancer will be diagnosed in 1.5 million American women in this decade and will claim nearly half a million lives.

and premises as part of a comprehensive breast cancer screening and education program offered by the company. AstraZeneca has been largely responsible for rallying the radiology community to support National Mammography Day.

Across the country, National Mammography Day will be marked by town hall rallies, health fairs, mobile mammography vans visiting underserved communities and a groundswell of local and national publicity.

To locate an accredited radiologist participating in National Mammography Day or to ask questions about mammography, women may call any one of five toll-free numbers. The numbers are:

American Cancer Society
1-800-ACS-2345

National Cancer Institute
1-800-4-CANCER

National Alliance of Breast Cancer Organizations
1-800-719-9154

Susan G. Komen Breast Cancer Foundation
1-800-I'M AWARE

Y-ME National Breast Cancer Organization
1-800-221-2141

Y-ME Spanish Language Hotline
1-800-986-9505

Screening Recommendations – The National Cancer Institute, the American Cancer Society and many other cancer organizations recommend that screening should begin at age 40 and be repeated routinely. As risk factors vary, however, the exact frequency of screening should be determined by each woman and her physician.

Mammography Reliability – In 1992, Congress passed the Mammography Quality Standards Act (MQSA) to ensure that mammography performed at more than 10,000 facilities throughout the U.S. is of high quality and reliable. In order to lawfully perform mammography, each facility must prominently display a certificate issued by the U.S. Food and Drug Administration, which indicates that the facility meets quality standards. In 1998, President Clinton signed the reauthorization of the MQSA which included a provision to directly notify women of their mammogram results in easy-to-understand language, a top priority of the American Cancer Society.

Paying for Mammograms – Other than health insurance plans, which are required by most states to pay for mammograms, Medicare covers the cost of annual screening for women age 65 and over. In addition, as mandated by the Balanced Budget Act of 1997, women ages 40-64 will be covered by Medicare for mammograms if they qualify for coverage as specified by the Social Security Administration

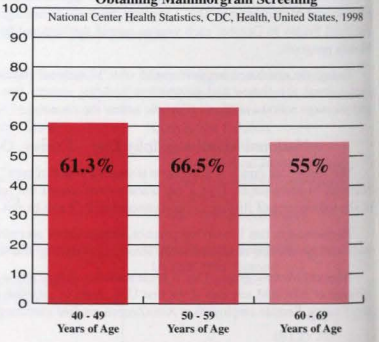
During National Breast Cancer Awareness Month, many mammography facilities may offer a lower fee for services or may be willing to establish a payment schedule. In addition, the YWCA's Encore Plus program provides low-cost or free services throughout the country.

All states and territories of the United States have programs that cover the cost of mammograms if insurance does not. Contact the American Cancer Society at 1-800-ACS-2345 to find the locations of those services in your community.

Through the National Breast Cancer and Cervical Cancer Early Detection Program (NBCCEDP), the Centers for Disease Control and Prevention (CCD) provide financial and technical assistance to health departments and collaborates with several national organizations that have breast cancer initiatives. The NBCCEDP was established in 1990, when Congress authorized the CDC to create a national program to ensure that women receive breast and cervical cancer screening, regardless of ability to pay.

The Known Risk Factors for Breast Cancer

- **Age** – The risk of breast cancer increases as a woman gets older. About 85 percent of breast cancers occur in women aged 50 and older. The risk is especially high for woman older than age 60. Breast cancer is uncommon in women younger than 35.
- **Family History** – The risk of getting breast cancer increases for a woman whose mother, sister, daughter, or two or more close relatives, such as cousins, have had the disease.
- **Personal History** – Women who have had breast cancer may develop it again. Women with a history of breast disease (not cancer but a condition that may predispose them to cancer), and women having so much dense breast tissue on a previous mammogram that a clear reading is difficult are also at increased risk. Laboratory evidence that a woman is carrying a specific genetic mutation or change will also increase her susceptibility to breast cancer.
- **Other Risk Factors** – Other risk factors include having a first child after age 30 or never having children. Currently, research is investigating the roles of obesity, hormone replacement therapy, diet and alcohol use.



Breast Cancer Today

By William M. Jordan, D.O., F.A.C.O.I.

Over the last decade we have finally seen positive downward trends in cancer death rates. That "good news" is likely the result of many different factors ranging from the esoteric to the very practical. Clearly, there has been a heightened public awareness of concepts of prevention and early detection, and information has never been more accessible. Improved skills, technology and advancements in pharmaceuticals and molecular biology have significantly added to our ability to manage oncology problems at all levels. All of these factors are products of better understanding of the fundamental nature of cancer and certainly breast cancer is at the forefront of that understanding. All of these factors notwithstanding, it remains the job of the clinician to maximize the effectiveness of breast cancer management. In fact, major advancements have little meaning if not properly put into play.

There will be about 180,000 new breast cancer cases in the U.S. this year and about 25% of those will die from the disease. Long term survival or cure is likely in 90% of Stage I patients but that number decreases to 10% with Stage IV disease, emphasizing the profound importance of screening and early detection. Several factors have been identified as increasing a woman's risk of developing breast cancer and can be quantified with new risk assessment software tools which are of a simple nature. Those risk factors include:

- Family history of breast cancer in first-degree relatives, especially if that relative was pre-menopausal at the time of diagnosis.
- Personal history of breast cancer significantly increases the chance of a second primary breast cancer.
- Early menarche (<12 years old) and late menopause (>55 years old) increase risk.
- Prior exposure to radiation increases risk.
- Prior diagnosis of proliferative breast disease such as sclerosing adenosis, atypical or lobular hyperplasia,

moderate or florid ductal hyperplasia and lobular carcinoma in situ all increase risk of invasive breast cancer.

- Long term exogenous estrogen use in pre-menopausal women possibly increases risk. In post-menopausal women the effect is unclear.
- Obesity may increase risk.
- Alcohol intake (moderate) may increase risk.
- High fat diet may increase risk.
- Genetic factors including the presence of genes BRCA1 and BRCA 2 and TP53 gene mutations are identified increased risk factors.

Detection is the result of a partnership among the patient, her physician and technology. Unfortunately, physical findings are not always evident. Breast pain, skin changes, nipple retraction or discharge is seen in less than 5% of breast cancer cases. Less than 25% of breast cancer cases are found by palpation and less than 5% of women continue with an ongoing self-examination program. Clearly, mammography is the most useful tool in breast cancer detection. While screening recommendations remain somewhat controversial, a practical approach is an annual screening mammogram for average risk patients starting at the age of 40. High-risk patients should start annual mammography ten years earlier than the age that the first-degree relative was diagnosed with breast cancer with clinical breast exam by the physician every six months.

All masses should be evaluated. A cystic mass should be aspirated and should be biopsied if the fluid is bloody, if it does not completely resolve after the aspiration, if it reoccurs after three or more aspirations or if the mammography or cytology has any suggestion of possible malignant characteristics. All solid masses should be evaluated. Fine needle aspiration (FNA) is simple, safe and reliable. In experienced hands, false positives are seen in less than 1% of FNA cases and false negatives in less than 10%. If any doubt exists, a core or excisional biopsy should be performed. Observation of a solid breast mass should only be considered after careful examinations and deliberation with the patient.

The staging of breast cancer is evolutionary. While the "TNM" staging system of breast cancer has not undergone major changes recently, the factors that result in the treatment strategies frequently go well beyond the TNM system. Examples of those factors, which have unfavorable prognostic significance, include a young age, pre-menopausal, negative estrogen and progesterone receptors, high S-phase fraction, aneuploid cytogenetics, positive TP53 mutations, positive HER-2-neu and positive epidermal growth factor. Other factors are under study and will likely add to better prognostic predictability.

The concepts of treatment options for breast cancer go well beyond the scope of this discussion. The prognostic factors, TNM staging and multiple other variables are put together to provide "the context" by which complex treatment decisions are made. During the last few years, new approaches and new pharmaceuticals have been developed. Breast cancer treatment has been "fine-tuned" for every individual patient. Using selective surgical techniques and combining the best of neoadjuvant, adjuvant and "overt" therapeutic chemo, radiation and hormonal therapies, patients are receiving maximum multi-

disciplinary approaches while minimizing toxicity.

The primary care physician is in the position to make a significant impact in breast cancer management. In fact, the family physician is on the front line of the breast cancer war and through ongoing patient education and evaluation, he or she intervenes where it counts the most—early in the disease.

The medical oncologist should have all current information at hand and should be an active participant in clinical investigational trials where new "cutting edge" approaches are being studied. He or she must be prepared to "direct" the treatment plan and follow-up for the patient. The medical oncologist frequently acts as the "primary care cancer doctor."

The surgeon should be well skilled at both diagnostic and therapeutic surgical approaches and provide clear counseling regarding surgical options.

The radiation oncologist must be well versed in the very latest radiotherapeutic techniques and be able to work within the framework of the entire treatment plan.

The mammographer must be experience, aggressively suspicious and communicative.

Clearly, breast cancer management, from prevention to palliation, is a team effort. While significant prognosis has been made in the technology of breast cancer management, it remains the clinician who must make it work. The next decade will reveal new and revolutionary approaches to breast cancer management. We will see genetic intervention for identification of high-risk patients as well as prevention and treatment. There will be new highly specific chemotherapeutic drugs and drugs that better control treatment toxicity. Technologies that have high specificity for detection and diagnosis are nearing practical reality and will eliminate a high percentage of biopsies and unnecessary surgeries.

As a champion of primary care philosophy and preventive medicine, osteopathic physicians are in a unique position to lead the way to eliminate breast cancer deaths in the decade to come. Cancer is the biggest health challenge for the foreseeable future. Through advancements in science, perseverance and unwavering commitment that challenge can be met.

Dr. Jordan is a practicing oncologist in Fort Worth. He is president of Texas Cancer Care, a medical oncology practice with six oncologists and one hematologist.

Notable Quotes

"Until [we find a cure], we know that early detection is the most potent weapon we possess in our battle against breast cancer, and we know that mammography is the best way to detect breast cancer so that it can be treated before it's too late."

-President Bill Clinton
Saturday Radio Address, October 25, 1997

"Maybe if I, as First Lady, could talk about it candidly and without embarrassment, many other people would be able to as well."

-Former First Lady Better Ford,
who underwent radical surgery for breast cancer in 1974.
(Source: White House Internet site - Glimpse of "The First Ladies")

"As a result of this law, the quality of mammography has improved at practically all facilities that perform mammography in this country – whether in a hospital, a doctor's office, a mobile van, or on a military base. This program has been very good news for women, and we want to assure that its success continues."

-Health and Human Services Secretary Donna Shalala
at a press conference April 9, 1997, regarding legislation to reauthorize the Mammography Quality Standards Act.

Susan Ford Bales National Spokesperson for NBCAM

Daughter of former President Gerald R. Ford and Mrs. Betty Ford, Susan Ford Bales became personally involved in the battle against breast cancer in 1974.

"It is because of my mother's fight against breast cancer that I can relate so well to the ongoing fight against the disease," says Ms. Bales.

"As the daughter of a woman who had breast cancer, I am a high-risk candidate for the disease. My two daughters (Tyne and Heather Vance) are at increased risk as well."

Ms. Bales has served as National Spokesperson for National Breast Cancer Awareness Month since the campaign was founded in 1985. One of the program's most visible advocates, she spends much of the year traveling across the country to bring the message about the importance of early detection of breast cancer to cancer organizations, businesses interested in worksite breast cancer education and screening programs, women's groups, and other audiences.

Numerous interviews in newspapers and magazines and on television and radio attest to her dedication to the National Breast Cancer Awareness Program.

"My role as National Spokesperson enables me to tell my own story about the effects of breast cancer on both patient and family, and to emphasize the importance of early detection and proper treatment."

In 1985, Ms. Bales testified to the Subcommittee on Health and Long-Term Care to secure coverage under Medicare for mammography screening. In 1987, she received the John W. Sherrick Humanitarian Award from Peralta Cancer Research Institute.

Ms. Bales is a member of the board of the Betty Ford Center and the Gerald R. Ford Museum and Library. She is also serving her 14th year as Chairperson for the Capitol Council for Early Detection, a group of wives and daughters of Presidents and Vice Presidents who have joined forces to spread the message of early detection.

Advances in the Treatment of Breast Cancer

By Gregory G. Marino, D.O.

Breast cancer is one of the most common cancers worldwide and remains one of the major health problems in the United States. Nineteen ninety-nine will see an estimated 800,000 new cases with 176,000 being diagnosed in this country alone. This is the most common malignancy in women, and in total new cases of cancer in the United States, it is exceeded only by prostate cancer which will be diagnosed over 179,000 times this year. More than 43,000 American women will die of this disease this year. Despite these grim statistics, there have been some major successes in the battle against breast cancer. Perhaps the most notable was the publication of the National Surgical Adjuvant Breast and Bowel Project P-1. Other significant work includes a better definition of the role of high dose chemotherapy and stem cell support, and the continued development of new drugs and treatment regimens.

The use of the taxane group of cytotoxic agents, including Taxol and Taxotere, has been more accurately defined. These agents, although not curative, constitute the biggest advance in the adjuvant treatment of breast cancer, as well as for the treatment of metastatic disease. Other agents which continue to be studied include vinorelbine and gemcitibine, which appear to also have much to offer.

The use of high dose chemotherapy against this disease remains controversial. Although not curable with chemotherapeutic agents, breast cancer is one of the most chemo-responsive tumors that oncologists deal with. This tantalizing high rate of response has lead to the theory that dose intensive therapy, which would otherwise be limited by bone marrow suppression, might offer the hope of cure for some patients if the bone marrow could be supported by stem cells and colony stimulating factors. Data released this year do not seem to show an overall survival benefit, although some patients will have a significant improvement in their disease-free survival. This therapy is expensive and morbid and should be done only as part of a clinical trial.

The biggest impact in cancer research this year was made by the publication of NSABP P-1 in the *Journal of the National Cancer Institute* in September of 1998, with presentation of follow-up data at this year's American Society of Clinical Oncology annual meeting. P-1 was a randomized, double-blind, placebo control trial of the efficacy of tamoxifen at 20mg per day at preventing breast cancer. A total of 13,388 women meeting appropriate risk, as defined by the Gail model of the Breast Cancer Risk Assessment Tool, were studied. Of note, the Breast Cancer Risk Assessment Tool is available as an interactive computer program through the National Cancer Institute at 1-800-4-CANCER, or online at http://cancertrials.nci.nih.gov. Significantly reduced risk was seen in all patient categories, with an overall risk reduction of approximately 50%. Although there was not a reduction in the risk for myocardial infarction in the treatment group, those receiving tamoxifen had a reduced risk of fractures. There were 36 cases of endometrial cancer, all FIGO stage I, 35 episodes of deep vein thrombosis, and 18 pulmonary emboli in the tamoxifen arm. Those receiving placebo experienced 16 cases of endometrial cancer, 22 deep vein thromboses and 6 cases of pulmonary embolus.

The NSABP P-2 study of tamoxifen and raloxifene (STAR) will further define the role of raloxifene, a drug effective against osteoporosis and observed to reduce the incidence of breast cancer, as a breast cancer preventative in post menopausal patients. This trial is presently accruing patients and is ongoing.

A ten year survey of breast cancer recently published by the American Cancer Society reveals overall continuous improvement in the fight against breast cancer. Nearly 60% of newly diagnosed cases are stage 0 or I with ten year survival rates of 95% and 88% respectively. Ten year survival data for patients with stage II disease is 66%, stage III, 36%, and for those with stage IV disease, 7%.

Clearly much more needs to be done. The answers to these challenges lie in clinical trials, and such trials should receive the full support of all physicians, drug companies, and hospitals. There have been major improvements in early detection, and we finally have a model for chemoprevention. The biggest problem is that of the management of metastatic disease. The solution will be found in drug development and the rapid, careful and thorough completion of clinical trials. This will take focus and commitment.

Dr. Marino is a practicing oncologist affiliated with the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in Fort Worth.

Breast Cancer in Minorities

Group Profiles of the Leading Cancer Sites During 1988-1992

- **African-American women** – include breast, colon and rectum, lung, corpus uteri, and cervix uteri.
- **Asians and Pacific Islander women** – breast, lung, and colon and rectum, with the following exceptions: The stomach is a leading cancer site among Japanese and Korean women, and the cervix is a leading cancer site among Vietnamese women. Cervical cancer incidence rates among Vietnamese women are more than two and a half times higher than rates for any other racial or ethic group.

Note: Information on cancer incidences among Native Americans is only available for American Indians from New Mexico and Alaska Natives.

- **Alaska Native women** – leading cancer sites are breast, colon and rectum, and lung.
- **American Indian women from New Mexico** – breast, ovary, and colon and rectum are the leading sites.
- **Caucasian** – breast, lung, colon and rectum, corpus uteri, and ovary. Breast cancer rates among white women are higher than those for women of any other racial or ethnic group.
- **Hispanics** – breast, lung, colon and rectum, corpus uteri, and ovary. Cervical cancer rates among Hispanic women are highest of any group other than Vietnamese women.

(Statistics taken from Cancer Facts & Figures – 1997, The American Cancer Society)

Breast Cancer and African American Women

Nationwide studies suggest that, overall, the lifelong chances of having breast cancer are similar for African American women compared with Caucasian women in the United States. African American women are slightly more likely than Caucasian women to develop breast cancer before age 50, and slightly less likely to develop breast cancer after age 50.

The overall chances of developing breast cancer for African American women are listed below, with nationwide and Caucasian comparisons listed beside:

Age	AfricanAmerican	Nationwide	Caucasian
30-34	33.3	12.6	23.6
40-44	123.9	60.3	119.5
50-54	236.4	129.1	260.2
60-64	297.0	184.3	366.1
70-74	378.2	263.5	484.3
80-84	362.5	304.1	490.9

Rates are per 100,000

The overall chances of dying from breast cancer for African American women are listed below, with nationwide and Caucasian comparisons listed beside:

Age	African American	Nationwide	Caucasian
30-34	7.7	2.1	3.8
40-44	33.2	10.6	19.7
50-54	70.9	26.5	49.6
60-64	96.5	43.5	81.1
70-74	128.0	66.4	116.7
80-84	162.8	102.7	159.0

Rates are per 100,000

(Data obtained from the NCI's SEER [Surveillance, Epidemiology, and End Results] program.)

A study conducted by the National Cancer Institute found that African American women are more than twice as likely as Caucasian women to die from breast cancer. A significant number of studies have been done in an attempt to understand why this is so. Researchers have studied the tumors of African American women and compared them to tumors of other groups of women. Overall, there have been no discoveries of any basic differences in the disease between populations. One well known fact, however, is that more African American women are diagnosed when their cancers are at more advanced stages.

(Source: U.S. Public Health Service's Office on Women's Health)

Course of Breast Cancer Treatment Differs for African American and Caucasian Women

Researchers from the NCI have found significant differences in how black and white breast cancer patients are treated during their illness. The results were published in the April 29, 1999, issue of the journal Ethnicity and Disease.

Using a new method of analysis developed by the authors, the study confirms and adds knowledge to previous findings about the impact of socioeconomic differences on breast cancer treatment for black and white women. This method examines the first course of treatment (that is, the first three months of treatment) recommended for stage-specific diagnoses of breast cancer, rather than only individual types of treatment, such as surgery, radiation or chemotherapy. Each woman's actual treatment was compared against the "minimum expected treatment," which was defined in the study using National Institutes of Health Consensus Conferences for each stage of diagnosis.

"It's disconcerting, as these results show, that older patients are not receiving chemotherapy, as NCI Consensus Conferences advise," said Otis W. Brawley, M.D., NCI assistant director, Office of Special Populations Research. "We need more research to determine how cancer treatment for different groups is influenced by social and economic factors. I commend the authors on developing a method that evaluates whether patients received the

course of treatment advised for their stage. This sort of study should be conducted more often."

Since the distribution of nearly all characteristics were significantly different for black and white women, black and white cases were examined separately to evaluate factors most likely to be associated with early or late stage of disease at diagnosis. Income was associated with stage only for white women. For black women, who were concentrated in low-income groups, the significant predictors of late stage of disease were: no usual source of care and lack of screening. The study then examined only those breast cancer patients who were diagnosed with a later stage of disease and found that age was most strongly associated with not receiving minimum expected treatment. These older women were also likely to report having lower income, less education, public health insurance, and no usual source of health care.

When results for all diagnostic stages were combined for each race, 21 percent of black women and 15 percent of white women did not receive the minim expected treatment. The shorter survival and higher mortality observed for black women compared to white women was attributed to a "cumulative process," whereby race was correlated with lower social class and the lack of a usual provider, less screening, later stage at diagnosis, and consequently, less likelihood of receiving the minimum expected therapy. Data were not adjusted for comorbidity. An appendix to the paper details the rationale for the expected minimum treatment for each stage of disease.

The BWCSS used age, race, gender, and staging data on breast cancer patients reported to local cancer registries in three metropolitan areas, then matched black patients by age to white patients. This group of black and white patients were interviewed about their income, insurance, screening, and usual source of care. Data were also obtained from medical records. Patients were between the ages of 20 and 79 years old and lived in Atlanta, New Orleans or San Francisco.

"This study found that disparities in breast cancer diagnosis and treatment most adversely affected women who are black, or older, or poor," said lead author Nancy Breen, Ph.D., NCI Division of Cancer Control and Population Sciences, Applied Research Branch. "These data were collected in 1986, before screening for breast cancer was widespread. This raises the question of whether these same inequalities still prevail. It may be time to monitor this again."

Brawley added, "It would be useful to monitor other racial and ethnic groups in which disparities in cancer care are suspected as well. Differences in treatment, as shown in this paper, clearly contribute to racial disparities in disease outcomes."

Having health insurance facilitates access to a regular health care provider, which in turn may facilitate screening and early diagnosis, the paper notes. The health insurance situations of BWCSS participants mirrored national employee benefits studies conducted in the mid-1980s, which showed whites were more often covered by employer-based health plans than blacks. Of the under-age 65 group of women studied, 68 percent of black s and 94 percent of white had private health insurance; 16 percent of blacks and 3 percent of whites had public insurance; and 16 percent of blacks and 4 percent of whites had no insurance. For the 65 and older group, 50 percent of black women in the sample depended on unsupplemented public insurance compared to 8 percent of white women.

The paper, entitled "The Relationship of Socio-Economic Status and Access to Minimum Expected Therapy Among Female Breast Cancer Patients in the National Cancer Institute Black-White Cancer Survival Study," *appeared in the April 29, 1999 issue of the journal* "Ethnicity and Disease", *published by The International Society on Hypertension in Blacks. The authors are Nancy Breen, Ph.D., NCI, Margaret N. Wesley, Ph.D., Information Management Services, Inc., Silver Spring, MD., Ray M. Merrill, Ph.D., NCI, and Karen Johnson, M.D., previously with the Food and Drug Administration, and now with NCI.*

Breast Cancer Statistics by State

State	*Estimated New Breast Cancer Cases by State, 1999	*Estimated Breast Cancer Deaths by State, 1999
Alabama	2,500	600
Alaska	200	100
Arizona	2,600	700
Arkansas	1,700	400
California	16,900	4,200
Colorado	2,000	500
Connecticut	2,100	500
Delaware	500	100
District of Columbia	500	100
Florida	11,900	2,900
Georgia	4,000	1,000
Hawaii	500	100
Idaho	700	200
Illinois	8,500	2,100
Indiana	3,900	1,000
Iowa	2,100	500
Kansas	1,700	400
Kentucky	2,700	700
Louisiana	3,100	800
Maine	1,000	200
Maryland	3,500	900
Massachusetts	4,400	,100
Michigan	6,500	1,600
Minnesota	2,800	700
Mississippi	1,700	400
Missouri	3,600	900
Montana	600	200
Nebraska	1,000	300
Nevada	1,000	300
New Hampshire	700	200
New Jersey	5,900	1,500
New Mexico	1,000	200
New York	13,000	3,200
North Carolina	4,700	1,200
North Dakota	400	100
Ohio	8,400	2,100
Oklahoma	2,300	600
Oregon	2,100	500
Pennsylvania	10,000	2,500
Rhode Island	700	200
South Carolina	2,600	600
South Dakota	500	100
Tennessee	3,900	1,000
Texas	11,300	2,800
Utah	800	200
Vermont	300	100
Virginia	4,200	1,100
Washington	3,300	800
West Virginia	1,200	300
Wisconsin	3,400	800
Wyoming	300	100

Data Source: American Cancer Society Surveillance Research, 1999

* Estimates are a rough guide and should be interpreted with caution.

Breast Cancer Education

for Patients and Health Professionals

NCI's Cancer Information Service Assists Patients and Health Professionals

The NCI's Cancer Information Service (CIS), a national information and education network, provides the latest, most accurate cancer information for patients, the public and health professionals. Approximately 25 percent of all CIS calls are related to breast cancer.

Specially trained staff provide the latest scientific information in understandable language, and will provide the location of the caller's nearest FDA certified mammography facility. CIS staff answer questions in English and in Spanish and distribute NCI materials.

The toll free number for the CIS is 1-800-4-CANCER (1-800-422-6237). Through its Outreach Program, the CIS reaches the medically underserved, including minority groups and people with limited access to health information. The CIS has numerous partnerships with state and regional organizations that serve these audiences focused on breast health education.

First-Ever Patients' Version of NCCN Practice Guidelines for Breast Cancer Available

A collaborative effort between the National Comprehensive Cancer Network (NCCN) and the American Cancer Society (ACS) has resulted in a valuable new resource for breast cancer patients.

This past March, the NCCN and ACS unveiled the first-ever patient version of the NCCN's breast cancer treatment guidelines. With the ACS translation of the NCCN guidelines, which were originally designed for oncology professionals, breast cancer patients and their families now have the reliable, specific and easy-to-understand information they need to make timely and well-informed decisions about this critical health care issue.

Guideline topics include: types of breast cancer, stages of the disease, medical decisions and treatment options, important questions for patients to discuss with their doctors, general information about clinical trials, and a glossary of terms commonly used in breast cancer treatment.

Each of the topics are covered in-depth and incorporate the latest available information in cancer care. There are also numerous visual aides, including six flow chart algorithms that represent appropriate treatment for different stages of breast cancer. The charts illustrate in a clear manner steps patients and the doctors can take in determining the most effective treatment.

To obtain copies of the patient version of the breast cancer guidelines, contact the National Comprehensive Cancer Network at 1-888-909-NCCN or the American Cancer Society at 1-800-ACS-2345. You may also visit their Web sites at www.nccn.org or www.cancer.org.

Selected Cancer Drugs Approved by the FDA
(June 1996 through September 1999)

Nolvadex (tamoxifen citrate) – Zeneca Pharmaceuticals
Received additional approval on October 29, 1998, to reduce the incidence of breast cancer in women at high risk for breast cancer.

Herceptin (trastuzumab) – intravenous injection by Genentech, Inc.
Received additional approval on September 25, 1998, for use alone for certain patients who have tried chemotherapy with little success or as a first-line treatment for metastatic disease when used in combination with paclitaxel (trade name Taxol).

Taxotere (docetaxel) – injection concentrate (20 mg and 80 mg) by Rhone-Poulenc Rorer
Received additional approval on June 22, 1998, for the treatment of patients with locally advanced or metastatic breast cancer after failure of prior chemotherapy.

Xeloda (capecitabine) – tablets by Hoffman-LaRoche
Received accelerated approval on April 30, 1998, for treatment of patients with metastatic breast cancer resistant to both paclitaxel and an anthracycline containing chemotherapy regimen or resistant to paclitaxel and for whom further anthracycline therapy may be contraindicated, e.g., patients who have received cumulative doses of 400 mg/m2 of doxorubicin or doxorubicin equivalents.

Femara (letrozole) Tablets – Novartis Pharmaceutical Corp.
Received approval on July 25, 1997, for the treatment of advanced breast cancer in postmenopausal women.

Fareston (toremifene citrate) Tablets – Orion Corp.
Received approval on May 29, 1997, for the treatment of metastatic breast cancer in postmenopausal women with estrogen receptor positive or receptor unknown tumors.

Aredia (pamidronate disodium) for Injection – Ciba Geigy Corp. Pharmaceutical Division
Received an additional indication on July 16, 1996, for the treatment of osteolytic bone metastases of breast cancer. Aredia was previously indicated for hypercalcemia associated with malignancy, osteolytic bone lesions of multiple myeloma, and Paget's disease of bone.

Taxotere (docetaxel) – Rhone-Poulenc Rorer
Received approval on May 14, 1996, for the treatment of locally advanced or metastatic breast cancer which has progressed during anthracycline-based treatment or relapsed during anthracycline-based adjuvant therapy.

(Source: FDA Office of Special Health Issues)

Breast Cancer Survival Rates

- The five-year relative survival rate for localized breast cancer has increased from 72% in the 1940s to 97% in 1999.
- If breast cancer has spread regionally, the rate is 77% and, for women with distant metastases, the rate is 22%.
- Survival after a diagnosis of breast cancer continues to decline beyond five years.
- Sixty-nine percent of women diagnosed with breast cancer survive 10 years.
- Fifty-seven percent of women diagnosed with breast cancer survive 15 years.

- The five-year survival rate for all cancers improved from 51% in the early 1980s to almost 60% in the early 1990s.

(Data obtained from the American Cancer Society)

Selected Legislative Highlights and Pending Legislation Relating to Breast Cancer

The Breast and Cervical Cancer Mortality Prevention Act

In 1990, Congress passed this legislation which authorized the Centers for Disease Control and Prevention to establish the National Breast and Cervical Cancer Early Detection Program.

The Balanced Budget Act of 1997

Under this legislation, Medicare was directed to provide annual screening mammography for eligible women age 40 and over. Previously, Medicare covered a mammogram only every other year.

Breast Cancer Research Stamp Announced

The nation's first "semi-postal" stamp was issued nationwide in August, 1998, marking the first time the U.S. Postal Service had issued a stamp that costs more than its face value. As a 40-cent stamp, it was deemed valid for postage at the current prevailing first-class rate, which was 32 cents at the time. Seventy percent of net proceeds were earmarked for the National Institutes of Health, and 30 percent for the Department of Defense.

As of March 11, 1999, the stamp had already raised $5.2 million to help research breast cancer, according to the U.S. Postal Service.

Mammography Quality Standards Act Reauthorization

On October 9, 1998, President Clinton signed the reauthorization of the Mammography Quality Standards Act (MQSA), under which the Food and Drug Administration sets high standards to ensure that mammograms are safe and accurate, and certifies those facilities that meet those standards. The reauthorization included a provision to directly notify women of their mammogram results in easy-to-understand language, which was a top priority of the American Cancer Society.

The MQSA was passed by Congress in 1992, in response to concerns that mammography practices did not meet quality standards in all facilities. The law established a number of requirements aimed at strengthening the quality of mammography services nationwide. Facilities must meet quality standards set by the FDA for personnel, equipment and image quality in order to be certified. In addition, they must be inspected annually by a FDA-trained inspector to assure continuing compliance with standards.

The Women's Health and Cancer Rights Act of 1998

On October 21, 1998, the Women's Health and Cancer Rights Act was signed into law, part of the Omnibus Appropriations Act of 1998. The legislation contained protections for breast cancer patients who elect breast reconstruction with a mastectomy.

The provision applies to women who are eligible for mastectomy benefits under their medical coverage and allows for: breast reconstruction; surgery and/or reconstruction on the other breast to produce a symmetrical appearance; prostheses; and treatment for complications arising during or after the mastectomy.

Legislation Pending in the 106th Congress

The following are some of the various bills relating to breast cancer and cancer in general, pending before the 106th U. S. Congress:

H.R. 383 – The Women's Health and Cancer Rights Act of 1999
This bill requires that health plans provide coverage for a minimum hospital stay for mastectomies and lymph node dissection for the treatment of breast cancer, and coverage for secondary consultation.

S. 115 – On the same day as H.R. 383 was filed, a companion bill was introduced in the Senate. This legislation would protect women from being forced out of hospitals by insurance companies only hours after undergoing breast cancer surgery, a practice known as "drive-through mastectomies." The bill would:

- For breast cancer, require insurance plans to cover hospital stays as determined by the attending physician, in consultation with the patient, to be medically appropriate. It does not prescribe a fixed number of days but leaves the length of hospital stay up to the treating physician.
- For breast cancer, requires insurance plans to provide notice to plan subscribers of these requirements.
- For all cancers, prohibits insurance plans from linking financial or other incentives to a physician's provision of care.
- For all cancers, requires plans to cover second opinions by specialists to confirm or refute a diagnosis.

A similar bill was introduced in the last Congress. A portion of that bill, requiring health plans to pay for breast reconstruction, became law as part of the FY 1999 Omnibus Appropriations Bill, but other major issues have not been resolved.

H.R. 1132 – The Mammogram Availability Act of 1999
This bill would amend the Public Health Service Act and Employee Retirement Income Security Act of 1974 to require that group and individual health insurance coverage and group health plans provide coverage for annual screening mammography for women 40 years of age or older if the coverage or plans include coverage for diagnostic mammography.

H.R. 1285 – The Cancer Screening Coverage Age of 1999
This bill would require all private health insurance providers – those operating under ERISA, group or individual plan guidelines – to cover routine screenings for breast, cervical, colo-rectal and

prostate cancers. Provisions in the legislation are based on American Cancer Society guidelines and follow the Medicare cancer screening benefits as provided by the Balanced Budget Act of 1997.

H.R. 302 – The Medicaid Women's Basic Health Coverage Act of 1999

This bill would amend Title XIX (Medicaid) of the Social Security Act to require State Medicaid Programs to provide coverage of screening mammography and screening pap smears.

S. 110 – The Breast and Cervical Cancer Treatment Act of 1999

This legislation would amend Titled XIX of the Social Security Act to provide medical assistance for breast and cervical cancer-related treatment services to certain women screened and found to have breast or cervical cancer under a federally funded screening program.

H.R. 547 – Taxpayers' Cancer Research Funding Act of 1999

This legislation would amend the Internal Revenue Code of 1986 to establish and provide a check-off for a Breast and Prostate Cancer Research Fund, and for other purposes.

H.R. 524 – Screening Mammography Act of 1999

This bill would amend the Public Health Service Act and Employee Retirement Income Security Act of 1974 to require that group and individual health insurance coverage and group health plans provide coverage for annual screening mammography for any class of covered individuals if the coverage or plans include coverage for diagnostic mammography for such class; and to amend titles XVIII and XIX of the Social Security Act to provide coverage for annual screening mammography. Prohibits: 1) denying screening coverage on the basis that it is not medically necessary or not pursuant to a referral or recommendation; 2) denying eligibility, enrollment or renewal solely to avoid this requirement; 3) providing monetary incentives to participants or beneficiaries to encourage them to accept less; or 4) penalizing or providing incentives to providers.

H.R. 1911 – Women's Cancer Recovery Act of 1999

This legislation would require that health plans provide coverage for a minimum hospital stay for mastectomies and lymph node dissection for the treatment of breast cancer and coverage for secondary consultations.

H.R. 1070 & S. 662 – Breast and Cervical Treatment Act of 1999

This bill amends Title XIX (Medicaid) of the Social Security Act to give states the option of making medical assistance for breast and cervical cancer-related treatment services available during a presumptive eligibility period to certain low-income women without creditable coverage, who have already been screened for such cancers under the Centers for Disease Control and Prevention's breast and cervical cancer early detection programs, and need treatment. Provides for an enhanced match with regard to such Medicaid treatment services.

H. R. 278

This resolution expresses the sense of the House of Representatives regarding the importance of education, early detection and treatment, and other efforts in the fight against breast cancer.

– Flu Season is Here –

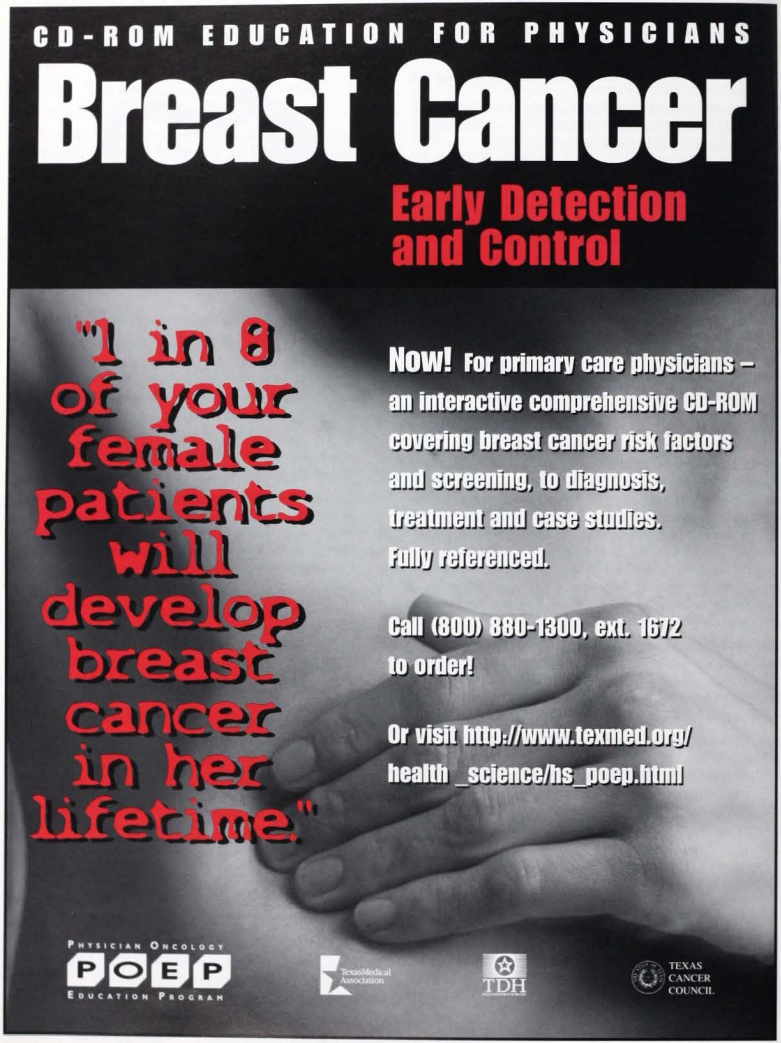
Immunize Your Patients

Physicians are reminded to immunize their patients now that flu season, which generally lasts from October through April, is upon us.

This is especially true of people in high-risk groups which, according to the Texas Department of Health, include the following:

- Diabetes – People with diabetes are about three times more likely to die from complications of flu and pneumonia. According to the Centers for Disease Control and Prevention, deaths among people with diabetes rise five to 15 percent during a flu epidemic;
- People aged 65 or older – Those in this age group have a higher risk of serious illness or death resulting from flu-related complications. More than 90 percent of the deaths from pneumonia and flu occur in people aged 65 or older, yet 32 percent of people in this age group failed to get a annual flu shot in 1997, according to the TDH.
- Those with weak immune systems – These include people with kidney disease and blood problems, transplant recipients and people with AIDS;
- People with chronic heart or lung disease, including children with asthma;
- Pregnant women;
- International travelers; and
- Children on long-term aspirin therapy.

"Flu Shot Reminder Postcards" are available to TOMA members by contacting the TOMA office at (800) 444-8662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Surgeon General Unveils Suicide Prevention Strategy

On July 28, 1999, U.S. Surgeon General David Satcher, M.D., unveiled a blueprint to prevent suicide in the U.S. The document, entitled, *The Surgeon General's Call to Action to Prevent Suicide*, outlines steps that can be taken by individuals, communities, organizations and policymakers.

Dr. Satcher's call to action emphasizes public awareness, in that the public should understand that suicides are preventable; intervention, whereby collaboration between public and private sectors must be accomplished in order to complete a National Strategy for Suicide Prevention; and an advance of the science of suicide prevention through research in intervention and prevention.

Physician involvement in suicide prevention is highly stressed. "Far too many health professionals are failing to ask about depression or to encourage patients to talk about it. In fact, about 70 percent of elderly suicide victims have seen a health care professional within the month preceding their suicide," stated Dr. Satcher.

Suicide in the U.S.

- Suicide was the eighth leading cause of death for all Americans (up from ninth in 1996), and the third leading cause of death for young people aged 15-24.
- Suicide took the lives of 30,903 Americans in 1996.
- More people die of suicide than from homicide. In 1996, there were three suicides in the U. S. for every two homicides committed.
- Males are four times more likely to die of suicide than are females. However, females are more likely to attempt suicide than are males.
- Suicide rates are generally higher than the national average in the western mountain states and lower in the eastern and midwestern states.
- There are an estimated 16 attempted suicides for each completed suicide.

Suicide Among the Elderly

- Suicide rates increase with age and are highest among Americans aged 65 years and older. While this age group accounts for only 13% of the U.S. population, Americans 65 or older account for 20% of all suicide deaths.
- The ten-year period 1980-1990 was the first decade since the 1940s that the suicide rate for older Americans rose instead of declined, although that rate again declined during the 1990s.
- In 1996, men accounted for 84% of suicides among persons aged 65 years and older.
- Suicide rates among the elderly are highest for those who are divorced or widowed.
- Nearly 5 million of the 32 million Americans aged 65 and older suffer from some form of depression.
- Most elderly suicide victims - 70% - have visited their primary care physician in the month prior to their committing suicide.

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Suicide Among the Young

- For young people 15-24 years old, suicide is the third leading cause of death, behind unintentional injury and homicide. In 1996, more teenagers and young adults died of suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined.

- Important risk factors for attempted suicide in youth are depression, alcohol or other drug use disorder, and aggressive or disruptive behaviors.

- Over the last several decades, the suicide rate in young people has increased dramatically. From 1952-1996, the incidence of suicide among adolescents and young adults nearly tripled, although there has been a general decline in youth suicides since 1994. From 1980-1996, the rate of suicide among persons aged 15-19 years increased by 14% and among persons aged 10-14, by 100%. For African-American males aged 15-19, the rate increased 105%.

- Among persons aged 15-19, firearm-related suicides accounted for 63% of the increase in the overall rate of suicide from 1980-1996.

- The risk for suicide among young people is greatest among young white males; however, from 1980-1996, rates increased most rapidly among young black males.

- Although suicide among young children is a rare event, the dramatic increase in the rate among 10-to-14-year olds underscores the urgent need for intensifying efforts to prevent suicide among persons in this age group.

D.O.s Needed to Testify for Congressional Hearings or Represent the AOA on Federal Committees

The AOA is seeking qualified osteopathic physicians to testify at congressional hearings and/or serve on federal boards, committees, or task forces on Medicare reimbursement, managed care, and other issues affecting the osteopathic medical community.

All candidates will be reviewed by the AOA Board of Trustees and, if chosen, receive compensation for traveling expenses. Additionally, designated representatives will be included in an AOA database that will be used as a resource for future assignments.

Interested parties should FAX their curriculum vitae to Janet Horan, J.D., American Osteopathic Association, at (312) 202-8212. CVs can also be E-mailed in Word or text-only format to <jhoran@aoa-net.org>. Please indicate areas of interest, e.g., reimbursement, Medicare, clinical issues, etc.

Sumatriptan and Naratriptan Pregnancy Registries

The sumatriptan and naratriptan pregnancy registries are ongoing, international prenatal exposure registration and follow-up studies, established by Glaxo Wellcome in conjunction with the Centers for Disease Control and Prevention and experts in obstetrics and gynecology, teratology, clinical genetics, pediatrics, internal medicine, and epidemiology.

The purpose of the registries is to monitor for evidence of any major effect on developing fetuses when women have intentionally or inadvertently taken sumatriptan (Imitrex) or naratriptan (Amerge) during any portion of their pregnancy. Patient confidentiality is strictly maintained.

If you have patients who have taken sumatriptan or naratriptan at any time during their pregnancy, you are encouraged to notify the registry, as early in the pregnancy as possible. To obtain a copy of the most recent interim report and/or to register patients, health care providers can contact their local Glaxo Wellcome Medical Department or call the registry collect at (919) 483-9441 or (888) 825-5249, ext. 39441; FAX (919) 315-8747; or e-mail: RRE38996@glaxo.com.

TDH Issues Dengue Fever Precautions

State and local health officials are urging persons in Texas border counties to take precautions against dengue fever following reports of the illness in two Webb County residents. The viral illness is spread by mosquitoes.

One case of dengue fever has been confirmed in a Webb County resident, and another case is suspected. Health officials have not determined if the illnesses were contracted in Texas or in Mexico. Recent cases of dengue fever have been reported in Nuevo Laredo on the Mexico side of the border.

Dengue fever is caused by a virus spread to humans by the Aedes aegypti and the Aedes albopictus mosquito species. Both species are plentiful in Texas. Texas Department of Health epidemiologist Julie Rawlings said the species rarely migrate more than a few hundred feet from where they were hatched. She said the best way to reduce the risk of dengue fever is to eliminate mosquito hatching grounds by emptying sources of standing water such as old tires, tin cans, barrels, jars, birdbaths and flower pot bases.

HEALTH NOTES

Symptoms of Dengue include sudden onset of high fever, severe headaches, joint and muscle pain, nausea, vomiting and a rash which can appear three to four days after onset of fever. Symptoms usually appear five to seven days after exposure and can last several days. The illness is usually treated with fever-reducing agents, fluids and bed rest. Aspirin should not be taken to relieve dengue fever symptoms. The illness is not usually fatal, but a more severe form of the illness, dengue hemorrhagic fever, can be life threatening.

Dengue fever is common in Central and South America and in Asia. Texas is the only state in the United States where locally acquired dengue has been confirmed in recent years. Texas recorded one travel-related case of dengue fever in 1998. An outbreak of dengue fever occurred in Texas in 1995 when 29 cases were recorded, including seven contracted in the state.

Ozone Alert

The production of ozone-depleting substances is being phased out worldwide under the terms of an international agreement. Since most of the metered-dose inhalers (MDIs) available in the United States contain ozone-depleting chlorofluorocarbons (CFCs), these MDIs will eventually need to be reformulated to no longer use CFCs. The reformulation effort is underway and several non-CFC products are currently marketed. Several other non-ozone-depleting substance products are in the latter stages of development. Many people have expressed concern that the medicines they need to treat their asthma or chronic obstructive pulmonary disease will be removed from the market. There are no immediate plans to discontinue marketing any CFC-MDI for these indications. CFC-MDIs will not be removed until sufficient alternative medicines exist to serve the needs of patients.

FDA is developing a strategy to ensure that patients in the United States who rely on MDIs for their health and well being have continuing access to an array of safe and effective treatment options. A new web page <www.fda.gov/cder/mdi/default.htm> contains information about the use of ozone-depleting substances in medical products and the transition from their use.

Important Message for Health Professionals

The Food and Drug Administration has been warning the public about a group of products sold as dietary supplements for bodybuilding, weight loss and sleep inducement which have been determined to pose a significant public health hazard. These products are chemically related to gamma butyrolactone (GBL), gamma hydroxybutyric acid (GHB), and 1,4 butanediol (BD), and can cause dangerously low respiratory rates (intubation may be required), unconsciousness/coma, vomiting, seizures, bradycardia and death.

GBL, GHB and BD have been linked to at least 122 serious illnesses reported to FDA, including three deaths. These agents contain powerful hypnotic substances known to produce significant and potentially dangerous sedative effects.

While these products are listed as "party drugs" on Internet sites, advertised in muscle-building magazines, and sold in health food stores as dietary supplements, the FDA considers them to be unapproved new drugs and has conducted seizures to prevent their sale to consumers and any further illnesses or deaths. GHB, which is legally available in the United States only as an investigational new drug for specified purposes (thus, it cannot be legally marketed), has been implicated as a "date rape" drug.

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Regarding the products themselves:

- GBL, when ingested, rapidly metabolizes into GHB.
- Some of the suspect products may list 1,4 butanediol, tetramethylene glycol, gamma butyrolactone or 2(3H)-Furanone dihydro on the label, or have no label at all.
- Health authorities believe manufacturers are renaming their products and substituting BD for GBL – however, the effects of ingesting BD are as dangerous as those of GHB and GBL.
- GBL product names include Longevity, Revivarant, G.H. Revitalizer, Gamma G, Blue Nitro, Insom-X, Remforce, Firewater and Invigorate.
- Products that contain BD include Revitalize Plus, Serenity, Enliven, GHRE, SomatoPro, NRG3, Thunder Nectar and Weight Belt Cleaner.
- Consumers have been warned by FDA not to drink the products named Cherry fX Bombs, Lemon fX Drops and Orange fX Rush, as all contain BD.

FDA cannot ensure the effectiveness or safety of any product for sleep inducement other than FDA approved drugs. People who use unapproved sleep inducement products, especially without proper medical supervision, may be unnecessarily exposing themselves to serious harm.

FDA strongly encourages you to report any serious adverse events that occur with the use of any dietary supplement containing GBL, GHB or BD to the FDA's MedWatch program by:

- Phone (1-800-FDA-1088)
- FAX (1-800-Fda-0178)
- Via the MedWatch Website at www.fda.gov/medwatch
- Mail (using postage-paid form) to MedWatch, HF-2, 5600 Fishers Lane, Rockville, MD 20852-9787

By reporting to MedWatch, you can contribute to the public health by helping to prevent further illnesses or deaths.

FDA Announces Changes in Requirements for Medical Gloves

On July 30, the FDA issued a proposed rule, allowing 90 days for comment, announcing significant changes in the requirements for all medical gloves. The proposed regulation is available at <www.fda.gov/ohrms/dockets/98fr/073099a.txt>

For your information, the summary is as follows:

The FDA is proposing regulations to reclassify all surgeons' and patient examination gloves as Class II medical devices because it believes that general controls are insufficient to provide a reasonable assurance of safety and effectiveness. The reclassified gloves, including those made of natural rubber latex (NRL) or synthetic material, will be regulated in four categories: powdered surgeon's gloves, powder-free surgeon's gloves, powdered patient examination gloves, and powder-free patient examination gloves.

The proposed special controls are in the form of a proposed guidance document entitled "*Medical Glove Guidance Manual*," which includes recommend protein and glove powder limits, and new label caution statements including protein and powder labeling requirements.

The FDA is also proposing to require expiration dating. This proposed rule is intended to reduce the adverse health effects from allergic and foreign body reactions caused by the natural latex (NL) protein allergens and glove powder found on surgeon's and patient examination gloves, and to reduce the adverse health effects from defects in the barrier integrity and quality of surgeon's and patients examination gloves.

Written comments may be submitted (by October 28) to: Dockets Management Branch (HFA-305), FDA, 5630 Fishers Lane, Room 1061, Rockville, MD 20852.

For further information, contact Donald E. Marlowe, Center for Devices and Radiological Health, at 301-827-4777.

In Memoriam

J. L. "Jack" Prendergast, D.O.

Dr. J. L. Prendergast of Panhandle, Texas passed away on August 14. He was 78. Memorial services were held at First United Methodist Church.

A 1950 graduate of the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri, Dr. Prendergast was a practicing family physician until his retirement in 1985. He moved to Panhandle from Kit Carson, Colorado, in 1952. He was a veteran of the Air Force.

Dr. Prendergast was a longtime TOMA member and had been awarded Life Membership in the association. He was also a member of TOMA District I and the American Osteopathic Association.

Survivors include his wife, Phyllis Clark; two sons, James C. Prendergast of Saratoga Springs, New York, and George K. Prendergast of Kerrville; and six grandchildren.

Changes in Texas Immunization Requirements

On April 19, 1999, The Texas Board of Health adopted several revisions to the "Immunization Requirements for Children and Students in Texas Public and Private Schools, Child-Care Facilities and Institutions of Higher Education" [Title 25. Health Services, Chapter 97. Texas Administrative Code (TAC) §§97.61-97.77]

• **Hepatitis A Vaccine**: Effective August 1, 1999, children and students attending school or child-care facilities in 32 Texas-Mexico border counties are required to be vaccinated against hepatitis A as follows: Children born on or after September 2, 1992 who are 5 years old or older will be required to have received 2 doses of hepatitis A vaccine. (Affected counties are: Brewster, Brooks, Cameron, Crockett, Culberson, Dimmitt, Duval, Edwards, El Paso, Frio, Hidalgo, Hudspeth, Jeff Davis, Jim Hogg, Kenedy, Kinney, La Salle, Maverick, McMullen, Pecos, Presidio, Real, Reeves, Starr, Sutton, Terrell, Uvalde, Val Verde, Webb, Willacy, Zapata and Zavala.)

• **Hepatitis A Vaccine**: Effective August 1, 2000, children and students attending school or child-care facilities in 32 Texas-Mexico border counties will be required to be vaccinated against hepatitis A as follows: Children born on or after September 2, 1992 who are 2 years old but not yet 3 years old will be required to have received 1 dose of hepatitis A vaccine. Children born on or after September 2, 1992 who are 3 years old or older will be required to have received 2 doses of hepatitis A vaccine. (See counties listed above.)

• **Varicella Vaccine**: Effective August 1, 2000, children and students attending school or child-care facilities will be required to be vaccinated against varicella (chickenpox) as follows: Children born on or after September 2, 1994 who are 1 year old or older will be required to have received 1 dose of varicella vaccine or to present documentation of previous varicella illness. Children born between September 2, 1988 and September 1, 1994 (inclusive) must show proof by 30 days after their 12th birthday of either having received 1 dose of varicella vaccine or of having previously had varicella illness.

• **Hepatitis B Vaccine**: Effective August 1, 2000, children and students attending school or child-care facilities will be required to be vaccinated against hepatitis B as follows: Children born between September 2, 1988 and September 1, 1992 (inclusive) must show proof by 30 days after their 12th birthday of having received 3 doses of hepatitis B vaccine. This requirement is in addition to the one which went into effect August 1, 1998, and affected children born on or after September 2, 1992. These children are required to have 3 doses of hepatitis B vaccine by the time they turn 5 years old.

The Immunization Division has revised three existing documents to reflect the changes adopted by the Texas Board of Health. They are as follows:

Immunization Requirements for Children and Students (Stock No. 6-103). This document reprints sections of the Texas Administrative Code which describe the immunization requirements for children and students and contain information about record-keeping and reporting requirements. This document is intended for use by professionals who administer vaccines or who enforce immunization requirements.

Minimum State Vaccine Requirements for Texas Children (Stock No. 6-14 in English, Stock No. 6-15 in Spanish). These documents summarize age-specific vaccine requirements and are intended for use by anyone interested in child and student immunization requirements, including parents and the general public.

These documents (6-103, 6-14 and 6-15) may be ordered from the Immunization Division's Communication and Training Program at 800-252-9152. The ordering limit for Stock No. 6-103 is 25 copies; there is no limit for orders of 6-14 and 6-15.

Contact Kristin Hamlett, Immunization Compliance Coordinator, at 800-252-9152 for any questions or further information about immunization requirements.

THE INDEPENDENT
INVESTOR

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The Benefits of Diversification

Everyone has heard the adage, 'Don't put all your eggs in one basket.' This advice is the basis behind asset allocation, the concept of diversifying an investment portfolio across several major asset classes such as stocks, bonds and cash.

Lately, there has been a certain level of volatility in the financial markets, with concern about rising interest rates and high stock prices continuing to affect the averages. Asset classes often respond differently to changing economic and political conditions. Historically, stocks have at times returned higher percentages than bonds, while in other instances bonds have been the stronger performers.

It may be tempting to simply invest in whatever asset is performing well at the time. However, this approach does not take into account the sometimes surprising swings in market behavior that can quickly erase gains made by an undiversified portfolio.

Asset allocation can help provide the best protection against the whims of a fickle market. By diversifying your investments, you create a well-balanced portfolio. Asset allocation, by spreading risk, helps financial advisers create a portfolio that best suits your tolerance for risk - and maintains that balance as your goals and life stages change.

Diversification also allows you to take advantage of imbalances among markets. For example, the differences between the stock and bond markets and between domestic and foreign markets could create investment opportunities. Further, diversification allows you to take advantage of potential imbalances within markets, such as price differences between value and growth stocks in the equity markets and between short-term and long-term bonds in the fixed income markets.

THE CHART BELOW DETAILS WHAT A DIFFERENCE ASSET ALLOCATION CAN MAKE IN PORTFOLIO PERFORMANCE.

Here's the return (through June 30, 1999) you would have earned if you had invested a portfolio four different ways on Dec. 31, 1994.

	Aggressive	*Equity*	*Balance*	*Income*
Stocks	90%	70%	50%	20%
Bonds & Cash	10%	30%	50%	80%
Annualized Return	18.0%	15.5%	12.9%	8.8%
Standard Deviation	14.7%	11.8%	9.0%	5.2%

Stocks are based on the Wilshire 5000 Index. Bonds are based on the Merril Lynch Corporate Bond Index. Past performance is no guarantee of future results. Indices are unmanaged and cannot be invested into directly.

Unfortunately, many novice investors spend far too much time searching for the "hot" investments of the day rather than reviewing whether the investments they buy support a solid asset allocation framework. This is where the value of a financial adviser's advice comes into play.

The main objective of any financial adviser who uses asset allocation is simple: to grow the value of an account at a rate equal to the client's goals - without taking unnecessary risk. For most investors, reducing or managing the risk in a portfolio so they can sleep at night is equally as important as increasing their return.

Give us a call and we'll be glad to help you review your own investments from an appropriate asset allocation philosophy for your risk tolerance.

FORT WORTH 817-335-3214
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AOA Adopts Alternate Pathway for Board Certification

By Michael Fitzgerald
AOA Assistant Director for Publications

As part of the Campaign for Osteopathic Unity, the AOA Board of Trustees approved a "re-entry pathway" that will allow D.O.s to obtain AOA board certification if they completed training in residency programs accredited by the Accreditation Council for Graduate Medical Education without having served AOA-approved internships.

In approving the re-entry pathway during its midyear meeting in St. Petersburg, Florida, in early March, the Board heeded a recommendation that the AOA Task Force on Osteopathic Unity made last year for reaching out to D.O.s who received all of their graduate training in allopathic medical programs.

Until now, D.O.s were ineligible to take the examinations of AOA certifying boards if they had not completed AOA-approved internships or received AOA approval of their first year of allopathic residency training.

"In the spirit of the unity campaign, creating the re-entry pathway is one of the most significant actions that the AOA can take," notes Michael I. Opipari, D.O., the chairman of the AOA Council on Postdoctoral Training. "The new pathway will truly assist hundreds of D.O.s so that they may be part of the osteopathic medical family once again through recognition of their graduate training".

"Many of these D.O.s had excellent graduate training, and they can give a great deal back to our colleges and residency programs."

New Policy Supports Unity Campaign

The AOA is offering the re-entry pathway for the next six years. To qualify to take AOA board certification examinations through the re-entry pathway, D.O.s must meet the following requirements in addition to the certifying boards' standard eligibility requirements:

- They must be members in good standing of the AOA.
- They must have begun their residency training no later than October 31, 1999.
- They must have their residency training recommended for approval by the appropriate osteopathic specialty college, and their training must then be approved by the executive committee of the AOA Council on Postdoctoral Training.
- Within two years prior to applying for residency approval, they must have completed 100 hours of AOA Category 1 continuing medical education, including 25 hours devoted to osteopathic principles and practice.

  ➞ Or they must have attended three scientific meetings of their osteopathic specialty college throughout which osteopathic principles are integrated.

  ➞ Or they must submit a letter from the dean of an osteopathic medical college verifying that they have been on the college's faculty for at least five years and that they have taught and demonstrated the use of OPP to students.

This re-entry pathway is not available to D.O.s who matched with osteopathic internships and then dropped those positions for allopathic positions, unless they were released without prejudice by the institutions that sponsored the internships.

"The re-entry pathway helps to reunite the osteopathic medical profession without compromising the integrity of osteopathic medical education," Dr Opipari adds. "The pathway is not a giveaway program. It cannot be construed as amnesty for not completing an osteopathic internship. D.O.s have to earn their way back by meeting CME requirements."

Reprinted with permission from the June 1999, issue of The D.O.

AOA Re-implements "Health for the Whole Family" Project

The Public Relations Division of the American Osteopathic Association has announced the re-implementation of the "Health for the Whole Family" project.

Each quarter, a pair of articles is prepared for use by AOA members and non-members in an effort to share important general health information with the public, as well as building awareness for osteopathic medicine and D.O.s . When D.O.s receive these articles, they just fill in the blank attributions with their information, and the pieces can be published in local newspapers, hospital newsletters, etc.

This is the first prepared article for use by D.O.s.

Health for the Whole Family

Is Attention Deficit Disorder Affecting Your Child?

Have you noticed that your child has trouble staying focused on a specific task at hand? Whether they're working on homework or playing catch, they just doesn't seem to be able to concentrate on anything for a period of time. If this has this been happening over the course of at least six months, they could have attention deficit disorder (ADD).

Once referred to as hyperkinesis or minimal brain dysfunction, ADD has become one of the most common mental disorders among children, affecting approximately 2 million of them. In order to be diagnosed with ADD, the behaviors must appear before the age of 7 and continue for at least six months. In addition, the behaviors must be more frequent and severe than other children of the same age. They must also affect at least two areas in the child's life, such as family, school or social life.

"Attention deficit disorder is a diagnosis applied to children who consistently display certain characteristic behaviors over a period of time," explains (insert name), D.O., an osteopathic (insert specialty area) from (insert practice town).

Because ADD does not have distinct physical symptoms, it is necessary to recognize specific behavior patterns. These patterns include:

- Inattention - children have a difficult time concentrating on one project for any length of time;
- Hyperactivity - children are always moving. They move about the room or squirm in their seats;
- Impulsivity - children are unable to think before they act or control their immediate reactions. They may find it hard to wait for things they want or take their turn while playing games.

When this disorder is diagnosed by a health professional, it is only natural for parents to ask themselves how this happened. "Unfortunately, we don't know what causes ADD, and there are too many possibilities to pinpoint a cause with precision," says Dr. (insert last name). "The most important thing to focus on is how can we help the child deal with the disorder."

If parents suspect their child may have ADD, there are several professionals to turn to for diagnosis - pediatricians, family physicians, psychiatrists, psychologists or neurologists. While they may all diagnose the disorder, some of them can prescribe medications for ADD while others can provide counseling as well.

Medications have been used for years to help treat ADD. Ritalin, Dexedrine/Dextrostat, and Cylert seem to work most effectively in children.

According to the National Institute of Mental Health, the behavior improves for nine out of 10 children when using one of these three medications. If the prescribed medication isn't working for your child, ask your physician to adjust the dosage, recommends Dr. (insert last name). Your physician can prescribe one of the two other medications if the initial treatment doesn't work.

When placing children on any medications, there is always concern. However, weighing the potential side effects against the benefits can help families decide whether or not to choose medications as a method for treating ADD. "Some side effects while on these drugs include loss in appetite, a slower growth rate and weight loss," adds Dr. (insert last name). While medication can do a good job of

controlling symptoms, many professionals believe that medication and therapy are the best combination for treating ADD. Other therapies include psychotherapy, support groups, cognitive-behavioral therapy and social skills training which can help people with ADD learn new behaviors or accept themselves despite the disorder.

Rather than just prescribing drugs, the more osteopathic approach looks for the underlying causes of the symptoms of ADD. For instance, a common cause of behavioral problems is hypoglycemia which is easily treatable with diet changes. Food and inhalant allergies can also be common culprits that aren't difficult to treat either.

Another treatment modality that some osteopathic physicians use is osteopathic manipulation which can affect the nervous system of a child with ADD. Because so many children with these symptoms have allergies, they often have congestion that affects how they think, feel and act. One of these treatment techniques, designed to drain fluid from the head, can leave the child with the ability to think more clearly.

No matter which treatment your physician orders, your child can still learn to adapt to ADD and live a normal life.

Join the AOA's GOAL E-Team and Receive E-mail Alerts

The American Osteopathic Association (AOA) has announced the formation of its Grassroots Osteopathic Advocacy Link (GOAL) E-Team.

This site will provide physicians with regular grassroots updates and e-mail alerts, as well as allow physicians to relay questions to the AOA via the quickness and convenience of e-mail.

To join the GOAL E-Team, send your e-mail address to: HEcker@aoa-net.org.

Washington Update

- A study recently published in the *New England Journal of Medicine* documents huge disparities in what Medicare pays, per-resident, for graduate medical education (GME) in different parts of the country. Among the findings: GME payments to teaching hospitals in New York are three to four times those paid to hospitals in Los Angeles or Cleveland and seven times higher than in Houston. These disparities are at least partly attributable to differences in the way hospitals accounted for residency training costs in the 1984 base year. The issue likely will come into play in the debate over Balanced Budget Act (BBA) relief, the fiscal year 2000 budget, and recommendations on the way in which Medicare pays for GME. Given the likelihood of even larger disparities for osteopathic hospitals, it's also an issue that the American Osteopathic Healthcare Association will be following.

- The Congressional Budget Office (CBO) has criticized estimates for prescription drug benefit provisions in the Administration's Medicare reform proposal, pegging their cost at $168.2 billion over 10 years, $49.4 billion more than the White House had projected. According to the CBO, the proposal also overestimates savings from modernization of Medicare fee-for-service payments. In order to help fund the drug benefit, the President's plan calls for extending Medicare payment cuts for hospitals and other providers beyond 2002. According to the CBO, savings would amount to $48.2 billion, $16 billion less than the White House estimate. Besides extending the cuts, the President's proposal includes a "quality assurance fund" that would allocate $7.5 billion to providers over 10 years to address access and quality of care problems resulting from the BBA's payment reductions.

- The Department of Health and Human Services' Office of the Inspector General (OIG) has issued a special advisory bulletin on "gainsharing" – practices whereby hospitals reward physicians for efforts to reduce hospital costs with a share of the savings. According to the OIG, these practices pay physicians to "reduce or limit care" to Medicare and Medicaid patients and are prohibited by federal law.

- On July 17, the American Osteopathic Association's House of Delegates voted unanimously that physician unionization is "not a viable solution" to problems currently faced by physicians. In so doing, the AOA parted company with the American Medical Association, which voted earlier this summer to create a labor organization for the nation's 200,000 employed physicians and residents.

- The AOA and AMA are agreed, however, in their support for H.R. 1304, the Quality Health Care Coalition Act of 1999, which would provide an antitrust exemption for competing self-employed physicians to bargain with managed care plans. Both the Federal Trade Commission and Department of Justice have opposed the exemption, warning that such an "unprecedented" departure from established competition policy would drive up premium costs and increase physician income rather than protecting patients and quality of care. On the state level, Texas' governor recently signed legislation that would allow joint bargaining by competing physicians under the supervision of the state's attorney general. That law went into effect September 1.

- As you know, the Medicare Payment Advisory Commission (MedPAC) has issued its long-awaited report to Congress on Medicare payment for graduate medical education (GME). The report, entitled *Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals*, responds to the Balanced Budget Act's requirement that MedPAC examine the need for changes in federal policy affecting GME, Medicare payments to teaching hospitals, and federal health care workforce issues.

As anticipated, MedPAC has suggested that policymakers view Medicare payments for the direct costs of operating approved medical residency programs as payment for patient care, not as payment for training. It also believes that payments for direct graduate medical education (DGME) should be combined with the indirect medical education (IME) adjustment to better reflect the higher costs of the enhanced patient care

teaching hospitals provide to Medicare beneficiaries. In line with this thinking, MedPAC makes these six specific recommendations:

1.) Medicare should pay more for patient care in teaching settings when the enhanced value of that care justifies its higher costs.

To capture more accurately differences in teaching hospitals' costs of care arising from differences in patient complexity and the complexity and intensity of care, MedPAC suggests that Medicare payment policies should be changed:

- to make case-mix measurement methods account more fully for differences in patient severity of illness;
- to apply a combined DGME/IME payment adjustment to per case payment rates under the prospective payment system (PPS); and
- to base the enhanced patient care (EPC) adjustment on a different proxy measure than the resident-to-bed ratio in order to reduce the potential for influencing hospital demand for residents.

2.) The Congress and the Secretary should improve the diagnosis related groups to reflect more accurately the relationship between illness severity and the cost of inpatient care, thereby making Medicare payments more consistent with efficient providers' costs.

To more accurately reflect this relationship, MedPAC suggests improving inpatient case-mix measurement methods:

- by refining DRG definitions to better reflect severity of illness;
- by changing the method of calculating DRG weights to account more fully for differences in markups hospitals apply in setting charges; and
- by financing outlier payments on a DRG-specific basis.

3.) The Congress should revise Medicare's payments to recognize the higher value of patient care services provided in teaching hospitals through an enhanced patient care adjustment.

To help ensure beneficiary access to care in teaching hospitals, MedPAC has suggested implementing an EPC adjustment merging DGME payments into the IME adjustment. Creating such an adjustment, however, raises a number of questions:

- What direct GME costs should be included in cost per discharge?
- What measures and methods should be used in estimating the adjustment?
- What impact should the adjustment have on aggregate payments to teaching hospitals?
- How should the adjustment be implemented for facilities that are exempt from PPS?
- Should the adjustment be reflected in payments to Medicare+Choice plans?

In raising these questions, MedPAC identifies a number of secondary questions that will need to be considered in the next phase of its examination.

4.) The Congress should phase in the payment adjustment for enhanced patient care and any related policies that substantially change payments to individual providers.

According to MedPAC, the changes it recommends focus on the accuracy of Medicare payment policy, not on aggregate spending for GME in the Medicare program. Nonetheless, if implemented, these changes would have a significant impact on individual hospitals, depending on the size of the per-resident DGME payments they currently receive. MedPAC plans to examine possible transition periods and mechanisms in a March 2000 report.

5.) The Congress and the Secretary should develop payment adjustments for enhanced patient care in all settings where residents and other health care professionals train when the added value of patient care justifies its higher costs.

In MedPAC's view, recognizing the contribution residents and other trainees make to patient care in other settings would improve the consistency of Medicare payment policies and give providers incentives to use the most appropriate setting for patient care and training. Accordingly, it recommends using the same criteria – the value and cost of efficiently provided care – in determining whether and what EPCs should be applied in these settings.

6.) Federal policies intended to affect the number, specialty mix, and geographic distribution of health care professionals should be implemented through specific targeted programs, rather than through Medicare.

In its report, MedPAC concludes that although Medicare payment for health care services influences the health workforce, payment policy is "too blunt an instrument" for achieving specific workforce goals.

While these recommendations appear relatively straightforward, implementation would involve a number of changes in Medicare policy or law. MedPAC has stated that these changes would not substantially alter aggregate GME payments but that they would "significantly affect" payment to individual hospitals. For this reason, the Commission has suggested that changes in current payment methods should be phased in over several years.

MedPAC plans to make specific recommendations on implementing these changes in Medicare payment policy in a March 2000 report.

Source: AOHA Washington Update

Texas ACOFP Update

Talented Family Practice D.O.s Wanted!!

The Program Committee of the 2000 Annual Clinical Seminar (July 27 – 29, 2000 in Arlington), is seeking members who may have a "hidden" talent for music, magic, juggling, comedy, or just about anything else that you may want to share with us. The Committee is considering having a "Member Talent Show" as the entertainment after our President's Banquet.

There will be no auditions as we simply think it would be a fun evening for all of us to watch colleagues perform with groups they currently work with or have in the past. (Come on, those of you who performed while attending TCOM – call or we'll call you!) Those who perform solo are also encouraged to participate.

Please call Janet Dunkle at 888-8921-2637 if you think you're interested. We would love to see this happen!

AOBFP Certification

For those osteopathic family physicians who have been in practice for many years and are not yet certified, assistance is only a phone call away. The door is rapidly closing on the Phase-out of the grandfather clause for the American Osteopathic Board of Family Physicians Certification. The procrastination phase is over. It has been replaced by the "Get It Done" phase.

The exam contains "hands-on" OMT and written questions. As President Franklin Roosevelt said, "The only thing to fear is fear itself'. Your ACOFP colleagues are available to help you and the ACOFP Intensive Update in Family Medicine is there to prepare you for the exam. It includes OPP Practicums to enhance and improve OMT skills which are needed to successfully take the certification exam.

The process can start with a single phone call to the ACOFP (1-800-323-0794). Don't wait – the professional consequences of inaction are great.

Central Texas Dinner

The Family Practice D.O.s of Central Texas and spouses met for dinner on Thursday, October 7, 1999, at 6:30 p.m. at the TOMA State Headquarters. With the rapid growth in Austin and surrounding areas, many new family physicians have opened practices and we felt it was appropriate to get together to learn more about them.

We will be scheduling another dinner for November. If you did not receive an invitation to the first and are interested in attending (TOMA and TXACOFP membership are not required), please contact Janet Dunkle at 888-892-2637.

What Our Members Are Doing

Reginald Platt, III, D.O. currently volunteers as a supervising physician of the Shalom Zone, a mobile unit for indigent people in East Houston. He also runs the clinic opened by his father in 1946 as well as serves as staff physician for the Eastwood Clinic. This clinic, established in 1983 as a simple outreach program, has expanded to a full time clinic funded by grants from various institutions. Patients who are unable to pay for services pay their fees by volunteering their time doing yard work, translation, and clerical duties. Dr. Platt demonstrates the philosophy of giving back to his community.

David E. Garza, D.O. was installed as a member of the Texas State Board of Medical Examiners on August 21, 1999, in Laredo. Dr. Garza was President Elect of the TxACOFP until his appointment but remains on our Board as a Governor. Congratulations to Dr. Garza. We are proud of you!

Welcome New Members

The following physicians were accepted for membership at our Board of Governors Meeting on July 22, 1999:

Dralves Edwards, D.O., Dallas
Jamie Glover Inman, D.O., Fort Worth
Lewis Charles Perry, D.O., Lufkin
Donald Ray Whitaker, D.O., Jefferson

FUNDAMENTAL MEDICAL TERMS

Bacteria. . . . Rear entrance of a cafeteria
Nitrate. . . . . Cheaper than day rate
Urine . . . . . Opposite of "You're Out"
Dilate. . . . . To live longer
Outpatient. . A person who has fainted
Barium . . . . What happens if CPR fails

Texas Hospitals Introduce New Interns and Residents

Recently graduated osteopathic physicians from osteopathic colleges across the United States have begun their training programs at Texas hospitals and medical centers.

Bay Area Corpus Christi Medical Center

Frank Cummins, D.O.
COMP
Family Practice Resident

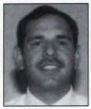
Jennifer DeVoke, D.O.
UNTHSC/TCOM
Family Practice Resident

Randy Henderson, D.O.
UNTHSC/TCOM
Family Practice Resident

Hunter Leigh, D.O.
UOMHS
Family Practice Resident

Shirat Ling, D.O.
UNTHSC/TCOM
Family Practice Resident

Angela May, D.O.
UNTHSC/TCOM
Family Practice Resident



Ismael Mena, D.O.
COMP
Family Practice Resident

Jeff Wang, D.O.
UNTHSC/TCOM
Family Practice Resident

Charlton Methodist Hospital (Dallas)

Charlie Ruby, D.O.
UNTHSC/TCOM
Intern

Brooke Army Medical Center (Fort Sam Houston)

Ronald D. Allen, D.O.
Western U
Resident

Michael D. Becker, D.O.
UOMHS/COMS
Intern

Scott R. Dalton, D.O.
LECOM
Resident

Nicolo B. Geralde, D.O.
CCOM
Fellow

Marc R. Happe, D.O.
LECOM
Resident

David M. Hufnagel, D.O.
CCOM
Intern

Matthew J. Isom, D.O.
UOMHS/COMS
Intern

David P. Jones, D.O.
PCOM
Fellow

John T. Kolisnyk, D.O.
PCOM
Intern

David T. Nguyen, D.O.
UHS-COM
Intern

Brandon M. Rhinehart, D.O.
OSU-COM
Intern

Wayne L. Rosen, D.O.
Western U
Resident

Sean M. Siler, D.O.
Western U
Intern

Dallas/Fort Worth Medical Center (Grand Prairie)

Jeffrey R. Counts, D.O.
UHS-COM
Intern

Theresa A. Mutzig-Erwin, D.O.
UNTHSC/TCOM
Intern

Binh D. Nguyen, D.O.
UNTHSC/TCOM
Intern

John R. Pearce, D.O.
UNTHSC/TCOM
Intern

Samrath S. Sokhey, D.O.
UOMHS/COMS
Intern

John Peter Smith Hospital (Fort Worth)

Susan Conroy, D.O.
UNTHSC/TCOM
Intern

Cheri Francis, D.O.
UNTHSC/TCOM
Family Practice Intern

Amy Klein, D.O.
UNTHSC/TCOM
OB/GYN Intern

John Leaton, D.O.
UNTHSC/TCOM
Family Practice Intern

Rowena Maclin, D.O.
UNTHSC/TCOM
Family Practice Intern

Waleed Mahmoud, D.O.
UNTHSC/TCOM
Family Practice Intern

Wendall McDaniel, D.O.
NSU-COM
Family Practice Intern

Tuan Nguyen, D.O.
NSU-COM
Family Practice Intern

Barbara Webster, D.O.
UNTHSC/TCOM
Intern

Osteopathic Medical Center of Texas (Fort Worth)

Karen L. Benz, D.O.
UNTHSC/TCOM
OB/GYN Intern

Brooks M. Blake, D.O.
UNTHSC/TCOM
Intern

Niska A. Blevins, D.O.
UNTHSC/TCOM
Intern

Mark Brennan, D.O.
PCOM
Vascular Surgery Resident

Patrick A. Conway, D.O.
OSU-COM
Family Practice Intern

Brian R. Crowhurst, D.O.
CCOM
Intern

Osmany DeAngelo, D.O.
UNTHSC/TCOM
Intern

Christian Ellis, D.O.
OSU-COM
General Surgery Resident

Jeremy G. Enslein, D.O.
NSU/COM
Internal Medicine Intern

Ryan S. Farrer, D.O.
UNTHSC/TCOM
Intern

Craig A. Ferrara, D.O.
UNTHSC/TCOM
Intern

E. Scott Ferree, D.O.
UNTHSC/TCOM
Manipulative Medicine
Plus One

Lisa L. Gardner, D.O.
UNTHSC/TCOM
Intern

W. Todd Gray, D.O.
UNTHSC/TCOM
Internal Medicine Intern

Jessica Hals, D.O.
LECOM
Internal Medicine Intern

Osteopathic Medical Center of Texas (Fort Worth) continued on next page

Bryan P. Hoffman, D.O.
UHS-COM
Family Practice Intern

Christopher G. Jordan, D.O.
UHS-COM
Internal Medicine Intern

Shane P. Kimball, D.O.
UNTHSC/TCOM
Internal Medicine Intern

Adriane K. Martin, D.O.
UNTHSC/TCOM
Intern

Megan McDonald, D.O.
OUCOM
Diagnostic Radiology Resident

Timothy P. Metzger, D.O.
UHS-COM
Family Practice Intern

Scott E. Neumann, D.O.
UNTHSC/TCOM
Family Practice Intern

Esiquiel P. Olivarez, D.O.
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Family Practice Intern

Trisha Parks-Beakly, D.O.
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OB/GYN Resident

Himanshu Patel, D.O.
Western U
Internal Medicine Resident

Robert G. Parrott, D.O.
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Family Practice Intern

Michael Rimlawi, D.O.
NYCOM
Orthopedic Surgery Resident

Melinda J. Velez, D.O.
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Internal Medicine Intern

C. Brien Wofford, D.O.
UNTHSC/TCOM
Family Practice Intern

St. Paul Medical Center (Dallas)

Cheri L. Mann, D.O.
UNTHSC/TCOM
Family Practice Intern

Renee C. Stock, D.O.
UNTHSC/TCOM
Internal Medicine Intern

Aimee L. Wright, D.O.
UNTHSC/TCOM
Family Practice Intern

University of Texas Medical Branch at Conroe

Cheryl Renee Beau, D.O.
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Family Practice Resident

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Pediatric Resident

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Salvador Molina, Jr., D.O.
OUCOM
Internal Medicine Resident

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UNTHSC/TCOM
Pediatric Resident

Dronabinol is Transferred to Schedule III

The administrator of the Drug Enforcement Agency has issued a final rule transferring a drug between schedules of the Federal Controlled Substance Act. The drug containing synthetic dronabinol in sesame oil and encapsulated in soft gelatin capsules in a product approved by the Food and Drug Administration has been transferred from Schedule II to Schedule III of the Federal Controlled Substances Act. The Texas Controlled Substances Act has been amended to reflect the change.

Dronabinol is marketed under the trade name Marinol® as an oral treatment for the nausea and vomiting associated with cancer chemotherapy. This action was based on the following:

- Dronabinol has a potential for abuse less than the other drugs or other substances in schedules I and II;
- Dronabinol is a FDA-approved drug product and has currently accepted medical use in treatment in the United States; and
- Abuse of Dronabinol may lead to moderate to low physical dependence or high psychological dependence.

The Schedules of Controlled Substances are now posted on the Texas Department of Health Drugs and Medical Devices Division's homepage at: <www.tdh.state.tx.us/bfds/drugs/schdrug99.html>

New Legislation Affects Disabled Person Parking Placards

The 76th Texas Legislature passed several bills relating to disabled person parking placards as follows:

SB 132 – This bill amended the Transportation Code by allowing physicians licensed to practice medicine in this state or a state adjacent to this state, or authorized by applicable law to practice medicine in a hospital or other health facility of the Veterans Administration to sign the initial Application for Disabled Person Identification Placards and/or License Plates, Form VTR-214.

News You Can Use

SB 21 – This legislation added two sections to the Transportation Code, which allows institutions, facilities, and residential retirement communities that are licensed under Chapter 242, 256 or 247 of the Health and Safety Code, to obtain disabled person placards and/or license plates. The disabled person license plates may be obtained for a van or bus operated for the transport of residents of the institution, facility, or retirement community.

In order to apply for a disabled person placard and/or license plate, the manager or administrator of such institution, facility, or retirement community must complete the initial application, Form VTR-214 REV. 8/99. Earlier copies of this form can be accepted for institutions, facilities, and retirement communities provided that the manager/administrator includes the license number issued by the Texas Department of Human Services (DSH) in the space for the driver's license, personal identification, or DHS number. The Disability Statement, which is normally completed by a physician on the front of the VTR-214, is not required.

HB 1032 – Differences in the Definition of Permanently Disabled: HB 1032 provides that for disabled person placards issued on or after September 1, 1999, the disabled person or applicant is required to have additional information regarding the type of disability prior to issuance of the disabled person placard. The Application for Disabled Person Identification Placard and/or Disabled Person License Plate, Form VTR-214, has been revised to include a statement from the physician regarding the nature of the disabled person's disability. In the Disability Statement completed by the physician, the physician will have two boxes to choose from regarding the disabled person's type of disability. If the disabled person has a "mobility disability," they will receive a Blue Permanent Disabled Person Placard. All other permanently disabled persons will received Red Permanent Disabled Person Placards.

Mobility Disabilities - In order for the county to issue a blue permanent disabled person placard, the physician will select the first box in the Disability Statement. By selecting this box, the physician is stating that the disabled person has one of the following disabilities:

- cannot walk without the use of or assistance from an assistance device, including a brace, cane, crutch, another person or prosthetic device; or
- cannot ambulate without a wheelchair or similar device.

Persons with either of these mobility-related disabilities will receive the blue placards.

Non-Mobility Disabilities - If the physician selects the second box in the Disability Statement, the physician is stating that the disabled person has one of the following disabilities and will receive red permanently disabled person placards:

- legally blind – if the person has not more than 20/200 of visual acuity in the better eye with correcting lenses, or visual acuity greater than 20/200 but with a limitation in the filed of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees;
- cannot walk 200 feet without stopping to rest;
- is restricted by lung disease to the extent that the person's forced respiratory volume for one second, measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 millimeters of mercury on room air at rest;
- has a cardiac condition to the extent that the person's functional limitations

are classified in severity as Class III or Class IV according to standards set by the American Heart Association;

- is severely limited in the ability to walk because of an arthritic, neurological, or orthopedic condition; or
- has another debilitating condition that, in the opinion of a physician licensed to practice medicine in this state, limits or impairs the person's ability to walk.

Parking Restrictions – Beginning September 1, 1999, some disabled person parking spaces may be color-coded with blue-colored spaces and re-colored spaced. If the disabled person parking spaces are color-coded, the disabled persons using blue disabled person placards may park in either blue or red spaces. Persons using red placards may only park in spaces that are red color-coded. If a disabled person is operating or being transported by a vehicle displaying disabled person license plates, the vehicle may only be parked in red-coded spaces unless a blue permanent disabled parking placard is also displayed from the vehicle's rearview mirror.

Temporary Disabled Person Placards – The temporary disabled person placards will continue to be issued the same as in the past. These placards will remain red in color and will expire six months after issuance. Vehicles displaying red temporary disabled person placards may only park in red-colored disabled person spaces if the disabled person parking spaces are color-coded.

EPSDT Fees Increase

Effective for dates of service on or after September 1, 1999, the Texas Department of Health has increased the fee paid for EPSDT Medical Checkups from $47.20 to $48.19. This increase applies to traditional fee-for-service as well as managed care providers.

Additionally, physicians should be aware that they may also receive an additional $5.00 administration fee for each immunization that is provided.

Blood Bank Briefs for Physicians

By Leland B. Baskin, M.D.
Carter Blood Care

Neonatal Alloimmune Thrombocytopenia: The Newborn with a Severe Platelet Deficiency

Introduction

Neonatal alloimmune thrombocytopenia (NAIT) is a severe platelet deficiency in newborns cased by maternal antibodies directed against platelet antigens inherited from the infant's father. These antibodies cross the placenta during the third trimester causing destruction of platelets, which typically becomes manifest within 24 to 36 hours after delivery. NAIT is reported in about one of every 2,000 to 5,000 live births, So, it is seen several times a year in north Texas.

Human Platelet Antigens

Under current nomenclature, the biallelic human platelet antigens (HPA) are numbered in chronological order of identification. The more common allele is given the label "a" while the less common allele is designated "b."

All HPA reside on platelet membrane glycoproteins and are inherited in an autosomal codominant manner. The most common platelet antigen involved in NAIT in Caucasians is HPA-1 (formerly PLA1), located on the platelet membrane glycoprotein GP IIIa. The other common antigens include HPA-2 through HPA-5. Antibodies to HPA-1a account for about 78 percent of proven cases of NAIT, while those against HPA-5b account for about 19 percent of cases. Most of the remaining three percent of cases are due to antibodies against antigens in the common HPA groups. Rare cases involving antibodies against human leukocyte antigens have been reported.

Mechanism

In a manner similar to that in Rh hemolytic disease of the newborn, Anti-HPA IgG antibodies are produced by the mother in response to exposure to foreign antigens on the infant's platelets. This usually occurs by way of fetal maternal hemorrhage or prior transfusion. Since the antigens are foreign to the mother, they must be paternal in origin. To cross the placenta, the antibodies are necessarily of the IgG class.

The mechanism for producing these antibodies differs from HDN in two significant ways: 1) Since the major HPA appear around the 18th week of gestation and are fully developed by the 19th week, thrombocytopenia may develop early in the first pregnancy. Form 50 to 60 percent of cases of NAIT involve first pregnancies. In contrast, HDN never develops during the sensitizing pregnancy. 2) Maternal anti-HPA antibodies may not always be detected, whereas the presence of anti-D antibodies accurately predict the risk of HDN in subsequent pregnancies. The presence of anti-HPA is neither sensitive nor specific. Anti-HPA may be detectable in unaffected pregnancies and undetectable in cases of NAIT. Thrombocytopenia develops in about two percent of fetuses of women with circulating Anti-HPA-1a and in only about 30 percent of those with a titer greater than 1:32. Interaction of HPA with class II HLA phenotype DR3, DR52a is suspected but currently inadequately understood. The absence of HLA-DRB3 has been reported to have a negative predictive value of 99.6 percent for the presence of Anti-HPA-1a.

Clinical Features

Affected infants typically present with purpura, petechiae or bleeding within 24 to 36 hours after birth. NAIT resolves spontaneously in two to four weeks without complication in about 80 percent of patients. The major complication is intracranial hemorrhage either in utero or following trauma of delivery in about 20 percent of infants. This may result in porencephalic cyst, hydrocephalus or intracerebral hematoma. Without prompt

treatment, the overall mortality for NAIT is about 10 to 15 percent.

Diagnosis

As in the case of most diseases, diagnosis of NAIT rests in the clinical observation of signs and symptoms with supporting laboratory information. The presence of unexplained petechiae or purpura in an infant with a falling platelet count of less than 100,000/mm (100 x 109/L) should raise the suspicion of NAIT. Other causes of neonatal thrombocytopenia must be excluded. These include nonimmune causes such as infections, congenital anomalies, malignancies and immune causes, such as maternal drug-induced anti-platelet antibodies and maternal autoimmune disorders, such as SLE or ITP.

If an infant's thrombocytopenia is isolated and the maternal platelet count is within the normal reference interval, than NAIT is the probable diagnosis. It may be confirmed by detecting anti-HPA in the infant's plasma. If no antibody is detected, HPA typing of mother and father yielding parental antigen incompatibility is sufficient to confirm NAIT.

Treatment

Random platelets are usually transfused initially, but are unlikely to be effective. The most effective treatment for an infant with NAIT is transfusion of washed, irradiated maternal platelets. The standard dose is 10 to 15 mL of platelet concentrate per kg body weight. These maternal platelets will be negative for the target antigen, and washing will remove the offending antibodies in the maternal plasma. Moreover, maternal platelets will prevent exposure of the infant to any new antigens or agents. Irradiation is necessary to prevent graft versus host disease. Maternal platelets are usually collected by apheresis. Coordination with the blood center is mandatory to ensure proper handling.

If maternal platelets are not available, HPA-compatible platelets should be equally effective. In the event that an antibody is not identified, platelets that are negative for HPA-1a and HPA-5b should be effective in more than 95 percent of cases.

Conclusion

NAIT is a life-threatening deficiency of platelets in newborn infants that requires an immediate, coordinated response by the attending clinician, the transfusion service and the blood center. If treated promptly by transfusion with washed, irradiated maternal platelets, the probability of complete recovery is extremely high.

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GAO Says States are Flouting Lead Level Testing Law

The General Accounting Office (GAO) has stated that most states are ignoring a 1989 law that requires young Medicaid recipients to be tested for lead poisoning. As a result, the GAO said that hundreds of thousands of children exposed to high levels of lead are neither tested nor treated. Medicaid recipients are three times as likely as other children to have high amounts of lead in the blood.

Separately, a federal advisory panel noted that "current lead screening rates among children covered by Medicaid are very poor, despite federal requirements."

Health officials say that cost is not the main reason for the failure to test children. Instead, officials believe that physicians are either unaware of the federal requirements or do not see lead exposure as a problem for their patients. Under federal law, states are responsible for the screening of children on Medicaid, and they can provide such services directly or make arrangements for the service to be provided by physicians, clinics and HMOs. Federal rules state that Medicaid recipients must be tested for lead poisoning at 12 months and again at 24 months. Medicaid recipients ages 3 to 6 must also be tested if they have not previously been screened.

Medicaid will pay for testing and treatment, but will not pay for testing of substances like paint and water that are sent to a lab for analysis.

The Centers for Disease Control and Prevention estimate that 890,000 children ages 1 through 5 have so much lead in their blood that it could harm their health and/or their learning ability. About 535,000 of these children are Medicaid recipients, but fewer than 20 percent of children on Medicaid in that age group – 1.2 million of the 6.3 million recipients – are ever tested.

IN BRIEF

Two More Hospitals Cancel Managed Care Contracts

Arlington Memorial Hospital has ended its agreement to treat United Healthcare's health plan members. This move is expected to affect approximately 1,200 members whose primary physicians have staff privileges at the hospital.

Additionally, All Saints Health System of Fort Worth has canceled its contract to serve members of the NyLCare 65 senior health plan. No figures were available as to how many members were affected by the contract cancellation.

Humana's Medicaid HMO to be Canceled in Several Counties

Humana Health Plan of Texas will end its Medicaid managed-care contract in Tarrant, Denton, Johnson, Parker, Wise and Hood counties. The company has been offering a HMO for low-income young mothers and children under the name PCA Star. Humana indicated that members of the health plans will be served until they find another plan. Humana does plan to continue to offer its Medicaid HMO in the Austin and San Antonio areas.

Similarity of Drug Names Sparks Campaign

Since Celebrex (the new arthritis pill) was launched this January, federal regulators have received 95 reports of errors by physicians and pharmacists in dispensing Celebrex – errors blamed on health professionals confusing the painkiller with similar-sounding drugs. Similar-sounding drug names are Celexa (for depression) and Cerebyx (an anti-seizure drug).

None of the cases involved serious injury or death. However, in an effort to try and clear up the confusion, Pfizer, Inc., and Monsanto Co., the companies that jointly sell Celebrex, are launching an educational campaign aimed at physicians and pharmacists.

This spring, Celebrex became the fastest-selling new drug ever, with about 9.3 million prescriptions written to date.

Florida Doctors to be Fingerprinted

In an effort to weed out physicians who have concealed criminal backgrounds, the state of Florida has mandated fingerprinting of physicians as a condition of license renewal. The prints will be sent to the Federal Bureau of Investigation's national database for analysis. The law also applies to chiropractors and podiatrists.

Annual National Drug Survey Results Released

Health and Human Services Secretary Donna E. Shalala has released findings of the 1998 National Household Survey on Drug Abuse (NHSDA), showing that illicit drug use declined among young people ages 12-17 from 1997 to 1998, and that illicit drug use among the overall population remained flat.

An estimated 9.9 percent of youths ages 12-17 reported current illicit drug use in 1998, meaning they used an illicit drug at least once during the 30 days prior to the time of the survey interview. This estimate represents a statistically significant decrease from the estimate of 11.4 percent in 1997.

Teen use of inhalants decreased significantly from 2.0 percent in 1997 to 1.1 percent in 1998. The survey also found that the rate of youth reporting they tried marijuana for the first time declined significantly and the average age of first-time use went up. The percentage of teenagers who were current users of marijuana declined from 9.4 percent in 1997 to 8.3 percent in 1998, although the decline was not statically significant. "For the past two years we have been cautiously optimistic as a series of encouraging reports seemed to indicate a leveling off and even a possible decline in drug use among teens after years of dramatic increases," said Secretary Shalala. "While it looks like we have turned the corner with [this] report, we must not rest. Too many young people are still using drugs, and we must continue to build on our promising efforts to push the rate of drug use down ever further."

Also included in the report was the following:

Trends in New Use of Substances (Incidence)

Because information on when people first used a substance is collected on a retrospective basis, information on first-time use or incidence is always one year behind information on current use.

- In 1997, an estimated 2.1 million persons first used marijuana, approximately 5,800 new marijuana users per day. The rate of first use of marijuana among youths age 12-17 declined significantly from 79.3 per one thousand potential new users in 1996 to 64.4 per one thousand potential new users in 1997. This is after years of rising incidence during the 1990s when the rate of new use among youth age 12-17 rose from 37 per one thousand potential users in 1991 to about 79.3 per one thousand potential users in 1996.
- An estimated 81,000 persons used heroin for the first time in 1997. The rate of initiation for youths age 12-17 increased from below 1.0 per one thousand potential new users during the 1980s to 2.7 in 1996 and, while not statistically significant, dropped to 1.1 in 1997.
- There were an estimated 730,000 new cocaine users in 1997. The rate of new use among youths age 12-17 increased from 4.1 per one thousand potential users in 1991 to 10.8 per one thousand potential users in 1997.
- In 1997, there were an estimated 1.1 million new hallucinogen users. The rate of first-time hallucinogen use among youths age 12-17 increased from 11.1 per one thousand potential new users in 1991 to 23.9 per one thousand potential users in 1997.

Summary findings from the 1998 National Household Survey on Drug Abuse are available at <www.samhsa.gov>

Self's Tips & Tidings

By Don Self

Texas D.O. Magazine

Doctor, please let me encourage you to give this monthly column to your billing staff so that they can use the information to help increase your income, simplify your billing and keep you out of trouble with audits.

Billing Medicaid for Injections

We all know that Medicare will not allow us to bill an administration fee (90782) when giving an IM injection, but Medicaid's rules are different. They expect you to bill for the administration and the injectable drug. Therefore, when you provide the service, be sure to use the 90782 as well. We also recommend that you bill private insurance and managed care for the administration of injection using 90782. Also, Medicaid requires you to use certain modifiers if you want to be paid for the injectable drug. To denote the oral method does not suffice for the patient's needs.

- OC Injection is medically necessary if the oral route is contraindicated or an acceptable oral equivalent is not available.
- JI (that's a capital I and not a number one). This injection into bursa, joints, tendon sheaths or trigger points is medically necessary to treat an acute condition or the acute flare-up of a chronic condition
- ET is an emergency situation
- 6A Injectable medication is the accepted treatment of choice. Oral medication regimens have proven ineffective or are not available.
- 6B The patient has a temperature over 102 degrees Fahrenheit and a high blood level of antibiotics is needed quickly.

Note: The above modifiers are for Medicaid only, and should not be used for Medicare or private claims.

A Common Misconception

Every once in a while, I'll get a call from a TOMA member asking if I know of a good medical collection consultant or private insurance consultant. They always seem to mention that I'm a Medicare consultant. Please allow me the opportunity to point out that Medicare is only part of what I specialize in. I am responsible for managing the accounts receivable, all insurance claims, all coding, and appeals for seven clinics that have been entrusted to us by Triad Hospital System. We teach workshops on collections, private insurance and coding, and Medicare is only part of that. We handle patient statements for practices, provide charts and forms to offices (let us compare prices for you), provide year labels for charts and we're trying to be a one-stop shop for all medical business needs. There are times when we'll refer you to others we trust, for such areas as practice value reviews (how much to sell your practice for), employee hiring practices, legal contracts, malpractice insurance, computer systems or consultants who specialize in Oncology, Radiology, Pathology, Anesthesiology or Ophthalmology. Consultants who specialize in those areas can do a much better job than we can - so we refer you to them.

How to Handle Attorneys Who Ask for a Discount

We recently heard the very best advice we have ever heard on how to handle attorneys who settle a claim and ask you to accept a lower or reduced fee. It's brilliant. We recommend that you tell the attorney you will take the same reduction on your fee that he or she takes from the patient. In other words, if they're asking you to discount your fees by 50%, tell them you will if they'll reduce their fee to the patient by 50% as well. Ask for a certified statement showing their reduction before you make any reductions to your own fees.

Reward that Employee with a Seminar and Some Fun

On Friday, November 5, we will be teaching a full-day workshop at the Isle of Capri Casino in Bossier City. Bossier City is across the river from Shreveport - right by the Texas state line on Interstate 20. The seminar will be covering a lot of the changes we expect to see with coding, Medicare, coverage and insurance issues in 2000. We have arranged for a special rate for the Thursday evening before the seminar - $79 plus tax. The workshop will be held on Friday from 9am to 4pm. Exhibitors will be present and will be giving out door prizes, which include cash, software programs, E&M sliderules, coding books, newsletter and magazine subscriptions and more. The tuition is only $175 for TOMA members and $135 for each additional person. If you would like a flyer on this seminar faxed to you, please call 1-800-256-7045 or fax a request to 903-839-7069. Attendance is limited to the first 30 people. You can see a schedule and download registration forms for all of our seminars at <www.donself.com>. We have 13 seminars coming up in different cities in the next few months.

How to Bill for Removing Sutures

When laceration repair was done in the ER:

There are occasions when you have a patient, who was treated in the emergency room, show up in your office to have sutures removed. When this happens, the AMA says to bill for the service using an office visit code (99212). Some consultants say you should use the suture removal under anesthesia code (15851) and, since you're not using general anesthesia, they say to append the procedure code with a 52 modifier. Both ways seem appropriate to me, so the choice of either billing for 99212 or 15851-52 is up to you.

continued on next page

When laceration repair was done by you:

If the repair was done within the past 10 days and the patient returns to have the sutures removed, there should not be any charge for suture removal, due to the global fee period rules. If it has been longer than 10 days, you should charge for it, again with your choosing whether to use the 99212 or the 15851-52.

Billing for Emergency Room Visits

You receive a call from the Emergency Room with the news that one of your patients is there, and the family is requesting your presence. You go to the ER, confer with the ER physician and the ER physician turns the care over to you. How do you bill? You know the ER physician used the Emergency Department codes 99281-99285.

Simple. You may also use the same codes. As long as the ER physician is a different specialty (Emergency Medicine), there should be no problems in both physicians billing the same E&M codes. We do not recommend billing for a consultation, however, as a consultation reflects that the ER physician is asking your advice on how to proceed with the care. It is very, very rare for an ER physician to ask for your opinion as to the continued treatment of a patient. In the vast majority of cases, they turn the care over to you before the consultation.

Flu Vaccine Code Changed

This flu season, instead of using 90724 (which has been deleted), you should use 90659 for the influenza vaccine, along with code G0008 if you are billing Medicare, or 90782 if you are billing private insurance or managed care.

Thank You

So far, we've sold over 1,500 E&M documentation sliderules to physicians, office managers and coders around the country for $9.50, plus $1.50 s/h. Time after time, we receive e-mails, faxes or notes stating that the sliderule not only makes it easier for doctors to code, but also increases the levels of E&M codes they are using, resulting in greatly increased income to the practice. If you wish to order any of these sliderules, give us a call at 800-256-7045, e-mail us or fax us at 903-839-7069.

New Seminar Schedule, which includes Isle of Capri Casino can be found at <www.donself.com/seminars.html>

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Spotlight on Members

Georgetown Physician Elected Vice President of Texas Medical Foundation Board of Trustees

The Texas Medical Foundation physician membership elected longtime Georgetown physician William R. Jones, D.O., vice president of the TMF at the annual membership meeting held in Irving on July 10. A board member since 1992, Dr. Jones will be instrumental in advancing TMF's mission to assure quality health care for Texans during his two-year term as vice president.

Dr. Jones has demonstrated his dedication to his profession throughout this 20-year career. A 1979 graduate of the University of North Texas Health Science Center/Texas College of Osteopathic Medicine, he has held staff memberships at Georgetown Hospital and Round Rock Hospital since 1986. In 1991, he was certified by the American Osteopathic Board of Family Physicians. Dr. Jones also serves as a Texas delegate to the American Health Quality Association. He has a long association with TMF, serving as a physician reviewer since 1985 and member of the State Review Program Committee.

The Texas Medical Foundation is the medical peer review/quality improvement organization of Texas. TMF is a private, nonprofit organization of licensed physicians (D.O.s and M.D.s) whose purpose is to promote, develop, define and encourage the delivery of high quality, cost-effective medical care and Health. TMF's membership consists of over 6,000 physicians, 20 of whom serve on the Board of Trustees.

Dr. David Garza Sworn in as Member of TSBME

David E. Garza, D.O., of Laredo, was officially sworn in as a member of the Texas State Board of Medical Examiners by Phillip Kazen, a state district judge from Bexar County. The event took place August 21 at the Executive Club in Laredo, and included elected officials and colleagues, as well as Dr. Garza's family members.

"We are honored that the governor has seen fit to appoint Dr. Garza as one of the 18 members of this auspicious board," said Webb County Clerk Henry Flores, who spoke at the ceremony. State Representative Henry Cuellar stated, "He is a true, fine doctor in our community."

A 1989 graduate of the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine, Dr. Garza is a certified in family practice.

Phillip Cohen, D.O., Receives OMTC's "Physician of the Year" Award

Phillip D. Cohen, D.O., of Fort Worth, was honored with the 1998-99 "Physician of the Year" award by the Osteopathic Medical Center of Texas. The award was presented during the 1999 Medical Staff Awards, held June 8 at River Crest Country Club in Fort Worth. The recipient is selected by his or her peers for outstanding leadership and example.

A 1973 graduate of the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery in Des Moines, Iowa, Dr. Cohen is certified in internal medicine.

Upon receiving the award, Dr. Cohen stated, "I was very touched by the award. I did not expect such recognition...OMCT is a wonderful institution with really good people to work with. I would like to thank everyone for such a wonderful honor."

Have you received an honor or award or know of someone who has? TOMA would like to know about it.
Send information to: Editor, Texas Osteopathic Medical Association, 1415 Lavaca, Austin, TX 78701-1634
FAX: 512-708-1415 or E-mail: <toma@txosteo.org>.

News

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

UNT Health Science Center Awarded $950,000 Cardiovascular Research Grant

The old saying that people don't use their brains to exercise is being tested through research at the University of North Texas Health Science Center. Peter B. Raven, Ph.D., chair of the department of integrative physiology at the UNT Health Science Center, has been awarded a four-year $950,000 grant from the National Heart, Lung and Blood Institute of the National Institutes of Health (NIH) for related work.

Researchers have known that blood pressure is regulated by brain activity. Also during exercise, they have found that muscle activity modulates what the brain tells the heart to do. Dr. Raven's research is working to prove that the brain resets the baroreflexes; which are a collection of sensory nerve endings specialized to monitor changes in blood pressure. The impulses from the muscle reflexes reach the brain so heart rate and blood vessels can adjust appropriately during exercise.

The research will involve measuring the interactions between the brain and the muscles. Altering muscle activity during the exercise will help researchers determine how much brain power is needed to perform the work.

According to Dr. Raven, certain drugs may hinder brain responses during exercise, therefore causing the brain to fail to respond appropriately.

"What's known as a 'blood brain barrier' may be playing a role with the interaction of certain drugs and exercise," said Dr. Raven. "Data obtained through this research has the potential to change the way doctors use exercise therapy, particularly in individuals with certain health problems."

Clinical faculty at the health science center will be working with Dr. Raven and colleagues to evaluate the use of drugs during exercise to help determine if these drugs affect the brain responses.

With the awarding of this grant, Dr. Raven and his researchers will now be funded by the NIH for 20 years for their work in showing how the brain is involved in the cardiovascular responses to exercise.

Dr. Raven's research grant is just part of the reason for the increased health science center figures in the recent Texas Higher Education Coordinating Board report on Expenditures for Research and Other Sponsored Projects. The percentage of increase the UNT Health Science Center has experienced in Research & Development since 1995 is the highest in the state of Texas – an increase of 62 percent. The average among the state is just under 20 percent, and the next highest after the UNT Health Science Center is at 37 percent.

UNT Health Science Center Achieves Patient Care Accreditation

The University of North Texas Health Science Center at Fort Worth has achieved three-year accreditation from the Joint Commission on Accreditation of Healthcare Organizations. The accreditation applies to all health science center patient care services, largely provided by the center's physician group practice, the Physicians & Surgeons Medical Group.

An organization voluntarily undergoes a site visit by a full team of Joint Commission experts every three years, with three years as the maximum accreditation award.

"The health science center seeks accreditation to demonstrate our commitment to the community of providing high quality patient care and service," said David M. Richards, D.O., health science center president. "We view obtaining Joint Commission accreditation as an incentive to continue to improve our services."

Joint Commission accreditation recognizes an organization's performance in complying with national health care standards for ambulatory care organizations. These standards help organizations achieve the highest level of performance possible, reduce patient risk for undesirable outcomes and create an environment for continuous improvement.

Presidential Search Narrows to Three Candidates

A search committee has narrowed its nationwide search to three finalist candidates for the post of president of the UNT Health Science Center.

According to Dr. Alfred F. Hurley, chancellor of the UNT system, regents will conduct final interviews with candidates on October 15. The UNT regents hope to name the new president as soon as possible after the interviews.

The three finalists are Dr. Thomas Wesley Allen, provost, dean and professor of internal medicine at Oklahoma State University College of Osteopathic Medicine; Lieutenant General Ronald R. Blanck, Surgeon General of the U.S. Army and commander of the U.S. Army Medical Command; and Dr. Benjamin L. Cohen, vice president for health affairs for the UNT Health Science Center at Fort Worth and executive dean of the center's Texas College of Osteopathic Medicine.

UNT launched the search early this year after current Health Science Center President Dr. David M. Richards, announced plans in December 1998 to serve one final year and then retire.

Since becoming president in 1986, Dr. Richards has taken a key role in the development of partnerships between the Health Science Center and other health education and health care institutions throughout the nation.

Praising the retiring president for his leadership, Chancellor Hurley said, "Dr. Richards has brought national attention to the capabilities of the UNT Health Science Center, especially to his work in primary care medicine and in related research such as its nationally recognized study on cholesterol.

"His eventual successor will take the helm of an already highly successful institution."

TRICARE's Point-of-Service Option: Why Unlimited Access Costs More

The point-of-service option under TRICARE Prime is one of the least-understood benefits by DoD TRICARE beneficiaries enrolled in the Prime (health-maintenance-organization-like) plan. Point-of-service means TRICARE Prime enrollees have the freedom to receive services without a referral or authorization. Such unlimited access can be costly, however, as Prime enrollees have to pay significantly higher cost-shares and a deductible, neither of which apply when enrollees use Prime network primary care managers (PCMs) to coordinate all their non-emergency care.

By choosing and using a PCM for all non-emergency care, enrollees have much lower out-of-pocket costs. Network PCMs determine when access to specialty care is medically necessary, and when it is, they make the referral. After a referral is made, TRICARE's health care finders give out the referral information.

When patients bypass their PCMs and seek care without a referral, they should be aware of the following:

- Care must be medically necessary and obtained from authorized providers, or TRICARE will pay nothing.
- The beneficiary will be responsible for an annual deductible of $300 per individual or $600 for a family. This deductible applies to both inpatient and outpatient services and is applied on an enrollment-year basis.
- After the deductible is met, the enrollee is responsible for 50 percent of the TRICARE allowable charges. The TRICARE allowable charge is the amount a provider can charge for a specific service. The charge depends on the service provided.
- If care is sought from a non-network provider, the provider may charge the patient even more – up to 15 percent above the TRICARE allowable charge.
- The point-of-service option does not apply to emergency care. Enrollees should review and understand the definition of emergency care in the TRICARE Prime handbook.
- Charges paid with the point-of-service option do not apply to the catastrophic cap (including deductibles and cost-shares).

TRICARE Prime was designed to involve very little paper work, low out-of-pocket costs, and to ensure that an enrollee's care is coordinated. In addition, Prime encourages enrollees to actively participate in their own health care and health promotion.

TRICARE beneficiaries need to consider what they want in regard to unlimited versus limited access to providers and the price they are willing to pay. Only then can they make their decision accordingly. It is nice to know enrollees may visit any provider they choose, but they must understand the costs involved in making this decision.

For more information, Prime enrollees should visit or call their TRICARE service center or visit the TRICARE Web site at <www.tricare.osd.mil>.

Expanded Access to Clinical Trials

By Douglas J. Gillert American Forces Press Service

The Defense Department and National Cancer Institute have expanded access to clinical trials for DoD health care beneficiaries. Since 1996, the DoD/NCI Cancer Clinical Trials Demonstration Project has provided patients with an opportunity to participate in NCI-sponsored cancer treatment clinical trials Phases II and III. They can receive the care either in military medical facilities or through participating civilian providers. DoD covers the cost of the trials under its managed health plan, TRICARE. Now, DoD also will cover the costs for participation in early detection and prevention clinical trials.

"To underscore our commitment to wellness and prevention, we feel we must provide reimbursement for clinical trials that offer some of the most promising advances in cancer prevention and treatment research," said Sue Bailey, D.O., assistant secretary of defense for health affairs. "For some TRICARE beneficiaries with an increased risk of developing cancer, the experimental trials offer new choices to minimize chances of developing cancer. It is another way to keep our troops and families healthy."

This is the first time any health plan has agreed formally to cover the cost of clinical cancer prevention trials, according to Dr. Richard Klausner, NCI director. "This agreement will become a model for providing access to the best possible health care for people, while ensuring that cancer research can continue to make progress," he said.

Nearly 12,000 TRICARE beneficiaries are diagnosed with cancer each year, Bailey said. Meanwhile, other military patients are seeking ways to lower their risk. "Prevention and early detection," she said, "are two of the most important and effective strategies for reaching the American Cancer Society's goals of saving lives lost from cancer, diminishing suffering due to cancer and eliminating cancer as a major health problem.

"When people hear the words, 'You have cancer,' they experience a wide and frightening range of emotions. They enter a world of bewildering choices about treatment, pain management, health maintenance and financial burden."

This agreement gives DoD patients access to the most promising advances in cancer research, Bailey said. More than 2,000 sites throughout the United States, including military hospitals and clinics, comprehensive and clinical cancer centers, community hospitals and practices, will conduct the clinical trials. In some cases, patients may be able to get part of their care from their own physicians. To obtain more information about cancer

prevention, early detection or treatment clinical trials covered by the DoD/NCI demonstration, contact the NCI Cancer Information Service at (800) 422-6237 or the demonstration coordinator at (800) 779-3060. Information also is available on the Military Health System Web site, <www.tricare.osd.mil/cancer-trials> or the NCI Web site, <www.cancertrials.nci.nih.gov>.

TRICARE Prime Stresses Prevention

By Douglas J. Gillert American Forces Press Service

As TRICARE Prime, the DoD managed health care plan, moves toward the DoD goal of not only treating but preventing sickness and injury, military medical facilities are looking to two tools to help out: Health Enrollment Assessment Reviews and patient medical records.

"Military medicine - and U.S. medicine in general – has traditionally emphasized intervention after you become sick or are injured," said Navy Dr. (Capt.) Mitch Heroman, chief of staff of the TRICARE Management Activity. "This is episodic care, where a patient may see a different provider each time, often at a different facility. One of the biggest benefits of TRICARE, however, is that you're enrolled in a program that is committed to maintaining your health, not waiting for you to get sick or injured."

If someone gets sick or has a chronic disease, we want to treat them with the best and latest technology in medicine," Heroman said. "But we'd rather prevent breast cancer, keep children from getting diseases that immunizations prevent, or try to get smokers to quit smoking instead of treating them for lung cancer down the road."

TRICARE asks all new enrollees to complete the Health Enrollment Assessment Review, or HEAR — a questionnaire they fill out and mail to their servicing medical facility. The review helps primary care managers understand patient needs and tailor preventive health programs to meet those needs, Heroman said.

"One of the things we're moving toward - and one of the advantages of TRICARE - is continuity of care, where providers know you and take care of you most of the time," Heroman said.

"In order to do that, it will be very helpful for them to know what your health status is as you enroll. That's what the HEAR does." Heroman said medical records also are important to providing continuity of care and delivering preventive services. "It may have been practical or even necessary in the past to carry your own record, because you did see a different doctor, maybe in a different facility, sporadically and episodically," he said. But under TRICARE Prime, patients get all their routine care at one facility and are referred out only for specialty care. By periodically reviewing patient records, primary care managers know when to call their patients in for mammograms, immunizations and other preventive services. They also know from the record what type of treatment to consider, based on previous episodic care."

"For providers to know the most about their patients, they need to know what drugs they're on and what procedures they've had before," Heroman said. "That's all in the medical record. There's not much time during a patient visit to go through the medical record. This is something that can be done before the visit if they have the record."

"Letting your primary clinic maintain your health record can also help out in an emergency," said Army Lt. Col. Mike Montgomery, senior health program analyst for patient administration at TRICARE. "If we know where you get your care and the record is there, another emergency room or hospital where you've gone for urgent care can find out your blood type, allergies and other important medical information by contacting your primary care manager," Montgomery said. "If you've got your medical record in the trunk of your car, living room or desk at work, the information isn't available. It's a safety factor and a quality care factor," Heroman said. "Letting primary care facilities maintain your patient record ensures you'll get the right care at the right time."

News
from District VI

District VI met on September 14, 1999 at the San Francisco Steak House in Houston. Carl Mitten, D.O., the out-going president, hosted the installation of the 1999-2000 president, Morton Rubin, D.O. Dr. Rubin, then installed the following 1999-2000 officers:

Theresa Bobo, D.O. - Vice President
Cuong Nguyen, D.O. - Recording Secretary
Harlan Borcherding, D.O. - Treasurer

Dr. Rubin also appointed several standing committees for the year and introduced four osteopathic medical students, from Des Moines, Iowa, who were visiting the district meeting. Askok Balasubrananyam, M.D. was the guest speaker for the evening.

10 Years Ago in the Texas D.O.

- Ronald Stephen joined Fort Worth Osteopathic Medical Center as senior vice president and associate administrator. The announcement was made October 19 by Jay E. Sandelin, chairman of the board.

- TCOM freshman Paul Gerstenberg was chosen to receive the second annual scholarship award from the Doctors Hospital/TCOM Scholarship Foundation in Groves, Texas.

- A new law passed by the 71st Texas Legislature required customers using tanning booths to sign release forms stating their awareness of the potential cancer risks posed by artificial sunlight. Persons under 18 were also required to have parental consent to use the booths.

- The Texas infant mortality rate dropped below the national average, according to a report from the Southern Regional Project on Infant Mortality. In 1987, Texas had an infant mortality rate of 9.1 deaths per 1,000 births, below the U.S. rate of 10 deaths per 1,000 births. The Texas Department of Health announced that Texas' rate continued to decline in 1988 to nine deaths per 1,000 births. The number of infant deaths had decreased steadily since 1983, when the state's rate was 11.1 deaths per 1,000 births, according to the project report.

- The Food and Drug Administration approved the limited use of AZT for children with AIDS. Although AZT for adult use had been approved three years ago, separate clinical trials for children had to be performed. The federal government said approximately 1,900 U. S. children had been diagnosed with AIDS.

- The U. S. Air Force began recognizing the equivalency of general practice and family practice training and included osteopathic general practice physicians in the Medical Officer Retention Bonus (MORB) program. The MORB program was designed to retain certain board certified physician on active duty in the military. When the Deputy Secretary of Defense included family practice as one of the medical specialties to receive a MORB, the U.S. Army and Navy automatically included those trained in general practice as well. The Air Force, however, denied D.O. participation in its MORB program based on the osteopathic general practice certification. The AOA Council on Federal Health Programs wrote to the Air Force and Department of Defense (DoD) requesting that the Air Force uphold the DoD policy recognizing the equivalency of general practice and family practice training. As a result of the communication and others from ACGP members, the Air Force relented.

- The following demographics on aging in the year 2000 were included in "2000 – A Strategic Plan," from the Office of Strategic Planning of the Department of Health and Human Services.

  By the year 2000, 35 million Americans will be older than age 65. By the year 2050, that number will nearly double to 65 million.

  The median age of the U.S. population will be 37, representing a 19 percent increase over the 1986 median age of 31.

  Men who retire in 2000 will be expected to live for 15.7 additional years; women for 20.5 additional years.

  Of people age 65 and older, approximately 47 percent (16.4 million) will be limited in activities due to chronic conditions.

  From 2000 to 2040, the number of elderly persons in nursing homes will more than double, from two million in 2000, to three million in 2020, to 4.6 million in 2040.

- In other issues relating to the next century, the World Future Society addressed a variety of trends, which were expected to have far-reaching implications. These included:

  In the year 2000, $500 from every taxpayer in the U. S. will go to care for AIDS patients. By the year 2000, the mandatory retirement age will increase to 70.

  Genetic engineering will consume $100 billion by 2000 for such advances as artificial blood, memory-recall drugs and disease immunities for newborns.

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Texas State Board of Pharmacy 512/305-8000
Texas Workers' Compensation Commission 512/448-7900
Medical Review Division..... 512/707-5889
Texas Hospital Association 800/252-9403
Texas Department of Insurance 512/463-6169
Texas Department of Protective and Regulatory Services 512/450-4800
Texas Poison Control Center Network 800/POISON-1
..... 800/764-7661

FEDERAL AGENCIES

Drug Enforcement Administration
For state narcotics number..... 512/424-2000 ext. 2150
For DEA number (form 224)..... 214/640-0801
Diversion policy & related questions..... 214/640-0849

CANCER INFORMATION

Cancer Information Service 713/792-3245
in Texas 800/392-2040

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