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Western New York
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West Ridge Ob-Gyn: Teamwork and Technology

Enhancing a Comprehensive Patient-Centered Experience

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Contents

COVER STORY

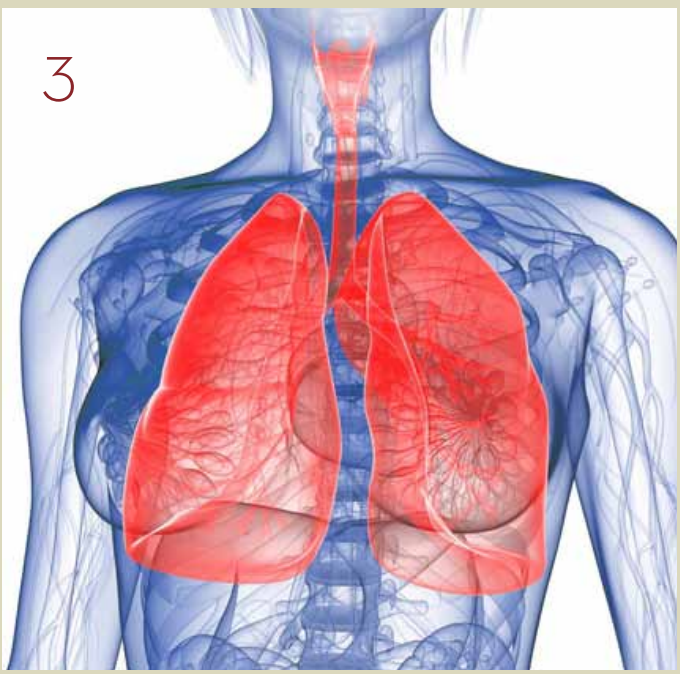
CLINICAL FEATURES

PRACTICE MANAGEMENT

FINANCE MATTERS

Photographer: Lisa Hughes

West Ridge Ob-Gyn Ultrasound Team.
Left to right is Tamra Allen, Songographer, Dr. Derek tenHoopen, Director of Ultrasound and Dr. Colleen Raymond.



Over the past three decades, we've seen an alarming rise in lung cancer rates in women. And a growing number of those women are non-smokers.

Cover Photo:
Seated on bench - L to R: Jeroo K. Bharucha, MD, Wendy M. Dwyer, MD, Derek J. tenHhoopen, MD, Judy E. Kerpelman, MD, Michelle M. Herron, MD. Standing - L to R: Marc H. Eigg, MD, Beverly Shaheen, MSN, WHNP, Colleen A. Raymond, MD, Edward B. Ogden, MD, Donald J. Gabel, MD, Mary Frachioni, MSN, WHNP, Marc S. Greenstein, DO, and Sandra Moore, MSN, WHNP.

Welcome to the July Issue of Western New York Physician

With a focus on Women's Health, this month we highlight West Ridge Ob Gyn. For nearly 30 years, this team of highly-trained, board certified physicians have dedicated their practice to providing comprehensive and exceptional care to their patients. Their collaborative team approach to care delivery benefits the evolving needs of their patients.

Read on as we hear from local medical experts on some of the top health concerns for female patients. Dr. Manoj Agarwal from the Wilmot Cancer Center provides an update on Lung Cancer – the latest trends, diagnostics, treatments and techniques for risk reduction.

Colorectal Caner is often considered a "man's disease" yet more than 26,000 women in the U.S. die of this often curable disease. Drs. Claudia Hriesik and Stephen M. Rauh of Rochester Colon & Rectal Surgeons, offer some fundamental information on risk management, warning signs, diagnostic screening and the latest approaches to treatment.

Also hear from internationally acclaimed expert, Dr. Steven Feldon, Director of the Flaum Eye Institute, as he offers insight on Thyroid Eye Disease, a disease often difficult to diagnose in the early stages.

Many thanks to all of the contributors and advertisers. These informative articles provide referring physicians in our region a more in-depth look at the resources available to their practice and their patients – creating a relevant and personal dialogue between providers and a better understanding of all disciplines of medicine.

We invite you to share your clinical and practice expertise with your medical colleagues through *Western New York Physician*.

We hope you enjoy the read and we look forward to hearing from you.

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Managing Editor
Julie VanBenthuysen
WNYPhysician@rochester.rr.com

Creative Director
Lisa Mauro
lmauro@rochester.rr.com

Photography
Lisa Hughes
lisa@lisahughesphoto.com

Marketing Director
Melissa Henderson
melissavh@rochester.rr.com

Medical Advisory Board
John Valvo, MD
John Garneau, MD
Joseph L. Carbone, DPM

Contributing Writers
Julie VanBenthuysen
Steven E. Feldon, MD, MBA
Manoj Agarwal, MD
James M. Sperry, MBA, PhD
Al Campagna
Claudia Hriesik, MD
Stephen M. Rauh, MD

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Phone: 585.721.5238

Lung Cancer and WOMEN

Manoj Agarwal, M.D.

Manoj Agarwal, MD

Lung cancer is a quandary for doctors and oncologists. In the United States, this disease is diagnosed in about 219,000 people each year and more than 150,000 people die. Lung cancer is the number one cancer killer for men and women.

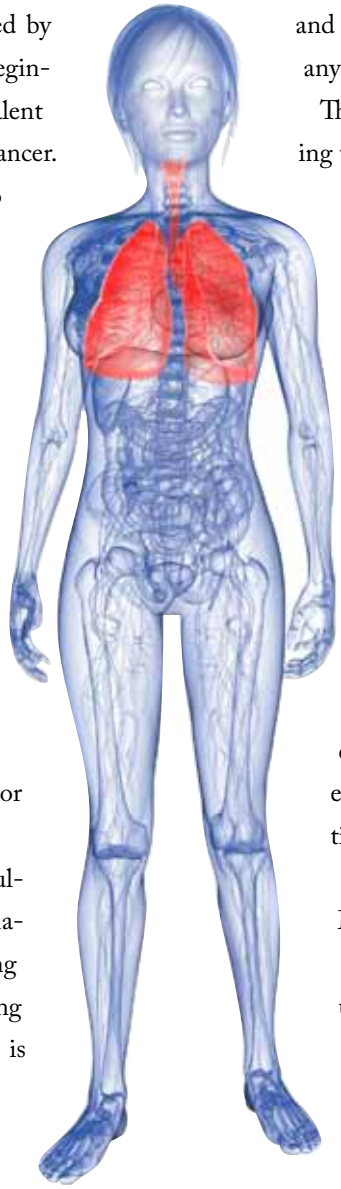
For most part, it is a man-made disease caused by tobacco smoking. Lung cancer was rare in the beginning of 20th century. As smoking became prevalent and fashionable, so did the incidence of lung cancer. Generally, it takes about 20 years of smoking to cause enough damage to the lungs to cause lung cancer.

Our nation has invested heavily in anti-smoking campaigns and the results have been positive – primarily in men. Over the past three decades, we've seen an alarming rise in lung cancer rates in women. And a growing number of those women are non-smokers.

Reasons behind the gender disparity are unclear and scientists are scrambling to figure out why and how to reverse the trend. They're looking at estrogen and other genetic factors that make women more susceptible to carcinogens in cigarettes, second- hand smoke or other environmental exposures.

The gold standard for lung cancer care is the multidisciplinary approach, which is available at major academic medical centers. When we're dealing with a disease as challenging as lung cancer, having specialists in all aspects of lung and cancer care is essential.

At the University of Rochester Medical Center's James P. Wilmot Cancer Center, the multidisciplinary thoracic oncology team includes medical oncologists, radiation oncologists, thoracic surgeons, pulmonologists, radiologists and pathologists. This diverse group of subspecialists meet weekly to review information for each new patient to develop the best approach to care and whether they could benefit from participating in any clinical trials of new therapies.



There have been advances in therapies and in imaging technology to improve accuracy in staging disease which is essential for providing quality care and extending survival.

At the recent meeting of the American Society of Clinical Oncology, we heard about a study of a new class of drug that blocks a very specific mutation (called ALK translocation) that is present in a small number of the lung cancer patients. In early clinical trials, this drug called crizotinib showed dramatic reduction in tumor size in 90 percent of the 82 patients studied. That's a huge response, as we commonly see response rates in only about 10 percent patients with most other drugs. The entire lung cancer community is very excited about this drug and we are anxious to participate in larger studies.

In terms of new imaging techniques, Strong Memorial Hospital began using a combination of endoscopic ultrasound (EUS) and endobronchial ultrasound (EBUS) to diagnose and better stage lung cancer. EUS and EBUS also can diagnose pathology in the mediastinum, the area that separates the lungs and contains the heart, large blood vessels, trachea, thymus gland and connective tissues.

With these complementary procedures, we aim to accurately and rapidly identify and stage cancers to distinguish patients who will benefit from surgery from those with advanced disease who will not, and to accurately identify mediastinal diseases other than cancer. These techniques are also significantly more accurate at staging lung cancer than non-invasive methods such as CT and PET scans. This spares patients with late-stage cancer any pain or complications from unnecessary surgery, while saving mediastinoscopy for patients that might require restaging after neoadjuvant chemotherapy.

And, within the clinical arena, new technology for delivery therapeutic radiation gives doctors greater accuracy to destroy tumors while reducing damage to the vital healthy tissue in the lung. The use of tomotherapy, stereotactic radiosurgery, intensity modulated radiation therapy (IMRT) or image-guided radiation therapy (IGRT) offers doctors pinpoint precision when targeting tumors.

These technologies are vital to providing comprehensive care and the greatest chance for survival, which in lung cancer is low. Fewer than 20 percent of patients live five years. Despite the very serious outlook for people with lung cancer, some people are cured and we are committed to curing more and more people every year.

Quit Smoking and Reduce Your Lung Cancer Risk

The best way to prevent lung cancer is to reduce exposure to tobacco products. Don't smoke, quit smoking if you do now and avoid second-hand smoke as much as possible.

Consider these tips:

1. If you can give up cigarettes for 24 hours, you double your chance for success.
2. Make a plan for quitting. Talk your doctor about strategies such as cold turkey versus using a nicotine patch, gum or inhaler.
3. Tell your friends, family and co-workers that you plan to quit and rally them to help you stick with it.
4. Avoid risky situations or behaviors, and remove triggers such as ashtrays and lighters.
5. Remove all ashtrays, lighters, matches and cigarettes from the house. Just seeing them can make you want to smoke.
6. Start eating hard candy or chewing crunchy vegetables – like carrot sticks – to keep your mouth busy. Consider using cinnamon candies, because it's "burning" sensation mimics the feeling of smoking and kills the craving.
7. Drink a lot of water. It helps keep you feeling "full," and prevents you from overeating and gaining weight. It also helps "cleanse" your body of the toxins from years of smoking.
8. Practice breathing deeply when craving a cigarette. Smoking involves taking long deep breaths, but now it'll be fresh air rather than chemicals entering your lungs.
9. Consider using nicotine replacements – gum, patch or Zyban – to help you quit.
10. Take a walk whenever you want a cigarette. The fresh air is good for you and this can help change your habit.
11. Remind yourself why you are quitting – and reward yourself every day you forego cigarettes.
12. Older smokers are less likely to try to quit, but when they do try, they are more likely to succeed.

If you find yourself tempted, contact the New York State Smokers' Quitline at 1-866- NY-QUITS (1-866-697-8487) or go to www.nysmokefree.com. Smokers can hear a "tip of the day."

Physicians should encourage patients who smoke to quit at every appointment and offer assistance to them if they listen. The Greater Rochester Area Tobacco Cessation Center provides offers doctors free training to help identify patients and coach them to quit.

To learn more about earning CME credit or to schedule a workshop, contact GRATCC at: gratcc@gmail.com or call (585) 758-7815.

About the author

Manoj Agarwal, M.D., M.B.A., is director of the multidisciplinary thoracic oncology program and clinical director for the James P. Wilmot Cancer Center at the University of Rochester Medical Center.

He studied medicine at Christian Medical College Vellore in India and completed fellowship training in hematology-oncology and bone marrow transplantation at University of Illinois and Rush University Medical Center, respectively. He then joined the thoracic oncology team at University of Arkansas, and also earned a master's degree in business administration.

He is an active member of the Southwest Oncology Group and has led a number of clinical studies in lung, prostate and renal cancers and has published several articles in oncology journals.

West Ridge Ob-Gyn: Teamwork & Technology

Enhancing the Comprehensive Patient-Centered Experience

Julie VanBenthuysen

Keeping customer-centric while managing the care of tens of thousands of patients can seem an impossible feat for any medical practice worth its salt. Not so for the dedicated staff at West Ridge Obstetrics & Gynecology (WROG), LLP, who every day maintain their patient focus through a combination of dynamic teamwork and cutting-edge technology.

Gynecologic Robotic surgery at RGH with Dr. Wendy Dwyer, the Robot, and Dr Marc Eigg.
Robotic hysterectomy, myomectomy and advanced pelvic reconstruction is done regularly by the surgeons at West Ridge Ob-Gyn.

"We've distinguished ourselves from other larger practices by a partnership approach to patient care," says Dr. Marc Eigg, Associate Managing Partner and Director of Urogynecology & Pelvic Surgery. "Through proactive collaboration, we provide the broadest scope of services while keeping the single doctor-patient relationship so valued by our patients."

From obstetrics to urinary incontinence management to fertility treatments and robotic surgery, patient needs run the gamut, with a single provider overseeing each patient's care. Even when patients require an evaluation or procedure with a different WROG physician with a specialized skill set, they are always followed and cared for by their primary provider.

Patient Amanda DeVito, who recently underwent a robotic multiple myomectomy, experienced the WROG approach from her initial visit through post-operative care. "At 36, it's extremely frightening when your doctor talks about surgery," says Ms. DeVito. "Your mind races to all the horrible things that can go wrong, but from the second I walked into West Ridge Ob/Gyn, I knew everyone truly cared about my well-being. The receptionist greeted me with a smile and the nurses instantly put me at ease."

For Ms. DeVito, the pressing need to remove five uterine fibroids was a complicated procedure beyond the capabilities of her primary gynecologist, who referred her to WROG. "When I first met Dr. Eigg, I knew I was in good hands and he had my best interests at heart." He took the time to have a lengthy dialogue about my options – giving me the best, worst and plenty of "what if" case scenarios. He wanted to make sure he really informed and educated me."

Within a day, Ms. DeVito was home and feeling comfortable; two days later she was using only Ibuprofen. "This was my body and my life, and I deserved the best care from the best doctors and staff around."

The Practice – Experience & Longevity

Ms. Devito's experience exemplifies the philosophy behind WROG that's mirrored in its 66-person staff. For nearly 30 years, the practice has set the pace for excellence in women's healthcare with a steady team of highly-trained, board certified physicians, three certified nurse practitioners, experienced managers and support staff. "Our goal is to provide stellar medical care and customer service based on trust, communication and compassion, so that no one ever loses touch with the patient," says Managing Partner Dr. Derek tenHoopen, a 16-year veteran and past president of the Monroe County Medical Society. In fact, the practice's three most senior physicians, Drs. Bharucha, Gabel and Ogden provide more than 100 years of experience between them. To highlight patient loyalty, they are now delivering the children of those they delivered when West Ridge was first established.

The practice's larger size, rather than diminishing the attention paid to each patient, has actually strengthened the doctor-patient bond through a continuous commitment to teamwork and acquiring new technology offerings. WROG, which covers two ends of the city east to west, continues to be among the region's first to introduce new lines of service at both its Webster and Greece locations. "Each of the ten doctors can be their best by pursuing their own area of interest," says Dr. Marc S. Greenstein, DO, Director of WROG's Minimally Invasive Surgery and the most recent team member. "This in turn keeps us completely focused on the total health of each patient."

Dr Eigg and 3rd year Resident in Ob-Gyn at the RGH independent Ob-Gyn Residency program. Dr Eigg co-directs the urogynecology training for the RGH residency. The practice also has URMC medical students rotate through the office. Giving back through education is at the core of West Ridge's team philosophy.

The doctors themselves represent an equal balance of skilled men and women ranging from their mid 30's to mid-60's – which appeals to their broad patient demographic serving pediatric patients, adolescents, adults and the elderly. Dr. Eigg, who also co-directs the Rochester General Health System's Uro-Gyn residency program, provides the Ob/GYN residents the unequaled learning experience of observing a cross-section of the community with a vast range of needs. In fact, all WROG physicians are university-trained and have faculty-appointments at the University of Rochester School of Medicine.

High-Tech/High-Touch

Providing stellar service means having the best access to patients. "We use the latest medical technology to ensure that care and practice communications are more inclusive and instantaneous," says Dr. Eigg. To that end, WROG became the first large, private Ob/Gyn group in Rochester to institute an Electronic Medical Record (EMR) system – one of the largest stand-alone health information systems used regionally that allows storage and retrieval of patient records. Not only has this given staff access to the latest patient information in-office, at home or in-hospital, but the technology provides a built-in safety net, flagging any prescribed medications with potential adverse drug interactions and catching patient information errors. Within seconds, the practice's secure, encrypted network lets every physician know the current condition of any patient and allows team members to lend advice from any corner of the organization.

Each provider also receives instant access to lab and imaging data – from bone density reports to blood work to pap smears

The DXA Bone Density Testing Team. From L to R: Gayle DiSisto, DXA Technologist, Diane Bozenhard, Medical Secretary and Dr. Judy Kerpelman, Director of Bone Density Services.

that used to take three weeks – which allows results to be immediately conveyed to patients. "Patients want communications in real time," says Dr. Dwyer.

For WROG's Medical Director Dr. Wendy M. Dwyer, patient safety remains the top concern for staff, so the practice's communications component keeps everyone accountable. "We're passionate about keeping it safe," she says, "particularly with high risk patients." Instead of pagers, everyone carries a smart phone. "There are no delays in communicating the needs of an acute patient," she says. "Any provider can text the on call WROG physician, hospital-based triage nurse, and office manager all simultaneously." In fact, hospital staff from the ob residents to the entire Department of Anesthesia have followed suit. Doctors also check their up-to-the-minute surgical schedule using smart phone technology.

Depth & Scope

WROG offers a full range of women's healthcare with the depth of knowledge, skill and technology to support virtually any need. WROG provides high risk obstetric care as well as specialized services and advanced training in minimally invasive gynecology, advanced laparoscopy, robotics, office surgery for management of abnormal bleeding and permanent contraception, bone health evaluation and promotion, wellness promotion, the latest imaging technology, the most current advances in treating bladder conditions, and continence evaluation and care – including interstitial cystitis, symptomatic pelvic organ prolapse – as well as fistula care and treatment.

WROG's Wellness Center is thoughtfully designed to offer lifestyle choices and services to help women maintain and improve their health and well-being throughout their adult years – including a spectrum of laser therapy services for medically indicated conditions and aesthetic hair removal and skin care services. Promoting bone health, particularly with DXA technology, has evolved greatly over the decade, says Dr. Judith E. Kerpelman, Director of Bone Health Evaluation and WROG's Wellness Center and a 15-year veteran. As the general population ages and the diagnosis and treatment of osteoporosis increases, all patients are educated on the importance of calcium and Vitamin D, strength training and weight bearing exercises. "Having the scope AND depth of services conveniently available to our patients dramatically improves their satisfaction, compliance with medical care and overall health," says Dr. Kerpelman.

Consensus guidelines for DXA scanning and osteoporosis treatment are constantly updated and improved. The practice recently implemented VFA software to diagnosis vertebral fractures. Dr. Kerpelman has attended numerous ISCD-sponsored courses for certification in VFA interpretation. FRAX guidelines and interpretation software will also be implemented soon, based on the most recent ISCD and NOF guidelines to assist in selecting patients who will most benefit from osteoporosis treatment.

While the practice handles the more common conditions related to pregnancy, fertility, and perimenopausal problems; the latest in office-based surgeries truly sets the practice apart. Surgical trends have led to more minimally invasive surgeries

and robotically-handled hysterectomies with less post-op, discomfort and disability. "Patients have come to expect it," says Dr. Eigg. "No one has the luxury of taking time from work to recover. Everyone wants the least possible disruption to their lives." WROG patient satisfaction rates for minimally invasive surgery are close to 100%, with the last 200 robotic procedures successfully performed with no need for open surgery. In the Webster office's Minor Surgery Suite, Dr. M. Herron has performed almost 30 Novasure Ablation procedures, once done only in the hospital setting.

The Ultrasound Team. Left to right is Tamra Allen, Songographer, Dr. Derek tenHoopen, Director of Ultrasound and Dr. Colleen Raymond.

"Performing a surgical procedure requiring no IV is a huge people pleaser," says Dr. Eigg. Global ablation and cystocopy procedures are done in a comfortable exam room supported by a family member or friend. To better understand their condition, patients have the option of viewing the procedure live on-screen. For urinary incontinence, patients can receive an out-patient, single incision suburethral sling procedure in just 15 minutes. Other cutting edge therapies include Interstim and posterior tibial nerve stimulation for overactive bladder, vaginal reconstruction and laparoscopic suspensions.

"The 3-D and 4-D technology in our in-house Ultrasound Lab at both facilities are second to none," adds Dr. tenHoopen who codirects the division with Dr. Colleen Raymond "With real-time results allowing for immediate discussion with patients." The office is AIUM (American Institute of Ultrasound in Medicine) certified and each sonographer is likewise RDMS certified. Both require a rigorous credentialing process. Of course, the software and machines at both locations are constantly upgraded.

Other in-house offerings include osteoporosis screenings, biopsies and even flu vaccine updates for pregnant patients. More complex evaluations are also performed, like Multichannel Urodynamic Bladder testing. Some evaluations have led to the first pacemaker procedures at Rochester General Hospital for bladder spasms. Referrals to West Ridge come largely from local and regional PCPs from Buffalo to Elmira. Solid working relationships with their colleagues in general and colorectal surgery and urologists at RGH also extend the teamwork atmosphere and ensure conditions are best treated through combined expertise.

Educating Patients

WROG offers a wide range of educational information and resources for women in the region, with an extensive patient library in both facilities with books and pamphlets on topics ranging from infertility and menopause to childbirth and cancer. Its comprehensive website, WROG.org, includes continuously updated information to familiarize patients with the practice, its policies and procedures, newsworthy information and links to women's health-related sites. A Patient Portal with more interactive Internet options is forthcoming to even further enhance doctor/patient access.

Dr. Greenstein reviews urodynamic results with a patient. He is the director of minimally invasive surgery for West Ridge Ob-Gyn and runs the bladder testing lab.

Working Hard/Playing Hard

The Corporate Challenge Team L to R – Team Captain Dr. Dwyer, and Drs. Herron, Eigg, Greenstein, Bharucha and Kerpelman.

They say a team that plays together stays together. Every year, physicians and staff participate in the JP Morgan-Chase 5K Corporate Challenge celebrating their achievements with a casual dinner afterwards. "It's a wonderful team building event," says Dr. Dwyer. Each year, the practice also supports the American Diabetes Association's Tour de Cure bike race. There's a philanthropic entity to what we do as well," added Dr. Kerpelman. Several of the doctors regularly mountain bike together, practicing what they preach through healthy lifestyle choices.

With their love of obstetrics, all 10 Partners continue to deliver babies. In fact, the doctors meet monthly to discuss their complicated High Risk pregnant patients, reviewing patient care and the clinical challenges they face. Recognizing that the majority of patients prefer to see their own doctor throughout their pregnancy, they discuss each pregnant patient to keep everyone apprised of their status. "We stay a huge part of the process," says Dr. Greenstein. "Even if we're not at the delivery, we all make it a priority to see the patient postpartum."

Fast Forward

With expectations of continued growth, WROG plans to add an eleventh physician this fall. In its ongoing commitment to bone and heart health and overall well-being, Dr. Kerpelman also hopes to expand WROG's Wellness Center to include massage therapy, more in-depth nutrition counseling and fitness services like yoga and pilates. Soon staff will provide First Trimester Screening and Nonstress Tests studies in the facility's new Antenatal Testing Center. The practice will continue to upgrade its technologies and ultimately become paperless with forms and billing.

Always looking one step ahead, the practice has become a key source for clinical trials, most recently working with Bio-Optronics as an 18-month beta site for global scheduling of patients through EMR, which resulted in the company's product going to market. Staff anticipates additional clinical trials on health records will follow. "We're always looking at new options and new products on the horizon," says Dr. Kerpelman.

"We always provide compassionate state of the art service to our patients."

"There's essentially nothing in the Ob/Gyn scope of practice we can't do," stated Dr. Eigg "We always provide compassionate state of the art service to our patients. This is accomplished by having the patient's primary Ob/Gyn physician in the practice overseeing their individualized comprehensive care." Added Dr. tenHoopen, "We've never lost sight of that 'touch' factor, even as we pursue the most progressive healthcare around."

The Corporate Challenge race is one of the team building charity events each year for the West Ridge Ob/Gyn family.

Women and Colorectal Cancer

Claudia Hriesik, MD and Stephen M. Rauh, MD
of Rochester Colon and Rectal Surgeons

Claudia Hriesik, MD

Stephen M. Rauh, MD

Each year more than 26,000 American women die of colorectal cancer (CRC). CRC takes as many lives as ovarian and cervical/uterine cancers combined. A common misconception is that CRC is "a man's disease." In fact it is an "equal opportunity killer."

Are your female patients at increased risk?

Age and Menopause: Are the most important risk factors for developing CRC. As women grow older, their risk doubles every five years.

Colorectal polyps: If you or your family has a history of polyps there is a higher risk.

Cancer history: Women with breast or uterine cancers and/or a family history of CRC are at higher risk than others.

Crohn's disease and/or colitis: These chronic inflammatory conditions increase your CRC risk tenfold.

How can patients reduce the risk of CRC?

Healthy weight: Exercising regularly, a diet low in animal fats and high in fiber can reduce your risk. Overweight women (body mass index of >30) are at increased risk.

Hormone replacement therapy (HRT): Decreases the risk of developing CRC in postmenopausal women by 20-45%.

Calcium: Taking supplemental calcium decreases the development of polyps and reduces the risk of CRC by 30-50%.

GET CHECKED! Participation in CRC screening exams and tests works to prevent CRC

How does CRC develop?

CRC typically develops from precancerous polyps (abnormal growths). Over time some become CRC.

What are some warning signs?

Alarming symptoms are bleeding from the rectum, change in bowel habits, such as new constipation or persistent diarrhea. Abdominal or rectal pain and unexplained weight loss may be symptoms of larger cancers. Blood from the rectum, with stool or on the toilet paper is NEVER okay.

"If CRC is diagnosed early the cure rate can be as high as 90%."

When should patients be checked for CRC or colon polyps?

Screening for CRC should start at age 50. An earlier evaluation is essential for symptoms like bleeding, anemia, abdominal pain, weight loss, change in of bowel habits or fatigue.

CRC can be caused by a genetic defect that leads to a familial predisposition to get CRC. Patients with a genetic defect (e.g. familial polyp syndrome) that is linked to CRC should be screened in their late teens. Screening in people with Crohn's disease and ulcerative colitis is also mandated.

What screening tests are available?

Digital rectal examination and stool occult blood testing, flexible sigmoidoscopy and colonoscopy are available. The latter use a narrow flexible camera "scope" that visualizes polyps and allows their removal.

Stool testing for hidden (occult) blood should be carried out yearly; flexible sigmoidoscopy should be performed every 5 years. A colonoscopy should be carried out every 10 years.

X-ray tests like "virtual colonoscopy" and lower GI studies can be used for screening. However, polyp removal is not possible with x-ray tests.

Is CRC curable?

If CRC is diagnosed early the cure rate can be as high as 90%. Sadly, less than half of colorectal cancers are detected at an early stage. Many individuals ignore colorectal symptoms. Currently only about 50% of women undergo the recommended screening for CRC.

How is CRC treated?

An operation to remove CRC is necessary if not confined to a polyp. Minimally invasive surgery (laparoscopy and robotic surgery) has made surgery more precise. Incisions are smaller than with open surgery; healing is usually faster and less painful. With specialized technique, very rarely this requires a permanent colostomy which is a surgically created abdominal opening for passage of stool ("a bag".)

If the cancer has spread, proper treatment may include chemotherapy and/or radiation.

CRC is preventable. Early detection and prevention by undergoing regular screening is the best approach. Hence, do not overlook any changes in bowel habit, bleeding or pain; rather, discuss your CRC concerns with your doctor, a gastroenterologist or a colorectal surgeon.

What is a Colorectal Surgeon?

Colorectal surgeons have completed advanced training in the treatment of colon and rectal cancer and other problems (after five years training in general surgery.) Colon and Rectal Surgeons are experts in the treatment of benign and malignant colorectal conditions, perform routine screening examinations and perform operations when necessary.

Dr. Rauh *grew up in Cincinnati, Ohio where he attended college and medical school. He completed his surgical residency at the University of Rochester, and trained in colon and rectal surgery at the Lahey Clinic Medical Center in Boston. Dr. Rauh joined RCRS in 1988 and lives in Webster.*

Dr. Hriesik *was born and raised in Germany where she attended medical School. She completed her Surgical Residency at Drexel University of Medicine in Philadelphia. She graduated from two fellowships; the first in Surgical Oncology at the University of Pittsburgh and then in Colon and Rectal Surgery at the Cleveland Clinic in Ohio. Dr. Hriesik joined the practice in 2008.*

Thyroid Disease: *A Medical Enigma*

Steven Feldon, MD, MBA

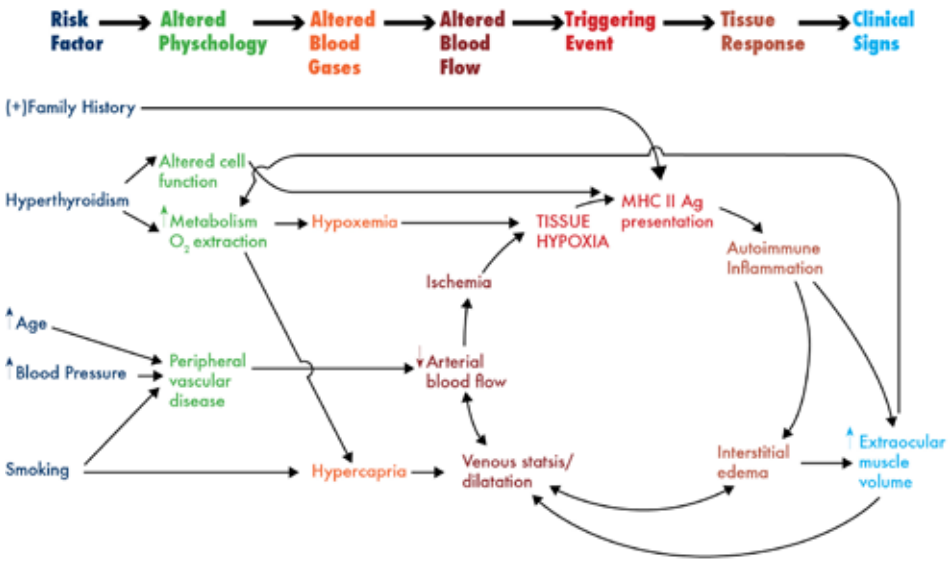
Steven Feldon, MD, MBA

Thyroid Eye Disease (TED), also called Graves' ophthalmopathy, remains an enigmatic association with Graves' Disease and, occasionally, with Hashimoto's Thyroiditis. The mystery encompasses cause, diagnosis, progression, and treatment. Perhaps half of the patients with Graves' Disease will develop some eye manifestations, but fewer than 15% will have disease severe enough to cause visual problems. For a large majority, the eye symptoms begin within months of when the hyperthyroidism is detected. Occasionally, the eye disease predates the hormonal disturbance by years; rarely, thyroid function remains normal (euthyroid TED).

The earliest eye manifestations are often confused with allergic or infectious conjunctivitis. There may be lid swelling, redness of the conjunctiva, tearing, and foreign body sensation even before characteristic lid retraction (stare) and bulging of the eyes (exophthalmos) occur. Occasionally, the more acute, inflammatory symptoms and signs are absent. Instead, there is an insidious scarring of retrobulbar tissues, leading to problems with ocular motility and optic nerve function. More commonly, patients develop a combination of orbital inflammatory and scarring changes so that edema, dry eye, exophthalmos, diplopia, and visual loss can co-exist.

Most patients with TED have a positive family history for thyroid disease. While Graves' Disease affects young women primarily, the risk factors for clinically important TED other than hyperthyroidism include age over 50, male gender, diabetes, hypertension and, above all, smoking history. This demographic suggests an interaction between the autoimmune process thought to trigger TED and peripheral vascular disease.

TED involves a complex interrelationship of several pathophysiologic events. One working hypothesis is that there is a common auto-antigen that triggers both the eye and the thyroid disease, causing orbital fibroblasts to differentiate into fat cells. Once the autoimmune disease is underway, the increase in fat cells, fibroblasts, and water content generate a substantial accumulation of soft tissue within the confines of the bony orbit. As a result, there is increased tissue pressure which reduces both arterial flow and venous drainage. This low flow environment results in tissue ischemia and passive congestion. The tissue ischemia



Schematic representation of a proposed mechanism for development of Thyroid Eye Disease.

stimulates more inflammation while the passive congestion increases local edema, further increasing tissue pressure. This spiraling sequence of events is difficult to control or reverse, since there are autoimmune, non-specific inflammatory, ischemic, and congestive factors that are mutually enhancing.

Despite the complex pathophysiology of TED, the disease is self-limited. The progress of the orbital process has an S-shaped curve of activation. Most of the clinical symptoms and signs progress rapidly for the first 6-12 months, and then more slowing over the ensuing months, before the disease stabilizes with some resolution of the inflammatory and congestive components, usually within 36 months. Unfortunately, there are permanent tissue changes from cell proliferation and differentiation, GAG deposition and extracellular edema, as well as from circulatory compromise. The disease cycle is described as Rundle's Curve.

Given the complex pathophysiology, there is little surprise that multiple approaches to treatment have been advocated and that none are wholly effective in preventing or reversing TED. For the most part, the mainstays for treatment of many autoimmune diseases such as corticosteroids and immunosuppression have modest effect on the course of TED. Orbital radiation, usually in combination with steroids, is often advocated, but the results of controlled clinical studies have been disappointing. Some early experience with B-cell depletion and other immunomodulatory drugs is available, but clinical improvement seems modest given the risk profiles of the treatments.

If there were good predictors of progressive, visually-threatening disease, early intense medical treatment may be effective. However, other than the general risk factors already described, there are no known biomarkers identifying patients who will develop debilitating TED. For most patients who will develop only cosmetic sequelae, therapy using drugs with substantial side-effects or marginal safety profiles, cannot be justified. Thus, many experts opt for the most conservative management possible, directed toward alleviating the most bothersome symptoms and signs during the progressive portion of Rundle's Curve and managing the permanent tissue changes with surgical intervention after the disease "burns itself out."

"If there were good predictors of progressive, visually-threatening disease, early intense medical treatment may be effective."

Conservative measures for symptomatic patients include artificial tears for management of associated dry eye, elevation of the head of the bed to reduce passive orbital edema, taping lids closed at night to reduce exposure from lid retraction, prisms to address double vision (diplopia), and sometimes a mild diuretic such as hydrochlorthiazide. Surgical management of the chronic manifestations of TED include fat or bony decompression of the orbit for severe exophthalmos or optic nerve compression, strabismus surgery for correction of diplopia, and lid surgery to adjust lid position or reduce periorbital swelling. In general, orbital decompression is performed first, if necessary and strabismus surgery precedes lid surgery. Of course, both medical and surgical therapy must be tailored to address individual patient needs.

The search for an answer to the enigma of TED is elusive for two reasons. First, there is no animal model of the disease. Second, clinical trials are difficult to perform due to the variability in disease progression and in therapeutic response. Future research may help identify biomarkers for patients at the highest risk for vision-threatening disease. Also, elucidation of the pathophysiology may suggest more effective medical therapies specifically targeting each stage of the disease.

***Dr. Feldon** is an internationally acclaimed clinical and basic scientist with a specialty in orbital disease and neuro-ophthalmology. In 2001, he was appointed chair of the University of Rochester Department of Ophthalmology, and is now Director of the Flaum Eye Institute.*

Devoted to patient care, Dr. Feldon's special interest is in the management of patients with thyroid-associated eye disease. He also treats patients with cranial nerve palsies, disorders of the optic nerve, visual field loss, and eye movement problems. He offers surgical services for orbital tumors, reconstruction, and decompression, as well as paralytic strabismus and correction of abnormalities. His clinical expertise has been recognized by "Best Doctors in America."

Developing a Positive Office Culture

Physicians, Patients, Payers and Staff All Benefit

Al Campagna

Al Campagna

Whether you realize it or not–and no matter how large or small your practice is–you already have an office culture. And that culture–for better or worse–is affecting your practice and your patients. By taking a look at your current office culture, and actively taking steps to foster specific aspects of that culture, you can improve your life at work, increase your referrals, reduce staff turnover and create a practice where people want to practice and patients want to come.

What is culture?

For centuries, the word culture has been interpreted many different ways. For the purposes of this article, culture can be defined as:

- The observable differences in the activities and expressions of people and organizations
- The parameters, behaviors and values that an organization expresses externally and internally
- A learned and shared way of interacting with both internal and external customers

Organizational Cultures

Two opposite styles of organizational culture exist:

a positive culture and a toxic culture.

A positive culture inspires internal customers, helps performance under pressure, assists in resolving conflict and offers uncompromising service.

A toxic culture operates on rumors instead of information, includes bias, uses innuendo as the method of communication, is filled with suspicion and mistrust and practices discrimination among customers.

What can you anticipate resulting from a toxic culture? High costs, poor morale and a high turnover among staff are among many adverse outcomes. But the most destructive result of a toxic culture is that patients will sense it the minute they walk through your door.

What can result from having a positive culture? A positive culture improves teamwork; generates a shared vision, synergy and excitement across your practice; creates a whole that's greater than the sum of its parts; and results in a more successful organization.

What does a positive culture lead to? Internal and external customer satisfaction, which naturally increases referrals.

Why You Need a Positive Culture

The entire health care environment is changing. Patients are more informed – and better informed – than ever before, and they are more proactive in making decisions about their own care. The Internet has made it easy for patients to shop around, explore treatments and even diagnose themselves. Patients are aware of the multiple costs and options available to them. Mainstream magazines feature articles on "How to find 'Dr. Right.'"

Yet despite – or perhaps because of – this plethora of information and their own good intentions, patients are often misguided. Thus, they need their doctor's decisiveness and expertise more than ever. This means that doctors need to communicate better both directly with patients and through their support staff.

Employers, payers and patients are demanding more value for fewer dollars. With rising health care costs and decreasing reimbursement, there is more competition among practices. Increased competition drives practices to find ways to differentiate themselves, with varying degrees of success.

Another reason for fostering a positive culture in your practice is the growing movement to evaluate doctors through surveys that gauge their patients' satisfaction and measure more than just clinical expertise. There is a direct correlation among patient satisfaction, future referrals and a practice's financial health.

The outlook is for these trends to continue and even accelerate. What can you do? You can cut costs—or you can compete more effectively. For an orthopaedic practice, this means taking a good, honest look at your practice culture.

The Impact of a Positive Culture

A positive culture will help deliver:

- Positive ratings from patients. By providing prompt, affordable and friendly service, you show that you value your patients' time. They will, in turn, rate you highly.
- Positive ratings from referring physicians. Referring physicians appreciate it when their patients are scheduled and seen promptly, and when they receive feedback as quickly as possible.
- Positive ratings from payers. Payers appreciate a cost-effective business operation and may provide financial incentives that positively affect your bottom line.
- Increased staff morale. A positive culture results in reduced sick time, increased employee loyalty and retention, and staff who are motivated to work together toward a common goal.

It's all About Respect

Aretha Franklin put it so well when she sang about

R-E-S-P-E-C-T. Use this mnemonic to help create a positive culture in your practice:

R = resourceful

Use the resources you have in a way that creates value to your external and internal customers.

E = effective

Get the anticipated results from your efforts.

S = service-focused

Provide excellent service to referring physicians, patients, payers and staff. This enables you to deliver your services in a focused, effective and streamlined workflow. The physicians and staff communicate pride and confidence in their team as well as in their own abilities, which will be positively reflected in your customers' experiences.

P = professional

Build a practice that treats everyone as a professional, just like yourself. Staff who are treated as professionals will be dedicated to their roles, whether they are answering the phones or taking an X-ray.

E = efficient

Minimize redoing work. Complete each task that is started. Ensure that everything that can be done for a patient is done by the conclusion of the visit.

C = customer-centric

Do everything with the customer in mind – whether the customer is the patient, a payer or a referring provider.

T = team-based

Ensure your service is delivered by a team whose common goal is greater than the sum of its individual objectives. If your team is less than excellent, how can the excellence customers require and deserve be guaranteed?

Building a Positive Culture

Specific steps to build a positive culture in your office include:

- Define your practice offerings to eliminate internal competition. Offer services that complement your practice strengths in a way that responds to your customers' needs.
- Consider establishing schedule protocols—templates that allow you to respond to urgent appointment requests.
- Define the different tiers of customers you need to service.
- Remember that your staff is an important customer and must be treated as a valued commodity!
- Break down any barriers between you and referring providers and be sure to provide referring providers with prompt, efficient feedback.
- Teach your staff specific skills, such as managing workflows, efficient message taking, effective communication, problem solving rather than blame placing, personality assessments and, most important, how to work supportively.
- Create a brand image and communicate that brand. Your practice and culture will be embodied and reflected in that brand image. In other words, make your culture a brand.
- Use multiple ways of communicating with your customers—phones, e-mail, automatic call distribution centers and a Web site that customers clearly understand and that enhances their interaction with your practice.

- Develop forms that are easy to read, complete and process.
- Plan your office environment so it is easy to access, enter, move around inside and exit.
- Adopt a modern but understated clinical look and feel to your office. This could include practice apparel, which embodies your brand and helps to communicate the notion of a unified staff.
- Involve your staff and customers in defining and developing your culture through staff retreats, surveys, focus groups and nominal group techniques.
- Never skimp on training; allocate a defined number of hours per year to staff training and development.
- Keep yourself receptive to innovative technologies and paradigms. Look at the same problem but in a new or different way. Most important, take pride in a job well done.

Expect Results

Once you've established a positive culture, you'll be delighted with the results. Among the benefits are the ability to attract and retain talented staff, efficient staff-to-provider ratios, premium contracting opportunities, the potential for payer gainsharing opportunities, high quantifiable customer satisfaction, sustainable growth in provider referrals and high self-esteem among staff.

Al Campagna is the business manager for Greater Rochester Orthopaedics, P.C., in Rochester, N.Y. He can be reached at ACAlberto@aol.com

What does a positive culture lead to? Internal and external customer satisfaction, which naturally increases referrals.

ten things *you* need to know

1. Make sure the physicians in your practice understand what is going on at all times.
2. Get a feel for your marketplace. A gap in your market is not necessarily the same gap in another's market
3. View your patients as customers. Treat them as though your practice depends on it because it does!
4. Remember that a customer with a problem is not a problem customer.
5. Resolve the issue, instead of winning the argument. Respect the experience of your customers. They are the reason your practice exists!
6. Some doctors like to see long waiting lists. Most patients don't.
7. Create a culture of openness. Each doctor knows the progress of all the others.
8. Empower your staff, but set boundaries. You want to protect your culture while allowing staff enthusiasm to flourish.
9. Make your practice a culture and your culture a brand. Your standing in the community and consistency in all practice communications give staff a sense of pride among their peers.
10. Show your customers R-E-S-P-E-C-T.

Weathering the Perfect Storm

New Taxes and Your Retirement

James M. Sperry, MBA

James M. Sperry, MBA

Most physicians, especially those in the Rochester area, are acutely aware of a disturbing trend in the US: while health care costs are rising dramatically, these expenditures are not necessarily translating into proportional increases in physician incomes. Further, at exactly the same time that physician incomes are experiencing increasing downward pressure, impending tax increases on both income and investments will not only reduce a physician's ability to accumulate assets during their working years but also reduce their after-tax income from these assets during their retirement. In this way, a perfect storm is brewing for physicians seeking to retire in the next 10-15 years or so. The good news is that we have some tools and tactics to mitigate the damage, but these strategies require time for the benefits to compound materially, so get moving now.

Health care costs as a fraction of gross domestic product (GDP) in the US have been rising at a greater rate than the other industrialized nations for the past 40 years.1 In 1970, health care costs in the US accounted for about 7% of GDP, on par with Canada and above Germany at 6%. By 2006, it had risen to 16% of GDP in the US, outpacing Canada and Germany which had only risen to roughly 10%. Currently, physicians were not appropriating a proportionate share of this increase. Indeed, most physicians in the Rochester area today are experiencing greater pressure on their incomes.

The Tax Man Cometh...

Most analysts agree that federal, state, and local governments will seek ways to boost revenues to fund the unprecedented spending prescribed in response to the financial and economic disaster of 2008. Indeed, several pending tax increases in the coming 3 years will conspire to reduce your ability to fund your retirement, in some cases significantly. First, most are aware that income tax rates for the top income bracket will rise from 35% to 39.6%. Everything else being equal, this has the obvious effect of reducing one's contributions to one's savings each year.

> *"While health care costs are rising dramatically, these expenditures are not necessarily translating into proportional increases in physician incomes."*

What has been less conspicuously advertised, but is perhaps more pernicious to your retirement aspirations, are tax increases that will reduce the effective rate at which those savings and investments will grow. Taxes on interest, royalties, and short-term gains, for example, are scheduled to increase from 35% to 39.6% in 2011 and 43.4% in 2013. Tax rates on long-term capital gains are proposed to increase from 15% to 20% in 2011 and 23.8% in 2013 (and many experts I work with believe it is more likely to go to 25%). Taxes on dividends are proposed to increase in similar fashion, but if they don't, then everyone will need to adjust their portfolios to reflect that new relative after-tax benefit. [Interestingly, Congress is referring to these as tax decreases because they represent tax rates that are lower than what would be scheduled to go into effect when the Bush tax cuts sunset if Congress does not act otherwise!][1]

[1] Organization for Economic Cooperation and Development (OECD). OECD Health Data, 2006. (Paris: OECD, 2006).

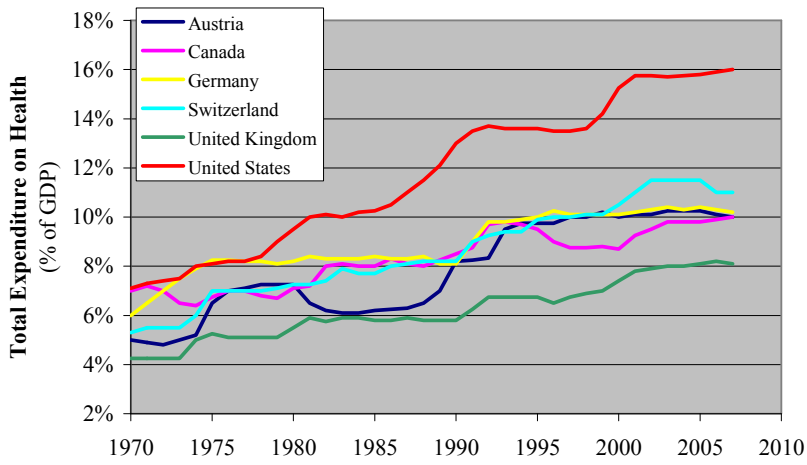
Tools and Tactics

There are several concepts to consider for boosting your after-tax accumulations in preparation for retirement. Don't despair; just be proactive because none of these approaches represents a silver bullet. Many tax efficiencies you can squeeze from your current approach will need to compound over time, so the sooner you start the better. Also, confer with a qualified advisor who can help you coordinate the necessary analyses with your tax and legal counsel where appropriate.

Tax efficient investing:

The investment markets were historically the domain of large institutional investors (e.g., pensions and academic institutions) which are typically tax-exempt. Unfortunately, you and I do not enjoy the same tax-exempt status. Chances are that most of you invest in at least some funds whose managers are not tax-sensitive because they believe that doing so reduces returns. This is not necessarily true and it explains why many investors actually had to pay taxes on gains in funds that lost up to 35% and more (on average) during 2008 - ouch! The single greatest investment expense for a taxable investor like you and me is usually taxes. So, seek advice to position the assets in your portfolio to streamline your tax exposure. For example, populating one's qualified accounts (e.g., 401(k) or IRA) with a disproportionate share of income- generating assets such as bonds and dividend-paying stocks can defer and reduce taxes. Note that it may be possible to do this without changing your actual investment selections or allocation, but just by shifting which investments reside in which accounts. This requires managing all of your various investment accounts (i.e., your 401(k) or 403(b), any IRAs or Roth IRAs, and any taxable investment accounts or mutual funds) as one aggregated whole. In addition, there is real value in your investment losses. Harvesting real losses to offset current income or as a carry forward to offset future income or gains can generate real savings. Higher-income tax payers should consider the potential benefit of a reduced tax burden through the sale of capital assets such as real estate, business interests, or concentrated low basis equity positions.

Rising Health Care Cost (1970-2006)
(*OECD Health Data* , 2006)



To Roth or Not to Roth...???

There are at least two basic types of tax-qualified plans that differ in when taxes are paid. In a traditional IRA, an investor makes contributions with money before paying taxes (so-called pre-tax contributions), growth is tax-deferred, and taxes are finally paid when the investor begins making withdrawals, presumably in retirement when their income is lower so they would pay lower taxes. Roth IRAs are different in that they are funded with after-tax contributions, so both the growth and subsequent qualified withdrawals are income tax-free. With many forecasting steep increases in income tax rates, the relative appeal of Roth IRAs is growing. Further, Congress removed the income-based restrictions on converting retirement plan assets to Roth IRAs for 2010, so this year represents what appears to be a unique opportunity to diversify the tax characteristics of your retirement assets. Roth conversion will not be for everyone, but everyone should seek assistance in evaluating whether or not the potential long-term distribution advantages outweigh the current costs. For example, if a family forecasts that there will be significant qualified retirement plan assets remaining in their estate upon their death, then the income tax burden to the beneficiaries like children may be mitigated if those particular assets were in the form of a Roth IRA.

Life insurance: Unless they understand exactly how it works, very few say they "want" life insurance. Many people think of life insurance only as a necessary expense to protect their incomes in the event of premature death. However, higher-income families realize how valuable permanent life insurance is as an asset in retirement. Cash values in permanent life insurance grow tax-deferred and can be accessed in most cases tax-free.

[2]In this way, it has similar income tax characteristics as Roth IRAs and can thus be a powerful source of supplemental income during retirement. During the working years, the death benefit protects the insured's income and is paid to the beneficiary income tax- free. In retirement, the death benefit gives the couple comfort in spending down their retirement plan assets more aggressively knowing that they will still be able to leave a legacy for their children and grandchildren even if their retirement plan assets are depleted.

Diversification (of income sources):

Most investors are familiar with the conventional wisdom of diversifying their investments across a broad array of stocks and bonds to minimize the potential damage to their portfolio if any one stock or bond were to tank. Doing so can minimize so-called individual security risk, but can do nothing for protecting against a decline in the broader market (so-called market risk). When it comes to retirement, my concept of diversification extends beyond this to include strategies for producing income that is de-correlated from the market. As an investor and prospective retiree, it is critically important to determine what fraction of your income that is generated from assets in retirement should be protected from market declines and understand how to position your assets in anticipation of this. As a rough rule of thumb, in many cases it is desirable to position enough assets to cover the majority of one's basic needs (e.g., housing expenses, health insurance, and food) – typically requiring about one-third of one's invested assets.

Statistics on Cardiovascular Disease and Stroke in Women

- Cardiovascular disease (CVD) ranks first among all disease categories in hospital discharges for women.
- Over 35 percent of all female deaths in America occur from CVD, particularly coronary heart disease and stroke.
- CVD is a particularly important problem among minority women. The death rate due to CVD is substantially higher in black women than in white women.
- In 2006, CVD claimed the lives of 432,709 females while cancer (all forms combined) killed 269,819 females.
- In part because women have heart attacks at older ages than men, 23 percent of women (age 40 and older), compared with 18 percent of men, will die within one year after a first heart attack.
- Stroke is a leading cause of serious, long-term disability; an estimated 15 percent to 30 percent of stroke survivors are permanently disabled.

source: American Heart Association

Finally, diversification also should include the creation of asset classes with different tax characteristics as something of a hedge against additional future tax changes. During retirement, different asset classes will be drawn on according to the specific needs and conditions (including the tax environment) at that time. At a minimum, to offer the greatest flexibility and leverage in managing future taxes, one should consider building up assets in several categories:

- *Qualified accounts (e.g., 401(k)s, 403(b)s, IRAs, Roth IRAs, etc)*
- *Non-qualified (or taxable) accounts*
- *Cash value permanent life insurance*
- *Vehicles that produce income which will not decline if the market drops*

At precisely the time when you may be focusing your efforts on accumulating assets for retirement, numerous pending tax increases will make this job significantly more challenging. Yes, headwinds are stiffening, but a careful analysis of your current situation and future retirement goals will produce a coordinated strategy that calls on the appropriate mix of available tools and tactics to give you peace of mind about retiring as you've dreamed.

[2] Outstanding loans and withdrawals will reduce the stated cash value and death benefit.

Jim develops individualized protection, growth, and transfer strategies for clients in diverse lines of business, including medicine. He earned his MBA from the Simon Business School at the University of Rochester (2002) and his Ph.D. in engineering from Duke University (1997). Jim joined Centra Financial Group in June 2006.
To reach Jim by email jsperry@CentraFinancialGroup.com or call 585-899-1273.

Advertiser Index

WHAT'S NEW IN Area Healthcare

URMC LAUNCHES NEW TREATMENT FOR LIVER CANCER

Radioactive Microbeads Use Body's Pathways to Destroy Tumor Cells

URMC physicians recently performed upstate New York's first radioembolization procedure for primary liver cancer. This technique combats the tumor in patients who can not be treated with surgery and are awaiting an organ transplant.

The outpatient procedure, called **TheraSphere**, involves the insertion of millions of microscopic radioactive glass beads into the vascular system near the tumor. The tiny, glass microspheres, about one-half the diameter of a human hair, attack cancerous cells while minimizing the impact on healthy tissue. This procedure is only available at two other sites in New York and 50 select hospitals in the United States.

"This is another option for patients who are waiting for a curative transplant," said **David Waldman, M.D., Ph.D.**, chair of Imaging Sciences. Medical Center interventional radiologists and radiation oncologists collaborate to calculate the precise dosage and deliver the microspheres filled with yttrium-90, the radioactive isotope that destroys the cancer.

About 22,600 cases of primary liver cancer are diagnosed each year in the United States, according to the American Cancer Society. The most common form of primary liver cancer is hepatocellular carcinoma, which in the U.S. is commonly caused by the hepatitis B or hepatitis C viruses or alcohol abuse. It is the fifth most common form of cancer in the world and is increasing globally due to an increase in the incidence of hepatitis.

The Medical Center's Division of Solid Organ Transplantation includes the only liver transplant program in upstate New York. The transplant team and its four surgeons serve patients from across New York State and northern Pennsylvania.

GENEVA GENERAL HOSPITAL MEDICAL STAFF WELCOMES INTERNAL MEDICINE PHYSICIAN

Emilio Lastarria, M.D. has joined the medical staff of **Geneva General Hospital**, specializing in the field of Urology.

Emilio Lastarria, M.D.

Dr. Lastarria received his medical degree and residency in Surgery and Urology, both from New York Medical College in Valhalla, NY. He is board certified by the American Board of Urology, and was recertified in 2003.

Most recently, Dr. Lastarria worked at Bay Pines VA Healthcare System in Bay Pines,Florida.
Dr. Lastarria joins FLH Medical, PC in April, with his new Urology office located at 158 North Street Geneva

MALE SEX HORMONES IN OVARIES ESSENTIAL FOR FEMALE FERTILITY

Implications for treatment of polycystic ovarian syndrome, No. 1 cause of female infertility

Stephen Hammes, M.D., Ph.D.

Male sex hormones, such as testosterone, have well defined roles in male reproduction and prostate cancer. What may surprise many is that they also play an important role in female fertility. A new study finds that the presence and activity of male sex hormones in the ovaries helps regulate female fertility, likely by controlling follicle growth and development and preventing deterioration of follicles that contain growing eggs.

This study and others highlight the fact that women need certain levels of male hormones, or androgens, in their bodies to function normally. Understanding how male hormones influence ovulation in mice may provide clues as to how to better regulate androgens and combat infertility in humans.

"The need for certain levels of male hormones in the female body and the strong influence these hormones have is often underappreciated," said **Stephen Hammes, M.D., Ph.D.**, **Louis S. Wolk Distinguished Professorship in Medicine** (Endocrinology and Metabolism) at the University of Rochester Medical Center and a lead author of the study. "Our findings open up a new line of research into how we can regulate male sex hormones, specifically in the ovaries, to improve fertility."

These findings are relevant to women who suffer from polycystic ovarian syndrome (PCOS), a condition characterized by androgen excess. PCOS is marked by the overproduction of male hormones and causes ovarian changes that prohibit regular ovulation, often contributing to infertility. Hammes, chief of the **Division of Endocrinology and Metabolism** at the **University of Rochester**, believes that better understanding the overall effects of androgen levels in the ovary may help researchers determine how to target and control the increased levels that lead to fertility problems in women with PCOS.

Polycystic ovarian syndrome is the No. 1 cause of infertility in women. The condition affects 5 percent to 10 percent of women of childbearing age and is nearly as common as (and often associated with) Type 2 diabetes. Overall, more than 6.1 million women in the United States ages 15 to 44 have difficulty getting pregnant or staying pregnant, according to the **Centers for Disease Control and Prevention**.

MEDICAL SOCIETY OF MONROE COUNTY WELCOMES NEW PRESIDENT

The Monroe County Medical Society elected its 2010/2011 officers at the Society's 189th annual meeting on May 18, 2010. The officers are:

President: Jerry J. Svoboda, MD, of Rochester, vascular surgeon in practice with Unity Vascular Surgery, part of Unity Health System

President-Elect: James E. Szalados, MD, Esq. of Rochester, critical care specialist and anesthesiologist with Westside Anesthesiology Associates of Rochester, LLP; and a NY attorney concentrating in health law

Vice President: Leslie Algase, MD, of Honeoye Falls, an internist and geriatrician in private practice with Partners in Internal Medicine

Secretary: James Fetten, MD, of Pittsford, a hematologist and oncologist with the Interlakes Oncology Group

Treasurer: Wallace Johnson, MD, of Rochester, an internist, director of the University of Rochester Center for Primary Care

Assistant Treasurer: Peter Deane, MD, of Rochester, an allergist and rheumatologist with Allergy, Asthma, Immunology of Rochester, PC.

CHILDREN'S HOSPITAL TOPS IN ORTHOPAEDICS, NEUROLOGY & NEUROSURGERY

U.S. News ranks URMC's Golisano Children's Hospital programs among nation's best

Golisano Children's Hospital at the University of Rochester Medical Center (URMC) has been named among the nation's best hospitals for pediatric orthopaedics, neurology and neurosurgery by **U.S. News & World Report**. The annual survey, which will be published in the 2010 edition of ***America's Best Children's Hospitals*** in July, was sent to 160 pediatric institutions nationwide.

URMC's reputation for excellence in care for **Child Neurology** and **Pediatric Neurosurgery** brings children and families from across the country for the treatment of Tourette syndrome, movement and neurodegenerative disorders and epilepsy. Its Pediatric Orthopaedic division has expanded exponentially to meet demand for its highly specialized care of scoliosis and spinal and ribcage deformities.

"We are delighted that Golisano Children's Hospital has – again – been recognized nationally for the expert care we are known for regionally," said **Nina F. Schor, M.D., Ph.D.**, chair of URMC's Department of Pediatrics and pediatrician-in-chief of Golisano Children's Hospital. "We are able to provide this top-notch care because of the collaboration among the Departments of Pediatrics, Orthopaedics, Neurology and Neurosurgery, the Division of Pediatric Critical Care, the Department of Physical Medicine and Rehabilitation, the Ronald McDonald House and the community."

Golisano Children's Hospital is a hospital within a hospital at URMC. The hospital serves more than 70,000 children from the 17-county Finger Lakes Region and beyond every year – both as inpatients and outpatients. It houses 124 beds and 34 pediatric specialties and subspecialties, including Pediatric Orthopaedics, Child Neurology and Pediatric Neurosurgery.

ROCHESTER GENERAL HOSPITAL

ROCHESTER HEART INSTITUTE

ROCHESTER GENERAL HOSPITAL'S CARDIAC SURGERY PROGRAM HONORED FOR EXCELLENCE

The Rochester Heart Institute (RHI) at Rochester General Hospital has received a prestigious THREE STAR rating for the highest level of cardiac surgical quality designation from **The Society of Thoracic Surgeons (STS)**.

Only 12% of the almost 1,000 cardiac surgical programs in the database have achieved this elite level of quality and patient outcome.

"We work tirelessly to ensure that we provide the highest quality care to our patients," said Ronald L. Kirshner MD, Chief of Cardiac Services and Cardiothoracic Surgery at Rochester General. "This STS designation is evidence that our commitment to process improvement and excellence is serving our patients well."

EDITORIAL OUTLOOK

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AUGUST

Cover Story: Janet Williams, MD

Meet the Medical Director of Rochester's newest urgent care center – Rochester Immediate Care.

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Special Focus: *Pediatric Palliative Care*
Issues in Pediatric Cardiology
Imaging and the Pediatric Patient
Obesity- Breaking the Cycle
Sports Medicine for Kids
Medical Talk with the Teenage Patient

SEPTEMBER

Clinical Focus: ***Ophthalmology / Prostate Cancer Awareness***

Special Focus: *Medical Innovations*
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