ROCHESTER / MAY 2011

Western New York
PHYSICIAN
THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

Madonna ObGyn Invision Health

Rejuvenating Women's Health Care

MEDICAL

ADVERTISING

PORTRAITS

LISA HUGHES
PHOTOGRAPHY

www.lisahughesphoto.com
585.264.0409

Contents

COVER STORY

CLINICAL FEATURES

PRACTICE MANAGEMENT

LEGAL

Front row – L to R: Sraddha Prativadi, MD and Catherine Falcon, NP, RNC, MS, WHNP.
Second row – L to R: Madonna Tomani, MD, FACOG and Carole Peterson, MD, FACOG.

Welcome to the May Issue

With this issue, Western New York Physician celebrates our 1 year anniversary!! Over the past year, I've enjoyed the honor of meeting so many of the talented physicians and dedicated healthcare professionals in the region. Whether through an in-depth cover story, a profile or as a contributing author, I thank you for sharing your time and expertise with all of your colleagues through the pages of Western New York Physician.

As a locally owned and published magazine, our commitment is unwavering – each month will deliver perspective from regional experts – *names you know, people you trust* – on topics, resources and services relevant to your practice, to your patients, to your business and to your lifestyle. Nothing competes with that!

With a focus on Women's Health, the cover story this month visits the area's newest women's practice – Madonna ObGyn Invision Health. This experienced group of practitioners recognized that since the ObGyn is often the only doctor women see regularly, it was not a healthcare opportunity to squander. Committed to strengthening the patient relationship, these doctors make the most of each visit lending to a holistic view of their patients' health.

Hear from our medical legal expert, James Szalados, MD, MBA, Esq as he discusses *Medical Guidelines and Protocols*. Also in this issue, we explore a variety of women's overall health issues including Primary Hyperparathyroidism, liver disease in women, sleep challenges and treatment options and the residual podiatric problems women may experience with pregnancy.

Many thanks to our advertisers! Your presence in the magazine sets you apart– positioning your practice, your business as an invested leader in the health care community in western New York. Your continued trust and support ensures that all physicians in our region benefit from this collaborative sharing of information.

All best,
Andrea
WNYPhysician@Rochester.rr.com

Western New York
PHYSICIAN

THE LOCAL VOICE OF PRACTICE MANAGEMENT AND THE BUSINESS OF MEDICINE

PUBLISHER
Andrea Sperry

MANAGING EDITOR
Julie Van Benthuysen

ADVERTISING DIRECTOR
Vince Bryant

CREATIVE DIRECTOR
Lisa Mauro

PHOTOGRAPHY
Lisa Hughes

CONTRIBUTERS
Julie Van Benthuysen
Cheryl Nelan
Karen Dunnigan, MD
Beth Freeling Gusenoff, DPM
James Szalados, MD, MBA, Esq
Alice Hoagland, PhD, MBA
John Coniglio, MD, FACS
Steven Cannady, MD

Contact Us
For information on being highlighted in a cover story or special feature, article submission, or advertising in

Western New York Physician
WNYPhysician@Rochester.rr.com
Phone: 585.721.5238

MLMIC Announces New Claims Free Discount for Physicians

Medical Liability Mutual Insurance Company (MLMIC), in its continuous effort to reduce the onerous burden of high premiums paid by its physician and surgeon policyholders, has recently received the approval of the New York State Insurance Department to offer them a claims free discount, effective July 1, 2011. This new and important benefit will provide a 7.5% premium discount to those physicians and surgeons who qualify and who are insured for professional liability coverage through MLMIC. Currently, 54% of MLMIC-insured physicians will qualify for the discount. The discount may also apply to new applicants who provide claims free loss histories and meet the qualifications.

MLMIC filed this program with the Insurance Department because its actuaries have indicated that past favorable claim experience is strongly indicative of what can be expected in future years. Therefore, it stands to reason that policyholders who are claims free should receive a reduction in premium. To qualify, a physician must have been in practice for a minimum of five years, and he/she must have no open claims and no closed claims with paid indemnity or expense within the five-year period immediately preceding June 15, 2011, regardless of the accident date or report date.

As the largest physician-owned professional liability insurance company in New York State, with over $590 million in annual premium, MLMIC has always maintained its commitment to provide policyholders with the highest quality professional liability insurance available at the lowest possible cost.

For more information about MLMIC's new claims free discount, physicians visit **www.MLMIC.com.**

Below are answers to questions we anticipate receiving about MLMIC's *claims free* discount

1. ***Do I have to apply to receive the discount?***

a. If you are a *current physician policyholder* with sufficient experience on file with us (at least a 5-year history) and have completed your specialty renewal application within the past 2 years, updating any previous carrier's loss experience, the **claims free** discount will automatically be applied to your renewal premium on July 1, 2011 if you qualify.

b. If you are a *current physician policyholder* without sufficient experience on file with us (less than a 5-year history), but have completed a specialty renewal application update within the past 2 years and have provided loss histories that demonstrate you qualify, we can apply the premium discount.

c. If you are a *new applicant* seeking the **claims free** discount, you must fill out an application and provide loss histories that demonstrate your qualification.

2. ***If a physician has a closed claim with no indemnity payment within the last 5 years, would the physician qualify for the claims free discount?***

Unfortunately, if the claim had any paid claim expense, the physician would not qualify for the discount. Regardless of a claim's merit or the amount paid in a judgment or settlement, a claim has an additional financial impact on MLMIC in the form of claim expense (mainly defense attorney fees). Claim expense is still paid by the Company, even if a claim is closed without an indemnity payment.

3. ***Does the discount apply if a policyholder is receiving another discount?***

The claims free discount will also apply to policyholders participating in the Voluntary Attending Physician (VAP) Program or who receive a part-time and/or risk management discount. The discount will not apply if the policyholder is receiving any other discount, e.g., the new doctor discount.

4. ***Does reporting an incident or event that could reasonably lead to a claim in the future disqualify a physician from the claims free discount?***

No, reporting an incident is encouraged and would be considered an event (not a claim) by MLMIC. Therefore, it would not disqualify a physician from the discount.

5. ***If a physician has purchased optional Defense Costs Coverage ("defense only coverage") from MLMIC and reports a defense only claim, would this disqualify the physician from the discount?***

No, Defense Cost Coverage is not professional liability coverage but a separate optional coverage purchased by the physician. Therefore, reporting a "defense only" claim would not impact the claims free discount.

6. ***Does the discount apply to entity policies?***

Yes, if the physician members qualify for the discount, the discount will be reflected in the calculation of the entity premium. However, an entity does not receive a **claims free** discount based upon its own experience.

7. ***Does the discount apply to policies issued to physician extenders who are supervised and/or employed by a claims free physician?***

No, extenders are not subject to the discount program.

8. ***What happens if a claim is subsequently reported that disqualifies the physician for a claims free discount?***

The claims free discount will be removed the next policy year beginning on the following July 1.

Podiatric Problems of the Pregnant Patient

Beth Freeling Gusenoff, DPM

Residual pedal pathology is a common entity encountered after pregnancy. Symptoms include an increase in shoe size, foot fatigue, cramping, and hyperpronation. Relaxin is a hormone produced during pregnancy to permit relaxation of the pubic symphysis and prepare for parturition. Due to the high elastic composition of the plantar calcaneal navicular ligament, relaxin may encourage the relaxation and elongation of this ligament during pregnancy. This increases the pronation and collapse in one's foot. Pronation encourages muscle imbalance which is the major cause of bunion, hammer toe and heel spur formation. Weight gain during pregnancy magnifies hyperpronation.

Biomechanical changes during pregnancy increase the base of gait during ambulation causing a more abducted angle of gait. Due to the anterior displacement in the center of mass, it is hypothesized that a widened base of gait serves as a compensatory mechanism to increase the functional base of support. The female therefore ambulates in a more abducted and hyperpronated fashion and as thigh circumference enlarges, an increase in hip abduction allows the limb to continue through swing phase without obstruction.

This combination of muscle imbalance, increased joint laxity compounded by weight gain, and compensatory ambulatory functions result in indelible pedal manifestations following parturition including: bunion deformity, hammertoe deformity and heel pain.

Bunion Deformity

Bunion or hallux valgus is a deformity of the first metatarsal-phalangeal joint (MPJ) involving a medial prominence at the first metatarsal head and a lateral deviation of the hallux. Clinically, individuals may present with complaints of pain, inflammation, callus formation, stiffness and inability to wear conventional footgear with comfort. Bunions have a strong hereditary basis and seem to be more common among women than men. Certain foot types (especially flexible flatfoot) and inappropriate shoe gear are major etiological factors in bunion formation.

Range of motion at the first MPJ may be restricted due to arthritic changes in the joint and osseous changes. Hallux Valgus forms due to the tightening of the adductor hallucis tendon and weakening of the abductor hallucis tendon. Consequently, the great toe joint joint surface becomes exposed and malaligned. The hallux valgus places a retrograde pressure on the first metatarsal causing a metatarsus primus varus. Propulsion during gait when there is subluxaton of the first MPJ encourages inflammation, pain and degenerative changes.

Hammertoe Deformity

Hammertoe is a sagittal plane flexion contracture of the toe at the proximal and/or distal interphalangeal joint. In absence of a neuromuscular disorder, a hammertoe is caused by an imbalance of the extensor and flexor digitorum longus or brevis tendons of the foot. Clinical manifestations include thickening

of the skin at the joint area along with occasional erythema and edema. Symptoms increase with improper shoe gear.

Heel Pain

Heel pain is characterized by pain, tenderness and discomfort at the plantar and/or posterior aspect of the heel. The differential diagnosis may include inflammatory conditions, plantar fasciitis, calcaneal stress fracture, tarsal tunnel syndrome, rheumatoid arthritis or enthesiopathy and bursitis. Clinical manifestations may include pain at the plantar aspect of the heel upon initial ambulation after rest or progressive pain throughout the day. Radiographic findings may include osseous spurring at the plantar or posterior aspect of the calcaneus.

The ligamentous flexibility in the foot and collapse of the arch encourage traction of the plantar fascia on the calcaneal tuberosity and bursal formation. Treatment includes limiting the traction of the plantar fascia or Achilles on the calcaneus. Conservative management may consist of changes in foot wear, arch support, orthotics, stretching exercises, steroid injection, non-steroidal anti-inflammatory drugs, or physical therapy. Consequently, "Barefoot and pregnant" is most discouraged and the greatest perpetrator of heel pain in pregnancy.

Foot Orthoses

Foot orthoses may help control symptoms from the aforementioned pathologies by providing mechanical control, realignment and shock absorption. Orthotics serve to provide support to the vulnerable pregnant foot.

Due to physiologic changes during pregnancy, proper shoe gear such as supportive sneakers versus flimsy sandals are necessary. Walking barefoot is forbidden, especially in the third trimester. Foot orthoses may be used as a prophylactic measure to maintain proper foot alignment. A woman should not force her post-pregnancy feet into pre pregnancy shoes. Permanent changes may occur in one's feet after pregnancy but the gift of a baby makes it worth it!

Madonna ObGyn Invision Health

Rejuvenating Women's Health Care

Julie Van Benthuysen

The providers and staff of Madonna ObGyn, Invision Health, strive to create a positive, loving and caring environment where patients feel like family. Patients often comment that the environment is relaxing and is in itself therapeutic.

THE CHANGING FACE OF OBSTETRICS & GYNECOLOGY

means more women are seeking and receiving a far broader range of care to address their overall health needs. Here in Western New York, a small group of energized physicians is bringing new life to the practice by offering a hands-on, multidisciplinary approach.

Dr. Madonna Tomani performs botox injections on a patient. Following a "boutique" practice model, Madonna ObGyn, Invision Health also provides other aesthetic services including injectable fillers, Latisse, light-based laser and photo facial treatments for various conditions including hair removal, wrinkle reduction, scars, acne, skin rejuvenation and stretch marks.

Last November, Madonna ObGyn Invision Health opened its doors in Brighton, conveniently located adjacent to the Rochester expressway for easy patient access from across the region. As a division of Buffalo-based Invision Health, this team of vibrant women is already providing exceptional care – from routine gynecological screenings and maternity care to managing complicated conditions and high-risk pregnancies – using the latest preventative techniques, technology and treatments.

"Our goal is to blend modern technology with compassionate care to accommodate the health care needs of women throughout all phases of their lives," says Dr. Madonna Tomani.

As the visionary behind Madonna ObGyn, Dr. Tomani recognized the need to develop stronger relationships with patients that encourage them to take an active role in their own care and allow them consistent provider access. Within larger practices, she says, patients might see any number of separate providers throughout the course of their condition. "Prior to opening Madonna ObGyn, patients were calling me at home because they couldn't get in to see me for months," she says. "I knew we had to provide something different.

Dr. Tomani took the non-traditional route to becoming a physician. She began as a nurse and later became an ObGyn Nurse Practitioner with a focus on infertility – always feeling a close connection to her patients. Her drive to be involved in the evolving state of women's health eventually led her to medical school. Practicing since 1998, her exposure to multiple hospital settings and fast-growing medical practices made a strong impact on her approach to care.

"We really try to honor the doctor/patient relationship here, which can get lost in a larger practice setting," she says. "We're passionate about what we do, and it shows."

Celebrating Its New Home

Madonna ObGyn's facility at Cambridge Place exudes warmth. Coming from a large, all female practice, Dr. Tomani and Dr. Carol Petersen were keenly aware of the importance of atmosphere. "Women are especially anxious when they need to visit their ObGyn," says Dr. Tomani. "Sometimes the visit is more stressful than the actual issue involved, so we always spend the time with every patient." Citing a trend in ObGyn towards a more "spa-like" feel, the 6,700 square foot office space was thoughtfully designed by the entire team to be mindful of lighting, comfort and privacy, while offering the latest in equipment and technology. "We want to dispel that anxiety from the minute they walk through our doors."

Through Dr. Tomani's relationship with Dr. Michael Landi, Chief of Neurosurgery at Kenmore Mercy Hospital in Buffalo, Madonna ObGyn formed an alliance with Invision Health. Dr. Landi provided guidance and administrative support as Dr. Tomani forged ahead to bring the new practice to fruition.

The latest in ultrasound imaging technology is used for diagnostic purposes in the care of women's obstetrical and gynecologic concerns. Ultrasound-guided procedures are performed in the office for selected patients to maximize safety and positive outcomes.

"We're not business people," she says, "we're doctors." Once she found the right building, staff was encouraged to help create their own space, from choosing wall colors to determining the height of tables in the ultrasound room. "It's the way of the future. By designing a space that serves as a functional mini-OR, we can be more efficient, give patients access they want and help cut hospital-based costs."

The inviting waiting area is separated by a privacy wall for patients utilizing the practice's infertility services, with a separate mens' bathroom connected to the fertility room. Each hallway and patient room comes alive with life-sized baby photographs and father and child photography by local photographer Keith Trammel.

Practice of Same Minds

The staff exudes the same positive energy and sensibility found throughout the facility. "We're invested in this place heart and soul," says Dr. Peterson, who has been practicing in the region for nearly 30 years.

While Madonna ObGyn is new, the relationship between its team of physicians, nurses and administrative staff spans decades. "Each of us shares the same method of care, and there's a lot of love between us," adds Dr. Sraddha Prativadi, a Rochester native who returned here for her residency and fell in love with the region all over again. She has dedicated her career to helping women achieve their highest possible level of health.

From the manner in which patients are greeted in reception to the nurse practitioners, ultrasound technicians and doctors, the team promotes a therapeutic relationship with each patient. "We follow our discipline as healers," says Dr. Prativadi. "We separate the science of medicine from the healing part of it, so it's as much about how you deliver care as its intellectual aspects."

Dr. Petersen agrees. "It's easy to be a doctor here, academically and emotionally." With her many years of care, she enjoys a patient base largely in the 40-60 year range. "I'm now seeing my third generation of patients," she says, thrilled that many of her patients have followed her to Madonna ObGyn. "I feel very blessed to work here," adds Dr. Prativadi. "Everyone's happier."

Already Thriving Practice

Word of mouth has come a long way in short order. As part of its Grand Opening, staff began holding "get-acquainted" visits with potential patients. "People definitely feel the love," says Dr. Prativadi. "Everyone who has visited our offices has made an appointment to become a patient."

Julie Pikuet learned about Madonna ObGyn from a neighbor. "I was very frustrated with my practice and tried another one that couldn't get me in for months. Finding Dr. Prativadi was a blessing, she says. Admitted after two days, Ms. Pikuet was immediately taken under her wing. "Dr. Prativadi's recommendation took into account what was best for me personally and professionally. She fought to get me in for DaVinci robotic surgery as soon as possible despite the high demand. She went above and beyond my expectations."

Referring doctors have been big supporters. "I can speak confidently about the group's well-established qualifications both as a patient and as a physician treating their patients with breast disease," says Dr. Posy Seifert from Elizabeth Wende Breast Care. "The entire staff works with us seamlessly and tirelessly to care for their patients."

As a patient, Dr. Seifert emphasizes that not only does the team provide superior quality care, but each woman is treated as a special individual. "When you go to their office as a patient, you're greeted by people who know your name. There is a true

sense of caring and family."

As the practice grows, the doctors express confidence that managing up to 50,000 patients seems a reasonable goal – anticipating another physician who shares their practice philosophy will join them. Its accessible location is very appealing to patients in outlying areas like Hornell, Geneva and Clifton Springs who want to avoid city traffic, they say. Patients can cluster appointments by combining their annual exam with other services, with an ACM lab located nearby. In the coming months, Dr. Prativadi and NP Katie Falcon will also maintain a presence at Clifton Springs Hospital to provide additional access.

Latest in Obstetrics

The practice provides a range of family planning services. These include pre-conceptual evaluation and counseling, routine and high risk prenatal and postnatal care, surgical and medical management of miscarriage, fetal monitoring, complete ultrasound services including First Trimester genetic screening, Second Trimester level three anatomic screening, twin obstetrical care and biophysical profiles.

Its ultrasound team specializes in the diagnosis of low and high-risk pregnancies, utilizing the latest in ultrasound technology. Its third trimester 3D and 4D "entertainment" imaging offers a non-medical technique for capturing the patient's baby in action in an exciting, unique way.

The team also provides infertility evaluation and the latest in-office treatments once handled solely within the clinical hospital setting.

Patient Tricia Palmer recently gave birth to twins after undergoing in-vitro fertilization. She followed Dr. Tomani to the new practice, knowing her reputation first-hand having worked with her as a labor nurse at Highland Hospital. "I knew her background as a nurse and her knowledge of infertility issues would provide guidance and reassurance," she says. "You can tell she still has that nurse in her." Considered high risk, Dr. Tomani followed her patient every step of the way. "She meets with you one on one. Anytime I had a question, she was always encouraging." After a successful delivery, Ms. Palmer suffered a bout of Bell's Palsy. "Even with half my face in paralysis, she put my fears at ease."

"the dynamics of each procedure feel supported, efficient and safe"

The operative suite at Madonna ObGyn, Invision Health allows the providers to address many gynecologic concerns through procedures and minor surgeries in the private setting of the office. Patients find that the experience is well-coordinated and accommodative to busy schedules.

Growing Gynecological Care

The practice provides general gynecological care for well women and adolescents, addressing everything from a patient's initial visit, menstrual irregularity, PMS and cramps to evaluation of fibroids and ovaries, abnormal bleeding and treatment of fibroids and endometriosis. The team provides STD testing, diagnosis and treatment of abnormal pap tests, and menopause evaluation and treatment in including bio-identical hormones, as well as. The doctors also evaluate vaginitis, vulvitis, and other vulvar disorders. Diagnostic ultrasound is used for many procedures.

Numerous gynecological procedures previously handled only as in-hospital procedures are now performed in the comfort of Madonna ObGyn's facility. These include D & C, Hysteroscopy, Endometrial ablation/ NOVASURE, permanent contraception/ ESSURE, ADIANA, Colposcopy, LEEP, Vulvar biopsy, IUD insertion and removal and treatment of miscarriage.

"Our team is well-prepared, whether it's a pre-op visit or surgery," says Dr. Tomani. "From check-in to medical assistance, the dynamics of each procedure feel supported, efficient and safe."

Collaboration with area hospitals like Highland Hospital has given the physicians broader access for those procedures still handled in-hospital, like advanced laparoscopy and vaginal and abdominal hysterectomy. As a state leader in women's services and robotic surgery, Highland enables the practice to maintain its leading edge position. Robotically-trained, Dr. Prativadi enthusiastically supports the latest tools for less invasive procedures. "We want to see more patients going home the next day."

From Bone Health to Pain Management

Offering a full breadth of bone health services, Madonna ObGyn provides evaluation of metabolic bone disease, nutrition and interpretation of bone density scans (DEXA scan), lifestyle and exercise counseling, medical treatment and decision making and IV infusion services for Boniva and Reclast.

The practice has teamed up with Take Shape For Life (tsfl), a program which incorporates physician-developed and clinically-proven Medifast Meals, free monthly one-on- one coaching, and on-line support to help patients reach and maintain optimal health.

Spearheaded by Nurse Practitioner Catherine Falcon, RNC, MS, WHNP, the program is also available to the patient's family and friends. "If patients want success, we tell them to go see Katie," says Dr. Petersen.

Aesthetics, its newest offering, represents an exploding trend in womens' health. Treatments include Botox®, injectable fillers, Latisse, light-based laser and photo facial treatments including treatment for hair removal, Rosacea maintenance, stretch marks, broken capillaries, scars, acne, wrinkle reduction, pigmented lesions and skin rejuvenation.

Care also extends to other areas, with chiropractic services available once a week. For patients with pain management issues, Neurosurgeon Dr. Landi performs consults for potential neurostimulator placement.

Reaching a Wider Demographic

Addressing the needs of college-age students has become a focus area for staff. Collaborating with area pediatricians on adolescent health means a smooth transition for any patient requiring gynecology services. "It's critical that adolescents and young adults be exposed early to that care and have a positive first experience with their ObGyn," says Dr. Prativadi.

Referring pediatricians, including Fairport Pediatrics and Highland Family Medicine, collaborate to help patients gain the support they need. Patients often meet jointly with their pediatrician and a Madonna ObGyn. "As it relates to reproductive health," she adds, "patients know who they can call and that it will be confidential."

Elevate the Annual

"The idea of Elevate the Annual was born from feeling that my interaction with a woman during the annual is oftentimes the only opportunity she has to divulge sensitive information about her life and seek out help at a deeper level. My approach to annuals are not just about the Pap but rather an opportunity to elevate the experience to involve compassion, empowerment, inspiration and motivation to help the patient achieve not only her highest level of health possible but live her highest life possible in terms of happiness, fulfillment, spiritual and emotional well-being. I might be the only person whom she trusts and the only person to demonstrate love and compassion in her life.

Thus, the annual can become a powerful experience and opportunity to help change lives."

Sraddha S. Prativadi, MD

Paving Way for More Personal Care

Patients far and wide are thrilled with the personal care they receive. Every delivering mother receives a congratulatory gift basket, complete with certificates from Sheer Ego salon and Keith Trammel photography. "It's a phenomenal gift," says patient Tricia Palmer, who received blue and pink 'Special Delivery from Madonna ObGyn" onesies after her twins' birth. Baby photos are posted on the Madonna ObGyn website.

"As a smaller practice, we can balance that personal touch with the latest treatments available," says Dr. Tomani. "We're invested and motivated to bring the best to our patients every day."

Liver Disease in *Women*

Karen Dunnigan, MD

Some liver disorders, such as the autoimmune liver diseases, are far more common in women. Others, such as alcoholic liver disease, progress more rapidly in women. Yet others are unique to pregnancy.

AUTOIMMUNE LIVER DISEASE

Primary biliary cirrhosis and autoimmune hepatitis, like many autoimmune disorders, occur more commonly in women than in men. Primary biliary cirrhosis (PBC) is a slowly progressive disorder that peaks in the 5th decade and is caused by immune-mediated destruction of intrahepatic bile ducts, which leads to fibrosis, cirrhosis and eventual liver failure. Ninety-five percent of affected individuals have anti-mitochondrial antibodies in their serum. PBC may be associated with other autoimmune disorders including Sjogren's, celiac disease, and idiopathic thrombocytopenic purpura. PBC is usually asymptomatic when diagnosed, but may present with fatigue and pruritus. Treatment with ursodiol slows or halts progression of the disease.

Autoimmune hepatitis (AI) is a chronic hepatitis that usually occurs in younger women, with a clinical course of waxing and waning activity. Its presentation may vary from asymptomatic to fulminant hepatic failure. Like PBC, AI may be accompanied by other autoimmune disorders such as thyroiditis, type 1 diabetes, or rheumatoid arthritis. Serum globulins are often elevated, and one or more autoantibodies, including ANA, smooth muscle antibody, anti-actin antibody, pANCA, and anti-LKM are present. Treatment includes corticosteroids and azathioprine.

ALCOHOLIC LIVER DISEASE

Alcoholic liver disease (ALD) is more commonly observed in men than in women; however, women have been shown to be at higher risk for the development of ALD, and develop more severe disease with less alcohol consumption than men.

In most cases, the level of ethanol consumption required for developing the advanced forms of alcoholic liver disease (ALD) is 40-80 grams of alcohol daily for men for several years. In women, half of this amount may cause clinically significant liver disease. A woman consuming as little as one and a half 12 ounce bottles of beer or two 4 ounce glasses of wine daily for ten years is at risk for ALD.

Despite weight adjustments, a similar level of alcohol consumption results in higher blood levels in women than in men. Theories to explain this include a relative deficiency of gastric alcohol dehydrogenase in women, sex differences in alcohol bioavailability, and female hormone effects.

PREGNANCY

Abnormal liver function tests occur in 3-5% of pregnancies. Most liver dysfunction in pregnancy is due to one of five liver disorders unique to the pregnant state. Hyperemesis gravidarum (HG) is intractable vomiting during the first trimester. Half develop abnormal liver function tests, with an up to twenty-fold elevation of transaminases. Treatment includes hydration, antiemetics, nutritional support, and occasionally steroids.

Intrahepatic cholestasis of pregnancy (ICP) occurs in the second half of pregnancy, and is characterized by pruritus and elevated bile acids. It may recur in subsequent pregnancies or with the use of oral contraceptives. Ursodiol may produce relief of pruritus in some. The main risk in ICP is to the fetus, and includes placental insufficiency, premature labor, and sudden fetal death.

Pre-eclampsia occurs in the third trimester, and liver involvement is seen in the most severe cases. About 10% of severe cases of pre-eclampsia are complicated by Hemolysis, Elevated Liver tests, and Low Platelet count, the HELLP syndrome Nausea, vomiting, abdominal tenderness, and hepatomegaly are common.

Hepatic parenchymal bleeding or rupture can occur. Definitive therapy for both entities is delivery.

Acute fatty liver of pregnancy, (AFLP) also occurs in the third trimester. This is a catastrophic illness with the risk of significant maternal and fetal mortality and may be associated with coagulapathy , renal failure, hypoglycemia, and encephalopathy. Immediate delivery is required.

ORAL CONTRACEPTIVES

Despite the declining incidence of liver disease associated with oral contraceptives several potential entities may occur with this drug. Cholestatic jaundice can occur within the first six months of therapy. A predisposing factor may be cholestasis of pregnancy. Thrombosis of the hepatic (Budd-Chiari syndrome) or portal vein, especially in women with concomitant disorders of coagulation, may be augmented by estrogen use, related to the thrombophilic effect of the drug. Benign hepatic tumors, such as adenomas, focal nodular hyperplasia (FNH), and hemangiomas have also been associated with oral contraceptive use.

2011 EDITORIAL CALENDAR MAY–OCTOBER

JUNE
Ophthalmology / Imaging
Medical Technology • Dermatology

JULY
Sexual Health
Telemedicine
Wound Care

AUGUST
Pediatrics
Mental Health
Orthopaedics

SEPTEMBER
Chronic Diseases
Prostate Cancer Awareness

OCTOBER
Oncology Issue
Breast Cancer Awareness
Advances in Physical Therapy

NOVEMBER
Geriatrics - Caring for Older Patients
Diabetes and Related Health Issues
Lung Cancer Update

DECEMBER
Sleep Medicine
Pain Management
Infectious Disease

SPECIAL COLUMNS

Healthcare Reform Update
Invited experts offer perspective on the impact of healthcare reform – what it means, what it might cost, and the impact to the healthcare system and patients in western New York.

Primary Care Perspective
A forum created to share insights from the physicians who deliver primary care to area patients.

Medical Innovation
Learn about the latest developments in technology to improve practice management, patient care and the delivery of medicine.

Electronic Health Records
Area experts and practitioners share valuable expertise in managing the implementation process, avoiding pitfalls and guiding your practice into the through the transition.

Primary Hyperparathyroidism; an Insidious Threat to Women's Health

Steven Cannady, MD

John Coniglio, MD, FACS

Primary hyperparathyroidism (HPT) is predominately a female illness with far-reaching implications in the management of women's health. It is two to three times more common in women than in men and affects 1 in 500 women over 60 years of age. There can be extensive overlap in the manifestations of HPT, menopause and aging. It is not uncommon for HPT to be detected on routine lab testing, and only after its discovery to realize that many subtle symptoms have been referable to HPT.

Hyperparathyroidism was considered uncommon until the advent of auto-analyzers in the 1960s, which allowed physicians to routinely screen calcium levels and diagnose the disease before leading to it most severe form, osteitis fibrosa cystica. In the 1970-80s most patients with HPT presented with advanced symptoms of long untreated hypercalcemia such kidney stones or bone and joint pain. By the 1990s, with the advent of a more specific iPTH assay, the disease has been recognized as broader in its spectrum of manifestations; HPT now presents most frequently with non-specific symptoms: fatigue, weakness, depression, memory loss, nausea, constipation, reflux and nocturia. The ability to powerfully detect early serum abnormalities with only mild symptoms led physicians to label the disease 'asymptomatic HPT'. However, chronic hypercalcemia from HPT has inherent risks to the well being of woman an in particular; in a basic sense, hyperparathyroidism directs the body to secure more calcium for the bloodstream – an act that results in loss of bone density, gastrointestinal discomfort, kidney stones, bone pain, psychiatric manifestations and other subtle findings. Many of these disorders can be mistaken for menopause and multiply the risks of fractures and quality of life depreciation over that of aging alone. Thus, the disease is far from 'asymptomatic' when carefully considered

By the 1990s, with the advent of a more specific iPTH assay, the disease has been recognized as broader in its spectrum of manifestations

The National Institute of Health convened The Workshop on Asymptomatic Primary Hyperparathroidism in 2002 to revise the guidelines for surgical indications in HPT (parathyroidectomy). A list of 'absolute' indications were constructed; the list includes any patient who is under 50, with a serum calcium >1.0 mg/dL above reference range, a 24 hour urine >400mg, a creatinine clearance reduced by 30%, reduced bone density by > 2.5 SD in forearm, lumbar spine or hip. Several matched and controlled studies have shown, however, that the NIH guidelines are overly limiting - If one carefully questions these patients, they may be symptomatic without absolute indications for surgery and still derive tangible metabolic, musculoskeletal, and cardiovascular benefits when parathyroidectomy is performed. One study by Rao et al. in 2004 matched 53 patients to parathyroidectomy versus regular follow up and noted statistically improved bone density at the femoral neck and hip as well as improved quality of life and psychological function. A retrospective study of over 1569 patients published in the Archives of Surgery in 2006, as

well as a sex matched study published in the British Medical Journal in 2000 showed a decreased fracture risk in those patients who, without absolute indications, underwent parathyroidectomy. A Swedish study of 4461 patients in 1998 demonstrated an increased risk of cardiovascular events and death in patients with untreated HPT.

Given this data and the derived benefits in avoiding kidney stones, improving bone density and avoidance of cardiac compromise a subset of 'relative' indications have emerged for parathyroid surgery. It has become the practice at The Head and Neck Center to recommend parathyroidectomy with a confirmed diagnosis of primary HPT that may not meet absolute NIH criteria, when clear subtle manifestations of disease are seen. An additional New England Journal of Medicine article published in 2004 indicates that upwards of 1/3 of untreated patients will develop a major manifestation of HPT within 10 years of diagnosis if left untreated. Thus, when provided this information, our patients and practitioners often preempt major future morbidity in favor of safe and effective surgery.

Parathyroidectomy is the gold standard for primary HPT of any age. The surgical approach at The Head and Neck Center has evolved to a scan-directed, minimally invasive approach resulting in unilateral exploration based on preoperative localization studies. This has lead to innovative ways to approach a solitary adenoma utilizing video assisted endoscopic and robotic techniques. Open surgery can now be done on an outpatient basis, through a 2 cm incision placed in the low neck, with little time off of work. A unilateral, solitary parathyroid adenoma occurs 85% of the time and can typically be localized prior to surgery by combining a technetium Tc99m Sestamibi-SPECT scan or ultrasound, with added benefit of incidental thyroid pathology detection. Our practice utilizes intraoperative rapid assay iPTH (done with the patient still under anesthesia) to confirm removal of diseased glands; a 50% reduction in preop iPTH within ten minutes of parathyroidectomy precludes the need for bilateral exploration and yields a 95% success rate for long term serum abnormality correction. In the rare instance of four-gland hyperplasia, double adenomas, or carcinoma, more extensive intervention is required.

Hyperparathyroidism and subsequent hypercalcemia afford significant threats to woman's health. Bone density, psychiatric, and quality of life improvements can be achieved through increasingly less morbid surgery. As detection becomes increasingly sensitive, The Head and Neck Center has continued to innovate, improve and above all, to consider the needs and benefits of intervening earlier in this deceptively and insidious threat to woman's health.

ASK THE EXPERT

Do you have a clinical, financial, legal or business question for our experts? Our contributing authors and area specialists will respond.

Please email your question to WNYPhysician@rochester.rr.com

What is My Liability?

Medical Guidelines and Protocols

James E. Szalados, MD, MBA, Esq.

Issue

Evidence-based medicine (EBM) emphasizes clinical reasoning, which is based in empirical evidence derived from clinical research. When guidelines, care pathways, and protocols first became widely publicized, the medical profession was resentful and critical, seeing them as 'cookbook medicine' that threatened medical experience and judgment and even patient's individual treatment preferences. Criticism of EBM continues challenging the validity of the conclusions reached within the supporting studies; citing faulty study design, bias, and premature generalization. With time, as the volume and rigor of evidentiary support increased, EBM has become more widely recognized to represent, at the very least, a persuasive outline of "best practices" to be considered during individualized clinical decision-making. Indeed, some would even argue that strict adherence to EBM guidelines would support a practitioner's medical decision-making by demonstrating adherence to an authoritative and widely accepted published statement of a clear 'standard of care' - thereby reducing legal liability.

The impact of guidelines in day-to-day medical practice is enormous. Algorithms help practitioners determine risk stratification, testing, and interventions. Examples of such guidelines range from Driving Risk in Dementia, DVT and VTE Prophylaxis, Immunizations, Sleep Apnea Management, and Glycemic Management, pre-operative cardiac assessment and peri-operative beta-blockade; and peri-operative glycemic control. Undoubtedly, such guidelines will become more important in medical negligence litigation with time.

The law requires physicians to use customary skill and care consistent with good medical practice during the preoperative evaluation of a patient prior to elective surgery. Health care providers are judged by professional standards or norms of behavior. The relevant standards range from general principles of reasonableness, which can be determined by lay persons; to "customary" standards ("due" or "reasonable") of care which are determined by the medical profession. The knowledge regarding appropriate professional standards for care is introduced into evidence by experts who must testify in order to inform the court and the jury regarding medical norms. Expert testimony is the basis by which the plaintiff and the defendant in a malpractice lawsuit argue the appropriateness of the medical care rendered. A great deal of the legal uncertainty in medical negligence cases is based on the lack of comprehensive statements of professional standards.

Although expert testimony defines the relevant professional standard of care, it is recognized that ancillary sources may also be relevant. These ancillary, or supporting standards may include

1. standards promulgated by accrediting agencies;
2. state health care statutory law;
3. standards or guidelines set by national or local medical societies or organizations;
4. hospital or medical group rules, regulations, or bylaws;
5. local practice. Of these, it is the standards and guidelines that may have caused the greatest confusion.

Unfortunately, the law continues to require physicians to exercise medical judgment; and the law continues to regard expert testimony, not guidelines, as the basisfor judging the standard of care. Medical judgment is individualized to particular clinical circumstances and represents a professional judgment based a careful balancing of factors that are both intuitive and data-based. In these situations, there are no specific standards other than the general rule that the physician, nurse or other professional must make judgments that are within the range of judgments that other health care professionals would have made under similar circumstances. The requisite duty is that the physician's judgment conforms to judgments that other similarly situated physicians would have made under similar circumstances; and must conform to the practice expected of a reasonably competent and prudent physician.[1]

Thus, the introduction of guidelines as evidence in the defense of malpractice claims has met with variable success. The courts continue to be skeptical regarding the clinical effectiveness and validity of practice guidelines, algorithms, and clinical pathways. A recent New York case, decided by Judge Kaye represents a departure from the courts' traditional skepticism regarding guidelines, and may have significant future impact on the admissibility of guidelines as evidence at trial.

Medical judgment is individualized to particular clinical circumstances and represents a professional judgment based a careful balancing of factors that are both intuitive and data-based.

On May 2, 2006 the New York Court of Appeals decided Hinlicky v. Dreyfuss,[2] a ruling that addressed the importance of adhering to accepted standards of care as a legal duty. In this important case, 71 year-old female patient underwent a successful carotid endarterectomy but suffered a post-operative myocardial infarction and died 25 days later. The administrator of her estate brought a medical malpractice action alleging negligence on the part of the patient's internist, surgeon, and anesthesiologist. The issue at trial was whether the defendants were negligent in not obtaining a preoperative cardiac evaluation. The patient's physician, a family practitioner testified that he had evaluated Ms. Hinlicky yearly in the period from 1984 until the date of surgery; primarily for treatment of hypertension. However, the in 1993 the patient began to complain of exertional dyspnea and chest pain; EKG was benign and instead the diagnosed and treated gastritis and gallstones, concluding that her heart was not at risk. In 1995, the patient again complained of left arm and chest discomfort but the EKG was again benign and the internist determined that her symptoms were not cardiac in nature. Symptoms of decreased vision in her right eye prompted the patient to have a carotid ultrasound, which revealed 75% stenosis of the left carotid artery, and the vascular surgeon recommended an endarterectomy. The vascular surgeon decided not to request a stress test because the patient did not have a clear history of heart disease and because in his opinion, further testing represented risks that had little likelihood of altering his prescribed plan. Preoperatively, the anesthesiologist also reviewed Mrs. Hinlicky's medical history and records, nursing assessments laboratory data and the EKGs from 1995 and 1996. the anesthesiologist specifically questioned Ms. Hinlicky regarding her cardiac history and although he assigned her to ASA Class III, he decided not to send her for a preoperative cardiac evaluation based on the type of surgery involved, her history and her functional capacity. The plaintiff's cardiology expert asserted that as a "mandatory minimum" the patient should have had a preoperative cardiac stress test. At trial, the anesthesiologist testified at length regarding the 1996 American Heart Association (AHA) /American College of Cardiology (ACC) guidelines, and stated that these guidelines provided him with an algorithm on which to base his decision to require pre-operative cardiac testing. On the other hand the plaintiff's cardiology expert was of the opinion that the AHA/ACC Guidelines "were ...too simplified" and only a "general summary." Plaintiff also introduced the testimony of an anesthesiologist who agreed that the patient would not have been allowed have surgery without further cardiac testing; maintaining that the AHA/ACC guidelines were neither published by a recognized anesthesia journal at the time and that "guidelines are guidelines."

For at least ten years, the courts have debated whether clinical practice guidelines such as the AHA/AHA algorithm could be admitted into testimony as evidence of the prevailing standard of care or whether these guidelines merely represented hearsay. The initial ACC/AHA algorithm incorporated clinical predictors and functional status into a preoperative risk-assessment algorithm.[3] The American College of Physicians (ACP) published similar but distinct evidence based guidelines in 1997.[4] The AHA/ACC guidelines were subsequently revised in 2002 and propose risk stratification according to clinical predictors

of cardiac risk as a basis for preoperative cardiac testing.[5]

The NY court recognized that clinical practice guidelines have been defined to represent "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances," and as "standardized specifications for care, either for using a procedure or for managing a particular clinical problem."[6]

Few other cases have addressed the reliance on algorithms as a standard of care. In 1999, a Florida patient, a poorly controlled insulin dependent diabetic, smoker, and diagnosed with developed tightness in his shoulder which was surgically debrided under general anesthesia. At trial, the defense relied on the pre-operative cardiac testing algorithm at trial, which had been adopted by the ASA, and the court determined that there was no violation of the standard of care.[7]

The importance of the seminal ruling in Hinlicky is that the NY court circumvented the general unacceptability of patient care algorithms that would be offered as substantive evidence; choosing instead to admit the algorithm as a demonstrative device to aid the jury in understanding the process that the anesthesiologist had followed in the pre-operative evaluation process. This is critically important since practitioners have long recognized that algorithms can be used not only prescribe a plan of care, but to simplify decision making and describe the basis on which the more complex clinical judgments are founded.

In conclusion, although the Hinlicky decision may still be subject to appeal and is certainly not binding in other jurisdictions outside NY, it is persuasive. The potential implication is that evidence-based medicine may work not only as a tool to improve collective and individual patient care via established and nationally accepted best practices; but that tested and well-accepted guidelines may help document and describe adherence to widely accepted standards of good medical care.

---

[1]See Sheeley v. Memorial Hosp., 710 A.2d 161 (1998).
[2] Hinlicky v. Dreyfuss 815 N.Y.S.2d 908 (2006).
[3]Eagle KA, Brundage BH, Chaitman BR, Ewy GA, Fleisher LA, Hertzer NR, et al. Guidelines for perioperative cardiovascular evaluation for noncardiac surgery. Report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines (Committee on Perioperative Cardiovascular Evaluation for Noncardiac Surgery). J Am Coll Cardiol 1996;27:910-48.
[4]American College of Physicians. Guidelines for assessing and managing the perioperative risk from coronary artery disease associated with major noncardiac surgery. Ann Intern Med 1997;127: 309-12.
[5]Eagle KA, Berger PB, Calkins H, Chaitman BR, Ewy GA, Fleischmann KE, et al. ACC/AHA guideline update for perioperative cardiovascular evaluation for noncardiac surgery–executive summary: a report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines (Committee to Update the 1996 Guidelines on Perioperative Cardiovascular Evaluation for Noncardiac Surgery). J Am Coll Cardiol 2002;39: 542-53.
[6]Rosoff AJ. The Role of Clinical Practice Guidelines in Health Care Reform. 5 Health Matrix 369 (1995).
[7]Bardfeld v Abinader. Docket No.: 01-25269 CA 31; FJVR Reference No. 06:5-27. Verdict Date: December 15, 2005. Florida Jury Verdict Reporter (FJVR) 2006.

Women and Sleep

Unique Challenges and Treatment Options

Alice Hoagland, PhD, MBA

Diagnosing and treating women with sleep difficulties presents a sleep doctor with multiple challenges and a variety of treatment options. Interestingly, there appear to be some significant sex differences, starting at birth, which differentiate male and female sleepers. Female babies have more mature EEG recordings and more stable respiration patterns than male infants do. Females seem to sleep longer and more efficiently then males during childhood. Finally, females appear to maintain slow wave sleep longer than males.

The Menstrual Years

Despite these early sleep advantages; females seem to develop increased rates of insomnia with age. Clearly, hormonal effects

have some influence on sleep, both positive and negative. During a woman's menstrual years, the interaction between progesterone and estrogen contributes to some significant changes in the pattern of sleep. After ovulation, the core body temperature increases by approximately .5 degrees Celsius. This elevation contributes to increased awakenings, increased stage 2 sleep and possible decreases in REM sleep. Women who take oral contraceptives have consistent elevations in body temperature. This results in decreases in slow wave sleep and possible alterations in the production of melatonin. The long term impact of birth control pills on sleep are unknown.

Monthly menstrual blood loss and poor diet can also contribute to a chronic iron deficiency. Low iron stores are frequently associated with the symptoms of restless legs and periodic leg movements during sleep. Young females who complain of restlessness and difficulties with sleep onset may need lab work to determine if low iron is a contributing factor.

The Pregnancy and Postpartum Years

Pregnancy can also contribute to poor sleep. Even normal pregnancies are sleep disruptive with increased nocturnal nausea, nocturia, and reflux. As the pregnancy continues, respiratory patterns change and are stimulated by progesterone. One of the biggest concerns for the pregnant women is the development of sleep apnea. Obesity before pregnancy places the women and her fetus at a significantly higher risk. There is growing evidence to suggest that sleep apnea during pregnancy is associated with adverse maternal and fetal outcomes. These include preeclampsia, intrauterine growth restriction, and gestational diabetes. Sleep disorders centers will often treat sleep apnea in pregnancy with auto-titrating units, which will adjust the pressures as needed with increased weight gain.

Postpartum sleep is also influenced by an abrupt drop in estrogen and progesterone with a concomitant increase in prolactin. These hormonal changes contribute to a more "alert"

mother, who is significantly more vulnerable to chronic insomnia. Many studies suggest that maternal insomnia is the biggest predictor of postpartum depression. Some of the newer nonpharmacological approaches for the treatment of insomnia are ideal for postpartum insomnia, especially if breastfeeding is part of the picture.

The Menopausal Years

The menopausal transition is clearly associated with sleep disturbances. Frequent awakenings typically begin in the late peri-menopausal phase and are associated with a reduction in estrogen. Night sweats increase as menopause continues, and women experience an average of two to three hot flashes per night. Interestingly, many women report that they are awakened by hot flashes, but studies show that women often initially and spontaneously wake up and then experience the hot flash. The sequence is so rapid that women assume that the hot flash was the cause of the arousal. Thus, non-hormonal treatments which suppress arousal during sleep are often helpful.

Unfortunately, 37% of women between the ages of 40 and 59 have a BMI of 30 or greater (obese). This increases adiposity (especially central) is associated with the development of sleep apnea. Post menopausal women have the same incidence rate for the development of apnea as do men. This increase occurs, even without weight gain and is likely due to decreased progesterone and estrogen.

Sleep disorders centers have historically been seen as resources for the diagnosis and treatment of the obese male with suspected sleep apnea. This pattern is changing with increasing knowledge of sleep problems exclusively seen in women. Women specific insomnias, as well as other sleep disorders, can now be effectively diagnosed and treated.

Dr. Hoagland is the medical director of the Unity Insomnia Clinic at Unity Sleep Disorders Center.

Data Security and Patient Privacy

A few precautions every medical practice should implement

Cheryl Nelan, President,
CMIT Solutions of Monroe

POP QUIZ

Computer data is:

a plentiful
b fragile
c at-risk
d valuable

Of course, the correct answer is "all of the above." Though most physicians understand this, a surprising number of them fail to take some or all of the necessary measures to safeguard these important assets. Unfortunately, many physicians are so focused on navigating the care of their patients in a quickly changing healthcare landscape that the other aspects of running their practices like IT security may not be a priority until a breach or data loss occurs.

Data loss occurs due to a variety of factors.
According to one expert, the numbers break down thusly:

- 40% from hardware failure
- 29% from human error, such as accidental deletion or dropping a laptop
- 13% from software corruption
- 9% from theft – from inside and/or outside the company
- 6% from computer viruses
- 3% from hardware destruction due to disasters such as flooding or fire

By then, of course, it's too late.

Though data loss or security breaches are damaging to any business, medical practices face not only an economic loss, but also risk enormous liability exposure due to federal HIPAA requirements for patient confidentiality.

Thankfully, several cost-effective solutions exist that greatly reduce the risk of both security breaches and permanent data loss. (Note: These tips do not represent the full security measures needed for HIPAA compliance. Visit http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html for more information.)

Build a wall. If your computer network is the castle, the firewall is the moat that keeps intruders at bay. Network breaches can cause serious problems. One medical practice reported receiving a demand for an extortion payment by a hacker who had tapped patient data and was threatening to post the records on the web. Invest in the correct hardware or software firewall solution to safeguard patient information.

Update your virus protection. Virus protection vendors typically issue new virus definitions weekly, and robust protection requires timely updates. I've found that most practices run some type of protection, but more than half are not protected from new viruses because the subscription or free trial period had expired or the software was not configured to update automatically.

Use adware/spyware protection. Adware and spyware often slow down or crash PCs and networks. No single program seems to remove all adware or spyware from a PC, but some programs do a better job than others. A professional IT service or computer-oriented publication can provide the latest recommendations. Be careful with free programs—some are actually spyware programs posing as spyware removal software.

Maintain quality backup systems. Random or infrequent on-site back-ups don't protect a practice effectively. For true protection, invest in a state-of-the-art backup solution. The best systems have these characteristics:

- Automated back-up (minimizes human error)
- Redundant off-site storage (backup data kept on-site in a building that burns down is still gone)
- Proactive virus protection (eliminates the possibility of data corruption)
- Continual monitoring by trained support staff to ensure the system operates properly
- An automated, simple, and reliable method of restoring data in the event of a loss

Clean house. Simply deleting files on a Windows PC is like removing the label from a file in a cabinet. The data isn't gone; it just no longer appears in the operating system's file structure. An enterprising hacker can easily recover deleted files using the correct tools. Even reformatting of a hard drive won't necessarily keep old information from being recovered.

Data wiping, in which the operating system overwrites old data with new data, removes any trace of the deleted file. When getting rid of old computers or hard drives, it's vital to perform a data wipe to prevent the drive's content from being accessed.

A few years ago, two MIT students conducted a study. They bought 158 used hard drives. Of the 129 drives that still functioned, 69 had recoverable files and 49 contained files with correspondence, documents and thousands of credit card numbers. One hard drive had a year's worth of transactions, including account numbers and balances from an ATM in Chicago.

The common thread among these practices is to get your security measures in-place and tested before disaster strikes. Even the best backup system or anti-virus program won't do you much good if you install them after the fact.

All Women Should Be Offered Cystic Fibrosis Screening, Regardless of Ethnicity

Preconception and prenatal cystic fibrosis (CF) carrier screening should be made available to all women of reproductive age as a routine part of obstetric care, according to a revised Committee Opinion issued by The American College of Obstetricians and Gynecologists. In addition to an update of current guidance for CF screening practices, the document discusses counseling strategies, special reproductive health considerations for women with CF, and clinical management recommendations.

Cystic fibrosis is a progressive, multisystem disease that primarily impacts the lungs, pancreas, and digestive tract. CF significantly shortens the lifespan of people affected by it—median survival is approximately 37 years. Because CF is caused by an inherited genetic mutation, carrier screening is recommended to identify couples at risk for having a child with the disease.

The incidence of CF is highest among non-Hispanic white individuals (roughly 1 in 2,500) and people of Ashkenazi Jewish ancestry. It is considerably less common (but still occurs) in other ethnic groups. The College recommends that CF carrier screening be offered to all women of childbearing age, preferably before conception. Women who are CF carriers and their reproductive partners may need additional screening tests and referrals for genetic and reproductive counseling.

The College also recommends contraception and preconception consultation for women with CF who are considering pregnancy. They should be told that their children will be CF carriers and that their partners should also be screened to determine carrier risk. Women with CF who want to become pregnant can work with a multidisciplinary team to manage issues such as pulmonary function, weight gain, infections, and the increased risk of diabetes and preterm delivery.

"Update on Carrier Screening for Cystic Fibrosis," is published in the April 2011 issue of Obstetrics & Gynecology.

WHAT'S NEW IN Area Healthcare

Golisano Children's Hospital Clinician Researcher Wins AHA Award

The American Heart Association named local volunteer Stephen Cook, MD, MPH. "Science Advocate of the Year." The award was presented at the association's annual Congressional Lobby Day, in Washington, DC on Monday, April 11, 2011.

Stephen Cook, MD, MPH

"Dr. Cook is passionate about ending childhood obesity and has been invaluable as a volunteer, serving as an advocate and offering his expertise," said **Bonnie Webster**, Executive Director of the **American Heart Association's Rochester Division**. "He has joined forces with the American Heart Association to ensure that his research findings actually help children and families in addressing this most critical health concern of our time."

Cook, an assistant professor of Pediatrics at **Golisano Children's Hospital at the URMC**, is a strong advocate for healthy living and has served as the president of the local chapter of the American Heart Association. He is Chairman of the **Childhood Obesity Committee** for the NY State chapter of the **American Academy of Pediatrics**, a member of the **National Advocacy Task Force of The Obesity Society** and serves on state and national committees of the American Heart Association. Cook was also instrumental in developing the **Healthi Kids** initiative in Monroe County and its policy agenda to reverse childhood obesity.

Telemedicine Program Performs 10,000th Visit

Health-e-Access has helped thousands of children get medical care quickly, conveniently

Health-e-Access has hit a huge milestone – 10,000 telemedicine visits with health care providers since the program began in May 2001 with pediatricians at the **Golisano Children's Hospital at the University of Rochester Medical Center**. The 10,000th visit occurred recently at **Eugenio Maria de Hostos Charter School** in Rochester.

In recent years, Health-e-Access has expanded beyond its initial focus of children in city child care programs to include every Rochester city school as well as weekend and after hours care. It uses the internet and specialized equipment to connect health care providers with sick children at convenient community locations to diagnose common childhood illnesses and prescribe medication as appropriate. It has allowed parents to avoid missing work or delaying care for their children. It also means parents don't have to go to the emergency room, which costs significantly more and takes much more time.

"We're delighted to reach this milestone – it means we've helped thousands of families get care both when and where they needed it most," said **Kenneth M. McConnochie, M.D., M.P.H.**, a professor of Pediatrics at the **University of Rochester Medical Center** and director of Health-e-Access. "Moreover, more that 80 percent of the time the child is seen by a doctor from their own primary care medical home."

St. Ann's Community Announces New Chief Nursing Executive

Michele A. Sinclair, BS, RN, C-NE was recently appointed Chief Nursing Executive at **St. Ann's Community**. Sinclair will oversee the day-to-day functions of the nursing departments in **St. Ann's Home** and **The Heritage**, two skilled nursing communities on St. Ann's Irondequoit campus, and will act as the Director of Nursing for St. Ann's Home.

Michele A. Sinclair, BS, RN, C-NE

Sinclair is a Certified Nurse Executive by the **American Association of Nurse Executives** and comes to St. Ann's Community with 40 years of nursing experience. She previously worked as the Vice President for Clinical Services in the Long Term Care Division of **Catholic Health of Western New York** during which she received a **2010 Healthcare Top 50 award** from **Business First in Western New York** for her innovation, creativity and achievements in developing a cardiac program for transitional care patients.

Sinclair earned her Bachelor of Science in Health Care Administration from **St. Joseph's College** in Standish, Maine, and is a candidate to receive her Master of Science in Nursing Administration and Leadership from the same school in 2012.

Geneva General Hospital's Acute Rehabilitation Unit

Ranked in Top 1% Nationwide

Geneva General Hospital's Acute Rehabilitation Unit was recently recognized by the **Uniform Data System for Medical Rehabilitation (UDSMR)** for the unit's patient outcomes ranking in the 99th percentile when compared to similar facilities and programs nationally. The Acute Rehabilitation Unit received a ***"2010 Top Performer Award"*** from UDSMR in honor of its high level of performance and outstanding rehabilitation program excellence. This is the fifth year in a row

that the unit has been honored with this award.

Geneva General Hospital's Acute Rehabilitation Unit serves patients following a stroke or other neurologic condition, amputation, polyarthritis, or orthopedic injury or surgery. Performance outcomes are based on improvements in a patient's ***Functional Independence Measure (FIM)*** score between admission and discharge. The degree of FIM improvement and the ability to reduce the patient's length of stay (LOS) constitute the core outcome metrics used by UDS in evaluating the unit's overall performance and the level of efficacy of its programs. With the UDS award comes the unique privilege of being a mentor organization to other acute rehabilitation centers in the United States.

Rochester General Health System

RIT- RGHS Alliance Announces Institute of Health Sciences & Technology

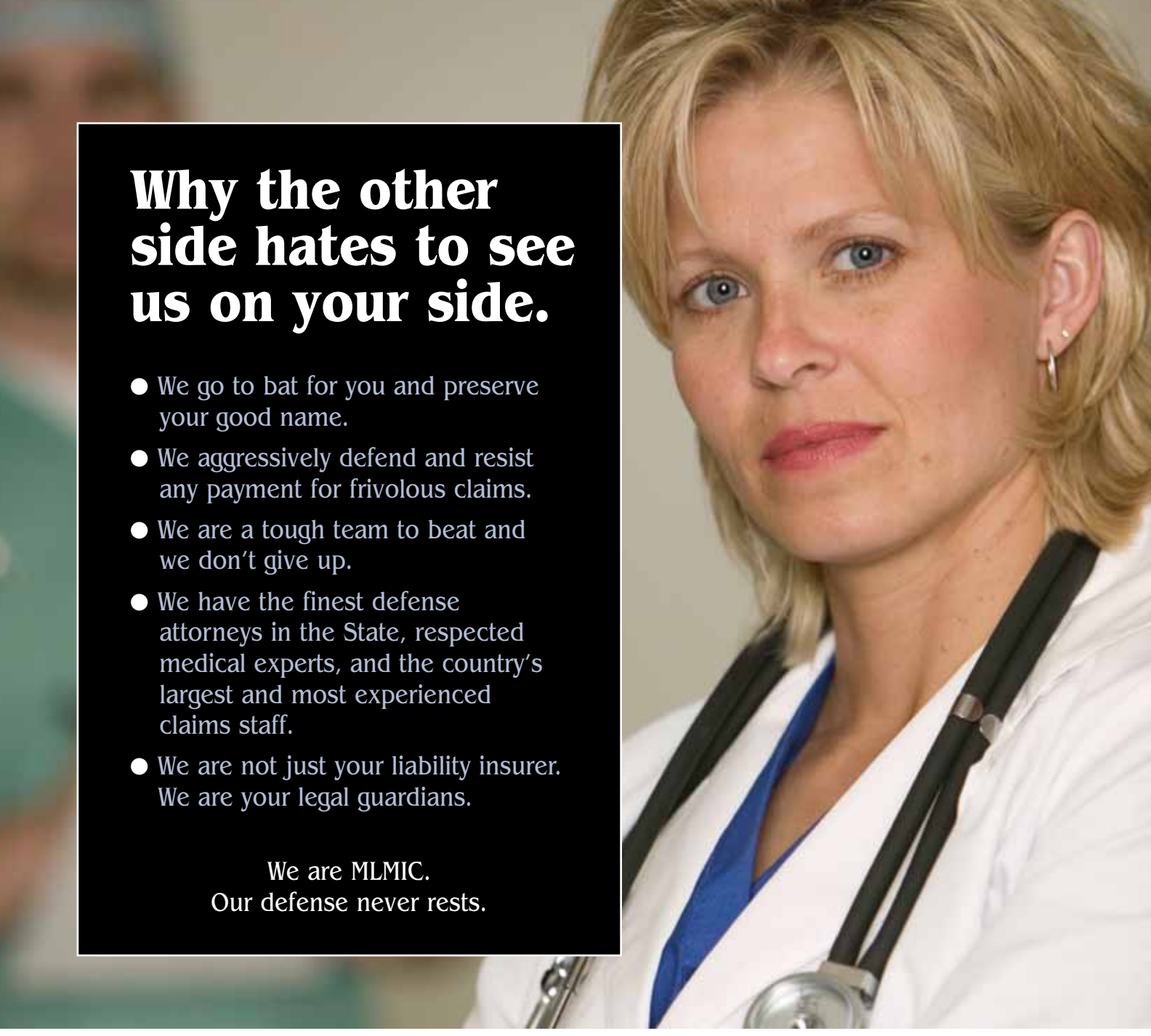
Rochester Institute of Technology and **Rochester General Health System** will open the Institute of Health Sciences and Technology this September. The new institute will channel the strengths and expertise of the **RIT-RGHS Alliance**, formed in 2008 to produce technological solutions to health-care delivery and improve the efficiency of the "smart hospital."

The institute will address three aspects of health care and position the RIT-RGHS Alliance as a contributing player in the reform of the nation's health-care system by educating the next generation of health-care professionals, cultivating innovative research and addressing community health needs. Three distinct prongs comprise the institute: the **College of Health Sciences and Technology**, the **Health Sciences Research Center** and the **Health Science Outreach Center.**

"This is another tremendous milestone for the university and Rochester General Health System," says RIT President **Bill Destler**. "Our partnership creates a climate for the kind of innovative problem solving that will improve quality health-care delivery. The unlimited possibilities of technology drive the collaborative research of our physicians, faculty and students."

"The launch of the **Institute of Health Sciences and Technology** is a unique collaboration that will allow the alliance to innovatively respond to the growing convergence of medicine and technology in the advancement of clinical practice as well as the unprecedented changes expected to come from health-care reform," says RGHS President and CEO **Mark Clement**. "By combining institutional strengths of clinical medicine, research and technology, the institute will train a growing number of future health-care professionals while advancing technology-based research that will benefit our community locally and the health-care delivery system nationally."

Advertiser Index



Why the other side hates to see us on your side.

- We go to bat for you and preserve your good name.
- We aggressively defend and resist any payment for frivolous claims.
- We are a tough team to beat and we don't give up.
- We have the finest defense attorneys in the State, respected medical experts, and the country's largest and most experienced claims staff.
- We are not just your liability insurer. We are your legal guardians.

We are MLMIC.
Our defense never rests.

Medical Liability Mutual Insurance Company (MLMIC) is the one ally you want when you enter the courtroom and your practice and reputation are on the line. The jury may be out. But, you can feel confident, knowing you are protected by the one company that has successfully defended more New York physicians than all other insurers combined.

Exclusively endorsed by MSSNY since 1975, MLMIC is a mutual company, owned and operated by the physicians we insure. For more information and an application, call 800-275-6564 (NYC), 800-356-4056 (Syracuse), 877-777-3560 (East Meadow), or 800-635-0666 (Latham). ■

Endorsed by MSSNY

MLMIC
Medical Liability Mutual Insurance Company

Our defense never rests.

New York
Latham
Syracuse
East Meadow

Bullseye!

Elevate is a total transvaginal, comprehensive and standardized prolapse repair system to treat apical, anterior and posterior defects. Providing tactile feedback and minimal blind needle passes to ensure you hit your target.

***To learn more about the Elevate prolapse repair systems or for training opportunities available call** 1.800.328.3881 **or visit** www.amselevate.com*

AMS
Solutions for Life®