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Welcome to the latest issue of Western New York Physician where you will find informative stories and articles about and for physicians in western NY.

Spring has finally sprung in upstate NY! And with this, we are pleased to introduce Western NY Physician Magazine – Buffalo and the Great Lakes. Our premier issue visits the leaders of the Gates Vascular Institute and looks at how this neurovascular team is changing the “face of stroke care” giving patients throughout the region and Canada incredible hope and access to the latest options for much improved recovery and treatment. Rochester readers will have full access to the digital version of the magazine via the website www.wnyphysician.com.

In January 2015 when President Obama introduced the Precision Medicine Initiative (PMI), the field of medicine and the approach to treating patients entered a new dynamic era. With expanding large-scale capacity to collect, manage and analyze patient data – prevention and treatment of disease is beholding a paradigm shift towards personalized medicine. Our cover story this issue discusses opportunities to personalize treatment and also how improved tools to assess risk empower patients to engage in prevention and disease avoidance.

Coming up in Western NY Physician

• Pain management and a current look at the use of opioids
• The new gold standard in prostate cancer diagnostics
• Advances in orthopaedic surgical approaches

Take Part in the Conversation

Sharing your expertise is a valuable way to communicate with your medical colleagues. If you would like to be a part of an upcoming story or wish to submit an article, please email or call me to discuss timing and submission criteria. In the meantime, please enjoy the numerous other articles within the issue.

As always, we thank each of our supporting advertisers – your continued partnership ensures that all physicians in the region benefit from this collaborative sharing of information and provides the WNYP editorial staff with a deep pool of expert resources for future interviews and articles.

Please drop us an email to share feedback and suggestions to improve your reading experience.

In good health –

Andrea Sperry
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In 2014, New York law was changed to gradually increase the estate exemption over time to tie to the indexed 2019 federal exemption. As of April 1, 2016, the New York exemption increased to $4,187,500. The New York estate tax exemption is scheduled to be as follows:

**For deaths on or after:**

**The exemption (basic exclusion amount) is:**

- 4/1/16 - 3/31/17 $4,187,500
- 4/1/17-12/31/18 $5,250,000
- 1/1/19 Whatever the indexed federal amount is

This law is advantageous for New York residents with taxable estates under that exemption amount, as they will be able to pass wealth to their heirs free of estate taxes. The impact of that advantage has become more significant as the exemption increases. However, this law has presented drawbacks for some and important differences from federal law.

**Cliff phase-out**

The 2014 law introduced a cliff. The exemption gradually phases out for taxable estates between 100 and 105 percent of the exemption at the time of death. It completely disappears for estates exceeding 105 percent—the cliff over which the exemption is fully phased out. For those larger estates, the current law is worse than the old law, where there would have been at least a $1 million exemption. This aspect needs to be considered and monitored for residents with larger estates. As the exemption has increased, this impacts fewer estates, but may still come as a surprise for the larger ones. Careful planning can mitigate this effect.

**No portability**

The federal law has a feature called portability. That means that any spouse’s unused exemption can be elected to be ported over to the surviving spouse and added to his/her own exemption. There are considerations and implications for portability that need to be weighed when deciding whether to plan for portability or to use certain trusts in the estate plan. Though the state exemption will catch up to the federal exemption on January 1, 2019, New York still does not have portability. It’s use it or lose it, therefore each spouse’s state exemption can be lost or wasted if not used. That was a waste at a $1 million exemption, but becomes even more of a waste as the exemption gets to be a bigger and bigger number. Careful review and planning becomes even more valuable.

**Look back on gifts made within three years of death**

The law also created a look-back on gifts made within three years of death between April 1, 2014, and January 1, 2019. Where New York didn’t have a gift tax before the law change, any gifts made during this time will be added back to the taxable estate, inflating it for calculating the tax. This addback has been applied to gifts of life insurance, but now will be applied to all gifts. Careful review and planning becomes even more valuable.

The potential to shelter a significant amount of assets from New York estate tax warrants a careful review of each person’s overall estate plan—wills, trusts, beneficiary designations, asset titling, etc.—and where and how assets flow. No matter what your will says, it’s very possible that your New York exemption might not be fully used, depending on whether you have a certain type of joint account or who you’ve named as beneficiary of retirement accounts, insurance policies, annuities, etc. The New York estate tax implications should be coordinated with the federal estate tax, especially while there’s a gap between the federal and New York exemptions.
Office of Civil Rights Enters Into Phase 2 of the HIPAA Audit Program

Q: What is the OCR’s Phase 2 of the HIPAA Compliance Audit Program?

A: The OCR’s efforts to assess compliance with the HIPAA Privacy, Security and Breach Notification Rules continue as it begins its next phase of audits of covered entities and their business associates. In its 2016 Phase 2 HIPAA Audit Program, OCR will review the policies and procedures adopted and employed by covered entities and their business associates to meet selected standards and implementation specifications. Although most of these audits will primarily be “desk audits,” some on-site audits are expected.

OCR announced that the 2016 audit process begins with verification of an entity’s address and contact information. An email is being sent to covered entities and business associates requesting that contact information be provided to OCR in a timely manner. OCR will then transmit a pre-audit questionnaire to gather data about the size, type, and operations of potential auditees; this data will be used with other information to create potential audit subject pools. If practices ignore the OCR request, the OCR will use publicly available information about the entity to create its audit subject pool. Practices that do not respond to OCR, therefore, may still be selected for an audit or subject to a compliance review.

Since the communications from OCR will be sent via email, it is cautioned that practices actively check their spam folder. The OCR has made it clear that it expects entities to check their junk or spam email folder for emails from OCR.

OCR will post updated audit protocols on its website closer to conducting the 2016 audits. The audit protocol will be updated to reflect the HIPAA Omnibus Rulemaking and can be used as a tool by organizations to conduct their own internal self-audits as part of their HIPAA compliance activities.

On-Site Visits Increasing Among Large Employers

Q: What is behind the drive by large employers to employ on-site or near-site doctor visits?

A: Employers looking to reduce monthly healthcare premiums are finding that operating clinics on-site to provide primary and preventive care, and encourage exercise, are keeping workers healthier, reducing absenteeism and cutting benefit costs. Employers are finding that on-site centers also reduce the amount of time workers spend away from work visiting off-site healthcare providers. As an added bonus, on-site centers can help companies identify occupational health and safety risks, such as poorly designed workstations that result in back and neck problems.

This new area of healthcare has produced a growth market for companies that operate clinics for employers, including Healthstat, Marathon Health, Premise Health and QuadMed. Health systems also have jumped into the market, operating about 18% of worksite clinics, according to benefits consultant Towers Watson, which surveyed firms with clinics this year.

Since employers believe in the cost-saving potential of on-site clinics, many employers plan to continue investing in them even though the cost will likely be included in calculating the Affordable Care Act’s Cadillac tax on high-value health plans starting in 2018. Earlier this year, the Internal Revenue Service said spending on on-site clinics would be considered in the tax calculation unless the clinics offered only de minimis care. Regardless, two-thirds of large employers with on-site health facilities say they plan to expand such facilities in the future.

In smaller communities, employers are cognizant of the risk they run in upsetting independent physicians and other providers in the community who may worry about losing patients to worksite providers. Studies, however, show that 40% to 60% of people who go to on-site clinics do not have a personal doctor.

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Not long ago, treatment for breast cancer followed a fixed approach based on anatomy – even though the biology of the cancer might result in completely different outcomes. However, modern approaches to breast cancer are benefiting from advances in many fields. Most importantly, genetic and genomic testing are making possible a new era of truly personalized medical care.

With these new advances, doctors are now able to better tailor therapy based on predisposition and biology to determine the optimal treatment strategy. This allows a more precise approach — commonly termed as “Precision Medicine” in popular media — which seeks to lower the risks of over- and under-treatment.

Rather than treating patients by their cancer type, stage and prior therapies, doctors are using a more refined approach – Precision Medicine — to dig deeper to the genetic level. More doctors are embracing Precision Medicine in hopes that one day cancer will be defined by its molecular structure.

**Understanding Cancer Genetics**

Nationally, Precision Medicine has become a high priority. In January 2015, President Obama announced the Precision Medicine Initiative in his State of the Union address. A total of $130 million was allocated to NIH to build Precision Medicine Initiative a national, large-scale research participant group, and $70 million was allocated to the National Cancer Institute to lead efforts in cancer genomics.
For years, Rochester Regional Health System’s (RRHS) Lipson Cancer Center and the Rochester General Breast Center was an early adopter of this approach — providing precision medicine with the incorporation of individualized cancer risk assessment genomic testing for treatment planning. Success stories abound — proving that this approach can foster early cancer detection, improved quality of life and even cancer prevention.

“To us, Precision Medicine means different things,” says Dr. Lori Medeiros, Medical Director of Rochester General Breast Center at RRHS’s Lipson Cancer Center. “For one, it reflects patient care from the initial consultation through any and all treatments, recovery and post-treatment assessments.”

The precision concept also relates to how the medical team considers the complex interplay of the tumor biology or genetic makeup and the entire makeup of the individual affected by the cancer. “We really need to understand each patient and how their individual characteristics might impact on treatment and recovery from cancer.” Precision Medicine marks a dramatic shift — from traditional treatments based on a representative sample of similar cancer patients — toward more precise therapies tailored to specific tumor markers and gene makeup.

Early successes in precision medicine have been seen primarily in breast cancer, but that’s changing as the knowledge base builds. Currently RRHS manages one of the state’s highest volumes of breast cancer cases. However, there is understandably a very strong interest in trying to prevent women from having to be diagnosed in the first place. The RGH Breast Center has a very successful program for high risk women and men that partners with many area private and employed physicians as well as self-directed patients. This program allows referred patients who have a higher than average risk picked up during routine family history to enroll in a program which may include advanced high risk screening modalities and preventative therapies targeted to their individual risk.

Whether a woman presents with cancer or not, high risk patients undergo multi-generation pedigrees and complete reviews of family histories. Comprehensive genetic risk assessments, including the probability that a patient may carry a heritable or germ-line mutation, are also performed. Patients undergo psychosocial assessments along with counseling on the risks, limitations, and benefits of genetic testing and receive education on suspected hereditary cancer syndromes. This counseling includes possible other cancer risks associated with gene mutations, basic genetic concepts and inheritance patterns.

If an unfortunate diagnosis of cancer is made, genomic testing helps generate data to better predict if a cancer will require less or more in terms of treatment in order to successfully eradicate it. This can be helpful in certain cases of very early breast cancer or ductal carcinoma in situ (DCIS), where there is controversy regarding how much treatment is really needed. “The management of DCIS can be very complex, despite its generally very favorable prognosis,” says Dr. Medeiros. “The team is very invested in weighing the pros

To us, Precision Medicine means different things
and cons of all treatments including surgery and radiation, because unfortunately, some treatments may bring other unintended toxicities.” Genomic testing is also used routinely in cases of more advanced breast cancer with favorable tumor markers to help patients avoid a more toxic chemotherapy regimen in favor of less toxic medications.

This personalized approach to breast cancer means that the medical team — including other surgeons, radiation oncologists and pathologists — maintains a weekly working conference to help advance care quickly and even identify patients for potential clinical trials.

“Tha’s why the team approach to precision medicine works so well,” says Dr. Medeiros. “We personalize care on multiple levels to identify the best option. We try to consider everything including a patient’s individual goals and day-to-day issues - all within the context of targeting successful treatment for breast cancer.”

Implications for Other Cancers

Lung cancer still represents the deadliest cancer, but genomic testing may change all that, says Dr. Mehul Patel, Medical Oncologist at Lipson Cancer Center. “Up until 2008, treatment of non-small cell lung cancer was approached in essentially one way,” says Dr. Patel. “Now, we ask if the lung cancer is of squamous or non-squamous histology and whether or not the patient’s tumor harbors EGFR mutation of ALK gene rearrangement.”

“For me, Precision Medicine means the development of the
best treatment based on the patient’s tumor biology,” says Dr. Patel. “In the past, we took a ‘one size fits all’ approach, but now for many patients a treatment is determined by a patient’s tumor histology and biology. We don’t necessarily have to offer the same chemotherapy upfront to all patients with advanced lung cancer. Patients with advanced lung cancer who harbor EGFR mutation or ALK gene rearrangement are now offered oral targeted therapy upfront, rather than intravenous chemotherapy.” Four FDA-approved drugs, Erlotinib, Gefitinib, Afitinib and Osimertinib are now available for advanced lung cancer patients whose tumors harbor EGFR mutation. Three FDA-approved drugs, Crizotinib Ceritinib and Alectinib are now available for advanced lung cancer patients whose tumors harbor ALK gene rearrangement.

**Immunology Groundbreaker**

As NCI and other research initiatives identify the potential of tumors to alter their genetic code and generate potent antigens, immunotherapy is becoming an integral part of Precision Medicine.

“We are made with an immune system to can protect us, yet we have tried to kill cancers using chemotherapy,” Dr. Patel adds. “Through immunotherapy, PD1 inhibitors like Nivolumab and Pembrolizumab empower the immune cells to fight cancer.” Both these drugs are now FDA-approved for second line treatment of non-small cell lung cancer (NSCLC) patients whose disease progressed during or after first line therapy.”

Dr. Patel envisions that within just five years, immunotherapy and targeted therapy will largely replace chemotherapy when considering treatment for patients with advanced non-small cell lung cancer. His team has witnessed notable success with targeted therapy.

A female patient of Dr. Patel’s was diagnosed with Stage 4 non-small cell lung cancer three years ago. The initial biopsy revealed adenocarcinoma histology. Her tumor harbored EGFR mutation and she had a single metastatic deposit on her thoracic spine. She was treated with chemoradiation followed by Tarceva for maintenance. Her most recent scan showed no evidence of active cancer, and she is working full time and enjoying her life, he says. In this situation, maintenance therapy would typically be required for the remainder of the patient’s life as long as the treatment is tolerable and the cancer remains under control.

**Overcoming Challenges**

“The cost of testing for genetic alterations is negligible compared to the treatments themselves,” says Dr. Patel. “It’s money well spent because it helps us determine the best treatment for the patient. My hope is that checking a tumor for various genetic alterations will become more commonplace for each cancer, whether it’s from a needle biopsy or a blood sample.”
These innovative doctors acknowledge the complexity of the system. A given tumor might be responsive to a drug initially but may shortly develop resistance to that same drug by acquiring a resistant mutation. Tumor tissue may hence need to be re-biopsied and checked for these resistant mutations. Research has already shown that for those patients who test positive for a genetic risk, they do well over time by remaining proactive and engaged in risk reduction behaviors. While actress Angelina Jolie Pitt has become an example of the influence of genetic information in breast cancer care, her case also illustrates the challenges of making sense of it— in terms of determining what action to take, based on genetic tests.

With the knowledge of the mutations linked to cancer and access to more cost-effective genetic testing, researchers and doctors are increasingly able to identify if a person is at a higher risk for cancer and even if a cancer patient is at increased risk for getting another cancer. Precision Medicine through genomic testing represents a truly transformational moment for cancer care.
Bipartisan Bill Aimed at Curbing Opioid Abuse Moves to Senate

Question: What is the scope of the Comprehensive Addiction and Recovery Act bill?

Answer: The Comprehensive Addiction and Recovery Act bill seeks to curb the abuse of prescription opioid painkillers by providing much needed funding to states for strengthening their prescription monitoring programs and providing more education and treatment opportunities for people with addiction issues. The bill also provides access to naloxone, a drug that can reverse opioid overdoses.

Although both parties agree with the substance of the bill, Sen. Jeanne Shaheen (D-N.H.) plans to introduce an amendment that would require $600 million in emergency funding to implement the bill. Republicans disagree that the emergency funding is needed and although Democratic leaders remain silent regarding whether or not they would vote against the bill without the emergency funds, Sen. Patrick Leahy (D-Vt.) believes the bill would be meaningless without the funding.

Meanwhile, another likely amendment to the bill would allow the CMS to restrict some Medicare Part D patients to using a single prescriber and pharmacy in an attempt to cut down on “doctor shopping” for opioid prescriptions.

The bill comes at a time when multiple levels of government are attempting to deal with the growing crisis of opioid misuse and overdose deaths.

Weekly Charting Tip
Always chart the name of the chaperone in the room at the time of a patient examination. That will be Exhibit in your defense against any “patient inappropriate” allegations!

If you have any questions, please contact Kern Augustine Conroy & Schoppmann, PC at 1-800-445-0954 or via email at info@DrLaw.com.

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Retirement Planning: 
Dealing with Volatility and Economic Concerns in Early Retirement

Dana F. Vosburgh, CFP
Director, Family Wealth Management, Manning & Napier

For many doctors nearing retirement, the shortened time horizon for saving and the anticipation of losing meaningful income can create a renewed focus on investing. Attention previously devoted to practicing medicine, building a career, and potentially raising a family is now directed toward the next phase in life and how to go about pursuing personal interests while maintaining a desired standard of living. One of the more challenging aspects of investing for new retirees is keeping short-term market volatility and market anxiety in context relative to longer-term investment goals.

Investing in retirement is a balancing act; dampen market volatility to fund ongoing living expenses, but also take on some risk along the way to generate enough growth in the portfolio to fund those expenses for a long period of time. While it might feel safe, and even prudent, to put a large portion of a portfolio in savings accounts upon retirement in an effort to avoid the ups and downs that exist in the market, it likely will not achieve the returns necessary to fund retirement over a 20 to 30 year time period, especially when considering current interest rates, the impact of inflation over time, and the possibility of increasing health care costs. In order to help achieve meaningful returns that can fund spending needs over longer life expectancies, it’s often necessary to invest a portion of an investment portfolio in the stock market and accept a certain level of volatility associated with investing in stocks.

The volatility we’ve experienced in the markets early this year can be unnerving to retirees or people close to retirement. It’s important to note, however, that there is a distinct difference between short-term market volatility, which has been with us since the formation of the stock market, and real loss of capital due to risk exposure. If you own a diversified portfolio of securities, its value will generally move up and down with the market. For instance, since 1970, a portfolio comprised of 50% stocks (the S&P 500 Total Return Index) and 50% bonds (U.S. Intermediate Government Bonds) has had 54 calendar quarters with a negative return, yet the average annual return over that time period is 9.2%. On the other hand, if you own a concentrated portfolio of stocks based in an emerging market country that is suddenly faced with serious financial concerns (e.g., Greece, in recent years) or political unrest (e.g., Brazil) and there is a market collapse, it’s possible that the money will be lost forever. Therefore, building a diversified portfolio and understanding your personal risk tolerance (how comfortable you are with typical market volatility) is essential to developing a successful investment strategy throughout retirement.

Furthermore, active management and the ability to manage risk should be a key component of a retiree’s investment approach. Active management (both active security selection and asset allocation decisions) is designed to provide flexibility to move in and out of certain areas of the market when risks develop. After all, it’s not necessarily what you own, but what you don’t own, that can result in a successful investment approach throughout retirement (for example, not owning Technology stocks in 2000-2002, Financial Services stocks in 2008, and likely long-term Treasuries today). In contrast, a passive index approach doesn’t assess geopolitical shocks and risks in the market, or your own personal financial situation for that matter. Owning an index forces an investor to ride the market up and down and creates the potential for being exposed to risks that can be particularly damaging if a retiree is withdrawing assets from a portfolio every year and perhaps
It's important for people nearing retirement to have a proper plan in place and pursue an overall investment approach that is suited to their specific goals, time horizon, and tolerance for volatility. The first step is to estimate an annual spending target for retirement (i.e., set a budget). Then, identify any annual non-investment income during retirement that can be used to cover a portion of the budget, such as Social Security income. Any amount over this non-investment income will need to come from the investment portfolio via income, capital withdrawals, or both. Next, determine how much of the budget is discretionary spending. In years when the market is experiencing increased volatility, reducing a portion of the discretionary spending (coming from portfolio withdrawals) can help to smooth out the ups and downs and provide an added element of control.

Each individual pool of investments, whether personal taxable money, tax-deferred retirement assets, or Roth IRAs, should then be evaluated and invested appropriately based on how each pool will be called upon to fund withdrawal needs. For instance, a taxable investment portfolio that is funding significant annual withdrawals may be invested under an approach that primarily provides income and dampens market volatility, while an IRA not facing near-term withdrawals or limited to required minimum distributions (RMDs) may be invested under a more growth-oriented approach that can generally result in greater short-term volatility.

While watching daily market results on our televisions, computers, and smart phones these days can be convenient, it can also create an increased sense of worry and a tendency to react quickly to typical near-term volatility. It’s important to work with your advisor to model retirement scenarios and set a portfolio structure that is coordinated with your financial goals and personal risk tolerance. After all, establishing and monitoring a proper plan can make the transition into retirement more enjoyable and help make it so a few bad days in the market doesn’t lead to even more sleepless nights.

Manning & Napier’s Family Wealth Management team can help you develop a plan to meet your specific needs, coordinating with the professionals necessary to implement your customized plan. To read more from Dana or other members of the Family Wealth Management team visit: www.manning-napier.com/familywealthmanagement

SMA-ART014 (5/16)
As springtime blossoms, it seems all living creatures—groundhogs, ladybugs, even couch potatoes—start to stir. If you’ve spent months indoors, not working and stretching your muscles, it’s wise to ease into spring activities gradually to avoid injuries, aches and strains. UR Medicine sports medicine specialist Dr. Katie Rizzone offers advice for safely rousing our joints, tendons, ligaments and muscles from a long winter’s sleep.

If warm, sunny days are inspiring you to get active again, remember that sudden athletic activity can lead to things like acute tendon and muscle injuries, especially in adults over age 40. Even non-sporting activities like gardening and yard work can lead to injury if you’re trying to do too much, too soon. If that’s the case for you, you can treat minor injuries with RICE—rest, ice, compression and elevation.

But a little preparation can prevent injuries from happening. Here are a few steps to help ease you back into shape.

**Stretch.**
Get in the habit of doing simple stretches every day. Real Simple magazine offers some basic stretches for the major muscle groups and your spine. You can even do stretches at your desk.

**Think “low and slow.”**
If you did no exercise over the winter, start with gentle walks to get your body going again. Whatever exercise you choose, do shorter periods of activity at a lower intensity; if you were doing 30-minute walks or runs last summer, start your spring regimen with 15 or 20 minutes at a slower pace.

**Check the “fitness” of your sports gear.**
Whether you run, play tennis, or do aerobics, you need good-fitting, supportive athletic shoes designed for that activity. Runners should replace their shoes every 300 to 500 miles, and walkers should do so about every 500 miles. If you go for a 30-minute walk five times a week, plan to buy a new pair of walking shoes each year.

**Try something new.**
Consider adding different activities into your routine. Rather than riding your bike five days a week, try biking two days a week, and do some weight training in between. You’ll work different muscles by varying your routines, which makes your whole body stronger and cuts boredom, too. You could try yoga, Pilates, or tai chi.
Just get going.
Walking is the easiest way to become active again and can be the gateway to expand the exercises you enjoy. If you’ve been inactive or less active than usual over the winter, take advantage of spring to develop new habits that you build on during the warmer months and that you can continue to enjoy all year ‘round.

Tap new resources to help you stay fit.
Exercise classes are a great way to learn new skills. If joining a fitness club isn’t an option for you, community centers offer a low-cost alternative. You could also borrow exercise DVDs from your local library or follow exercise classes on TV or online. Just be sure to pace yourself and match the program to your current fitness level.

Watch your heart rate.
The American Heart Association offers guidelines on heart rate targets during exercise, based on your age and gender. Check with your doctor to find out what your goal should be for your maximum heart rate to get the best benefit, especially if you have been inactive and have other medical problems.

Gather a group.
Working out with friends and family makes exercise more fun and helps you stay motivated.

Walking is the easiest way to become active again

Katie Rizzone, MD, a non-operative sports medicine physician at UR Medicine and an assistant professor of Orthopaedics at URMC. She specializes in musculoskeletal ailments including strains, sprains, tendonitis, fractures, sports concussions, and arthritis, as well as medical problems unique to the female athlete, and runners. Her research focuses on the long-term effects of young athletes overtraining and specializing in one sport.
Rochester Regional Health Changes Lives Hosting National Diabetes Prevention Program

Q & A with Joy Valvano

Q. What is the Diabetes Prevention Program? How long did it last and how many people participated?

A. The CDC-led National Diabetes Prevention Program (NDPP) is a public–private partnership of community organizations, private insurers, employers, health care organizations, and government agencies. These partners throughout the US are working together to establish local evidence-based lifestyle change programs for people at high risk for type 2 diabetes. These evidence-based lifestyle change programs are based on the Diabetes Prevention Program (DPP) research study, which showed that type 2 diabetes can be prevented or delayed through modest lifestyle changes involving healthy eating and physical activity.

The lifestyle change program is led by a trained facilitator called a Lifestyle Coach. In the lifestyle change program, participants meet in a group with their Coach over the course of one year to work towards the goal of losing 5 to 7 percent of their starting body weight in order to reduce their risk for type 2 diabetes. The group meets once/week for the first 16 weeks and then once a month thru the balance of the year. The program emphasizes improving food choices, being physically active for at least 150 minutes each week, and developing skills to identify and overcome barriers to making lifestyle changes.

Q. How long has the test program been offered?

A. Rochester Regional Health, Unity Diabetes and Endocrinology have been running NDPP sessions locally since 2012. There are other organizations that also hold NDPP including the YMCA; to find out more about locally run programs contact the American Diabetes Association, Rochester branch.

Q. What are some takeaways from the program?

A. Some of the positive benefits participants have shared include enjoying the group experience – they feel well supported and connected to others who are also working towards healthful dietary and lifestyle choices; they also appreciate the accountability of checking in, being weighed and reporting physical activity minutes weekly – it helps “keep them on track.” Support from others is critical because behavior change is extremely difficult. Support systems that are in place (other participants, health coaches) can really help people stay on track when the going gets rough.

The curriculum design is well thought out. Questions that come up at the end of classes are generally answered in the following session.

Participants who complete the program leave with more than a sense of accomplishment. They have valuable resources to review and reinforce during support sessions.

The program promotes positive relationships among participants; their individual growth and development is reinforced by their peers in the group. Many groups leave as friends who support and continue to grow together in their friendships.

Success can be measured in more than just weight loss and minutes of exercise. We note decreases in A1c’s, lipid profiles and blood pressures.

Group participation and support strongly contribute to the success of individuals and the group as a whole.

Q. What aspect of the program has been the most valuable based on post program data?

A. Dietary awareness, portion control, the power of positive thinking and regular physical activity.

The NDPP is all about lifestyle change; how to incorporate all
of the healthful behaviors around eating and being physically active we all “know” we should do on a day to day basis but find challenging to incorporate consistently; it promotes a new way of eating, living, behaving that is permanent and not a temporary fix or diet that eventually falls by the wayside. The NDPP provides strategies on how to make these changes stick. Once again, the participants say over and over again that they need support after the program is over. The support groups offered monthly (after the initial 16 weekly meetings) have been described by attendees as a “necessary shot in the arm”. Managing health is a long term process. Meeting with others who are going through similar challenges can help people stay or get back on track. Aside from emotional support, attendees provide ideas, strategies that may have worked for them, thus, making support group a hotbed for brainstorming and new ideas.

Q. What measures of success has Rochester Regional seen with the program?

A. Since 2012, Rochester Regional Health, Unity Diabetes and Endocrinology has enrolled 296 people in the program with a 92% rate of program completion; and for those who completed the program an average weight loss of 5% in the first 16 weeks. Most participants successfully increased their weekly physical activity level and for those who had follow up blood work post class completion; many saw their FBG and A1c significantly reduced, often within the non-diabetes range.

Q. What are some takeaways of the program that physicians can share with patients during regular checkups?

A. Those physicians that do conduct post program blood-work note the changes. Most participants note decreases in weight – some very significant – as well as staying true to regular physical activity.

Physicians should be sharing with their patients that prediabetes should be taken seriously. They should encourage education/knowledge about this condition. Physicians can share that with small changes in lifestyle (mindful eating, increase in activity), type 2 diabetes can be prevented: especially with early intervention of prediabetes. Like with other diseases states, early detection/intervention is key!

When patients are provided with not only knowledge around what to do to improve their health; but given intensive support and a blueprint on what to do – they are often motivated to make changes they previously thought were overwhelming and untenable.

Joy is a certified diabetes educator and certified pump trainer at Rochester Regional Health. She has over 10 years of experience providing both individual and group diabetes education. She also offers nutrition counseling for children, people with eating disorders, and cardiopulmonary patients. Joy was instrumental in creating and co-facilitating the “Seeds of Change” vegan class offered at Unity Diabetes and Endocrinology Center in Greece. She is a graduate of the Rochester Institute of Technology and completed her registered dietician internship at Iowa State University.

Last February, Will Haines, 50 of Brockport, learned from his doctor that he was pre-diabetic. Wanting to improve his health, Will followed his doctor’s recommendation to lose weight, exercise more, and enroll in the Rochester Health Center’s Diabetes Prevention Program. So he applied what he learned in the DP program and got back into cycling, a sport he’s loved all his life. Just over a year later, Will now rides three times a week, having logged over 3,300 miles this past year. He’s lost close to 70 lbs, and his glucose levels are now normal. Will is riding in the upcoming Tour De Cure, June 11th, in Rochester. To sponsor Will’s ride and help the American Diabetes Association, go to: http://main.diabetes.org/goto/thewillhaines
Dr. Michael Silber grew to become the co-founder of Western NY’s largest and most successful radiology practice through smarts, grit, and a willingness to take calculated risks. In 2003, Dr. Silber recognized an opportunity to build a world-class radiology practice in the growing Buffalo market. With five partners, he arranged to acquire an existing practice, which would serve as the foundation for their growth plans. Over the ensuing 13 years, Dr. Silber and his partners have grown Great Lakes Medical Imaging (GLMI) to assume the leadership position in expertise and market share in the western NY region. GLMI now boasts 40 physicians, including 19 partners, and five PA’s. With total employment at 87, GLMI is still growing in size and dominance.

Dr. Silber is no stranger to hard work — his typical day is 12-16 hours long. The work ethic and discipline for which he is known today are consistent with his former life as a high school football player and wrestler. Prior to medicine, Dr. Silber recalls fondly the odd jobs he worked to fund his education, including busting suds as a dishwasher in a local restaurant. But he is most proud of his work in a tuxedo rental shop. “My job was to measure our clients for tuxedo fittings. No, it wasn’t glamorous - but I never had a single client return because of a mismeasurement...!” His intolerance for mistakes and his discipline, characteristics he honed early in his life, are the hallmarks of his approach to radiology.

We recently sat with Dr. Silber to learn more about what this goal-oriented radiologist does outside of medicine.

**WNYP:** We understand that you are an avid golfer — our inside sources report that you have an entirely un-coachable and unorthodox, but effective, swing and that you play about as fast as most people can power walk. What are you working on outside of medicine and golf?

**MS:** [Laughs] Yes, golf is a great diversion — a completely maddening game that can abuse you for 80 shots and grants you one perfect shot that brings you back again the next time. But I can’t tolerate a slow pace of play — if my group can’t walk 18 holes in less than 2 ½ hours, then I start to crawl out of my skin!

I have always been entrepreneurially inclined, but for the first chapter of my career in medicine, I was totally focused on growing our practice. More recently,
I have been able to dedicate more time and energy to finding opportunities for managing my investible assets more intelligently.

**WNYP:** What do you mean when you say “more intelligently” and what are your concerns?

**MS:** In addition to making investments in several startups (not all related to medicine), I have begun to examine how to structure my balance sheet for life after medicine. I have no plans to retire soon, but I’m working to figure out how to produce income after retirement. In this environment, I see several shortcomings with the conventional wisdom that is practiced by brokers and advisors in the financial services field. This is where I see an opportunity to manage my assets more intelligently.

**WNYP:** What is the conventional wisdom and what are your concerns with that advice?

**MS:** Investment and financial planning professionals advise that income (from investments) in retirement be derived from some mix of bonds, dividend-yielding stocks, and perhaps annuities. But dividend yields on stocks are only 2.5 – 2.8%. This means that if I need, say, $250,000/yr to support my lifestyle in retirement, I would need to invest $10,000,000 to achieve the income goal. Not every physician has saved that much by retirement, and of those who have, very few are likely to be comfortable with that degree of exposure to equities and their attendant volatility during retirement.

**WNYP:** What about Bonds?

**MS:** Bonds present their own challenges. First, they’ve just enjoyed a 40-yr run, so you are acquiring them at the highest prices in decades. Second, interest rates are at historical lows, which means that they will be rising at some point in the future. Rising interest rates push bond prices down. Finally, and more to my point, coupons on high-grade corporates are less than 3.5%. Even if you weren’t concerned about the downside risk in bonds in a rising interest rate environment and you needed to generate $250,000/yr in income during retirement from bonds, then you would need to have over $7,100,000 invested in bonds alone.

Even for a doctor who has been successful in his/her career and been a fairly diligent saver - not all accumulate $10,000,000 to $20,000,000. So, I’m wondering how they will accommodate their lifestyles without finding asset classes that generate more income per dollar invested.

**WNYP:** So, what types of opportunities have you been researching?

**MS:** I have begun working with a group that’s been investing in other asset classes — outside of stocks and bonds — to find comparable stability as bonds with 2-3 times the income-producing power. This group has been investing in various real estate categories for many years, especially commercial and multi-family assets. Investing in these asset classes requires incredible commitments of time and expertise to undertake adequate due diligence as well as the discipline to walk away from deals that don’t fit your model. I’m fortunate to be partnered with them because I have neither the time nor the expertise. It is proving to be very successful — we’ve been generating income up to three times what we would be generating with bonds, with several times the growth potential. So instead of needing $7-10 million to achieve my income goal I only need $2-3 million — a huge difference!

**WNYP:** So, what’s next?

**MS:** Continue to grow both my practice and investments. While my goal is not necessarily to produce all of my retirement income from these asset classes, I would like to diversify my income sources substantially from stocks and bonds, maintain a comparable or lower degree of risk, and commit less capital in the process.

The entire process very much appeals to the analytical side of my brain and my competitiveness. So, when the time comes for me to begin to reduce my time in medicine, I could envision taking a deeper role in this. Without access to these types of investment alternatives, I honestly don’t know how most doctors are going to support their retirement lifestyles. I’m fortunate to have met the right people who have helped educate me on how to achieve greater income and capital appreciation with less risk, while diversifying both my assets and income-producing sources. It is truly transforming my future for me and my family. Several of my partners have participated and been very happy with the income-generating power of these asset classes.
Medical Marijuana has Arrived in New York!
Will this help your patients?

By Jeffrey R. Allen, MD, FACP

Clearly, there is considerable debate over the therapeutic use of medical marijuana in treating clinical problems. The New York State Department of Health (DOH) has developed its own unique clinical criteria for determining which patients are candidates for receiving medical marijuana. Patients must have one of the following diagnoses: Cancer, HIV/AIDS, Amyotrophic Lateral Sclerosis, Multiple Sclerosis, Parkinson’s Disease, Spinal Cord injury with spasticity, Epilepsy, Inflammatory Bowel Disease, Neuropathy, or Huntington’s Disease AND an associated condition including cachexia or wasting syndrome, severe or chronic pain, nausea, seizures or refractory muscle spasms. The NYS DOH has legalized only the oral form of medical marijuana for therapeutic use.

There are regulations for physicians who would like to consider medical marijuana for their patients (NYS does not allow Advance Practice Providers to certify medical marijuana). Physicians must complete a four hour on-line course, at a cost of $259, in order to register with the NYS Department of Health and certify patients for the use of medical marijuana. They must have an established relationship with patients and also be qualified in treating the conditions for which they are planning to certify medical marijuana. The NYS Prescription Monitoring Program will be utilized for recording use of medical marijuana, similar to other controlled substances. A distinct difference between FDA approved medications and medical marijuana is that physicians can opt to have the pharmacist at the marijuana dispensary select and adjust the dose of the substance.

The evidence for medical marijuana as a therapeutic treatment remains somewhat marginal. Although there is copious anecdotal information available to support the use of marijuana for treatment of multiple medical conditions,
there is a paucity of randomized controlled trials. Obtaining approval and funding for research studies is difficult due to fact that marijuana is a Schedule I controlled substance (i.e. drug of abuse), variability in formulations, dose and route as well as “incomplete” blinding due to the psychoactive effect of the actual drug.

Recently there have been some systematic reviews and meta-analyses of marijuana for medical use (see references). Dr. Penny Whiting and colleagues in UK summarize trends in data which favor medical marijuana (oral form) over placebo to treat cancer pain and neuropathic pain, as well as spasticity related to multiple sclerosis and spinal cord injury. Dr. Ben Wilsey at UC Davis showed statistical significance in RCT comparing vaporized marijuana with placebo in treating pain associated with peripheral neuropathy and radiculopathy. Seizure frequency in two forms of refractory childhood epilepsy (Dravet’s syndrome and Lennox-Gastaut syndrome) have significantly decreased with oral form of marijuana when added to concurrent anticonvulsant regimen.

Although there are over 107 different cannabinoids in the Cannabis Sativa plant, the measured therapeutically active components include cannabidiol (CBD) and delta-9-tetrahydrocannabinol (THC). THC is the psychoactive component which is a partial agonist, binding to receptors in the central nervous system causing modulation of appetite, mood and motivation. CBD is an inverse agonist and decreases effects of THC and activates receptors in periphery and immune cells modulating release of pro-inflammatory factors associated with decreased pain and inflammation. The ‘dose’ is reported as a ratio of THC and CBD content. Clinically, a high CBD and lower THC ratio is preferable.

Dr. Kevin Hill of Harvard Medical Group has offered some guidelines to help physicians determine which patients could be considered for trial of medical marijuana. Patients would first have to have a debilitating medical diagnosis which evidence suggests would respond to marijuana (e.g. chronic pain, neuropathic pain, spasticity with MS, nausea/vomiting with chemotherapy, wasting syndromes). They will have failed trials of first and second line FDA approved pharmacotherapy indicated for the condition and also failed a trial of an FDA approved cannabinoid (e.g. marinol). Patients should not have a history of substance abuse, psychosis or mood disorder as these could be exacerbated by using marijuana.

For patients, obtaining medical marijuana includes registering with the NYS Department of Health and paying a yearly fee ($50). Additionally, medical marijuana is not covered by insurance plans and cash is required to pay for it at the Dispensary because it remains an illegal substance from Federal law perspective. The approximate cost for a month of medical marijuana will be $215. Currently there are twenty dispensaries in New York State and four supplier sites where the marijuana is grown. There are three dispensaries in Western New York (two in Buffalo and one in Rochester) and one supplier in Rochester.

Medical marijuana presents a challenge for physicians and patients. Clinical effectiveness is not well defined and special interest groups are very active in promoting its use. The pharmacology is complex and poorly understood and dosing is not entirely clear. There are significant regulatory, financial and social barriers within New York State. More research is needed to provide evidence based approach to clinical use of medical marijuana.

Dr. Allen has lectured extensively on Medical Marijuana in local and regional meetings over past two years. He currently is a Hospice and Palliative Care consultant at Rochester Regional Health’s Unity Hospital.

REFERENCES:
Exercise May Reduce the Risk of Cervical Cancer

Roswell Park study strongly supports benefits of exercise

Even 30 minutes of exercise per week has the potential to significantly reduce a woman’s risk of developing cervical cancer, according to a study from scientists at Roswell Park Cancer Institute (RPCI). The case-control study was recently published in the Journal of Lower Genital Tract Disease.

“To our knowledge, this is the first U.S.-based study looking at the associations between physical inactivity and cervical cancer. Our findings suggest that abstinence from regular physical activity is associated with increased odds of cervical cancer,” says J. Brian Szender, MD, MPH, lead author of the study and a fellow in the Department of Gynecologic Oncology at Roswell Park.

The study included 128 patients diagnosed with cervical cancer and 512 women suspected of having cancer but ultimately not diagnosed with the disease. Physical inactivity was defined as having engaged in fewer than four sessions of physical activity per month. The reported rates of physical inactivity were 31.1% for women diagnosed with cervical cancer and 26.1% among the control group. The difference in risk remained present even after accounting for potential differences in smoking, alcohol intake, family history of cervical cancer and body mass index.

The findings show that women who reported that they did not engage in any physical activity were two-and-a-half times more likely to develop cervical cancer when compared to women who reported that they exercise.

“We think that this study sends a powerful public health message: that a complete lack of exercise is associated with the greater likelihood of developing a serious disease. Our findings show that any amount of exercise can reduce cervical cancer risk,” says Kirsten Moysich, PhD, MS, senior author of the study and Distinguished Professor of Oncology in the Department of Cancer Prevention and Control at RPCI. “In addition to smoking cessation and undergoing regular screening, we have identified another important modifiable risk factor for this disease.”

The study, “Impact of Physical Inactivity on Risk of Developing Cancer of the Uterine Cervix: A Case-Control Study,” is available at journals.lww.com/jlgtd.

Researchers Report Progress as They Develop New Approach to Treating Metastatic Melanoma

Adoptive T cell therapy proves effective in preclinical study; strategy to be evaluated in clinical trials

Adoptive T cell therapy, which involves the expansion and infusion of a patient’s own immune cells, has emerged as a promising treatment for patients with metastatic melanoma. But efforts to apply these advances clinically have been limited by difficulties in obtaining long-lasting T cells that can survive following infusion. A team of researchers from Roswell Park Cancer Institute (RPCI), the University of Michigan and Kyoto University has reported significant progress in this area, achieving the first successful generation of pluripotent stem cells from melanoma-targeting T cells in a preclinical study, results of which have been published in the Cancer Research, a journal of the American Association for Cancer Research.

Induced pluripotent stem (iPS) cells — adult cells reprogrammed to function like embryonic stem cells — hold great promise in the field of regenerative medicine because they are long-lasting, can be made to differentiate into a wide range of tissues, and can be stored for use in generating an unlimited number of patient-specific T cells for use in cancer immunotherapy.

A team led by Fumito Ito, MD, PhD, Assistant Professor of Oncology in the Department of Surgical Oncology at...
Roswell Park, established a pre-clinical model for developing and evaluating these iPS cell-derived T cells. The authors report that these adoptively transferred iPS cell-derived T cells evaded immune rejection; mediated regression of large tumors; improved survival of the lab models studied; and established antigen-specific immunological memory, suggesting that this therapeutic approach could be effective long-term. This latest work developed concepts explored in an earlier study, first reported in 2015 in the journal Stem Cells International, in which Dr. Ito and colleagues demonstrated that iPS cells can be generated from T cells within human melanoma tumors.

“Our findings are highly encouraging, and we expect that this work will provide the foundation for developing personalized, immune-based therapies for patients with advanced and metastatic melanoma,” says Dr. Ito, who also holds a faculty appointment with the Roswell Park Center for Immunotherapy. “We plan to further develop this strategy using T cells derived from engineered iPS cells, and looking not only at melanoma but at other types of cancer.”

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**Rochester Regional Health Introduces New Cardiac Procedure**

**WATCHMAN device helps prevent strokes in patients with non-valvular atrial fibrillation**

Rochester Regional Health’s Sands Constellation Heart Institute is among the first in western New York State to offer patients with non-valvular atrial fibrillation (AFib), an alternative to long-term medication with the WATCHMAN Left Atrial Appendage Closure (LAAC) Implant.

Implantation of the WATCHMAN device, a catheter-delivered heart implant performed without surgery, permanently closes a small pouch in the heart called the left atrial appendage. This pouch is responsible for the majority of strokes in patients with Afib.

Patients who suffer from atrial fibrillation are at a significantly higher risk of stroke due to blood clots forming in the left atrial appendage. According to the American Heart Association, an estimated 3 to 6 million Americans are living with AFib; approximately one-third will suffer a stroke. People with Afib are often treated with blood thinners to reduce the risk of stroke but blood thinners also increase the risk of serious or life-threatening bleeding. WATCHMAN was approved by the FDA in March 2015 and is a permanent alternative for patients whom blood thinners are not a viable long-term option.

“We are proud to offer this minimally invasive and permanent solution for our patients with atrial fibrillation,” said Rochester Regional Health cardiologist Jeremiah Depta, MD, MPH, FACC. “We already have multiple patients scheduled for the procedure, and are very excited about its potential use in patients that cannot be maintained on blood thinners.”

Patients will typically return home the day after the one-hour procedure, and more than 90% will be able to stop using blood thinners within two months.

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**UR Medicine’s Strong Memorial Hospital Fights Antibiotic Resistance**

**Pew Report Highlights Strong’s Efforts to Curb Inappropriate Use of Antibiotics**

In a recent report published by The Pew Charitable Trusts, UR Medicine’s Strong Memorial Hospital was featured as an academic center that is leading the way in the fight against antibiotic resistance, an urgent health threat that leaves providers and patients with fewer options to treat dangerous infections.

The report, titled “A Path to Better Antibiotic Stewardship in Inpatient Settings,” highlights ten institutions across the country that have implemented effective antibiotic stewardship programs, which are designed to minimize the harmful effects of inappropriate or unnecessary antibiotic use.

“We realized several years ago that the judicious use of antibiotics is beneficial for our patients and for the hospital as a whole,” said Christopher Evans, Pharm.D., an infectious disease pharmacist and co-leader of the antibiotic stewardship team at Strong. “Overuse increases the number of organisms that don’t respond to antibiotics. If we fail to address this problem, we’ll struggle to treat many infections because drug choices will be limited and, in some cases, nonexistent.”

Evans adds that the incorrect use of antibiotics ups the risk of patients acquiring Clostridium difficile or C. diff, a bacterial infection that can cause life-threatening diarrhea and inflammation of the colon. Antibiotics wipe out much of the good bacteria in the gut, allowing dangerous bacteria like C. diff to flourish uncontested.

Finally, ensuring antibiotics are only used to treat bacterial infections (they don’t work against viruses) and prescribing them in the correct doses and for the right amount of time reduces health care costs.
St. Ann’s Community is proud to introduce HeartMatters, a new evidence based program that was developed in collaboration with Cardiologists and Cardiothoracic surgeons including Rochester General Hospital Chief of Cardiology, Gerald Gacioch, M.D. and St. Ann’s Chief Medical Officer, Diane Kane, M.D.

HeartMatters provides the region’s best program for patients with cardiac conditions such as heart failure, myocardial infarction and post cardiac surgery (i.e., CABG, valve replacement).

We recognize the uniqueness of each individual and will work with you to develop a plan of care that will improve your quality of life and reduce the likelihood of readmission back to the hospital. You and your family will receive the knowledge necessary to better manage your condition after returning home.

For more information or to learn how to preplan a rehab stay, please call 585-697-6311 or visit stannscommunity.com.

The HeartMatters cardiac rehab program is available at: St. Ann’s Community, Irondequoit and St. Ann’s Care Center, Cherry Ridge Campus in Webster.

HeartMatters Cardiac Medical Director, Gerald Gacioch, M.D. and St. Ann’s Chief Medical Officer, Diane Kane, M.D.
Omega 3 Fatty Acids May Reduce Bacterial Lung Infections Associated with COPD

Compounds derived from omega-3 fatty acids – like those found in salmon – might be the key to helping the body combat lung infections, according to researchers at the University of Rochester School of Medicine and Dentistry.

The omega-3 derivatives were effective at clearing a type of bacteria called Nontypeable Haemophilus influenzae (NTHi), which often plagues people with inflammatory diseases like chronic obstructive pulmonary disease (COPD).

COPD, which is most often caused by years of smoking, is characterized by inflammation and excessive mucus in the lungs that blocks airflow. Quitting can slow the progress of COPD, but it doesn’t halt the disease. Anti-inflammatory drugs are the most common treatment; however they suppress the immune system, which can put people with COPD at risk for secondary infections, most commonly NTHi bacterial infections.

“Our biggest concern with patients who have COPD is bacterial infections, which often put their lives at risk,” says Richard Phipps, PhD, professor of Environmental Medicine and director of the URSMD Lung Biology and Disease Program. “If we can figure out how to predict who is likely to get an infection, physicians could put them on a preventative medication.”

Omega-3 fatty acids, which are abundant in fish like sardines and salmon, are touted for their many health benefits. These superstars of the diet world are normally broken down to form molecules that help turn off inflammation after an infection or injury.

“We never really knew why diets high in omega fatty acids seemed good, but now we know it’s because they provide the precursors for molecules that help shut down excessive inflammation,” says Phipps. Doctors used to believe that shutting down inflammation only required removing whatever caused it, for example pulling a thorn from your finger or, in this case, getting rid of bacteria. While that might work some of the time, we now know that shutting down inflammation is an active process that requires a certain class of anti-inflammatory molecules.

Is It Time for New Strategies to Treat Aggressive Prostate Cancer?

A new URMC study confirms that androgen deprivation therapy, which initially shrinks aggressive prostate tumors, is a double-edged sword that ultimately might fuel the spread of cancer.

It’s a controversial topic that has been investigated for years by Chawnshang Chang, PhD, the George Hoyt Whipple Distinguished Professor of Pathology, Urology, and Radiation Oncology at the University of Rochester and Wilmot Cancer Institute. As his research gained momentum, other investigators across the country began reporting similar results about androgen deprivation therapy (ADT). In fact, a recent review in the journal Cancer Letters (where Chang’s research was also published), calls for a fundamental shift in the way advanced prostate cancer is treated.

“It’s the right time in history for this, and I’m very happy that other major research groups are confirming our initial observations that ADT actually promotes metastasis,” Chang said.

Early stage prostate cancer is usually treated successfully with surgery and/or radiation therapy. Some early cases don’t even require treatment beyond careful monitoring. In advanced disease, however, ADT remains the standard of care.

Chang’s latest study in Cancer Letters suggests a new mechanism through which ADT inadvertently spreads cancer—by boosting the stem cell population associated
with prostate tumors. Previous studies have suggested that a larger stem cell population usually feeds a more aggressive cancer, Chang said, although his study does not specifically address that issue.

Chang is also developing an alternative therapy to ADT known as ASC-J9, which is a chemically modified derivative of the spice ginger. The recent data suggest that in preclinical testing, ASC-J9 suppresses aggressive prostate tumors and their stem cell populations by altering an important protein pathway known as EZH2/STAT3.

New Bone Chewing Role for B Cells in Rheumatoid Arthritis

URMC researchers have uncovered a new mechanism of bone erosion and a possible biomarker for rheumatoid arthritis (RA). The group is the first to demonstrate that immune cells, called B cells, contribute directly to the breakdown of bone in RA by producing a signaling molecule called RANKL.

Jennifer Anolik, MD, PhD, professor of Medicine at the URMC and author of the study found that B cells extracted from RA patient blood produced more RANKL and led to production of more bone chewing cells, called osteoclasts, than B cells from the blood of healthy volunteers. This effect was even greater when study authors inspected B cells extracted from RA patients’ joint fluid and tissue.

“The novel finding is that B cells contribute to bone erosion in RA by producing RANKL,” says Anolik. “The other striking thing is that RA patient B cells produce more RANKL - especially in the joint itself.”

According to the latest data from the Centers for Disease Control and Prevention, approximately 1.5 million adults are affected by RA in the US. These patients’ immune systems attack their own joint tissue causing painful stiffness and swelling of the joints as well as erosion of the bones in the joint that can cause permanent damage. These symptoms often leave patients unable to perform normal activities of daily life, like dressing themselves.

Because B cells are essential for the immune system attack of joint tissue in RA, therapies that target B cells have recently been used to combat the disease. However, nearly half of patients that receive B cell depletion therapy do not get better and even if they appear to get better, bone erosion can continue undetected.

Nida Meednu, PhD, Research Assistant Professor of Medicine at URMC and first author of the study believes that targeting specific populations of B cells may be a new and better way to treat RA patients.

“We know that there are good B cells and you don't want to eliminate those,” says Meednu. “But, there are some B cells that are more pathogenic. So, you might want to target subsets of B cells, not all of them at once.”

“We know that there are good B cells and you don't want to eliminate those”

Anolik and Meednu believe RANKL could be used as a marker to decide which RA patients are most likely to have progressive joint damage and which drugs are most likely to halt that progression. “Patients with high RANKL on B cells - especially in the joint - may be most responsive to different types of B cell targeted therapies,” says Anolik. But she cautions, “Longitudinal studies looking at [joint] tissue are necessary to define that further.”
SR Scales Introduces New Stand-on Scale for Improved Patient Safety

Easy-to-Grip Wrap-around Handrails, 1000 Lbs. Capacity, Four-Year Warranty, and EHR-ready, SR585i Provides Robust Features for Medical and Long-Term Care Facilities.

SR Instruments, a leading manufacturer of purpose-built scales for hospitals, medical facilities, and long-term care centers today announced the addition of a new stand-on scale, the SR585i, to its SR Scales product line.

“This new scale provides an attractive weighing solution for long-term care facilities and other healthcare centers that need a sturdy platform for obtaining accurate weight data.

The SR585i is easy for staff and patients to use, while providing greater true-cost ROI with our long-lasting products.”

Mark Schulz, OEM product design manager at SR Instruments.

Key features of the new SR585i Stand-on Scale include:

- Wide-grip, wrap-around handrails for improved patient support
- Digital display with optional EMR / EHR data send or printer output via serial connector
- Light-weight aluminum base
- 1,000 pound capacity
- Made in the USA

SR Instruments will be demonstrating the SR585i in booth 3209 at the 2016 National Teaching Institute & Critical Care Exposition in New Orleans, LA from May 16-19, 2016.

Hospital purchasing managers, facility managers, and medical professionals needing more information on the new SR585i can access more info at http://bit.ly/SRScales-SR585i.
Rochester Regional Health System
Rochester Regional’s Unity Hospital Receives Award for Stroke Care

Rochester Regional Health System’s Unity Hospital has received the American Heart Association/American Stroke Association’s Get With The Guidelines®-Stroke Gold Plus Achievement Award with Target: StrokeSM Honor Roll Elite Plus. The award recognizes the hospital’s commitment and success ensuring that stroke patients receive the most appropriate treatment according to nationally recognized, research-based guidelines based on the latest scientific evidence.

To receive the Gold Plus Quality Achievement Award, hospitals must achieve 85 percent or higher adherence to all Get With The Guidelines-Stroke achievement indicators for two or more consecutive 12-month periods and achieved 75 percent or higher compliance with five of eight quality measures.

Unity Hospital earned the Target: Stroke Honor Roll Elite Plus, by meeting quality measures developed to reduce the time between the patient’s arrival at the hospital and treatment with the clot-buster tissue plasminogen activator (TPA) the drug used to significantly reduce the effects of stroke and lessen the chance of permanent disability.

“With a stroke, time lost is brain lost. This award demonstrates our commitment to ensuring patients receive care based on nationally-respected clinical guidelines,” said Chris Burke, MD Medical Director of Rochester Regional’s stroke programs. “Rochester Regional Health is dedicated to improving the health of this community. We’re committed to providing quality of stroke care and the American Heart Association/American Stroke Association’s ‘Get With The Guidelines-Stroke’ program helps us achieve that goal.”

Rochester Regional’s Golisano Restorative Neurology and Rehabilitation Center Receives Accreditation

Rochester Regional Health’s Golisano Restorative Neurology and Rehabilitation Center at Unity Hospital is pleased to announce that it been awarded a three-year term of Accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF).

This was the program's eighth consecutive CARF survey that resulted in a three year (highest level) accreditation period for the following programs:

- Inpatient Rehabilitation Program – Hospital (Adults)
- Inpatient Rehabilitation Program-Hospital: Brain Injury (Adults, Children and Adolescents)
- Inpatient Rehabilitation Program-Hospital: Stroke Specialty Program (Adults, Children and Adolescents)
- Interdisciplinary Outpatient Medical Rehabilitation Program: Brain Injury Programs (Adults, Children and Adolescents)
- Interdisciplinary Outpatient Medical Rehabilitation Program: Stroke Specialty Program (Adults)

CARF accreditation signals a service provider’s commitment to continually improving services, encouraging feedback, and serving the community. An organization receiving a three-year term of Accreditation has voluntarily put itself through a rigorous peer review process and demonstrated to a team of surveyors during an on-site survey that it is committed to conforming to CARF accreditation conditions and standards. Furthermore, an organization that earns CARF accreditation is commended on its quest for quality programs and services.

UR Medicine Heart and Vascular Performs 200th High-Tech Heart Valve Replacement

Cardiologists lead region in life-saving treatment for aging adults with advanced heart disease

UR Medicine Heart and Vascular recently performed its 200th transcatheter aortic valve replacement, a life-saving procedure for seriously ill, aging adults with faulty heart valves. The high-tech treatment restores quality of life for people, many of whom have no other treatments available to them.

“This procedure has dramatically changed the care for the elderly with advanced aortic stenosis who can’t tolerate traditional surgeries,” said Frederick Ling, MD, director
of the Cardiac Catheterization and Electrophysiology Lab at Strong Memorial Hospital. He leads the region’s most experienced TAVR team. UR Medicine Heart Valve Center introduced the procedure to the Rochester area in 2012 as a new therapy for people with aortic stenosis who are too fragile to endure traditional open-heart surgery. Specialists are now studying the effectiveness of performing the minimally invasive procedure, currently reserved only for people at high risk for open surgery, for people with low and intermediate surgical risk.

Rochester RHIO Provides Users Access to More Streamlined Patient Records with New Technology
The RHIO’s Implementation of NextGate MatchMetrix® EMPI Solution Enhances Care Delivery
To provide its users access to more streamlined patient information, the Rochester Regional Health Information Organization (RHIO) has implemented a new patient-matching technology platform within its system. As one of the nation’s leading regional health information exchanges, the RHIO is committed to continually improving the functionality of its exchange with the latest technology solutions. The new platform, NextGate’s MatchMetrix® Enterprise Master Patient Index (EMPI) solution, reconciles and correlates patient records that are the result of patients being seen in multiple settings with different health record systems.

With the algorithm the EMPI solution uses to organize patient data, a more streamlined record-matching process helps to provide a clearer and more accurate picture of a patient’s medical history. The result is improved interactions with patients and enhanced information sharing among the RHIO’s users.

“The RHIO’s health information exchange offers providers access to valuable patient information that enables them to deliver the best possible care to their patients,” said Jill Eisenstein, executive director, Rochester RHIO. “The NextGate patient matching solution has streamlined the records available, making it even easier for providers to access exactly what they need.”

The RHIO’s Explore tool and master patient index is at the foundation of reliable health information exchange. The RHIO’s health information exchange includes over 142 million clinical documents for 1.4 million residents.

Dr. Brian Day Joins Medical Team at St. Ann’s Community

St. Ann’s Community, Rochester’s leading senior housing and health services provider, is proud to announce the addition of Dr. Brian Day to its Medical Department.

Certified in family and geriatric medicine, Dr. Day’s primary clinical responsibilities will be in long-term care at St. Ann’s Home. Prior to joining St. Ann’s, Dr. Day was a family medicine physician at Ridgeway Family Medicine, Rochester Regional Health System. He also provided primary care to nursing home eligible patients in their homes and the community as part of an interdisciplinary team through Rochester Regional Health System’s ElderONE program.

Dr. Day earned his BA from Bucknell University and his Doctorate from Philadelphia College of Osteopathic Medicine. He did his family medicine residency at United Health Services Wilson Medical Center (Johnson City, NY) and his Geriatric Medicine Fellowship at the University of Rochester School of Medicine and Dentistry.
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