



The El Paso Physician

Volume 41 Number 2



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President's Comment

Juan R. Perez, MD, FAAFP
President, El Paso County Medical Society



It is hard to believe we are half way through 2018! So far this has been an exciting year and very challenging year for the El Paso County Medical Society. The El Paso County Medical Society was well represented at TexMed 2018 in San Antonio. Our votes were casted at the House of Delegates meeting. During the event, Dr. Douglas Curran MD was sworn into office by his predecessor Dr. Carlos Cardenas in front of the attendees as the 2019 TMA President. Dr. Curran is a Family Medicine Physician in Athens, Texas. The upcoming TMA Fall conference will be held on September 28-29 at the Hyatt Regency Lost Pines in the greater Austin area. The El Paso County Medical Society will continue to be represented. Also the Border Health Caucus will travel to Washington DC in September to continue our advocacy for our bordering US towns, and counties with Mexico.

During the same weekend of TexMed, The Texas Tech Paul L Foster School of Medicine held its graduation commencement for the Class of 2018 School of Medicine. We will continue to see great things from the medical school as our community grows and physicians continue to come into our community. This was demonstrated during the physician mixer held at Dr. Richard McCallum's home held on Saturday May 19th. We had a great turn out from community physicians and academic physicians in order to continue to grow our membership. It is imperative for our success for the Texas Tech Faculty to be involved in our medical society, as well as for the community physicians to be involved as preceptors to the medical students. The El Paso County Medical Society will continue to support the Texas Tech Paul L Foster School of Medicine students, our local physician members, and will continue to care for patients in our community.

The El Paso County Medical Society will continue to ask for your support as members, and as physicians in the El Paso community. We will continue to strive to meet our mission:

“TO ADVANCE THE ART AND SCIENCE OF MEDICINE
PROTECT THE PHYSICIAN AND SERVE THE PATIENT”

Juan R. Perez, MD, FAAFP
President, El Paso County Medical Society

Mix and Mingle - May 2018

Thanks to Drs. Perez, Tyroch, Days, Urrea, Mansfield, Delarosa and Marwah our current and past leaders for attending to show their continued support of the El Paso County Medical Society. Thanks to Specialty Hospital and El Paso Wellness for their support at this event.

Special thanks to Dr. and Mrs. Richard McCallum for opening their home for this event.





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Editorial Comment

Alison L. Days, MD
Editor
El Paso Physician, EPCMS



“Life has two rules: #1 Never quit #2 Always remember rule # 1.”

~Anonymous

“Whatever you do, hold on to hope. The tiniest thread will twist into an unbreakable cord. Let hope anchor you in the possibility that this is not the end of your story, that change will bring you to peaceful shores.”

~Unknown

June is National Cancer Survivor Month, established to recognize those who have successfully fought or are in the process of fighting the disease. The American Cancer Society defines a cancer survivor as any person who has been diagnosed with cancer, from the time of diagnosis through the balance of life¹. I think we often believe that cancer touches “other” people or other families or our patients, but not us.

However, cancer is the second most common cause of death in Texas and it is still the second leading cause of death (following fatal injuries) in Texas children 5 to 14 years old². Among Hispanics/Latinos, the most common types of cancer are prostate for men (22% of newly diagnosed cases in 2015) and breast for women (29% of newly diagnosed cases in 2015).³

What can we do as physicians to help those affected by cancer continue to be survivors and what can we do to prevent cancer in the first place? Start by following guidelines and helping patients and families stick to them. Advise against smoking/tobacco use and prolonged sun exposure. Advise for sunscreens and eating healthy. Advocate for vaccines, such as HPV, that prevent the spread of viruses that cause cancer. Help patients get regular check-ups and appropriate screening and testing. Believe them when they think “something might be wrong.”

This month we reach out to all those currently diagnosed with cancer, including our own Managing Editor Diana

Murillo. Please remain vigilant about the statistics and support the cancer research. For more info, you may consider the following websites:

- www.cancer.org
- www.dshs.texas.gov
- www.texascancer.info
- www.thencs.org

¹<https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-treatment-and-survivorship-facts-and-figures/cancer-treatment-and-survivorship-facts-and-figures-2012-2013.pdf>


²Texas Department of State Health Services. *Leading Causes of Death by Race Ethnicity in Texas. 2015*; Available from: <http://www.dshs.texas.gov/chs/vstat/vs13/t16.aspx>.

³<https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-hispanics-and-latinos/cancer-facts-and-figures-for-hispanics-and-latinos-2015-2017.pdf>

Alison L. Days, MD, Editor, El Paso Physician Magazine

The El Paso County Medical Society is once again updating our files. In this ever changing technological world, we realize emails and phone numbers change frequently. Please assist us by sending us your current Practice Name, Address, Phone Numbers, email and if you have a current photograph please email to epmedsoc@aol.com

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American Medical Association Alternate Delegate Report

Roxane Tyroch, MD, FACP



L

LEGISLATIVE

E. P. C. M. S.

I wish to take a moment to describe an oncologist that was an inspiration to me. The late Dr. Byron Chesbro made an impression upon me when I was a hospitalist in the Tenet system and during my first years in private practice. When I was a hospitalist, I was impressed by the loyalty of his patients. I admired the relationships he had with his patients, they felt safe in his care. They trusted their lives to him, and he gave them every fiber of his being to make their lives as meaningful and lengthy as he could. He was never too rushed to teach me or discuss a case with me. Dr. Chesbro passed away earlier this year and is greatly missed by all of us.

We are so happy and grateful to have the continued involvement of our past presidents—we need you! All members are encouraged to get the most out of their dues—please join us at the EPCMS monthly meetings at 5:30 pm, second Tuesdays of every month at 1301 Montana and get to know current board members and involved membership. We have a table set aside for medical students and residents in the graduate medical programs. My father used to tell me “the most important lessons in life are not learned by reading books, but by interacting with other people”.

TEXMED was recently held in San Antonio. If you are interested in becoming a delegate, please let leadership know. You would be expected to attend the meetings and vote on behalf of the El Paso County Medical Society membership Saturday morning of the event. I will be a delegate in Chicago in June representing the Texas Medical Association and I have been assigned to Public Health. I will dedicate a great amount of time to assist a campaign for a TMA delegate who is an incumbent for the AMA Council on Medical Service. At our delegation meeting in San

Antonio, we reviewed resolutions on telemedicine, gun control, prudent layperson standard for delivery of emergency care, dedication of resources towards vector borne illnesses, insurance changes regarding emergency out of network services and insurance companies determinations of whether emergency care will be covered after retrospective review.

I serve on the Council on Legislation and we discussed topics involving Medicaid, advertising practices of insurance companies that adversely impact physicians, emergency services and more. I also serve on the TEXPAC Candidate Evaluation Committee and was impressed of the work of the TEXPAC. Please contribute. Many El Paso physicians attended the Border Health Caucus and we share our experiences with other communities on the border. TMA staff is excellent and we will go to Washington DC in September with key messages for legislators. The Lone Star Caucus is comprised of Border Caucus and Small Districts. We met to discuss candidates for TMA positions and other relevant topics.

I truly believe that if you can familiarize yourself with the resources available to you through your El Paso County Medical Society, American Medical Association and Texas Medical Association, you will become much more resilient to the forces that overwhelm the practicing physician.

**Roxanne Tyroch, MD, FACP, AMA Alternate Delegate,
El Paso County Medical Society Delegate.**

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New Shingles Vaccine - You Need This!

Michael H. Simpson, MD
Jana L. Simpson, MD
Brenda M. Simpson, MD

If you are 50 years or older, this new vaccine could save you from suffering a bout of shingles which can be very painful and lead to other severe complications.

The CDC recommends all immunocompetent adults 50 years or older obtain this new Shingrix shingles vaccine. Shingrix is a non-live virus vaccine that is about 90 to 97% effective in preventing shingles, whereas the old Zostavax is only about 70% effective, and its effectiveness is much less in older patients.

The Shingrix vaccine is recommended whether or not you have already received the Zostavax vaccine, and whether or not you have already suffered a bout of shingles. The Shingrix vaccine is

given intramuscularly (usually in the deltoid arm) in two doses, 2 to 6 months apart. Shingrix is now available at several local pharmacies. No prescription from your physician is required if you are 50 years or older. Telephone the pharmacy in advance to determine availability and cost. The cost will vary depending upon your insurance.

Google Shingrix and go to the www.cdc.gov for more information.

Michael H. Simpson, MD is a Dermatologist in El Paso, TX
Jana L. Simpson, MD is a Dermatologist in El Paso, TX
Brenda M. Simpson, MD is a Pediatric Dermatologist in El Paso, TX

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GiGi's Playhouse has received funding for the second year in a row to organize another conference on Down Syndrome. The Playhouse located at 960 Chelsea Street Suite B in El Paso is a dedicated space where children and adults with Down Syndrome can participate in educational and therapeutic programs free of cost. The conference main goal is to present research updates and new therapies for Down Syndrome to parents and caregivers of children, teens, and adults with Down Syndrome and for health professionals who care for them learn about new medical advances.

Traditionally, Down Syndrome has been a pediatric condition, but as the average life expectancy (60 years)¹ has increased so much that individuals with Down Syndrome outgrow pediatric care and as they grow older end up needing more care from internists, family physicians, and emergency physicians than from pediatricians.

Last year, the 1st West Texas Down Syndrome Health Symposium took place on December 2, 2017 at Texas Tech University Health Sciences Center – El Paso. At the half-day conference Down Syndrome specialists who have dedicated most, or their entire practices, to the study and the care of people with Down syndrome presented various topics: Dr. Brian Chicoine talked about health promotion strategies for adolescent and adults with Down Syndrome, Dr. George Capone described research updates for better care for children with Down Syndrome, Dr. Dennis McGuire presented about wellness and adaptive skills strategies for children, teens, and adults with Down Syndrome, and Dr. Sarah Mann demonstrated better physical therapy across the Down Syndrome lifespan. The conference was attended by physicians, therapists, and nurses who at the end of the conference express their appreciation for opening their eyes to new therapies and strategies for people with Down Syndrome.

Down Syndrome is well known as it is the most frequent congenital disorder affecting 1 of every 700¹ children born in the U.S. In fact, every year 6,000 children are born with Down Syndrome in the U.S.¹ Children born with Down Syndrome have intellectual differences and health complications ranging from hypotonia, congenital heart defects, obstructive sleep apnea, feeding difficulties, etc., that require medical care and frequent hospitalizations, which are a challenge for the child and the family.² The health problems of Down Syndrome are most acute during childhood, but since these children are living longer health care professionals need to update their knowledge and skills for treating Down Syndrome in teens and adults.

Besides the well-recognized characteristic features there are others health issues that affect the child with Down Syndrome globally. Throughout their lives people with Down Syndrome need regular health management by a variety of specialists to treat conditions such as: congenital heart defects, obstructive sleep apnea, feeding difficulties, hearing loss, otitis media, and vision and eye diseases (cataracts affect about 50% of adults with Down Syndrome). Other conditions include: hypodontia and delayed teeth eruption, hypothyroidism, neurologic disorders, autism, gastrointestinal atresia, serious hematologic problems, atlantoaxial instability and Hirschsprung Disease, obesity, abnormal blood leptin, decreased activity, and vitamin and mineral deficits that may lead to further intellectual deterioration as

well as conditions related to their unusual immune function (which can make treatment difficult and worsen the prognosis).⁴

Many of the disorders that affect individuals with Down Syndrome do not present until they are adults thus, it is essential for the physicians (internists, family physicians, and emergency physicians) taking care of these patients to do a thorough exam and order tests on a regular basis including echocardiography, ASD and TSH screening, and celiac disease testing.⁵ Further, physical and occupational therapy is required throughout their lives and counseling is needed to deal with behavioral issues and learning differences.

The group interventions like the ones that take place at GiGi's Playhouse have contributed immensely to enhance the support to families with children with Down Syndrome and improve the children's achievements. Throughout the life span of people with Down Syndrome it is crucial for physicians and health care providers to have a systematic and detailed approach to follow the heart condition, intellectual and neurologic function and behavioral and psychologic well-being so individuals with Down Syndrome can live happy and productive lives.

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Retroperitoneal Bleeding Post-PCI

Jerry Fan, MD

Abstract

Coronary angiography and percutaneous coronary intervention is fast becoming one of the most common procedures performed in the United States. However, this procedure comes with risks including hematoma, fistula formation, thrombosis, and hemorrhage. We present a 68 year old male who acutely decompensated after coronary angiography and percutaneous coronary intervention was complicated with a large retroperitoneal bleed.

Introduction

Coronary angiography with and without percutaneous coronary intervention is one of the most common procedures performed in the United States.¹ Transfemoral has been the standard vascular access for these procedures, but the radial artery approach offers advantages.^{1,2} We discuss a case of a 68-year-old male who presented with Legionella pneumonia complicated by a myocardial infarction, needing coronary angiography and percutaneous coronary intervention, which resulted in retroperitoneal hemorrhage.

Case Presentation

A 68-year-old male with hypertension, hyperlipidemia, multiple cerebrovascular events, chronic kidney disease, and benign prostatic hypertrophy presented from home with generalized weakness, dizziness, and pre-syncope without head injury, or focal neurological deficits.

In the emergency department, he had two episodes of hematemesis. Initial vital signs were within normal limits, WBC $6.0 \times 10^9/L$, hemoglobin 10.7 g/dL, platelet count $72 \times 10^9/L$, procalcitonin 1.33 ng/mL, and lactic acid 2.8 mmol/L. His chest x-ray and CT chest showed left upper lobe, right upper lobe, and right middle lobe of the lung with right hilar adenopathy. He was started on vancomycin, cefepime, and metronidazole. *Streptococcus* urine antigen, respiratory viral panel, Q-fever, and *Ehrlichia* antibodies were negative. He underwent esophagogastroduodenoscopy, which showed no abnormalities.

The patient continued to have oscillating fevers that ranged from 101-103 F despite broad spectrum antibiotics. Due to progressive clinical deterioration, he underwent bronchoalveolar lavage. Linezolid and doxycycline were added to his antibiotic regimen.

On the 3rd day of hospitalization, the patient was admitted to

the medical intensive care unit due to tachycardia, tachypnea, hypotension and increased oxygen requirements with saturation remaining in the low 80%. The patient was emergently intubated, and pressor support was initiated. Antibiotics were changed to doxycycline, vancomycin, and meropenem. A fungal workup returned negative. The bronchoalveolar lavage fluid was positive for *Legionella*, so he was transitioned off all other antibiotics to levofloxacin.

On the 10th day of hospitalization he reported chest pain. Troponins were elevated at 0.99 ng/mL. Echocardiogram at the time showed left ventricular ejection fraction of 25%, with regional wall motion abnormality consistent with multi-vessel coronary artery disease. He underwent transfemoral coronary angiography, which showed 50% occlusion of mid-left anterior descending artery, and 70% occlusion of the right coronary artery. He was initiated on dual antiplatelet therapy (aspirin and clopidogrel) and a statin.

The next day, he became somnolent, tachycardic, tachypneic, and hypotensive with a hemoglobin of 5.8 g/dL. CT abdomen showed large retroperitoneal hemorrhage. He was managed conservatively with fluid resuscitation, blood transfusion, and pressor support. The retroperitoneal hemorrhage resolved over the next 10 days.

Discussion

Coronary angiography is performed approximately 3 million times per year, with a complication rate of approximately 0.1%.^{3,4,5} During the procedures, an anticoagulant, usually heparin, is required to prevent thromboembolisms, but that increases the risk of retroperitoneal hemorrhage, which complicates approximately 0.5-0.74% of procedures.^{1,3,5} The mortality from retroperitoneal hemorrhage is approximately 4.2-8.6%.^{1,4}

The most prevalent risk factor for the development of retroperitoneal hemorrhage is high femoral puncture, typically above the inferior gastric artery.⁷ Abdominal pain is the most common presenting symptom of retroperitoneal bleed. Hemorrhage is usually confirmed with a CT scan, although ultrasound is quickly becoming a modality of choice.⁴ Most patients are managed conservatively with watchful waiting, fluid resuscitation, and pressor support. A minority will require vascular surgical intervention.⁴ Transfemoral vascular access is most common in the United States.¹ Radial access confers less risk

Continued on page 10

Retroperitoneal Bleeding Post-PCI (Continued)

of bleeding and vascular complications, but bleeds can still occur, especially if low molecular heparin is given along with dual antiplatelet therapy.² This patient presented with a relatively uncommon type of pneumonia, complicated by myocardial infarction requiring coronary angiography, and that procedure resulted in retroperitoneal bleeding (Figure 1).



Figure 1: Right paracolic gutter, rectus, and bilateral psoas hemorrhage post coronary intervention

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CASE REPORT

E.P.C.M.S.

Factors that Predispose Conversion from Laparoscopic to Open Cholecystectomy in a Mexican – American Population

Brian R. Davis, MD
Feras Yamin, MD
Alejandro Rios - Tovar, MD
Victor Olivas, MD
Hayder Azeez, MD

Abstract:

Management of cholecystitis has evolved over many years. Laparoscopic cholecystectomy has become standard treatment. Still, a portion of patients must undergo conversion to open cholecystectomy. Those patients have increased risk of morbidity, such as infection which prolongs postoperative hospitalization. To reduce the number of patients who require conversion, it is necessary diagnose the severity of patients who present with gallbladder disease earlier, and with more accuracy. This can be achieved by applying standard objective diagnostic criteria, which would allow surgeons to better predict which patients have higher risk of complications, and inform decisions on converting to an open procedure. Beyond diagnostic criteria for symptomatic gallbladder diseases, such as the 2007 Tokyo Guidelines for acute cholecystitis, we are aiming to create diagnostic criteria to more accurately predict conversion risks and complications for a wider array of symptomatic gallbladder diseases on the Texas-Mexico border region that includes El Paso.

Our study has reinforced the importance of preoperative white blood cell (WBC) counts in predicting the severity of the gallbladder disease. In addition, the study has shown that the higher the WBC count, the more likely the need to convert to an open procedure. Accordingly, high WBC can be reliably considered a major risk factor for converting laparoscopic cholecystectomy to open. Our study is unique for distinguishing the severity of gallbladder disease among Hispanic populations along the US – Mexico border.

Introduction:

The approach to the surgical management of cholecystitis has evolved over many years with the gold standard for treatment being laparoscopic cholecystectomy. Despite advantages of laparoscopic cholecystectomy, there is still a portion of patients that undergo necessary conversion to open cholecystectomy. As a result of conversion these patients have increased risk of morbidity, such as infection and prolonged postoperative hospitalization^{(12), (13)}. In order to decrease the proportion of patients who undergo conversion, it is necessary to diagnose the severity of patient's disease who present with gallbladder pathology at an earlier state. This diagnostic process needs

Tables

Table 1: Descriptive of the continuous variables

Variables	n	mean	SD	Min	Max
Age (years)	287	44.24	14.9	19	86
BMI (kg/m ²)	282	31.29	7.13	14.52	66.48
Weight (kg)	284	83.8	19.96	36.8	164.9
Height (m)	282	1.64	0.08	1.45	1.88
White Blood Cell Count	261	10.2	4.05	4.03	35.4
Total Bilirubin	268	1.07	1.84	0.1	17.8
Direct Bilirubin	154	0.65	1.77	0.05	14.2
Alkaline Phosphatase	268	118.91	84.81	1.8	817
Lipase	149	826.36	2020.29	14	7500
Gallbladder Wall Thickness (mm)	265	3.43	1.77	1	12.8
Gallbladder Length	251	8.43	2.32	3.1	15.7
Gallbladder Width	260	3.63	0.92	1	7.8
Common Bile Duct Diameter (mm)	263	5.55	2.62	1.3	19
Duration between admittance and surgery (days)	287	4.88	21.92	0	265

to be done with more accuracy utilizing predictive risk factors^{(1), (3), (5), (9)}. This can be achieved by applying standard objective diagnostic criteria which would allow surgeons to better predict which patients have higher risk of complications. Predictive criteria would inform decisions on converting to an open procedure versus selecting another route of management such as interval cholecystectomy⁽¹⁰⁾.

Although diagnostic criteria for symptomatic gallbladder diseases such as the 2007 Tokyo Guidelines for acute cholecystitis have been promulgated,⁽¹⁾ we are aiming to create diagnostic criteria to predict conversion risks and complications more accurately for the wider array of symptomatic gallbladder diseases occurring in the Texas-Mexico border region that includes El Paso. The majority of patients in the region have limited access to health care, and present later in the disease process. Over the past several years, many studies have discussed preoperative risk factors that reflect the severity of cholecystitis and to some degree predict the need for conversion to an open procedure^{(2), (3), (4)}. However, none of these studies has focused on a unique patient population that has limited access to health care and the effect of that on the severity of the disease at the time of presentation⁽¹¹⁾. This study aimed to identify risk factors specific for that patient population, present recommendations for a different course of management for patients presenting with more advanced gallbladder disease, wanting for better out-

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comes and less complications among the Mexican – American patient population with gallbladder disease ^{(6), (7), (8), (18)}.

Table 2: Descriptive of the categorical variables

Variables	N	%
Gender		
Male	79	27.53
Female	208	72.47
Ethnicity		
Hispanics	235	81.88
Non-Hispanics	52	18.12
Previous Abdominal surgeries		
0	167	58.19
1	88	30.66
2	23	8.01
3	6	2.09
4	3	1.05
Elective or Non-Elective Procedure		
Emergency Department	155	54.01
Clinic	132	45.99
History of Comorbid disease		
No	166	58.04
Yes	120	41.96
Sonographic Murphy's Sign		
No	170	65.38
Yes	90	34.62
Presence of Stones in Neck of Gallbladder		
No	230	85.82
Yes	38	14.18
Presence of stones in Common Bile duct		
No	256	95.52
Yes	12	4.48
Diagnosis		
acute cholecystitis	24	8.36
chronic cholecystitis	182	63.41
acute and chronic cholecystitis	42	14.63
cholelithiasis	6	2.09
acute necrotizing cholecystitis	30	10.45
porcelain gallbladder	3	1.05

Methods:

A retrospective chart review of patients that were managed at the University Medical Center in El Paso, a county hospital located at the Texas – Mexico border, serving a large patient population with a wide socio-economic spectrum. Data were collected from 2010 to 2015, on patients with gallbladder disease requiring operative management. This was a case-matched control study that compared: demographics, ultrasound measurements, laboratory values, and comorbidities. Multiple ranges are applied to indi-

vidual variables and ranges were analyzed for statistical significance. Student's t-test and Wilcoxon rank sum test assess the differences in risk factors for continuous variables. If they were categorical, the Fishers exact test, or chi-squared test was used to assess differences. The logistic regression model assessed the likelihood of conversion to open cholecystectomy. P values less than 5% were considered statistically significant. All analyses were performed using SAS V.9.4.

All patients requiring cholecystectomy were identified, whether presented through the emergency room or the outpatient clinic. Patients with a variety of gallbladder disease were included in the study: symptomatic cholelithiasis, acute cholecystitis, acute necrotizing cholecystitis, porcelain gallbladder, biliary pancreatitis, choledocholithiasis, chronic cholecystitis, and cholangitis. Diagnoses were confirmed with laboratory findings, and imaging studies. Also, the postoperative pathology reports were recorded to confirm the final diagnosis. Gallbladder cancer was the only excluded diagnosis. Also, other exclusion criteria were: patients younger than 18 years old, procedure that started as open cholecystectomy, robotic assisted cholecystectomy, and cholecystectomy for trauma patients as part of trauma exploratory laparotomy and damage control surgery. CPT codes and ICD 9 diagnoses were used to identify patients. The search identified 73 patients who had required conversion from laparoscopic to open cholecystectomy. For those patients, the surgery was planned and began laparoscopically, then for a specific reason the procedure was converted to open. The reasons identified in the operative notes were one or more of the following: suspicious or visualized bile duct injury (at different levels), unclear anatomy, extensive adhesions, and densely calcified gallbladder wall with difficult dissection. 214 patients were randomly selected to represent the population of 2000 patients that had a successful laparoscopic cholecystectomy during the same time period. For those patients, data on all of the study parameters were ascertained. Since the data collected from those patient's showed strong statistical significance pointing toward the same group of risk factors previously identified in the literature, with no outliers, collecting more data from the same patient population will continue the trend in the same direction and will skew the results. Therefore, the data gathered from the sample group of the patient population was projected to represent all patients that did not require conversion to open cholecystectomy. For those patients, the operation was completed laparoscopically. Accordingly, the rate of conversion to open cholecystectomy in our study is less than 5% which is similar to what is previously mentioned in the literature.

The parameters that were collected and analyzed from the 287 patients in this study, included: demographics, preoperative laboratory values, radiological characteristics of gallbladder on ultrasound, previous abdominal surgeries, presence of comorbid diseases, elective versus non-elective procedure, and length of hospitalization prior to surgery. Predictors of disease severity that were previously described in Tokyo guidelines 2007 were

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Table 3: Comparison of risk factors across lap and open groups for continuous variables

Variables	Laparoscopic (n=214)		Open (n=73)		P value
	mean	SD	mean	SD	
Age (years)	43.61	14.31	46.08	16.46	0.22180
BMI (kg/m ²)	30.89	6.84	32.53	7.88	0.09710
Weight (kg)	82.13	19.76	88.83	19.84	0.01400
Height (meters)	1.63	0.08	1.66	0.08	0.00530
White Blood Cell Count	9.67	4.03	11.63	3.75	0.00040
Total Bilirubin	0.88	1.29	1.61	2.84	<0.0001*
Direct Bilirubin	0.54	1.34	0.93	2.57	0.0453*
Alkaline Phosphatase Levels	119.39	79.37	117.50	99.47	0.0946*
Lipase Levels	1020.47	2236.42	315.02	1163.13	0.0003*
Gallbladder Wall Thickness (mm)	3.29	1.76	3.84	1.73	0.0583*
Gallbladder Length	8.25	2.24	8.96	2.46	0.00440
Gallbladder Width	3.52	0.83	3.96	1.1	0.02730
Common Bile Duct Diameter (mm)	5.42	2.70	5.92	2.36	0.0395*
Duration between admittance and surgery (days)	5.43	25.35	3.26	2.13	0.50860

*Wilcoxon rank sum test

recognized as risk factors for conversion to open cholecystectomy. These factors outlined the parameters that were gathered for the study from the patients' charts. Demographics included age, gender, ethnicity, BMI, weight, and height. The preoperative laboratory values collected were white blood cell count, total bilirubin, direct bilirubin, alkaline phosphatase, and lipase. The radiological characteristics of gallbladder of study interest were gallbladder wall thickness, gallbladder length, gallbladder width, common bile duct diameter, presence of sonographic Murphy's sign, and presence of stone in the neck of the gallbladder and/or in the common bile duct. Those parameters were grouped into continuous and categorical variables. The mean, standard deviation and range of the continuous variables was listed. Also, the percentages of the categorical variables were reported. A comparison of the risk factors between the two groups of patients was analyzed. Also, a statistical study was done to show the adjusted and unadjusted association between the conversion to open cholecystectomy and selected risk factors. The adjustment was done to other risk factors to eliminate the effect of other variables on the specific association result.

Results:

In the unadjusted model, we found white blood cell count, gallbladder wall thickness, length and width, total bilirubin, gender, and ethnicity were significant risk factors associated with conversion to open surgery. However, in the adjusted model, only white blood cell count, gender and ethnicity were significant. Continuous variables were described using mean, standard deviation (SD), minimum and maximum observations (table 1). Categorical variables were described using frequencies and proportions (table 2).

A comparison of variables between the two groups of patients (table 3 and 4), showed, with statistical significance, higher values of white blood cell count and bilirubin in the patients that required conversion to open cholecystectomy, and larger dimensions of gallbladder and thicker wall in the group that converted to open. In the same group of patients, there were significantly more male and more Hispanic patients compared to the other group.

The odds of a patient of Hispanic origin converting to open surgery are 10 times higher than a patient of non-Hispanic origin. The odds of a male patient converting to open surgery are 3 times that

of a female patient. Also, the odds of a patient converting to open surgery are 7% higher for every unit increase in white blood cell count. In addition to risk factors previously described in the literature, the presenting severity of disease among the Mexican American patient population conferred an increased chance of conversion to open procedure. That trend can be largely attributed to the late presentation with more advanced disease process.

Discussion:

Although the risk factors and predictors for a complicated laparoscopic cholecystectomy has been discussed in the literature. There has not been any clear description whether the socio-economic status and insurance coverage would influence these risk factors. Eventually, the late presentation of this specific group of patients to health care provide; will impact these predictors for complications and the need for conversion to open procedure. This study was structured to target patients that were managed at a county hospital along the US-Mexico border, where most of the patients are uninsured and usually seek medical attention late in the disease process.

The statistical analysis of the study has shown that being a male Hispanic is a risk factor for more severe gallbladder disease in our region, which can be related to late presentation. As a result, they have a higher chance of conversion to open cholecystectomy, suggesting that risk factors for conversion can relate to regional variations in access to healthcare. In conclusion, the major risk factors for conversion as seen in our study will be male Hispanic patients in addition to the high WBC that has been discussed in the literature. Consequently, we would like to recommend to the surgeons practicing a similar region when faced with these risk factors to either consider another methods of managing gallbladder disease or proceed with the laparoscopic approach with the knowledge of the conversion risk.

The study has its own limitations. The sample population size of the converted procedures. Also, using a sample population to project the data for the much larger population of laparoscopic cholecystectomy cases. This limitation comes from the fact the conversion rate is very small, less than 5% (in our study and the literature in general). Which makes a big discrepancy between the sizes of the two patient populations.

Conclusion:

Our study has reinforced the importance of preoperative WBC value in predicting the severity of the gallbladder disease. In addition, the study showed that the higher the WBC value the more likely the procedure will be converted to an open one. Accordingly, high WBC can be reliably considered a major risk factor for converting laparoscopic cholecystectomy to open. Our study is unique in highlighting greater presenting severity of gallbladder disease among Hispanic population along the US – Mexico border. The statistical analysis of the study has shown that being a male Hispanic is also a major risk factor

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Table 4: Comparison of risk factors across lap and open groups for categorical variables

Variables	Laparoscopic (n=214) n, %	Open (n=73) n, %	P value
Gender			0.0002
Male	46 (58.23)	33 (41.77)	
Female	168 (80.77)	40 (19.23)	
Ethnicity			0.0007
Hispanics	166 (70.64)	69 (29.36)	
Non-Hispanics	48 (92.31)	4 (7.69)	
Previous Abdominal surgeries			0.4501
0	120 (71.86)	47 (28.14)	
1	72 (81.82)	16 (18.18)	
2	16 (69.57)	7 (30.43)	
3	4 (66.67)	2 (33.33)	
4	2 (66.67)	1 (33.33)	
Any surgery			0.2203
No	120 (71.86)	47 (28.14)	
Yes	94 (78.33)	26 (21.67)	
Elective or Non-Elective Procedure			0.6857
Emergency Department	114 (73.55)	41 (26.45)	
Clinic	100 (75.76)	32 (24.24)	
History of Comorbid disease			0.2145
No	129 (77.71)	37 (22.29)	
Yes	85 (70.83)	35 (29.17)	
Sonographic Murphy's Sign			0.7689
No	126 (74.12)	44 (25.88)	
Yes	65 (72.22)	25 (27.78)	
Presence of Stones in Neck of Gallbladder			0.5535
No	173 (75.22)	57 (24.78)	
Yes	27 (71.05)	11 (28.95)	
Presence of stones in Common Bile duct			0.0414
No	189 (73.83)	67 (26.17)	
Yes	12 (100)	0 (0)	

for more severe gallbladder disease in our region, and is related to late presentation. As a result, they have a higher chance of conversion to open cholecystectomy. This study revealed that risk factors for conversion vary depending on the region and access to healthcare. In conclusion, the major risk factors for conversion were male Hispanic patients, and high WBC. Consequently, we recommended that surgeons practicing in a similar population, when faced with these risk factors, consider other methods for managing gallbladder disease, or proceed with the laparoscopic approach cognizant of the conversion risk.

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Table 5: Unadjusted association between conversion to open or not and selected risk factors

Dependent variable: Conversion to open surgery				
Variables	OR	95% CI	P value	
Age	1.01	0.99	1.03	0.190
BMI	1.03	0.99	1.07	0.122
White Blood Cell Count	1.11	1.04	1.20	0.003
Common Bile Duct Diameter (mm)	1.07	0.96	1.18	0.219
Gallbladder Wall Thickness mm)	1.17	1.01	1.36	0.035
Gallbladder Length	1.14	1.01	1.29	0.038
Gallbladder Width	1.66	1.20	2.31	0.002
Total Bilirubin	1.20	1.02	1.40	0.027
Direct Bilirubin	1.12	0.93	1.35	0.224
Alkaline Phosphatase levels	1.00	1.00	1.00	0.917
Lipase Levels	1.00	1.00	1.00	0.100
Gender				
female	ref			
Male	3.27	1.83	5.84	<.0001
Ethnicity				
Non- Hispanics	ref			
Hispanics	4.48	1.55	13.00	0.006
Previous Abdominal surgeries				
0	0.76	0.07	8.61	0.825
1	0.40	0.03	4.72	0.467
2	1.17	0.09	15.32	0.907
3	1.00	0.05	18.92	1.000
4	ref			
Elective or Non-Elective Procedure				
Clinic	ref			
Emergency Department	1.42	0.80	2.50	0.228
History of Comorbid disease				
Yes	ref			
No	0.71	0.41	1.24	0.225
Sonographic Murphy's Sign				
Yes	ref			
No	1.00	0.56	1.80	0.993
Presence of Stones in Neck of Gallbladder				
Yes	ref			
No	0.95	0.43	2.09	0.898
Presence of stones in Common Bile duct				
Yes	ref			
No	N/A	N/A	N/A	N/A

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Factors that Predispose Conversion from Laparoscopic to Open Cholecystectomy in a Mexican – American Population

Table 6: Adjusted association between conversion to open or not and selected risk factors

Dependent variable: Conversion to open surgery				
Variables	OR	95% CI		P value
White Blood Cell Count	1.07	0.99	1.16	0.085
Gallbladder Wall Thickness (mm)	1.14	0.95	1.36	0.174
Gallbladder Length	0.96	0.81	1.14	0.665
Gallbladder Width	1.31	0.86	1.98	0.204
Total Bilirubin	1.16	0.94	1.43	0.169
Gender				
female	ref			
Male	3.23	1.56	6.69	0.002
Ethnicity				
Non- Hispanics	ref			
Hispanics	10.07	2.18	46.48	0.003

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Components of the Childhood Obesity Epidemic: An Analysis of School Lunch Nutrition in a U.S.-Mexico Border Town

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ABSTRACT

Introduction: Childhood obesity is a serious concern within the Hispanic community. This study analyzes and compares nutritional content in meals provided to Ysleta Independent School District (YISD) elementary school students to United States Department of Agriculture (USDA) nutritional guidelines. **Methodology:** YISD was chosen as it participates in the National School Lunch and School Breakfast Program (NSLSBP), with a participation rate exceeding 90%. The nutritional content from a five week menu was broken down into macro- and micro-nutrients and compared to USDA guidelines. **Results:** All groups consumed more calories, carbohydrates, total fat, saturated fat, protein, and sodium than recommended by USDA guidelines. All meals provided sufficient fiber, calcium, iron, and vitamin A and C. **Conclusion:** Considering the average lunch meal contained excessive macronutrients for all groups, the NSLSBP guidelines are incongruent with USDA's daily nutritional guidelines. These findings are significant considering the child obesity epidemic, with Hispanic children being disproportionately affected.

INTRODUCTION

Childhood obesity has become an epidemic in both developed and underdeveloped countries, with children of racial and/or ethnic minorities being disproportionately affected (Figure 1).¹ 25.8% of Hispanic youth aged 2-19 years are considered obese, whereas only 14.1% of non-Hispanic white youth meet obesity criteria, which is a body mass index at or above the 95th percentile.⁵ In addition, children of the urban poor seem

to be more affected in developed countries due to poor diet and limited opportunities for exercise, whereas children in higher socioeconomic strata are disproportionately affected in developing countries.² Children affected by the obesity epidemic are at an increased risk for cardiopulmonary disease, metabolic disorders, orthopedic conditions, et cetera.²

With these statistics in mind, a United States (U.S.)-Mexico border town such as El Paso, Texas, where 82.2% of the population identifies as Hispanic or Latino,⁶ provides an ideal environment to analyze any relationship that may exist between culture, school lunches, and the childhood obesity epidemic.

School lunch nutrition in many public schools is guided by the NSLSBP, a federally assisted meal program that was established in 1946 under the National School Lunch Act.⁴ The NSLSBP provides low-cost or free lunches to children each school day, provided that the meals meet the requirements shown in Figure 2.

To access the impact that school lunches have on childhood

National School Lunch Meal Program Nutritional Standards: Grade K-5th		
Meal Pattern	Daily Minimum	Weekly Requirements
Milk, cups	1	5
Vegetables, cups	0.75	3.75
Meat or Meat Alternatives, oz	1	8
Fruits, cups	0.5	2.5
Grains/Breads, oz	1	8
Calories, minimum/maximum		550 / 650
Saturated Fat (% total calories)		<10%
Sodium, mg		<1230

Figure 2. Nutrition standards in the National School Lunch and School Breakfast Program.⁴

obesity, we compare the NSLSBP guidelines, through a nutrient analysis of YISD meals, to the USDA guidelines to assess for any inconsistencies. In addition, we provide an analysis of YISD school lunch nutrition, reported as daily nutrient content.

METHODS

We sought to compare the USDA Dietary Guidelines for Americans 2015-2020 with YISD's weekly nutritional lunch meal averages for elementary school aged students. The USDA daily nutritional goals for age-sex groups based on dietary reference intakes and Dietary Guidelines recommendations were used.⁷ To represent elementary aged students, kindergarten through 5th grade, the age and sex groups chosen include: females 4-8 years

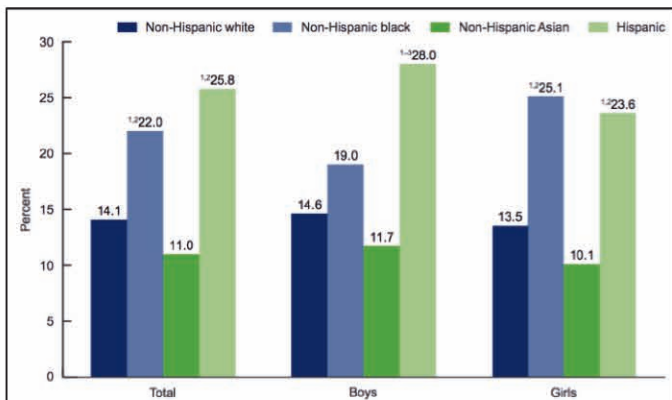


Figure 1. Prevalence of obesity among youth aged 2-19 years by race and ethnicity in the United States from 2015-2016. Adapted from Segal, et. al., 2018.

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Components of the Childhood Obesity Epidemic: An Analysis of School Lunch Nutrition in a U.S.-Mexico Border Town (Continued)

old (dark red), males 4-8 years old (navy), females 9-13 years old (light red), and males 9-13 years old (light blue) (Figures 3-6).

The daily nutritional goals for each age and sex group were divided by three to determine the nutritional goals per meal. This allowed comparison with YISD's weekly lunch meal averages for weeks one through five (represented by shades of green). Graphs were generated using Microsoft Excel® and categorized by total calories, macronutrients, minerals and vitamins.

RESULTS

Total calories (Figure 3)

Females and males 4-8 years old receive between 170-221 and 70-120 more total calories at lunch, respectively, than recommended by USDA guidelines. For the 9-13 year old students, females receive between 36.7-87.7 more total calories at lunch compared to USDA guidelines. Males between 9-13 years old receive adequate total calories.



Figure 3. Total calories for one meal. USDA total calorie goal per meal based on age and sex group (first four bars).⁷ YISD total calorie content for one lunch meal, derived from the average of five lunch meals over one week, weeks 1-5 (last five bars).

Macronutrients (Figure 4)

All age and sex groups receive approximately 3.5 times the amount of protein recommended by USDA guidelines. All age and sex groups receive more than twice as many carbohydrates, total fats, and saturated fats as recommended by USDA guidelines. On average students receive 1.7 times as much dietary fiber as recommended by USDA guidelines.

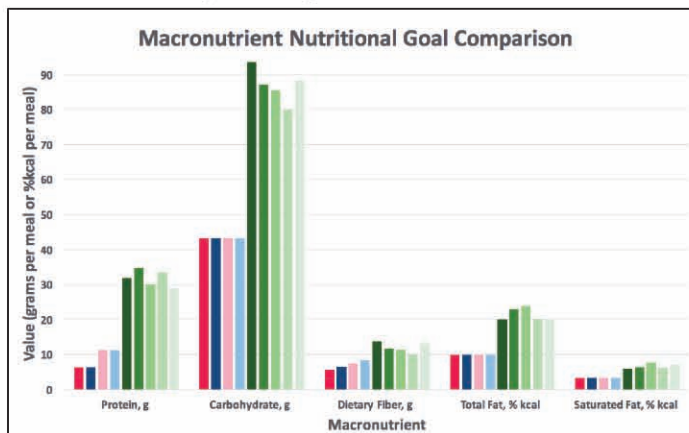


Figure 4. Macronutrient goal comparison between USDA guidelines and YISD lunches (per meal).⁷

Minerals (Figure 5)

All meals provide sufficient calcium and iron for all age and sex groups. All meals provide excess sodium for all age and sex groups, especially for males and females 4-8 years old and females 9-13 years old. Females 4-8 years old received 1.6-1.9 times as much sodium as stated in USDA guidelines. In addition, males 4-8 years old and females 9-13 years old received 1.2-1.5 times as much sodium.

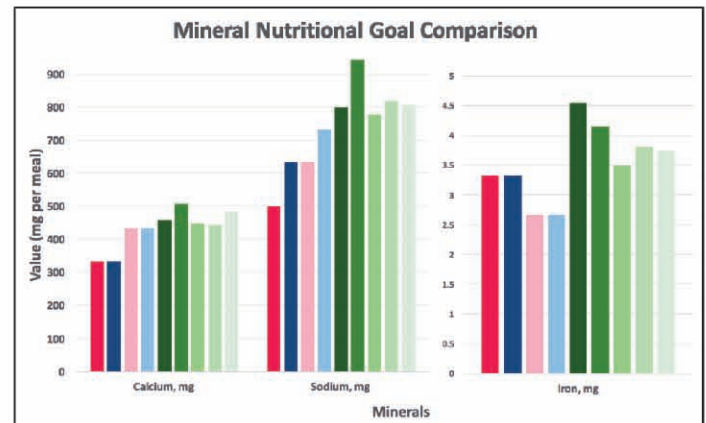


Figure 5. Mineral goal comparison between USDA guidelines and YISD lunches (per meal).⁷

Vitamins (Figure 6)

All meals provide a surplus of vitamin A and vitamin C for all age and sex groups. Both sexes 4-8 years old and 9-13 years old received 9.2-14.4 and 6.2-9.6 times as much vitamin A, respectively. In addition, both sexes 4-8 years old and 9-13 years old received 3.1-9.2 and 1.7-5.3 times as much vitamin C, respectively.

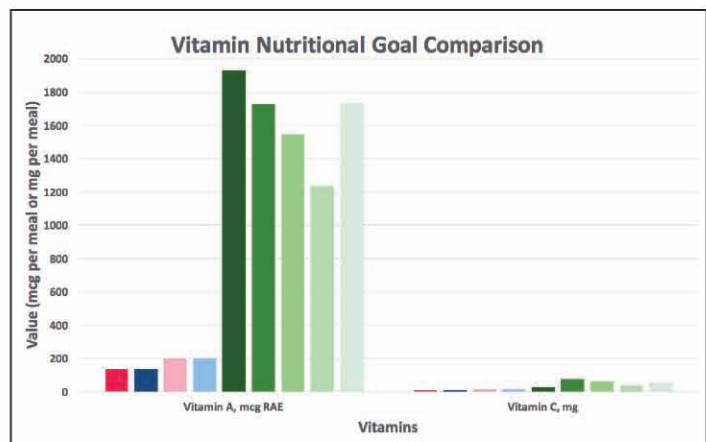


Figure 6. Vitamin goal comparison between USDA guidelines and YISD lunches (per meal).⁷

DISCUSSION

Interpretation

Firstly, YISD adheres to NSLSBP guidelines. However, the NSLSBP guidelines are not completely congruent with USDA guidelines for childhood nutrition requirements ages 4-13 years. The NSLSBP guidelines provide children with more calories,

Continued on page 20

Components of the Childhood Obesity Epidemic: An Analysis of School Lunch Nutrition in a U.S.-Mexico Border Town (Continued)

sodium, and saturated fats than recommended by the USDA. This discrepancy between USDA guidelines and what children are being served in schools, as mandated by the NSLSBP guidelines, may contribute to the rise in childhood obesity.

Limitations and future directions

Our study has several limitations that must be addressed. Firstly, we provide an analysis of the children's weekly nutrient intake assuming that each child eats all of his/her food. Food waste is a significant problem observed by the child nutrition specialists at YISD, especially with respect to fruits and vegetables. A food waste study would be of tremendous value to discern what children are consuming versus what they are served.

Not all children who attend each school participate in the NSLSBP. We purposely chose elementary schools that are considered economically disadvantaged to maximize the number of students who participate in the NSLSBP. However, the participation rates still remain below 100% for the past 3 months, with averages of 92.3% for Ascarate Elementary, 93.7% for Capistrano Elementary, and 90.7% for South Loop Elementary.

In addition, USDA guidelines were provided as daily requirements, whereas the YISD nutrient breakdown summary included data for lunch only. We addressed this by dividing the USDA nutrient guidelines by three, assuming each child consumes three meals per day.

Conclusion

Overall, our results demonstrate a discrepancy between NSLSBP guidelines and USDA guidelines for children, with the NSLSBP guidelines requiring more macronutrients in school lunches than recommended by the USDA. While the nutritional content of school lunches in YISD strongly adhered to the NSLSBP guidelines, the consumption of those lunches likely still contributes to childhood obesity because the NSLSBP-mandated intake exceeds that which is recommended.

We believe there needs to be discussion between the NSLSBP and USDA organizations to provide schools a united set of guidelines for school meals. We propose that the NSLSBP adopt the USDA nutritional guidelines, as they provide stricter regulation of most macronutrients and sodium in school lunches.

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ACKNOWLEDGEMENTS

We express our deepest gratitude to Alan R. Crawford and Flor Esnayra of Ysleta Independent School District, who took their own time to educate the authors on the National School Lunch Program Guidelines and the structure of Ysleta Independent School District's child nutrition services. We are also grateful to Dr. Ines Anchondo and Dr. Mark Francis for their guidance in nutrition and statistics, respectively.

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Diana V. Murillo



“ At times like this, we can't help remember how fragile life is.....

Diana Murillo was a loyal and dedicated employee of the El Paso County Medical Society for the past 21 years. During this time her job titles included Managing Editor of the El Paso Physician Magazine and Membership Coordinator. In her spare time, Diana enjoyed working out at the gym, being with family, and participating in cancer awareness races and events. She became a strong advocate for breast cancer even as she struggled with this condition herself.

On Saturday, June 24th, 2018, Diana's fight came to an end as she passed out of this life. Diana's outgoing personality and energy as well as her contagious smile will long be remembered in our hearts and in our minds.

Our condolences to family and friends. She will be dearly missed every day!”

MS

MEDICAL STUDENTS

E. P. C. M. S.

Providing Free Healthcare to the Indigent in Indian Himalayan

Joshua K. Dodderer, MS III

Across the globe, the iconic Himalayan mountain range is recognized for its breathtaking peaks and frigid winters; yet, beyond the magnificence of the environment, the region is sadly impoverished and lacking basic access to healthcare. Between the terrifying natural barriers and the treacherous transportation system, it is no surprise that in the isolated locations of the Himalayas, a trip to the nearest clinic or hospital would require days to weeks and over a hundred miles of travel. In June of 2017, between my MS1 and MS2 years, I had the privilege of participating in a three-week medical expedition to this famous region in Northern India with the objective to provide medical clinics throughout various villages in the State of Himachal Pradesh to alleviate this discrepancy and bring modern healthcare to the natives. It is certainly not an overstatement to say outside of these medical expeditions, the locals have minimal access to modern healthcare. Fortunately, organizations such as the one I traveled with answer this call to bring healthcare to the indigent in this region, and the opportunities for healthcare professionals and students to serve internationally are abundant.

The organization I traveled with is a for-profit medical expedition organization known as the "Himalayan Health Exchange." The expeditions in this region range in intensity and can include situations when hiking and driving through dangerous terrain is necessary in order to provide healthcare to certain villages. Landslides, ice bridges, and traveling over 1000 kilometers on some of the world's most elevated roadways, including the infamous Manali-Leh National Highway, are just a few of the hazards encountered over our expedition. Although the composition for each expedition's team ranges dependent on the region being served and the nature of the trip, for this specific expedition, our team consisted of attending physicians, a dentist, a pharmacist, and numerous medical students. This diverse team represented approximately nine different countries, multiple languages, and various cultural, socioeconomic, and religious backgrounds. Staying true to the name 'expedition', our team slept on the ground in sleeping bags and tents, enjoying luxuries such as bucket showers and

outhouses, as we trekked across roads blown into the sides of the towering peaks. At each of our clinics across the three weeks, we were able to provide a wide-range of health opportunities over 1000 patients, including free medical and dental services, health physicals, medicines, and counseling. Patients with acute conditions were provided adequate medications to alleviate the chief complaint, while those in chronic conditions were provided up to one month's worth of medicine, a directed treatment plan, and, if able, directions towards the nearest village or city with a pharmacy, clinic, or hospital for continued



treatment. Although management of certain conditions was limited, medicines offered to patients included ACE inhibitors, antibiotics, antifungals, antihistamines, diuretics, eye drops, insulin, and NSAIDs, many of which would be inaccessible to these patients otherwise, regardless of how basic of medicines they might seem. In addition to a number of different medications, over 200 pairs of sunglasses and eyeglasses were provided to patients suffering from various ocular conditions. As one might anticipate, the diagnoses and diseases were wide-ranging, from the rare and exotic diagnoses such as Becker's Muscular Dystrophy and Intestinal Parasites to the more well-known Congestive Heart Failure and Osteoarthritis.

Continued on page 23

Providing Free Healthcare to the Indigent in Indian Himalayan

Personally, this trip represented a special opportunity to gain valuable clinical experience in international medicine, logging over 80 clinic hours, auscultating my first “real” heart murmur, and rotating through each of our offered specialties – Internal Medicine, Pediatric, Ob/Gyn, Dental, Pharmacy, and Triage. Aside from clinics, the expedition also presented time to learn how to play cricket from the locals, learn basics in Wilderness and Survival Medicine, and lead an educational session on ‘Servant Leadership in Medicine.’

It is my personal belief that every student or professional who is interested in or wishes to participate in international medicine should partake in a medical expedition, humanitarian or mission trip. Personally, this expedition proved to be an excellent service-learning opportunity, as it allowed me to exercise knowledge acquired from my first two years of medicine and public health studies, while simultaneously improving the lives and conditions of patients in a remote area of the world suffering from inadequate healthcare.

serve in international medicine resounds deeply in the pursuit of my MD/MPH degrees, and this medical expedition reinforced my desire to use my education to provide healthcare to impoverished populations worldwide. We live in a beautiful, breathtaking world with people in all corners of the Earth waiting for individuals like us who will serve, bring hope, and, perhaps, even play cricket with them.



“I don’t know what your destiny will be, but one thing I know: the only ones among you who will be really happy are those who will have sought and found how to serve.”

Dr. Albert Schweitzer, Nobel Peace Prize Awarded Physician

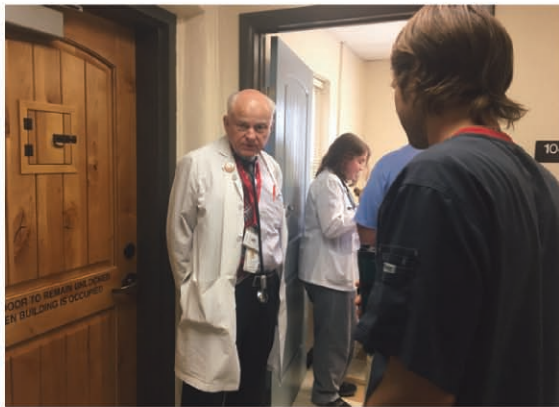


Joshua K. Dodderer, MD/MPH Candidate, MS III,

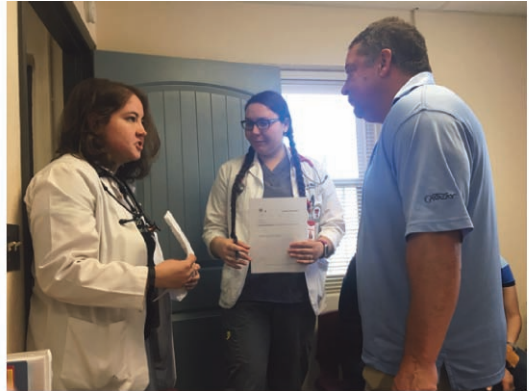
Continued on page 24

PLFSOM medical students and UTEP students work together to help run the lab at the RotaCare Clinic.

RotaCare is a clinic that is free to the public and does not require patients to have an I.D. RotaCare provides health care to those who cannot afford it. The clinic is open on Saturdays from 8am to 12pm.



Dr. McCallum spends his free Saturday mornings seeing patients at the RotaCare. He is what millennials would refer to as "Doctor Goals."



Medical Students Eryn and Amanda presenting a clinical case to Dr. Mansfield. Students along with physicians volunteer their Saturday mornings in order to provide health care to medically underserved communities in El Paso.



First year medical students at the monthly EPCMS board meetings along with PLFSOM Associate Academic Dean for Admissions Dr. Schydlower. (Left to right: Sandrine Defu, Abbas Zaidi, Kristopher Van Huss, Tayana Rodriguez, Amy Arrieta)

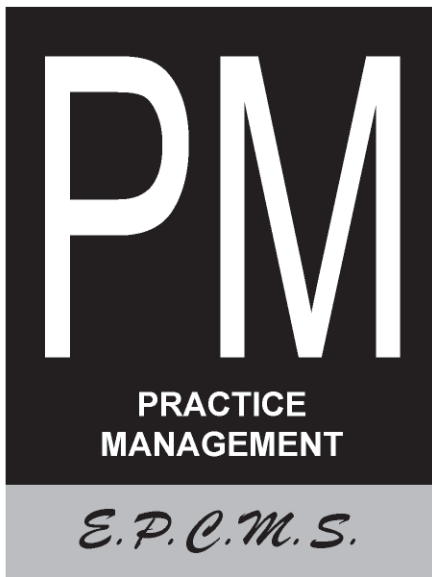
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Benefits of Health Information Exchange

Veronica Patton

Unreliable and inefficient health information sharing can make caring for patients even more difficult. Waiting for faxes and calls can be frustrating and takes valuable time away from patient care. When physicians do not have the right information when they need it, care coordination is difficult, lab tests are unnecessarily repeated, and patients are left struggling to remember their care history when they go to the emergency department.

Health Information Exchanges (HIEs) address this problem by centralizing health information from across different hospitals and providers to create an electronic community health record for each patient. This community health record enables physicians to see the full picture of a patient's health from across the community in one place.

When physicians, nurses, and other providers have secure electronic access to this essential medical information, there is significant potential to improve the efficiency, quality, and safety of patient care. For example, a physician in El Paso was recently caring for a patient who they believed may have had a stroke. Before they performed any imaging and lab studies to evaluate the patient, they searched for the patient's community health record in El Paso's HIE. They found that an MRI and labs had been performed a few days earlier by a physician in the hospital. They were able to utilize these imaging and lab results in the patient's care. As a result, the provider could provide more targeted care faster and the patient avoided additional costs from repeated imaging and lab studies.

Our region's HIE is called PHIX. We are a non-profit that has already connected many health care providers in the region, including The Hospitals of Providence, University Medical Center of El Paso, El Paso Children's Hospital, and the Veteran's Administration. Since our region has a

large veteran population, we are proud that our partnership with the Veteran's Administration is helping to connect VA and community providers to improve veterans' care.

PHIX is also partnering with the Department of Defense, Emergence Health Network, Texas Tech University Health Sciences Center El Paso, The City of El Paso Department of Public Health, Project Vida, Centro San Vicente, El Paso Health, the El Paso County Medical Society, and the Paso del Norte Health Foundation.

El Paso has a strong network of independent physicians, and we are building our technical team to connect these physicians to the HIE. I am leading the effort to expand our local technical resources so that we can work closely with physicians to grow the HIE in our region together.

Veronica Patton, Manager of Physician Engagement, PHIX



WIC: The Underused Tool in a Physician's Toolkit

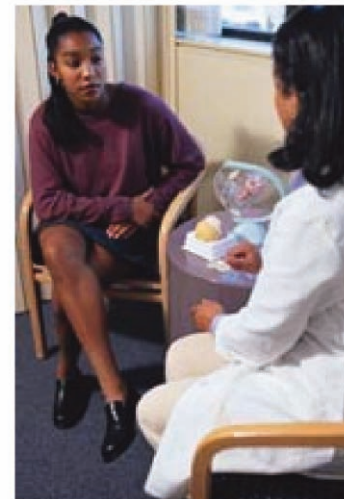
Vanessa St Pierre, RDN, LD, IBCLC

"I am so grateful to WIC for providing my son Oscar with the special formula he needed for being a premature infant. I would not have been able to provide him the formula the doctor recommended without the help of WIC." ---Alicia Martinez. Alicia is just one of many families we help support at WIC while working with physicians to help improve health outcomes for infants and children in the El Paso area.

As one of El Paso's premier public health nutrition programs, WIC currently reaches approximately 33,000 pregnant women, infants and children in El Paso and Hudspeth counties. WIC's goal is to work side-by-side with healthcare providers countywide in attempt to make certain that our most vulnerable families have the opportunity to build the foundations of lifelong health.

At WIC, we know that keeping your patients healthy requires more than regular doctors' visits. So, when you refer income-eligible women who are pregnant, postpartum, or children under the age of five, you're helping to ensure they have wholesome food, access to breastfeeding and nutrition education/counseling, and community support to keep their families healthy between doctor visits.

Some Ways WIC Can Help Your Practice:



- **WIC measures length, height, and weight every six months, and screens for anemia and will inform you if we observe questionable results**
- **WIC offices have qualified nutritionists, registered dietitians, and lactation consultants to meet your patients' needs upon referral**
- **WIC provides healthy foods, infant formulas, and specialized nutritional supplements in an attempt to meet as many nutritional needs as possible for your patients**

The foods provided by WIC are those supplying nutrients commonly inadequate in the diets of lower income people surveyed in the United States. The food prescription is based on individual needs; therefore, the foods and the nutrients supplied vary depending on category, age and medical condition. WIC further attempts to assist individuals requiring special supplemental nutrition supplements, such as therapeutic formulas, with the submission of a formula request form.

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**WIC: The Underused Tool in a Physician's Toolkit
(Continued)**

• WIC provides individual counseling as needed

Individuals who have medical conditions that impact their nutritional status are counseled by a Registered Dietitian. Some of the conditions include gestational diabetes, low birth weight infants, inadequate growth patterns during infancy and early childhood, obesity, and more. You may let your patients know they can request a dietitian visit at WIC if they require nutrition assessment and intervention beyond what is feasible in your office visit.

• WIC is dedicated to providing breastfeeding support

The WIC Program is committed to helping women understand the benefits of breastfeeding to both mother and infant. Every pregnant and postpartum woman sees a breastfeeding peer counselor to help provide support in her breastfeeding journey. An International Board Lactation Consultant (IBCLC) is available for any woman who requests or requires extra support beyond our peer counselors. We provide a variety of breastfeeding supplies and pumps to assist your patients. We encourage you to refer to WIC if your patient or parent is struggling with breastfeeding.



• WIC provides regular nutrition education

Group education sessions are offered on nutrition concerns common to our WIC population. Recent local topics offered include: Ellyn Satter's dividing your feeding responsibilities with your child, teaching your child to be a good eater, how to handle a picky eater, feeding so your baby can eat well, and making meal times matter. As you can see, the lasting effects of nutrition education help families years after their program participation ends. Ask patients what they last learned about

at WIC if they are having nutrition concerns. You may also refer them to us and we are happy to answer any nutrition question.

• WIC staff connects families to health and social services in the local community

WIC staff refer families to programs that provide services WIC families need. These programs include a variety of social service programs available in the community such as food pantries, early childhood intervention, nurse family partnership, or even fatherhood or grandparent support services.

Please consider WIC as your resource for providing nutritious foods, nutrition education, individualized nutrition counseling, breastfeeding support, or community referrals the next time you have a patient that may benefit from our services.

For further questions about partnering with WIC, please call (915) 212-6566. Or further information is also available at www.TexasWIC.org by clicking on Health Partners Patients can reach us at (915) 212-4WIC4942 to schedule an appointment.

Vanessa St Pierre, RDN, LD, IBCLC
Nutrician Service Manager
City of El Paso - Department of Public Health

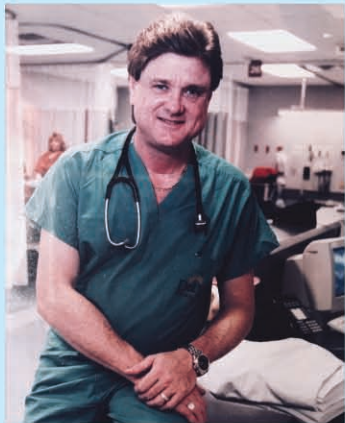
In Memoriam



Dr. Richard Jay Harris passed away on Friday, April 6th, 2018, at the age of 87. He was a life-long resident of El Paso, Texas, graduating from Dudley Elementary School and El Paso High School. Dr. Harris was the first member of his family to graduate from college, Vanderbilt University in 1951, where he met his future wife, Toni Davidson. He obtained his medical degree from University of Texas, Galveston Medical Branch in 1955.

Dr. Harris was commissioned as Captain in the United States Army where he completed his surgical residency. He served as Commander Officer of the 225th Station Hospital in Muenchweiler, Germany, retiring from the military with the rank of Major. Among his many accomplishments in the military was serving as a surgeon on the recovery team, Project Mercury, NASA.

Upon retirement from the military, he returned to El Paso, Texas, to continue his medical career. Dr. Harris was the most respected general surgeon in the city, with a caring and compassionate bedside manner. He practiced with Gary Schabacker, M.D. for over twenty-two years. Dr. Harris was Chief of the Department of Surgery at both Thomason and Providence Hospitals and was the founding Chief of Staff at Sierra Medical Center. He retired from his active practice of surgery in 1994.



Dr. Kenyon Robbins Behrens, of El Paso passed away on March 29, 2018. He was born on March 16, 1955 in El Paso, Texas to Ernest Behrens and Vivian Webb. Kenyon graduated from Eagle Pass High School in 1972. He was an Eagle Scout and enlisted into the Navy, where he stationed in Key West, Florida. Returning to El Paso, he enrolled into the University of Texas at El Paso, and became a member of the SAE Fraternity.

He later graduated from the Texas College of Osteopathic Medicine in Fort Worth. After interning at Stevens Park Hospital in Dallas, Kenyon completed his residency in Anesthesia and Family Practice at Valley Community Hospital.

He became chief of family practice and Doctor of the Year in 2001 at Del Sol Medical Center, and was one of the proud owners and doctors of Valley Medical Clinic. Additionally, he was the Medical Director for the El Paso County Jail Annex and Detention Facility, and had been practicing for 34 years.



Dr. Lynn W. Neill Joined the Larger Life on April 20, 2018 – Trusting in the most Sacred Heart of Jesus. Known affectionately to family and friends as “Possum” or “Dr. Possum”, he will be deeply missed by all whose lives he touched.

Born in Winters, Texas, July 11th, 1932 to Henry Paul Neill and Mozelle Wilson Neill, he lived throughout West Texas with his sisters Mary Cochran Schlottman and Margie Forrest. He graduated from Ballinger High School in 1949 and was known for his loving, gracious, and humble nature.

With support from his mentor, Dr. Charles Bailey, Sr. (wife Catherine), he attended Texas Christian University with Dr. Charles Bailey, Jr. – a lifelong friend – from 1949-1953, graduating Cum Laude with a Bachelor of Arts in Biology. He completed medical school at the University of Texas Medical Branch at Galveston in 1957 where he was President of Alpha Kappa Kappa fraternity and a member of Mu Delta, an Honorary Medical Service Society. Dr. Neill served in the U.S. Air Force, beginning with an internship at William Beaumont Army Medical Hospital in El Paso, Texas, before serving as an Aviation Medical Examiner and Flight Surgeon in Savannah, Georgia. Dr. Neill completed his anesthesiology residency at Parkland Memorial Hospital in Dallas, Texas, and was certified by the American Board of Anesthesiology in 1964. Dr. Neill was also recognized as a Fellow of the American College of Anesthesiologists in 1965.

Dr. Neill entered private practice in El Paso, Texas, where he was a co-founder of Anesthesia Consultants Associated and helped establish the Surgical Center of El Paso. Dr. Neill developed an interest in pain management and became a founding member of the Texas Pain Society in 1989. He was certified by the American Board of Pain Medicine from 1996 to 2006. He held memberships in: American Medical Association, Texas Society of Anesthesiologists, El Paso and Bexar County Medical Societies, and the Texas Medical Association. Dr. Neill worked and lived in El Paso until 2007. Upon retiring to San Antonio, Texas, he continued to work part-time at Theda Oaks Surgical Center.

He was a member of The Church of St. Clement of El Paso where he served in a variety of roles, most notably as Acolyte Master for several generations of church youth. He volunteered as a team physician for El Paso High School athletics, offering physicals and sideline support for their football team.



Dr. James Roy “Jim” Anderson, passed away into the loving arms of his Lord and Savior Jesus Christ on April 6, 2018. He was born in Grapeland, Texas on September 11, 1936. After attending Sam Houston State Teachers College, he went to the University of Texas Medical Branch at Galveston and earned his Doctor of Medicine in 1964. He joined the Army and completed his Internship at William Beaumont Army Medical Center and Residency at Brook Army Medical Center. Jim served as an anesthesiologist in Vietnam and returned to El Paso where he practiced medicine for over 25 years.

Jim adored his wife, Jan; they were inseparable. He modeled Christian values and a strong work ethic. He loved being “Papa” and teaching his grandchildren life lessons.

Jim loved airplanes and enjoyed flying as a private pilot. He flew a Piper Cherokee Six and a Beechcraft Bonanza. His other hobbies included reading, metal detecting, history, and target shooting. He spent many weekends at the gun range teaching his grandchildren gun safety or target shooting.



Texas Doctors Ready to Help Care for Migrant Children

Just as they did several years ago, Texas physicians stand ready to volunteer their help as the federal government addresses an influx of thousands of migrant children and their families at the United States-Mexico border.

The state has no current role in the medical efforts at the border, and the children's medical care at the border facilities "is all coming from the Feds," Lara Anton, press officer for the Texas Department of State Health Services, told Texas Medicine on Thursday.

"They haven't asked for assistance," she said. "We can provide a vaccine if needed, and we would expect any infectious diseases to be reported to us. But that's where we are right now."

Border authorities had been enforcing the Trump administration's "zero-tolerance" policy on illegal crossings, leading to reports of thousands of children being separated from their family members. On Wednesday, President Donald Trump signed an executive order to end those separations.

"Texas physicians, whether volunteers or government employees, have tended to the medical needs of children crossing our border for years. Our commitment to them is steadfast and everlasting," said TMA President Douglas Curran, MD (above). "We commend the president's executive order to 'maintain family unity,' but we urge that the children's pressing medical concerns also be addressed. Research has documented that adverse childhood events — such as violence experienced in their home countries, the long and dangerous travel to America, and unexpected separation from their families — when left untreated, lead to a lifetime of serious health problems."

The numbers and types of practitioners the federal govern-

ment and its contractors are deploying at the facilities are not clear.

The U.S. Department of Health and Human Services (HHS) and the Office of Refugee Resettlement, which operates under

HHS, did not respond to interview requests for this story. Carlos Diaz, southwest branch chief for U.S. Customs and Border Protection, responded to an interview request by referring Texas Medicine to HHS.

Back in 2013 and 2014, Texas physicians volunteered their time to tend to the medical needs of thousands of undocumented immigrants, most of whom came from Guatemala, El Salvador, and Honduras.

El Paso pediatrician Carlos Gutierrez, MD, says the pediatric community is on standby to help out at the nearby detention facility in Tornillo. And local medical organizations are agreeing to care for children who need it, Dr. Gutierrez says.

Juan Perez, MD, President of the El Paso County Medical Society (EPCMS), says the Border Regional Advisory Council (BorderRAC) is responsible for organizing medical responders for natural disasters or other events. BorderRAC then approaches EPCMS for help.

"We reached out to the RAC, and ... HHS told [the RAC] that at this point there was nothing to be done," Dr. Perez said. "So our efforts mainly are to get our providers ready and get numbers in order to get people out there once they need us."

Joey Berlin, Texas Medicine Today

Continued on page 31

Congratulations to Elenor Poe for receiving the Lucy G. Acosta Humanitarian Award. Received at Project Amistad Gala held on April 27, 2018.



Texas Medicine Investigation Exposes Threats to Texas Ban on Corporate Practice of Medicine

An Austin physician group, one of the city’s largest hospital systems, and an outside hiring firm are engaged in a tug of war that pits corporate finances against the physicians’ view of what’s best for their patients, a three-month investigation by Texas Medicine magazine found. “It wasn’t like this previously. Our daily duties were previously focused on taking care of our patients,” Ellis Doan, MD, the physician group’s chief medical officer, told Texas Medicine. “Now, we’re constantly pressured to discharge patients faster and earlier in the day, tracked with discharge time goals created arbitrarily by non-clinical hospital administrators, and pushed to quickly issue admission orders under time goals — oftentimes prior to seeing the patients — to meet a time metric. It has nothing to do with patient care at all.” The Texas Medicine story, “Corporate Encroachment,” will be published in the July 2018 edition of the magazine. A special republication version has been released today online.

The Austin struggle is similar to complaints physicians have shared with the Texas Medical Association (TMA) that demonstrate a growing disregard for Texas’ legal ban on what is known as the “corporate practice of medicine.” That law is intended to keep lay people and organizations from interfering in a physician’s medical judgment, especially for financial reasons. “Physicians have the highest duty, a fiduciary duty under Texas law, to put each patient’s needs first,” said TMA Vice President and General Counsel Donald P. “Rocky” Wilcox. “We continue to work on this issue, and more needs to be done to ensure that non-physicians are not able to unduly influence how medicine is practiced.”

The arrangement between the three Austin parties — now clouded even more by a lawsuit the physician group filed May 31 — was

was supposed to work like this. Hospital Internists of Texas, or HIT) would supply the internists for five of the six hospitals in the St. David’s HealthCare chain, which is majority-owned by HCA Healthcare. With about 85 physicians and 35 nurse practitioners, HIT would work through TeamHealth, one of the nation’s biggest medical staffing companies. TeamHealth, owned by Blackstone Group, would recruit the emergency physicians for the hospital chain.

Instead of leaving patient care to the physicians, HIT doctors told Texas Medicine reporter Sean Price, TeamHealth’s demands to cut costs and raise revenue gradually became more frequent and less reasonable. They say the company encouraged the hospitalists to speed up discharge times to clear out beds for new patients, and it promoted transfers from other hospitals, even when those transfers were not medically necessary.

“Over the past three years, we’ve been having increasing encroachment from TeamHealth on our decision-making and increasingly we’re being asked to do things that are unsafe or against the patients’ best interest,” said Dieter Martin, MD, HIT past president.

Since 1956, Texas has had some of the strictest corporate practice prohibitions in the country that, among other things, bar non-physicians from employing physicians. Mr. Price’s story reveals a potential pattern in which the state has failed to enforce that law amid a changing business environment. TMA will push during the 2019 session of the Texas Legislature to give physicians — especially those hired by a nonprofit health corporation — more recourse.

The TMA House of Delegates in May directed TMA to develop legislation that stops nonprofit health corporations from retaliating against employees who file complaints or reports of suspected violations of state or federal law. The house also told TMA to ask lawmakers to give the Texas Medical Board (TMB) authority to accept, process, and dispose of complaints against licensed nonprofit health corporations, which are currently certified by TMB.

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