The El Paso Physician

Volume 41 Number 4

BorderRAC - Award Winning Regional Collaboration

Official publication of the El Paso County Medical Society and District I of the Texas Medical Association

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EPCMS Mission:
"to advance the art and science of medicine, protect the physician and serve the patient"

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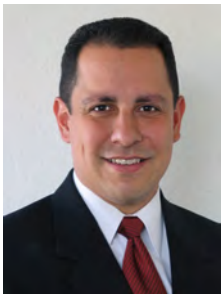
PRESIDENT COMMENT

E.P.C.M.S.

President's Comment

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



As 2018 comes to an end, we are looking forward to keep the momentum going for the El Paso County Medical Society growth and to serve and represent the El Paso community.

The El Paso Physician television program aired 21 programs this year and has been greatly accepted by the viewing audience. We are planning for more growth with community partners and continue to grow our viewing audience. We are the only Medical Society in the nation promoting health education via this type of media and we are proud of it. Dr. Raj Marwah has been instrumental in the success of the show.

The Texas Medical Association Border Health Caucus descended to Washington in October. They met with the VA, Office of Global Health, CMS and HRSA. As a result, HRSA will begin to track programs on the Border so as to effectively assist in their roles with the community and academic physicians. Dr. Manuel De La Rosa and Dr. Gilbert Handal were in attendance representing our border community of El Paso.

The Installation of the new EPCMS President will be held on Feb.6, 2019 at the Double Tree Hotel. Dr. Roxanne Tyroch will take over the leadership role for our society. We are looking for a great turn out from our members in order to support Dr. Tyroch's presidency and the EPCMS agenda.

I would like to thank all the people that have worked tirelessly to improve the EPCMS, the community that has supported our efforts, the EPCMS members and the great people that make this society function. We have a society that any physician should be proud to be a part of.

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

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EC

EDITORIAL COMMENT

E.P.C.M.S.

Editorial Comment

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

We shape our buildings; thereafter they shape us.
--Winston Churchill

The Turner House in which the El Paso County Medical Society has been housed since 1946 is an old building in need of upkeep and repair. However, it is also a historical building and is on the list of El Paso historical houses. Many of those who have walked through it or come to meetings or those who passed by it on the street do not know its full story. Both the house itself, designed by Henry Trost, and the original owner, Dr. S. T. Turner, have played important roles in the cultural and medical history of the city of El Paso. Please read the discussion about the history and importance of the Turner Home. It is in the best interests of the Medical Society to continue to maintain this building.

Additionally, in this issue of the magazine we have the second part to our debate about medical marijuana. In the last issue, we had a discussion about the positive sides of legalizing medical marijuana. In this month's issue, we discuss the opposing view. Despite the positive effects that marijuana seems to have on certain medical conditions, there are problems that may arise if it is readily and legally available. Two recent studies have found that recreational use of marijuana has increased in states that have legalized medical marijuana.[1] These studies, done by the RAND corporation and Emory University, show a correlation only, but are concerning given some of the dangers our society currently struggles with regarding legalized alcohol. Please read more in the discussion of the downsides to legalizing medical marijuana.

Every one of us has dealt with a difficult patient in the past. Sometimes it is an issue with the personality of the patient or family member. Sometimes they are just having a bad day. Sometimes it is a misunderstanding. In any case, how we go about dealing with a "difficult" patient/family can go a long way to improving doctor-patient relationships and may also keep us out of court. Read about options on how to avoid these situations in this month's issue.

Lastly, please have a safe and happy holiday season. See you in 2019!

https://www.vox.com/identities/2018/8/20/17938388/marijuana-legalization-more-use

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

DEBATE

E.P.C.M.S.

Medical Marijuana: Six Thousand years of Therapeutic use

Perspective in opposition to Medical Cannabis

James R. Skidmore, MS1
Dale Quest, Ph.D.

What is medical cannabis?
Cannabis is used for recreational and medicinal purposes. Medicinal use is when cannabis is used in anticipation of relieving symptoms, correcting illness and restoring health. The medicinal use of the cannabis plant, its parts and derivatives dates back millennia, and continues into present day. [1,2] The dried buds and leaves are smoked, vaporized extracts are inhaled, prepared as edibles, capsules, lozenges, patches, sprays, rectal suppositories, vaginal tampon/suppositories, and other formats. Any form of cannabis could be considered medical cannabis when physicians recommend a cannabis product for their patients' medicinal use. It is merely that context that distinguishes medical cannabis from cannabis products used for self-medication or recreation.

None of those forms of cannabis have been approved by the United States Food and Drug Administration (FDA) for any therapeutic indication. The FDA has approved three cannabinoid drugs that can be legally prescribed: dronabinol [Marinol®, Syndros®] was approved in 1985 as a Schedule III drug. Nabilone [Cesamet®] was approved in 1985, then cannabidiol [Epidiolex®] in June 2018, and both can be prescribed according to Schedule II of the Controlled Substances Act.

What distinguishes cannabinoid drugs from the natural plant and cannabis-derived crude medicinals is the concept that a **"drug"** contains a known quantity of an identified pure biologically active substance. Therefore, for example, morphine 10 mg as either a sulfate tablet or hydrochloride solution is a drug; whereas opium (the dried latex of the poppy seed capsule, which contains an inconsistent mix of more than 20 distinct alkaloids, including morphine, codeine, papaverine, thebaine, and noscapine, may be considered a 'crude medicinal', not a drug. Likewise, the cannabis plant contains over 80 cannabinoids in addition to many more non-cannabinoid compounds, all in amounts and proportions varying with the plants' genetics and growing conditions. [3,4] Δ9-tetrahydocannabinol (THC) is the psychoactive component of cannabis is regulated and quantified in the aforementioned FDA approved drugs. Cannabidiol is a non-psychoactive component of interest for its purported anti-inflammatory and analgesic activity. There are two principal cannabinoid receptors: CB_1 are expressed in the central and enteric nervous system, and CB_2 receptors are expressed and function in the immune system.

The legal status of cannabis in El Paso, Texas
Cannabis was removed from the U.S. Pharmacopeia in 1941 and was subsequently banned for any use in 1970 by the Controlled Substances Act. Cannabis remains illegal at the federal level as a Schedule I substance defined in 21 USC 812(b) as, "having no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse". A petition in 2001 to reschedule marijuana to Schedules II…IV was denied. Several states have legalized cannabis for medical purposes, beginning with California in 1996. Meanwhile, the Rohrabacher-Farr amendment of 2014 prohibits the Department of Justice from prosecuting those acting in accordance with laws governing cannabis at the state level. [5]

In 2003, the U.S. Supreme Court ruled that physicians have a First Amendment right to recommend medical cannabis to patients, as long as they don't actually provide marijuana. No physician in the U.S., not even in the 31 states that have legalized medical marijuana, can prescribe marijuana, because prescription is a federally-regulated process and cannabis currently falls under Schedule I of the Controlled Substances Act.

Texas is currently one of 13 states where marijuana is illegal for medical and recreational use, with exception that on June 1, 2015, Governor Greg Abbott signed Senate Bill 339 allowing limited medical use of cannabidiol to control seizures in patients with Dravet syndrome or Lennox-Gastaut syndrome. At that time, Governor Abbott stated, "I remain convinced that Texas should not legalize marijuana, nor should Texas open the door for conventional marijuana to be used for medicinal purposes. As governor, I will not allow it; SB 339 does not open the door to marijuana in Texas."

As a federal agency operating within Texas, U.S. Department of Veterans Affairs physicians can neither prescribe nor recommend, but may discuss medical marijuana use with any veteran requesting information about marijuana, in accordance with internal policy (VHA Directive 1315, 08 December 2017), but, "To comply with federal laws such as the Controlled Substances Act, Title 21 United States Code (U.S.C.) 801 et al., VHA providers are prohibited from completing forms or registering veterans for participation in a state-approved marijuana program." The current directive remains in effect, subject to review in December 2022.

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Medical Marijuana: Six Thousand years of Therapeutic use

(Continued)

As for our neighbors, in Mexico, medical cannabis of limited potency was legalized in 2017, but has remained otherwise illegal since 1920. Governor Bill Richardson signed Senate Bill 523 in April 2007 to legalize medical marijuana in New Mexico. Arizona legalized medical marijuana with Proposition 203 in November 2010. Recreational cannabis became legal across Canada on October 6th, 2018.

Legal bottom line for El Paso physicians:
Physicians in Texas can legally prescribe three FDA-approved cannabinoid drugs, dronabinol [Marinol®/Syndos®], nabilone [Cesamet®], and cannabidiol [Epidiolex®]. No physician anywhere in the United States of America can otherwise legally prescribe cannabis in any form for any medical purpose, but the U.S. Supreme Court has ruled that physicians have a First Amendment right to recommend medical cannabis to patients. Patient use of medical cannabis is illegal in Texas. Veterans Health Agency policy allows its physicians to provide information about medical cannabis, but prohibits recommending medical cannabis to veterans.

Weighing against medical cannabis
Medicinal properties of the cannabis plant have been extolled for millennia, and cannabis is still being advocated for an extensive list of clinical conditions: fibromyalgia, diabetic neuropathic pain, post-herpetic neuralgia, symptoms of multiple sclerosis, opioid-sparing reduction of acute pain, migraine, nausea & vomiting, glaucoma, menstrual cramps, neuropsychiatric problems including treatment of substance abuse and posttraumatic stress disorder, epilepsy, benefits in rheumatic diseases, Crohn's disease, a component of treatment for types of cancers and more. [6-17] Efficacy and safety are principal attributes of any therapeutic intervention. For all the purported therapeutic potential of marijuana (cannabis), current evidence of efficacy and safety is less compelling for any indication than many realize. [18-20] Virtually every recent systematic review concludes that evidence is insufficient to draw conclusions about the therapeutic benefits and harms of cannabis, but future studies may provide evidence sufficient to justify practice recommendations. [7,8,17,21-23] Testimonials do not constitute evidence, and "the plural of anecdote is not data". [24] Double-blind controlled trials provide reliable, but not necessarily generalizable evidence. Bias is pervasive, even in published clinical trials. [25] It will take several well-designed and adequately powered trials to provide compelling evidence of efficacy and safety of various cannabis products to treat particular conditions in different patient populations. That evidence is not being generated at a pace consistent with hopes and prospects that cannabis and cannabis derivatives might safely provide some patients with real benefit for conditions that cannot be managed as well or better with proven conventional therapeutic options. Legitimate researchers must comply with federal laws and regulations governing access, containment and accountability for supplies of cannabis, thus access to cannabis for research is more restricted than access for other use by the vast majority of American citizens, and that remains an impediment to evidence-generating translational and clinical research on therapeutic potential of cannabis and derivatives of cannabis.

Double-blind randomized placebo-controlled trials have provided reliable evidence that cannabidiol is more efficacious than placebo in reducing frequency of seizures among patients with Dravet syndrome. [26] Texas Senate Bill 339 effective June 2015 permitting sourcing non-FDA-approved cannabidiol, became unnecessary in June 2018 with FDA approval of cannabidiol [Epidiolex®] for seizures associated with Dravet syndrome or Lennox-Gastaut syndrome, and unless Senate Bill 339 is repealed, that Bill leaves legal access open to continued sourcing of non-prescription cannabidiol formulations of less certain quality while quality-regulated FDA-approved treatment options are available by prescription. Quality is a legitimate concern. A study published in The Journal of Toxicological Sciences found that over 80 per cent of samples obtained from the California medical cannabis market were contaminated with pesticides, molds, fungi, and residual solvents . Cannabidiol formulations contained quantities of Δ9-tetrahydrocannabinol that would be illegal in Texas. [27] Meanwhile, there is no rational scientific explanation for how cannabidiol specifically addresses the inhibitory interneuron pathophysiology associated with the SCN1A loss of function mutation, the basis of Dravet syndrome. [24,26] In terms of efficacy, the seizure-free response rate was only five per cent above placebo, and cannabidiol evoked vomiting, anorexia and diarrhea in 25% of patients treated. [26] Evidence of efficacy for other severe treatment-refractory forms of pediatric epilepsy remains less compelling. [28]
Cannabis use is not without potential harms. [29] Recent large epidemiological studies in Sweden and the USA similarly concluded that heavy cannabis use predicts shorter life. [30,31] Although most studies suggest that smoking marijuana is less detrimental than smoking tobacco, it is associated with cough, sputum production and wheezing. [32] Memory impairment is acknowledged anecdotally and by research. [33] Bill Mahr quipped, "Colorado has re-legalized cannabis. Questioned about the reason for re-legalizing pot, a spokesperson explained, *Dude, 'cuz we totally forgot that we already did!"*. Cannabis can produce tachyphylaxis and withdrawal. The majority of patients in cannabis treatment studies report clinically distressing withdrawal symptoms which motivate continued use and relapse. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnostic criteria for cannabis use disorder include use resulting in failure to fulfil major role obligations, repeated use in hazardous situations, continued use despite social/interpersonal problems, cravings, tolerance, withdrawal, use for longer periods or in larger amounts than intended, persistent desire or unsuccessful attempts to control use, and continued use despite physical or psychological problems. As with many drugs, there are genetically-determined differences in how individuals metabolize component compounds of cannabis, and single nucleotide polymorphism in the CNR1 gene may confer predisposition to cannabis addiction. [34] Although cannabis products are used to manage nausea and vomiting, heavy use can lead to severe vomiting and thermodysregulation, termed cannabis hyperemesis syndrome, which purportedly results when gastroparesis and pro-emetic cannabis type 1 receptors in the gut override central nervous system antiemetic activity. [35]

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(Continued)

There are risks and costs for society in terms of cannabis-related emergency room visits, extensive burn injuries associated with cannabinoid extraction using butane, injuries and insurance consequences of impaired driving, motivating deployment of roadside saliva screening e.g., Drager DrugTest 5000 (Sacramento,CA) or Hound Labs (Oakland, CA) 'pot breathalyzer' by some police departments such as California Highway Patrol. Seven states including Washington and Montana have set legal guidelines on THC to curtail dangerous driving. Research by the Center for Injury Epidemiology and Prevention at Columbia University showed that half of young drivers, age 16 to 25, who died in car crashes were under the influence of alcohol, marijuana or both. [36]

A concerning unanticipated health system consequence of medical cannabis liberalization has been the impact on children. Children's Hospital of Colorado has reported increasing numbers of emergency room visits for ingestion of adult supplies by children. [37] According to US government data, about 1 in 20 women report using marijuana during pregnancy. A recent American Academy of Pediatrics clinical guidance report cited studies estimating marijuana use by pregnant young urban socioeconomically disadvantaged women may range up to 28%, and that women turn to marijuana to manage pregnancy-associated cramps, nausea and vomiting. [38] A recent study of breastfeeding women reporting marijuana use has shown that the psychoactive Δ9-tetrahydocannabinol component was measurable for up to six days after marijuana use in a majority of breast milk samples. [39,40] The American College of Obstetricians and Gynecologist commented in its Committee Opinion in 2017, that because marijuana is neither regulated nor evaluated by the U.S. Food and Drug Administration, there are no approved indications, contraindications, safety precautions, or recommendations regarding its use during pregnancy and lactation, and none of the states with legal medicinal marijuana list pregnancy as a contradiction for recommending or dispensing medicinal marijuana. [41] Research published this year in *Obstetrics & Gynecology* concluded that nearly 70% of Colorado cannabis dispensaries surveyed recommended cannabis products to treat nausea in the first trimester, and few encouraged discussion with a health care provider. [42] There is credible evidence that prenatal exposure is associated with developmental delay in social and fine motor domains. [43]

Conclusion

Based on the current body of evidence on efficacy and safety of cannabis and cannabis derivatives, it is reasonable to predict that future research will establish cannabis as neither a wonder drug nor a killer drug. Future research will more likely confirm that cannabis products will safely provide some patients with real benefit for a few conditions that cannot otherwise be managed as well or better with proven conventional therapeutic options. We're still waiting for such compelling evidence. Physicians practicing in jurisdictions where dispensaries require a physician's recommendation for medical cannabis face doctor-patient relationship problems in refusing to recommend medical cannabis under pressure from patients. [44-46] For the time being, there is insufficient basis in evidence to mobilize physician advocacy for liberalization of Texas policy on cannabis. The legal status of cannabis in Texas puts physicians on a solid footing to conservatively refrain from advising patients to engage in an illegal activity.

References

1. Hi HL. An archaeological and historical account of cannabis in China. Econ Bot 1974;28:437-48.
2. Aggarwal SK, CArter GT, Sullivan MD, ZumBrunnen C, Morrill R, Mayer JD. Medicinal use of cannabis in the United States: historical perspectives, current trends, and future directions. J Opioid Manag 2009;5:153-68.
3. Mackie K. Cannabinoid receptors: Where they are and what they do. Journal of Neuroendocrinology 2008;20:10-4.
4. Pertwee RG. The pharmacology of cannabinoid receptors and their ligands: an overview. Int J Obes (Lond) 2006;30 Suppl 1:S13-8.
5. Haffajee RL, MacCoun RJ, Mello MM. Behind Schedule - Reconciling Federal and State Marijuana Policy. N Engl J Med 2018;379:501-4.
6. Anbar TS, El-Badry MM, McGrath JA, Abdel-Azim ES. Most individuals with either segmental or non-segmental vitiligo display evidence of bilateral cochlear dysfunction. Br J Dermatol 2015;172:406-11.
7. O'Neil ME, Nugent SM, Morasco BJ, et al. Benefits and Harms of Plant-Based Cannabis for Posttraumatic Stress Disorder: A Systematic Review. Ann Intern Med 2017;167:332-40.
8. (CADTH) CAfDaTiH. Medical marijuana for post-traumatic stress disorder: a review. CADTH IN BRIEF: a summary of evidence 2018.
9. Alviar JM, Hale T, Lim-Dungca M. Pharmacologic interventions for treating phantom limb pain. Cochrane Database of Systematic Reviews 2018;7.
10. Mucke M, Phillips T, Radbruch L, Petzke F, Hauser W. Cannabis-based medicines for chronic neuropathic pain in adults. Cochrane Database Syst Rev 2018;3:CD012182.
11. Amato L, Minozzi S, Mitrova Z, et al. [Systematic review of safeness and therapeutic efficacy of cannabis in patients with multiple sclerosis, neuropathic pain, and in oncological patients treated with chemotherapy]. Epidemiol Prev 2017;41:279-93.
12. Bowles DW, O'Bryant CL, Camidge DR, Jimeno A. The intersection between cannabis and cancer in the United States. Crit Rev Oncol Hematol 2012;83:1-10.
13. TKafil T, Nguyen TM, MacDonald JK, Chande N. Cannabis for the treatment of Crohn's disease. Cochrane Database of Systematic Reviews 2017;11.
14. Seal K, Severn M. Medical canabis in residential transition or addiction programs: a review of clinical and cost-effectiveness and guidelines. . Canadian Agency for Drugs and Technologies in Health (CADTH) Rapid Response Report: Summary with Critical Appraisal 2017;1.0:8.
15. Zhang H, Xie M, Archibald SD, Jackson BS, Gupta MK. Association of Marijuana Use With Psychosocial and Quality of Life Outcomes Among Patients With Head and Neck Cancer. JAMA Otolaryngol Head Neck Surg 2018.
16. Deshpande S, Mailis-Gagnon A, Shah ZN. Efficacy and adverse effects of medical marijuana in chronic noncancer pain: systematic review of randomized contolled trials. Can Fam Physician 2015;61:e372-3381.

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17. Stockings E, Campbell G, Hall WD, et al. Cannabis and cannabinoids for the treatment of people with chronic noncancer pain conditions: a systematic review and meta-analysis of controlled and observational studies. Pain 2018;159:1932-54.
18. Allan GM, Finley CR, Ton J, et al. Systematic review of systematic reviews for medical cannabinoids: Pain, nausea and vomiting, spasticity, and harms. Can Fam Physician 2018;64:e78-e94.
19. Koppel BS, Brust JC, Fife T, et al. Systematic review: efficacy and safety of medical marijuana in selected neurologic disorders: report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology 2014;82:1556-63.
20 Rubin R. Medical Marijuana Is Legal in Most States, but Physicians Have Little Evidence to Guide Them. Jama-J Am Med Assoc 2017;317:1611-3.
21. Wang T, Collet JP, Shapiro S, Ware MA. Adverse effects of medical cannabinoids: a systematic review. Can Med Assoc J 2008;178:1669-78.
22. Nugent SM, Morasco BJ, O'Neil ME, et al. The Effects of Cannabis Among Adults With Chronic Pain and an Overview of General Harms: A Systematic Review. Ann Intern Med 2017;167:319-31.
23. Aviram J, Samuelly-Leichtag G. Efficacy of cannabis-based medicines for pain management: a systematic review and meta-analysis of randomized controlled trials. . Pain Physician 2017;20:E755-E96.
24. Berkovic SA. Cannabinoids for epilepsy - real data, at last. N Engl J Med 2018;376:2075-6.
25. Whiting PF, Wolff RF, Deshpande S, et al. Cannabinoids for medical use: a systematic review and meta-analysis. [Errata published in four subsequent issues]. JAMA 2015;314:2456-73.
26. Devinsky O, Cross JH, Laux L, al. e. Trial of cannabidiol for drug-resistant seizures in the Dravet syndrome. New England Journal of Medicine 2017;376:2011-20.
27. Raber JC, Elzinga S, Kaplan C. Understanding dabs: contamination concerns of cannabis concentrates and cannabinoid transfer during the act of dabbing. J Toxicol Sci 2015;40:797-803.
28. Thiele EA, Marsh ED, French JA, et al. Cannabidiol in patients with seizures associated with Lennox-Gestaut syndrome (GWPCARE4): a randomized, double-blind, plcebo-controlledphase 3 trial. Lancet 2018;391:1085-96.
29. Caulley L, Caplan B, Ross E. Medical Marijuana for Chronic Pain. N Engl J Med 2018;379:1575-7.
30. Hasin DS, Saha TD, Kerridge BT, et al. Prevalence of Marijuana Use Disorders in the United States Between 2001-2002 and 2012-2013. JAMA Psychiatry 2015;72:1235-42.
31. Manrique-Garcia E, Ponce de Leon A, Dalman C, Andreasson S, Allebeck P. Cannabis, Psychosis, and Mortality: A Cohort Study of 50,373 Swedish Men. Am J Psychiatry 2016;173:790-8.
32. Ghasemiesfe M, Ravi D, Vali R, et al. Marijuana use, respiratory symptoms, and pulmonary function, a systematic review and meta-analysis. Annals of Internal Medicine 2018;169:106-15.
33. Doss MK, Weafer J, Gallo DA, de Wit H. Delta-9-tetrahydrocannabinol at retrieval drives false recollection of neutral and emotional memories. Biological Psychiatry 2018.
34. Hryhorowicz S, Walczak M, Zakerska-Banaszak O, Slomski R, Skrzypczak-Zielinska M. Pharmacogenetics of Cannabinoids. Eur J Drug Metab Pharmacokinet 2018;43:1-12.
35. Cheung E, Ng C, Foote J. A hot mess: a case of hyperemesis. Can Fam Physician 2014;60:633-7.
36. Brady JE, Li G. Trends in alcohol and other drugs detected in fatally injured drivers in the United States, 1999-2010. Am J Epidemiol 2014;179:692-9.
37. Wang GS, Roosevelt G, Heard K. Pediatric marijuana exposures in a medical marijuana state. JAMA Pediatr 2013;167:630-3.
38. Ryan SA, Ammerman SD, O'Connor ME, Breastfeeding. CoSUaPaSo. Marijuana use during pregnancy and breastfeeding: implications for neonatal and childhood outcomes. Pediatrics 2018;142:e20181889.
39. Bertrand KA, Hanan NJ, Honerkamp-Smith G, Best BM, Chambers CD. Marijuana Use by Breastfeeding Mothers and Cannabinoid Concentrations in Breast Milk. Pediatrics 2018;142:e20181076.
40. Kim J, de Castro A, Lendoiro E, Cruz-Landeira A, Lopez-Rivadulla M, Concheiro M. Detection of in utero cannabis exposure by umbilical cord analysis. Drug Test Anal 2018;10:636-43.
41. Gynecologsts TACoOa. Marijuana use during pregnancy and lactation. Committee Opinion No. 722,. Obstet Gynecol 2017;130:e205-e9.
42. Dickson B, Mansfield C, Guiahi M, et al. Recommendations From Cannabis Dispensaries About First-Trimester Cannabis Use. Obstet Gynecol 2018;131:1031-8.
43. Gutierrez Alvarez AV, Rubin D, Pina P, Velasquez MS. Neurodevelopmental outcomes and prenatal exposure to marijuana. Pediatrics 2018;142.
44. Charonneau G. Cannabis and the doctor-patient relationship. Can Fam Physician 2018;64:477.
45. Jansson LM, Jordan CJ, Velez ML. Perinatal Marijuana Use and the Developing Child. JAMA 2018;320:545-6.
46. Chaudhry HJ, Hengerer AS, Snyder GB. Medical Board Expectations for Physicians Recommending Marijuana. JAMA 2016;316:577-8.

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LEGISLATIVE

E.P.C.M.S.

Report of the American Medical Association Alternate Delegate

Roxanne Tyroch, MD, FACP

I wish to take a moment to describe a very special physician who made a huge impact on the landscape of this community during his lifetime. The late Dr. Laurance Nickey was an inspiration to many in the state of Texas as a true community leader. He was the City-County Health Director for over 20 years, he was one of the first Border Health commissioners appointed by President Clinton and was very instrumental in having the commission's office established in El Paso and was appointed a Lifetime member of the commission by President Bush. He was a one man army in the late 1950's and "stamped" out polio in the El Paso Region. He traveled extensively on behalf of the Border and to bring great notoriety to the region and El Paso's proximity to Mexico. He, too, was a El Paso County Medical Society Past President. This is just the tip of the iceberg of all of Dr. Nicky's lifetime accomplishments. He and Dr. Gordon McGee were very influential in overcoming the moratorium of the building of medical schools in Texas. Together they influenced the TMA House of Delegates and the legislators to lift the moratorium and fund the FIRST Medical School on the Border. He was a true mentor and inspiration to all. He had been a member of the El Paso County Medical Society for over 50 years.

The late Dr. Angelo E Romagosa left behind many friends and we will miss him beyond what words can describe. He was always willing to share ideas and opportunities and was always friendly with those around him. He left us too soon.

We continue to invite the involvement of our past presidents in the activities of the society and we are always happy to see new faces! All members are encouraged to get the most out of their dues-please join us at the monthly meetings 5:30 pm second Tuesdays of the month at 1301 Montana and get to know current board members and involved membership.

I attended as a Texas Alternate Delegate of the AMA the meeting in Washington DC in November. I was asked to serve on the reference committee on medical education. As a community doctor in private practice, my interests in the topic area revolve around maintenance of certification. Please know that as delegates we are here to represent you, the AMA member. This is a hot topic and I have been in meetings through the years on this matter that just get more and more interesting.

The Texas Delegation to the AMA is happy to announce that our Texas candidates won their elections as incumbents in Chicago in June: Russ Kridel remains a member of the Board of Trustees for a second term and Assa Lockhart remains on the Council on Medical Services. The final days of the meeting were dramatic because Texas filed the lawsuit over the Affordable Care Act and in subsequent days the states coalesced on different sides of the matter. The same thing happened at the AMA and it presented a challenge to us all on how to work together when you passionately disagree. I think innovation is the best tool in this scenario-no winners or losers-just new solutions!

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

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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CQ

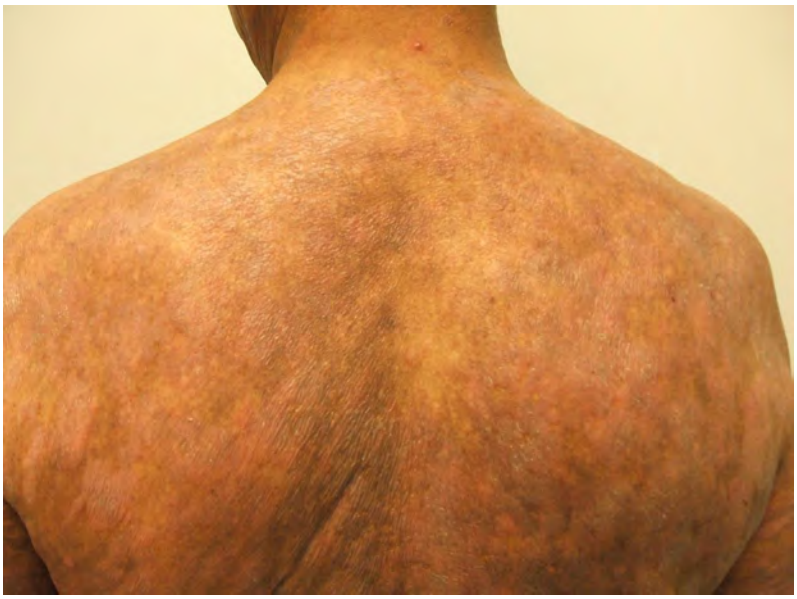
CASE QUIZ

E.P.C.M.S.

Erythematous Scaly Rash on Back: What is your Diagnosis?

Meenakshi Manivannan, MS3.
Hector L. Franco, MD., DABD

A 17-year-old male presented with a three year history of worsening rash on his shoulders and back. The rash started on his left shoulder, then spread gradually to cover his entire back. The rash is sometimes itchy, and a hot shower elicits a burning sensation. His medical history is unremarkable. Family history is significant for malignancies: mother with uterine cancer, maternal grandmother with colon cancer, and maternal uncle with colonic polyps and a sebaceous carcinoma, from which the excisional biopsy was positive for loss of MSH2 expression.



Physical exam findings: non-confluent, erythematous and scaly patches on his back (Figure 1). Laboratory test results revealed no metabolic abnormalities. Histology of a skin biopsy taken from his left shoulder showed a typical lymphocytic infiltrate with enlarged nuclei that were mainly CD-3 positive T lymphocytes with elevated CD-4 to CD-8 ratio. Patient's symptoms resolved after continuous use of tazarotene gel 0.05% and psoralen ultraviolet-A (PUVA) light therapy.

Which of these diagnoses is most likely?

A. mycosis fungoides (cutaneous T-cell lymphoma)

B. pityriasis rubra pilaris

C. small plaque parapsoriasis

D. tinea corporis

E. tinea versicolor

Turn to page 14 for the diagnosis and discussion.

CR

CASE REPORT

E.P.C.M.S.

Beware of the J-Stomach: Implications for Misinterpretation of a Gastric Emptying Scintigraphy

Sumana Reddy, MS4
Ryan Bou-Said, MD.
Jesus Diaz, MD.
Richard McCallum, MD.

BACKGROUND INFORMATION

Gastric emptying (GE) scintigraphy is the standard method used for measuring gastric motility. It is commonly used to evaluate patients who have symptoms suggesting a gastric emptying and motility disorder. A common entity that is diagnosed with GE scintigraphy is gastroparesis, also known as "stomach paralysis", in which the stomach cannot empty itself of food in a normal manner, and results in delayed emptying. Other common disorders include dumping syndrome, a condition that results in rapid gastric emptying, where food rapidly moves from the stomach to small intestine, limiting adequate digestion of food.

The standard GE procedure usually consists of an overnight fast before the day of the study. This is followed by the consumption of a standard radiolabeled Egg-Beater™ meal (250 calories-1% fat) with T99m-sulfur colloid. As the food moves from the posterior fundus to the anterior antrum, anterior and posterior images are taken. The protocol for timing of image capturing is standardized to obtain images hourly up to 4 hours while calculating the geometric mean. Data acquisition is completed with the region of interest (ROI) drawn around the activity seen in the stomach. (1) Gastric retention of >10% at 4 hours is diagnostic for delayed emptying. (2)

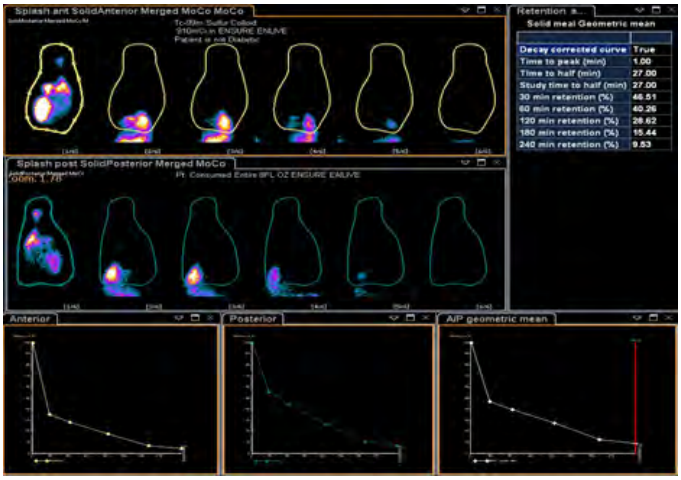


Fig. 1. Regions of interest (ROIs) from a scintigraphic GE initial interpretation described early emptying of labeled supplement in the small bowel indicating the diagnosis of rapid gastric emptying with a calculated retention of only 46.51% (normal >70%) at 30 minutes.

The anatomical structure of the stomach can impact the interpretation of a GE scintigraphy scan. Anatomical variations of the stomach can be congenital or acquired (3). According to a *Surgical and Radiological Review* in 2012, five primary classifications of anatomical variations were established: (i) abnormal position along longitudinal axis (ii) abnormal position along horizontal axis (iii) abnormal shape (iv) abnormal stomach connections (iv) mixed forms (4). Those anatomical variations of the stomach can cause misinterpretation of results from a GE scintigraphy study.

CASE PRESENTATION

A 46-year-old female was referred to the Texas Tech Gastroenterology Motility Center for abdominal pain, distention, nausea, and intermittent vomiting after meals. She had inconsistent GE results from previous medical centers, but the working diagnosis was gastroparesis. Therefore, our goal was to ascertain the status of her GE before considering any therapies.

The standard Egg-Beater™ meal could not be tolerated, so the patient ingested 8 fluid ounces of nutritional Ensure™ Supplement (250 calories) labeled with T99m-Sulfur colloid. Anterior and posterior images of the stomach were obtained in a standing position at 30 minutes, and then hourly over 4 hours with the geometric mean being calculated. Based on initial ROI calculations (Figure 1), early rapid GE results indicated dumping syndrome, as the diagnosis. However, after careful re-examination of the images, the ROIs were altered after images of isotope ascending from a vertically elongated stomach were identified (Figure 2). The repeat calculations revealed moderate gastroparesis: 23% retained at 4 hours (normal <10%). An Upper GI series (Figure 3) performed the following day confirmed the diagnosis of a J-shaped stomach, with the gastric body located in the pelvic cavity, and the antrum ascending to join the duodenal bulb.

DISCUSSION

The prevalence of a J-shaped stomach is unknown, but awareness of its existence is necessary because it can significantly alter the diagnosis obtained by GE scintigraphy, and hence significantly change treatment decisions.

Continued on page 12

CR
CASE REPORT

Beware of the J-Stomach: Implications for Misinterpretation of a Gastric Emptying Scintigraphy

(Continued)

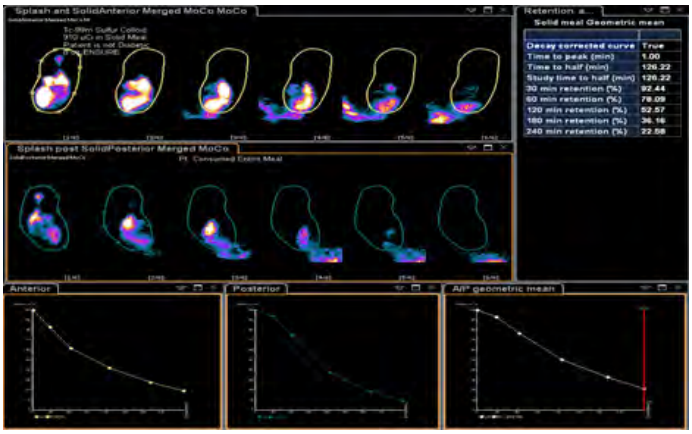


Fig. 2. Further review of ROI images, it was noted that what was deemed to be the small bowel was instead the antrum demonstrating a vertical orientation with subsequent images showing an atypical configuration of a stomach with a persistent waisting representing the fundic band. Hence, ROIs were adjusted to include a larger area encompassing specifically the isotope ingested and present in outlined stomach. This re-assessment revealed the presence of an elongated J-shaped stomach.

In the case of our patient with a vertically elongated J-shaped stomach, the initial assumption of normal gastric morphology resulted in incorrect calculation of the GE scintigraphy results, misleading the diagnosis of rapid gastric emptying. After entertaining the possibility of an abnormal gastric morphology, recalculations showed moderately delayed gastric emptying, confirming the clinical suspicion of gastroparesis that we had based on her symptoms. The unusual anatomy was well illustrated by obtaining a "road map" utilizing barium for an upper GI series study.

When a patient's past history includes discordant interpretations of diagnostic workups by specialists at different medical centers, consider the possibility of an anatomical anomaly of the stomach, the so called J-stomach, and undertake a detailed re-analysis of the GE scintigraphy results, along with an upper GI series to further define the anatomy.

Continued on page 13

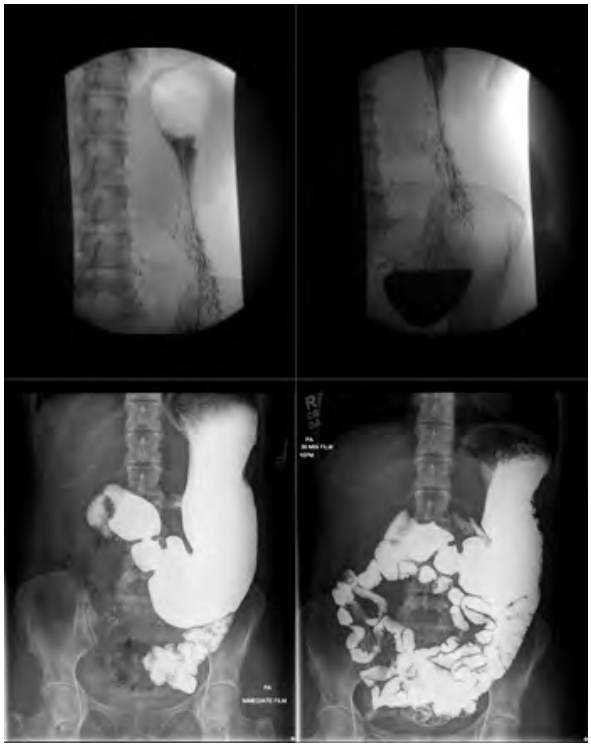


Fig. 3. Images from an upper GI and small bowel series with barium demonstrate an elongated, J-shaped stomach with the gastric body located in the pelvic cavity, fundic band on initial images and then the vertical orientation of the antrum ascending to join the duodenal bulb. On subsequent images the contrast material progresses into an attenuated duodenal C-loop and an unremarkable small bowel accompanied by a decrease in the length of the elongated stomach over time.

REFERENCES

1. Seok, JW. How to Interpret Gastric Emptying Scintigraphy. *Journal of Neurogastroenterology and Motility.*2011; 17(2): 189–91. doi:10.5056/jnm.2011.17.2.189
2. Gervais T, Eaker EY, Abell TL, Abrahamsson H, Boivin M, Chen J, McCallum R, et al. "Assessment of Gastric Emptying Using a Low Fat Meal: Establishment of International Control Values." *American Journal Of Gastroenterology* 2001;95: 1456.
3. Watanabe, K. (2016). Stomach. In Bergman's Comprehensive Encyclopedia of Human Anatomic Variation (eds R. S. Tubbs, M. M. Shoja and M. Loukas). doi:10.1002/9781118430309.ch106
4. Burdan F, Rozylo-Kalinowska I, Szumilo J, et al. Anatomical classification of the shape and topography of the stomach. *Surg Radiol Anat*. 2011;34(2):171-8.

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CQ CASE QUIZ

Erythematous Scaly Rash on Back: What is your Diagnosis?

(Continued)

Most likely diagnosis: mycosis fungoides (cutaneous T-cell lymphoma)

Less likely:

• pityriasis rubra pilaris: typically presents with reddish-orange waxy palmar-plantar keratoderma. Can be excluded with biopsy on the basis of the distinct histology.

• small plaque parapsoriasis: very similar clinical presentation, but this is a histologically benign disease with no potential for transformation to lymphoma.

• tinea corporis and tinea (pityriasis) versicolor are superficial fungal infections. The erythematous plaques have raised red scaling borders. Central clearing is typical of tinea corporis. Tinea versicolor is caused by conversión of the dimorphic Malassezia yeast to filamentous form, triggering a wide-spread maculopapular rash coalescing into scaly plaques of varying pigmentation (fluorescent under Wood's lamp). Microscopic exam of KOH-treated skin scrapings will reveal branching fungal hyphae and spores, spaghetti and meatball hyphae and spores in the case of Malassezia.

Discussion:

Mycosis fungoides (cutaneous T-cell lymphoma) is the most common primary cutaneous lymphoma (1), which typically presents with skin manifestations in the form of patches and plaques and in later stage, tumors. Prevalence is greater in males than females and positively associated with advancing age, which makes this case of a 17-year-old unusual (2). Other variants include lymphomatoid papulosis, pagetoid reticulosis, follicular (pilotropic) forms, cutaneous anaplastic large cell lymphoma and the advanced stage of mycosis fungoides known as Sézary syndrome, which is distinguished by generalized lymphadenopathy, the presence of malignant lymphocytes (Sézary cells > 1,000/μL), CD-4 to CD-8 ratio > 10, and extensive pruritic erythroderma covering more than 80% of the body, including the face (3).

Diagnosis:

Histological studies show a lymphoid infiltrate surrounding fibroconnective tissue (1). Presence of the grenz zone, epidermotropism, and lymphocytes with nuclear atypia (3). The differential diagnosis for cutaneous T cell lymphomas includes other cutaneous T- or B- cell lymphomas, eczematous dermatitis psoriasis, nonlymphomatous erythroderma, and erythema neurolyticummigrans. A definitive diagnosis may require multiple biopsies and specialized pathology . Typing and staging are central to developing a treatment strategy and prognosis.

Treatment:

Topical corticosteroids, topical vitamin A gel (tazarotene gel), topical mechlorethamine gel (FDA-approved for stage 1 mycosis fungoides in adults who have not responded adequately to prior skin-directed therapy), and PUVA phototherapy are used in early patch and plaque stages. Radiation for single tumors and systemic treatments such as immunosuppressants (e.g. rituximab, methotrexate) and biologic agents (e.g. adalimumaub [Humira®], mycophenolate mofetil [Cellcept®]) are used more commonly for more severe disease cases (4).

Prognosis and follow-up:

This disease has a good prognosis with very low mortality with treatment in the early stages, but a worse prognosis if it progresses to tumor stages, in which case this lymphoma can spread to lymph nodes, blood and viscera (5). By the Sézary syndrome stage, the five-year survival is less than 25%. Relapses can and do occur, so it is important to maintain long-term vigilance and resume treatment as needed (6).

Further research:

Mycosis fungoides patients typically present with an abnormality in DNA mismatch repair gene MSI with promotor hypermethylation in MSI and hMHL1 leading to more MSI prevalence particularly in the tumor stage of mycosis fungoides (7). Defects in DNA mismatch repair genes MLHI and MSH2 are characteristic to Muir Torre syndrome which often presents with a sebaceous tumor (8). There have not yet been any studies regarding the link between Muir Torre syndrome and Mycosis fungoides.

References:

1. Lewis DJ, Turkeltaub AE, Dai J, Nagarajan P, Rieger KE, Nunez CA, et al. An adolescent with granulomatous mycosis fungoides infiltrating skeletal muscle successfully treated with oral prednisone. JAAD case reports. 2017;3(4):276-9.

2. Su C, Nguyen KA, Bai HX, Cao Y, Tao Y, Xiao R, et al. Racial disparity in mycosis fungoides: An analysis of 4495 cases from the US National Cancer Database. Journal of the American Academy of Dermatology. 2017;77(3):497-502. e2.

3. Kempf W, Ostheeren-Michaelis S, Paulli M, Lucioni M, Wechsler J, Audring H, et al. Granulomatous mycosis fungoides and granulomatous slack skin: a multicenter study of the Cutaneous Lymphoma Histopathology Task Force Group of the European Organization For Research and Treatment of Cancer (EORTC). Archives of dermatology. 2008;144(12):1609-17.

4. Lewis DJ, Byekova YA, Emge DA, Duvic M. Complete resolution of mycosis fungoides tumors with imiquimod 5% cream: a case series. Journal of Dermatological Treatment. 2017;28(6):567-9.

5. Rappaport H, Thomas LB. Mycosis fungoides: the pathology of extracutaneous involvement. Cancer. 1974;34(4):1198-229.

6. Mycosis Fungoides [Internet]. American Osteopathic College of Dermatology. Available from: http://www.aocd.org/page/MycosisFungoides.

7. Querfeld C, Rosen ST, Guitart J, Rademaker A, Pezen DS, Dolan ME, et al. Multicenter phase II trial of temozolomide in mycosis fungoides/sezary syndrome: correlation with O6-methylguanine-DNA methyltransferase and mismatch repair proteins. Clinical Cancer Research. 2011:clincanres. 0556.2011.

8. Scarisbrick JJ, Mitchell TJ, Calonje E, Orchard G, Russell-Jones R, Whittaker SJ. Microsatellite instability is associated with hypermethylation of the hMLH1 gene and reduced gene expression in mycosis fungoides. Journal of investigative dermatology. 2003;121(4):894-901.

Figure 1 caption: Image from patient with similar presentation. Image reproduced with permission from Robert A Schwartz, MD, MPH, Rutgers New Jersey Medical School, published by Medscape Drugs & Diseases (https://emedicine.medscape.com/), Cutaneous T-Cell Lymphoma, 2018, available at: https://emedicine.medscape.com/article/2139720-overview

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PM

PRACTICE MANAGEMENT

E.P.C.M.S.

How do you handle patient Confrontations?

Your front-desk staffer:
Oh, no. Here comes Mrs. Baker, and she looks irritated. She was furious on the phone yesterday when I told her that the doctor wouldn't renew her prescription without an exam. And now she's been in the reception area for 25 minutes because the doctor was called away for an emergency. I've been watching her out of the corner of my eye, and she's about ready to blow. The office manager is at lunch, the waiting room is full ... what am I going to do?

Ninety-five percent of your patients are a dream to work with. They are easy-going and cooperative with the practice's policies and procedures that ensure efficiency and quality patient care. On occasion, however, things can go very wrong and patients become angry, stubborn, manipulative, and even abusive. Some people are ready for confrontation while others avoid it at all costs by hiding, giving in to strong demands, or finding someone else to handle the problem. How do you handle confrontational patients?

Recognize your weaknesses

The human body reacts quickly to challenge, and the natural tendency is to fight or take flight. So, the first step in managing a confrontational situation is to recognize your personal physical and emotional reactions and take steps to get them in check. Do you become flushed or begin to cry? Do you avoid eye contact and begin to make excuses, or do you lose your temper quickly or get sarcastic and nasty right back? Ask your family and coworkers for feedback so you can improve your communication style.

Verbal communication techniques

If you communicate in ways that show empathy for and understanding of a patient's situation, you'll stand a better chance of reducing tension and resolving problems, even if you disagree with the patient's point of view. Try this three-step assertive response to take control of the situation:

1. I wish I could. This phrase is an empathic way to say "no." Use it with a sincere tone of voice to let the patient know that you would like to help, but you can't. "I wish I could do that for you, Mrs. Baker, but our policy is very clear."

2. Agree in principle. Rather than argue over an issue, use this technique to acknowledge that the patient's point of view is possible, and then present what you are willing or able to do.

"I can understand how you might see it that way. ..." This technique shows empathy for the patient plus validates your understanding of the complaint.

3. Be a broken record. This technique is most effective with patients who keep trying to get you to do something their way. Your response is to stay firm, use a calm tone of voice, and repeat over and over what you are willing or able to do. Don't waste time coming up with new excuses or reasons; this just engages the patient in an argument and suggests that the policy can be changed. Simply repeat your position politely and calmly. This technique is particularly effective with patients who use abusive language, whether in person or on the phone.

For example:

- "Mrs. Baker, with this medication, the doctor requires patients to come in for a checkup before a refill. Is 2 p.m. tomorrow a good time?"
- "Mrs. Baker, I know it would be easier for you to just get a refill, but it is important that the doctor check your condition first. Will 2 p.m. tomorrow work for you?"
- "Mrs. Baker, I know this is frustrating you. If you can come in tomorrow, you'll be able to talk to the doctor about the need for a refill, based on your condition. Why don't I put you down for 2 p.m.?"

Tips for nonverbal communications

In a confrontational setting, your tone of voice should become slightly firmer and deeper, not necessarily louder. Be careful to keep a calm, businesslike tone even though it's easy to be sarcastic or patronizing. Keep eye contact with the patient and maintain a straight posture. This adds to your credibility. Put yourself at the patient's eye level. If the patient is standing, then you stand; if the patient is sitting, you sit. If you are much shorter or smaller than the patient, you may appear to be at a physical disadvantage. Having the patient to sit down with you reduces that difference. If possible, move an angry or disruptive patient to a private office so other patients and staff are not disrupted. You could ask the office manager to join you or to take over the problem, but it's better to use the situation as a learning experience so you'll be confident in handing similar problems later. Solving patient problems is just another part of your job.

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- Shattered Dreams Experience coordinated by BorderRAC

BorderRAC - Award Winning Regional Collaboration

West Texas and Southern New Mexico's BorderRAC was recognized by the Department of State Health Services as the 2018 Regional Advisory Council of the Year in Texas. The award recognizes a Regional Advisory Council in Texas that has demonstrated strong leadership and high standards in improving emergency medical service and improving the Texas EMS/Trauma System.

WHAT IS A REGIONAL ADVISORY COUNCIL?

Originally intended to develop a stronger trauma delivery system of care within their multi-county region, Regional Advisory Councils are now recognized for also bringing together the finest medical minds within their region, comprised of otherwise competing healthcare providers to share best practices and collaborate about emergency medical protocols that save lives when a medical emergency happens.

BORDERRAC TERRITORY

Established in 1997, BorderRAC's mission is to advance the Far West Texas and Southern New Mexico trauma and emergency healthcare system through prevention, education, preparedness, and response. BorderRAC serves an area of more than 40,000 square miles with a population of approximately two million. The BorderRAC region includes Catron, Dona Ana, Grant, Hidalgo, Luna, Otero and Sierra counties in Southern New Mexico and El Paso, Hudspeth and Culberson counties in West Texas. BorderRAC members are a coalition of healthcare professionals, hospitals, emergency medical services and healthcare agencies. Strong collaboration and participation of members guides the BorderRAC Committees to complete needs assessments and determine professional and community education needs.

BORDER RAC
REGIONAL ADVISORY COUNCIL

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- Professional Education Actvities

To serve the needs of the region, BorderRAC Programs include:

TRAUMA AND EMERGENCY HEALTHCARE SYSTEM OF CARE

BorderRAC plays a key role in promoting a system of care that builds upon a network of designated trauma hospitals and a network of EMS agencies. The agencies rely on best practices to assess and stabilize each patient, and to select and communicate with the most appropriate designated trauma hospital. This system of care and ongoing training enables the traumatic injury mortality rate to maintain or remain below the national average.

STROKE EMERGENCY CARE AND PUBLIC EDUCATION

BorderRAC brings value to the region through public education and statistical data tracking that helps identify new medical care opportunities. For instance, by tracking the incidence and timely administration of tPA, regional teams can discuss strategies to increase ischemic strokes treatment and subsequently minimize costs.

CARDIAC CARE AND PUBLIC EDUCATION

"Time means muscle" is an overarching theme. EMS agencies and hospitals examine ways to shave minutes off normal treatment processes, optimizing patient outcomes. For patients with an occlusion, EMS and hospital teams work together in advance of patients arriving at hospitals in order for cardiac interventions to occur in 90 minutes or less from first patient contact. BorderRAC coordinates regional data collection, benchmarking the region against statewide data to improve performance.

BorderRAC provides physician offices with Stroke and Cardiac community education flyers with information about early detection and immediate calls to 911. Flyers may be obtained from BorderRAC at (915) 838-3200.

DISASTER PREPAREDNESS AND EMERGENCY RESPONSE

BorderRAC leads the medical component of preparedness planning and response via the Hospital Preparedness funding. BorderRAC is responsible for assessing the availability of beds in each hospital, to ensure that resources are wisely allocated, and to conduct training and joint exercises of all stakeholders as a team. BorderRAC participated in the development of the Texas Emergency Medical Task Force program to enable statewide mutual aid by mobilizing medical teams when a disaster happens.

Regional assets, such as the AmBus and the Mobile Medical Unit, have been deployed to a number of emergency situations including Hurricane Harvey, where more than 1300 individuals in Orange, TX received care. Providing medical care at the annual Bataan Memorial Death March is a means to prepare and train for such deployments and for austere environments. "Bataan" is scheduled for March 17, 2019 – contact BorderRAC if you are interested in participating in disaster preparedness.

PERINATAL CARE AND PUBLIC EDUCATION

BorderRAC is responsible for bringing together regional healthcare providers to share and benefit from best practices to ensure newborns and their mothers are provided exceptional care and to reduce mortality. BorderRAC has worked with hospitals to learn the new rules regarding neonatal and maternal care and assist in designation surveys.

PROFESSIONAL EDUCATION – CME ACCREDITATION WITH COMMENDATION

BorderRAC's professional education mission is to provide lifelong learning opportunities for physicians and other healthcare professionals to increase knowledge, skills, attitudes, and competence and to enhance their ability to improve their performance and patient and system-level outcomes to the fullest extent possible. BorderRAC is proud to have received CME Accreditation with Commendation from the Texas Medical Association.

For information on upcoming educational activities or if you would like to participate in teaching a CME program, please contact BorderRAC.

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ACADEMIC ABSTACTS

E.P.C.M.S.

Role of epigenetic changes in neuronal cells under hyperglycemic condition

Bryan Koppa, Narah Alcoreza , Vikram Thakur
Munmun Chattopadhyay, MD.

Diabetes Mellitus is a systemic disorder which leads to chronic elevated levels of blood glucose and causes a multitude of long term complications including neuropathy. These debilitating complications lead to decreased quality of life in patients, hence the exact mechanisms of the disease are not fully understood. In this study, we used a dorsal root ganglion (DRG) neuronal cell line (F11) as a model to study the effects of epigenetic modifiers and inflammatory and stress markers under hyperglycemia. These neurons were exposed to high glucose to mimic the changes seen in diabetes. Using Western Blot and Immunocytochemistry, we examined various markers of oxidative stress and epigenetic modifications including superoxide dismutase 2 (SOD2), toll-like receptor 4 (TLR4), histone deacetylases (HDACs), and mono-methylated histone 3 lysine 9 (H3K9me1).

The cells under hyperglycemic condition are constantly exposed to free radical oxygen species and demonstrate appropriate mechanisms to deal with the oxidative stress. Superoxide dismutase is one such enzyme that helps protect our cells from oxidative stress by catalyzing the reaction of superoxide to less harmful products. The levels of oxidative stress marker SOD2 and inflammatory marker TLR4 were increased in F11 DRG neurons exposed to high glucose. TLR4 is a transmembrane protein and its activation leads to an intracellular signaling pathway responsible for activating the innate immune system. However, chronic inflammation can be detrimental and perpetuate disease states. TLR4 may be an important contributing factor to the chronic low grade inflammation seen in diabetes.

Epigenetic modifications influence gene expressions necessary for cell function. Chromatin is continually changing from a highly condensed state (heterochromatin; that inhibits gene expression) to a relaxed state (euchromatin) that ultimately allows gene transcription. Enzymes such as HDACs remove acetyl groups from histones, keeping DNA in heterochromatin state rendering it inaccessible to transcription factors. Another mechanism of gene repression is histone methylation which also keeps DNA in heterochromatin state and inhibit gene transcription. We found substantially elevated levels of HDAC2, HDAC4, and H3K9me1 in F11 DRG neurons exposed to hyperglycemic conditions. This indicates that epigenetic mechanisms may be involved in the pathogenises of diabetes. Oxidative stress and inflammation, as evidenced by the increased
levels of SOD2 and TLR4 may also be the contributing factors in the disease process.

The complications of diabetes are far reaching and significantly contribute to increased mortality and morbidity. Even patients with well controlled blood glucose levels experience diabetic complications. Therefore, it is important to further investigate the underlying mechanisms of diabetes so that we can develop the most effective therapeutic treatments. Targeting epigenetic modifications such as HDACs and histone methylation may help cells properly respond to hyperglycemic insults by allowing them to transcribe the necessary gene products. HDAC inhibitors and lysine-specific demethylases may be future therapeutic options to treat diabetes and reduce complications.

Cyclic Vomiting Syndrome in Diabetic Patients: A new Diagnosis and Clinical Challenges

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Mohammad Bashashati, Irene Sarosiek MD

PURPOSE: Investigate the clinical presentation and characteristics of diabetic patients who present with upper gastrointestinal (GI) problems.

INTRODUCTION: Patients with Diabetes Mellitus (DM) often present with symptoms of visceral autonomic neuropathy, along with sympathetic nerve damage and vagal nerve dysfunction.1 The vagal neuropathy, the number of interstitial cells of Cajal as pacemaker cells, along with hormonal changes like increased glucose

Continued on page 19

level lead to development of gastroparesis (GP) or Cyclic Vomiting Syndrome (CVS) with a similar clinical presentation of early satiety, nausea, vomiting, abdominal pain and bloating. 1,2,3. The overlap of GP and CVS gastric symptoms in diabetics increases the difficulty of making a correct diagnosis.3 Unfortunately, there has been little clinical research done on possibilities for coexistence of the cyclic vomiting appearance which is associated with diabetic gastroparesis. Such cases are causing tremendous challenges for clinicians and for patients as well, who have to go through extensive testing and procedures in order to establish a right diagnosis, and propose the treatment.

MATERIALS AND METHODS: We conducted a national survey on patients who present with the medical characteristics and clinical profile of functional gastrointestinal disorders. Patients were invited to complete an anonymous, online survey (Qualtrics Inc., Provo, UT) designed to capture varieties of information including demographics, comorbidities, clinical and psychological profile, and economic burden of their challenging conditions.

RESULTS: From September to November 2016, 449 CVS patients responded to our survey, 77.7% of them were women. The mean age was 29.9 (14.7) years. 398 patients declared their ethnicity as Caucasians (88.6%). A positive childhood history of a traumatic incident, abuse or neglect was acknowledged by 82 (18.3%), 48 (10.7%) and 26 (5.8%) patients, respectively. The most common comorbidities were anxiety, migraine, depression, gastroesophageal reflux disease and diabetes seen in 217 (48.3%), 212 (47.2%), 161 (35.9%), 126 (28.1%) and 89 (20%) of patients, respectively. In the past 12 months, 62.8% CVS patients visited the emergency room due to (median: 4 times) and 67.0% of patients had at least one admission to the hospital because of their stomach problems. The most common surgical procedure performed based on their CVS symptoms was cholecystectomy in 81 patients (18.0%) followed by appendectomy (12.2%) and exploratory laparotomy (6%) of all patients. 45.4% of patients believed that they were not adequately managed by their gastroenterologists while 40.5% were unable to participate in social life events. Many patients reported the association of CVS symptoms with financial difficulty 180 (40.1%), loss of job 129 (28.7%), quitting school 75 (16.7%) or divorce 38 (8.5%). Among the 215 patients who answered questions on financial burden, 127 (59.1%) declared that treatment of upper CVS symptoms costs them at least $10,000/year.

DISCUSSION: The existence of CVS subset of diabetic patients deserves increased awareness of such diagnosis, which if missed or delayed could cause significant medical problems, social-economic challenges and psychological/ psychiatric comorbidities. Future studies should address the knowledge gaps on the pathophysiology and treatment of this functional disorder.

CONCLUSION: Based on the largest patient driven database in the field, our study confirms that CVS continues to be a challenging and debilitating entity, including up to 20% of diabetic patients. The suboptimal management, and serious economic impact from inappropriate medical interventions associated with increased utilization of hospital and ED services by this population is also of note. By looking out for CVS in the DM population, we will be able to effectively and efficiently diagnose, treat, and manage their associated symptoms.

REFERENCES:

1)*Christensen, C. J., Johnson, W. D., & Abell, T. L. (2008). Patients with cyclic vomiting pattern and diabetic gastropathy have more migraines, abnormal electrogastrograms, and gastric emptying. Scandinavian journal of gastroenterology, 43(9), 1076-1081.*

2)*Nam, Y. J., Kim, S. E., Park, M. I., Park, S. J., Moon, W., Kim, J. H., ... & Gwoo, S. (2017). Diabetic Gastroparesis Presenting with a Cyclic Vomiting Pattern. The Korean Journal of Helicobacter and Upper Gastrointestinal Research, 17(3), 148-153.*

3)*McCallum, R.W, Molinares, Vanina, Torres-Villamil, E.A. (2018). The Challenges of Cyclic Vomiting Syndrome in Type 1 Diabetic Adult: A Multidisciplinary Approach. El Paso Physician, 36 (1), 6-8*

We take this opportunity to thank all of the contributors for their interest and support of the El Paso Physician. Without each and every one of you, this magazine would not exist. the superior quality of the scientific articles through provoking happenings, news and notices drive the success of this publication. We look forward to your continued support in the year ahead, as we continue to produce this much needed magazine.

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Tribute donations are a wonderful way to acknowledge a special person. You can make a donation in memory or honor of someone or to commemorate a holiday, birthday, wedding, or other occasion. An acknowledgement letter of your donation will be sent to the person(s) you designate, and a copy of the letter will be sent to you for tax purposes.

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Please charge my gift of $_____to my Visa/ MasterCard/Discover/American Express

Card #_____Security Code:_____ Exp. Date_____

I have enclosed my gift of $_____. (Please make check payable to EPMH Foundation.)

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Name: _____

Address: _____

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Specify the purpose for your recognition: _____

In Memoriam

Dr.Miguel Barron began his medical journey in Mexico City at the Universidad Nacional Autonoma de Mexico. He was student instructor in Biochemistry, Physiology and Pharmacology. Dr. Barron began his sojourns to Butterworth Hospital, Grand Rapids,Michigan and to St Alexis Hospital, Cleveland, Ohio for externships. He was thrilled with the opportunity to attend a clinical workshop with the pioneering physician of congenital heart disease, Dr. Maurice Lev. Upon completion of Medical School, Dr. Barron was accepted for a Rotating Internship at Butterworth Hospital, Grand Rapids,Michigan, followed by a General Surgery Residency at St Mary's Hospital , Grand Rapids, Michigan. He rapidly entered community life, with support of the symphony orchestra. The Romero Family of classical guitar, performed with the Grand Rapids Symphony after which Dr. Miguel Barron invited all for paella. He cultivated a 50 yr friendship with them . He also met Franco Iglesias, of the New York Metropolitan Opera who was a hit not only with the Symphony but for his free concert on the patio between the School of Nursing and the Resident's Quarters, causing the appearance of student nurses from every window to find the source of the powerful tenor voice. He was called to join the Army National Guard in Michigan.

Henry Ford Hospital, Detroit , Michigan offered the opportunity of a CardioVascular and Thoracic Surgery Residency which Dr. Barron completed in 1974. He was impressed by the dream of Dr. Edward Downs to create a Henry Ford medical model in El Paso, Texas. He became director of Medical Education at Eastwood Hospital . Dr. Barron continued educational interactions with fellow graduates from Universidad Nacional Autonoma de Mexico, The goal of improvement of Hispanic Health in border areas was a driving force of the founding members of the Soutwest Association of Hispanic American Physicians: President , Alberto Melgar, MD; secretary Jose O Castillo, MD; Treasurer Marco A. Ochoa, MD; Out of Town Public Relations, Carlos Miranda, MD; Medical Education Health Careers Jose Roman, MD :, continuing Medical Education Miguel L Barron, MD; First annual Congress of SWAHAP program chairman - Miguel I. Barron MD. He soon became the director of Medical Education and Coordinator of the Clinical Rotations in El Paso for the Universidad Autonoma de Ciudad Juarez, School of Medicine 1975-1984. This cooperative agreement provided El Paso with many of it's current physicians. Other professional activities included, President of the Association de Cirujanos de Ciudad Juarez; Member of the Board of El Paso City County Health Department 1984-1985, Chairman of the Regional Health Planning Advisory Committee for the West Texas Council of Government 1985-1988,, Member Board of Directors of the Interamerican College of Physicians and Surgeons. He continued his service in the Army National Guard as Major in Texas. He attended a course "hands on training in Yag Laser rigid bronchoscopy in Paris, France. Extensive knowledge of classical music beckoned participation of service as Chairman of the Board of El Paso Symphony Orchestra with two rotations as member of the board of trustees, He also sang in performances by Gilbert and Sullivan .Dr. Barron was the first chairman of the Festival of La Zarzuela, followed by membership on the executive committee until 1989. He also was one of the founding members of the Club de Espana. Like his father , he too was a Rotarian and received the Paul Harris Award medal

On January 4th 1989, a Christmas Tree fire destroyed home and the health of Dr, Miguel Luis Barron. He suffered 2nd and 3rd degree burns of torso, neck, arms, face, hands and corneas. He remained at Sun Tower's Hospital Burn Unit for 6 months. A 2 yr recovery period with 13 surgeries followed his near death experience. He experienced the same challenges of all patients - high copay for medications, dropped from insurance coverage due to pre-existing conditions. . Dr. Miguel Barron continued his participation in teaching. by presenting various conferences of Yag laser rigid bronchoscopy for tumors, radio programs in Los Angeles -Leg Alert. He visited Hispanic Health initiatives of the Pan American Health organization and the Interamerican College of Physician and Surgeons. He reached out to the youth of El Paso by coaching the Pumas - winning team. He started the Cathedral High School Soccer Team. His love of music and teaching provided strength to overcome his life threatening experience. With his return to practice of primarily Vascular and Thoracic surgery, Dr. Miguel Barron trained further in wound care and Hyperbaric medicine. He also complete post graduate courses Endovascular venous surgeries. He was a 50 yr member of TMA, member of the Roy McClure Surgical Society of Henry Ford Hospital, member Rocky Mountain Vascular Surgical Society and the International Society of Endovascular Surgery, the El Paso County Medical Society.He retired in 2009. During the final days of his life , Pepe Romero, his dear friend, came to El Paso to play Dr. Barron's favorite classical guitar solos. He was eased into the blessing of eternal life in the presence of his family within his home.

Dr. William Arnold Pitchford, son of Norman J. and Lydia Belle Pitchford, was born in El Paso and attended Austin High School and the New Mexico Military Institute. He received his Bachelor of Science from the University of Texas at Austin and his Doctor of Medicine from Southwestern Medical School in Dallas. He specialized in Obstetrics and gynecology and moved back to El Paso to establish his practice, where he delivered thousands of babies over the next few decades. Arnold was a founding partner of Physicians Healthcare Associates LLC. which was acquired by WellMed, and transitioned to family practice there. Dr. Pitchford practiced medicine for over 60 years and continued to work until shortly before his death.

Arnold was a devoted follower of Christ and a long-time member of the First Baptist Church.

We would like to extend a special thank you to his friends and teachers at Sarita's Custom Sewing, where he learned to put his surgical skills to use by knitting a wide range of accessories for his family and friends.

MS

MEDICAL STUDENTS

E.P.C.M.S.

A five-member team of Paul L. Foster School of Medicine (PLFSOM) students finished in second place out of seven Texas medical schools at the inaugural Shift 2018 – Texas Health Challenges Case Competition at Texas A&M College of Medicine.

The event, held Sept. 22-23, aimed to develop innovative solutions to improve health care delivery in rural Texas. The PLFSOM students' solution proposed a network of community health care centers that worked with local high schools and churches to connect small-town hospitals to a broader network of Texas medical schools. The plan incorporated telemedicine and rotating specialty services.

The second-place award brought not only pride to a team representing one of the youngest medical schools in Texas, but also a $3,000 cash prize.

"We were absolutely thrilled," third-year PLFSOM student Jacob Winters said of his team's performance. "We were most proud of the fact that we were able to represent our school, to put our school's name out there, and to give a testament of the strength of our education."

Members of the TTUHSC El Paso team included fourth-year medical students Brandy Mills and Alex Palmer, third-year medical students Brittany Harper and Winters, and second-year medical student Roxann Lerma.

Jake Wilson, TTUHSC presented an abstract/Poster at the American College of Physicians meeting. Seen here with his mentor Dr. Richard McCallum,Professor of Medicine-Gastroentologist at TTUHSC, El Paso, TX

HISTORICAL VIGNETTE

E.P.C.M.S.

THE OFFICES OF THE EL PASO COUNTY MEDICAL SOCIETY, commonly called, THE "TURNER HOME"

Barbara Dent

The structure, located at 1301 Montana Street, El Paso, Texas 79901, was the home of Dr. and Mrs. Stephen Thomas (S.T.) Turner. Its' history covers 108 years and has touched many lives and events in the El Paso community, including Medicine. As all houses, the Turner Home has taken on the personality of its 2 owners.

Dr. Turner and his 1st wife, Anne Laurie Camp, moved to El Paso in 1889. He came to town as a contract physician for the Southern Pacific Railroad. Two infant sons died before their move to El Paso.

Dr. Turner (b-1856 -d 1945) was a man of deep convictions, concerning Medical education and Medical organizations. He was a Charter Member of the EPCMS and in1902, its 4th President. He served in official positions in the Texas Medical Association. He was well read and contributed to various Medical publications.

The Turners built the house on Montana Street and moved into the residence in 1910. No expense was spared on the building, decorations, and furnishing.

The house is believed to be a Henry Trost design, but the original plans have not been found. The H.T. Ponsford Brothers Construction Firm of El Paso were the builders. The house is described as Greek Revival style with 4 majestic front columns and large porches on both levels, in the front and rear of the structure. There are 2 floors, a full basement, and three stairways.

The top floor had 5 bedrooms, 2 full bathrooms, and a large central hall. Four of the bedrooms are connected to baths. The 5th bedroom has a wash basin for convenience. Both front bedrooms, including the master bedroom and the room across the hall, have fireplaces. In all, there are 5 fireplaces in the house with a "clean out." in the basement.,

The ground floor consist of 6 rooms plus a entry vestibule and a large central hall, a ½ bath, living room, Dr. Turner's library, dining room, 2 butlers' pantries, and a well-planned kitchen of that day. The stairway to the basement is entered through the 2nd pantry.

In the full basement, on the left side, there was a servant's quarters with a 3/4 bath. These quarters had its' private entrance. There is a large "all purpose" room in front of these quarters.

Across the hallway is the furnace room, a coal room with the coal shoots, and a large laundry room. The large basement area served well for drying clothes in bad weather. There is also an enclosed area beneath the front porch giving 2 extra rooms to the basement.

In the 1960s, the El Paso Art Museum, located across the street from the Turner Home, was in need of extra storage space. The basement of the Turner Home fit the bill. A partition was built securing this area.

An unattached, 2 car, drive through garage, with servants quarter upstairs is located to the side of the house.

Some other interesting features adorning the house include a dumb waiter connecting all levels, a speaking tube connecting the master bedroom with the front porch, an intercom system, beveled glass front doors, decorative stained glass windows in one of the upstairs bathrooms and in the front entry, and a servants' call buzzer under the dining table. The light fixtures were all of top quality with the a number of them carrying the Stuben name.

In the early 1900s ,Montana Street was one of the social neighborhoods of El Paso. Here many wealthy and prominent people enjoyed their large lovely homes and life style. The Turners were no exception. Mrs. Turner was a strict Baptist and Dr. Turner was a teetotaler, so at all of their social functions, of which there quite a few, no liquor was ever served.

Dr. Turner retired from Medicine when they moved into their Montana Street home. He then bought a large irrigated farm in Fabens. The great pleasure of retirement was his love for the work on this farm, to which he drove every day.

Annie Laurie died in 1938. The farm became great source of comfort. The fruit orchards, the dairy, poultry, vegetable production, and fishing pond all served him well, financially, mentally, and emotionally, in the pre-war days as well during WWII.

He remarried Mrs. Lucy Fall Roberts, in September 1942.

Continued on page 26

WWII was raging. Our whole country was involved in the War effort. Since Ft. Bliss was in El Paso, the population grew and housing was in demand. Mrs Lucy Turner remodeled the garage servants quarters into a full apartment and began renting rooms in the Turner home. I do not know if the rent covered meals or not, but if meals were included, she had the renters Ration Stamps and because of the farm, there was plenty of food. All meals were prepared on a large double wood stove in the kitchen. Mrs. Lucy Turner described a number of these meals in letters to her nephew. She and a servant lady did the cooking on that stove. There was a large wooden "ice box" just off of the kitchen on the downstairs screened-in back porch. This ice box in now stored in the double garage.
On week-ends, the Turners would hold a neighborhood farm fresh market on the back porch. This market was well attended and appreciated.

Dr. Turner died August 7, 1945. He is buried with his 1st wife Annie Laurie in the Masonic Section of Concorida Cemetery.

"Under the terms of Dr. Turner's will, his home in El Paso will become the property of the El Paso County Medical Society upon the death of his wife, Lucy, or at any time she wishes to surrender it to the Society.."(#1.)

Before Mrs. Turner relinquished the house in 1946, she held an Estate Sale to dispose of some of the furniture and personal items. All of the Dining room furniture remained in the house, as well as Dr. Turner's library table and some other furnishings.

From 1946 on, the history of the Turner Home is connected to the history of the El Paso County Medical Society and its Auxiliary. Most of their meetings and social gatherings were held in the Turner Home. The Home became their hub! In the beginning, when the Society first occupied the premises, they collected medical books and journals and opened a public Medical Library. It it was not successful and the City canceled their certificate.

In 1950, the kitchen was renovated, replacing the old appliances and fixtures. Flat ware, china and glass ware were purchased, along with a lovely Silver Tea Service.

On the 2nd floor two walls and the master bath room were removed. Thus making a large meeting room with auditorium chairs. Both the Society and Auxiliary were quite active for quite a number of years. Many a lecture, luncheon, tea, cocktail party, and dinner graced these hallowed halls. The House was the gathering place to view the Sun Bowl Parade.

In 1966, Dr. Werner Spier was named property manager of the Turner Home. In preparation for his job, he and wife, Cheri, began a thorough examination of the house. In the basement, they found "A TREASURE!" Antique medical equipment, documents, and memorabilia, not only from Dr. Turner, but also from other pioneer physicians and facilities were discovered. These items were moved up to the top floor and put on display. This was the beginning of the Medical Museum. In 1985, the El Paso Medical Heritage Foundation, a non- profit, tax exempt 501C6 entity was formed as a support organization for the museum.

In 1982, the Turner Home was designated a "Texas Historical Site" by the Texas Historical Association. Prior to 1945. a "lean to "shed had been added to the main floor of the garage. Early in the 2000s some well needed restorations and repairs were preformed on the Turner Home. At which time, permission was asked and granted by the Texas Historical Association to remove this structure, since the "lean to" was not original to the House,

Sometime in the 1990s the screens on the back porches rusted and deteriorated. These were taken down and not replaced, and security was added to the house.

An interesting contribution to the El Paso Medical Foundation occurred in the early 2000's by the architectural firm of Boyd & Associates . No one had lived in the house since 1945 and copies of the structural changes had been documented. Mr. Boyd was able to reconstruct plans of the house. Most of the plumbing and electrical fixtures are original and date to the early 1900s giving authenticity to his plans.

The building still has its charm! It 's has served the past 100+ years quite well and it remains a beautiful feature of El Paso.

But – Times changed! Medicine changed! Neighborhoods changed! Organizations changed! Membership numbers in most organizations around the globe diminished drastically.

The EPCMS now holds only special & Board meetings at the Turner Home.

The El Paso County Medical Society Alliance/ Auxiliary disbanded in 2006. This year, their historical scrap books and year books were donated to the UTEP Library - Special Collections.

In the large kitchen, the 1950 restaurant gas stove that replaced the wood stove was donated to Sacred Heart Church. The flat ware, china, glass ware, and the silver tea service are no longer used. No meals are prepared and served from the butlers' pantries.

"THIS OLD HOUSE", as the country western song says, needs a lot of TLC, and I hope we have time to fix it.

Foot notes: #1. Texas State Journal of Medicine, Vol.41 Nov.1945 pg.388

Ref.: Author's Personal research and oral histories.
Funkhouser, Barbara, "THE CAREGIVERS" El Paso's Medical History 1898-1998 Publisher
Michael Moses, c.1999
Barbara Dent, October 2018

N

NEWS

E.P.C.M.S.

The following is a list of new/re-instated members of the El Paso County Medical Society. congratulations to all new members!!!

Bevevino, Adam James, MD
ORS OSS
Georgetown University School of Medicine, 2008
5005 N. Piedras
El Paso, TX 79920

Carrillo, Raul., MD
EM
UT Health Science Center @ Houston, 2004
1625 Medical Center
El Paso, TX 79902
(915) 532-4000

Garcia, Estephan Jesus, MD
ORS OP
University of Colorado School of Medicine
P.O. Box 12793
El Paso, TX 79913

Garcia, Hernando, MD
PUD CCM
Facultad de Pontificia Univ. Javerian, 1981
4800 Alberta
El Paso, TX 79905
(915) 215-5195

May, Evan Elizabeth, MD
CD IM
Georgetown University School of Medicine, 2007
4301 N. Mesa St., Ste 100
El Paso, TX 79902
(915) 532-6767

Orr, Justin D., MD
ORS OTR
Pritzker School of Medicine of Univ. of Chicago, 2003
5005 N. Piedras
El Paso, TX 79920
(915) 742-2288

Martinez, Pablo F., MD
FM
Texas Tech Univ. HSC Paul L. Foster School of Medicine, 2010
1111 Hawkins Blvd., Ste 2-A
El Paso, TX 79928
(915) 771-8346

Governor Reappoints TTUHSC
El Paso Professor to Advisory Council

EL PASO, Texas – Texas Governor Greg Abbott has reappointed Alan Tyroch, M.D., professor and founding chair of surgery at Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso), to a six-year term on the Advisory Council on Emergency Medical Services. The council works to ensure Texans receive efficient and competent emergency and trauma care.

Dr. Tyroch is also chief of surgery and trauma medical director at University Medical Center of El Paso. Dr. Tyroch is board certified in general surgery and surgical critical care.

He is a member of the American College of Surgeons, American Association for the Surgery of Trauma, Society of Critical Care Medicine, Texas Surgical Society, Southwestern Surgical Congress, American Trauma Society, Pan-American Trauma Society, Pediatric Trauma Society, Western Surgical Association, Association for Academic Surgery, Association for Surgical Education, Society of Surgical Chairs, South Texas Chapter of the American College of Surgeons, Texas Medical Association and El Paso County Medical Society.

Continued on page 30

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

Hassle Factor Log "User Guide"

Please observe the following Hassle Factor Log (HFL) guidelines to help us expedite processing while maintaining the integrity and credibility of the HFL program.

General Guidelines

- The Texas Medical Association accepts HFLs from current TMA members only.
- Submit HFLs by mail to Payment Advocacy Dept., Texas Medical Association, 401 W. 15th St., Austin, TX 78701; or by fax to (512) 370-1632. (You don't need to mail us originals of faxed information.)
- Exhaust and document reasonable attempts to resolve your claim issues, including the appeals process, before submitting an HFL (unless you are submitting an HFL as "informational only").
- Clearly identify health plans and/or contractual relationships on the HFL form.
- Keep in mind that Medicare's Correct Coding Initiative (CCI) determines bundling standards.
- Do not report slow-pay issues until 45 to 60 days after you have submitted the claim and you have received confirmation that the claim is being processed.
- TMA copies the physician on any letter we send a health plan regarding his or her HFL.
- TMA generally processes HFLs within two to four weeks of receipt. TMA cannot guarantee a response from the health plan.

Using the Form

- Use the current HFL form available on the TMA website.
- Fill out the HFL form completely and legibly.
- Give a brief description of the hassle on the form. If you need to include a more detailed description, attach it to the form.
- You may use one form to submit multiple hassles that address the same issue and are from the same health plan.
- Use separate forms to submit multiple hassles that are dissimilar in nature or are similar but from different health plans.
- Use separate forms to submit hassles from different TMA physician members.
- **All HFLs require attachments to be processed.**

Attachments

Attachments should contain only the protected health information (PHI) that is relevant to the patient(s) for which a physician is submitting an HFL. Physicians should delete all other patient information from the attachments TMA will return to the practice any HFLs that have non- pertinent PHI.

Examples of frequently needed attachments are:

- CMS-1500 claim forms
- Remittance notices (e.g., EOBs, RAs, R&S reports) with definitions of comment indicators and/or denial messages
- Copies of relevant prior correspondence to and from the health plan, including appeal letters and/or denial letters
- Reports for proof of timely filing (e.g., batch acceptance reports from the payer or clearinghouse showing the payer accepted the claims)
- Operative notes/Medical records
- Patient insurance identification cards
- Preauthorization/Referral forms

Informational Only HFLs

TMA adds the following types of HFLs to its database as "informational only":

- The HFL was submitted to TMA expressly for "informational only" purposes.
- The claim currently is being appealed with the health plan for the first time.
- The claim is for services older than 12 months.
- The physician office failed to follow up timely on the claim.
- The information submitted is a copy of a complaint filed with the Texas Department of Insurance.
- The hassle is not clear, legible, or understandable.
- The HFL contains unclear issues and /or conflicting information.
- Physician billing errors are construed as payer hassles.
- The HFL lacks appropriate attachments.

TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

Hassle Factor Log

Mail or fax
(please don't do both)
to: (512) 370-1632
Texas Medical Association
401 W. 15th St.
Austin, TX 78701-1680

Physician Name _____ TMA Member # _____

Specialty _____ Address _____

Date Submitted _____ Contact Person _____

E-mail _____ Phone _____ Fax _____

Name of Insurance Company _____ Amount in Dispute _____

Name of Network _____

Request in relation to *(circle one)*:

Commercial HMO	Medicaid (TMHP)	Medicare Advantage Plan	Third Party Administrator
Commercial PPO	Medicare (Novitas)	PBM (Pharmacy Benefit Manager)	Tricare
Medicaid (HMO)	Medicare Part D- drug plan	Class Action Settlement	Workers' Comp

Type of problem *(circle all that apply)*:

Appeal Pending	Excessive Telephone Hold Time / Busy	Preauthorization
Bundling *(list specific codes)*:	Filing Deadline	Quantity Billed Amounts
_____	Inaccurate Data Entry by Insurer	Referral Denial
_____	Medical Record / Documentation Requests	Claim Denial
_____	Non recognized/Incorrect/Omitted CPT, HCPCS, Modifiers	Claims/Documents Lost
_____	Overpayment/Refund Request	Downcoding
	Payment Delay	Out of Network Payment

Other *(specify)*: _____

Brief Description of the Problem *(required)*: _____

Important: To achieve optima results utilizing the Hassle Factor Log (HFL) Program, please review the *HFL User Guide* for complete program guidelines. The most current version of the form and user guide may be obtained at www.texmed.org/hasslefactorlog. For HIPAA privacy compliance, a one-time business associate agreement (BAA) must be on file with TMA before submitting any protected health information (PHI). TMA/HFL program is not responsible for missed claims and/or appeal deadlines.

Any questions, need a BAA? Contact: (800) 880-1300, ext.1414.

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CMS Delays Dramatic Office-Visit Coding Changes Until 2021

Following advocacy by the Texas Medical Association and much of organized medicine, the Centers for Medicare & Medicaid Services (CMS) has delayed its proposal to dramatically overhaul evaluation and management (E&M) coding for physician services, a proposal that TMA warned would make treating Medicare patients "even more challenging."

CMS released its final 2019 physician fee schedule Thursday afternoon, saying in a release that it was delaying implementation of E&M coding changes until 2021 to "allow for continued stakeholder engagement."

That's an indication CMS listened to the objections of TMA and others. The CMS proposal, released in July, sought to collapse the five levels of outpatient-visit payments down to just two levels, with one payment for level 1 visits and the same flat payment rate applying to levels 2-5.

In comments to CMS, TMA warned of ugly consequences if that payment scheme became reality, telling the agency that it would remove incentives for physicians to care for patients with complex and complicated conditions. TMA's comments, which offered 75 distinct recommendations for improvements, called the proposal "neither accurate, fair, nor adequate."

But for now, it won't happen, as the final rule maintains the current five-level payment structure for 2019 and 2020. Meanwhile, CMS says "several documentation policies to provide immediate burden reduction" are going into effect with the 2019 fee schedule.

CMS also announced it's not implementing another proposal that would have reduced payments when E&M visits occur on the same day as procedures. TMA also strongly objected to that proposal.

The final rule also contains changes to Medicare's Quality Payment Program. Among those changes: Adding a new, third criterion — number of covered professional services — to the criteria that determine whether physicians fall under the low-volume threshold that would exempt them from the Merit-Based Incentive Payment System (MIPS).

TMA is hard at work analyzing the more-than-2,300-page final rule. We'll provide more information on what's in the rule in a future issue of Texas Medicine. In the meantime, read a fact sheet on the physician fee schedule portion at tma.tips/2019FeeSchedule, and a fact sheet on the QPP parts of the rule at tma.tips/2019QPP.

Joey Berlin

Get a Pass on MIPS Promoting Interoperability

Sometimes practices go through some rough patches and could use a little help — especially when it comes to complying with Medicare's Merit-Based Incentive Payment System (MIPS).

If your practice has 15 or fewer eligible clinicians and is experiencing some type of "significant hardship" that has created "overwhelming barriers" to complying with MIPS' Promoting Interoperability (PI) category, you are eligible to submit a hardship application.

If you are eligible for a hardship exemption, the Centers for Medicare & Medicaid Services (CMS) will reweight the PI performance category from 25 percent to zero percent when calculating your final score for the 2018 performance period. That 25 percent will then be reallocated to the quality performance category.

Because CMS doesn't thoroughly define what qualifies as a "significant hardship" or an "overwhelming barrier," the Texas Medical Association recommends saving all documentation of your circumstances and how they've affected your ability to participate in the PI category. If you can't back up the reasons for your hardship, your score may be adjusted back to pre-exemption status.

Apply for a hardship exemption at qpp.cms.gov/mips/exception-applications. The deadline to apply is Dec. 31, 2018.

If you have questions related to MIPS or PI, call the TMA HIT helpline at (800) 880-5720, or e-mail HIT@texmed.org.

David Doolittle

Continued on page 29

Dr. Richard McCallum at the Capital Austin, Texas with the (ACP) American College of Physicians seeing Legislators regarding patient related priorities for the upcoming season.

LUGPA, the only nonprofit Urology trade association in the U.S., has elected Dr. Jeffrey M. Spier to its board of directors. Dr. Spier is a managing partner at Rio Grande Urology. The Large Urology Group Practice Association is based in Chicago and has more than 2,300 member physicians.

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