



# *The El Paso* Physician

Volume 41 Number 1

## El Paso County Medical Society 2018 Officers



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“to advance the art and science of medicine,  
protect the physician and serve the patient”

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# President's Comment

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



Welcome to the 2018 first edition of the El Paso Physician Magazine. This year will be an exciting year and challenging year for the El Paso County Medical Society. This was demonstrated during our installation on February 7<sup>th</sup> at the Double Tree Hotel where we had several distinguished guests, including our keynote speakers, UTEP President, Dr. Diana Natalicio and Texas Medical Association President, Carlos Cardenas, MD. Present at the invocation were Robert Kirken, Dean College of Science at UTEP, Dr. Richard Black, Interim Dean of the School of Dentistry, Dr. Jose Rivera, Dean of the School of Pharmacy-UTEP, Mr. Tommy Gonzalez, El Paso City Manager, Dr. Erik Gonzalez and Dr. Francisco Berumen from Cd Juarez Medical Society. Our audience encapsulated the exciting new things in health care occurring in our border city of El Paso.

The El Paso County Medical Society will continue to work on strengthening our membership in numbers, be involved at the state and national level, and continue to grow alongside our medical community, our educational institutions, and hospital systems. Like Dr. Cardenas said, "If you are not at the table, you will be on the menu." As always, our administrative team, is set to have 2018 be a success as it was 2017 under Dr. Handal's presidential tenure. Our 2018 Officers Dr. Roxanne Tyroch, Internal Medicine, Dr. Alison Days, Pediatrics, Dr. Richard McCallum, Gastroenterology, and Dr. Jeffrey Spier, Urology, were also sworn into office.

The El Paso County Medical Society will continue to support the Texas Tech Paul L Foster School of Medicine students, our local physician members, and will continue to care for patients in our community. It is an exciting time as Texas Tech PLFSOM accepts the new entering class as the interview season has ended, and their current students will be entering the match process for residency with the results coming in late March.

As a society we are proud of The El Paso Physician Television show. It is a proud endeavor that has local recognition. Our society is the only medical society in Texas with a show to educate patients in important up to date medical topics. We will continue to air the TV show in order to educate our community, and give our local physicians a place to show and display their skills. Dr. Marwah has done an outstanding job for several years heading the show.

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 be involved at the local, state and federal level to improve the healthcare of our community as a whole. We will continue to strive to meet our mission:

**"TO ADVANCE THE ART AND SCIENCE OF MEDICINE  
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I look forward to serve as your President for 2018.

---

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

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# Editorial Comment

**Alison L. Days, MD**

*Editor*

*El Paso Physician, EPCMS*



*"I love America more than any other country in the world and exactly for this reason, I insist on the right to criticize her perpetually."*

**--James Baldwin**

Welcome to 2018, physicians! Although we are already concluding the first quarter of 2018, this is the first magazine issue of the year. 2018 is proving to be another year of controversy and change, both in and out of the medical arena. I would like to briefly discuss three issues close to my heart that have been in the news lately. Two topics pertain to public health and policy, the third is more pertinent to us financially as physicians.

My first topic is that of the recent increase in measles outbreaks. Measles is definitely making a comeback. Our first large measles outbreak in the United States occurred in 2014 in an unvaccinated Amish community in Ohio. There was a total of 383 cases in that one community (with 667 cases for that year in all states) which amounted to the greatest number of cases since measles was considered eliminated in the U.S in the year 2000.<sup>i</sup> In 2015, a multistate outbreak garnered national news due to the fact that the source case was thought to have traveled from the Philippines to Disneyland in California where children were vacationing. In April to May of 2017, another outbreak was investigated in a community of Somali-American where 95% of cases were unvaccinated.<sup>ii</sup> Most recently, the Texas Dept of State Health Services distributed a health advisory concerning 6 new reported cases of Measles in Ellis county in 2018, all in unvaccinated children.<sup>iii</sup>

Despite the resurgence of infectious diseases previously thought to be eliminated in the United States, parents continue to make the choice to refuse vaccination for their children. This is an area in which we, as physician-leaders, must continue to remain diligent and involved. Please push for vaccination both in those we treat and for those in our personal lives.

My second topic is that of gun violence. Guns and the regulation of them are hot button topics currently. I am not going to speak here about regulation or policy, but instead about the need for more research and statistics about gun violence on which to base laws concerning regulation. That means more research not just on mass shootings, but also on domestic violence, suicides and gang deaths/injuries where a firearm was involved. Initially, this seemed like a far-fetched idea given the general consensus, among those not in the health field, that gun violence was not a medical issue and should not, therefore, be under the jurisdiction of the CDC. Recently, there has been a change. A spending bill signed by President Trump on 3/23/18 has a line-item allowing the CDC the authority to do research on gun violence. However, the Dickey Amendment, passed in the late 1990's, continues to state that

no money appropriated for research will go to gun control promotion or gun control lobbying.<sup>iv</sup> This means that there will still be a fight as to which types of funding/grants may be used for research.

Lastly, I want to touch on the rapid increase in required prior authorizations for both prescribed medicines and referrals/procedures over the last year. These increases are occurring with Medicaid and commercial insurances and has warranted recognition by multiple medical societies including the TMA, AMA, AAFP, and the American College of Cardiology. According to an AMA survey conducted Dec. 2017, 92% of doctors said that prior authorizations caused delays in patient care. Compare that to AMA's 2016 survey in which 90% of doctors reported delays.<sup>v</sup> Also noted in the same survey is that 30% of MDs reported waiting 3 days or longer for decisions from insurance. The AMA has recently stated the Prior Auth is being overused and the "existing processes are costly and inefficient." As of January 2018, many insurances have changed their formularies, causing even more delays. As a result, the AMA, along with the American Hospital Association (AHA), America's Health Insurance Plans (AHIP), American Pharmacists Association (APhA), Blue Cross Blue Shield Association (BCBSA) and Medical Group Management Association (MGMA) have formed a coalition to address issues of prior authorization.<sup>vi</sup> Keep an ear out for more info on their consensus statement and progress in this area.

These are some of the issues about which I am passionate. They may not be yours. However, it is extremely important that we each find a cause to be passionate about and continue to remain involved in that cause, whether by researching the topic, informing others about the issues, calling legislators or attending a march or rally as protest. This is the only way to affect change.

Read on to learn about those making changes here in El Paso.

<sup>i</sup><https://www.cdc.gov/measles/cases-outbreaks.html>

<sup>ii</sup><https://www.cdc.gov/mmwr/volumes/66/wr/mm6627a1.htm>

<sup>iii</sup><https://www.dshs.texas.gov/news/releases/2018/HealthAdvisory-01232018.aspx>

<sup>iv</sup><https://www.theverge.com/2018/3/23/17157938/cdc-gun-violence-research-omnibus-bill-dickey-amendment-funding-ban>

<sup>v</sup><https://www.texmed.org/Template.aspx?id=47092&terms=prior%20author>

<sup>vi</sup><https://www.ama-assn.org/health-care-leaders-collaborate-streamline-prior-authorization>

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

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CASE REPORT

*E.P.C.M.S.*

## The Use of Complementary and Alternative Medicine in the Treatment of Gastrointestinal Symptoms along the US-Mexico Border

Christopher Skalomenos, MS4

Luis A. Alvarado, M.S.

Richard W. McCallum, MD, FACP, FRACP (Aust), FACG, AGAF

CASE REPORT

### INTRODUCTION

Other studies have assessed the use of complementary and alternative medicine (CAM) in the treatment of gastrointestinal disorders, but there is a paucity of such studies specifically along the US-Mexico border.

### AIMS

This survey aimed to identify the reasoning and frequency for CAM, linking symptoms and diagnoses with specific CAM products utilized by patients of an academic medical center on the US-Mexico border.

### METHODS

49 patients voluntarily completed an anonymous 25-item questionnaire during a visit to a university-based GI motility referral center.

### STATISTICAL ANALYSIS

The data on CAM used to treat GI problems was analyzed by gender, age groups, and ethnicity using a Poisson regression analysis.

### RESULTS

46.8% of the 49 patients answered that they used CAM. More females than males reported using CAM for abdominal pain ( $p < .001$ ), as well as for heartburn ( $p = 0.03$ ). Patients between the ages of 18-40 were more likely to use CAM than those over 40 ( $p = 0.049$ ). Hispanics were less likely than non-Hispanics to use CAM for abdominal pain ( $p=0.005$ ), or nausea/vomiting ( $p=0.006$ ). Between ethnicities, there were no significant differences in the use of CAM for other symptoms. Patients who listed constipation as their most bothersome symptom were nine times more likely to be using CAM ( $P = 0.004$ ).

### CONCLUSIONS

The most common reasons patients at a GI Motility clinic gave for utilizing CAM were abdominal pain, heartburn, nausea, vomiting and constipation. Non-Hispanics, females and patients under 40 were significantly more likely to use CAM for gastrointestinal symptoms. Identifying specific CAM products and recognizing that CAM is commonly utilized could improve the doctor-patient understanding with potential to recognize and avoid CAM interactions with pharmaceuticals.

### Introduction and Goals

There have been multiple studies on use of complementary and alternative medicine (CAM) for gastrointestinal disorders. One large

study, using data from the 2012 Nation Health Survey, found that 42% of respondents with a GI condition in the previous year had used CAM to treat the symptoms.<sup>1</sup> Another study that estimated the prevalence of CAM use at 44% found that users were more likely to be female, regardless of age, race or diagnoses.<sup>2</sup> There is a paucity of studies looking at the use of CAM along the US-Mexico border, but one study performed along the US-Mexico border devised a guide that indexed common herbal products, listing their use and possible side effects.<sup>3</sup> The study found that 71% of respondents used herbal products, but it did not focus on epidemiology or patient perspectives.<sup>3</sup> Another study attempted to elucidate reasons for using CAM, including where patients may have learned about them.<sup>4</sup> Those past studies raised concerns that patients might be unaware of dangers and that physicians might be unaware of that their patients are using CAM products.<sup>3,4</sup> A questionnaire on CAM use for GI symptoms along the US-Mexico border could help bring a better understanding between patients and physicians to help identify their reasons for using CAM.

### Methods

**Survey.** A 25-item survey, comprised of multiple choice questions and questions asking respondents to write-in answers, was devised to obtain both quantitative and qualitative data on the use of CAM for gastrointestinal symptoms. The survey included questions on patients' age, race and gender, and to ascertain gastrointestinal diagnoses. The questionnaire asked questions about problematic and easy to treat symptoms such as diarrhea or constipation, if and why they used CAM, and their satisfaction with prescribed treatments. The survey attempted to associate specific symptoms with use of specific CAM.

**Population.** The study sampled the population of patients from a single gastrointestinal motility referral clinic located at an academic medical center in El Paso, Texas. They were patients who came to the clinic with a variety of gastrointestinal tract diagnoses and symptoms. Some were attending the clinic on a regular basis, while others were recent referrals. Patients were invited to participate based solely on their presence in the clinic on the day that surveys were being distributed.

**Data Collection.** Patients were informed that the survey was anonymous and voluntary. Patients who were willing to complete the survey did so in the privacy of an exam room prior to being seen by the physician. Participants had their choice to complete the survey in either Spanish or English. The data was gathered without

Continued on page 8

## The Usage of Complementary and Alternative Medicine in the Treatment of Gastrointestinal Symptoms along the US-Mexico Border (Continued)

any patient identifiers for analysis. A total of 49 surveys were collected during the study period in 2016-2017.

**Statistical Analysis.** The number of complementary and alternative therapies that participants reported using to treat gastrointestinal disorders was analyzed by univariate Poisson regression according to gender, age and ethnicity. Univariate and multivariate logistic regression was employed to assess use of specific CAM products for specific gastrointestinal symptoms. The results are reported as odds ratios, 95% confidence intervals (C.I.), and p-values. P-values less than 0.05 were considered significant. All of the statistical analyses were carried out using SAS 9.4.

Quantitative data were expressed as mean, standard deviation, median, and inter-quartile range. Qualitative data were expressed in terms of frequency and proportion.

### Results

A total of 49 clinic patients were surveyed (Table 1), 46.8% of them reported using CAM to treat GI symptoms, 43.8% believed that alternative medicine can be more effective than Western medicine, and 76.9% reported that they were unaware of a potential for side effects when alternative therapies are combined with prescribed medicines.

**Table 1: Summary of demographic variables**

| Variables        | Frequency | Percent |
|------------------|-----------|---------|
| <b>Gender</b>    |           |         |
| Male             | 20        | 40.82   |
| Female           | 29        | 59.18   |
| <b>Age</b>       |           |         |
| 18-30            | 1         | 2.04    |
| 31-40            | 7         | 14.29   |
| 41-50            | 14        | 28.57   |
| 51-60            | 6         | 12.24   |
| 61-70            | 14        | 28.57   |
| > 70             | 7         | 14.29   |
| <b>Age</b>       |           |         |
| 18-40            | 8         | 16.33   |
| 41-60            | 20        | 40.82   |
| > 60             | 21        | 42.86   |
| <b>Race</b>      |           |         |
| Hispanic         | 27        | 55.1    |
| Caucasian        | 18        | 36.73   |
| African American | 3         | 6.12    |
| Other            | 1         | 2.04    |
| <b>Ethnicity</b> |           |         |
| Non-Hispanic     | 22        | 44.9    |
| Hispanic         | 27        | 55.1    |

When asked why they use alternative therapies, 30.6% stated it was to do everything they could to treat their symptoms.

Comparing specific types of GI disorders (Table 2a-2c), more females than males reported using CAM for abdominal pain ( $p < .003$ ), and for heartburn ( $p = 0.03$ ). When looking at CAM use for specific symptoms Table 3 summarizes types of CAM used for specific symptoms.

**Table 2a: Number of alternative therapies for specific gastrointestinal issues by gender**

| Variables   | Male<br>Mean (SD) | Female<br>Mean (SD) | P-value |
|---|-------------------|---------------------|---------|
| Number of alternative therapies for diarrhea            | 0.5 (0.83)        | 0.41 (1.02)         | 0.658   |
| Number of alternative therapies for constipation        | 0.45 (0.76)       | 0.45 (0.78)         | 0.993   |
| Number of alternative therapies for bloating/excess gas | 0.35 (0.67)       | 0.62 (0.98)         | 0.198   |
| Number of alternative therapies for abdominal pain      | 0.15 (0.37)       | 0.9 (1.4)           | 0.003   |
| Number of alternative therapies for heartburn           | 0.15 (0.49)       | 0.59 (0.87)         | 0.029   |
| Number of alternative therapies for indigestion         | 0.2 (0.52)        | 0.52 (0.87)         | 0.091   |
| Number of alternative therapies for nausea/vomiting     | 0.3 (0.66)        | 0.69 (1.28)         | 0.073   |
| Number of alternative therapies for incontinence        | 0.1 (0.45)        | 0.14 (0.44)         | 0.71    |

**Table 2a: Number of alternative therapies for specific gastrointestinal issues by gender**

| Variables   | Male<br>Mean (SD) | Female<br>Mean (SD) | P-value |
|---|-------------------|---------------------|---------|
| Number of alternative therapies for diarrhea            | 0.5 (0.83)        | 0.41 (1.02)         | 0.658   |
| Number of alternative therapies for constipation        | 0.45 (0.76)       | 0.45 (0.78)         | 0.993   |
| Number of alternative therapies for bloating/excess gas | 0.35 (0.67)       | 0.62 (0.98)         | 0.198   |
| Number of alternative therapies for abdominal pain      | 0.15 (0.37)       | 0.9 (1.4)           | 0.003   |
| Number of alternative therapies for heartburn           | 0.15 (0.49)       | 0.59 (0.87)         | 0.029   |
| Number of alternative therapies for indigestion         | 0.2 (0.52)        | 0.52 (0.87)         | 0.091   |
| Number of alternative therapies for nausea/vomiting     | 0.3 (0.66)        | 0.69 (1.28)         | 0.073   |
| Number of alternative therapies for incontinence        | 0.1 (0.45)        | 0.14 (0.44)         | 0.71    |

**Table 2c: Number of alternative therapies for specific gastrointestinal issues by ethnicity**

| Variables   | Non-Hispanic<br>Mean (SD) | Hispanic<br>Mean (SD) | P-value |
|---|---------------------------|-----------------------|---------|
| Number of alternative therapies for diarrhea            | 0.59 (1.18)               | 0.33 (0.68)           | 0.186   |
| Number of alternative therapies for constipation        | 0.55 (0.8)                | 0.37 (0.74)           | 0.366   |
| Number of alternative therapies for bloating/excess gas | 0.5 (0.8)                 | 0.52 (0.94)           | 0.928   |
| Number of alternative therapies for abdominal pain      | 0.95 (1.5)                | 0.3 (0.67)            | 0.005   |
| Number of alternative therapies for heartburn           | 0.36 (0.66)               | 0.44 (0.85)           | 0.66    |
| Number of alternative therapies for indigestion         | 0.36 (0.79)               | 0.41 (0.75)           | 0.091   |
| Number of alternative therapies for nausea/vomiting     | 0.86 (1.46)               | 0.26 (0.53)           | 0.006   |
| Number of alternative therapies for incontinence        | 0.09 (0.43)               | 0.15 (0.46)           | 0.572   |

Significantly more participants between 18-40 years of age than those over 40 reported using CAM ( $p = 0.049$ ).

Hispanics were less likely than non-Hispanics to use CAM for abdominal pain ( $p = 0.005$ ), or nausea/vomiting ( $p = 0.006$ ). Between ethnicities, there were no significant differences in the use of CAM for other symptoms.

Patients who listed constipation as their most bothersome symptom were nine times more likely to be using CAM ( $p = 0.004$ ).

### Discussion

A report on the use of CAM published by CDC in 2008 found that people between ages 50-59 comprised the largest portion of CAM users (44.1% of respondents), followed by 40-49 years olds (40.1%) and 60-69 year olds (41.1%).<sup>5</sup> Our survey data showed that patients aged 18-40 were more likely to use CAM than those over 40. That might be attributed to a variety of reasons, including differences in what we included in the definition of CAM. Our study mainly focused on orally ingested therapies, whereas the CDC included other thera-

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## The Usage of Complementary and Alternative Medicine in the Treatment of Gastrointestinal Symptoms along the US-Mexico Border (Continued)

pies such as “mind-body therapies” and “energy healing therapies”.<sup>5</sup> Our finding that females were more likely to use CAM was consistent with other studies.<sup>1,2,6</sup> That is in line with data showing that overall, patients with GI disorders were more often female.<sup>1</sup>

The finding that non-Hispanic patients were more likely than Hispanics to use CAM for certain symptoms was consistent with a systematic review in which 38 studies concluded that non-Caucasian ethnic minorities were less likely to use CAM, while 15 concluded the opposite.<sup>6</sup> That runs somewhat contrary to notions that CAM is rooted mainly in cultures of traditional medicine. The most frequently reported rationale for using CAM was not tradition, but because the patient wanted to do everything they could to manage their own health. A 2012 survey similarly figured “general wellness or disease prevention” as the top choice, and “part of your upbringing” ranked towards the bottom.<sup>1</sup> Our data also showed that patients were nine times more likely to use CAM when constipation was perceived as the chief concern.

Physician-patient rapport and communication are of paramount importance. Along the US-Mexico border, it is especially important to ask patients whether they are using any alternative therapies. In some traditional Latino cultures, indigestion, referred to as “empacho”, might sometimes be treated with harmless teas, but other options might contain lead salts or mercury.<sup>7</sup> Our data showed that most patients were unaware of any potential that, using CAM could have adverse effects.

### Conclusions

Among our survey sample of GI motility clinic patients, the most frequently reported reasons for using CAM were abdominal pain, heartburn, nausea, vomiting and constipation. Hispanics were significantly less likely than non-Hispanics to use CAM for abdominal pain or nausea. Females were more likely than males to use CAM for gastrointestinal symptoms. According to our data, patients under 40 were more likely than those over 40 to use CAM. Identifying specific CAM products and recognizing that CAM is commonly used, could improve doctor-patient communication and reduce potential for adverse interactions between CAM products and prescribed pharmaceuticals.

**Limits.** This study was done at a single clinic, and included patients under the care of the same gastroenterologist. This could bias toward patients referred for problems of which the physician specializes, specifically gastroparesis and disorders of which nausea and vomiting figure prominently. Generalizability might be limited with a sample comprised of only 49 respondents. The definition of CAM can also vary, and the patients may not have fully understood what would and would not constitute CAM by our survey definition while providing data during the survey.

**Acknowledgements.** We would like to thank Dr. Armando Gonzal-

**Table 3:** Summary of alternative therapies for specific gastrointestinal issues

| Q17. If applicable, please circle or list any alternative therapies you use for: | Diarrhea  | Constipation | Bloating/excess gas | Abdominal pain | Heartburn | Indigestion |
|--|-----------|--------------|---------------------|----------------|-----------|-------------|
|  | N (%)     | N (%)        | N (%)               | N (%)          | N (%)     | N (%)       |
| A. Herbal teas   | 7 (14.29) | 3 (6.12)     | 6 (12.24)           | 6 (12.24)      | 8 (16.33) | 6 (12.24)   |
| B. Cinnamon  | 0 (0.00)  | 0 (0.00)     | 1 (2.04)            | 1 (2.04)       | 2 (4.08)  | 1 (2.04)    |
| C. Peppermint  | 1 (2.04)  | 0 (0.00)     | 3 (6.12)            | 4 (8.16)       | 2 (4.08)  | 3 (6.12)    |
| D. Ginger  | 3 (6.12)  | 1 (2.04)     | 3 (6.12)            | 3 (6.12)       | 3 (6.12)  | 2 (4.08)    |
| E. Garlic  | 0 (0.00)  | 0 (0.00)     | 0 (0.00)            | 0 (0.00)       | 0 (0.00)  | 0 (0.00)    |
| F. Psyllium  | 1 (2.04)  | 2 (4.08)     | 0 (0.00)            | 0 (0.00)       | 0 (0.00)  | 0 (0.00)    |
| G. Senna   | 0 (0.00)  | 1 (2.04)     | 0 (0.00)            | 0 (0.00)       | 0 (0.00)  | 0 (0.00)    |
| H. Wormwood  | 0 (0.00)  | 0 (0.00)     | 0 (0.00)            | 0 (0.00)       | 0 (0.00)  | 0 (0.00)    |
| I. Aloe Vera   | 1 (2.04)  | 1 (2.04)     | 0 (0.00)            | 0 (0.00)       | 2 (4.08)  | 1 (2.04)    |
| J. Celery  | 0 (0.00)  | 0 (0.00)     | 0 (0.00)            | 0 (0.00)       | 0 (0.00)  | 0 (0.00)    |
| K. Anise   | 0 (0.00)  | 0 (0.00)     | 0 (0.00)            | 0 (0.00)       | 0 (0.00)  | 0 (0.00)    |
| L. Probiotics, Yogurt  | 9 (18.37) | 11 (22.45)   | 11 (22.45)          | 11 (22.45)     | 3 (6.12)  | 5 (10.2)    |
| M. Other, (please list)  | 0 (0.00)  | 3 (6.12)     | 1 (2.04)            | 4 (8.16)       | 0 (0.00)  | 1 (2.04)    |

lez-Stuart for helping with the Spanish survey translation, and thank the staff at the gastroenterology clinic.

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# CR

## CASE REPORT

*E.P.C.M.S.*

## Myasthenia Gravis Presenting with Fecal Incontinence

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### ABSTRACT

**Background:** Fecal incontinence (FI) is defined by involuntary loss of stool. Urge incontinence occurs when voluntary attempts to control the passage of rectal contents fails. In this report we present a case of Myasthenia gravis who presented with FI as the primary gastrointestinal symptom. This is an example for consideration of uncommon etiologies in patients with FI especially those with refractory symptoms.

**Case Summary:** 70 year old man was referred to the gastroenterology clinic with a complaint of FI described as urgency and occasional accidents. He did not respond to antidiarrheal therapy and subsequently underwent anorectal manometry which demonstrated decreased external anal pressures during rest and squeeze state. He was also noted to have symptoms suggestive of Myasthenia gravis and the diagnosis was subsequently confirmed. He partially responded to cholinesterase inhibitors; however he required further escalating therapy to prednisone and immunomodulator. Eventually IVIG was administered with dramatic response and resolution of his symptoms including FI.

**Conclusion:** We report a case of new onset FI which was found to be secondary to Myasthenia gravis, a relatively rare disorder. Detailed attention to the patient's history and physical exam was the key to resolution of this case which would have been otherwise unrecognized. ARM is able to identify both smooth and striated muscle function in evaluating FI, however, it is complementary and not an alternative to history and physical exam. Clinicians should consider the unusual causes of FI especially in those who do not respond to standard therapy.

### INTRODUCTION

#### Fecal incontinence

Fecal incontinence (FI) is characterized by involuntary loss of solid or liquid feces which can occur despite efforts to retain bowel contents (urge incontinence) or result from leakage of stool (fecal seepage) and inability to feel the need for defecation (passive incontinence).<sup>1</sup> FI can occur in people of all ages with a wide range of severity and significant impact on the productivity and quality of life of the affected individuals.

FI is often multifactorial and occurring when the integrity of mechanical barriers and/or sensory machinery ("sampling reflex") has been disrupted to the degree that compensatory mechanisms fail to maintain continence of rectal contents.<sup>2-4</sup> For in-

stance, obstetrics injury is recognized as a major contributor to FI in women as a result of injury to the internal anal sphincter (IAS), external anal sphincter (EAS) or pudendal nerves during delivery. Other pathogenic factors include iatrogenic injury during anorectal dilatation or surgery as well as direct trauma to anal sphincter, rectal prolapse, and longstanding inflammation or fibrosis.<sup>5</sup>

In the absence of mechanical injury FI may be caused by neuromuscular disorders such as myopathies, muscular degenerations or neurological condition that can affect sensory or motor function of peripheral nerves and center nervous system.<sup>6,7</sup> Disorders affecting skeletal muscles such as autoimmune myopathies, muscular dystrophies and MG can result in FI. Here we discuss a case of new onset FI with impaired EAS function where the diagnosis of MG was identified as the underlying etiology.

#### Myasthenia Gravis

Myasthenia Gravis (MG) is a rare T-cell dependent autoimmune disorder of neuromuscular junction with an annual incidence of about 10 case per million<sup>8,9</sup>, caused by binding of auto antibodies to acetylcholine receptors or related molecules and presents with variable degrees of muscle weakness.<sup>10</sup> MG primarily involves proximal skeletal muscle and almost always affects ocular muscles with diplopia and ptosis as the hallmark of this condition. Patients affected with MG typically notice increased weakness with exercise and repetitive muscle contractions which could be variable. Variants of presynaptic myasthenic syndrome include; the Lambert-Eaton syndrome, neuromyotonia, congenital myasthenic syndromes and toxin-induced muscle dysfunction. MG is typically suspected based on clinical manifestation and diagnosis is usually made with serologic tests positive for antibodies against acetylcholine receptors, muscle-specific kinase, and lipoprotein receptor-related protein 4 (LRP4).<sup>11</sup> Occasionally neurophysiological studies are required to establish diagnosis in seronegative patients. From a clinical standpoint MG can present with limited form which exclusively affect ocular muscles or generalized disease which commonly affects other musculatures in addition to periorbital muscles. Considering factors such as genetic features, molecular mechanisms, thymic status, autoantibody characteristics and disease phenotype, patients with MG can be allocated to different subgroups. This classification is important in prognosis and tailoring therapeutic options.

Continued on page 12

**Myasthenia Gravis Presenting with Fecal Incontinence  
(Continued)**

**CASE PRESENTATION**

A 70 year old man with history of diabetes mellitus, hypertension, and nicotine dependency was referred by his primary care physician to our gastroenterology clinic with complaint of FI first noted about a year prior to the presentation and has been progressive since then. He describes his symptoms as urgency and inability to make it to the bathroom on time leading to accidents on average two times a week. He endorsed this has negatively impacted his quality of life and function. His stool was soft and semi-solid in consistency. On digital rectal exam he was noted to have external hemorrhoids but no rectal prolapse, normal relaxation of EAS but somewhat decreased resting anal pressure and squeeze tone. He has normal perineal descent. In terms of prior studies he had a negative colonoscopy three years prior to presentation. On initial visit plan was made to start him on antidiarrheal (loperamide) and fiber supplementation to improve stool consistency. He was advised on Kegel exercise and plan was made for re-evaluation with consideration of anorectal manometry (ARM) if he does not respond to abovementioned therapy. (Figure 1)

Patient followed the instruction that was provided but he continued to have FI despite improvement in stool consistency. ARM was performed which showed decreased squeeze response by the external anal pressure < 40 mm Hg (normal > 75 mm Hg, Figure 1, Table 1) with threshold for sensation of 50 cc (normal < 25 cc) but expulsion of 50cc water filled balloon was successful. IAS

pressure was within normal range. (Figure 2) On the follow up visit he was noted to have ptosis on exam. On further history he endorsed generalized muscle weakness, and fatigue with repetitive activities. He reported recurrent falling episodes due to weakness and intermittent oropharyngeal dysphagia. Given these findings he was referred for serologic testing for MG which confirmed the diagnosis. Given his long-term history of smoking cross sectional imaging (CT scan) of chest, abdomen and pelvis was performed to evaluate for Lambert-Eaton myasthenic syndrome (LEMS) secondary to small cell lung cancer or other occult malignancies which was unremarkable.

Subsequently, he was started treatment with cholinesterase inhibitor (Pyridostigmine 60 mg TID which gradually increased to 180 mg TID) with partial response. Later on systemic steroids (prednisone 20 mg PO daily gradually increased to 60 mg daily over a period of 2 weeks) and immunosuppressant (mycophenolate mofetil 500 mg PO BID increased to 1000 mg BID then to 1500 mg BID over a period of two months) added to his therapy. Despite these measures he continued to remain symptomatic and eventually underwent intravenous immunoglobulin infusion (Gammagard® 10% concentration) 0.5 gm/kg Infusion with dramatic response in terms of FI and his other symptoms. On a follow up phone interview he confirmed that he had not had any incontinent episodes for more than a month and how much his quality of life had improved.

**Continued on page 13**

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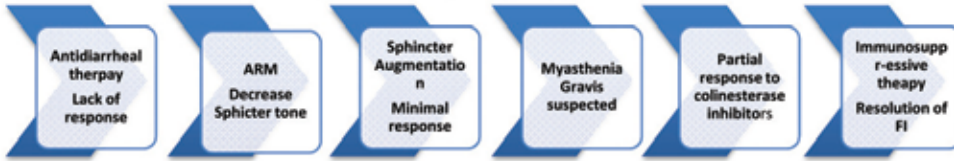
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**Myasthenia Gravis Presenting with Fecal Incontinence  
(Continued)**

Figure 1- Timeline for relevant information regarding diagnosis and response to treatment



**DISCUSSION**

In this report we present a case of MG refractory to conventional therapy that presented with FI associated with urgency as his primary complaints and responded to immunosuppressive therapy with significant improvement in his function and quality of life. Urge incontinence is a type of FI that is characterized by passage of fecal material despite active effort to control the bowel content and is primarily due to disorders of the EAS striated muscle or rectal capacity. Conditions that would affect striated muscles such as MG can result in FI. However this conditions and muscular dystrophies in general are relatively uncommon and clinicians may not readily consider them as the underlying culprit for the sphincter weakness and consequent incontinency.

Here we report a unique case of MG that presented with FI as the main initial complaints. Additionally his FI did not response to conventional medial therapy and local sphincter augmenting

exercises. After the diagnosis of MG, he partially responded to first line therapy, but resolution of his symptoms was not achieved until immunotherapy for MG was initiated. To our knowledge there is only one older report of a case of MG presenting as uncontrollable flatus and FI.<sup>12</sup> We believe this is an uncommon mechanism (MG) for a common condition (FI)

that is worth reporting to increase awareness for special etiologies of FI.

When evaluating patients with symptoms of fecal incontinency, it is important for the clinicians to attempt to categorize them into one of the three types of FI which include urge incontinence, passive incontinence and fecal seepage. Depending on these subtypes further diagnostic studies can be performed to establish the mechanism underlying this disorder which would lead to an effective therapy. Detailed attention to the history and performing a comprehensive physical examination is the key in approaching FI. Information obtained during ARM findings can further guide the management by quantifying EAS function and rectal sensitivity for stool but would not be a replacement for clinical data gathering. If the patient does not respond to conventional therapy uncommon causes of FI should be investigated.

**Continued on page 14**

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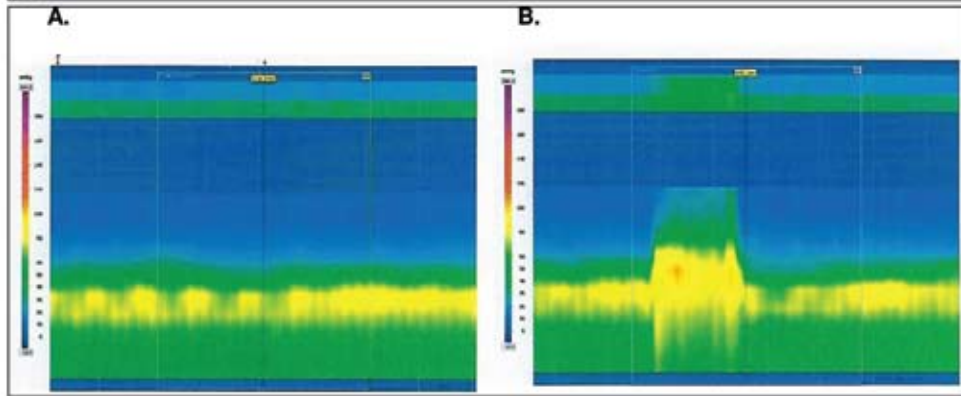
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**Myasthenia Gravis Presenting with Fecal Incontinence  
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**Figure 2- ARM findings in the patient with myasthenia gravis presented with urge fecal incontinence. Graph representative of decreased external anal sphincter tone during rest (A) and squeeze (B) state.**



**Table 1- ARM parameters with corresponding reference values**

| Parameters  | Value (mmHg) | Reference (mm Hg)     |
|---|--------------|-----------------------|
| <b>Resting Measurements</b>                         |              |                       |
| • Mean internal anal Sphincter Pressure             | 47.2         | 30 - 100              |
| <b>Squeeze Measurements</b>                         |              |                       |
| • Max. external anal Sphincter Pressure             | 94.2         |                       |
| • Rectal pressure above baseline                    | 50           | >75 mm above baseline |
| <b>Push (Attempted Defecation)</b>                  |              |                       |
| • Percent relaxation of the internal anal sphincter | 59           | >30%                  |

**Acknowledgements**

We would like to acknowledge this patient for kindly providing us with permission to present his history as a case report. We hope that this report add an insight to the medical community to improve patient care and wellbeing.

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# CR

CASE REPORT

*E.P.C.M.S.*

## Permanent His Bundle Pacing: Its Use in 4 Clinical Scenarios

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CASE REPORT

RV apical pacing causes interventricular (RV contracts before LV) and intraventricular (septum contracts before lateral wall) dyssynchrony and adverse hemodynamics. RV pacing burden >20% of the time increases congestive heart failure (CHF), atrial fibrillation and mortality.<sup>1</sup> Based on David II trial,<sup>2</sup> the current practice is to avoid frequent RV pacing. Interestingly, success of pacemaker therapy is measured by how minimally RV is paced.

Although Cardiac Resynchronization Therapy (CRT) via coronary sinus is widely used for re-synchronization of conduction abnormalities, up to 1/3 of patients do not respond to the treatment.<sup>3</sup> Perhaps biventricular pacing itself introduces non-physiological ventricular activation sequence; with RV pacing from the endocardium and the coronary sinus lead activates the left ventricle from the epicardium. Furthermore, diaphragmatic stimulation precludes many patients from benefits offered by the procedure. His Bundle is the ideal pacing site without causing dys-synchrony in electrical activation and avoids adverse effect on ventricular function. Permanent His Bundle pacing has the additional benefit of the lead not crossing the tricuspid valve which can cause tricuspid valve damage and regurgitation. The other benefit is no contrast injection is required.

Our facility has been performing permanent His Bundle pacing for the last 12 months and has successfully performed over 40 cases. We use the Medtronic fixed curve C315 Sheath in over 90% of cases and the Medtronic Select 3830 His leads. At the present moment, no other pacemaker manufacturer offers permanent His lead and the delivery system. The Medtronic lead is MRI compatible.

Four clinical scenarios are described to illustrate the unique usefulness of permanent His bundle pacing.

### Case 1: Patient with sick sinus syndrome, CHF but had an occluded coronary sinus precluding CRT.

80 years old Hispanic woman had mitral valve replacement for mitral regurgitation four years prior. She subsequently developed sick sinus syndrome with ejection fraction (EF) by echocardiogram at 30%. Her treating cardiologist in another facility attempted CRT but noted the coronary sinus was occluded probably secondary to the prior mitral replacement operation. She was treated with single chamber RV pacing for symptomatic bradycardia. Within 6 months after pacemaker insertion, the patient developed congestive heart failure requiring repeated hospital admissions in the other facilities. Because of severe shortness of breath, she was

taken by the ambulance to the "closest" hospital and was admitted to our facility with CHF and BNP greater than 2000 units and EKG showed LBBB on the account of RV pacing (Fig 1). She was brought to the EP lab and a hexapolar His bundle catheter was placed from the right femoral vein. His bundle record-

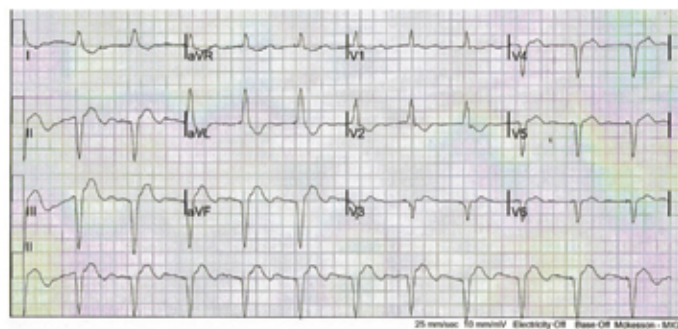


Figure 1. EKG shows atrial fibrillation with RV apical pacing and wide QRS complex.

ing was obtained and pacing resulted in a much narrower QRS after an iso-electric interval suggesting selective His pacing. A Medtronic His lead was placed and the resulting EKG showed a normal looking QRS. (Fig 2).

The His lead was connected to the atrial port of a new dual chamber pacemaker and preexisting RV lead connected to the RV port. The

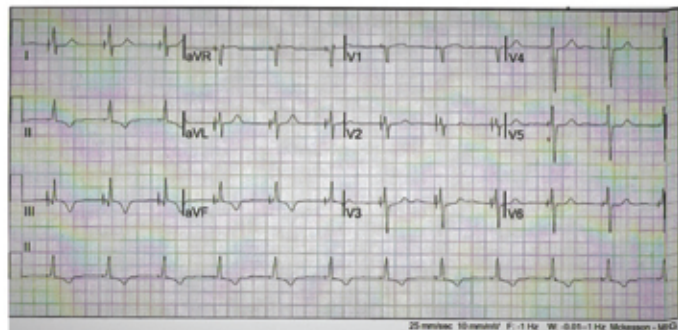


Figure 2. EKG shows atrial fibrillation with His bundle pacing and normal QRS complex.

His pacing was programmed 80msec before the RV pacing so the RV spike fell on the refractory period of the ventricle. Ever since the establishment of His pacing, the patient had an improved exercise tolerance and hasn't required hospital admission for congestive

Continued on page 16

heart failure. Repeat echocardiogram was not done since the practice guideline denies such study within 1 year after pacer therapy.

**Case 2. Sick sinus syndrome with impaired LV function EF 35%**

99 years old female was admitted with dizziness and light-headedness for 3 days. She had long standing atrial fibrillation/fibrillation, renal failure, and CHF with EF at 35%. She had documented repeated pauses greater than 3-second pauses with a narrow QRS complex. (Fig 3).

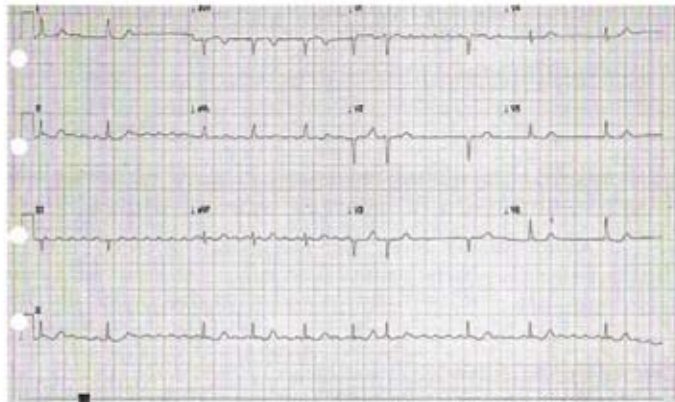


Figure 3. EKG shows atrial flutter fibrillation with periods of slow ventricular response and normal QRS complex.

Because of advanced age and long standing arrhythmias, AF/Atrial flutter ablation will be of low success rate. Traditionally, the patient's condition will call for biventricular pacing with contrast injection to locate the coronary sinus which would not be desirable in the presence of renal failure. A Medtronic delivery sheath with the lead was used to search for the His bundle spike. (Fig 4).

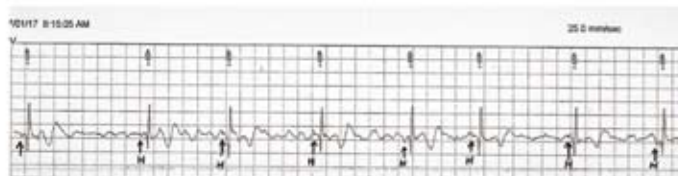


Figure 4. Intra-cardiac electrogram showing His potential with underlying atrial fibrillation.

The lead was screwed in at that location and connected to the atrial port of a dual chamber pacer and a RV lead was connected to the RV port. The pacer was programmed at DDD mode with RV stimulation 80 millisecond after the His spike so as to avoid RV pacing. The 12 lead EKG demonstrated His pacing at 70/min with identical narrow QRS complex.(Fig 5).

The patient went home without any symptoms or complications maintaining on anti-coagulations for the underlying atrial fibrillation.

**Case 3. AF with uncontrolled ventricular rate and CHF.**

76 years old female with chronic atrial fibrillation for 4 years. She was on anti-coagulation and rate control medications. However her ventricular heart rate became difficult to control and gradually developed symptoms of CHF. (Fig 6)

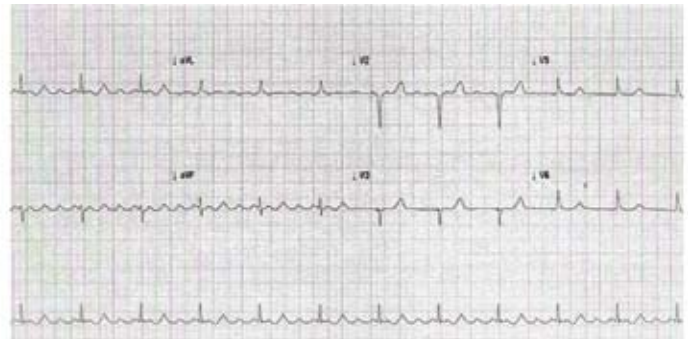


Figure 5. Selective His pacing with narrow identical QRS complex and T waves as compare to baseline EKG in Fig 3.

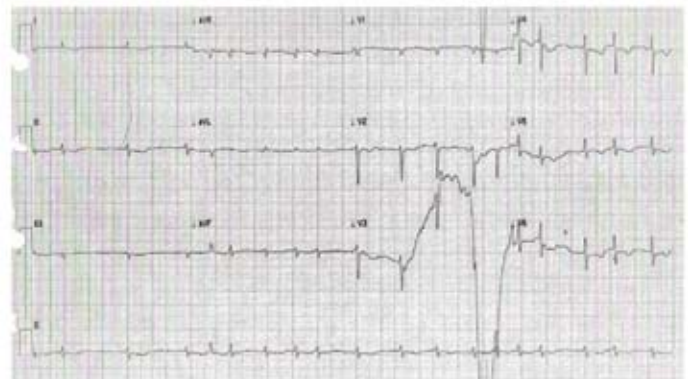


Figure 6. Atrial fibrillation with rapid ventricular response.

She was admitted for AV nodal ablation and permanent His bundle pacing. A RV lead was placed at the apex and a Medtronic His lead was screwed in at the His location. AV nodal ablation was performed. (Fig 7).

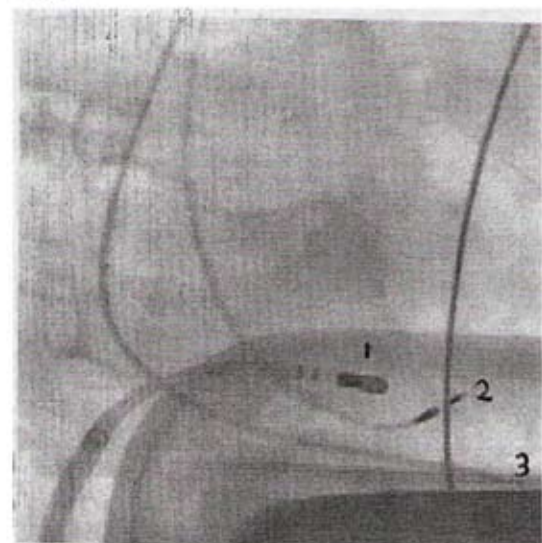


Figure 7. AV nodal ablation with irrigated electrode (label 1) introduced from the femoral vein. His bundle pacing lead (label 2) about 1 cm anterior to the ablation electrode. RV lead (label 3) at the apex of RV.

Continued on page 17

**Permanent His Bundle Pacing: Its Use in 4 Clinical Scenarios  
(Continued)**

The His lead was connected to the atrial port of a dual chamber pacemaker and the RV lead attached to the ventricular port with AV delay programmed at 80 millisecond to ensure His pacing and no contribution of RV pacing. (Fig 8).

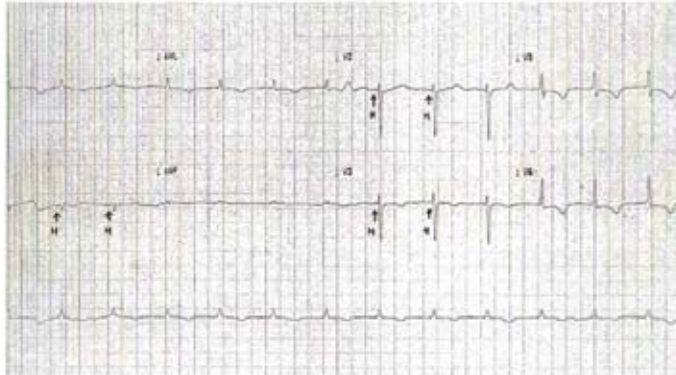


Figure 8. 12 lead EKG with selective His pacing. The similarity of the paced QRS complex and the T waves compares to the baseline EKG is remarkable in Figure 6.

The symptoms of congestive heart failure and exercise tolerance improved remarkably after the procedure.

**Case 4. LV epicardial lead had fallen and landed on the diaphragm.**

84 years old female was admitted with congestive heart failure. She had biventricular ICD implanted in another city. Because of difficulty implanting coronary sinus lead, the LV lead was implanted surgically in the epicardium. But the epicardial lead was dislodged and fell to the diaphragm causing persistent diaphragmatic stimulation shortly after the procedure and so the pacing was programmed to RV pacing. (Fig 9).

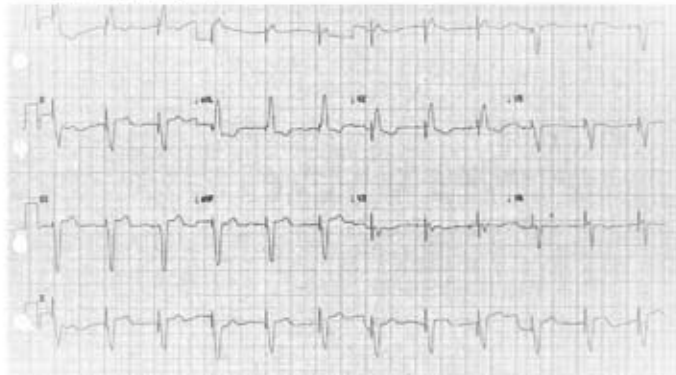


Figure 9. 12 lead EKG shows underlying AF and 100% RV pacing from the apex.

Echocardiogram showed severe global LV dysfunction with EF 30%. She had 100% RV pacing even when the pacer was programmed at 50 beats per minute suggesting high degree AV block. (Fig 10).

The patient was brought to the EP lab to explore the feasibility of permanent His pacing. Because of the underlying AF and pacer dependency, the His bundle potential could not be identified, perhaps His potential was buried in the paced QRS. It was decided to pace map the "traditional" area where His bundle was usually located.

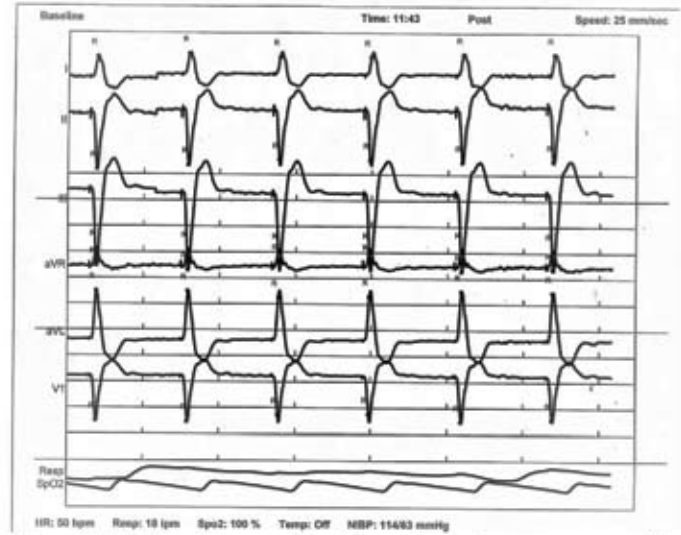


Figure 10. 100% pacing even when the pacing rate was programmed to 50 min suggest pacer dependent.

After a diligent search and pacing, an area was identified where pacing produced an iso-electric interval followed by a narrow QRS complex suggesting selective His bundle pacing.(Fig 11)

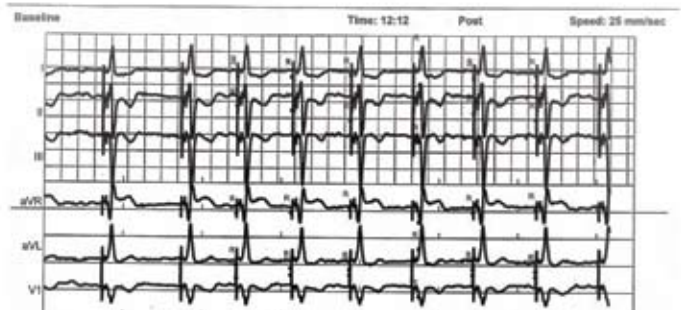


Figure 11. Selective His pacing as demonstrated by iso-electric interval following the pacing artifact with a "normal" looking QRS. The patient had no previous "normal" EKG for comparison.

The pacing lead was screwed in at that location. The 12 leads EKG (Fig 12) showed a narrow QRS "normal looking" complex.

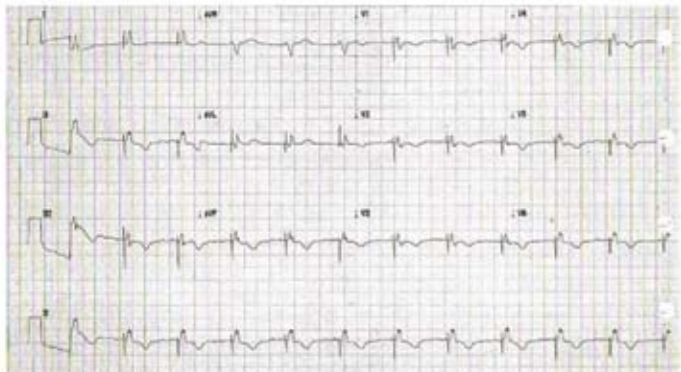


Figure 12. 12 lead EKG with selective His bundle pacing. Note the iso-electric interval following the pacer spike and much narrower QRS as compare to baseline EKG in Fig 9

Continued on page 18

**Permanent His Bundle Pacing: Its Use in 4 Clinical Scenarios  
(Continued)**

The His lead was connected to the LV port of the pre-existing biventricular device and His lead was programmed 80 millisecond before RV lead. The patients symptoms of shortness breath was much improved and required no further hospital admission for CHF.

**DISCUSSION**

His bundle pacing (HBP) was first described in 2000 (Ref 4). HBP engages the normal His-Purkinje system resulting in rapid depolarization of both ventricles without mechanical dyssynchrony. There is no concern of development of pacemaker induced cardiomyopathy. Due to anatomical variations, success rate of HBP is about 80% because up to 32.4% of the His bundle is "buried" inside the muscle of interventricular septum and may not be accessible to pacing.<sup>5</sup> Pacing threshold (usually <2 volts at 1 millisecond pulse width) is higher than the RV apical pacing but usually lower than LV pacing in CRT. Perhaps it is not surprising given that we target the His-Purkinje tissue with underlying cardiomyopathy. Another possibility is due to a virtual electrode effect requiring a higher output to capture the more distal fascicular tissue. The unknown factor of His pacing is the natural progression of His-Purkinje disease, although clinical studies suggests progression is <4% per year.<sup>6,7</sup> The current literatures suggest HBP is durable and demonstrates no significant change in pacing threshold.<sup>8</sup> HBP should be regarded as an alternative to biventricular pacing to those non-responders, in patients which the LV lead placement is not possible or causing annoying diaphragmatic stimulation.

His pacing is technically challenging and requires locating the His bundle, interpretation of the intra-cardiac electrogram and selective pacing at that site. But it is a life changing procedure and thankfulness of the patients is one of the joys of practicing medicine.

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# Electronic Prescribing of Controlled Substance

Sarah A. Norman, Pharm.D., BCPS, BCPP

The DEA has published guidelines for electronic controlled substance prescriptions. This article will discuss prescriber requirements for e-prescribing controlled substance prescriptions. In 2010 the DEA issued an interim final rule effective June 1, 2010 which authorizes electronic prescribing of controlled substances. As of June 2017, only 17.1% of Texas prescribers were enabled for use of electronic prescribing of controlled substances, yet the national average is 20.2%. Pharmacies on the other hand are 88.1% enabled for receiving electronic controlled substance prescriptions.<sup>1</sup> The following are the DEA requirements for the prescribing of controlled substances.

## Prescriber Responsibilities (§1311.102)<sup>2</sup>

Identity proofing of individual and institutional prescribers is required. Prescribers must obtain authentication credentials or digital signatures from federally approved credential service providers, certification authorities or institutional prescribers who are DEA registrants and receive permission to access the prescribing application using logical access controls involving two individuals, one must be a DEA registrant.

Once a prescriber has obtained proper credentials and granted access, the prescriber must sign the prescription using a two-factor authentication process. Prescribers must pick from two of the following: Something you know (a knowledge factor [i.e. user id/password or PIN]), something you have (a hard token stored separately from the computer being accessed) or something you are (biometric information).

## Requirements for Creating a Controlled Substance Prescription (§1311.135)<sup>2</sup>

Prescriber agents (i.e. office manager) may not be given access to the system or use the two-factor authentication to sign prescriptions. However, agents may enter prescription information for later authentication and approval by prescribers.

If a prescriber has more than one DEA registration, the prescriber or agent must select the correct registration number for the prescription being issued.

If an agent enters information at the prescriber's direction prior to the prescriber reviewing and approving the information and signing and authorizing the transmission of that information, the prescriber is responsible in case the prescription does not conform in all essential respects to the law and regulations.

## Requirements for Signing a Controlled Substance Prescription (§1311.140)<sup>2</sup>

For a prescriber to sign an electronic prescription for a controlled substance the following must occur:

A prescriber must access a list of one or more controlled substance prescriptions for a single patient. The electronic prescription application must present for the prescriber's review and approval all of the following data for each controlled substance prescription:

- (i) The date of issuance.
- (ii) The full name of the patient.
- (iii) The drug name.
- (iv) The dosage strength and form, quantity prescribed, and directions for use.
- (v) The number of refills authorized, if applicable, for prescriptions for Schedule III, IV, and V controlled substances.
- (vi) For prescriptions written in accordance with the requirements of §1306.12(b) of this chapter, the earliest date on which a pharmacy may fill each prescription. [See next section]
- (vii) The name, address, and DEA registration number of the prescribing prescriber.
- (viii) "By completing the two-factor authentication protocol at this time, you are legally signing the prescription(s) and authorizing the transmission of the above information to the pharmacy for dispensing. The two-factor authentication protocol may only be completed by the prescriber whose name and DEA registration number appear above."

A prescriber must indicate the prescriptions that are ready to be signed. While the prescription information and the statement remain displayed, the prescriber must be prompted to complete the two-factor authentication protocol. The completion by the prescriber of the two-factor authentication will constitute the signing of the prescription by the prescriber.

## Refilling Prescriptions and Issuance of Multiple Prescriptions (1306.12)<sup>3</sup>

(a) The refilling of a prescription for a controlled substance listed in Schedule II is prohibited.

(b) An individual prescriber may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of

Continued on page 20

## Electronic Prescribing of Controlled Substances (Continued)

a Schedule II controlled substance provided the individual prescriber provides written instructions on each prescription (other than the first prescription, if the prescribing prescriber intends for that prescription to be filled immediately) indicating the earliest date on which a pharmacy may fill each prescription.

- Sequential prescriptions up to a 90-day supply of a Schedule II controlled substance are permitted
  - Example: Writing 3 prescriptions to be dispensed every 30 days by the pharmacist (ALL prescriptions have the same date of issuance)
    - Write one prescription for one-third of the total quantity of controlled substance to be prescribed
    - Write a second prescription for one-third of the total quantity of controlled substance to be prescribed
      - ❖ Write DO NOT FILL UNTIL \_\_\_\_/\_\_\_\_/\_\_\_\_ on the second prescription, with the date 30 days after the first prescription date of issue
    - Write a third prescription for one-third of the total quantity of controlled substance to be prescribed
      - ❖ Write DO NOT FILL UNTIL \_\_\_\_/\_\_\_\_/\_\_\_\_ on the third prescription, with the date 60 days after the first prescription date of issue

Some pharmacy systems are not designed to hold electronic prescriptions for dispensing on a later date so another option is to provide a written prescription for months two and three.

### Prescriber Responsibilities (§1311.102)<sup>2</sup>

If a prescriber is notified by an intermediary or pharmacy that an electronic prescription was not successfully delivered, he must ensure that any paper or oral prescription (where permitted) issued as a replacement of the original electronic prescription indicates that the prescription was originally transmitted electronically to a particular pharmacy and that the transmission failed.

A prescriber must notify both the individuals designated at the registered location and the Administration within one business day of discovery that one or more prescriptions that were issued under a DEA registration held by that prescriber were prescriptions the prescriber had not signed or were not consistent with the prescriptions he signed.

A prescriber has the same responsibilities when issuing prescriptions for controlled substances via electronic means as when issuing a paper or oral prescription.

Continued on page 21

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## Electronic Prescribing of Controlled Substances (Continued)

It is prudent for a prescriber to check the prescription monitoring program (PMP) whenever they issue a new prescription for a controlled substance. It is recommended that all prescribers register in order to access the information in the PMP. The new PMP is available through the Texas State Board of Pharmacy (TSBP) website at <https://www.pharmacy.texas.gov/PMP/>. The TSBP has also produced a video tutorial on how to register for the PMP, visit: [https://youtu.be/u7aZm\\_hnfQ4](https://youtu.be/u7aZm_hnfQ4).

### Conclusion

The DEA has laid out specific requirements for prescribing controlled substances. When in doubt of the proper procedure(s) a prescriber should access the DEA website for clarification to ensure that there is no violation of federal law. There are multiple pros and cons to electronic prescribing (i.e. investment costs, benefits for patients) (Table 1), a prescriber must carefully weigh them in order to decide whether electronic prescribing will be a benefit.

Additional information may be found at the following Federally funded websites:

1. [https://www.deadiversion.usdoj.gov/ecomm/e\\_rx/faq/prescribers.htm#individual](https://www.deadiversion.usdoj.gov/ecomm/e_rx/faq/prescribers.htm#individual)
2. [https://www.deadiversion.usdoj.gov/ecomm/e\\_rx/faq/eapplications.htm](https://www.deadiversion.usdoj.gov/ecomm/e_rx/faq/eapplications.htm)

3. <https://www.healthit.gov/opioids/epcs>
4. [https://www.cdc.gov/drugoverdose/pdf/PDMP\\_Factsheet-a.pdf](https://www.cdc.gov/drugoverdose/pdf/PDMP_Factsheet-a.pdf)

Texas Medical Association:

1. Texas Medical Association Guide to E-Prescribing. <https://www.texmed.org/e-prescribe/>
2. You Write Scripts? You Better Sign Up With the PMP. Published January 24, 2018. <https://www.texmed.org/TexasMedicineDetail.aspx?id=46570>

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3. [https://www.ecfr.gov/cgi-bin/text-idx?SID=ca568bf2cf5903787934e5ccf0d36462&mc=true&tpl=/ecfrbrowse/Title21/21cfr1306\\_main\\_02.tpl](https://www.ecfr.gov/cgi-bin/text-idx?SID=ca568bf2cf5903787934e5ccf0d36462&mc=true&tpl=/ecfrbrowse/Title21/21cfr1306_main_02.tpl)

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# American Medical Association Alternate Delegate Report

Roxane Tyroch, MD, FACP



**L**  
**LEGISLATIVE**

*E.P.C.M.S.*

I wish to commend those physicians willing to serve as candidates in the recent election for assistant treasurer to the El Paso County Medical Society. Let's thank Dr. Juan Perez for his willingness to serve as our president for 2018 and Dr. Gilbert Handal for his service during 2017. We are so happy and grateful to have the continued involvement of our past presidents—we need you! Please join us at the monthly meetings, 5:30 pm on the second Tuesday of every month at 1301 Montana and get to know your current board members and involved membership.

Several individuals from the Texas Delegation to the AMA seek election in June at the AMA meeting in Chicago. Asa Lockhart seeks re-election to the Council on Medical Service. Speaker Susan Bailey runs for President Elect and Russ Kridel seeks re-election to the Board of Trustees. They have served us with the utmost dedication and skill thus far.

Please join the El Paso Delegation at TexMed in May 18-19 in San Antonio, TX. TexMed is when the House of Delegates holds elections and resolutions brought by individuals, county medical societies or caucuses are dealt with. If you have an idea that you would like to bring forth for development of a resolution please notify a board member.

Your AMA Board of Trustees is looking at the rapidly changing landscape of medicine and finding solutions to the challenges we face. Legislators do view passed resolutions of the AMA House of Delegates as the voice of medicine. There is good reason for this. There are so many states and specialty societies represented there that if we can actually agree on something that is to be recognized!

Our President Elect Barbara McAneny will take over the position currently held by Dr. Barbee in June. Dr. McAneny is a brave and amazing person who has been an inspiration to me and many others as she battles some of the darkest threats to our profession. I have witnessed many physicians surrender their independence and opportunity for prosperity. Dr. McAneny has been in situations in Albuquerque NM involving threats to her practice and independence as an oncologist. I deeply admire the way she has navigated this ongoing journey. She reminds me of Winston Churchill, known for saying "Never, never, never give in. Never, Never."

We have several members of the Board of Trustees of the Texas Medical Association who have similar strength and capability in helping the membership battle the threats to our ability to serve our patients. I will not name them only because there are so many—you

are so blessed by these people who bring their time and talent to serve the membership.

Please take the time to browse the AMA website. This is a vast resource. You can save money on consulting fees often by educating yourself with these resources as well as those on the TMA website. TMA has a Knowledge Center that can serve as a wonderful resource, you can call 1-800-880-1300 or [www.texmed.org](http://www.texmed.org). I truly believe that if you can familiarize yourself with the resources available to you through your AMA and TMA, you will become much more resilient to the forces that overwhelm the practicing physician. **EVEN MACRA!**

---

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



If you would like to see past episodes of the El Paso Physician TV show, go to the following link

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# MS

MEDICAL STUDENTS

*E.P.C.M.S.*

**LIFE AS A FIRST YEAR MEDICAL STUDENT**

Since I began my journey as a medical student and as a Hall Monitor at the Rotacare Clinic, I learned to work with people from diverse backgrounds and of different age groups. Although it is only my first year as a medical student my time here has made me into a strong leader and a better person. My educational journey has been rough, but I've been patient with myself and learned more about the way I learn and process high volumes of information. I love the constant challenge medical school is in both academic and clinical aspects. At the end of every day, no matter what my day consists of I feel fulfilled and thankful that I was given the opportunity to live my dreams. If I could do anything different from the beginning I would focus more on my mental and physical health. The high stress levels that I've lived through during the past year led me to neglect my personal health. I feel now that I'm in control, health is the most important element of good performance. Overall, my time here has made me very happy and I am glad that I am pursuing the career of my dreams, while being able to change other lives along the way.



Tayana Rodriguez, BS, MS, TTUHSC-Paul L. Foster School of Medicine, TMA Secretary.

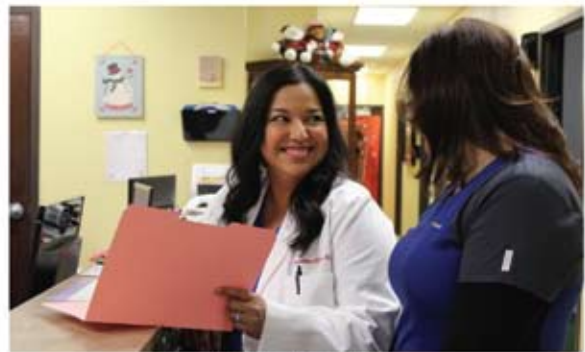
**MEDICAL STUDENT LOAN HELPS TWO NEW DOCTORS GIVE BACK TO THE COMMUNITY**

Jennifer Lopez and Iris Tomas didn't know each other growing up in the El Paso region, but they found a common path to achieve their lifelong dreams thanks to an innovative program sponsored by the Paso del Norte Health Foundation.

Lopez grew up in El Paso and graduated from Eastwood High, while Tomas grew up in neighboring Chaparral, N.M. Both aspired to become doctors, and both dreamed that one day they might even practice medicine back home on the border.



Iris Tomas, MD



Jennifer Perez, MD

The Health Foundation's Paso del Norte Medical Student Loan program made their dreams come true. Established in partnership with the Texas Tech University Health Sciences Center (TTUHSC) Paul

Continued on page 25

L. Foster School of Medicine (PLFSOM), medical students could receive a \$20,000 loan per year for four-years to attend TTUHSC PLFSOM. The full loan balance would be forgiven if they return to El Paso to establish a medical practice once their residency is completed.

Lopez, now Dr. Jennifer Perez following her marriage to Panfilo Perez, and Dr. Tomas are the first two doctors to complete residency and return to El Paso to set up their practices. "I'm so proud that the Health Foundation dedicated resources to support this program. It's been a great way for us to support the Paul L. Foster School of Medicine and address the shortage of physicians in our region," said Health Foundation CEO, Tracy J. Yellen. "Dr. Perez and Dr. Tomas's return to El Paso is evidence that the approach is working. We are investing in local students and cultivating a pipeline of future physicians for our community."

For doctors Perez and Tomas, coming home to establish their medical practices was also about returning home to be closer to family and providing medical services in a traditionally underserved Hispanic region.

"I wanted my daughter to grow up around family, and I wanted to work with the Hispanic population of El Paso," said Perez. "The loan forgiveness was a big plus. It helped me decide to come back here to start my practice without worrying about paying off a big loan."

To date, 15 students from the Paul L. Foster School of Medicine have taken out loans through the Paso del Norte Medical Student Loan program. Of those students, 11 are either in residency or fellowship programs and will soon have the option of returning to the border and having their loans forgiven. If they choose not to return to El Paso, they pay off the loan with interest.

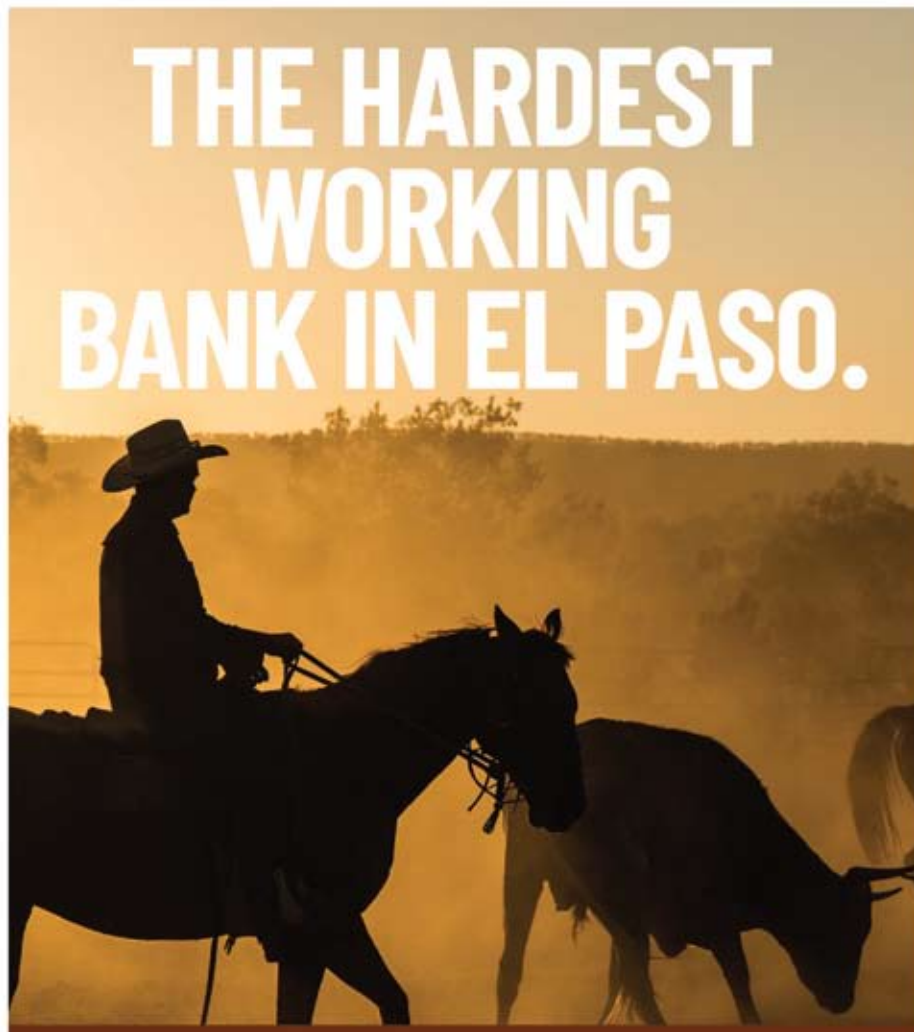
"I think that a program like this helps bring those doctors who either grew up here or fell in love with the region while attending medical school here to come back and practice here," Perez said. "It helps draw quality doctors to the area."

Dr. Perez set up her practice with Prestige Women's Healthcare on North Mesa. She earned her undergraduate degree from the University of Texas at Austin and completed her residency in San Antonio. Dr. Tomas is with UMC Family Practice on North Desert Boulevard. She earned her undergraduate degree and completed her residency at Baylor University.

"Dr. Perez and Dr. Tomas are the truest examples of our mission of service," said Dr. Richard Lange, president of TTUHSC El Paso and dean

of the Paul L. Foster School of Medicine. "TTUHSC El Paso was created to bring quality, culturally competent care to a population that is vastly underserved. And now, with our alumni leading the way, we are fulfilling that promise. We could not be more proud."


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# Medicare and The Quality Payment Program

Dona Schwendinger

## WHAT IS THE QUALITY PAYMENT PROGRAM?

The Quality Payment Program is the new Medicare payment program put in place to reform Medicare Part B payments to clinicians and to improve care across the entire health care system. Touted as the biggest change to physician reimbursement since Medicare was signed into law by President Lyndon Johnson in 1965, MACRA's QPP program combines the PQRS, Meaningful Use and Value-Based Modifier programs of the past into one new program for easier reporting.

2017 was the initial recording year, with 2019 as the reimbursement year for 2017. I expect that most clinicians have heard of MACRA and QPP at this point and have chosen the path in which to participate. MACRA has 2 pathways; MIPS and APMs. Most providers will fall into the MIPS category (Merit-based Incentive Payment System) which is geared to the traditional Medicare program, with most larger groups choosing the APM path (Advanced Alternate Payment Model). Beginning in 2017, CMS sent letters to all clinicians that were eligible to participate. The clinician could participate either as an individual or as a group.

Within the MIPS program, clinicians can choose the activities and measures that are most meaningful to their practice. By now, clinicians should have chosen one of four ways to report in 2017: either do nothing, "test" the system, report for a 90-day period, or report for a full year. Each one of the choices will result in how the clinician is reimbursed (or penalized) in 2019, with 3 points being the minimum scoring performance criteria. All data for the 2017 reporting year needs to be submitted by March 31, 2018. Data can be submitted via claims, Qualified Data Registries or Qualified Registries, or through your EHR.

Small/Rural Practices and Health Professional Shortage areas (HPSAs) have special considerations under this program. If you are a solo practitioner or in a group of less than 15 providers, you fall into this category. Advantages include: the ability to pick your pace, low volume threshold (under \$30,000 in Medicare Part B allowed charges or less than 100 Medicare Part B patients), 2017 minimal participation requirements, and flexible data requirements. If you are a Nurse Practitioner, you won't have to do any of the measures in the Advancing Care Information Category.

For 2018, CMS has adopted policies that may reduce your reporting burden and help you participate successfully. The 2018 MIPS

highlights include:

- The 2014 and 2015 Editions of your CEHRT are still allowed in 2018, with a bonus for using only 2015 CEHRT.
- You can use only 1 submission mechanism per performance category.
- For treating complex patients in 2018, you can receive up to 5 points.
- If you have been impacted by hurricane Irma, Harvey and Maria your Quality, Advancing Care Information and Improvement Activities can be automatically reweighted.
- 2018 is the year that Virtual Groups are an option for participation.
- The Quality final score is 50% in Year 2 vs. 60% in Year 1.
- The Cost final score is 10% of the total score in Year 2 vs. 0% in Year 1. CMS will calculate the individual MIPS eligible clinician's and group's cost performance using administrative claims data.
- Improvement Activities final score is 15% of the total score.
- Advancing Care Information final score is 25% of the total score.
- For the Quality category, 6 measures including 1 Outcome measure, or 1 High-priority measure are required to reach the full score of 50%.
- Advancing Care Information - NPs and PAs do not have to complete this category. The ACI category is automatically reweighted to zero and the Quality category is increased by 25%.
- The performance threshold is raised from 3 points in 2017 to 15 points in 2018.
- Facility-based measures are still not available for Year 2.
- Small practices can add 5 points to their final score.

There are additional options for small practices:

- If you have less than 200 Part B Medicare patients or have less than \$90,000 in Medicare Part B allowed charges, you are exempt from participation.
- As a small practice you can form or join a Virtual Group to participate with other practices.
- Continuing to award small practices 3 points for measures in the Quality category that don't meet data completeness requirements.
- Adding a new Hardship Exception for the Advancing Care Information category.

Continued on page 27

## Medicare and the Quality Payment Program (Continued)

- For Improvement Activities, small practices don't need more than 2 activities (2 medium or 1 heavy-weighted activity) to earn a full score for this category.
- Small practices receive 5 bonus points if the provider submits data for at least 1 performance category.

For 2018, there is a change for performance periods. The minimum performance period for the Quality category is 12 months. The minimum reporting periods for both Advancing Care Information and Improvement Activities is a 90-day period. CMS will measure the Cost category for 12 months.

Acceptable methods for data submission remain the same in 2018 as they were in 2017 (claims, Qualified Data Registries or Qualified Registries, or EHR).

I have provided you a basic overview of the Quality Payment Program and its latest updates. More information can be found on [www.qpp.cms.gov](http://www.qpp.cms.gov). You will find a resource library and other helpful ideas on how to be successful on the site.

**Donna Schwendinger, Operations Manager, Educator on Staff and Practice Management Consultant, Mednet, Inc.**

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## *In Memoriam*



*M*ichael Fushille, MD died peacefully at home on December 10, 2017 at the age of 94. Born into a working class family in Jersey City, NJ on October 26, 1923, Mike graduated from Lincoln High School and went on to Saint Peter's College in Jersey City. In June 1943, before completing college, Mike enlisted in the US Navy. He went through basic training in Great Lakes, IL and was sent to Cornell University for special training. He served as Seaman First Class and Radar Operator on the carrier USS Monterey in the Pacific theatre of World War II. Mike was awarded the Philippine Liberation Medal, the Victory Medal, the American Theater Medal as well as the Asiatic Pacific Medal and two stars. He was honorably discharged in March 1946. Mike was especially proud to be a WWII veteran. He returned to St. Peter's College and graduated in 1947 with a degree in Mathematics. His experiences in the war changed his career plans and he decided to study medicine. He completed the Pre-Med requirements at

Seton Hall and traveled to Switzerland, where he attended medical school on the GI Bill at the University of Fribourg and then graduated from the University of Lausanne. While in medical school Mike coached the professional basketball team, "Fribourg Olympic." He made lasting contributions to European basketball. Most notably, he is credited in the history of Swiss basketball with introducing the jump shot. Coincidentally, his wife-to-be, Isabel Gomez from Juarez, Mexico was also studying in Fribourg. Happily, they were introduced at a basketball game in 1953 and were married two years later in Juarez, Mexico. They returned to Switzerland where their first child was born. After graduating, Dr. Fushille completed his internship and residency at the Jersey City Medical Center and in 1962 moved his growing family to El Paso, TX where he began practicing Ophthalmology. Dr. Fushille was a dedicated eye physician and surgeon. He was passionate about treating his patients and serving his community. He gave his time weekly at the Eye Clinic at Thomason General Hospital and was the founder of the El Paso Eye Bank. He loved ballet and served for three years as president of the board of Ballet El Paso. In his free time, Mike, a life-long learner, enjoyed spending hours at the library. He loved reading, listening to classical music, discussing politics and studying Russian history.



*B*yron H. Chesbro, MD passed away on February 21, 2018 at the Mayo Clinic in Phoenix after complications following heart surgery. Byron was born in Utica, NY on December 4, 1949 to Harold and Ruth Chesbro. As a young man, he was involved in Boy Scouts for many years and enjoyed the great outdoors. He developed a passion for aviation and at the age of sixteen received his pilot's license; he never outgrew his love for flying. Byron graduated from Hamilton College in Clinton, NY; he studied pre-med and received his BA in history. He went on to attend Syracuse Medical School. He completed his residency in internal medicine at the Medical University of Ohio in Toledo. He completed his fellowship, subspecializing in oncology, at the National Cancer Institute of the National Health Institute in Bethesda, MD. Byron was inspired to pursue a career in oncology after his beloved brother-in-law Frank Tomek passed away from cancer. In 1981, Byron moved to El Paso to begin his medical practice with Dr.

Ekery, his mentor and good friend, and later joined the Texas Oncology PA with which he practiced oncology until the day he left to the Mayo Clinic for surgery. He was also a medical director for CIMA Hospice for many years. Throughout his 37 years of practicing medicine, he developed close friendships with his colleagues and impacted the lives of thousands of patients and their loved ones. Byron had a strong sense of adventure, enjoyed world travel with family and friends, and experiencing new cultures and cuisine. He especially enjoyed relaxing in the mountains of Cloudcroft, NM. He was an avid reader, history buff, and had a general curiosity for world happenings. Byron's ability to make everyone feel comfortable, secure, and loved were some of his greatest strengths. He will be remembered for his kindness, patience, generosity, diligence, level-headedness, and his surprisingly witty sense of humor.



**G**ary W. Schabacker, MD of El Paso, Texas was born on September 4, 1938, and passed away peacefully, surrounded by his family, on December 26, 2017.

Gary and his brother Bob grew up in Rockford, IL. Gary contracted polio as a boy, but overcame it and eventually became a competitive swimmer in high school. He studied accounting at Rockford College but his passion, which his beloved Aunt Mary encouraged him to pursue, was medicine. He graduated from the University of Illinois College of Medicine in 1964.

Upon receiving his medical license, Gary put his skills to use serving in the United States Army. He did a tour of duty in Vietnam in 1970-1971, commanding the 71st EVAC in Pleiku, Vietnam. He was recognized for his service with Army and Vietnam service medals.

First and foremost, Dr. Schabacker was a healer. Medicine was his calling, and he devoted his life to it with a fervent passion. His patients received care that was knowledgeable and compassionate. He treated so many people in El Paso that it was nigh impossible to go out with him and not have him run into a former patient who wanted to express their sincere gratitude for his care. Family lore has it that when his eldest child was on a train tour in Europe, she met a fellow traveler who was from El Paso and was a patient of his.

He was a beloved father and husband. Gary and P.J. opened their home to foster children for a time in the early 1970's, providing a stable and loving home to countless children in the foster system in addition to his own kids. A kind disciplinarian, he had high expectations for good behavior that his kids strove to meet, succeeding occasionally. He loved them fiercely and always guided them to a better way. He passed his wisdom, love and his impeccable work ethic on to his children.

As a business partner, his financial acumen rivaled his medical skills. His partner, Dr. Dick Harris, remembers first meeting Gary as a sharp-dressed young resident with his brass shining and his pants creased. Upon Gary's return from his Army service in Vietnam, Dick remembers a very different man showing up in his office with long red hair and sandals on, but the same sharp surgical skills. Gary and Dr. Harris ran one of the finest surgical practices in El Paso and shared a successful partnership for 23 years. After Dr. Harris retired, Gary worked to establish El Paso Surgical Associates with many other prominent surgeons in the El Paso area. He finished his career specializing in breast care with the Texas Tech Physicians of El Paso Breast Care Center. Although many patients could not afford care, none were turned away and many were healed under his care.

He was a passionate outdoorsman who shared his love of fishing with anyone interested in learning. As adults, all his children can fish thanks to his instruction, but none can catch as well as he did. Summers and weekends were spent fishing, water skiing, hiking, and camping when he and P.J. weren't rooting for their kids at soccer games and horse shows. As his children grew, he and P.J. traveled with family friends to explore the finest hikes in the country.

He will be remembered for many things, including his compassion, his sense of humor, his beautiful singing voice, his whistling skills, his curly red hair and distinctive mustache, and his passion for El Paso's people and history. He's now gone to see a man about a duck, and he wants all the men to be sure to get their prostates checked, and the women to do their breast exams!



**S**tefan G. Sarre, MD, beloved husband and father, passed away Sunday, March 4, 2018. Dr. Sarre was born in Tallinn, Estonia in 1932 to Nikolaus and Alma Sarre. Dr. Sarre carried on in the family tradition and followed both his parents into the medical field.

Dr. Sarre arrived in the United States as a teenager as part of an immigrant program, skipped high school, and graduated from Benedictine College in Kansas. He then graduated from Stritch School of Medicine in Chicago, and then entered the Army in 1958, where he rose to the rank of Colonel.

Dr. Sarre came to El Paso in 1969 to begin his practice in cardiology. He was a member of the Texas Medical Association, served as a past president, and sat on the Board of Counselors. Dr. Sarre was also a member of the Rotary Club of El Paso.

Outside of his practice, Dr. Sarre enjoyed traveling, food, and military history.

# 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!!!

**HOPEN, MICHAEL, MD**

OPH  
Indiana University School of Medicine, 2010  
1201 N. Mesa St.  
El Paso, TX 79902  
(915) 542-0279

**NEIRA-JUAREZ, CARLOS, MD**

ID IM  
Universidad Autonoma de Nicaragua, 1981  
5005 N. Piedras St.  
El Paso, TX 79920  
(915) 569-2723

**SHIMUNOV, SERGEY, DO**

GS  
San Francisco College Osteopathic Medicine of Touro Univ, 2012  
1250 E. Cliff, Ste. 5A  
El Paso, TX 79902  
(915) 532-1800

**TONARELLI, SILVINA B., MD**

P  
Universidad Nacional de Cordoba, 1991  
4800 Alberta Ave.  
El Paso, TX 79905  
(915) 215-5850

**ZATE, SARAH M., MD**

PD CAP  
Tulane University School of Medicine, 2005  
Mendoza SFCC  
Fort Bliss, TX 79918  
(915) 238-5703

**THE TEXAS SOCIETY OF PLASTIC SURGEONS ELECTS EL PASOAN HERBERT J. NASSOUR, M.D. AS NEW PRESIDENT**



Herbert J. Nassour, III, MD, FACS, PA, board certified plastic surgeon of El Paso, TX, was named president of the Texas Society of Plastic Surgeons (TSPS) at the TSPS Fall 2017 Annual Meeting. The TSPS is a professional medical specialty society composed solely of Board Certified Plastic Surgeons by the American Board of Plastic Surgeons. Dr. Nassour has been a member of TSPS since 1994 and is the first president ever elected from the El Paso area.

Dr. Nassour will take office this 2018 and will serve for one year.

"As president", says Dr. Nassour, "I plan to focus goals in the area of insurance practices controls and the limit on awards in lawsuits. I also plan to work toward initiatives that encourage young surgeons to stay and work in the State of Texas." The TSPS advocates for the laws and regulations that govern the practice and science of plastic and reconstructive surgery. The TSPS also promotes the highest standards of professionalism and competence among plastic surgeons and monitors the medical and legal changes that impact the practice at the state and national level.

Dr. Nassour completed his undergraduate education at the Univer-  
**Continued on page 31**

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sity of Texas at Austin and went on to receive his medical degree from the Texas Tech University HSC School of Medicine at Lubbock, where he graduated 8th out of 100 and was inducted into the Alpha Omega Alpha Medical Honor Society. He completed his plastic surgery residency at the University of North Carolina at Chapel Hill.

Dr. Nassour has lived and worked in El Paso, Texas since 1975. He has practiced plastic surgery for over 24 years and is among the only 10 Board Certified Plastic Surgeons in the area. He is also a member of the American Society for Aesthetic Plastic Surgery. Dr. Nassour has been listed as one of the Best Doctors in America for the Central Region in Plastic Surgery since 2001 to 2017 and as one of America's Top Plastic Surgeons since 2007 to 2017. His philanthropic endeavors include arranging and participating in medical missions to Guatemala where surgery was performed on over 200 children with various reconstructive pathology from 1994 to 2000.

Dr. Nassour serves on numerous committees, both as a member and chair, at Providence Memorial Hospital, is Clinical Assistant Professor in the Department of Surgery at Texas Tech University HSC El Paso, and is member and founder of the El Paso Society of Plastic Surgeons. He currently works at his private practice in Plastic and Reconstructive Surgery.

**TTUHSC EL PASO PROFESSOR NAMED LAUREATE BY AMERICAN COLLEGE OF PHYSICIANS**



Richard McCallum, M.D., professor and founding chair of the Department of Internal Medicine at Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso), was recently named a 2017 Laureate by the Texas Chapter of the American College of Physicians (ACP).

The Laureate Award is given to Texas physicians "who have demonstrated by their example and conduct an abiding commitment to excellence in medical care, education or research, and in service to their community, their chapter and the American College of Physicians," said George Crawford, M.D., the Texas Southern ACP governor.

Dr. McCallum, who has been a member of different state chapters of the ACP since 1975, has made major advances in the diagnosis and treatment of the digestive disorder gastroparesis. In patients with gastroparesis, food moves through the stomach much slower than normal. Dr. McCallum has researched the interactions between the brain and stomach to understand the causes of associated nausea and vomiting, and more effectively treat the disease.

Dr. McCallum holds three patents and is the inventor of a gastric pacemaker to help patients who cannot digest food properly. His findings have appeared in more than 450 peer-reviewed scientific

articles and 120 textbook chapters. He has also edited 14 scientific textbooks on gastroenterology.

"As a leader in the Texas medical community; teacher of students, residents and gastroenterology fellows; prodigious investigator; nationally and internationally recognized contributor to the field of gastroenterology; clinician; researcher and chair of departments and societies, Dr. McCallum exemplifies the best aspects of our profession and was unanimously selected by the Texas ACP nomination committee for the Laureate Award," Dr. Crawford said.

In his acceptance speech, Dr. McCallum noted that he was the second TTUHSC El Paso faculty member to receive the Laureate Award from the ACP, which has been awarded annually since 1985. Harry Davis II, M.D., associate professor and vice chair for education in the Department of Internal Medicine, received the award in 2011.

"The list of prior recipients of this honor includes some of the most well-known and productive physicians from the state of Texas," Dr. Davis said. "I was deeply honored to be included among those who had received this lifetime pinnacle award."

Dr. McCallum said he was proud of TTUHSC El Paso's evolution since his arrival in 2009. He said he has had great mentors in his career, and is dedicated to mentoring medical students, residents, fellows and junior faculty.

"This award is indeed an honor for my career, as well as for the school," Dr. McCallum said. "It is a recognition of my body of work focused on diagnosing and treating patients, while at the same time incorporating a teaching environment and a research culture to help produce the future leaders in clinical and academic gastroenterology."

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](mailto:epmedsoc@aol.com)

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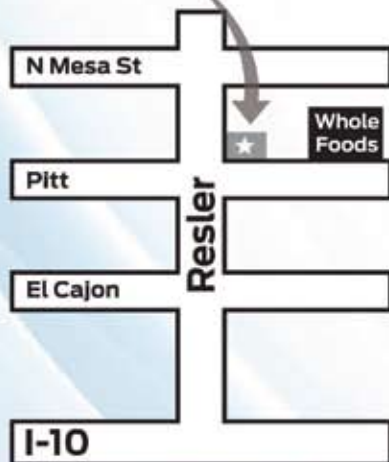
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