A Breath of Fresh Air for Central Florida Area Pulmonary Patients

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Central Florida Pulmonary Group, P.A. (“CFPG”) was established as a small practice in 1982 by the late Dr. Robert Bast and has grown to be among the largest pulmonary practices in the state. The group is currently comprised of fourteen physicians and three nurse practitioners offering quality health care at three area locations (Downtown Orlando, East Orlando and Altamonte Springs) with 24-hour a day on call emergency services. CFPG provides diagnostic and treatment services for a wide array of pulmonary conditions including asthma, chronic obstructive pulmonary disease (“COPD”), cystic fibrosis (“CF”), pulmonary fibrosis, emphysema, sleep apnea, lung cancer and other lung diseases. In aggregate, the group includes physicians who are board certified in internal medicine, pulmonary disease, critical care medicine and sleep medicine. CFPG is also proud to be one of the few nonacademic centers in the nation hosting an adult CF clinic and one of the largest programs in Florida.
I am pleased to bring you another issue of Florida MD. This month’s cover story focuses on the Central Florida Pulmonary Group and the work they do to help patients with breathing problems. If you think about it, breathing is something we take for granted. We don’t consciously think about every breath we take. This is not the case for people with cystic fibrosis who struggle for each breath. The Cystic Fibrosis Foundation works to assure the development of the means to cure and control cystic fibrosis (CF) and to improve the quality of life for those with the disease. Please join me in supporting this wonderful organization and their mission to better the lives of millions of Americans.

Best regards,

Donald B. Rauhofer
Publisher

CYSTIC FIBROSIS FOUNDATION IS MAKING AN IMPACT.

Since 1955, the mission of the Cystic Fibrosis Foundation is to assure the development of the means to cure and control cystic fibrosis (CF) and to improve the quality of life for those with the disease. The CF Foundation tirelessly pursues its mission by supporting scientific research, which is dedicated to the discovery and development of new therapies. At the same time, it funds and accredits a network of specialized treatment centers that provide state-of-the-art care for people with CF. By applying the same principles that a “for-profit company” follows — efficiency, innovation, and a results-driven approach — the CF Foundation is making a profound difference in the lives of those with CF.

But what is Cystic Fibrosis? The genetic disease affects the lungs and digestive systems of tens of thousands of young people. One in 31 Americans, more than 10 million people, is an unknowing, symptomless “carrier” of the defective CF gene. Each time two carriers conceive, there is a 25 percent chance that they will have a child with cystic fibrosis.

Although the outlook for a child born with CF today has improved tremendously over the years, it is not good enough. That’s why the CF Foundation holds fundraising events throughout the year to make sure momentum in CF research continues. This fall, the Central Florida Chapter of the CF Foundation will host several events: including the CF Climb on September 8th, CF Cycle for Life on October 7th, the Great Strides Walk in Apopka, and the 11th Annual 65 Roses Golf Classic on November 19th.

For more information on these events, please visit http://orlando.cff.org.

COMING NEXT MONTH: The cover story focuses on Moffitt Cancer Center in Tampa. Editorial focuses on Imaging Technologies and Interventional Radiology.
Reaching New Heights in Childhood Epilepsy Care

From the finest clinical minds and latest treatment technologies, comes an entirely new program at Walt Disney Pavilion at Florida Hospital for Children that is setting the standard in pediatric epilepsy care. Doctors Lee and Baumgartner are applying 45-years of combined experience and intraoperative MRI technology to significantly improve, and oftentimes cure the most challenging cases of childhood epilepsy.

Utilizing state-of-the-art operating suites with imaging capabilities that capture live images before, after and most importantly, during surgery, we are able to operate at the highest level of accuracy and precision. As one of only a few facilities in the country with this type of technology, and perhaps the only one with this level of dedicated clinical experience, the sky is the limit for what we are able to achieve for our patients.

Ki Lee, MD
Medical director of the Comprehensive Pediatric Epilepsy Center

James Baumgartner, MD
Surgical director of the Comprehensive Pediatric Epilepsy Center

Florida Hospital for Children

(407) 303-KIDS | www.FloridaHospitalForChildren.com/Epilepsy
Central Florida Pulmonary Group, P.A.

A Breath of Fresh Air for Central Florida Area Pulmonary Patients

By Nancy DeVault, Staff Writer

Central Florida Pulmonary Group, P.A. (“CFPG”) was established as a small practice in 1982 by the late Dr. Robert Bast and has grown to be among the largest pulmonary practices in the state. The group is currently comprised of fourteen physicians and three nurse practitioners offering quality health care at three area locations (Downtown Orlando, East Orlando and Altamonte Springs) with 24-hour a day on call emergency services. CFPG provides diagnostic and treatment services for a wide array of pulmonary conditions including asthma, chronic obstructive pulmonary disease (“COPD”), cystic fibrosis (“CF”), pulmonary fibrosis, emphysema, sleep apnea, lung cancer and other lung diseases. In aggregate, the group includes physicians who are board certified in internal medicine, pulmonary disease, critical care medicine and sleep medicine. CFPG is also proud to be one of the few nonacademic centers in the nation hosting an adult CF clinic and one of the largest programs in Florida.

Lung diseases are among the most common ailments worldwide. Within the United States, there is a greater incidence of lung disease throughout the southeast. This group is expanding to meet the demand for care within our community with highly skilled medical specialists concentrated on the latest cutting edge and minimally invasive procedures.

“CFPG is currently conducting 18 active research studies to identify new ways to treat CF, COPD, pulmonary fibrosis and pulmonary hypertension, with additional studies on the horizon,” said Dr. Daniel Layish (who joined the practice in 1997 after doing his Pulmonary/Critical Care Fellowship at Duke University Medical Center.) “It is unusual to see this level of clinical trials at a private practice group, but it simply illustrates our pledge to improve methods and overall care.” Dr. Layish explains that the physicians of CFPG further demonstrate their...
commitment to the field of pulmonary medicine and the Metro Orlando community by serving in various medical facilities, associations and university leadership roles. Presently, Dr. Layish is the Medical Director of the Intensive Care Unit, Respiratory Therapy and Pulmonary Rehab at Winter Park Memorial Hospital. He also serves as the Director of the Orlando Clinical Resource Center for the Alpha-1 Foundation (a non-profit organization focused on curing Alpha-1 Antitrypsin Deficiency, a hereditary lung disease).

EXPANDING FACILITY AND STAFF INCREASE CAPABILITIES

This fall, CFPG will replace their existing downtown location with a new state-of-the-art facility. The building will be situated on the same property allowing the current office to evolve into an administrative headquarters. The upgrade will allow for additional exam rooms, while maintaining the same convenient services to patients including onsite computed axial tomography scans. “In house CT imaging allows patients to receive rapid answers for their symptoms. For example, if a patient comes in with shortness of breath, we may give them an explanation that day. We review the scan results together and utilize the picture as a visual tool not only for diagnosis but to help explain findings (such as lung nodules),” explains Dr. Layish. He says the growth of the practice is necessary to accommodate an influx of patients due to aging baby boomers.

“Our area hospitals are growing and Orlando is becoming a go-to place for medical care and training,” says Dr. Layish. In fact, this summer the inaugural class of the University of Central Florida Medical School will be required to complete a medical rotation in critical care and many of the students will work alongside CFPG physicians at area hospital intensive care units. UCF medical students will not be the only new faces visiting with patients of CFPG as the practice is welcoming two new physicians. Presently an Interventional Pulmonology Fellow at Beth Israel Deaconess Medical Center at Harvard Medical School, Jorge Guerrero, M.D., will join the group this July; with Neveen Malik, D.O., a Pulmonary and Critical Care Fellow at the University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine, to join in October.

BED REST USED FOR DIAGNOSIS

Though common, many sleep disorders (including sleep apnea) remain undiagnosed and untreated. In 2009, CFPG established the Institute of Sleep Medicine under the direction of medical director Syed Mobin, M.D., F.C.C.P., F.A.A.S.M. “Roughly twenty to thirty percent of our patients present with sleep disorder related symptoms,” said Dr. Mobin. This sleep center includes a two-bed unit at the East Orlando clinic and six-bed unit at the Altamonte clinic. The Institute of Sleep Medicine is accredited by the American Academy of Sleep Medicine.

Dr. Mobin trained at the Mayo Clinic and serves as an Assistant Professor of Medicine at the University Of Central Florida School Of Medicine. He is also chairman of pulmonary medicine at Florida Hospital. Dr. Mobin, along with six other sleep specialists at CFPG (including Dr. Daniel Layish, Dr. Francisco Remy, Dr. Ahmed Masood, Dr. Eugene Go, Dr. Mahmood Ali and Dr. Tabarak Qureshi), as well as licensed sleep technicians,
conduct and evaluate various sleep studies. “Our sleep practice most often sees patients with obstructive sleep apnea (‘OSA’), followed by insomnia, in addition to other sleep disorders such as narcolepsy, restless legs syndrome, circadian rhythm problem, shift work disorder, REM behavior disorder, parasomnias and central sleep apnea,” says Dr. Mobin.

“The risk of sleep apnea increases with age and is more prevalent in men than women. Risk also increases in post-menopausal women. We help many patients diagnosed with narcolepsy that experience involuntary sleep attacks during the day. This can be a danger to their health as well as others,” says Dr. Mobin. Narcoleptic patients usually present in their adolescence, 20s, or 30s. Overnight sleep studies evaluate the sleep stages, sleep efficiency, and the number of times the patient stops breathing or wakes up during the night. When this process is complete, a ‘score’ is calculated. “These findings help our sleep team develop a treatment plan for patients suffering from OSA, which usually starts with continuous positive airway pressure (‘CPAP’) therapy,” explains Dr. Mobin.

CFPG’s sleep center provides a comprehensive and multidisciplinary approach. Depending on the severity of a patient’s OSA and ability to tolerate a CPAP machine, other interventions might be required. Specialists such as the orthodontist or otolaryngologist might perform upper airway surgery or recommend oral appliances. Patients suffering from insomnia may require behavioral therapy and relaxation technique with a sleep psychologist.

Obesity is a major contributing factor to sleep apnea. “Treatment plans often include nutritional discussions,” says Dr. Mobin. “Because sleep apnea patients are battling fatigue and excessive sleepiness, it can be especially challenging for them to lose weight physically. Often, treatment of OSA helps patients lose weight. It is essential to treat OSA, particularly since it increases risk of high blood pressure, heart disease, stroke and risk of diabetes,” explains Dr. Mobin. “The Institute of Sleep Medicine is successful because our well trained and dedicated staff provides a comprehensive and caring approach for our patients.”

**CUTTING EDGE TREATMENTS CAN ELIMINATE NEED ‘TO CUT’**

The physicians of CFPG now practicing in Metro Orlando stem from all over the world. “We have doctors from the Philippines, Israel, Pakistan, Vietnam, Puerto Rico, Colombia, India and several other countries. We are like the United Nations of medicine all working together for the well-being of our patients,” describes Dr. Layish. “Along with our diversity, we offer different skills complimentary of each other. It’s like a multidisciplinary practice where we all have our own niche,” adds Y. Daniel Haim, M.D., F.C.C.P., who graduated from Sackler School of Medicine in Tel-Aviv, Israel, before completing his residency at St. Lukes-Roosevelt Hospital in New York and fellowship at Temple University Hospital in Pennsylvania. For Dr. Haim, practicing at CFPG since 1995, that ‘niche’ is interventional bronchoscopy, which includes laser ablation of endobronchial tumors, airway

**Dr. Layish shows a patient his CAT scan on digital viewers only minutes after the scan was completed.**
stents and bronchoscopic biopsy of lung masses and lymph nodes with ultrasound guidance.

“I use laser bronchoscopy to remove endobronchial tumors obstructing the airway. For a benign tumor, the thermal energy of the laser can be a curative procedure; however a malignant tumor would also require chemotherapy in addition to the laser bronchoscopy technique,” describes Dr. Haim, currently serving as President of Florida Hospital’s Medical staff, a member on the Tumor Board, and Assistant Professor at University of Central Florida’s School of Medicine. According to Dr. Haim, this technique has minimal side effects and provides patients with significant relief of symptoms very quickly.

Dr. Guerrero, who has co-authored seven interventional pulmonology research studies, will soon offer another minimally invasive procedure at CFPG called medical thoracoscopy. “Patients with pleural effusions (pleural fluid) who require recurrent drainage of the pleural space to treat shortness of breath or respiratory failure are best treated with thoracoscopy or ultrasound guided tunnel pleural catheter, compared to the current option of thoracentesis. Thoracoscopy is better for the patient since it can be provided under conscious sedation or sometimes general anesthesia in a bronchoscopy suite or operation room. A rigid camera (thoracoscope) allows high definition visualization of the pleural space,” explains Dr. Guerrero.

Dr. Guerrero uses this painless procedure for patients with pleural cancer, fungal infections and inflammatory diseases such as sarcoidosis or Wegener’s Disease. He will be the only Interventional Pulmonologist within Metro Orlando utilizing this advanced technique.

**LUNG TRANSPLANT PATIENTS CAN SOON BREATHE EASY WITH NEW PROGRAM**

Central Florida area patients who suffer with advanced lung diseases such as emphysema, pulmonary fibrosis, pulmonary hypertension and CF may soon be eligible to improve their quality of life through a local lung transplantation program. Andres Pelaez, M.D., a CFPG physician since 2010, will serve as Medical Director of the Florida Hospital Lung Transplant Program, slated to officially launch in July 2012, alongside Surgical Director Hartmuth Bittner, M.D.

Over the past two years, Dr. Pelaez and his team at Florida Hospital have set the foundation for the first Lung Transplant Program in Central Florida by establishing a team of transplant experts, while educating area physicians on patient referral criteria.

*Pulmonary Function tests using full body boxes are used for a more accurate diagnosis of lung disorders.*
ria and processes. Dr. Pelaez, also serving as the Assistant Medical Director of TransLife Organ and Tissue Services, has also focused on optimizing donor management through this local organ procurement organization.

“CFPG will lead the pre and post transplant aspects of patient treatment. Through our collaborative process, physicians will first assist Florida Hospital’s Lung Transplant Program by referring appropriate patients and then be a part of the management team when patients are hospitalized,” stated Dr. Pelaez.

**CYSTIC FIBROSIS CLINIC: WHERE CALORIES COUNT**

Dr. Layish says that CFPG is proud of the impact of their Adult CF Center, in which he serves as co-Program Director alongside Francisco Calimano, M.D. “Just a decade or two ago, patients with CF did not reach adulthood. But now life expectancy has improved and we work with over 100 adults managing their genetic condition,” he says. CFPG hosts a CF Clinic twice a month for patients to receive consultations with their doctor, social workers, dieticians, nurses and a respiratory therapist.

“Our team has established a food pantry housed within the Altamonte location of CFPG. CF patients need to consume anywhere from 3,000 to 5,000 calories a day which can become very costly,” said Lindsay Samayoa, CRT, Respiratory Therapist and Adult Cystic Fibrosis Program Coordinator, adding that this effort aids both the patients nutritional and financial needs. “Some patients struggle financially as a result of constant medical costs including specialists’ visits, hospital stays and medication expenses. By having this food pantry, we are helping patients feed themselves and their families by decreasing the financial burden of groceries.” Samayoa says that the majority of patients live anywhere between 1 to 2 hours away and traditionally visit every 1 to 2 months or sooner if problems arise.

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“We are dedicated to delivering the highest quality of care for our patients; because that is what they expect and deserve,” states Dr. Layish. It is the mission of CFPG to provide the best quality of pulmonary and critical care medicine. Dr. Haim explains he is proud to be among such a dedicated and diverse group of physicians. CFPG looks forward to many years of continued service to the community in providing high quality care.

**Central Florida Pulmonary Group, P.A.**

[Website Link]

**LOCATIONS:**

**Downtown Orlando**

326 North Mills Avenue • Orlando, Florida 32803

***Relocating to 1115 East Ridgewood Street this fall***

**East Orlando**

10916 Dylan Loren Circle • Orlando, Florida 32825

**Altamonte Springs**

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What’s Your Practice’s Benefit Statement?

By Jennifer Thompson, President of Insight Marketing Group

We all know what a benefit is, right? Something that improves the life of the person who has it. If a product or service has benefits we want, we choose them over products or services that don’t have those benefits. A diet soda has no calories, that’s the benefit. A/C keeps you cooler. Your power windows in your car roll up with the touch of a button. Now that we’ve got that out of the way, finish this sentence: “It’s beneficial for patients to come to my practice over a competitor’s because...”

What did you come up with? Putting together a unified, encompassing benefit statement is essential to guide your marketing efforts, but it’s not as easy as it may seem on the surface. Consider it the compass helping to navigate your practice’s marketing ship. You want the most accurate compass you can find so you’re not drifting aimlessly at sea, don’t you?

Below are a few tips to help you define a quality benefit statement and guide your practice in the right direction.

**STEP 1: ASSESS YOURSELF**

Usually this is the hardest step when creating, well, anything. You have to be brutally honest with yourself and the piece of paper or computer screen you’re using as your confidant. Your only job here is to list what’s special/unique/phenomenal about your practice. Brainstorm what makes you different from someone around the corner, and be honest. Focus on the top one or two things you come up with, even if you write down 13 things. Patients won’t remember them all, so what’s most important? Is it your exceptional front desk service? Maybe it’s your “no wait” promise or you’re pristine surgical track record? Come up with a large list and don’t be afraid to cross a few items out.

**STEP 2: PURIFY AND REFINE**

After you’ve narrowed down a few of the key features of your practice, it’s time to refine them into your benefit statement. Imagine a patient walking up to you and asking, “Why should I come to your office? What’s in it for me?” Those are the questions that your benefit statement should answer. I know, I know – the reason should be, “So you can get healthy and continue with your day-to-day activities,” —but it’s just not that simple when it comes to marketing. Go figure.

Anyhow, create a statement that clearly states what your practice can offer. “Every surgery at my practice utilizes the most state-of-the-art equipment to perform minimally invasive surgeries, resulting in less pain, less scarving and a faster recovery for patients.” That’s a benefit statement for a surgical practice.

“My practice’s automated check-in process creates less wait time and saves you a headache at every visit.” That’s an example of a more general benefit statement, but you get the idea.

A good idea to help answer the “What’s in it for me?” question is to use strong action verbs and descriptive adjectives at some point in your benefit statement. A few examples include words like: create, save, take, reduce, result and help.

By focusing on the benefits, you immediately tantalize patients with what’s in it for them. A good benchmark goal is to read through some of your marketing material and time how long it takes you to find your benefit statement. You should be able to find it within the first 30 seconds or so of reading a brochure or perusing a website. You want patients to know that you are different and offer unique benefits that they just can’t live without as immediately as possible.

Think of it from a patient’s perspective: “With our health as one of our most prized commodities, once we know all we can get with your practice, how could we ever schedule an appointment somewhere else and be alright with that decision?” That’s what your statement should make them think.

**STEP 3: REHEARSE**

Make sure that you and your key staff members can recite your benefit statement, should the need ever arise. Make sure it sounds just as good out loud as it does on paper. The reason for this is simple – if you ever have to say it to a referring physician or a patient, you want to know it off the top of your head and speak it oozing with confidence.

Plus, if it’s memorized, it will start to creep in your everyday thought process. Suddenly, in the middle of an activity you’ll ask yourself if it’s in line with your benefit statement. Remember, that’s another one of the main benefits of the benefit statement: to guide you in your day-to-day activities. Now get working on that compass.

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**Look**

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LOOKING FOR MORE INFORMATION?

Contact Jennifer Thompson today for a free consultation and marketing overview at 321.228.9686 or e-mail her at Jennifer@InsightMG.com.

Jennifer Thompson is president of Insight Marketing Group, a full-service healthcare marketing group focused on digital and social media administration, referral and partnership development, creative services and graphic design, online reputation management/development and promotional products. She is co-author of Marketing Your Medical Practice: A Quick Reference Guide and an avid Twitter user, regularly posting medical practice marketing tips, articles and more at www.Twitter.com/DrMarketingTips. You can learn more about her and her company at www.InsightMG.com.

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Laryngopharyngeal Reflux (LPR)

By Daniel T. Layish, MD

Gastroesophageal reflux that advances all the way to the airway or pharynx is commonly known as laryngopharyngeal reflux (LPR). LPR has been implicated as a factor in asthma, chronic cough, recurrent laryngitis, and sleep disordered breathing. However, other entities such as vocal abuse, allergic rhinitis, sleep disordered breathing can be difficult, if not impossible to differentiate from LPR. Empiric therapy with proton pump inhibitors (PPIs) has been the previously accepted approach to the workup of such patients. However, such an empiric course of therapy can result in a significant expense, as well as potential for side effects.

Objective testing with the Restech Dx-pH Measurement System is an alternative to empiric PPI therapy for LPR diagnosis. This system measures and records airway pH levels twice per second for up to 48 hours. A pH sensor rests at the distal end of a thin (4.6 Fr) catheter that is placed trans-nasally into the patient’s oropharynx. A light emitting diode on the tip of the catheter is used to confirm the placement of the sensor just lateral to the uvula by visualizing it through the patient’s open mouth.

The Restech Dx-pH Probe is easily inserted in the office setting and remains in place without compromising the patient’s ability to eat, talk, sleep, or perform other normal tasks. By pressing designated buttons on the device, patients can easily input clinically relevant information such as meals, symptoms, and body position. This information is helpful for later analysis and discussion of the patient’s behaviors and their reflux patterns. Additionally, the Restech Dx-pH Probe study can be integrated into sleep studies, which can be helpful in the evaluation of unexplained sleep disturbances.

24-hour pH monitoring has been used in the diagnosis and management of gastroesophageal reflux (GERD) for several decades. As the atypical manifestations of reflux became more widely recognized and attributed to LPR, the need for a corresponding technology to measure LPR grew as well. In response, Restech developed an innovative new version of this standard pH technology, using a miniaturized sensor that is capable of measuring the pH of the aerosolized particles of refluxate that reach a patient’s upper airway.

Because the laryngeal epithelium lacks certain defenses comparable to those in the esophageal epithelium, it is much more susceptible to damage from reflux – even from less acidic reflux. Because of this, it is important that the data from a 24-hour pH study is interpreted and analyzed using a method that takes into account the sensitive nature of the laryngopharyngeal anatomy. Although a pH of 4 has been used traditionally (and appropriately) for assessment of gastroesophageal reflux exposure, it is widely agreed that a higher pH threshold is appropriate for the oropharynx.

Thoracic surgeons Dr. Tom DeMeester and Dr. Lawrence Johnson developed the first quantitative score for esophageal reflux measurement, which came to be known worldwide as the “DeMeester Score.” This score was based on calculations of time, duration and number of events that occur below the threshold of pH 4.0 (noted as the level at which pyrosis occurs and where cellular damage is inflicted on the epithelium).

When Dr. DeMeester and his team at the University of Southern California performed their clinical investigation with the Dx-pH Measurement System in normal subjects, they employed a mathematical graphic model to determine the discriminating pH thresholds for evaluation of oropharyngeal reflux exposure. These thresholds are pH 5.0 for the supine period, and pH 5.5 for the upright period. The frequency and duration of these events are used in algorithms that make up the RYAN Score, which is integrated into a software program that is used to objectively evaluate each case.

For many patients, review of their Restech pH study results with their doctor offers them a better understanding of their disease process. For example, showing a patient a severe nocturnal reflux event following a heavy, late night meal might encourage them to make better decisions about their eating habits. Hopefully, this improves their compliance with both their medical therapy and recommended lifestyle changes.

The Restech pH test is also useful in the assessment of patients whose symptoms may be inadequately controlled with proton...
PULMONARY AND SLEEP DISORDERS

pump inhibitor therapy. Many patients need twice a day proton pump inhibitor therapy for adequate control of their LPR, to manage the daytime and the nighttime components of the disease. By performing the Restech Study, we can design an optimal treatment regimen for each individual patient's needs based on their unique reflux patterns.

It should be noted as well that the Restech Dx-pH Probe is able to measure alkaline pH levels as well. While it is a subject that requires further elucidation, it is clear that alkaline pH levels in the throat can be deleterious. Cases have been noted in which a patient is taking too high a dose of PPIs (likely over the counter treatments), resulting in very high pH levels in the throat. The effects of alkalinity can be strikingly similar to those of acidity in the oropharynx, and thus virtually impossible to distinguish based on endoscopic evaluation and symptom assessment alone.

The Restech pH probe is clearly not meant to eliminate the need for esophageal manometry, esophagogastroduodenoscopy, and other gastrointestinal evaluation. However, the Restech Dx-pH probe can be an important adjunct in the evaluation of patients who exhibit signs of atypical reflux. The Restech Dx-pH Measurement System has been well validated in scientific literature by highly respected institutions throughout the United States as well as internationally. As clinicians become more aware of this new technology, I believe that it will play an increasing role in the management of patients with LPR.

Daniel Layish, MD, graduated magna cum laude from Boston University Medical School in 1990. He then completed an Internal Medicine Residency at Barnes Hospital (Washington University) in St.Louis, Missouri and a Pulmonary/Critical Care Fellowship at Duke University in Durham, North Carolina. Since 1997, he has been a member of the Central Florida Pulmonary Group in Orlando. He currently serves as Medical Director of the Intensive Care Unit, Respiratory Therapy and Pulmonary Rehab at Winter Park Memorial Hospital.

Dr. Layish may be contacted at 407-841-1100 or by visiting www.cfpulmonary.com.

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Herbal Remedies for Sleep Disorders

By Jill Weinstein, RPh, Ashley Addie, PharmD Candidate and Christopher Jackson, PharmD Candidate

Millions of Americans are affected every day by sleep disorders that range from acute transient sleep disturbances to long term chronic insomnia. Long-term consequences of sleep disorders include high blood pressure, increase risk of heart attack or stroke, emotional changes or weight gain. While there are many potential causes for sleep disorders, the main focus of treatment in long term chronic insomnia is to identify and correct the underlying cause. For acute transient sleep disturbances, many pharmacological treatment options including prescription and over the counter products are currently being marketed with FDA approval. However, for centuries people have successfully used herbal remedies and supplements despite minimal scientific evidence supporting their use. Recently, scientific studies have targeted melatonin, valerian root, kava, and 5-hydroxytryptophan (5-HTP) with relation to sleep disorders. This article focuses on evaluating these four herbal remedies and their potential use in acute sleep disturbances.

The U.S. Department of Health & Human Services reviewed the use of melatonin in sleep disorders and concluded that melatonin may have a modest benefit in people with delayed sleep phase syndrome. Melatonin has FDA orphan drug status for treating sleep disorders in blind patients. Dosing varies depending on use. Dosing for delayed sleep phase syndrome is 3 mg 1-2 hours before bedtime. Blind patients with delayed sleep phase syndrome are instructed to take 5-10 mg at bedtime. Dosing for the prevention of jet lag ranges from 3-6 mg 2200-2400 local time to help entrain the circadian rhythm. Caution should be used when taking melatonin with fluvoxamine, MAOIs, and TCA, as these may increase concentrations of melatonin; benzodiazepines (BZDPs) and valproate have been shown to decrease nighttime concentrations. Melatonin has been shown to decrease the effects of nifedipine.

For centuries, people have used valerian root to treat anxiety and insomnia. Although not as many studies have been done evaluating the effectiveness of valerian root for sedation as compared to melatonin, some studies show that it may have some effective sedative properties. It is believed that the sedative and anxiolytic properties of this root come from its affinity for GABAA receptors in the brain, similar to that of benzodiazepines. Valerian root is generally well tolerated and has very few reported side effects. Although studies do not agree on a standard dose, doses ranging between 225 and 1215 mg per day have been studied. One of the benefits of using valerian root compared to other herbs like melatonin is the lack of hangover effect, or sleepiness, the next morning. Caution should be used when taking valerian root in conjunction with CNS depressants such as alcohol, opiates, barbiturates, and BZDPs due to an increased risk of CNS depression.

Kava (Piper methysticum) has also been used to help with sleeplessness and promote relaxation in patients suffering from Generalized Anxiety Disorder (GAD). While there is some evidence to support the use of kava in mild insomnia when taken 30-60 minutes before bedtime, patients should be cautious using this herb. Kava has been linked to hepatotoxicity and may increase symptoms of Parkinson’s disease, interfere with INR, and potentiate the effects of other herbs including valerian. Kava should not be recommended in patients with history of liver disease or taking medications that may increase risk of hepatotoxicity.

As a precursor to melatonin, 5-HTP is believed to help with sleep disorders. Since 5-HTP is an immediate precursor for serotonin, it is also believed to help treat depression and regulate mood swings. After tryptophan was removed from the market in 1989 for serious risk of eosinophilia myalgia syndrome (EMS), 5-HTP was marketed as the safer alternative. There have been 10 cases reported worldwide associating 5-HTP with EMS; however, despite decades of use, none of these cases definitively link 5-HTP with EMS. If used, doses should not exceed more than 150-300 mg/day. Other adverse effects include nausea, vomiting, diarrhea, and flatulence. Caution should be used in patients taking SSRIIs, 5-HT1-agonists, and tramadol due to an increased risk of serotonin syndrome.

Given the research available, melatonin and valerian root are two possible options for patients wishing to treat acute sleep disturbances. Valerian root shows an additional benefit over melatonin as it does not result in a hangover effect, or sleepiness, the next morning. While there is some evidence to support the use of Kava and 5-HTP, due to the increased risk of hepatotoxicity and EMS, more studies are needed before these herbals can be recommended for use in sleep disorders. Based on historical use and limited scientific evidence, herbal medications can be used as an alternative to pharmacological medications in the treatment of sleep disorders. However, consideration must be given to potential side effects and adverse drug interactions.

Cortisol is secreted by the adrenal gland and influenced by circadian rhythm. Since sleep inhibits the secretion of cortisol, studies show that patients suffering from insomnia may have elevated levels of cortisol. Symptoms associated with high cortisol levels include weight gain, weakened immune system, acne and behavioral changes such as depression, anxiety, or mood swings. High cortisol levels in women can lead to irregularities in menstrual cycle, increase facial or body hair and infertility. In men,
high cortisol levels may decrease libido. Cortisol levels can be checked with simple saliva test. Pharmacy Specialists provides cortisol testing and consultation for sleep disorders. Contact Pharmacy Specialists at 407-290-7002 and speak with a pharmacist today. References available upon request.

Ashley Addie, PharmD Candidate and Christopher Jackson, PharmD Candidate University of Florida are currently on rotation at Pharmacy Specialists. Jill Weinstein, RPh, graduated from University of Florida and is the clinical pharmacist who does hormone, nutrition and weight loss consultations at Pharmacy Specialists. Pharmacy Specialists is proud to be the only pharmacy in all of Central Florida and one of only 129 pharmacies in the country that are accredited by the Pharmacy Compounding Accreditation Board (PCAB). We meet or exceed ALL standards for sterile as well as non-sterile compounding and we are the only USP 797 and USP 795 validated compliant pharmacy in all of central Florida. Currently, Sam Pratt, RPh at Pharmacy Specialists is the only Full Fellow of the International Academy of Compounding Pharmacists in the Central Florida area. Call Pharmacy Specialists to check with a clinical pharmacist for suggestions and recommendations. For additional information please call (407)260-7002, FAX (407) 260-7044, Phone (800) 224-7711, FAX (800) 224-0665.
Make Your Patient Your Partner in the Treatment Plan for Sleep Disorders

By James D. Huysman, Psy.D., LCSW

Centuries ago, sleep and dreams were surrounded by an array of rituals and remedies for dealing with sleep disorders, promoting sleep, and even preventing nightmares. It seems that sleep disorders have been around since the advent of recorded history! Today, though we know much more about the underlying medical and behavioral causes, sleep disorders continue to be a concern for a significant number in our patient population. To get in front of this trend we must recruit our patients to be proactive about their health.

What if we taught them to view the overall picture as a three legged stool? Using this analogy, the stool itself represents the patient, with one leg of the stool being the condition requiring treatment; the second leg representing the medical and/or behavioral treatment needed to solve or abate the condition and the third leg defining the patient’s responsibility in participating in the recommended treatment for their own wellbeing. Although unsteady at first, engaging in the treatment process will allow the patient to be supported as healthy balance is restored.

According to the National Institutes of Health, more than 40 million Americans are affected by chronic long term sleep disorders. An additional 20 million report “sleeping problems” that ebb and flow in their lives. Fortunately there is a definite line to be drawn in terms of what constitutes a sleeping disorder versus the meaning of a few sleepless nights.

If one’s sleep is routinely disturbed then an assessment and evaluation by a primary care doctor, skilled mental health professional or sleep disorder clinic is in order. Integrating the medical and behavioral health worlds makes good sense here as treatment often includes medication, cognitive behavioral therapy (CBT) and even durable medical equipment if Apnea is diagnosed. CBT teaches our patients important anxiety reducing interventions to modify behaviors that can perpetuate sleeping problems and is an extremely effective adjunctive approach to any medical solution.

Ruling out sleep apnea, stress, anxiety, clinical depression or another underlying psychiatric condition is an important first step. However, even if someone has sleep apnea we can never rule out the underlying behavioral causes such as anxiety and depression.

Depression can be treated successfully with a number of prescription medications, but non-drug alternatives such as interpersonal and cognitive-behavioral therapies are equally as successful, according to the University of Michigan Depression Center.

There are a number of serious psychiatric conditions that can exist beneath the surface of sleeping disorders. Bipolar disorder, General Anxiety Disorder, Obsessive Compulsive Behavior, etc can all contribute to the myriad of reasons why people can’t sleep. Also, it must be noted that sleep disorders do not always refer to the inability to fall asleep. Some sleeping disorders that cause anxiety and depression involve sleeping too much, or the inability to stay awake.

Stress and anxiety may not only cause sleeping problems but can make existing problems much worse. The “age old chicken and egg question” is always in a clinicians’ mind. Does anxiety cause a sleeping problem, as research has pointed out or does sleep deprivation potentially cause an anxiety disorder?

Whether a sleep disorder is diagnosed or not, the worlds of medical and behavioral health need to be on the same page as a united treatment team. After all, ongoing disturbed sleep contributes to a reduced quality of life for our patients and overall cost of care.

As mentioned, it is critical to see the remedy for sleeping disorders like a three legged stool. Without even one leg, the entire stool will fall. Medicine, medical devices or behavioral approaches may not be enough by themselves. Sometimes unless behavioral approaches to deal with anxiety and depression are suggested on the front end, costs of care can rise significantly. In some cases, anxiety reducers, exercise, a better diet, and even loss of weight can save countless dollars and reduce admissions and readmissions to hospitals on their own.

A healthy lifestyle shift may make so much sense for our patients. Here are several ways I make my patients their own health coach and a partner with the medical-behavioral process ahead.

When sleep disorders are involved, patients can easily become their own “Doctor in the Mirror” through several avenues. By watching their diet throughout the day, they become a partner. Reducing alcohol and caffeine use after 3 p.m. can have a profound effect on a person’s sleep cycle and daytime anxiety levels. They must be educated that even if it is possible to get to sleep after drinking an after-dinner coffee, the caffeine can prevent the brain from entering deep sleep, which is the type of sleep that creates that restorative feelings after a good night’s sleep.

A myth that needs to be dispelled here is that alcohol is a sleep aid. Current research reviewed by MedlinePlus indicates that alcohol actually contributes to insomnia in the long run. The same can be true of over-the-counter sleeping medications.

In addition to a simple diet change, there are a lifestyle changes that can go a long way to extending patients’ quality of life as they join in working as their own health coach with a remedy to their chronic disturbed sleep.
Simple lifestyle changes are a proven way to reduce expensive medical interventions while enriching the patient’s potential to recharge themselves. We know sleep “recharges” the brain and improves focus, concentration, and mood. Prescribed medicine is not the only option to treating sleep disorders as it often tends to complicate a long-term solution. Patients should be encouraged to try behavioral remedies on their own as partners in their own care. If need be, a well-trained behavioral health therapist can be of assistance while the physician is working with their patient. Consider the following:

- **Learn to Meditate.** Have the patient focus on breath work — breathing in and out slowly and deeply — while visualizing a safe serene environment such as a deserted beach or grassy hill. There are many guided imagery and meditation tapes available.

- **Exercise.** Make sure a patient gets regular exercise. All research has demonstrated that this is good for their physical and mental health, even for the most obese. It provides an outlet for frustrations and releases mood-enhancing endorphins. Yoga can be particularly effective at reducing anxiety and stress.

- **Prioritize a to-do list.** We suggest to patients that they spend some time and energy on the tasks that are truly important, breaking up large projects into smaller, more easily managed tasks. Suggest to them that they delegate responsibility when they can.

- **Establish a regular, relaxing bedtime routine.** We do not forget to mention to avoid stimulants like coffee, chocolate, and nicotine before going to sleep; advise them to not watch TV, use the computer or pay bills before going to bed.

- **Play music.** Suggest to them that soft, calming music can lower their blood pressure and relax their mind and body.

- **Direct stress and anxiety elsewhere.** Helping others can take one’s mind off of their own anxiety and fears. Suggest that they lend a hand to a relative or neighbor, or volunteer in their community.

- **Talk to someone.** And finally, we tell them not to isolate and to share their anxieties on an ongoing basis with someone they trust works as well. The acronym for TRUST is To Reach Ultimate Success Together. Letting friends and family know how they can help is a good thing to make sure they are compliant with the doctor’s orders on an ongoing basis.

Sleep disorders can be effectively approached with every patient we see as long as we see that the solution always requires a tri-fold approach. Quality of care will improve and overall cost effectiveness of treatment will be the rule rather than the exception.

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**Dr. James D. (Jamie) Huysman, Psy.D., LCSW began his career serving in vice presidential roles at freestanding psychiatric and chemical dependency treatment centers. Subsequently he was called upon to integrate behavioral healthcare with medical services in the same capacity at several national medical surgical hospital groups. Today, he is part of the WellMed Medical Management team that advocates for and integrates behavioral health into primary clinic settings to create better qualitative outcomes and care efficiencies.**

He received his Masters in Social Work from Barry University and Psy.D. from California Southern University. He is also certified as an addictions professional and compassion fatigue therapist.

A popular and engaging speaker, Dr. Huysman keeps an active schedule presenting on a variety of relevant topics for professional caregivers and service providers around the country. He can be reached at drj@drjamie.com or through his website www.drjamie.com.

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For many years, spinal surgery has been conducted using only open surgical techniques, demanding that surgeons cut into large areas of tissue to increase visibility in order to insure the accuracy and precision of the procedures. But since the late 1980s, new technologies and advancements in minimally invasive surgical techniques have allowed spine specialists like Stephen R. Goll, M.D., of Orlando Orthopaedic Center, to perform operations with minimal tissue damage resulting in less pain and faster recovery times for patients.

“When we say minimally invasive spine surgery, what we mean is that these are new methods by which we can accomplish, in some ways, the same types of operations that we have been doing for many years,” said Dr. Goll, “however, now we are able to do those very same operations through much smaller incisions and with much less muscle disruption for the patient.”

In the practice of traditional, or open, spinal surgeries, large incisions, sometimes running the length of the back, are made to access troubled areas of the spine that require attention, such as herniated discs, for example.

The traditional, open surgery, by its nature, involves scarring of large amounts of tissue, cutting of surrounding and supporting muscles, loss of blood, and overall disruption of important muscles including the multifidus, a strong muscle found in the center of the lumbar spine. For patients, this often results in painful and somewhat lengthy recoveries.

However, minimally invasive spinal surgery allows a decrease of all aforementioned consequences, resulting in incisions only an inch or so in length. Because of this, patients experience far less blood loss in addition to a faster recovery with severe reduction of patient reported pain.

“Therein lies the real strength and the real advantage of minimally invasive surgery,” said Dr. Goll. “Through those small incisions, we can get to the spine by simply spreading the muscles that surround and support the spine instead of having to cut through them. This doesn’t compromise our visibility of the spine; this doesn’t limit our ability to see what we need to see in the spine whatsoever. It’s a much less traumatic, less disruptive way for us as surgeons to expose the part of the spine that we need to.”

Though minimally invasive surgical techniques are not applicable for all spinal conditions, as technology and the practice advance, a greater number of conditions are now able to be treated, including spondylolisthesis, feraminal sterosis, recurrent disc herniation, degenerative scoliosis, spinal infection, fracture induced trauma, and spinal tumors.

With the increase of treatable conditions, so to has the eligibility of candidates for minimally invasive spinal operations, and while Dr. Goll says this increase “hasn’t created a host of additional surgeries,” it has extended the benefits of spinal surgery to two primary groups of patients previously unfit for conventional open surgical techniques; active patients interested in a timely return to work or physical activities like sports, and sick patients like the elderly or victims of extensive injury, ordinarily too frail to undergo such major operations.
But perhaps the greatest breakthrough in minimally invasive techniques for spinal treatment is its ability to be used in place of open surgery for spinal fusions, an operation meant to stabilize forward slippage of one vertebral body on another.

“The way that we do this is either through utilizing a series of sequentially enlarging tubes or specially designed retractors that can be placed down through a very narrow corridor directly to the part of the spine that we need,” said Dr. Goll. “Those specially designed retractors can be spread to allow us the visualization we need for that part of the spine. The series of tubes, each one a little bit larger than the last, is placed down so that we are working through a tubular corridor down to the spine. In this way, we can remove discs in their entirety, take pressure off pinched nerves, and can accomplish fusions of one vertebral body to the next.”

In the case of fusions, pedicle screws are “placed in a minimally invasive fashion” by passing a thin guide wire through the incision to the needed area, and using a series of instruments passed over the wire, the screws can then be placed, tightened and fastened with a connecting rod, stabilizing the spinal segment all while under x-ray guidance.

Research on the benefits and predominance of minimally invasive spinal surgery continues and a 2011 study conducted by the Orthopedic Research Network (ORN) looked at 10,000 spinal and trauma cases from 88 participating hospitals and found that sales for cannulated pedicle screws has risen from 8 percent in 2008 to 12 percent in 2011, a barometer of measuring the possible increase of minimally invasive spinal surgery industry wide.

As for the future of the technique, Dr. Goll sees great opportunity ahead. “Over the years we’re all going to see more and more procedures done in a minimally invasive fashion,” said Dr. Goll. “We’re going to see a lot of procedures that are done today in a hospital setting, involving several days stay in a hospital, perhaps done in an outpatient setting where the surgery can be done and the patients can go home the same day.”

*ORN data taken from article published in the Orthopedic News Network.

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How Should You Prepare for Florida’s Malpractice Insurance “Hard Market”?  

By Matt Gracey of Danna-Gracey – The Malpractice Insurance Experts

Q: With a more difficult, “hard market” predicted to hit Florida’s malpractice insurance market soon, what should we be considering in our medical practice to be prepared?

A: Just like creating hurricane plans before the fury of a storm descends upon you, now is a good time to be positioning your practice for the impending hard market in malpractice insurance that will be unfolding in the next few years, just at a time when many practices are challenged by decreasing income and rising expenses. The best strategy can be broken down as this:

1. Preventative: Focus yourself and your entire practice team on risk management. Many times doctors overlook the importance of including the staff in risk management discussions. Studies show that the friendlier your whole practice environment is the lower your risk of a lawsuit. Many higher end malpractice insurers offer risk management assessments of your practice including in-office observations and recommendations, all for free. Alternatively many offer self-assessment tools. Take advantage of these free services!

2. Review your malpractice insurance coverage with an experienced specialist to make sure you are on “high ground” when the storm unfolds. Beware of the many offers from small, new, unrated insurance companies now offering coverage in Florida. Ask your broker to shop your coverage to a number of rated insurers and remember that in this market cycle just before an upturn you will see many offers that are too good to last. The few strong insurers have the ability to withstand the upcoming market pressures because they are not highly leveraged, are not offering actuarially unsound rates, and have a long term not short term philosophy. Find those and you will be much better off when the high winds are pounding on your practice windows!

3. Create negotiating power: Many medical societies, networks, and hospitals have created malpractice insurance purchasing groups to give even smaller practices the negotiating power of larger ones. If you cannot find a suitable purchasing group then consider creating one with your peers, now before the market changes. Such groups are fairly simple to start, legal, and will help you weather the next cycle of sharply increasing malpractice rates.

4. Make sure that your asset protection plans are up to date and if you need to transfer assets around do so soon before many more claims get filed against doctors after the much predicted upcoming overturn of the 2003 caps on non-economic damages.

We at Danna-Gracey are here to help if you need specific direction and recommendations on any of these suggestions and would be honored to become part of your trusted team.

Matt Gracey, Jr. is a medical malpractice insurance specialist with Danna-Gracey, an independent insurance agency based in downtown Delray Beach with a statewide team of specialists dedicated solely to insurance coverage placement for Florida’s doctors. To contact him call (800) 966-2120, or email: matt@dannagracey.com.
Unfortunately obesity is becoming an endemic in USA. During the past 20 years, there has been a dramatic increase in obesity in the United States and rates remain high. In 2010, no state had a prevalence of obesity less than 20%. Thirty-six states had a prevalence of 25% or more; 12 of these states (Alabama, Arkansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Oklahoma, South Carolina, Tennessee, Texas, and West Virginia) had a prevalence of 30% or more.

In addition to cardiac problems with obesity there are various disorders associated with the gastrointestinal tract.

Body mass index (BMI) is a measure of body fat based on height and weight that applies to adult men and women.

- Underweight = <18.5
- Normal weight = 18.5–24.9
- Overweight = 25–29.9
- Obesity = BMI of 30 or greater

Various gastrointestinal tract disorders including esophageal disease, irritable bowel syndrome, biliary tract disorders, gallbladder disorders and gallstone pancreatitis, gastrointestinal cancer, inflammatory bowel disease, and liver and pancreatic transplant are all GI-health conditions impacted by obesity.

Gallstones are one of many serious health risks linked to obesity. Crash dieting and weight cycling can also increase the risk of developing gallstones.

**WHAT ARE GALLSTONES?**

Gallstones are clusters of solid material that form in the gallbladder; they are usually mostly made of cholesterol. They occur either as one large stone or many small ones. Gallstones vary in size and can be as large as a golf ball or as small as a grain of sand.

**HOW ARE GALLSTONES LINKED TO OBESITY?**

Obese individuals are more likely to develop gallstones than those who are at a healthier weight. For women, obesity is an even stronger risk factor for developing gallstones. Researchers have found that obese individuals tend to produce higher levels of cholesterol than normal. This leads to production of bile that contains more cholesterol than can be dissolved. When this happens, gallstones can form from the undissolved cholesterol. Additionally, in the obese, gallbladders may not empty normally or completely.

Research has shown that those who have excess fat around their stomach (abdominal obesity) may be at a greater risk for developing gallstones than those who carry excess fat mainly around their hip and thigh areas. As BMI increases, the risk for developing gallstones also rises. Women with a BMI greater than 32 may be as much as three times as likely to develop gallstones as those with a BMI of 24 or 25. The risk may be seven times higher in women with a BMI above 45 than in those with a BMI under 24.

It’s important to note that rapid weight loss (more than three pounds per week) due to crash dieting or losing a large amount of weight too soon can actually increase your chances of developing gallstones, too. Slower weight loss of about one-half to two pounds a week is much less likely to cause gallstones.

Although losing weight may increase the risk of developing gallstones, obesity poses an even greater risk. Weight loss can lower the risk of developing gallstones and many other obesity-related illnesses. Just a 10% reduction of body weight can lower disease risk. Losing 10% of your current weight over the next six months is a realistic goal that can significantly improve your life and your overall health.

**OBESITY AND GALLSTONE PANCREATITIS:**

Ninety-nine patients with acute pancreatitis in whom body mass index (BMI = weight (kg)/height^2 (m^2)) was measured were studied prospectively to determine the importance of obesity as a prognostic factor in this disease.

Of 19 obese patients with BMI > 30, 12 developed severe pancreatitis; seven had abscesses, of whom five died, and two further patients died.

In 80 non-obese patients, the incidence of severe pancreatitis (n = 5), abscess formation (n = 4) and death (n = 4) was significantly less (P = 0.0007). The mean (s.d.) BMI of 17 patients with severe acute pancreatitis was significantly higher than that in 82 patients with mild acute disease (31.2(5.6) versus 23.3(5.6) kg/m^2, P <0.001). As a single prognostic factor, obesity had a sensitivity of 63 per cent and a specificity of 95 per cent for predicting disease severity. When five obese women with gallstone pancreatitis were excluded, the sensitivity of obesity increased to 86 per cent. Severe pancreatitis occurred in all eight obese patients with disease of an alcoholic etiology.

These data suggest that increased fat deposits in the peripancreatic and retroperitoneal spaces in obese patients may increase the risk of peripancreatic fat necrosis, abscess and death. Consideration should be given to including obesity as a prognostic factor in acute pancreatitis.

**GERD:**

Relationship with obesity is not clear but most studies find a strong association. In the U.S accepted as an independent risk factor for the presence of GERD. Obesity is a risk factor that can identify patients with GERD who are at greatest risk for developing gastro esophageal junction adenocarcinoma.
OBESITY AND IRRITABLE BOWEL SYNDROME:
Significant association between obesity and irritable bowel syndrome was found with various studies. Etiology of association with obesity was unclear. Obesity was associated with more frequent constipation, diarrhea, straining, flatus whether or not subjects reported binge eating.

OBESITY AND CANCER:
Under the assumption that the relationship with obesity and cancer casual, more than 90,000 deaths per year from cancer might be avoided if everyone in the adult population could maintain a BMI of under 25 throughout their life.

ESOPHAGEAL AND GASTRIC CANCER
Increased risk of adenocarcinoma of esophagus by factor of 2-3 with increased BMI. Increased risk of adenocarcinoma of gastric cardia especially in men. The etiology is not clear.

GALLBLADDER CANCER:
Elevated risk for gallbladder cancer in women with increased BMI >40 by a factor of two and is mostly associated secondary to cholelithiasis.

OBESITY AND PANCREATIC CANCER:
Is an established risk factor for pancreatic cancer. A meta-analysis of 14 studies involving 6000 cases of pancreatic cancer estimated that the relative risk of developing pancreatic cancer was about 20% greater in patients with a BMI >30 compared to normal weight individuals.

There is clear association of increase risk of colon cancer in obese patients. While most research has focused on its effects in the fields of cardiology, and endocrinology, growing knowledge has been directed to the gut and its important role in contributing, managing and eradicating obesity.

Harinath Sheela, MD moved to Orlando, Florida after finishing his fellowship in gastroenterology at Yale University School of Medicine, one of the finest programs in the country. During his training he spent significant amount of time in basic and clinical research and has published articles in gastroenterology literature.

His interests include Inflammatory Bowel Diseases (IBD), Irritable Bowel Syndrome (IBS), Hepatitis B, Hepatitis C, Metabolic and other liver disorders. He is a member of the American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE) and the American Association for the Study of Liver Diseases (AASLD) and Crohn’s Colitis foundation (CCF). Dr. Sheela is a Clinical Assistant Professor at the University of Central Florida School of Medicine. He is also a teaching attending physician at Florida Hospital Internal Medicine Residency and Family Practice Residence (MD and DO) programs.

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Understanding and Managing Pediatric Food Allergy

By Jessie Rosenberg, MD and Steven Rosenberg, MD

One of the greatest fears a parent may face is whether their child can become seriously ill if he/she comes in contact with a food, such as peanuts, to which their child is allergic. Television and newspapers report numerous stories of a child having to be rushed to an emergency room for treatment because the child was exposed to a food at home, at a friend’s house, or in a restaurant, that resulted in an allergic (anaphylactic) reaction. Food allergies are a growing problem for pediatric patients and their families. While the incidence of food allergies in the general population is about 2%, there is a much higher incidence in pediatric patients with approximately 6-8% of children manifesting some type of sensitivity to a food. Most of these pediatric sufferers are under the age of 5 years. It is estimated that one quarter of households in the United States alter their dietary habits to some extent to accommodate a family member with a presumed food allergy. The manifestations of food allergic reactions range from mild throat and skin irritation to life-threatening anaphylaxis.

Food allergy is by far the most common cause of anaphylaxis seen in the emergency department. An estimated 30,000 emergency department visits and 200 deaths each year are attributed to food-induced anaphylaxis. Of anaphylaxis induced by food allergy, peanuts and tree nuts account for 80%. Trends have shown that the prevalence of peanut allergy has actually doubled within the last decade. Food allergy is very prevalent in children with eczema. It is estimated that 35% of children with moderate to severe eczema have IgE mediated food allergy that may be a triggering factor in their exacerbations.

Although awareness of food allergies in the population has increased, considerable confusion still exists in regard to defining it. The layperson often has only a limited understanding of the term and will refer to any form of food intolerance as an allergy. In many cases a parent may attribute the fact that a child simply does not like a food to the child having an allergy to it. Parents, nutritionists, and even physicians implicate “allergies” for behavioral problems such as Attention Deficit Disorder, poor performance at school, and even Autism. However to date, no study has been able to elicit a definite relationship between food allergy and any of these syndromes listed above.

When by careful history it is established that the child is indeed having a reaction to a food, it then must be determined if the reaction is Type I or IgE mediated (anaphylactic), induced by a non-IgE mediated reaction (anaphylactoid), or non-immune related (idiosyncratic reaction). Examples of idiosyncratic reactions to foods include individuals who develop headaches (Migraines) after eating foods rich in additives such as nitrates. Type I or IgE mediated reactions can be detected by skin or RAST testing. The diagnosis of non-IgE mediated reactions cannot be detected by conventional allergy testing. The only means to make a diagnosis in respect to non-IgE dependent food allergy is by oral provocation challenge, usually done in an office or hospital setting. Oral provocation challenge testing while effective, is time-consuming and not without risk.

Chicken, eggs, cow’s milk protein, peanuts, tree nuts, fish, and soy protein cause the vast majority of food reactions in children living in the United States. Delaying exposure to these foods may delay the development of clinical atopy, and decrease the severity of the allergic (atopic) state in children. However no study to date have
been able to demonstrate that delaying the introduction of these foods will completely prevent the allergic state in infants, children, and adults.

Breastfeeding, regardless of the mother’s diet has been proven to be beneficial to the health of the infant. Exclusive breastfeeding for at least 6 months compared with cow’s milk protein formula feedings provides a long-term protective effect on the development of respiratory allergy in the pediatric patient. In subgroups of neonates with a family history suggestive of allergy (atopy), it has been demonstrated that early exposure to cow’s milk protein compared with breast milk increased the risk of developing eczema by age 18 months. The best recommendations for mothers of high-risk infants at this time are to breastfeed for at least 4-6 months.

When it is time for the parents to consider adding solid foods to the high-risk infant’s diet, the least allergenic foods should be given first. Cow’s milk protein should not be added until 9-12 months, eggs at 12 months, and peanuts, nuts, and fish at 3 years. Adding solid foods to the infant’s diet in the first 4 months of life is not recommended and has been shown to predispose high-risk infants to eczema. It should be stressed that many children, despite preventive efforts, will still develop food allergies and clinical atopy.

Allergic disease has many different manifestations in children. Symptoms seen in IgE dependent food reactions include oral-pharyngeal irritation with pruritus, urticarial (hives), angioedema (swelling), laryngeal edema, bronchospasm, and gastrointestinal symptoms such as diarrhea, vomiting, pain, and cramping. We have recently seen a new syndrome, Eosinophilic Esophagitis that can present with dysphagia. The most feared consequence of IgE dependent food allergy is anaphylaxis or a generalized allergic reaction that can be life-threatening.

The diagnosis of food allergy is dependent upon a careful history, physical examination, and laboratory tests. The history should be a means in which the physician, patient, and family can begin to identify the foods in question which are thought to be triggering factors. At times the physician may request that the family keep a detailed dietary history. For a definitive diagnosis of IgE dependent food allergy skin or RAST testing should be done. Skin tests are highly reproducible, they have a positive predictive value around 50%, and their negative predictive value is greater than 95%. It is important to note that a positive skin or RAST test alone does not establish the diagnosis of food allergy. To make the diagnosis of IgE dependent food allergy the presence or absence of positive tests should correlate with the patient’s history. When there is a question, the physician may then proceed to oral provocation challenge testing to the food(s) in question. Because of this when there is any doubt in regards to food intolerance/allergy, referral to a physician who specializes in food allergy such as an Allergist/Immunologist would be of benefit.

The prognosis for children who suffer from certain food allergies is generally good. Many patients diagnosed with anaphylaxis

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to milk, wheat, eggs, and soybean will outgrow their clinical sensitivity. An estimated 50% of cases resolve by 18 months and 90% by 36 months. Children who develop food sensitivity after age 3 are less likely to lose their food sensitivity. However in the case of sensitivity to peanuts, tree nuts, fish, and shellfish the chances of the child going into remission are significantly less, and in fact, the sensitivities to these foods may persist into adult life.

Peanut/Tree Nuts are responsible for the majority of food-induced anaphylaxis cases seen in the emergency department in the United States. It is important for physicians to educate families about the management of peanut/tree nut allergy. Specifically, physicians should teach their patients to read food labels to see if peanuts or tree nuts have been added. Generally if a member of the family is allergic to peanuts/tree nuts, these foods should not be kept in the home. If they are in the home, they should have brightly colored warning labels and be out of reach of the pediatric patient. Restaurants and carry-out establishments should be contacted ahead of time and asked if they use peanuts, tree nuts, or cold-pressed peanut oil in their cooking. The treatment of choice for anaphylaxis is injectable epinephrine. Because of this an EpiPen should be carried at all times by the patient, and if necessary a school-nurse. Many schools will establish peanut/tree nut free areas in the school cafeteria. Some airlines are no longer serving peanuts to their passengers. The growing consensus is that an EpiPen should be available in all schools and even in restaurants.

It is important to recognize that these changes and restrictions require a lot of work by the family and can cause considerable stress and frustration. In peanut allergic patients, it is often not necessary to restrict other legumes. However, tree nuts are universally restricted due to cross-reactivity unless a particular nut has been individually tested and found to be safe for the patient.

Food allergy in the pediatric population can be difficult to diagnose and manage. While there is ongoing research in the field, other than dietary elimination, there are no other effective treatment modalities. While Immunotherapy has been found to be effective for the treatment of asthma and pollinosis, current studies do not reveal any benefit to the use of allergy injections for food allergy. Other treatment modalities such as food drops have also not been shown to be of any benefit. Hopefully in the future, agents such as Xolair (omalizumab) may be of benefit to reduce or eliminate an individual’s sensitivity to foods. Because of the difficulty in making a diagnosis and the serious implications of food, allergy referral to a physician specialist in the field of Allergy/Immunology will be of much benefit in the diagnosis and management of the child with food sensitivity.
Restless leg syndrome (RLS) is a poorly understood true medical condition that has long been shown to be more symptomatic in patients with venous insufficiency and venous reflux. There are some in the medical literature that believe venous insufficiency is causative in RLS patients. RLS is most pronounced when patients are resting, especially at bed time and has become a major source of debilitating sleep deprivation disorder. Patients’ symptoms seem to get better when they move around and frequently patients have to walk about in the middle of the night to get relief. Patients with venous insufficiency have tremendous lower extremity fluid shifts that create noticeable volumetric changes in the legs. This volume change in the lower extremity, which is clearly worse at the end of the day, causes an irritation and activation of the sensory nerves in the lower extremity, giving rise to the creeping, itching, pulling, creepy-crawly, tugging, and gnawing symptoms that are so debilitating with RLS.

Similar to venous insufficiency, RLS is three times more likely in women than men. It tends to run in families as does venous insufficiency. Up to 25% of women develop RLS during pregnancy but symptoms usually disappear after giving birth. Most likely the lower extremity fluid shifts that occur during pregnancy and that are almost uniformly due to venous insufficiency provide the backdrop for patients to become symptomatic with RLS. As the lower extremity volumetric changes progress, many of these women return with recurrent symptoms of both venous reflux and RLS.

Although the first line of treatment is usually medication, there are significant side effects from all of them. There are currently two prominent medications that are FDA approved for the symptoms of RLS: ropinirole (Requip) and pramipexole (Mirapex). There are other medications that have FDA approval for other conditions that are sometimes helpful. These drugs fall into four major categories: dopaminergic agents (eg. gabapentin), sleeping aids, anticonvulsants, and pain relievers. Clinical trials have shown that patients treated with medications for RLS with concomitant venous insufficiency had significantly lower medication requirements, if at all, once their venous reflux was resolved.

Other treatment considerations include dietary evaluation to ensure that there is no iron or vitamin deficiency, modifying or eliminating other prescription medications that may exacerbate the symptoms of RLS such as anti-hypertensives, anti-depressants, and anti-histamines. Eliminate alcohol intake. Employ lifestyle changes around the times when patients are required to be still such as activities that occupy the mind. Developing sleep habits that promote good sleep hygiene, such as eliminating coffee or other stimulants after noon will also help quell some of the symptoms.

In 2008, Dr. Kingsley reported a series of 35 patients with severe RLS (as determined by 2003 NIH RLS criteria) and duplex proven venous reflux. These patients were treated with endovenous laser therapy for their venous insufficiency and 89% enjoyed a decrease in their symptom severity score by 21.4 points, providing an average 80% improvement in their symptoms. Fifty-three percent of these patients had a symptom severity score of five or less after vein therapy, and thus had near complete resolution of their symptoms. Of note is that 31% of the patients in this study had a follow-up severity score of zero, indicating complete resolution of their RLS symptoms. This study led to the recommendation that venous reflux should be ruled out and resolved if discovered in all patients with RLS prior to initiating or continuing drug therapy. (Phlebology. 2008; 23(3):112-7.)

At the Central Florida Vein and Vascular Center we have become a referral center for patients with symptomatic RLS to evaluate and treat their underlying venous insufficiency in an attempt to decrease or eliminate their need for the RLS medications that have such a considerable side effect profile or that have lost their effectiveness.

John D. Horowitz, M.D. is Board Certified in both Vascular Surgery and Phlebology and is uniquely trained to offer patients the most advanced vein care possible. He graduated a member of the AOA Honor Medical Society from Temple University School of Medicine in 1986, from Temple University Hospitals General Surgery Residency in 1991, and from The Ohio State University Hospitals Vascular Surgery Fellowship in 1993. Dr. Horowitz is an active member in many nationally recognized societies including the Southern Vascular, Florida Vascular and Society for Vascular Surgery, as well as the American College of Phlebology. He is nationally renowned for his innovative practice of Minimally Invasive Vein Therapy, has presented his work at many national society meetings and has authored numerous journal articles and book chapters. The Central Florida Vein and Vascular Society is routinely used as a training site for physicians seeking to learn Minimally Invasive Vein Therapy. Dr. Horowitz may be contacted at 407-293-5944 or by visiting www.cfvein.com.
A child’s development can be significantly affected if he or she is born with a physical or cognitive impairment. Developmental problems and disabilities can also result from serious illness or injury. Intervening early with developmentally appropriate habilitation and rehabilitation programs can make all the difference in helping these children maximize their potential and feel included in activities in their homes, schools, and communities.

Nemours Children’s Hospital in Lake Nona Medical City will be the only health system in Central Florida offering an Inpatient Comprehensive Medical Rehabilitation Program for pediatric patients. After the opening, we will continue to build the largest and most comprehensive pediatric physical medicine and rehabilitation center in the region. This program will include the full array of outpatient physical medicine and rehabilitation therapies and services.

DEDICATED TO DOING WHATEVER IT TAKES

The Nemours vision is “freedom from disabling conditions.” The Nemours Foundation began to deliver on this vision in 1940 when the Alfred I. duPont Institute, a pediatric orthopedic hospital in Wilmington, Delaware, opened its doors and quickly became world renown for clinical and research excellence in the field of pediatric orthopedics. What we do in the Physical Medicine and Rehabilitation Program fits perfectly with this vision and allows us to breathe “gusto” into the lives of these children.

Nemours Children’s Hospital is bringing unique specialties to the area, and this program will fill a pressing need for rehabilitation tailored to meet the needs of infants and children with a variety of disabling conditions. We will provide evaluations and rehabilitation support to facilitate a normal childhood and transition into adulthood with a plan in place to meet their ongoing rehabilitation needs. Children served will include those with:

- Injuries (Brain, Spinal Cord, Bodily Trauma)
- Burns
- Birth Defects
- Cerebral Palsy and Orthopedic Conditions
- Neuromuscular and Neurological Disorders

Each child’s diagnosis is carefully examined, and consideration is given to any other underlying conditions that may exist. Our goals include not only addressing existing impairment and disability but promoting age appropriate independence as well as preventing secondary disability and complications.

THE PHYSICAL MEDICINE AND REHABILITATION DIVISION AT NEMOURS CHILDREN’S HOSPITAL

Nemours is a Hospital Built by Families for Families. Family-centered care is the essence of pediatric rehabilitation. The family is an integral part of the interdisciplinary team responsible for the child’s care and critical to recovery and successful outcomes. A family-centered model of care, along with an interdisciplinary team that works with the school, primary care provider, care coordinators, and other consultants and community programs will help ensure these patients receive the services they need to optimize their functional outcomes. That interdisciplinary team will include:

- Director of Rehabilitative Services
- Physical Therapist
- Occupational Therapist
- Speech and Language Therapists
- Social Worker
- Nutritionist
- Ortho Surgery, Neurology and Neurosurgery Consultants from Nemours Children’s Hospital

Children with medical conditions or injuries that impair their development or alter their capacity for age-appropriate independence need specialized assistance and therapeutic interventions reinforced by caretakers and involvement in activities of daily living that foster ongoing development and improved function. The Physical Medicine and Rehabilitation Division at Nemours Children’s Hospital will offer comprehensive assessment of assistive technology needs, considering both high and low tech options, to support function. These will include evaluation and training for power and manual mobility, adaptive computer access, augmentative communication devices, and environmental control units.

Our educational goals include giving families and caregivers knowledge and tools that will empower them to be effective advocates for their children and to support their ability to work with education, health care systems, and community organizations so that each child can become a healthy, happy, contributing member of his home and community.
FACILITATING TRANSITIONS

A challenge currently being faced by health care systems across the country is the process, or lack thereof, of transitioning adolescents and young adults with childhood-onset disability into adult systems of care. In many cases, adult providers are ill-prepared or without the system support required to take on these individuals and the multiplicity of their needs. Our commitment is to work towards an effective transition before the child graduates from our rehabilitation programs. This will promote continuity of care and limit the risk of complications.

Stephanie Ried, MD, MA, NCH, Division Chief for Physical Medicine and Rehabilitation at Nemours, is one of the very few physicians in the country to be board certified in both pediatric rehabilitation and spinal cord injury medicine. Prior to her medical training, Dr. Ried was a speech and language pathologist for 10 years, working with children with developmental disabilities and/or neurological conditions. She joins Nemours from Shriners Hospitals for Children in Philadelphia where she is the Medical Director for Rehabilitation and holds faculty appointments at Temple University and the University of Pennsylvania, as well as a clinical appointment at St. Christopher’s Hospital for Children.

She went to college at Howard University (Speech Pathology and Audiology) and Medical School at the University of Michigan. She completed her Pediatric Residency at Baylor College of Medicine and then returned to the University of Michigan for her residency in Physical Medicine and Rehabilitation. Dr. Ried has also held leadership positions in Rehabilitation at the Children’s Hospital of Philadelphia and Children’s Seashore House, Driscoll Children’s Hospital in Corpus Christi, and Children’s National Medical Center in DC.

Dr. Ried is board certified in Pediatrics, Physical Medicine and Rehabilitation, holds Subspecialty Certification in Spinal Cord Injury Medicine and a Certificate of Clinical Competency in Speech Pathology. She has published numerous articles in her areas of expertise and has long been recognized as a leader in the field.
A Step Forward in Enhancing Patient Care

In an economy where large hospitals are downsizing, Osceola Regional Medical Center stands out by appointing Dr. Aida Sanchez Jimenez M.D. as its first Chief Medical & Academic Officer (CMO). Dr. Sanchez Jimenez will focus on ensuring that Osceola Regional fulfills its aim of attaining increasingly higher quality of care for its patients and physician participation.

Her significant leadership and collaboration with members of the Executive Team and Medical Staff have prepared her for the role of CMO, where she will support the management of the hospital.

Dr. Sanchez Jimenez has served Osceola Regional Medical Center for many years in the role of Physician Advisor as well as currently serving as the Medical Director of Cardiac Rehab. She also served as a physician leader in Case Management and Utilization, Quality and Risk Management.

With primary responsibility for all matters regarding patient quality and safety, Dr. Sanchez’s newly appointed role as CMO couldn’t be a better fit, according to Kathryn J. Gillette, Chief Executive Officer at Osceola Regional Medical Center.

“Dr. Sanchez became the obvious and best choice for any number of reasons: she is very well credentialed and she knows us and our culture having been on-staff since 2003,” says Gillette. “She enthusiastically embraces change and communicates it well. She will become a permanent administrative fixture to the Board of Trustees and Medical Executive Committee – driving us to a higher level of performance both through process improvement and teaching.”

Not only does Dr. Sanchez Jimenez have the support of Gillette and physicians at Osceola Regional, but she has shown commitment and experience that proves her to be more than well qualified as CMO.

She completed her Internal Residency Program at Providence Hospital and Medical Center in Southfield, Michigan, received her Bachelor in Science from the University of Maryland in College Park, Maryland, and her Doctor of Medicine from the Universidad Central del Caribe in Bayamon, Puerto Rico.

Dr. Sanchez’s list of accomplishments continues to grow. She is a Fellow of the American College of Physicians and has seven different certifications and licensures, including a Certification in Health Care Quality Management (CHCQM), she has acquired great expertise on risk management, patient safety, and case management.

In addition, she is a member of the Florida Medical Association and board certified in Internal Medicine until 2020.

Dr. Sanchez believes in the idea that as a hospital, as a community, as a country, we have the duty and responsibility to provide safe, timely, patient centered, evidence-based, financially responsible, physician led quality patient care. As CMO, she will continue to ensure patients at Osceola Regional Medical Center receive the safe, quality primary care they deserve.

The “Summer Slide” Pattern Affecting Children

Studies show that all children can experience a learning set-back thanks to a lack of routine during summer months, often referred to as the “summer slide”; however children with special needs are at a greater risk of losing academic skills, along with social and behavioral gains during this extended summer time frame.

As a physician, you may already be familiar with referring parents of children with special needs to UCP of Central Florida, a not-for-profit charter school and therapy center, as a school choice for children with and without disabilities. Children can reach their true potential thanks to UCP’s set of services – support, education and therapy (speech, occupational and physical) – implemented all in one place.

Florida MD encourages you to also remind these families and patients to select summer programs that will maintain education and therapy goals while introducing new life skills. UCP’s Summer Enrichment programs are intended to aid in the consistency of development to preserve educational and therapeutic momentum without interruption during the summer months. This priority, especially necessary for children with special needs, is uniquely balanced with traditional summer camp fun and activities.

UCP is offering a variety of summer camp options for children with and without disabilities, grades VPK to 12th grade. For additional information, please visit ucpcfl.org or call (407) 852-3300.

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Florida Hospital for Children Receives Highest Designation For Epilepsy Care

Florida Hospital for Children named a Level 4 Epilepsy Center by National Association of Epilepsy Centers

In less than one year since its inception, the Comprehensive Pediatric Epilepsy Center at Florida Hospital for Children has been awarded the designation of a Level 4 Epilepsy Center, which is the highest designation for epilepsy centers in the nation. The designation was awarded by the National Association of Epilepsy Centers (NAEC), which evaluates the appropriateness and quality of specialized epilepsy care.

“Being named a Level 4 Epilepsy Center shows the Central Florida community that Florida Hospital for Children is committed to providing the best care available to children suffering from epilepsy,” said Dr. Ki Hyeong Lee, medical director of the Comprehensive Pediatric Epilepsy Center at Florida Hospital for Children. “It takes a multi-disciplinary team of physicians, nurses, researchers, therapists and others to create a comprehensive center that offers the best medical treatment for epilepsy.”

The Comprehensive Pediatric Epilepsy Center at Florida Hospital for Children is led by Dr. Lee and surgical director Dr. James Baumgartner. The center offers patients and families access to a multi-disciplinary approach and provides patients with access to a variety of treatments ranging from innovative non-surgical options, such as the ketogenic diet, to advanced surgical treatments, including operating rooms with the only intraoperative 3T MRI functionality in Central Florida.

Michele Peters saw her daughter suffer from epilepsy for more than 10 years without answers. “Mackenzie had suffered a stroke in the womb which had led to years of suffering from unexpected seizures,” said Michele. “Our family had tried a variety of medications but nothing seemed to work.”

At Florida Hospital for Children, Mackenzie underwent surgery to remove the part of her brain that had been causing her seizures using the latest technology available to help the physicians be as precise as possible and minimize the need for additional surgeries. Today, she is seizure free and able to enjoy activities that a normal fifth grader is supposed to enjoy without the constant worry of seizures.

“I cannot thank the team at Florida Hospital for Children enough,” said Michele. “I hope that other families see this designation of a Level 4 Epilepsy Center as a sign of hope and comfort that there is an epilepsy center right here in our community that can provide the best care possible. Mackenzie is now completely seizure free and back to doing her favorite activities: swimming, riding her horse and climbing trees. She is a normal kid again.”

According to NAEC, a fourth-level center should provide the more complex forms of intensive neurodiagnostics monitoring, as well as more extensive medical, neuropsychological and psychosocial treatment. Fourth-level centers also offer a complete evaluation for epilepsy surgery, including intracranial electrodes, and provide a broad range of surgical procedures for epilepsy.

For more information on The Comprehensive Pediatric Epilepsy Center at Florida Hospital for Children, please call 407-303-KIDS.

First Surgeon in Florida to Perform Surgery with the Renaissance by Mazor Robotic

Central Florida Neurosurgeon, Dr. Nizam Razack has partnered with innovators in the dynamic new field of robotic surgery. He was the first surgeon in Florida to perform surgery with the Renaissance by Mazor Robotics - a next generation robotic guidance system for spine procedures.

Mazor Robotics Ltd (TASE: MZOR), the leader in innovative surgical robots and complementary products for spine surgery, announced that Florida Hospital has purchased a Renaissance™ system. Renaissance is Mazor Robotics’ next generation surgical guidance system for spine procedures. The system is installed at Celebration Health hospital, part of the Florida Hospital system.

“Mazor aims to work closely with early adopters of Renaissance within large hospital networks to broaden the system’s potential exposure to a large number of surgeons,” said Ori Hadomi, CEO of Mazor Robotics. “With a state-of-the-art training facility, its large affiliate hospital network and global reputation, we are confident that Celebration Health will be a strong partner for training surgeons to perform robotic spine procedures and an excellent reference point for other hospitals considering the distinguishing features of surgical robotics.”

Nizam Razack, MD, JD, FAANS, FACS is Founder and President of Spine & Brain Neurosurgery Center. He is board certified in Neurological Surgery. Dr. Razack completed three post-doctoral fellowships: Reconstructive & Complex Spine Surgery at the Mayo Clinic in Rochester, Minnesota. Neurosurgical Oncology at the M.D. Anderson Cancer Center in Houston, Texas, and Orthopedic Spine Deformities at the Rancho Los Amigos Medical Center in Los Angeles, CA. Dr. Razack completed his residency at the University of Miami and earned his medical degree at the State University of New York at Buffalo in 1990.

Continued on page 31
Dr. Razack currently serves as the Chairman of the Department of Neurological Surgery for Orlando Health where he also serves as a member of the Joint Sections Tumor Board. Dr. Razack is an assistant clinical professor in the department of neurosurgery for the University of Central Florida College of Medicine and a former Assistant Professor of Neurological Surgery, Orthopedics and Rehabilitation from the University of Miami. He has also served as an educator in Neurosurgery for Barry University. Dr. Razack is a Fellow of the American College of Surgeons and of the American Association of Neurological Surgery, and a member of the Florida Medical Association.

### Baby Hears the Sound of Mother’s Voice for the First Time

*Florida Hospital for Children physician performs first double cochlear implant in Central Florida*

There was not a single dry eye in the exam room as one-year-old Jaely’s double cochlear implants were turned on for the very first time. Parents Tadzia and Jorge smiled as they watched their little girl respond to their voices and the noises around her, knowing their year long journey to help their little girl hear was finally coming to an end.

“Today, I was able to tell my little girl ‘I love you’ and I know she was able to hear it for the first time,” said Tadzia Jorge, Jaely’s mother.

After living the first year of her life in silence, Dr. Joshua Gottschall, medical director of the Ear, Nose and Throat Program at Florida Hospital for Children, performed Central Florida’s first double cochlear implant on Jaely Jorge. Having the implants finally turned on was the final step in the journey for the family.

According to the National Institute on Deafness and Other Communication Disorders, a cochlear implant is a small, complex electronic device that can help to provide a sense of sound to a person who is profoundly deaf or severely hard-of-hearing. Generally patients only receive one cochlear implant at a time, but due to the benefits of receiving a bilateral implant, the number of double cochlear implants is growing.

“Only recently has bilateral cochlear implant surgery become widely accepted, but I strongly believe it is a great option for children who qualify,” said Dr. Gottschall. “With double cochlear implants, deaf children are able to hear out of both ears, which has several advantages that those of us who can hear often take for granted.”

Patients who receive bilateral cochlear implants have functional advantages including sound localization, sound discrimination, and elimination of head shadowing, the phenomena where sound coming to the “deaf” ear has to pass through the head to be heard. These are all advantages that deaf children implanted with single implants do not benefit from.

“When Jaely’s cochlear implants were turned on, she started to cry and it was overwhelming,” said Tadzia. “Jaely had never cried like that before. I know she was crying because she could hear herself for the first time. It was amazing.”

Over the next several weeks, parents Tadzia and Jorge will have to slowly accommodate Jaely to the sounds around her and bring her to audiology therapy every couple of weeks.

“We are so grateful to Dr. Gottschall and the entire Florida Hospital team,” said Tadzia. “The moment her cochlear implants were turned on, I knew Jaely’s life would be changed for the better.”

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*Florida Hospital for Children offers a comprehensive pediatric cochlear implant program that provides care to patients throughout Central Florida.*

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*Florida Hospital for Children, medical director of the pediatric ENT program at Florida Hospital for Children, was the first surgeon in Central Florida to perform a double cochlear implant to correct deafness.*
FOR YOUR ENTERTAINMENT

The Orlando Philharmonic’s 20th Anniversary Season Presents Two Opera Favorites

The Orlando Philharmonic Orchestra marks its 20th Anniversary with the beginning of the 2012-2013 Season in September. In addition to its schedule of concerts, including the flagship Super Series, Focus Series and Sounds of Summer Series, this celebratory season also brings two beloved operas, Mozart’s *The Marriage of Figaro* and Puccini’s *Madama Butterfly*, to Central Florida audiences.

*The Marriage of Figaro* will be presented at the Bob Carr Performing Arts Centre on Friday, November 9 at 8:00 p.m. and again on Sunday, November 11 at 2:00 p.m. Conductor Joel Revzen returns to the Philharmonic to conduct this classic opera and Fenlon Lamb directs.

Mozart wrote this opera in 1786 after moving to Vienna and conducted the first performance in Vienna at the Burgtheater on May 1, 1786. It’s an “Upstairs, Downstairs” world – filled with seduction, lust, infidelity, love and forgiveness – all woven together seamlessly with sublime music. The Count and Countess Almaviva’s clever maid Susanna and her fiancé, Figaro the valet, plot to outwit the Count and his philandering ways in this comedy many opera lovers consider Mozart’s most “perfectly” written opera.

*The Marriage of Figaro* is now regarded as a cornerstone of operatic repertoire, and ranks Number 5 on the Operabase list of most-performed operas worldwide.

Puccini’s *Madama Butterfly* will be presented on Friday, April 5 at 8:00 p.m. and again on Sunday, April 7 at 2:00 p.m. at the Bob Carr Performing Arts Centre. The opera is based, in part, on a short story “Madame Butterfly” (1898) by John Luther Long. And according to one scholar, it was based on events that actually occurred in Nagasaki in the early 1890’s. Orlando Philharmonic Music Director Christopher Wilkins conducts this masterpiece and Robert Swedberg, former General Director of the Orlando Opera, directs.

*Madama Butterfly* is a staple of the standard operatic repertoire for companies around the world and ranks Number 8 on the Operabase list of most-performed operas worldwide.

The story of Butterfly, a beautiful young geisha, who sacrifices her family, her religion, and ultimately her life for an American World War II naval officer, Lieutenant Pinkerton, is known and beloved by opera lovers everywhere. Pinkerton takes Butterfly as his bride for convenience, with no intention of bringing her home to America. The sweeping emotional power of Puccini’s music is unsurpassed in all of opera and it is not unusual to see both male and females weeping as the story’s tragic ending unfolds! Both operas are sung in Italian with English supertitles.

Subscriptions to this two-concert series are currently on sale. Subscriptions range from $40 to $148. Single tickets go on sale August 27. Single tickets are priced from $22 to $82. Order your tickets by calling the Orlando Philharmonic Box Office at (407) 770-0071 or order online at www.OrlandoPhil.org.
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