UF Health Cancer Center – Orlando Health Gastrointestinal Cancer Center: Multidisciplinary Care Makes a Difference in Pancreatic Cancer Treatment
7th Annual International
Women in Surgery
Career Symposium

February 26-28, 2016
Caribe Royale All-Suite Hotel and Convention Center, Orlando, FL

Conquer the Challenge. Recognize the Opportunity.

The Women in Surgery (WIS) Career Symposium is the largest professional and academic event dedicated to supporting women surgeons and those pursuing careers in Surgery. It promotes both personal and professional growth and is designed to foster mentorship as well as a peer network.

The annual WIS Career Symposium serves as a forum to discuss the issues and challenges confronting women as they seek to advance in a changing but still male-dominated field and to share successes and advice for breaking the glass ceiling in Surgery.

For more information, visit women-in-surgery.com.

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Call for Abstracts
For consideration in the poster session for medical students, residents, and fellows, please submit your abstracts to jennifer@executive-office.org. Deadline: February 15, 2016

WIS is sponsored in part by an unrestricted educational grant from Medtronic.
Specialized multidisciplinary care at UF Health Cancer Center – Orlando Health provides improved outcomes and better quality of life for patients.

This approach translates across all specialty areas, including the high-volume Gastrointestinal Cancer Center, where the focus is on upper, middle and lower gastrointestinal tract cancers, including pancreatic cancer. Here, multiple medical providers – gastroenterologists, radiologists, interventional radiologists, surgical oncologists, medical oncologists and pathologists – collaborate to detect and provide effective, evidence-based care in a coordinated, comprehensive and personalized fashion.

“Having a team of specialists focused on pancreatic cancer and diseases allows us to more accurately determine the stage of disease and optimize our patients’ management, both in terms of treatment plans and coordination of care,” says surgical oncologist Debashish Bose, M.D., Ph.D. Dr. Bose is chief of gastrointestinal surgical oncology at the Gastrointestinal Center at UF Health Cancer Center – Orlando and director of its pancreatic cancer program.
FROM THE PUBLISHER

I am pleased to bring you another issue of FloridaMD and I hope your new year is happy, healthy and prosperous.

The emotional and physical trials and tribulations of parents and families with a child who is mentally and/or physical disabled. Where can they go and who can help them and their child? Since 1955 UCP of Central Florida has offered support, therapy and education for thousands of children with a wide range of disabilities. They continue to grow and provide much needed services. Please join me in supporting this wonderful organization.

Best regards,

Donald B. Rauhofer
Publisher

UCP of Central Florida is a not-for-profit charter school and pediatric therapy center providing support, education and therapy services for children, with and without disabilities, ages birth through 21. More than 3,000 children and their families receive services annually. There are seven campuses located throughout Central Florida in three counties – Orange, Osceola and Seminole.

The charter schools serve students of all abilities including children with cerebral palsy, Down syndrome, autism, spina bifida, speech delays, visual impairments and other developmental delays. UCP now embraces an inclusion education model allowing all children – with and without disabilities – to learn, grow and excel together in the same setting. Research illustrates that inclusion education strengthens socialization skills, test scores and acceptance of others for both students with and without special needs.

For more information, go to www.ucpcfl.org.

COMING UP NEXT MONTH: Editorial focus is on Cardiology, Heart Disease and Stroke.
Assisting my clients with improving the financial efficiency of their practice continues to be increasingly more important each year.

Your practice, like any business, spends money to make money. But how and where you do so involves numerous tactical decisions that can easily slip your notice. Even if you work with a bookkeeper and an accountant, periodically checking your financials will give you a better sense of how your practice is spending its money. All you need is a list of expenses (a detailed version of your P&L statement) and a willingness to think outside the box.[1] If you're reviewing with the specific aim of reducing your expenses, start with the most significant line items, such as occupancy costs, payroll and insurance, and make note of any ideas that come to mind that could reduce them. Continue this process from your largest expenses to your smallest so that you end up with a list of potential fixes, prioritized by expense significance.[2]

Need a few ideas to get started? Here are some options that could save your practice money:

**MAXIMIZE YOUR OFFICE SPACE**

If you have more square footage than you need, you may be able to rent out space to another practice, ideally one that complements your own. Even if you don't have excess space, consider leasing some or all of your suite to an after-hours clinic when you would normally be closed. What's more, your tenants could shoulder some of the burden of shared functions, such as utilities, receptionists and even electronic record systems.[3]

**REVIEW YOUR INSURANCE**

It's a good idea to get an annual checkup from a respected independent broker. The first consideration is making sure you have enough insurance to cover your risk without paying for coverage you don't really need. Periodically, get quotes from various carriers to make sure you're paying the most competitive rate. Research if it's possible to receive discounts if you hold multiple policies from the same company.[4]

**SHOP SMARTER**

Comparison shopping can be worth the effort. Delegate this task to the most knowledgeable staffer for the assignment, such as a technician for medical equipment and supplies, an IT expert for computer hardware and software, and your practice manager for office supplies. Consider buying remanufactured printer cartridges, gently used (rather than new) equipment, free or low-cost public-domain analogs instead of commercial software packages, and picking up supplies rather than depending on delivery.[5]

These are just a few examples to initially consider. Additional cost cutting and revenue generating options should also be discussed with your healthcare business professional partners.

The financial well-being of your practice is in your hands. Look for those qualified healthcare business professional partners who can help you in this and other areas.

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3. ibid.
4. ibid.

Jeff Holt is a Senior Healthcare Business Banker with PNC Bank’s Healthcare Business Banking and is a Certified Medical Practice Executive. He can be reached at (352) 385-3800 or Jeffrey.holt@pnc.com.
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“The initial diagnosis and staging is important because it puts the patient on the potentially correct – or unfortunately incorrect – trajectory of care,” Dr. Bose says. “It is important to have teams of physicians with experience involved from the very start because the best path to making a diagnosis can be very difficult.”

Pancreatic cancer is a formidable diagnosis. In the United States it is the 11th most common cancer among men and women, with between 40,000 to 45,000 cases annually. It is the fourth leading cause of cancer deaths.

Most of pancreatic cancer – greater than 95 percent – occurs as an exocrine tumor, with the vast majority being pancreatic ductal adenocarcinoma (PDAC) – approximately 90 percent. Pancreatic neuroendocrine tumors account for less than 5 percent of all pancreatic tumors.

Worldwide the number of cases of pancreatic cancer is on the rise due in part to an aging demographic. In the United States 90 percent of cases occur in the 55-and-up age group and 80 percent in those older than 65. The overall incidence in the state of Florida is consistent with national averages, occurring in 11 to 12 people for every 100,000.

“Of the 45,000 or so diagnosed with pancreatic cancer in 2016, we will have almost the same amount of deaths. Despite overall advances in treating cancers, pancreatic cancer treatment hasn’t advanced far enough,” says Dr. Bose.

MULTIDISCIPLINARY TEAM IS CENTRAL

The Surgeon General for the State of Florida recently recognized the critical importance of multidisciplinary care for cancer patients by awarding UF Health Cancer Center – Orlando Health as a Cancer Center of Excellence, the only such institution in Central Florida.

The “MCC Conference,” a multidisciplinary care conference of experts, is central to treatment following the pathologist’s experienced diagnosis. “The various medical disciplines come together to discuss every case prior to starting a definitive treatment program, so the input from all these experts can be maximized for each patient,” says Dr. Bose.

“With complex GI cancers, including pancreatic cancer, there is a sequence of steps that is necessary to treat patients in an optimal fashion,” says Dr. Bose. “A combination of making the correct diagnosis at staging, planning and care coordination is ultimately what leads to a better outcome for each patient.”

This is especially important for pancreatic cancer patients, whose disease is usually detected and treated at a potentially curable stage in fewer than 20 percent of patients. For this reason, the overall survival rate is less than 5 percent.

Early pancreatic cancer symptoms are vague and easy to miss or misclassify. When symptoms, such as abdominal pain, loss of appetite, weight loss, jaundice and itching appear, it is often too late.

“Usually symptoms are detected because the disease has progressed and become large and locally advanced or metastatic,” says Dr. Bose. “That’s why the disease carries such a short length of survival overall.”

Establishing the proper diagnosis of a biopsied or resected...
tumor requires a well-trained, expert pathologist. Dr. Bose also cautions patients that a biopsy cannot rule out pancreatic cancer because of the small area tested. “Those who undergo a biopsy with negative results should understand that they might still be confronting a pancreatic cancer diagnosis. This is especially true of needle biopsies and brush biopsies, which provide cytology, but not structure.”

“The stakes are high in the early stages, when we have the potential to produce better results,” says Dr. Bose.

**BORDERLINE RESECTABLE PROGRAM EXPANDS SURGICAL OPPORTUNITIES**

The Gastrointestinal Cancer Center has joined the few, elite centers across the country in offering a Borderline Resectable Pancreatic Cancer Program for patients.

Patients are classified as having resectable disease when it is determined the cancer in the pancreas can be surgically removed without damaging vital structures. Patients have locally advanced disease when the pancreatic cancer has invaded tissue and blood vessels around the pancreas, particularly the blood vessels in the area which include the portal vein and the superior mesenteric artery.

In the past patients with locally advanced disease were thought of as unresectable. Today, the emerging consensus is that pancreatic cancer patients – including those whose disease may have been viewed as unresectable – may now benefit from resection when preceded by neoadjuvant therapy, such as chemotherapy and chemoradiation.

“Traditionally, patients thought to have locally advanced disease were treated using chemotherapy and radiation, which was known to increase life expectancy modestly – from one and a half years to two years after diagnosis,” says Dr. Bose. “Now with the new classification, the borderline-resectable patient can get outcomes that are equivalent in some ways to those with resectable disease.”

Studies in the past 20 years demonstrated the benefits of pre-operative chemoradiation for patients with localized PDAC. One study found a significant reduction in the incidence of positive margins and lymph nodes when resecting tumors treated with pre-operative chemoradiation.

The consensus now is that neoadjuvant therapy may enhance resectability and inhibit local recurrence. Studies with more advanced disease also have proposed that neoadjuvant therapy may result in down staging, which improves the patient’s chances for surgery.

The best pancreatic cancer outcomes – and hope of cure – occur when the pancreatic cancer is totally removed, without lymph node or vasculature involvement, referred to as an R0 resection. This may be possible for about 20 percent of patients diagnosed with pancreatic cancer, according to Dr. Bose.

Patients who appropriately go to surgery have better outcomes, says Dr. Bose. In fact, with the multidisciplinary approach at the Cancer Center, the R0 resection rate for resectable and borderline patients is higher than 90 percent in those who get the surgery.
“Getting the right surgery and being appropriately operated on makes a difference, and accurate diagnosis, coordination of care and timing, and the right level of support are critical to the best outcomes,” says Dr. Bose.

**SURGICAL EXPERTISE IMPROVES OUTCOMES**

Studies have shown that pancreatic cancer surgery is one of many clinical procedures in which the quality of the hospital and physician experience improve the chances of a successful outcome. Because of the seriousness and complexity of pancreatic cancer, only cancer centers with specialized expertise that treat a high volume of these patients should be considered.

“Most surgeons with high volume and good outcomes have HPB (hepato-pancreato-biliary) fellowship training or surgical oncology training and in some instances may also have transplant training. Some form of advanced training where the doctor gains experience in pancreatic surgery is known to be important,” says Dr. Bose.

Dr. Bose was fellowship trained in surgical oncology at The University of Texas MD Anderson Cancer Center in Houston. He also trained at Johns Hopkins Hospital, which is the largest pancreatic cancer center in the world with the highest volume of pancreatic cancer surgeries.

“We are at an advantage” at UF Health Cancer Center – Orlando Health, where the pancreas program is part of a comprehensive gastrointestinal cancer program, says Dr. Bose. “Here, we regularly perform complex pancreatic surgery. Our team uses treatments in line with large academic programs, which makes it possible for us to care for patients who have more symptoms and complications. We get called on frequently to manage complications and uncommon issues.”

**COMPLEX PANCREATIC SURGERY AT UF HEALTH CANCER CENTER – ORLANDO INCLUDES:**

- **Pancreaticoduodenectomy:** Also known as the Whipple procedure, this is the most common surgery for attempting to remove a pancreatic tumor. It also is used to treat cancers of the distal bile duct and chronic pancreatitis. It involves removing the head of the pancreas (the body of the pancreas in some patients), part of the stomach, the duodenum, a small portion of the jejunum, lymph nodes near the pancreas, gallbladder and part of the common bile duct.

  A study of the Whipple procedure published in the New England Journal of Medicine found operative mortality rates to be four times higher at low-volume hospitals (16 percent), which perform fewer than a dozen Whipple procedures per year, than at high-volume hospitals (3.8 percent).

  During the past five years, surgeons at UF Health Cancer Center-Orlando Health performed more than 300 pancreatic resections and 200 Whipple procedures with a mortality rate less than 2 percent.

- **Distal pancreatectomy:** The surgeon removes only the tail of the pancreas or the tail and part of the body of the pancreas and usually the spleen.

- **Minimally invasive pancreatic resection:** Laparoscopic or robotic surgery may be possible for patients whose neuroendocrine (benign) tumors can be removed safely.

- **Palliative surgeries to help relieve symptoms of pancreatic cancer, such as jaundice, nausea, vomiting and pain, include:**

  - **Stent placement:** Metal tubes that help keep the bile duct open are inserted using an endoscope. This procedure is used more often than biliary bypass.

  - **Biliary bypass:** When a tumor blocks the small intestine and causes bile to build up in the gallbladder, the gallbladder or bile duct is sewn to the small intestine. This surgery also may help relieve pain.

  - **Gastric bypass:** When pancreatic cancer blocks the stomach, the stomach may be sewn to the small intestine, allowing the patient to eat normally.

  - **Celiac nerve block:** This can be done during a surgical procedure or as a sepa-
rate non-surgical procedure to improve tumor-associated pain and may reduce the need to use pain medications.

Ablative techniques to treat exocrine pancreatic cancer when a few tumors have spread include:

• Microwave thermotherapy and cryosurgery or cryoablation may be used to destroy cancerous tissue.

• Embolization or chemoembolization delivers substances, such as radiation therapy or chemotherapy, to the blood vessels around the tumor, cutting off the blood supply to the pancreatic cancer.

UF Health Cancer Center – Orlando Health offers the most up-to-date and advanced chemoradiation options for pancreatic cancer. New radiation therapy techniques and specialized skill allow the Cancer Center doctors to target pancreatic cancer tumors more precisely, delivering the maximum amount of radiation with the least damage to healthy cells.

RESEARCH OFFERS HOPE

UF Health Cancer Center – Orlando Health is part of a joint oncology program with UF Health Cancer Center in Gainesville. “Together we form one of the largest clinical cancer registries in the state, as well as one of the largest in the country. Because we have the volume, we hope to make significant contributions to advancing pancreatic cancer treatment,” Dr. Bose says.

The two facilities also have been participating in coordinated group and industry-sponsored trials. “With our partners in Gainesville, we will continue to engage in investigator-initiated trials and trials that we grow ourselves.”

Additionally, UF Health Cancer Center – Orlando Health is among a few cancer centers in the nation participating in clinical trials that offer targeted therapies for some types of pancreatic cancer. The innovative new drugs are used to stop the growth of cancer cells by interfering with certain proteins and receptors that feed tumors.

“Targeted therapy is the holy grail of cancer care right now. Rather than applying labels to the anatomy where the cancer arises, we will actually be characterizing the cancer and behavior by genetics. That would give us some better tools to treat patients with cancer,” says Dr. Bose.

“Our current data is just the tip of iceberg. As our sophistication grows in characterizing patients and their diseases, and we learn more about how patients respond to tailored therapy, we expect we will have a far greater chance to improve outcomes.”

A recipient of the Ruth L. Kirschtein National Research Service Award, Dr. Bose completed a postdoctoral research in cancer biology. He has been recognized with several awards and has been published in several peer-reviewed journals, including the Journal of the National Cancer Institute, Lancet Oncology and the Journal of the American College of Surgery.

He is particularly excited about the usefulness of the UF Health Cancer Center – Orlando tissue bank. “That’s an important tool to develop because today we don’t know the questions we have to ask tomorrow, and having tissue specimens will help us ask and answer future questions.

“We’re hoping that within a few years we can gain National Cancer Institute status, so together we will have a good cadre of research specialists, Ph.D.s and M.D.s, to leverage the tools we are building now to directly impact long-term survivability in patients with pancreatic cancer and other complicated gastrointestinal cancers.”

SPECIALISTS IN PANCREATIC CANCER CARE

UF Health Cancer Center – Orlando Health manages more than 125 cases of pancreatic cancer patients per year, far exceeding most hospital volumes.

Each patient can be assured of treatment by a multidisciplinary team of experts, who deliver personalized, comprehensive care using the latest knowledge, clinical expertise and compassion.

For more information visit UF Health Cancer Center-Orlando Health Gastrointestinal Cancer Center online at www.ufhealthcancerorlando.com/specialties/pancreatic-cancer. To reach Dr. Bose, call: (321) 841-1838. •
The Nature of The Affliction
By Sajid Hafeez, MD

“So… How long do I have to take the medication?” If a psychiatrist had a dollar for every time he has been asked this question, he’d be set to retire a few years after med school. It is a question that bears investigation in a larger context of how psychiatric care is understood by the general patient.

Generally speaking, the shorter the duration of a medication, the higher the compliance on behalf of the patient. When medications are required to treat chronic issues, the patient is less likely to see them as a cure and more as a burden. Antibiotics to treat an infection have a finite conclusion when the infection is cleared. Yet, illnesses such as diabetes or hypertension are afflictions that will likely persist through the rest of most patient’s lives.

Often times the public naively see mental illness as a transient problem. At some point in life, every person will know sadness in one form or another. More often than not, most people will recover and move on. When a person struggles from depression, this mirrors what they experienced when they were sad, but with lasting effects. The hope is that psychotropic meds act like an antibiotic to “cure the blues,” and once that sickness is cured, life will continue as normal. Part of the explanation to this could be explained by linguistics.

As a society, “depressed” and “sad” are often used interchangeably. A person may say that he or she is “depressed because the Denver Broncos lost the Super Bowl,” whereas another may say that he or she is “sad because the Denver Broncos lost the Super Bowl. A large part of mental health care is in educating the patient that sadness is a temporal emotion that relates to situational and environmental factors. Depression is a lasting condition that persists independent of situational and environmental context, which is related to the physiological make-up of the bodies’ chemistry. It is because of this chemical origin, that it can be treated with medications that adjust the levels of chemistry or how the body absorbs them.

Unfortunately, there is no dipstick in the back of the head that the doctor can check to measure the serotonin levels and top them off with a quart when needed. Patients are educated that rather these levels must be discerned by the clinical presentation of the patient, his affect, mood, and own subjective self-assessment of these. When set against lab values, history of recurrence, and environmental context the doctor is then best able to hone in on the issue and treat it accordingly.

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Some patients will be diagnosed with an Adjustment Disorder or Stress Response Syndrome, which is essentially a sadness caused by a specific event. A doctor may or may not choose to start a medication to help the patient through the event, in conjunction with therapy that will help the patient to deal with the psychological aspects of the event. These are the patients who may not need to stay on medication once appropriate coping skills and philosophies are established which allow them a certain level of mental resilience against future stressors.

However for those whose afflictions are the results of the body’s physical biochemistry, therapy and coping skills are typically not enough to overcome the chemical imbalance. It is through medication that these levels are corrected and that patient begins to feel the depression lifting. Unfortunately, this point of “feeling better” is what is responsible for much of the relapse in patients.

Often, once a patient begins to feel better, he or she incorrectly assumes that the affliction has been cured and medication is no longer needed. Inevitably some will attempt to wean themselves off the medication. However because the root of the affliction is chemical and not psychological, no matter how mentally stable and prepared he or she may feel, without the medication to maintain the stable chemistry, these patients will drift back into the affliction.

Ultimately a large part of treating the patient is educating him or her as to what is causing the issue and teaching that psychiatric medications are not cures to a sickness, but rather stabilizers of a chronic condition. In much the same way that a patient with hypertension requires beta blockers so too do those with mental illness need their medication to function at an optimal level. When a patient truly understands why the medications are important and how they work, the compliance ultimately increases, which as a result will improve the patient’s overall quality of life.

Sajid Hafeez, M.D., is a child and adolescent psychiatrist who is serving as a Medical Director of the Acute Care Baker Act Unit at the University Behavioral Center. He also served as the Center’s Medical Director of the long term Residential Units: ASAPP Unit (for adolescent boys with inappropriate sexual behaviors), Solutions Unit (for adolescent boys with behavior problems), Promises and Stars Unit (for adolescent females with behavioral problems as well as victims of sexual abuse), and Discovery Unit (for children ages 5-13 with behavioral as well as inappropriate sexual problems). In addition, Dr. Hafeez also served as an Assistant Professor of Psychiatry at the University of Central Florida (Voluntary Position). He was also the Chief of the Adolescent Psychiatry Unit, an Attending Psychiatrist of the Comprehensive Psychiatry Emergency Program and of the Mobile Crisis Team at the Westchester Medical College. At Vassar Brothers Medical Center in New York. Dr. Hafeez was the Director of Outpatient Child & Adolescent and Adult Psychiatric Clinic as well as Director of Consultation and Liaison Psychiatry. Dr. Hafeez received his adult Psychiatry and Residency Training at the University of Kansas Medical Center in Kansas City. He received his Child and Adolescent Psychiatry fellowship training at the New York Medical College New York and at Children’s National Medical Center of George Washington University in Washington, DC. Dr. Hafeez can be reached at 407-281-7000 or by visiting www.universitybehavioral.com.
Mepolizumab – A New Option in the Treatment of Severe Asthma

By Daniel T. Layish, MD, FACP, FCCP, FAASM

The FDA approved omalizumab (Xolair) in 2003 to treat patients with asthma and an elevated IgE level. Recently, the FDA approved mepolizumab (brand name Nucala) as a treatment for patients with asthma. Nucala was approved for patients aged 12 and above as add-on maintenance therapy for severe asthma with an eosinophilic phenotype.

Mepolizumab is a humanized interleukin 5 antagonist monoclonal antibody. IL-5 is the major cytokine responsible for the growth and differentiation (as well as recruitment and activation) of eosinophils. The only approved dosage is 100 mg subcutaneously every 4 weeks. Because of the possibility of a hypersensitivity reaction, it should be administered in a health care setting appropriate for biological agents. The most commonly reported manifestations of hypersensitivity reactions in the clinical trials of Nucala have included rash, angioedema, bronchospasm, hypotension and urticaria. However, the rates of these reactions were comparable to the placebo group.

Because eosinophils are involved in the immune response to helminthic infections, it is recommended to treat such an infection before starting mepolizumab therapy, and to consider discontinuation of therapy if such an infection occurs while a patient is on Nucala. Two patients in the mepolizumab clinical trials experienced serious adverse reactions of herpes zoster (versus none in the placebo group); therefore varicella-zoster vaccination should be considered prior to starting Nucala therapy. Injection site reactions (such as pain, swelling, itching or burning) occurred in 8% of the mepolizumab group versus 3% of the placebo group.

A total of 1,327 subjects with asthma were included in three randomized, placebo controlled multicenter studies of 24 to 52 weeks duration. The vast majority (1,192) of these patients had two or more asthma exacerbations in the 12 months prior to study enrollment despite being on high dose inhaled corticosteroids plus an additional controller therapy (which could include a long acting beta agonist, a leukotriene receptor antagonist, or theophylline). 135 of the subjects actually required daily oral corticosteroids in addition to using high dose inhaled steroids and an additional controller medication. The patients were required to have blood eosinophil levels of at least 150 cells/mcL within 6 weeks of dosing OR at least 300 cells/mcL within 12 months of enrollment. The patients who received mepolizumab in the clinical trials had significantly less exacerbations (approximately 47% less) and a significantly lower exposure to systemic steroids. There were also fewer exacerbations requiring hospitalization and/or emergency department visits in the mepolizumab group versus placebo. In some studies, the FEV1 improved by about 100 ml on mepolizumab. In the patients who were on maintenance oral steroids there was a significant decrease in their dose requirement overall with mepolizumab. The likelihood of a reduction of the glucocorticoid dose was 2.39 times greater in the mepolizumab group (95% CI 1.25-4.56) and the mean reduction from baseline was 50 percent compared with no reduction in the placebo group.

It is interesting to note that only about 30% of subjects enrolled in the mepolizumab studies met the prescribing criteria for omalizumab. Therapy such as omalizumab directed against IgE for asthma has not been evaluated in “non-allergic” patients. Asthma can be characterized as “allergic” and “non-allergic”. Allergic asthmatic patients are, in general, younger and have a better response to therapy. Non-allergic asthmatic patients are often adult onset and this is associated with non-allergic co-morbidities, such as rhinosinusitis and gastro-esophageal reflux and does not respond as well to therapy. The use of other currently available asthma treatments does not distinguish between allergic and non-allergic patients. At this point, there is no data regarding concomitant use of mepolizumab and omalizumab. As the science of asthma therapy advances, clinicians will need to learn more about the different asthma phenotypes and their response to these targeted therapies.

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/Sleep Medicine Fellowship at Duke University in Durham, North Carolina. Since 1997, he has been a member of the Central Florida Pulmonary Group in Orlando. He serves as Co-director of the Adult Cystic Fibrosis Program in Orlando. He may be contacted at 407-841-1100 or by visiting www.cfpulmonary.com.
How Do I Get My Doctor on the Best Doctors in America® List?

By Jennifer Thompson

No doubt you’ve seen those Best and Top Doctors lists circulating recently in local magazines and online. But what are they and how can you get listed?

Each year Best Doctors, Inc. comes out with the Best Doctors in America® List, which includes the nation’s most respected specialists and outstanding primary care physicians in the nation.

Your doctor is awesome, so... why didn’t they make the cut? That’s what we set to find out!

WHAT IS BEST DOCTORS, INC.?

To put some credibility behind the Best Doctors in America® List, let’s first understand who creates it. Headquartered in Boston, MA, the company integrates its services with employers’ other health-related benefits, to serve more than 30 million members in every major region of the world. So it’s safe to say they know their stuff.

HOW ARE THE BEST DOCTORS CHosen?

Best Doctors’ team of researchers conduct a biennial poll (every other year) using the methodology that mimics the informal peer-to-peer process doctors themselves use to identify the right specialists for their patients. The polling method and balloting software used has been audited and certified by Gallup®. They gather the insight and experience of tens of thousands of leading specialists all over the country, while confirming their credentials and specific areas of expertise.

Doctors cannot pay a fee and are not paid to be listed and cannot nominate or vote for themselves. It is a list which is truly unbiased and respected by the medical profession and patients alike as the source of top quality medical information.

TIPS TO GET RECOGNIZED

Since nominations are done by doctors’ peers, the usual reason a doctor isn’t selected or reselected in a poll is due to lack of peer support. If you feel your doctor is qualified to be on the Top Doctors List, these are a few steps they need to take to be considered:

• Get nominated. A physician must be nominated by a current listee to be considered for inclusion. A nomination means the doctor has been recommended for consideration and then must go through the evaluation process. Current listees are limited to ten nominations per two-year period, but not by specialty or geographic area.

• Verify qualifications. Once a consensus of peer support is achieved, the physicians are subject to additional qualifying criteria, including verification of clinical activity, accessibility to existing and/or new patients and an active medical license with no disqualifying disciplinary actions.

• Show clinical activity. Listed Best Doctors must be accessible to existing and/or new patients in order to qualify for inclusion and have a current medical license free from any disqualifying disciplinary actions.

• Encourage your peers to vote. Only currently listed Best Doctors physicians are eligible to submit nominations and vote in the biennial poll. Voting doctors are asked “If you or a loved one needed a doctor in your specialty, to whom would you refer them?” Make sure they would choose you!

Jennifer Thompson is co-founder and chief strategist for DrMarketingTips.com, a website designed to help medical marketing professionals market their practice easier, faster and better.
Some Reports of Adverse Medical Incidents are Privileged and Confidential

By George N. Meros, Jr. and Andy V. Bardos

A recent court case successfully challenged three discovery orders that would have required Southern Baptist Hospital of Florida – and potentially other Florida hospitals – to produce certain records of adverse medical incidents that are privileged and confidential under the federal Patient Safety and Quality Improvement Act of 2005. The First District Court of Appeal quashed the trial court orders on October 29, 2015.

In the underlying medical malpractice case (Jean Charles, as next friend and guardian of Marie Charles, et al. v. Southern Baptist Hospital of Florida, Inc.), the circuit court ordered Southern Baptist Hospital to produce tens of thousands of documents consisting primarily of incident reports. The court broadly interpreted Article 10, Section 25 of the Florida Constitution, a 2004 constitutional amendment that created a right to access “any records made or received in the court of business by a health care facility or provider relating to any adverse medical incident,” to require disclosure of all reports of adverse medical incidents.

On certiorari review, George Meros and Andy Bardos argued – and the First District agreed – that the incident reports at issue were “patient safety work product” which the federal Patient Safety and Quality Improvement Act protects as privileged and confidential. Congress enacted the Patient Safety and Quality Improvement Act with the express intent to provide a secure place for medical providers to report and evaluate errors or near misses, so that the systemic errors will not recur. That Act creates a national, confidential, and non-punitive system of data-sharing of healthcare errors among the health care industry for the purpose of improving the quality of medical care and patient safety.

This ruling relates only to documents developed or assembled in the patient safety evaluation system. Plaintiffs continue to have full access to original medical records, depositions, and other discovery from defendants and third parties, and experts on both sides will be able to utilize that information—and more—to opine on the quality of care and causation. However, the ever-growing amount of safety-related data that has been generated will enable the medical community to improve the quality of medical care consistent with the right of plaintiffs to seek redress.
Reconstructive Surgery Allows Patient to Regain Use of her Dominant Hand

By Corey Gehrold

Danna Olivo was in Brazil, enjoying a much needed vacation when tragedy struck. In the blink of an eye everything changed for the Orlando resident when she was hit by a bus while trying to cross a busy street. The impact would leave her with severe arm trauma and little to no use of her dominant right hand.

Three upper extremity surgeries later, she was released from the hospital in Brazil and cleared to return home to the United States. Once on American soil, she immediately made an appointment with Michael D. Riggenbach, M.D., a board certified orthopaedic surgeon specializing in hand and upper extremity surgery, peripheral nerve surgery and microsurgery at Orlando Orthopaedic Center.

“Dr. Riggenbach was extremely empathetic for what I was going through,” she says. “He went the extra mile to make sure I got as much function back as possible.”

During her first exam, Dr. Riggenbach quickly realized that if there was any hope of restoring the functionality in hand, additional surgery was necessary - and fast.

“I told her we had to go back in for another reconstructive procedure; and the sooner we did it the better chance she would have at using her right arm, wrist and hand like she did prior to the accident,” recalls Dr. Riggenbach. “Our goal was to restore as much function as possible. I’m happy to say we were able to help Danna get back to using her hand and arm at very similar levels to what she was used to prior to her injury.”

Dr. Riggenbach and his team used bone and tissue from Olivo’s hip to help reconstruct her arm which had not healed from the previous operations.

“Prior to surgery with Dr. Riggenbach, I couldn’t do much of anything with my wrist,” Olivo says. “Now I’m at the point where my wrist is pretty strong.”

Today, after months of physical therapy, Olivo is writing again with ease, opening doors without a second thought and even pouring her own morning coffee again - something she didn’t think she would ever be able to do while lying in a hospital bed in Brazil.

“I couldn’t be happier with Dr. Riggenbach or the results of my surgery,” she says. “I really appreciate the time he put in, especially in an era when doctors are forced to push patients through. He spent time with me and brought new technology and new techniques to the table.”

Now with full function nearly restored, Olivo is looking toward the future with a renewed sense of confidence.

“I’m very thankful to Dr. Riggenbach and appreciative of the progress he has helped me achieve,” she says. “Without his help I am not sure where I’d be or how much of my arm function I would have today.”

Danna Olivo lost most of the use of her right hand following an accident in Brazil. She came to Dr. Riggenbach to help save her hand and regain regain function.
New Technologies in Pancreatic Cancer: Using 3D Printing to Better Improve Diagnosis

By Sebastian de la Fuente, MD

Pancreatic cancer is a deadly disease that according to the National Cancer Institute affects 46,000 people every year in the United States and continues to be the forth-leading cause of cancer-related death in both men and women despite recent developments in treatment. Due in part to a lack of highly accurate diagnostic tools, the vast majority of patients present at an advanced stage making surgical resection not possible at the time of initial diagnosis. Although strides have been made in the recent past in the treatment of the disease, only patients who undergo complete removal of the tumor can potentially be cured and achieve relative prolonged survivals.

One of the obstacles physicians often face when diagnosing pancreatic cancer is determining the relationship of the tumor to vital structures that need to be preserved at the time of surgery such as the mesenteric vessels. Surgeons commonly rely on multiple different radiologic tests such as computer tomography and endoscopic ultrasound to allow planning of the surgical intervention in advance. Although these high-quality tests can predict the need to vascular reconstruction in a significant number of patients, unexpected findings at the time of surgery sometimes occur preventing the pancreatic surgeon from eradicating the cancer.

In order to improve the accuracy of pancreatic cancer diagnosis, investigators at the Institute for Surgical Advancement at Florida Hospital have recently applied 3D technology to patients with this deadly condition.

Sebastian de la Fuente, MD (a surgical oncologist at Florida Hospital Orlando) and Gareth Hearn (a medical engineer of the medical device innovation lab) have started utilizing 3D technology in the diagnosis algorithm if these patients. “Two-dimensional technology is adequate for the diagnosis of certain conditions but it doesn’t precisely tell us much about the true size, volume and correlation of tumors to other structures, especially crucial vascular anatomy” Dr. de la Fuente explains. “In this regard, 3D visualization has the potential to show us in advance critical findings not evidenced on conventional studies before rendering operations that might not benefit the patients”.

The technology of 3D reconstruction has been applied in the medical field to patients requiring complex interventions in a wide variety of fields such as orthopedics, reconstructive surgery and vascular surgery but has not been used to date for patients with cancer. “We are at a point in history where technology is allowing us to help patients and see things that were not possible to be seen before. I foresee the implementation of 3D reconstruction and 3D printing becoming part of the armamentarium in the diagnosis of pancreatic cancer in the near future” Dr. de la Fuente concludes.
First Aid for Your Online Reputation
By Dorothy Mowbray, M.O.R.O.F. Board Member

Doctors seem to have the typical love-hate relationship with online reviews. They love the positive reviews and hate the negative ones. Reviews are becoming increasingly important as more people read them to determine which healthcare provider to visit and as quality of patient care begins to factor into certain reimbursements. Plus, nobody wants to ever hear something bad about themselves or their healthcare practice! But can you do anything when you have no control over what patients write?

Medical Offices Resources of Florida’s mission is to bring all aspects of healthcare together through one unified source to complement healthcare professionals. Monthly breakfast presentations provide a platform to not only network with colleagues, but also to learn about compliance issues, ways to save money, techniques to grow revenue and more.

On Thursday, January 28, M.O.R.O.F. has secured a national digital media speaker and trainer, Matt Weber, to reveal the tools available to help manage and improve your practice’s online reputation. He will also discuss how online reviews impact your new patient lead generation and what you can do to have a healthy online reputation.

“Online reputation is the Silent Killer of your marketing efforts,” explains Weber, who is a national speaker and President of ROAR! Internet Marketing. Many doctors and practice managers don’t even know about their reviews. But prospective patients are reading them often before they ever go to the practice website or call their office. In fact, 70% of people make purchase decisions for all goods and services based on the digital recommendations of strangers, according to Mintel’s, American Lifestyles Report. For millennials, that number jumps to 80%! Bad reviews are silently killing opportunities to attract new patients!

As disheartening as a bad review can be, there is one thing that is far worse: an unanswered bad review. At this breakfast you’ll learn where to find your reviews, and how to respond to bad ones so that even a bad review can benefit your practice. Yes, there is a way to use bad reviews to your advantage!

Can you just delete them? Generally, the answer is no. What lives on the Internet stays on the Internet forever. Suppressing bad reviews is generally the best course of action. However, Weber has discovered a technique that has successfully allowed a local medical practice to have some bad reviews deleted. He’ll share that story with those that attend the M.O.R.O.F. breakfast on January 28.

M.O.R.O.F. meets the fourth Thursday of each month from 7:30 a.m. to 9 a.m. at the Venue On The Lake at the Maitland Civic Center. The address is 641 South Maitland Ave., Maitland, FL 32751. Healthcare professionals are always welcome as guests. RSVP at www.mor-of.net.
AID: What a Difference a Year Makes

By Marni Jameson

The start of a new year is a great time to take stock and ask whether you’re on the right course. For me, that includes reflecting on what has happened at the Association of Independent Doctors since I joined as executive director a little over a year ago.

What a difference a year makes.

Frankly, worthy though I thought the cause, I wasn’t sure the saving of America’s independent doctors was a fight we could win. But, fortunately, I relied on the opinions of two smart, forward thinking certified public accountants.

Tom Thomas and Carol Zurcher, both CPAs and partners at Thomas, Zurcher & White, an accounting firm in Winter Park, Fla., saw a need for a trade association dedicated to helping independent doctors survive. The worrisome trend of hospitals buying up medical practices was hurting the practice of medicine, driving up costs astronomically, and hurting communities financially.

But no one was speaking up for the doctors. So Thomas and Zurcher formed AID, and at the association’s charter meeting in April 2013, 100 doctors joined. Eighteen months later, when I came on board, AID had just shy of 300 members, and already a voice on the national stage.

Today, we are nearing 1,000 doctor members, in 14 states.

The reason behind AID’s exponential growth is simple. It’s the result of a timely message tied to a solution getting spread. When doctors ask me, “why should I join?” -- and lately they ask every day -- all I have to do is look back at the past year’s highlights, and share them.

**HERE ARE TEN REASONS:**

1. Fast Growth: AID is the only national association dedicated to supporting independent doctors, and we are growing fast. In the past year, we have tripled our membership and now have nearly 1,000 doctor members in 14 states, coast to coast.

2. State Chapters: We have three chapters of AID outside of Florida, where we are based, and are looking to form chapters in every state. The existing chapters – Maine (260 members), California (61 members), and So. Carolina (36 members) -- were all groups of independent doctors that recognized they were simply running in place, and would be better off joining a national association and being part of a larger collective voice.

3. AID-SAVE: Thanks to a partnership we have established with McKesson and a national group purchasing organization, AID members save between 15% and 35% on medical on office supplies. The AID-SAVE program typically allows members to recoup the cost of membership -- $500 a year -- in fewer than three months.

4. Online Directory: If they choose, members may be part of AID’s online directory of independent doctors, which we will then promote to media, as part of a campaign telling consumers why it’s important to go to an independent doctor, and providing a tool for them to find one.

5. United Front: We give doctors the resources to champion their issues, and answer their questions, such as what to consider when asked to join a CIN, and whom to call for help with insurance contracting issues. We provide templates for letters to send to lawmakers, and materials for media outreach. This...
is only a sampling of the support membership provides.

6. Time and Expertise: The fight for independence takes time, money and knowhow. We have all three. In December we hired our second full-time person, a publicist with 18 years of public affairs and media experience. Together, along with the occasional intern, we work full-time getting the message out to consumers, media, businesses, and lawmakers about the importance of keeping doctors independent. Doctors are good at complaining, but not very good at organizing, communicating strategically and effecting change. We are.

7. Focus: We stick to our goals: Stop hospital-doctor consolidation, promote transparency in health-care pricing, push for parity in provider reimbursement by promoting site-neutral payments; help enforce anti-trust laws; and stop nonprofit hospitals’ abuse of their tax-exempt status.

8. Infrastructure: We were founded by business people, two CPAs and a health-care attorney. We are a 501c6 nonprofit, have all the proper insurances, dedicated office space and support staff, and are well capitalized.

9. Presence: In the past three months alone, AID has presented at the national MGMA conference in Nashville, on Capitol Hill at the National Physicians Council on Healthcare Policy, and at Becker’s Healthcare Forum in Chicago. The speaking calendar is filling for 2016. We are also a go-to source for national media, and have been cited in media dozens of times in the past year. We give independent doctors a collective voice that’s long been missing from the discussion.

10. We are stronger together. We will do an even better job as we grow. But to stop the trend of hospital consolidation, we need significant numbers, resources, and you.

Yes, we still have days where we feel like David up against ten Goliaths, the personification of our nation’s giant hospital systems and their lobby on steroids. But mostly days are marked by small steps toward progress, and the years marked by great strides.

For more information or to join AID, go to www.aid-us.org or call 407-865-4110.

Marni Jameson is the executive director of the Association of Independent Doctors. You may reach her at marni@aid-us.org.
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