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FALL / WINTER 2020

LEHIGH COUNTY

Health & Medicine

Official Publication of The Lehigh County Medical Society

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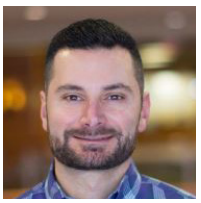
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Well, it seems that just a few weeks ago I was writing this article for the summer edition; how time flies. Now the fall – winter edition and holiday seasons are right around the corner.

This has been a troubling year for many; we're hoping this edition will give you resources that are timely and helpful. Many of the articles for this edition revolve around the COVID-19 pandemic.

In this issue you will find an article on pregnancy and COVID-19. We have all needed to adapt to what has become normal, but those who are expecting have the additional stress of delivering a baby during the current pandemic. Please read COVID-19 and Pregnancy: What we know so far.

Some have experienced skin conditions from wearing masks to protect ourselves and those around us. See the article Prevention and Treatment of skin conditions related to personal protective equipment in the era of COVID-19.

We have seen and heard how devastating COVID-19 can be on the body. Read on to find how physical therapy can play a role in COVID-19 recovery.

Another sad side affect of this pandemic is the increase in cases of child abuse and neglect. Approximately 155 children died or nearly died this year in Pennsylvania as a result of suspected child abuse or neglect, according to state data from Jan. 1 to July 15, which is more than all of 2019. Read on to see how your United Way of the Greater Lehigh Valley is trying to help.

Additionally, we have an article on Brain Aneurysms and Subarachnoid Hemorrhage. This is a disease that mostly affects younger individuals, with an average age of 53 but carries a high rate of mortality and many survivors report permanent disability in strength or cognition.

And last but not least, this year the American Academy of Pediatrics released a revision on its previous policy on the benefits and risks of resistance training for children and adolescents. See more detail inside.

We hope you enjoy this and past issues as we add to the conversation about how medicine and wellness can help us form strong communities in Lehigh County. If you are interested in back issues, or just want to read *Lehigh County Health and Medicine* online, please visit our website at https://lcmedsoc.org/our-publication.

If you have ideas or suggestions for upcoming issues, please consider contacting us, or see our website at https://lcmedsoc.org/contact. Thank you for reading! ✚

PHYSICAL REHABILITATION

Plays Key Role in COVID-19 Recovery

By GOOD SHEPHERD REHABILITATION NETWORK

COVID-19 can have a devastating impact on the body. It causes weakness, balance issues, swallowing problems, breathing challenges and more — even if you're never hospitalized due to the potentially deadly virus.

However, with guidance from physicians and therapists specializing in Physical Medicine and Rehabilitation, patients recovering from COVID-19 have options to receive care for better respiratory function, cognition and balance, all in an effort to regain their quality of life.

"Ultimately, because of the damage it can do to the lungs and heart, COVID-19 can make it harder for people to walk, breathe normally or complete everyday tasks, whether they were hospitalized or not," said Susan Golden, PT, NCS, administrative director of Neurorehabilitation at Good Shepherd Rehabilitation Network. "These quality of life improvements can be achieved through a number of approaches, including endurance training and helping patients understand how to conserve their energy."

In the case of patients who have been hospitalized due to COVID-19, especially the critically ill who were placed on a ventilator, the physical impact is far greater.

"In the case of COVID-19, any time you have a prolonged hospitalization without proper movement, muscle wasting can happen," Golden said. "Muscle wasting affects all of your body's function and usually takes twice as long to regain. Because COVID-19 has cardiac side effects, it is important to build strength and endurance in a progressive manner with careful monitoring by a physical rehabilitation professional."

Continued on page 6

Those who contracted the virus but avoided hospitalization can still experience a rapid heartbeat and endurance issues.

"Because of COVID's ability to damage the lungs, another key is training patients how to breathe through a variety of techniques," said Kelley Limbauan, PT, DPT, NCS, a physical therapist who specializes in treating COVID-recovering patients both in-person and virtually from the Good Shepherd Health & Technology Center in Allentown. "Some patients need help with pacing their breathing, while others can benefit from using a pursed-lip breathing technique as they recover. Body posture and relaxation also can offer relief."

In addition to the physical impact of COVID, there can be a psychological one, too.

"Some of these patients felt like lepers, even with their own families," Golden said. "It is important to create a rehabilitation environment where they feel just like everyone else. The more comfortable they are, the more they can concentrate on getting well."

Telehealth rehabilitation has taken on a newfound role in the era of COVID-19. In spring 2020, the federal government relaxed regulations, which allowed physical, occupational and speech therapy to be performed through secure video platforms.

Telehealth options have helped people receive outpatient rehabilitation in a number of ways, Limbauan said.

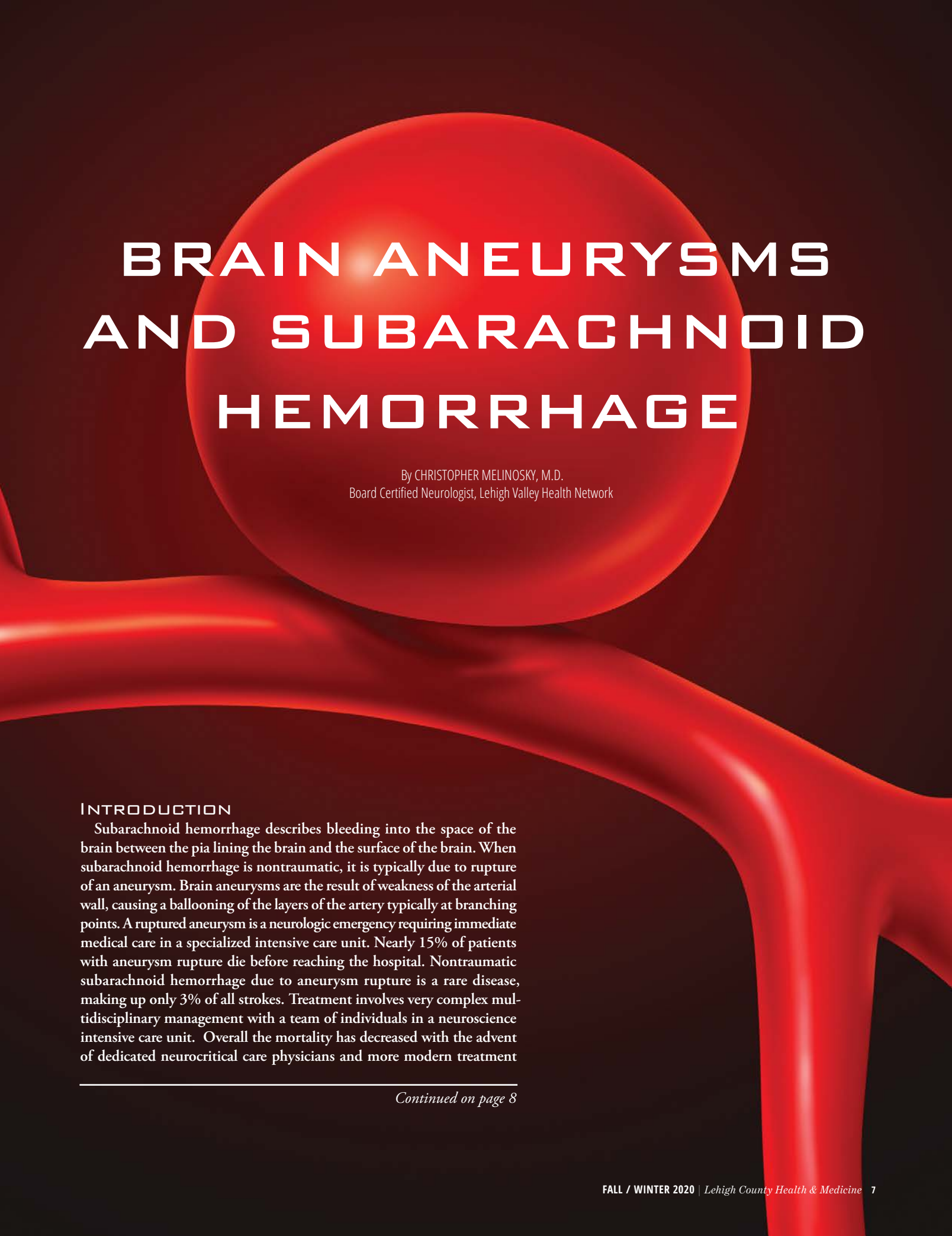
"The fact that outpatients can start their care early on when they still need to self-quarantine is important," Limbauan said. "Additionally, the quicker they receive care, the lesser the effects of muscle wasting. Everyone is at a different level of what they are comfortable with. Having a telehealth option has made some patients seek care when they would not have come to a clinic because they were uncertain about leaving home."

Telehealth also offers a peek into patients' home lives, where rehabilitation experts can literally look for potential fall hazards and other challenges that they wouldn't necessarily know about while treating patients in a clinic.

"It is a great way to problem solve specific problem areas they are facing at home in real-life situations," Golden said.

Arlene Dalessio is an example of telehealth helping a COVID-recovering patient. Uneasy about attending in-person appointments after her discharge from Good Shepherd Rehabilitation Hospital in Allentown, Arlene continued her outpatient rehabilitation from home via video. She worked with Good Shepherd clinicians on building stamina, balance and strength, and reducing shortness of breath.

"It's wonderful," Dalessio said of telehealth rehabilitation. "I can do it right in my house — and it works." +



BRAIN ANEURYSMS AND SUBARACHNOID HEMORRHAGE

By CHRISTOPHER MELINOSKY, M.D.
Board Certified Neurologist, Lehigh Valley Health Network

Introduction

Subarachnoid hemorrhage describes bleeding into the space of the brain between the pia lining the brain and the surface of the brain. When subarachnoid hemorrhage is nontraumatic, it is typically due to rupture of an aneurysm. Brain aneurysms are the result of weakness of the arterial wall, causing a ballooning of the layers of the artery typically at branching points. A ruptured aneurysm is a neurologic emergency requiring immediate medical care in a specialized intensive care unit. Nearly 15% of patients with aneurysm rupture die before reaching the hospital. Nontraumatic subarachnoid hemorrhage due to aneurysm rupture is a rare disease, making up only 3% of all strokes. Treatment involves very complex multidisciplinary management with a team of individuals in a neuroscience intensive care unit. Overall the mortality has decreased with the advent of dedicated neurocritical care physicians and more modern treatment

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techniques. It is a disease that mostly affects younger individuals, with an average age of 53 but carries a high rate of morbidity with many survivors reporting permanent disability in strength or cognition.

Subarachnoid hemorrhage

When an aneurysm ruptures, the typical presentation is the "worst headache of your life." There is a range of clinical symptoms, from isolated severe headache, to cranial nerve abnormalities (usually difficulty with eye movements), to a comatose state with posturing movements. Aneurysm rupture is often a sudden event but may be preceded by days or hours with a "sentinel bleed" typically causing headache. Modern CT scanners are able to detect acute subarachnoid hemorrhage 95-99% of the time in the first several days, but after one week the rate of detection is lower and may require a lumbar puncture for diagnosis. A CT angiography can often identify the aneurysm that ruptured, but a formal catheter angiogram is the most sensitive test for finding aneurysms.

Acute subarachnoid hemorrhage carries a host of immediate complications, including injury to the brain itself. The first concern is rebleeding of the aneurysm, which comes with a high mortality. It is important to find the aneurysm and treat it immediately to prevent re-rupture. Additionally, normal drainage of cerebrospinal fluid is impaired by the presence of subarachnoid blood, and acute nonobstructive hydrocephalus may occur. This life-threatening condition is only alleviated by placement of an external ventricular drain to monitor pressure and remove excess fluid. The hemorrhage itself affects the surface of the brain, and seizures may occur during the acute period. Fevers are also common, both due to concomitant infection as well as irritation of the hypothalamus, which is involved in temperature regulation for the body. Most concerning is the potential for cerebral vasospasm, or narrowing of blood vessels of the brain due to the subarachnoid hemorrhage. Vasospasm occurs in about 30% of subarachnoid hemorrhages and is a major cause of permanent brain damage and disability. Careful monitoring and immediate treatment of vasospasm can help improve the overall outcome for the patient.

When an aneurysm ruptures, there may be a host of systemic complications beyond injury to the brain. This can include a reversible nonischemic cardiomyopathy, called Takotsubo's cardiomyopathy. The hallmark is apical ballooning of the heart with a decrease in function that usually reverses in several weeks. There may be EKG changes due to the hemorrhage itself. There can also be neurogenic pulmonary edema, or fluid in the lungs that makes it difficult to oxygenate and ventilate. Hyponatremia due to cerebral salt wasting is a common complication and is due to the kidneys dumping salt and increasing urine output. There may be insulin resistance leading to hyperglycemia requiring insulin administration. Management of these critically ill patients with complex multisystem involvement requires specialized training and often the input of multiple subspecialists.

Unruptured brain aneurysms

It is estimated that 3% of the population has an aneurysm, and about 20-30% of those with aneurysms have multiple. Risk factors for developing brain aneurysms include high blood pressure, smoking, connective tissue disease (such as Ehlers-Danlos syndrome), family history of aneurysms, and female sex. They are most commonly found in people age 40 to 60. As brain imaging becomes more common and accessible, there is a higher rate of incidentally finding unruptured brain aneurysms.

Treatment of unruptured aneurysms is typically limited to observation with repeated imaging. Several factors play into the decision to electively treat an aneurysm before it may rupture. In general, the larger the aneurysm is, the more likely it is to rupture. Aneurysms less than 7mm may be observed for many patients. However, if a patient has had a prior subarachnoid hemorrhage, hypertension, or the aneurysm is in a location that is more prone to rupture, there is a higher likelihood of requiring preventive treatment. Guidelines recommend specific screening if a person has two or more first-degree relatives with aneurysms or subarachnoid hemorrhage. If an aneurysm is discovered incidentally, it is best to refer for evaluation by neurology, neurosurgery or interventional neuroradiology.

Aneurysm repair options

There are two possible approaches to repairing an aneurysm, both electively before rupture and immediately after a subarachnoid hemorrhage. Both have associated risks and benefits, but ultimately the determination is based on the location and imaging characteristics of the aneurysm itself.

Surgery

Aneurysm clipping was performed at Johns Hopkins in 1937 and has evolved since. The procedure requires general anesthesia and opening the skull to physically treat the aneurysm. A surgical clip is placed around the base of the aneurysm to prevent it from rupturing. No treatment is 100% successful for life – there is still a risk of aneurysm recurrence, though it is lower than the endovascularly treated patients. Additionally, clips may migrate or fail, though this is rare. Surgical recovery may be longer than with endovascular treatment, and there is a higher risk of seizures and disability. Certain aneurysms are only able to be treated surgically.

Endovascular treatment

The alternative to surgery is endovascular coiling in which a catheter is introduced through a peripheral artery and navigated to the brain to find the aneurysm. Though it has not been available as long as surgical repair, it has quickly become the choice of treatment when possible. First described in 1988, small detachable coils may be placed into the aneurysm to secure it and prevent re-rupture. More recently, flow diversion away from the aneurysm may be achieved with stenting. A combination of stenting and coiling may also be utilized based on the aneurysm. There is less immediate risk with endovascular repair, but there is a higher rate of aneurysm recurrence. Electively, this procedure can be performed in a day, and the patient is often discharged the next day. Repaired aneurysms usually require close follow up and may require retreatment in the future.

Conclusion

Though subarachnoid hemorrhage due to aneurysm rupture is a rare disease, it is important to immediately recognize and treat it to prevent complications and death. As with any brain injury, time is brain and early treatment is better. Recognizing a subarachnoid hemorrhage and transferring to a neuroscience intensive care unit is vital to the survival of patients with this disease. ✚

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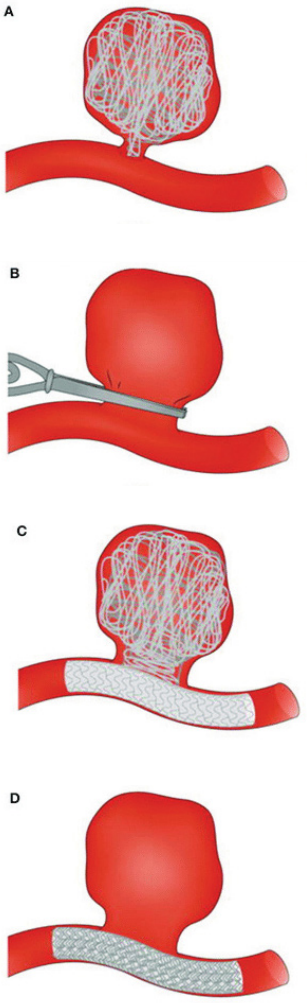
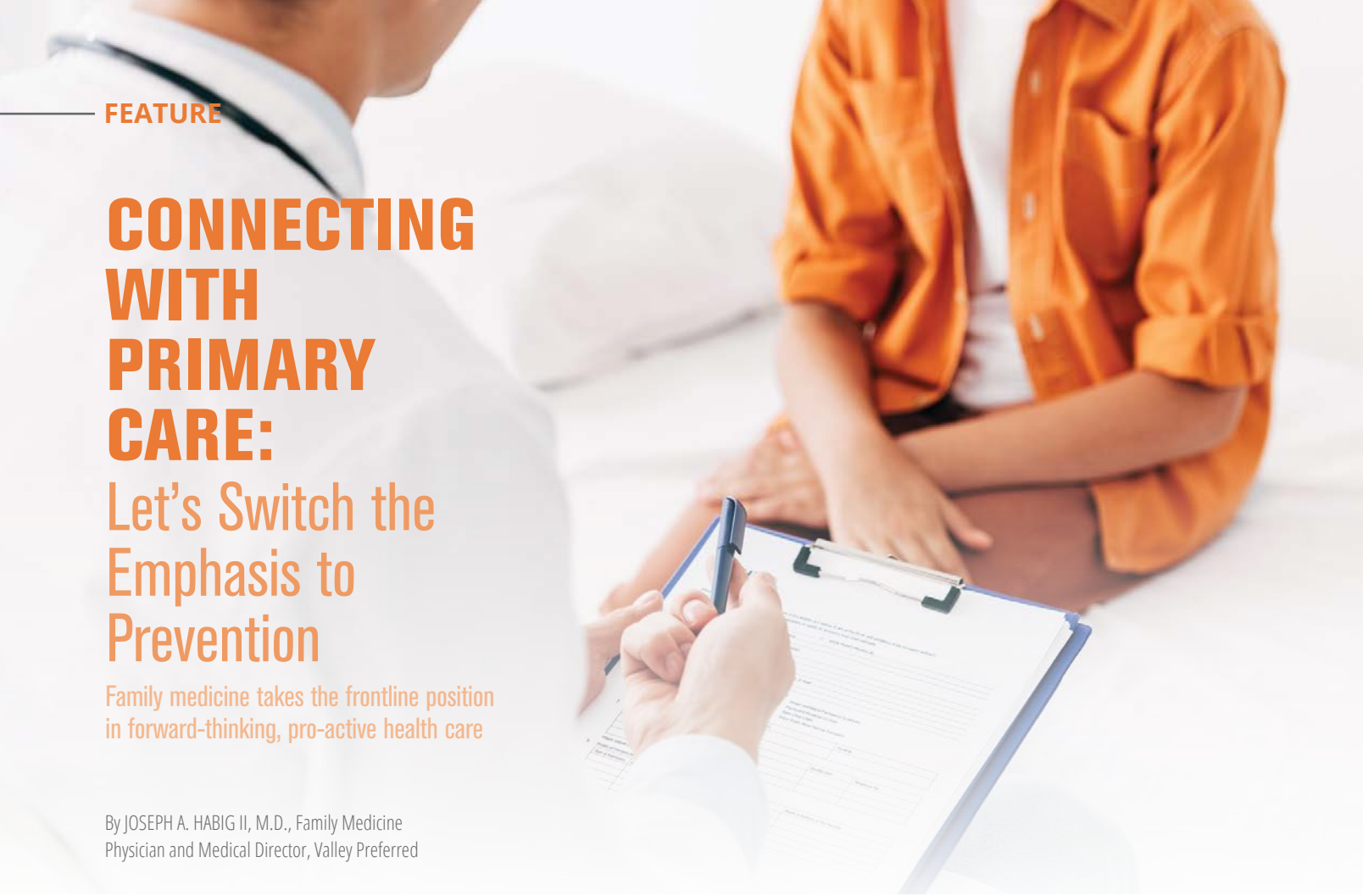


Surgical and endovascular treatments for cerebral aneurysm thrombosis.
(A) Endovascular coiling of the aneurysm sac.
(B) Surgical clipping of the aneurysm neck.
(C) Endovascular treatment combining use of coils and a stent. (D) Endovascular treatment with a flow diverter. Taken from Perrone et al. (2015).

FOR MORE INFORMATION GO TO THE BRAIN ANEURYSM FOUNDATION
BAFOUND.ORG



CONNECTING WITH PRIMARY CARE:

Let's Switch the Emphasis to Prevention

Family medicine takes the frontline position in forward-thinking, pro-active health care

By JOSEPH A. HABIG II, M.D., Family Medicine
Physician and Medical Director, Valley Preferred

U.S. adults who have a primary care physician have 33 percent lower health care costs and 19 percent lower odds of dying than those who see only a specialist. As a nation, we would save $67 billion each year if everybody used a primary care provider as their usual source of care.*

The concept of primary care is one that's absolutely necessary for any progressive vision of the future. This is evident even though some people may associate primary care physicians (PCPs) with the age-old notion of doctors who visited your house and discussed your condition over a cup of tea. However, if we borrow the sense of personal connection that was inherent in those past physician-patient relationships, and apply it to today's technology-driven medical practice, we arrive at a more evolved version of informed, compassionate, holistic patient care. This version is essential, as people continue to value a sense of humanity in their care, and physicians try to rediscover the joy of practicing medicine despite their increasing administrative and technological responsibilities.

WHY IS PRIMARY CARE SO IMPORTANT?

There are a number of answers to that question. The best is probably that seldom does an illness or medical condition exist in a vacuum. In other words, the systems in the body and mind are all connected and one can, and usually does, affect the others. PCPs have the unique advantage of having studied all the systems of the body, and, especially in recent years, have incorporated how behavioral health comes into play in any given condition.

The current pandemic underscores this advantage. As reported by the University of California San Francisco, "In late January, when hospitals in the United States confirmed the presence of the novel coronavirus, health workers knew to watch for precisely three symptoms: fever, cough, and shortness of breath. But as the number of infections climbed, the symptom list began to grow. Some patients lost their sense of smell and taste. Some had nausea or diarrhea. Some had arrhythmias, heart or other organ damage. Some had headaches, blood clots, rashes, swelling, or strokes. Many had no symptoms at all."

This situation exemplifies the need for a physician whose knowledge extends beyond one specialty. It also speaks to a physician who is close and familiar with his or her patients, has a long-term relationship with them, and therefore knows when something is awry.

The pandemic contributed to significant health implications because people did not seek medical care due to concerns of being infected with coronavirus. More mental health issues, and alcohol and substance abuse have occurred in the complex environment of COVID-19. Due to the physician's generalized experience, he or she can address a problem at its seemingly apparent source, and also have the background to dig deeper for other consequences and causes.

EARLY INTERCEPTION: THE ANNUAL WELLNESS VISIT

Another reason primary care is important is that the entire system

of health care is in the process of switching to a value based model of reimbursement, which is expected to be significant in the future. Since value based care transfers the emphasis from diagnosing sickness to keeping people well, primary care takes a frontline role. The primary care office serves as ground zero, where the physicians and staff can get an early jump on a problem that could become a serious health threat if left unattended.

An excellent tool for early interception is the annual physical, or for those age 65 and older, the Medicare Annual Wellness Visit. When physicians see patients once a year even when they are well, they are able to view the big picture. Besides any particular illness, physicians can evaluate factors such as how patients are getting along at home, and whether their life needs are being met. It's a good check-in for screenings relevant to the patient's age and a review of family health history. This is also an opportunity for PCPs to address mental health. Part of the annual wellness visit is a depression screening; however, the visit can be the opportunity for the physician to take note of any perceived problems with drugs, alcohol, falls or risky behavior, and discuss those issues with the patient.

These days, especially as we feel more vulnerable, there's an increasing understanding and acceptance of seeing the doctor when you're well. Employers are getting onboard by offering discounts to employees on their health insurance if they complete an annual wellness visit. Payers are seeing results in terms of lowering the cost of payouts, so they are joining employers as advocates of this form of preventive medicine.

FROM THE PHYSICIAN'S PERSPECTIVE

In order to bring more value for patients into the health care equation, it's imperative that physicians work together. From the insurer's point of view, physicians and their staffs are part of a team of hundreds of physicians managing a population of patients. Since patients are attributed to their PCP, what happens in the family medicine office is of utmost importance. As the PCP pursues quality in practice (completing annual wellness visits, closing care gaps, monitoring episode costs, and coding accurately), economies can result that ripple across the population.

For example, if during a wellness visit, a patient mentions bowel changes, the PCP can prescribe a colonoscopy. If during the screening, early colon cancer is diagnosed, then cured, it may contribute to overall cost savings. Contrast that to a patient who did not visit a PCP and their cancer advanced undetected. This would take more resources and potentially cost more to treat and manage.

Another example is when a patient visits the primary care office rather than going to the Emergency Department (ED) in the hospital. Many health problems can be initially addressed by a PCP, and PCP visits are less expensive than ED visits for patients and insurers.

The impact of the pandemic in terms of compelling the utilization of virtual visits has been significant and opens up another option for patients. They like video visits because they are more convenient and, during the pandemic, perceived as safer than going into the doctor's office. For physicians, it's an excellent way to gain insight into a patient's condition, state of mind, and even their home environment. The overwhelming positive reaction to this avenue of care has insurers evaluating the possibility of continuing reimbursement for video and phone visits beyond the end of 2020.

PRIMARY CARE IN TRANSFORMATION

Even before the pandemic, primary care was challenged. Fewer medical students were taking this route, contributing to what has been estimated as a shortage of 21,000 to 55,000 physicians by 2033**. When the pandemic hit, primary care visits declined by 20 percent, and many primary care practices folded. We have been fortunate in the Lehigh Valley to have retained most of our primary care practices, even though they were stretched, had to innovate, make rapid changes to their practice environment for the safety of patients and staff, and pivot to telemedicine to ensure patients have access to uninterrupted care.

Keeping flexibility, innovation, and readiness as staples, primary care practices that continue to grow will become better equipped to manage change. According to one source, "To successfully practice in the future, physicians will need a mix of relationship-oriented skills to connect with patients and colleagues, quantitative skills to interpret complex data, a strong foundation in prevention to deliver wellness-oriented care, and a robust understanding of business and economics of medicine to drive population health."***

This vision of the future is in the works now. Hospitals, physician hospital organizations, and providers themselves are prioritizing quality primary care and are passionate about strengthening access as a core component to better care and value. According to Primary Care Progress, "Access to primary care helps keep people out of emergency rooms, where care costs at least four times as much as other outpatient care. A study in one ER found that nearly 60% of the patients' problems could have been addressed in a primary care clinic for a savings of a whopping 320-720% – that's a value of three to seven times less."**** ✚

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COVID-19 *and pregnancy*

what we know so far

By PATRICIA MARAN, M.D., MA, FACOG, Department of Obstetrics and Gynecology, Lehigh Valley Hospital, and BRITTNEY GAUDET, MPH

As obstetricians we are in the family business. We worry if our patients can get pregnant; once pregnant, we work to educate them about how they can stay safe and make choices that will benefit the upcoming addition to their families. We are translators of the complex medical and physiologic wonders that allow for a child to grow inside a woman's body. We wait up through long nights, patiently watching and guiding moms and babies through the birth process. We are there when all too often, expectations go out the window and a routine vaginal delivery becomes an emergent cesarean – when a baby decides to show us a hand, a foot, a cord, or starts playing jump rope inside. At the drop of a hat, we have to change tactics. We abandon anticipated plans, and adapt to what the woman and baby present to us.

As health care workers, parents, children, and obstetricians, I daresay, nothing has made any of us worry, change plans, or spend more time focusing on the safety of our families, than this most recent COVID-19 pandemic.

These are surreal times. We all have adapted to this new normal. But for the pregnant woman, the anxiety associated with being pregnant, or those anticipating due dates during the COVID-19 pandemic cannot be underestimated. All the worries about the future, about one's health, about being a good enough parent, have escalated through these months of quarantine. Busy kitchen tables, frustrated outbursts by children and parents alike, relative isolation of

our elder relatives to protect them from those who are younger and likely asymptomatic all play a role in the heightened anxiety experienced by many since this past March.

With regard to COVID-19 and pregnancy, like every aspect of the medical field, we are being bombarded with snippets of information and headlines. Only recently has the data begun to be collated and analyzed so that we can start to synthesize information in meaningful ways. Below we have summarized salient points gleaned from scientific journals and literature in the past 6 months.

Though more concrete information has trickled into the milieu of obstetrics, what we know remains limited given the exclusion of pregnant women from many gold-standard investigations of novel treatments and potential vaccines[1]. However, it is clear that the possibility of maternal morbidity and mortality secondary to COVID-19 is a substantial risk. We learned from studies of the first four weeks of the pandemic in New York that women overall, are more apt to be asymptomatic and incidentally test positive at the time of admission for active labor. Reassuringly, this population is much less likely to be admitted for complications associated with COVID-19 than their non-pregnant counterparts[8]. The likelihood of being an asymptomatic carrier was echoed in a retrospective cohort study from September that revealed women presenting for gynecologic and/or obstetric procedures, including labor, were at significantly higher risk for asymptomatic COVID-19 than patients presenting for elective general surgery procedures after adjusting for age and sex. Pre-procedural asymptomatic infection rates in obstetrics have been reported as high as 14%[2]. We cannot delay or reschedule labor. Babies ultimately choose when they decide to come. The safety of our health care workers, especially those working on the labor and delivery units, the majority of whom are young women of child bearing age, raises the question of whether we should test every person admitted to our labor and delivery suite.

Among those in the community at large, women are faring better. Overall, pregnant patients have lower hospital admission rates and critically ill pregnant patients have lower case fatality rates (CFR) than their non-pregnant counterparts (5.3-12.9% vs 34.5%)[4,8]. While the risk of contracting COVID-19 appears to be the same, the risk of getting markedly ill with the disease still falls to our brothers, fathers, sons and husbands. Despite their propensity for better outcomes, nearly 25% of COVID-19 positive pregnant women admitted have required oxygen support, which included noninvasive oxygen via nasal cannula, high-flow oxygen and mechanical intubation[7]. Women with additional risk factors such as maternal age over 35 and obesity were at higher risk for utilization of interventions and poorer outcomes[7]. Thus the seriousness of COVID-19 must be acknowledged even in this relatively low risk population.

Not all aspects of maternal morbidity and mortality secondary to COVID-19 fall just on the mother. The growing fetus is at risk for consequences of COVID as well. Literature has shown a high likelihood of preterm delivery and delivery by Cesarean section, both of which come with their own set of risks for mom and baby[5,7]. Prior to delivery, vertical transmission from mother to neonate appears to occur at a rate of 2-3%[3]. Though this is at a rate similar to other pathogens that cause congenital infections, prevention and safety education for expectant mothers is a critical part of our job as obstetricians. Despite the risk for passage of the virus from mom to baby, we do know that there has been no increased risk of micarriage above baseline for those women who have tested positive early in pregnancy[9]. We do not yet know, nor is there enough data to say, if neonates delivered by women who were infected with the virus early in pregnancy will face unsuspected manifestations of the virus. What we do know is that COVID-19 does not seem to be as congenitally devastating as other viruses such as Zika, rubella, varicella, or cytomegalovirus. If we can keep mothers and families healthy, the newborns seem to do well.

Finally, we know that the COVID-19 pandemic has had a striking impact on the psychological well-being of our pregnant patients. It is likely that over 50% of expectant mothers have suffered severe psychological impacts, with one survey revealing that nearly 66% of respondents reported severe anxiety. Many cite concerns regarding potential for transmission to their baby as one source of their heightened worry. This psychological impact seems to be most severe in women in the first trimester of pregnancy[6]. At times I wonder if some of the escalation in anxiety for newly pregnant women is the unsaid question: what will happen to me if my partner gets sick? Now, more than ever, it is imperative that we, as a community, work with our families to educate, reassure, and provide physical and mental support in the context of pregnancy and the COVID-19 pandemic.

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Prevention and treatment of skin conditions

related to personal protective equipment in the era of COVID-19

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Due to the emergence of the coronavirus disease 2019 (COVID-19) pandemic, personal protective equipment (PPE) has been used beyond its normal measures to prevent the spread of disease. Healthcare and other frontline workers wear multiple layers of PPE including gloves, masks, gowns, and face shields/goggles. The extended use of the variety of PPE has accompanied a re-emergence of dermatologic conditions including mask-related acne ("maskne"), contact/irritant dermatitis, pressure-related skin damage, and exacerbation of existing dermatologic conditions.

Mask-related acne is a form of acne mechanica arising from occlusion of pores and irritation from prolonged wearing of masks and tight-fitting goggles or face-shields. Moisture and other irritants can accumulate on the inner surface of the PPE and contaminate the covered area of skin. With the increased moisture and friction, the natural skin barrier is susceptible to breakdown and secondary infiltration with inflammation-causing bacteria leading to acne breakouts. Treatment strategies include traditional acne therapy comprising of regular use of over-the-counter (OTC) benzoyl peroxide or salicylic acid cleansers, topical retinoid therapy (prescription or OTC), topical antimicrobial therapy, and, in severe cases, systemic therapy (antibiotics, retinoids, hormonal therapy). Prevention strategies include use of 100% cotton masks when possible, avoidance of makeup or other comedogenic products when masks are worn, regular cleansing or replacement of masks, and cleansing/moisturizing skin using non-comedogenic cleansers and emollients at least one hour prior to PPE use. In addition, taking appropriate and safe breaks from wearing PPE for 15 minutes after every 2 hours can be helpful in preventing accumulation of moisture and acne-inducing contaminants.

Contact and irritant dermatitis are also a potential consequence of increased hand-cleansing and PPE use. Hand dermatitis is characterized by redness, itching, burning, and cracking of the hands and fingers. It is caused by repetitive use of hand sanitizer, hand soaps, hot water exposure, and certain types of gloves in susceptible individuals. Prevention and treatment

strategies include the use of unscented or sensitive-skin hand soaps, use of warm instead of hot water, frequent use of hand moisturizers containing ceramides or petrolatum, and avoiding latex-containing gloves. More severe cases may need a prescription topical steroid to reduce inflammation.

Dermatitis secondary to PPE commonly affects the areas covered or in direct contact with the equipment. Contact or irritant dermatitis may be caused by rubber mask straps, adhesives, metals, and/or chemicals used to make the equipment. Affected skin may appear red and bumpy with associated itching or burning. To prevent or reduce dermatitis due to masks, an alcohol-free barrier film wipe can be applied to the skin followed by an adhesive foam dressing. Care must be taken to ensure proper fit of the mask. A fragrance-free, hypoallergenic moisturizer may also be applied to the skin directly in contact with the PPE. This should be done at least an hour in advance of donning of the PPE to ensure proper protection.

Pressure-related skin injuries have been reported due to the tight-fitting nature of N95 masks and goggles/face shields. Although a tight seal is imperative to decrease droplet exposure, masks and eyewear should be fitted and adjusted accordingly to prevent pressure-related skin changes such as bruising, erosions, or ulcers. Appropriate-fitting PPE should not cause significant discomfort when donned. It is recommended that 15-minute breaks every 2 hours be taken during work hours and when safe to avoid continued pressure on the skin. Use of a soothing moisturizer every morning and night will aid in healing any skin damage that may have occurred during work hours. Use of dressings or emollients should be done with caution to avoid compromise of the protective nature of the PPE.

Exacerbations of existing dermatologic conditions have also been observed during the COVID-19 pandemic including recurrences and worsening of rosacea and seborrheic dermatitis. Seborrheic dermatitis is characterized by redness and scaling in the eyebrows, around the nose, and in the scalp. Rosacea is characterized by pustules and inflammatory papules (similar to acne) on the cheeks, forehead, and chin. Increased duration of mask wearing and changes in grooming during the pandemic can lead to a build-up of moisture, overgrowth of yeast, and overgrowth of demodex mites resulting in a flare of these conditions. Treatment strategies for seborrheic dermatitis include the use of an over-the-counter anti-dandruff shampoo or prescription topical ketoconazole cream. A mild topical corticosteroid such as hydrocortisone may also be used. Treatment strategies for rosacea include topical metronidazole, azelaic acid, sulfur-based products, and/or ivermectin cream. Prevention strategies include mask breaks and resumption of pre-pandemic grooming practices.

The cutaneous effects of prolonged use of PPE cannot be ignored. They are prevalent and will continue to emerge as the pandemic persists. Although the proper equipment must be worn to protect one's self and others, the cutaneous adverse effects can be minimized if identified early and prevention strategies are undertaken. ✚

Fighting Cancer During a Pandemic

Keeping Patients, Physicians and Families Safe

By DONNA BAVER ROVITO

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COVID-19 has impacted society in incalculable ways. Or, as Huntsville, Alabama-based radiation oncologist Ashlyn Everett, MD, puts it: "Unfortunately, I think we have settled into a 'new normal' and will not be able to return to 'the way it was' for several months."

"New normal" has become 2020's catchphrase, as health care professionals strive to adopt safety measures to mitigate the impact of the pandemic on their patients and their own families.

We interviewed three oncologists in different parts of the country to learn how they have adapted their practice and interactions with their own families to minimize risk. In addition to Dr. Everett, we spoke with Carol Tweed, MD, from the Anne Arundel Medical Center Oncology & Hematology Group in Annapolis, Maryland and Mark Lewis, MD, Director of Gastrointestinal Oncology at Intermountain Healthcare in Murray, Utah. Dr. Lewis is a cancer survivor.

Oncology services have continued throughout the pandemic, albeit with modifications, including limiting the number of patients, due to: "PPE limitation, lack of established pandemic clinic operations practices, concern re: viral transmission and need to socially distance in the work place, financial strain caused by the pandemic, deployment of clinic staff to inpatient COVID care and furloughed staff," says Dr. Tweed.

Dr. Lewis has shifted to telemedicine for surveillance and follow-up patients. "We contact them remotely using phone or, preferably, video platforms. This allows them to avoid traveling to our clinic, which could be a high-volume node of viral transmission, and lets us keep patient volumes manageable in terms of social distancing and exam room turnover."

Dr. Tweed supports telemedicine's role: "The pandemic has offered a chance to restructure clinical care in general, with incorporation of telemedicine into the current care model and a continued role for telemedicine in the future. The future 'usual' will look quite different than the pre-pandemic 'usual.'"

All three physicians have continued to treat their sickest patients uninterrupted. "The metastatic group has continued on treatment almost without interruption, largely because we adjudged the threat of unopposed cancer to outweigh the risk of COVID-19," says Dr. Lewis, a topic he discusses further in the *New England Journal of Medicine*. (https://www.nejm.org/doi/full/10.1056/NEJMp2006588)

Their practices have adopted significant safety measures: "Patients and staff wear masks at all times; everyone is screened upon entry to our facilities. Limited visitors, social distancing in waiting areas. Special cleaning procedures. No contact check-in," says Dr. Everett.

"Patients stay in car until summoned for appointment. Patients are screened for COVID symptoms in advance. All must be masked. Surfaces/chairs are cleaned routinely. Check-out lines have been replaced by check-outs in patient rooms or by phone after visit," adds Dr. Tweed.

The three oncologists reassure patients that COVID-19 should not deter them from

obtaining the cancer care they need. Dr. Lewis says: "I reassure them that ongoing research and active case capture of cancer patients with COVID-19 is more reassuring than we initially feared. I also show them that we are assiduously tracking their own immunity; virtually every in-person visit is accompanied by a complete blood count that measures their lymphocyte count, which is key to viral defense." Dr. Tweed adds, "I take extra time to explain practices within the clinic or for infusion therapy or radiologic exam scenarios to reassure patients when they express concern or question the safety of medical care during the pandemic."

Such reassurance is vital, according to Dr. Everett, because: "Recent data have demonstrated that there have been fewer cancers detected because people are deferring their screening exams (mammogram, colonoscopy, etc.) during this time." Dr. Tweed agrees: "We will see delayed clinical presentations, leading to more advanced cancer presentation in some instances."

Dr. Lewis worries about a bimodal peak. "There was just a study in the UK concluding that 'Substantial increases in the number of avoidable cancer deaths in England are to be expected as a result of diagnostic delays due to the COVID-19 pandemic in the United Kingdom. Urgent policy interventions are necessary, particularly the need to manage the backlog within routine diagnostic services to mitigate the expected impact of the COVID-19 pandemic on patients with cancer.'" (https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(20)30388-0/fulltext)

How are they protecting themselves? "Continuing hand hygiene, wearing a mask at all times. Minimal physical contact with patients, social distancing in exam rooms. Eating lunch in my office as opposed to the breakroom or a restaurant," says Dr. Everett.

Masking is key, says Dr. Tweed: "Always, always wear a surgical mask. N95 if patient has any concerning symptom or exposure history, or for prolonged non-distanced encounters. Hand washing and sanitizer frequently. Sanitize surfaces in exam room and office frequently." Dr. Lewis agrees: "Masking, washing my hands and social distancing are the three biggest personal protective factors. Masks do not have to be medical-grade for the public to benefit bidirectionally from wearing them, but I am fortunate to have an N95 that excludes the majority of particulate matter."

Beyond their patients and themselves, though, oncologists are rightfully concerned about their families, too. Dr. Tweed worries: "I have been concerned about bringing the virus home to my family. Very much so." Dr. Everett is also concerned: "I have a 5-month-old daughter at home whom I work hard to protect."

Dr. Lewis's family has a routine: "My wife is a frontline urgent care pediatrician so I worry she is more at-risk than I am. We have a decontamination routine – going immediately to the laundry room and washing our scrubs on high heat. Then we shower before we make any physical contact with our kids, 9 and 12 years old, who both respect the process we go through as a dual-physician couple."

Dr. Everett's routine is similar. "Lots of hand hygiene. Social distancing from non-household family members. Change clothes if coming from outside of my house, ask about symptoms or sick contacts. I also don't want to take the virus to work and to my patients, who are ALL high risk."

Dr. Tweed changes immediately and doesn't wear work shoes into her home. "I have started wearing scrubs and other machine-washable clothing, to allow work clothes to be promptly thrown into a washer. I wear my hair back at work, minimal to no jewelry, to avoid the low likelihood of transmission from surface contact. I sanitize items brought back into the home upon entry: phone, work badge, etc. I do not hug/kiss/physically contact family until I have taken these 'reentry measures' or after I have showered when I return home from a higher risk environment/exposure scenario. We socially distance and limit excursions to stores or public locations. We have embraced more family time and hiking/outdoor activities and really enjoyed that aspect of recent months."

None of the three oncologists interviewed has felt the need to isolate themselves from family, although Dr. Everett's nuclear family self-isolated for eight weeks after the birth of their daughter. "This allowed us to understand better the virus, its infectivity and frequency in the population. It also allowed the baby to grow stronger and have her vaccinations. We have relaxed this isolation now and are seeing family. But if I or a family member were to have a sick contact, we would reinstate the restrictions."

Dr. Tweed agrees. "Should I have exposure to a known COVID patient without having worn proper PPE, or should I have COVID-related symptoms, I would consider isolation based on the specific scenario." Dr. Lewis's family has a plan: "Neither of us has yet tested positive, so we haven't sequestered, but would do so if one or the other became ill. In the hopefully unlikely event that we fell sick simultaneously, we would need to rely on local family to take care of our kids."

Physicians throughout the world are taking similar measures to ensure their own health and the safety of their families and patients, while recognizing the unique burdens the pandemic has imposed, including an aspect which concerns Dr. Everett. "One underappreciated aspect of the pandemic has been the economic impact on our patients. With the closing of many businesses, and the downturn of the economy, many patients can no longer afford transportation, medications, co-pays or other things necessary for them to seek healthcare. Unfortunately, the economic burden of the pandemic will be long-lived after the virus itself is less of a threat."

Dr. Lewis tries to see some positives. "The silver lining of the pandemic may be that care will be more patient-centered, especially telehealth and home health, after COVID-19 has passed, after we have learned what absolutely needs to be done in clinic and what can be done remotely."

Dr. Tweed summed it up nicely. "We really are all in this together. That's not just a social media tagline. Wear a mask. Wash hands. Socially distance. This helps your family, your neighbor, your community, your world. If you're struggling with mental health, as is common in this isolated and stressful time, reach out for help – speak openly with your loved ones and with your physician.

"We are here for this. We are here for you."

It Takes a Community to Keep Kids Safe

By TINA HASSELBUSCH
United Way of the Greater Lehigh Valley

Since the start of the pandemic, there has been a precipitous drop in reported cases of child abuse and neglect. In fact, reports are down by as much as 40-50% from this same time a year ago.

While that may sound like good news, this decrease unfortunately does not necessarily mean there are fewer cases of child abuse and neglect. Rather, there are fewer reported cases. In fact, part of the disturbing trend is a wave of severe injuries in abused children. At least 155 children died or nearly died this year in Pennsylvania as a result of suspected child abuse or neglect, according to state data from Jan. 1 to July 15, compared to 144 in all of 2019.

One of the main reasons for the lack of reported, suspected abuse is that there is limited to no contact between children and mandated reporters, who make the majority of the reports. Mandated reporters are individuals who work in areas where they have some direct contact with children, like teachers, counselors and physicians, and are required within their job description and job duties to contact the child welfare hotline when they have a suspicion or concern of child abuse or neglect.

With limited direct contact between children and mandated reporters due to pandemic-related school and child care closures and shifts to virtual or hybrid learning, dozens of community groups have come together to launch a campaign aimed at building awareness around community action and family support to prevent child abuse and neglect.

"It takes a community to keep kids safe," said Beth Tomlinson, Senior Director of Education for United Way of the Greater Lehigh Valley. "We need everyone in our community to know and understand the warning signs of abuse and neglect, and we need parents to know that it's ok to ask for help as well as where to turn for help."

Tomlinson is leading the effort through Resilient Lehigh Valley, a regional collaborative focused on building a trauma-informed Lehigh Valley where all kids are safe and supported. A coalition of educators, mental health specialists and local government, Resilient Lehigh Valley has been working with community partners to build awareness of individual's responses to everyday stressors that could potentially lead to abuse or neglect. This is especially important now during the COVID-19 pandemic. Stress during this global crisis may be especially high for parents, many of whom are charged with educating children from home, along with maintaining jobs, dealing with a loss of income and juggling other responsibilities. Students may also be stressed in new ways, such as the extended time learning in a different environment or being away from their teachers and peers for months. Throughout this time, loved ones may feel more anxious, frustrated or stressed.

"These are unprecedented times; even under normal circumstances, parents can feel overwhelmed and anxious, putting children at risk," states Tomlinson. "Our goal is to put families first and de-stigmatize asking for help. There are resources available that can strengthen individuals and families and help keep kids safe."

As part of the campaign, parents are encouraged to practice self-care and ask for help before hurting someone they love. Additionally, members of the community are called upon to pay close attention and ask questions. If they see something or have concerns, they should report their concern and connect a struggling family with help.

"When a family member, neighbor or friend calls the hotline to report their suspicion of child abuse or neglect, it does not necessarily mean automatic removal of the children," states Tomlinson. "Rather, it connects the family with resources with the ultimate goal of keeping children safe and families together."

According to Child Welfare Information Gateway, child maltreatment can be linked to later physical, psychological and behavioral consequences as well as costs to society as a whole. By reducing the incidence of child abuse and neglect through primary prevention approaches, and providing comprehensive, trauma-informed care when it does occur, communities can limit its long-term consequences.

"We are all in this together. There are direct societal impacts from childhood trauma, so if for no other reason than to build a stronger community, everyone must lean in and do their part to help support families and protect children," notes Tomlinson.

The Child Abuse Prevention and Mitigation Campaign is a multi-faceted marketing effort using social media, television PSAs, website and print-ready outreach materials to raise awareness around this important community issue. The goal of the campaign is to connect with as many people as possible, raising awareness of the risk and offering a potentially life-saving solution – making the call.

It is important to note that there can be hope and healing beyond the hurt. The keys to resilience in youth are having a safe, supportive relationship with an adult, opportunities to learn and grow, and trauma-informed counseling and supports. Prevention is also crucial and Resilient Lehigh Valley seeks to educate parents, caregivers and educators on best practices that can decrease anxiety and stress and increase healthy coping and parenting skills. Mindfulness and social emotional learning are important tools to assist individuals in the practice of self-care, coping and mitigating stress. Visit www.resilientlehighvalley.com for lessons and resources and follow @ResilientLV on Facebook and Twitter.

Resilience is defined as the capacity to recover quickly from difficulties. A program of United Way of the Greater Lehigh Valley, Resilient Lehigh Valley is a cross-sector coalition dedicated to creating a trauma-informed and resilient Lehigh Valley by:

- **Providing trauma awareness and trauma-informed practices training to any and all interested agencies and community groups.**
- **Creating a community awareness campaign to raise awareness of trauma, its impact on brain development and tips on building resilience.**
- **Sharing best practices in trauma-informed care and resiliency-building strategies**
- **Advocating for trauma-informed legislation, policies and funding streams with our state legislature.**
- **Aligning existing resources and securing new resources to provide more resiliency.**

RESISTANCE TRAINING IN CHILDREN

By ELISA GIUSTO D.O., Family Medicine Resident PGY-3

Resistance or strength training is designed to enhance muscular strength, power, and endurance whether for general exercise or competitive sports. It consists of a variety of modalities from free weights, weight machines, kettlebells, elastic tubing, or simply body weight. Given evidence of decreased muscular fitness, inactivity, and obesity academic in youth, year-round resistance exercise is essential regardless of sport participation. The American Academy of Pediatrics (AAP) released a revision on its policy statement from 2008 on the benefits and risks of resistance training for children and adolescents this year. Here is what you need to know:

Among the most obvious benefits of resistance training is building strength, but advantages of this in youth with proper supervision and correct techniques include improvements in motor skill performance, gains in speed and power, developing physical literacy, reducing risk of injury, and injury rehabilitation. Other health benefits have been seen as well resulting in enhanced cardiovascular fitness, body composition, bone mineral density, blood lipid profiles, mental health, and insulin sensitivity in overweight youth. It is important to note, though, that resistance training combined with aerobic training does not appear to impair strength gains and may be more beneficial than single-mode training.

Risks with resistance training injuries occur with prolonged training with heavy loads or inadequate rest and recovery between sessions. Youth with poorly controlled or preexisting hypertension require physician oversight, given the risk of marked elevation of blood pressure during resistance training. Youth with hypertrophic cardiomyopathy should also be counseled, given the risk of worsening ventricular hypertrophy and restrictive cardiomyopathy or hemodynamic decompensation from an acute increase in pulmonary hypertension. Caution should be advised in youth with a previous history of cancer treated with anthracycline chemotherapy, given an increased risk for cardiotoxicity and acute congestive heart failure during resistance training. Although resistance training has been determined to be safe in children with underlying seizures that are well controlled on medication, guidance from physicians should occur for those with uncontrolled seizures.

Starting resistance training at 5 years old is reasonable since strength gains can be made in ways other than lifting external loads with exercises such as frog jumps, bear crawls, crab walks, kangaroo hops, and one-leg hops. Resistance-training programs lasting over 23 weeks for 2-3 times a week are most effective in attaining maximal benefits. It is recommended to take 1-2 days off per week and rest 1 minute between sets for beginners and 2-3 minutes as the training intensity increases. Youth should begin with 1-2 sets of 8-12 repetitions using a low resistance training intensity as proper technique is developed. Dynamic warm-up exercises should be integrated into the training followed by cool-down periods with appropriate stretching techniques. It is important to note that detraining effects can occur after 8-12 weeks of no training. ✚

SOURCE:
Stricker, Paul R., et al. "Resistance Training for Children and Adolescents." Pediatrics, vol. 145, no. 6, 2020, doi:10.1542/peds.2020-1011.

TALKING WITH YOUR HEALTHCARE PROVIDER ABOUT

Domestic and Intimate Partner Abuse

By TURNING POINT OF LEHIGH VALLEY

Chances are if your partner is abusive, you probably do not get a lot of alone time. We know that one of many common tactics of abuse besides power and control is isolation. If your partner has isolated you from your family, friends, and the community, your healthcare provider might be one of the only people that you have the opportunity to speak with alone. Please consider speaking to them about any abuse that you may be experiencing since they are concerned with both your physical and mental well-being.

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If your abusive partner insists on attending your medical appointments with you, we know it is not easy to simply ask your partner to stay in the waiting room or say no when the nurse asks if you want your partner to come back with you. It can be a fine line asserting your right to privacy during your appointment in front of your partner. If you speak up, it could make things worse and you could potentially be less safe after you leave the appointment. Trust your instincts since you know your abuser better than anyone. Your safety is of the utmost importance.

Here are some options that you can consider prior to any medical appointment when you meet with your healthcare provider alone and away from your abuser during an appointment. Something to consider is to reach out to your provider before your next visit or if it's a new doctor, when scheduling the appointment and let them know you'd strongly prefer it if they could tell your partner they have to speak with you alone.

Many doctors are starting to screen for domestic and intimate partner abuse during their initial intake with patients. If you are in an abusive or toxic relationship, know that being upfront with a medical professional is best so they can help you with options. They will be able to provide you with information on local resources as well as document what you are going through. You might even ask your doctor if you can use the privacy of the exam room to call your local domestic violence agency, like Turning Point of Lehigh Valley, since you may not be able to make the call from home.

Privacy of your health information is important. One way you can protect your health information is to talk with your doctor or staff privately and ask to password-protect your chart/medical information as well as update your HIPPA form to reflect the people whom you approve to be able to get your information. Under HIPPA, you have the right to keep your medical information private. This way nothing about your medical history or appointments will be discussed over the phone unless the person calling can provide the correct password. The word you choose should be something easy for you to remember, but not something your partner would guess.

"When he hurt my animals, I knew he would hurt me."

– Wendy

"I remember standing in an elevator with a big smile on my face. Someone asked me, why are you smiling?" I said, "I'm finally safe and happy."

- Jan

We strongly encourage you communicate certain things to your doctor about any abuse that may have occurred. Did you know that if your partner has strangled, attempted to choke you, hit you in the head, or cause you to lose consciousness it could lead to a medical diagnosis such as traumatic brain injury (TBI)? This can be very serious and unfortunately is all too common. Abuse comes in many forms and it escalates and intensifies over time.

It is also very important to tell your doctor if you are pregnant as well as if you are concerned about your partner trying to getting you pregnant against your will. We know that abusers have the ability to control reproductive choices in their relationship, whether it is not using a condom or tampering with birth control. You may want to consider asking for a birth control method in which your abuser does not know you are using. You can talk to your health care provider about different forms of birth control that may be harder for your partner to interfere with. They may also be able to speak with you about emergency contraception that you could keep somewhere secret in case you have been forced to have unprotected sex. If you do not feel comfortable having conversations about your sexual health with your current doctor or OBGYN, you can always call your local Planned Parenthood.

We understand that it takes a lot of courage to speak up and share that your partner is hurting you in your relationship, whether that is emotionally, verbally, physically, or sexually; it can be scary. It is very important to practice self-care so that you have the strength to get through an abusive relationship. You deserve to be safe and happy in a healthy relationship based on trust, honesty, communication, respect, and equality. Speaking up and telling your doctor can be your first step towards getting the safety and protection you deserve.

If you are interested in speaking with an advocate specifically for survivors of intimate partner abuse, our advocates are available on our 24/7 Helpline – (610) 437-3369. Everything is at no cost and is confidential. You can also visit our website for more information at www.turningpointlv.org. ✚

LCMS NEWS

NEW MEMBERS

Muhammad Z Ajmal, MD (AM)
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Meghana Ganapathiraju, Medical Student
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