

LEHIGH COUNTY

Health & Medicine

Official Publication of The Lehigh County Medical Society

SPOTTING SKIN CANCER

By Cynthia L. Bartus, M.D.

BARIATRIC SURGERY

By Peter F. Rovito, MD, FACS





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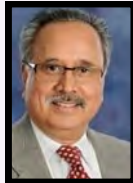
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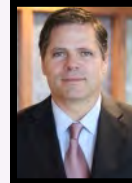
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WELCOME!



BRUCE D. NICHOLSON, MD
Lehigh County Medical Society President

Welcome to the first issue of the Lehigh County Medical Society magazine *Lehigh County Health and Medicine*. We are thrilled to provide this new service to you, and look forward to your response, ideas, and contributions.

Our inaugural issue covers a range of health issues, from skin cancer, concussions and obesity, to how to help our senior patients reduce falls, and the top 10 reasons people give for not having a colonoscopy.

The articles are insightful, provide statistical and background information, and tips and tools to consider using. The article on obesity talks about the pros and cons of bariatric surgery as a way to get on the road to wellness; the article on concussions helps parents think about protecting their kids in sports.

You'll also find some fascinating opinion pieces in this issue. One is a look back on a night in the emergency room from a physician satisfied to have made medicine his life choice. Another piece comes to us through the eyes of a fourth-year medical student getting ready to start his residency program. Additionally, an article talks about laughter being the best medicine, and provides resources for doctors who may need help lightening their load!

We're enthusiastic about contributing to the conversation in Lehigh County about how medicine and wellness can help us form strong communities.

Thank you for reading!

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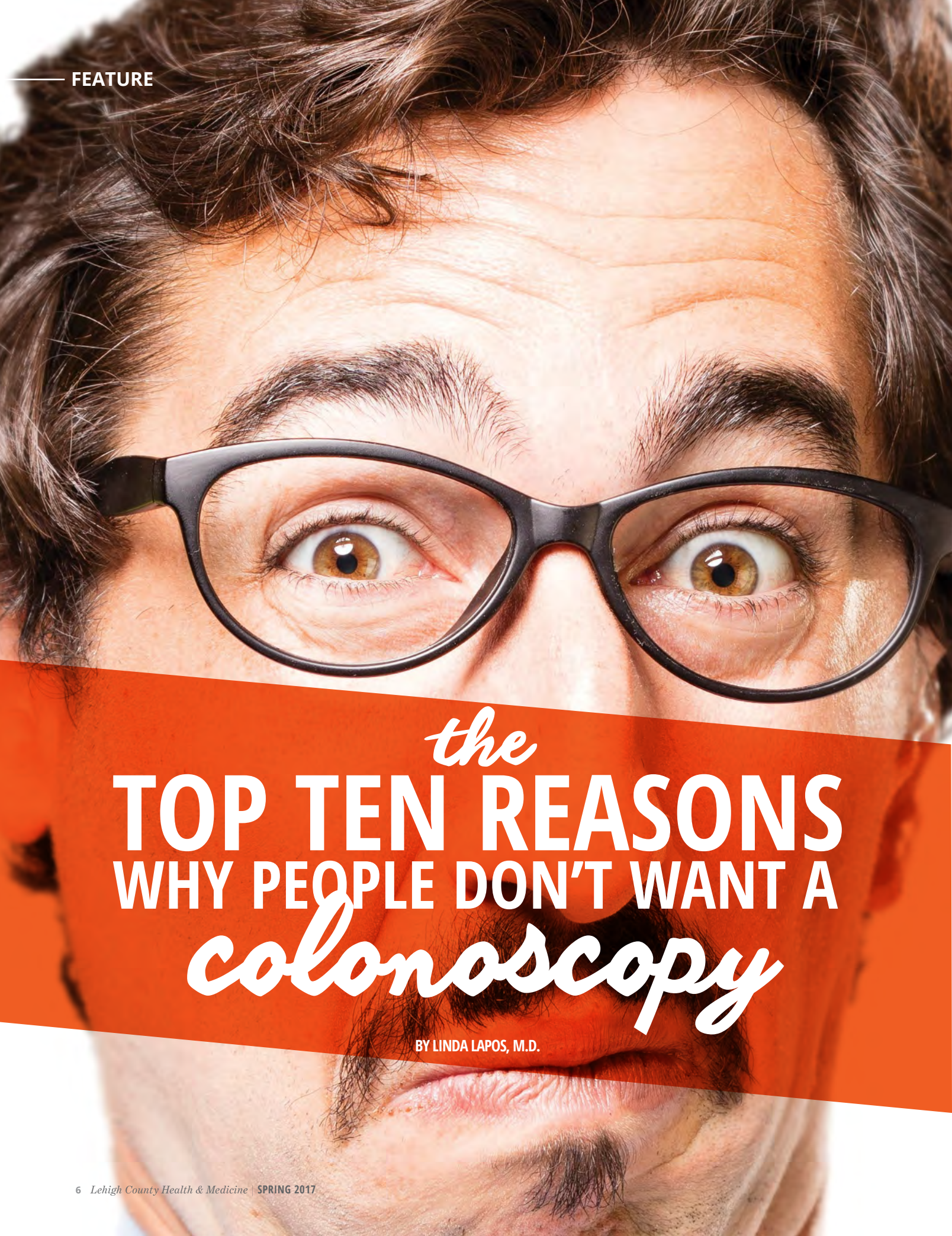
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the
TOP TEN REASONS
WHY PEOPLE DON'T WANT A
colonoscopy

BY LINDA LAPOS, M.D.

It's very common for some patients to resist the idea of having a colonoscopy, and they give a lot of reasons for not wanting the test. Here are the top 10, along with some suggestions on how to respond:

Reason Number 10
"YOU'RE GOING TO PUT THAT SCOPE WHERE?!"

Concerns about modesty are understandable. Patients can be reassured that colonoscopy is a common procedure, performed by professionals. Plus, the patient will be asleep throughout the test.

Reason Number 9
I'M AFRAID IT WILL HURT

This is one that patients really do not need to worry about. The sedation is very safe and effective. When they wake up, most people say they didn't feel a thing. Many say, "It was the best sleep I've ever had."

Reason Number 8
I'M AFRAID I WILL FIND OUT I HAVE CANCER

If detected early, before there are symptoms, colorectal cancer is highly curable. But the biggest benefit of colonoscopy is that, unlike most other cancer screening tests, colonoscopy actually can prevent cancer by finding and removing polyps that otherwise could develop into cancer at some point in the future.

Reason Number 7
IT'S INVASIVE

The risk of major complications from a colonoscopy is very low. And the benefits of prevention and early detection far outweigh the risks.

Reason Number 6
NO ONE IN MY FAMILY HAS COLON CANCER

That does not mean that you are not at risk. Only 20 percent of those diagnosed with colorectal cancer have a significant family history of the disease. Everyone should be screened

MANY PATIENTS SAY THAT ONCE THE PREP IS COMPLETE,
the worst is over!



upon reaching the age of 50, and some patients should have a colonoscopy sooner, whether or not they have relatives with colorectal cancer.

Reason Number 5
I CAN'T AFFORD IT, OR I DON'T HAVE INSURANCE

Under the Affordable Care Act (ACA), most health insurance plans cover screening colonoscopy. Because of uncertainty about the future of ACA, some patients are deciding to have their colonoscopy this year while it is still covered. And for someone without insurance, there are free or low-cost clinics offered by Lehigh Valley Health Network and other area providers.

Reason Number 4
I CAN'T GET OFF WORK

No problem. Our group and some other providers offer Saturday appointments.

Reason Number 3
I DON'T HAVE ANYONE TO DRIVE ME HOME

Driving after the procedure is not permitted because of the sedation. But most people can find a ride by asking a friend or family member. They also can call a taxi or use Uber or another ride-sharing service, so long as they have a responsible adult to accompany them home.

Reason Number 2
MAYBE I'M TOO OLD

Colorectal cancer screening is recommended for everyone up to age 75. From 76 to 85, the decision to screen should be individualized. Many healthy patients over 75 can benefit from screening, especially those who never had screening before.

Reason Number 1
THE PREP IS AWFUL!

Everyone has heard that the night before a colonoscopy is not fun. And the truth is, they're right. The bowel does need to be cleaned out for this procedure, and that means taking laxatives and then spending a fair amount of time in the bathroom. Colonoscopy preparations have come a long way in the last few years. They aren't as bad as they used to be. Some of them taste a lot better, or contain a smaller volume of liquid. In other cases, patients may be able to take pills to accomplish the task.

In the end, this is one of those things in life that you just have to make up your mind and do. It's not really as bad as everyone says. Just have some good reading material available and enjoy. And, many patients say that once the prep is complete, the worst is over! +

Linda Lapos, M.D., is a colon-rectal surgeon with Colon-Rectal Surgery Associates, P.C. She is the chief of the division of colon-rectal surgery at Lehigh Valley Health Network.

BARIATRIC SURGERY

A VIABLE OPTION FOR A HEALTHIER LIFESTYLE

BY PETER F. ROVITO, MD, FACS

Obesity is at almost epidemic proportions in this country. The Centers for Disease Control (CDC) estimated that from 2011 to 2014, 36% of adults and 17% of youth suffered from obesity. Even more striking, nearly 70% of Americans are considered overweight.

The World Health Organization (WHO), along with National and International medical and scientific societies, now recognize obesity as a chronic progressive disease resulting from multiple environmental and genetic factors. The disease of obesity is extremely costly not only in terms of economics, but also in terms of individual and societal health, longevity, and psychological well-being. Due to its progressive nature, obesity requires lifelong treatment and control.

“Morbid obesity” is a subset of obese patients and is defined as being 100 pounds or 100% over ideal weight. This also corresponds to a BMI of 40. BMI (Body Mass Index) is a measure which compares the weight and height of an individual. It is called “morbid” obesity because at that weight, a wide variety of medical problems may arise. These can include but are not limited to diabetes mellitus, hypertension, obstructive sleep apnea, coronary artery disease, cardiovascular accident, gastroesophageal reflux disease, osteoarthritis, depression, and more, all of which affect a patient’s health and longevity.

While diet and exercise is a viable and oftentimes successful approach to treating obesity, morbid obesity is resistant to these approaches. Fewer than 1% of morbidly obese patients are able to achieve long-term weight loss with diet and exercise.

Fortunately, bariatric surgery has given hope to patients seeking a solution for this condition which was once considered a matter of self-control. The National Institutes of Health (NIH) has recognized bariatric surgery as the only permanent and long-term treatment for morbid and severe obesity.

The laparoscopic or minimally invasive approach has made bariatric surgery a more practical option for morbid obesity, providing for less risk and easier recovery. The advent of laparoscopic bariatric surgery has contributed to a rapid expansion in the number of bariatric procedures performed in the United States, approaching a record 200,000 in 2015.

There are currently three popular bariatric procedures, although one, the gastric band, has fallen out of favor due to high complication rates and low long-term success.

- The Laparoscopic Sleeve Gastrectomy (LSG) removes about 85% of the stomach, leaving the remainder shaped like a tube or “sleeve” and making patients feel fuller sooner.

THE CENTERS FOR DISEASE CONTROL (CDC) ESTIMATED THAT FROM 2011 TO 2014, **36% OF ADULTS AND 17% OF YOUTH SUFFERED FROM OBESITY.**

- The Laparoscopic Roux en Y Gastric Bypass (LRYGB) makes the stomach smaller and allows food to bypass part of the small intestine, making patients feel full quickly and causing fewer calories to be absorbed.
- The Laparoscopic Adjustable Gastric Band (Lap Band) is an inflatable band placed around the stomach which restricts food to a small stomach section. While this procedure was extremely popular when first introduced, poor results and complications have caused most patients and surgeons to abandon it.

In 2015, laparoscopic gastric sleeves accounted for 53.4% of bariatric procedures and gastric bypasses for 32.1%, with only 5.7% of patients selecting the lap band, a number which goes down each year. Long-term results for the gastric bypass are slightly better than the sleeve because of the malabsorption factor, but both are highly effective when coupled with lifestyle changes, continued support and follow up.

Although individual results vary widely, most patients who undergo weight loss surgery will lose 60-80% of their excess weight. While some will regain some weight after hitting their “low point,” 90% will keep off at least 50% of their excess weight in the long term. Even more important are the effects of weight loss on the patients’ health. One study found an 89% reduction in overall mortality. Others found a 90% reduction in death from diabetes and 50% reduction in death from heart disease. 85%

of diabetes patients show improvement with remission in 78%. Improvements in patient mobility and reductions in anxiety and depression also contribute to a better quality of life post-bariatric surgery.

Of course, surgery isn’t the end game. It’s the beginning of a lifelong journey to a healthier lifestyle, a tool to help patients help themselves. Patients must embrace a whole new way of eating and taking care of themselves, incorporating high protein diets and regular physical activity into their lives to maintain long-term results. There’s no going back to “eating normally” after bariatric surgery. Sure, it’s possible to “beat” the surgery – but then, what’s the point of having it in the first place?

Although the number of patients helped by bariatric surgery increases each year, far more patients could benefit from bariatric surgery. Far too many insurance companies don’t cover it – including Pennsylvania’s state employee health insurance program and half of the plans offered through the Affordable Care Act. This is extremely shortsighted. Covering bariatric surgery costs far less than covering obesity-related chronic health conditions over a patient’s lifetime AND the patient will live a happier and more productive life. Patients and physicians alike should lobby insurers and government entities to cover these life-changing procedures.

Additional information about bariatric surgery is available from a variety of sources, including Bariatric Surgery Source (<http://www.bariatric-surgery-source.com/>)

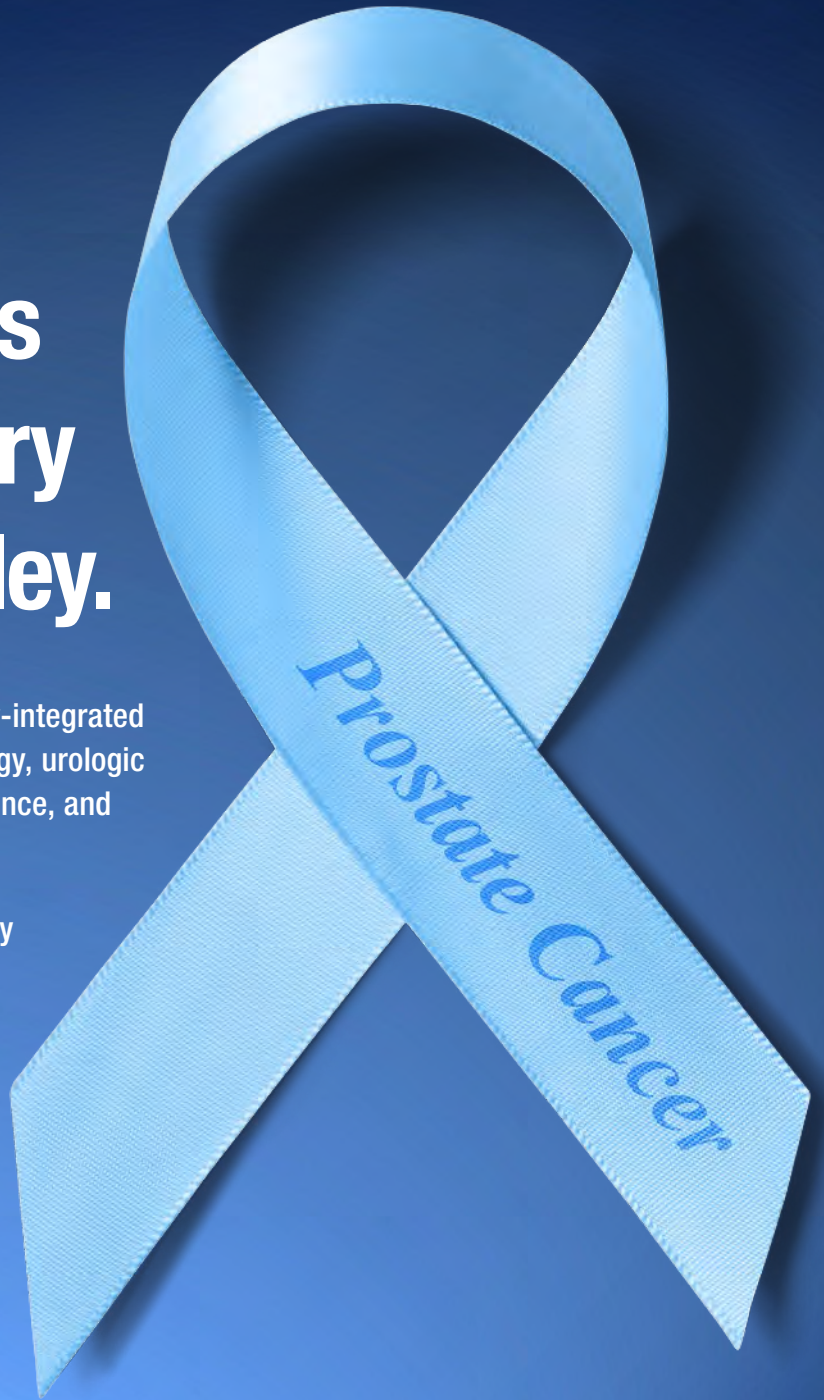
Continued on page 11

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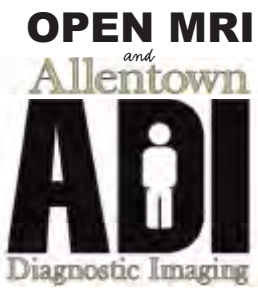
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types-of-bariatric-surgery.html), the American Society for Metabolic and Bariatric Surgery (www.ASMBS.org) and www.DrRovito.com and our Facebook Page: <https://www.facebook.com/PeterRovitoMD>, as well as the Facebook page for the Sacred Heart Bariatric Program Discussion group <https://www.facebook.com/groups/657388647640057>. +



Peter F. Rovito, MD, FACS, is a general and bariatric surgeon who has been practicing in Allentown since 1988. He pioneered weight loss surgery in the Lehigh Valley and performed the first Laparoscopic Gastric Bypass in eastern Pennsylvania in 2000. He has performed over 2,500 successful weight loss procedures and operates at Sacred Heart Hospital in Allentown. Dr. Rovito is a graduate of Temple University Medical School and the Pennsylvania State University and lives in Allentown with his wife Donna and two sons: Peter, a premedical student at Drexel School of Medicine, and Tony, a criminal justice major at Penn State.






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Laughter

is the best medicine for a physician family

BY DONNA BAVER ROVITO

So the patient says, “Doctor, it hurts when I do this!” and the doctor says, “Then don’t do that!”

That’s an OLD one, and the physician’s response should be delivered in his or her BEST Groucho Marx impression.

There are two ways to approach the craziness that comes with being part of a physician family. You can cry.

Or you can laugh.

Well, to be honest, you’ll do BOTH – but when you can choose, it’s probably better for your own mental wellbeing (not to mention the wellbeing of those around you) if you choose to see the lighter side and laugh through the challenges rather than crying over them.

There are a few “official” places to go to find ways to laugh at life in medicine. My personal favorite is ZDoggMD, an irreverent Las Vegas hospitalist who mixes video with music with rap with...well, anything else he can think of to make points in the funniest way possible. He promotes himself this way: Slightly Funnier Than Placebo: Medical Humor & Dope Rhymes. You can check him out at www.ZDoggMD.com or like him on Facebook.

GomerBlog offers up “medical news” in humorous and outrageous ways, including this recent headline: “Mother Who Pushed Child into Medicine Charged with Parental Malpractice.” They say they’re “Earth’s Finest Medical News,” but make no mistake, they’re all about making us laugh, kind of “The Onion” for medicine. Check them out at www.GomerBlog.com or find them on Facebook.

There’s also “The Journal of Medical Humor – Stitches,” which you can find here: <http://www.lucodes.ca/medhumor.html>, featuring humorous things which happened to real physicians in their practices.

Of course, the funniest things we hear are often from people we know – or have even happened to us personally. When the AMA Alliance created the nation’s first magazine for physician families, we wanted to incorporate a feature which would highlight the things that make us laugh.

Physician Family’s “You Might Live With a Doctor If...” feature is one of the most popular in the magazine and is comprised entirely of humor provided by readers. The quarterly publication is available in digital format at no cost at www.physicianfamilymedia.org and in hard copy to members of the AMA Alliance (which you can join here: www.amaalliance.org).

Here are some of our favorites from the past 11 issues – because it is SO much better to laugh at our crazy lives than feel sorry for ourselves. +

YOU MIGHT LIVE WITH A DOCTOR IF...

If your spouse rolls over in bed and says, “Page me if you have any questions” and then rolls back over and starts snoring.

– Brianna Leroy, Columbus, MO

If you’ve used DeBakey’s for unclogging drains and chip clips.

– Jodi Renee, Birmingham, MI

If the physician in the family was told in first grade he or she would never amount to anything because of poor handwriting.

– Candace Goldberg, Erie, PA

If your baby says “Uh oh!” every time the pager goes off.

– Deborah Lazar, Houston, TX

If you name your physician’s pager “Volde-mort.” Or “Darth Vader.”

– Amy Longfield, Baton Rouge, LA

If you’ve had an instant of panic when you wake up and there’s a man next to you in bed.

– Kara Smith Johnson, Chicago, IL

If your daughter puts “breathing tubes” in her dolls.

– Jennifer Grischken, Columbus, OH

If the doctor’s snoring drowns out the sound of the TV show you WERE watching together.

– Anon.

If a family member brings his x-rays to a family wedding for a second opinion.

– Jessica Fraser, Phoenix, AZ

If your ski boots have been surgically sutured for water resistance.

– Sandra Colone, Exeter, NH

If your trash bags are tied with multiple surgical knots.

– Samantha Dirks, Sioux Falls, SD

If all your kids were conceived in on-call rooms.

– Shawn Ostrower, Hollywood, FL


If “Call” is a four-letter word in your house.

– Jillian Robertson, NY

WANT TO SHARE SOMETHING FUNNY THAT HAPPENED IN YOUR PHYSICIAN FAMILY? EMAIL EDITOR@PHYSICIANFAMILYMEDIA AND PUT “HUMOR” IN THE SUBJECT LINE. WE’D LOVE TO HEAR FROM YOU!

Donna Baver Rovito is editor of Physician Family Media, which features a quarterly magazine, weekly blog and strong social media presence. Physician Family was created by the AMA Alliance to build connections and provide resources to physician families everywhere, defining a “physician family” as any family which shares a roof with a physician. Donna is married to general and bariatric surgeon Peter F. Rovito, MD, FACS, and is mom to two sons: Peter, a graduate premedical student at Drexel Medical School, and Tony, a senior criminal justice major at Penn State.



A blue-tinted photograph of a hospital hallway. In the foreground, an IV drip is hanging from a stand, with a clear plastic bag and tubing. The hallway leads into the distance, where a person is walking away from the camera. The lighting is bright, creating a high-contrast scene.

A NIGHT IN THE ER TO REMEMBER

BY J.D. NUSCHKE, MD, FACP

It was a cold November evening in 1987. I had just completed my residency in internal medicine and was serving as the chief medical resident. I had decided to moonlight in the emergency room at the Allentown hospital to begin paying back my school loans. Around 10:30 p.m. a disheveled and disoriented-appearing 30-year-old man appeared from the ambulance entrance of the ER. He was wearing slippers and was bare-chested. My initial impression was he may be seeking help from the psychiatric ward. That was until he spoke, saying: “My wife just had our baby in the car,” and then seemed to slide down to the floor.

As the ER nurses heard the word “baby” they snapped to attention and virtually trampled over the father to get to the car to attend to the mother and child. I helped the father to his feet and arrived at the ambulance bay to find the mother fully reclined in the passenger seat with a new baby wrapped in the father’s shirt. As I clamped the umbilical cord and checked the mother’s vital signs I simultaneously asked what happened.

The mother responded, “We live in Whitehall and this is our second baby. I started to have contractions and since the first labor lasted 12 hours we decided to wait. The contractions began to come quicker and I told my husband we should go. While driving down MacArthur Boulevard I told him to pull over. He pulled over into the parking lot of the Kiddie City toy store, I delivered the baby and we wrapped it in his shirt and drove here as fast as we could.”

I asked, “Is it a boy or a girl?” Both parents responded that the baby looked just like their daughter when she was born. As I removed the shirt from the baby to confirm a diagnosis, I explained there was a better way to identify the sex of the baby. I congratulated them on the birth of their son. The new family was transported quickly to the maternity ward. The nurses’ grapevine had broadcast that everyone was doing fine after the evening’s unusual events. An hour or so later, the father, who was now dressed in a scrub shirt, arrived to complete some papers for admission. I congratulated him again on his expanding family but I needed to inform him of some concerns. “I hate to tell you this but your car is trashed.” He responded, “That’s ok, it’s a company car.”

A few years ago I awoke listening to CAT country music on the radio. A caller was on the line speaking to the DJ. He was excited to announce that it was his 25th birthday and that he had been born in the Kiddie City parking lot. I was happy for him and felt fortunate that I had picked a career that had allowed me to witness this event.

A night in the ER to remember.+

John D Nuschke MD FACP is an internist at Lehigh Valley Internists a division of MATLV. He is on staff at Lehigh Valley Hospital.

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SPOTTING SKIN CANCER

BY CYNTHIA L. BARTUS, MD

Each year, more than 2 million people are diagnosed with skin cancer in the United States. Many of these people are diagnosed with more than one skin cancer in a year. It is currently estimated that one in five Americans will develop skin cancer at some time in their lives, and one in 50 Americans will develop melanoma, the deadliest type of skin cancer. Particularly worrisome is the increasing rate of skin cancers in children and young adults. Melanoma is the most common cancer in young adults (25-29 years old) and the second most common cancer in adolescents/young adults (15-29 years old). Melanoma rates have increased by 6.1 % annually in Caucasian women under the age of 44. Over the last 30 years, the rate of melanoma has increased by 2% per year in Caucasian children (newborn-19 years old). Early detection and prevention are essential for increasing survival and reducing the number of new cases of skin cancer.

Ultraviolet (UV) light exposure (sunlight, tanning beds) is a major risk factor for developing skin cancer and the most preventable. Daily use of sunscreen can significantly reduce the risk of skin cancer. A broad spectrum sunscreen (protects against UVA and UVB rays) with an SPF of 30 or higher is recommended for everyday use. If extended outdoor activities are planned, use of a water-resistant, broad spectrum sunscreen with an SPF of 30 or higher is recommended. One ounce (2 tablespoons) of sunscreen should be applied to the entire body (including the ears, neck, tops of the feet, and top of the head) 30 minutes prior to going outside and reapplied every 2 hours or after swimming or excessive sweating. Keeping the skin covered with protective clothing (wide-brimmed hat, sunglasses, long-sleeved shirts, and pants), seeking shade, and avoiding the outdoors during peak sun hours (10 A.M.-2 P.M.) are also ways to minimize exposure to harmful ultraviolet light rays. These rays are present 365 days a year; if there is light, damaging ultraviolet rays are present.

Avoiding tanning beds is also extremely important for keeping the skin healthy; there is no such thing as a safe tan. There is nearly a 60% increased risk of melanoma in those who have used indoor tanning equipment. Current Pennsylvania law prohibits the use of tanning beds in those under the age of 17, and more than 35 other states have passed laws in recent years to limit youth access to indoor tanning.

In addition to prevention, early detection is key to increasing survival. Regular self-monitoring of the skin by checking for new growths or spots that are changing in size, shape, or color can

***IT IS CURRENTLY
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ONE IN FIVE
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help identify skin cancer early. Skin cancer can occur anywhere on the body. When checking the skin, be sure to examine the not-just-sun-exposed areas, but also the scalp, genitalia, palms, soles, and spaces between the toes. Ask someone to help examine hard to see areas. If a spot of concern is found, an appointment with a dermatologist should be made. Individuals with a history of melanoma, other types of skin cancer, or a family history of skin cancer should be seen at least annually by a dermatologist for a full-body exam. During the exam, the dermatologist will look over the skin from head to toe. A special magnifying light called a dermatoscope is often used to help see a spot or lesion in greater detail. At times, the dermatologist will lightly palpate (touch) the skin to feel for lumps or bumps under the skin. If a suspicious lesion is found, then a skin biopsy of the lesion is usually performed at that time.

Continued on page 18



Prevent. Detect. Live.™

Prevent.

How can I prevent skin cancer?

The American Academy of Dermatology encourages you to have fun outdoors and follow these quick tips to decrease your risk of skin cancer:

- **SEEK SHADE BETWEEN 10 A.M. AND 2 P.M.** If your shadow appears shorter than you, seek shade.
- **WEAR PROTECTIVE CLOTHING**, such as a long-sleeved shirt, pants, a wide-brimmed hat and sunglasses, where possible.
- **GENEROUSLY APPLY A BROAD-SPECTRUM, WATER-RESISTANT SUNSCREEN** with a Sun Protection Factor (SPF) of 30 or higher to all exposed skin. Reapply approximately every two hours, even on cloudy days and after swimming or sweating.
- **USE EXTRA CAUTION NEAR WATER, SNOW AND SAND** because they reflect and intensify the damaging rays of the sun, which can increase your chances of sunburn.
- **AVOID TANNING BEDS.** Ultraviolet light from the sun and tanning beds can cause skin cancer and wrinkling. If you want to look tan, consider using a self-tanning product, but continue to use sunscreen with it.

1 in 5

Americans will develop skin cancer in their lifetime.



ANYONE
CAN GET SKIN CANCER,
REGARDLESS OF SKIN COLOR



ONE OUNCE OF SUNSCREEN, enough to fill a shot glass, is considered the amount needed to cover the exposed areas of the body.

spotme.org

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By following these recommendations, skin cancer can be prevented or at least detected in its earliest stages when the chance of cure is highest. Being sun smart and skin aware is the key.

*Cynthia L. Bartus, MD, Advanced Dermatology Associates, Allentown, PA
Fellow of the American Academy of Dermatology
Fellow of the American College of Mohs Surgery*

REFERENCE WEBSITES

- www.aad.org/media-resources/stats-and-facts/conditions/skin-cancer
- www.skincancer.org/prevention
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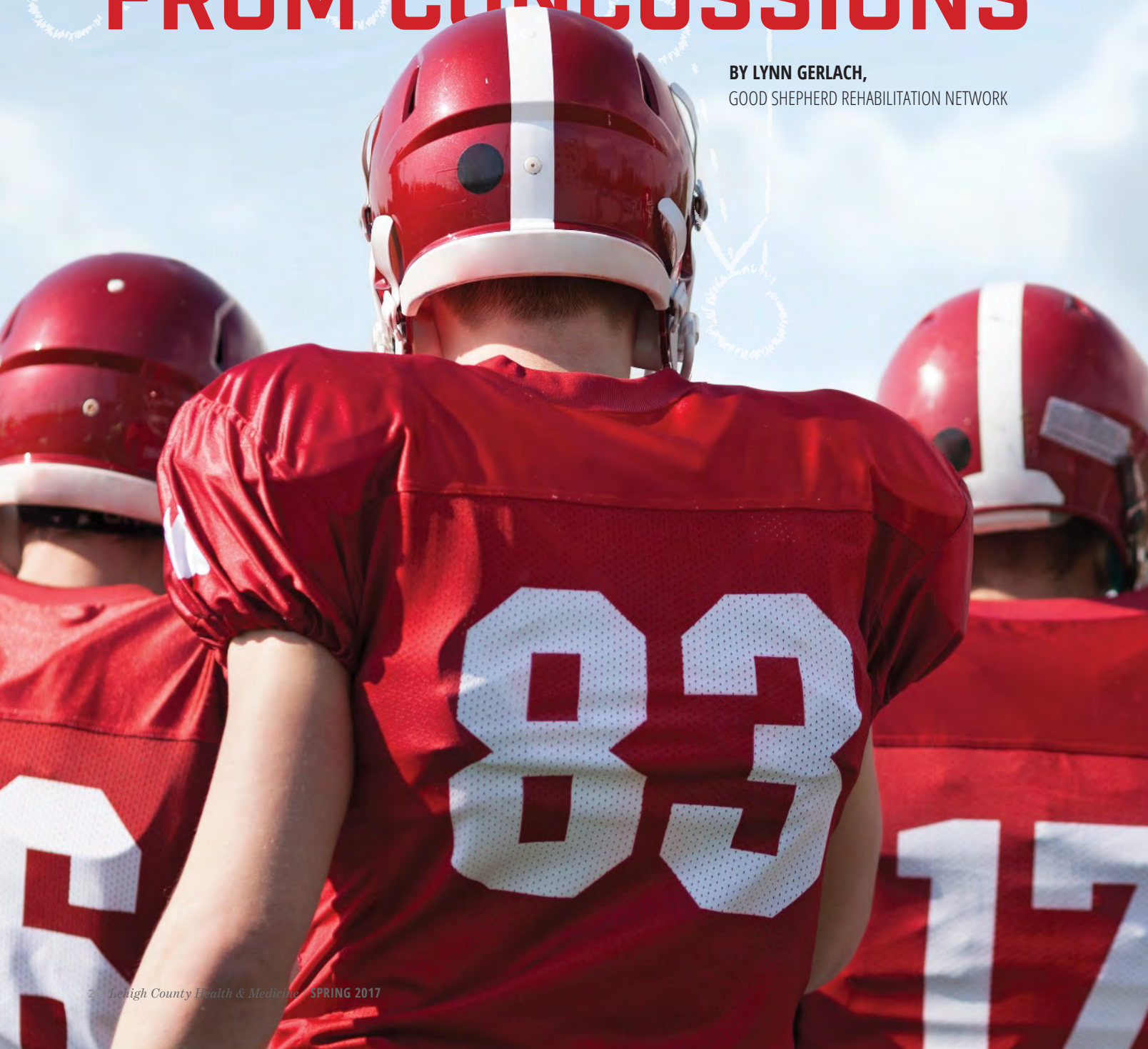


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FEATURE

PROTECT YOUR CHILD ATHLETE FROM CONCUSSIONS

BY LYNN GERLACH,
GOOD SHEPHERD REHABILITATION NETWORK



With an estimated 21 million children between the ages of 6 and 17 participating in sports on a regular basis, injuries are inevitable. For many, sports-related injuries include simple sprains or sore knees that heal quickly with ice and rest. But for others, what seems like a simple bump or header on the playing field actually injures the brain and results in a concussion.

“A concussion is a mild traumatic brain injury that occurs as a result of a direct blow to the head, face or neck,” says Kyle Klitsch, DO, of Good Shepherd Rehabilitation Network’s Concussion Management Program in Allentown. “This starts a complex chemical reaction in the brain that disrupts normal functioning and can cause symptoms such as confusion, personality changes, nausea and dizziness.”

For parents, much of the news around the impact of concussion on overall brain health and cognitive development is concerning. Consider that NFL players average 400 concussions during their careers, or that football players who started playing before the age of 12 scored 20 percent worse in cognitive testing than those who started later.

As kids participate in organized sports, Dr. Klitsch recommends parents weigh risks like these against the benefits. “Youth sports offer kids an opportunity to exercise and build social skills in a team environment,” he says. Dr. Klitsch recommends parents and players take the following steps to help minimize risk:

PLAY BY THE RULES.
Teach young athletes to respect the rules.

WEAR APPROPRIATE SAFETY EQUIPMENT FOR THE SPORT, AND WEAR IT PROPERLY DURING GAMES AND PRACTICE.
Close the chin strap if the sport requires a helmet.

EXAMINE THE PLAYING FIELD
or court for uneven areas or holes.

MAKE SURE THAT END AND GOAL POSTS ARE PADDED SUFFICIENTLY.

PRACTICE GOOD SPORTSMANSHIP
to minimize unnecessary aggression on the field.

LEARN AND USE PROPER TECHNIQUE FOR THE SPORT.

Some sports organizations have taken additional action to minimize the risk of concussion by limiting the number of contact practices allowed during the season.

MAKE SURE YOUR CHILD’S COACH AND TRAINERS KNOWS ABOUT ANY CONCUSSIONS YOUR CHILD HAS HAD IN THE PAST.

Parents of Pennsylvania youth athletes should also be familiar with the “Safety in Youth Sports Act,” which was signed in 2011 to protect student athletes from serious head injuries during games and practices. In short, the law established standards for managing concussions and brain injuries, including mandates for immediate removal from play if concussion is suspected, suspension from play until medically cleared and annual training for coaches with penalties for those who fail to comply.

Recovery from concussion depends on the symptoms and severity. “Each case is very different,” says Dr. Klitsch. “For some, rest and activity restriction for several weeks is sufficient. Others require more involved, long-term care.”

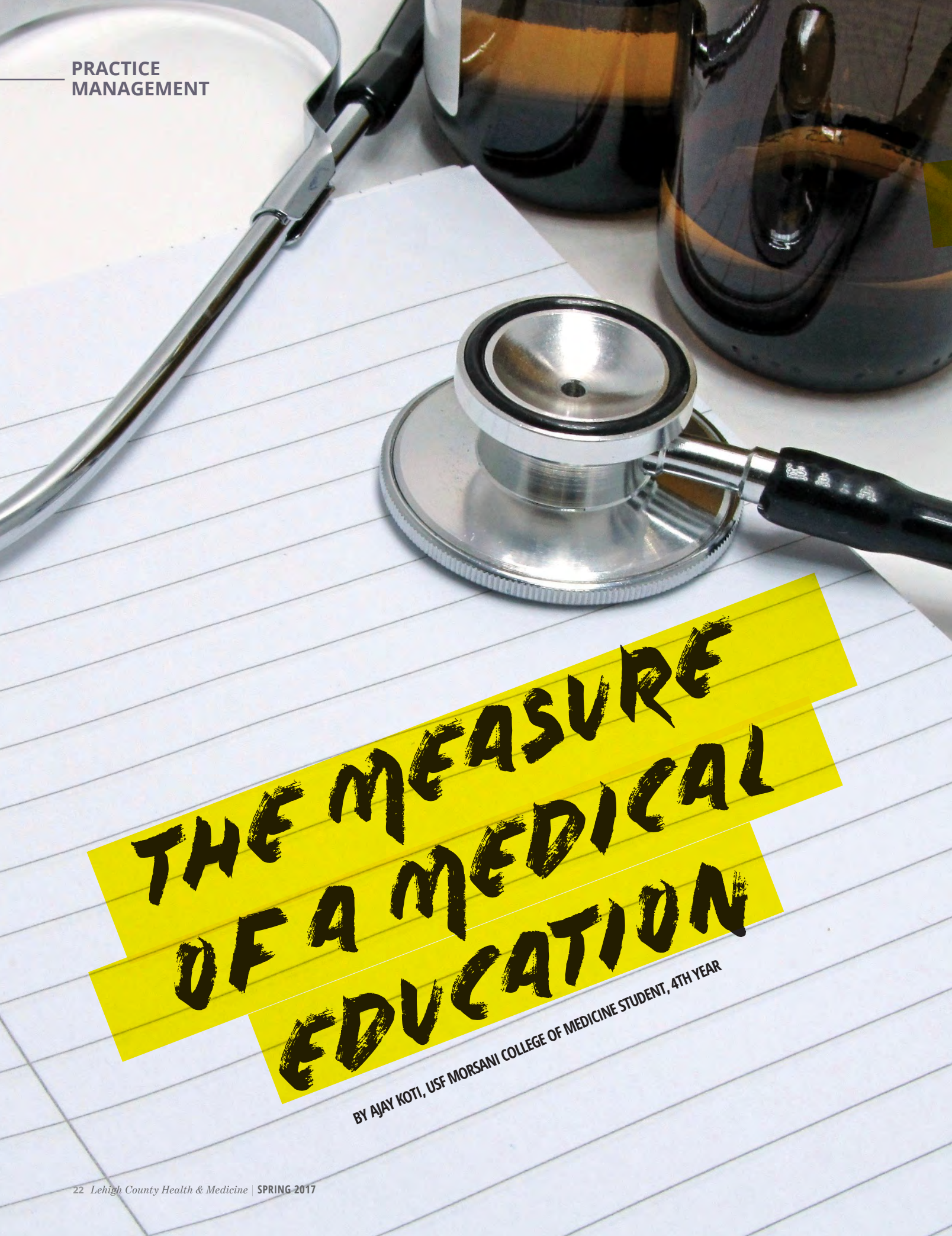
If rest does not resolve the symptoms, parents should seek additional treatment from a qualified, experienced concussion specialist. Depending upon the patient’s age and symptoms, a treatment plan may include vision, physical, occupational, speech language and/or balance therapies as well as neuropsychology.

Two of the most promising new concussion therapies available are vision therapy and the Interactive Metronome®. Vision therapy helps concussion patients with vision problems such as poor balance, double vision, learning, driving and memory difficulties. Specially trained therapists treat patients using a variety of exercises and computer-based games to address specific deficits. Good Shepherd has the largest vision therapy program east of the Mississippi River and will be doubling the size of the program in the next six months due to increasing demand.

The Interactive Metronome® works to improve the brain’s timing and processing skills through physical and cognitive exercise performed in the presence of a computer-generated beat. For instance, patients may be asked to name certain cards in a deck while clapping to the metronome’s beat.

If you suspect your child has a concussion, Dr. Klitsch recommends erring on the side of caution, given that you are dealing with a potential brain injury. Seek medical attention right away and do not let your child return to play until you have a doctor’s permission. +





THE MEASURE OF A MEDICAL EDUCATION

BY AJAY KOTI, USF MORSANI COLLEGE OF MEDICINE STUDENT, 4TH YEAR

I spent the better part of my senior year of college grappling with uncertainty. I had devoted months to writing my application. I agonized over standardized test scores. I racked up thousands of miles and thousands of dollars, all in pursuit of an elusive medical school acceptance. Now, I write this as a fourth year medical student, and it feels deeply ironic and entirely fitting that each of these statements still applies – I’ve come full circle. Four years later, and the more things change, the more they stay the same.

The measure of a medical education seems entirely too obvious now – it’s the **FRIENDSHIPS.**

The last four years have been a whirlwind of contradictory emotion – exhilaration and exhaustion, jubilation and heart-break. As medical school draws to an all-too-rapidly-approaching end, I find myself desperately clawing for some way to take stock of the experience.

How do you measure a medical school education? What metrics do you use?

Maybe all those hours spent poring over cadaver anatomy in the gross lab? The stacks of loose-leaf with increasingly indecipherable sketches of nephrons and neurons? How about ballpoint pens “borrowed” by attending physicians, never to be seen again?

I could just as easily point to the scores of memorized mnemonics, and mnemonics for those mnemonics. There’s always the student loan debt, the size of which long ago passed the limits of my comprehension. Perhaps my exponentially increasing amount of gray hair (though still a minority, if the pace keeps up, I will go full Anderson Cooper by my mid-thirties).

Maybe the last four years can be measured by the accumulation of medical knowledge. During the pre-clinical period, fourth year-medical students were practically deities to me. They had an intellect and a confidence that I was desperate for. Their position seemed unattainable, and yet, they also held a promise – if I trusted in the process, I might get there too.

It was the confidence that I envied the most. I spent exactly one day celebrating my acceptance to medical school; every day since has been consumed by some degree of “impostor syndrome.” I was convinced the admissions committee had made some critical error, that it was only a matter of time before I was found out for substandard intelligence or for misplaced ideals of medicine. But maybe if I wore that short white coat and acted the part, I could convince people that I belonged. If I was lucky, I might even persuade myself.

But that coat, and whatever authority came with it, only heightened my insecurity. Patients divulged deep, personal secrets to me. Strangers acknowledged me with a smile and a “Hey, Doc!” in hospital corridors. One even paid for my lunch when I found myself wallet-less in a cafeteria line, dismissing my objections with “You take care of others; let me take care of you.” Each felt like an undeserved courtesy, and I wanted to scream – I’m a fraud! And now at the end of four years, I’ve found that my only bulwark against the impostor syndrome has been two short words from a classmate: “Me too.”

And there’s the answer. The measure of a medical education seems entirely too obvious now – it’s the friendships.

The bonds forged in medical school escape whatever writing abilities I have. We have learned about medicine, yes,

but we have also shared the discovery of experiences that will characterize the rest of our careers – the thrill of childbirth, the stakes of a code blue, the nightmarish hallucinations of a schizophrenic, and the devastation of a dying newborn. We have witnessed the human condition in its most elemental forms – triumph and suffering.

I’m writing this from a hotel lobby far from home, on my final stop of the interview trail. My classmates are similarly dispersed across the country. In a few months we will reconvene briefly for Match Day and graduation. Then we will part ways for good. Medical school will be over. And while there will be reunions and weddings, and many of us will keep in touch, it will never be the same. And I will miss that. +



WHAT IS **STEADI**

AND HOW CAN IT BENEFIT YOUR PATIENTS?

BY DAVID SYNAMON,
INJURY PREVENTION MANAGER, ALLENTOWN HEALTH BUREAU

Falls are not an inevitable part of aging. There are specific things that you, as an older adults' health care provider, can do to reduce their chances of falling. Researchers at CDC's Injury Center created the STEADI (Stopping Elderly Accidents, Deaths, & Injuries) Tool Kit to assist health care providers who treat older adults who are at risk of falling or who may have fallen in the past.

As a health care provider, you are already aware that falls are a serious threat to the health and well-being of your older patients. More than one out of four people 65 and older falls each year, and over 2.8 million are treated in emergency departments annually for fall injuries. You play an important role in caring for older adults and you can help reduce these devastating injuries. The STEADI Tool Kit contains resources and tools that will help make fall prevention an integral part of your clinical practice.

The STEADI Tool Kit is based on a simple algorithm (adapted from the American and British Geriatric Societies' Clinical Practice Guideline). It includes basic information about falls, case studies, conversation starters, and standardized gait and balance assessment tests (with instructional videos). In addition, there are educational handouts about fall prevention specifically designed for patients and their friends and family.

STEADI materials can be used to assess, treat, and refer older adult patients based on their fall risk in three phases:

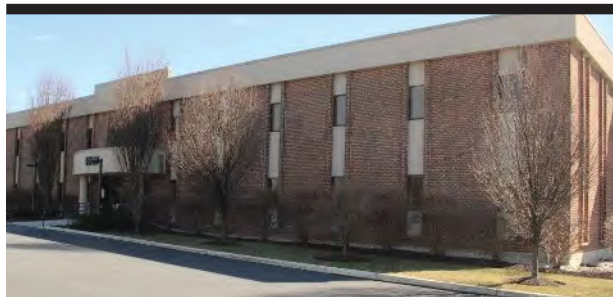
- IDENTIFY PATIENTS AT LOW, MODERATE, AND HIGH RISK FOR A FALL;
- IDENTIFY MODIFIABLE RISK FACTORS; AND
- OFFER EFFECTIVE INTERVENTIONS.

Educational materials specifically designed for older adults and their friends and family are also included.

To find out more information about these materials and the STEADI assessment and tool kit, please contact the Allentown Health Bureau at 610-437-7598. +



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SURVIVAL OF PHYSICIANS *in a value-based world*

We're past the tipping point as we proceed headlong into new market-driven accountability for quality, cost, and value. As employers and payers demand proven, value-based health care, and the market shifts from rewarding volume to rewarding value, physicians must be able to demonstrate the highest standard of care to effectively remain competitive for the foreseeable future. It's not something we should do – it's something we must do.

Information from the Centers for Medicare and Medicaid Services (CMS), the Commonwealth of Pennsylvania, and commercial payers indicates this value shift will account for a significant portion of physician reimbursement within just a few short years.

As payment models quickly change, employers and payers are demanding greater accountability. Physicians are in a unique position to work together to co-create meaningful solutions that result in the highest quality of patient care available and the appropriate rewards for its delivery.

As a result, many physicians are joining together to seek opportunities for higher levels of success amid these changes. By participating in an aggregated, larger network while maintaining practice autonomy, physicians are given every opportunity to succeed in the new value-based world.

One way physicians can succeed in value-based care is through CINs.

To lead this effort and help Pennsylvania physicians survive and thrive in this new health care landscape, the Pennsylvania Medical Society's 2016 House of Delegates (HOD) passed a landmark initiative on Oct. 23, 2016. This historic initiative – called the Practice Options Initiative – will create clinically integrated networks (CINs) as well as a Management Services Organization (MSO) to help Pennsylvania physicians succeed in value-based care, while maintaining leadership roles and clinical autonomy.

The MSO will eventually provide services within the general categories of insurance services, revenue cycle, practice operations, and finance and business operations. It will include services such as front-end management as well as back-end management of the practice, staff payroll, reimbursement, charge capture, appeals, coding, practice management, etc., as well as Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) readiness and Merit-Based Incentive Payment System (MIPS) reporting. These services will be available to any physician practicing in Pennsylvania or elsewhere.

Continued on page 28

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The Leapfrog Hospital Safety Grade is an elite distinction from the Leapfrog Group, a national, independent watchdog that sets the highest standards for patient safety in the United States.



One way physicians can succeed in value-based care is through CINs. A CIN is a group of separate practices – each with a unique Tax Identification Number (TIN) – collaborating to demonstrate value, meet quality metrics, and improve patient outcomes. This is a direct response to the evolving health care delivery system, which is moving rapidly toward value-based care led by passage of MACRA and its accompanying regulations. This guidance outlines the use of MIPS reporting and development of Alternative Payment Models (APMs).

A well-led CIN provides the infrastructure to efficiently, effectively, and comprehensively address the known issues in health care for the foreseeable

future, and an established physician-led, physician-owned network to efficiently address the unknown health care shifts of tomorrow.

In a physician-owned and physician-led CIN, physicians are not only “at the table,” but are creating and implementing the local approach collectively. The more physicians understand the value of physician-driven networks, the more successful and sustainable they will be as health care leaders. It will also increase professional satisfaction – a very important part of who physicians are, and something that has recently been at an all-time low.

The ultimate goal is for CINs to serve as the high-performing, local catalysts for

greater value for the health care dollar, while rewarding participating physicians for their work. PAMED plans to advance these networks by providing physicians with the knowledge, tools, and confidence that patients are receiving the best, most appropriate care possible throughout the entire continuum of care provided.

This means physician engagement must occur at a granular level. Physician-created initiatives, with input and buy-in from the entire network, and resulting in better overall coordination, are a cornerstone of success. This will allow physicians to directly affect health outcomes for large populations of patients while also being able to bend the cost curve, as the market so desperately needs.

The more physicians understand the value of physician-driven networks, the more successful and sustainable they will be as health care leaders.

PAMED must and will support physicians during this transition through use of services offered through the MSO or CINs. PAMED is looking to engage Pennsylvania physicians; provide the necessary education, clinical tools, and data; and offer hands-on practice support to assure successful transitions. This is the value of becoming part a CIN, and of being a PAMED member.

If you would like additional information about PAMED's Practice Options Initiative, please contact Dennis Olmstead, Senior Vice President Business Strategy and Development, at 855-PAMED4U (855-726-3348) or KnowledgeCenter@pamedsoc.org.

If you haven't already, check out PAMED's online, on-demand CME series – "Addressing Physician Uncertainty about Payment Reform: Skills for Success in Value-Based Delivery Systems." Free to PAMED members, this series is facilitated by Ray Fabius, MD, a PAMED member and a nationally respected expert in the field of population health. It covers a variety of important topics, including practical health informatics, using a data toolbox in your practice, quality management, process improvement, lessons learned from the managed care era, and population health. Access the CME at www.pamedsoc.org/valuebasedcare. +

A version of this article first appeared in the summer 2016 issue of Pennsylvania Physician and was updated on Jan. 10, 2017.

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LCMS NEWS & CALENDAR

National Health Observances from the National Health Information Center, a division of the U.S. Department of Health and Human Services, include the following for April, May and June.

APRIL

Alcohol Awareness Month

National Council on Alcoholism and Drug Dependence, Inc.
national@ncadd.org
www.ncadd.org



Irritable Bowel Syndrome Awareness Month

International Foundation for Functional Gastrointestinal Disorders
iffgd@iffgd.org
www.aboutibs.org/site/about-ibs/
april-ibs-awareness-month



National Autism Awareness Month

The Autism Society
info@autism-society.org
www.autism-society.org

National Child Abuse Prevention Month

Child Welfare Information Gateway
info@childwelfare.gov
www.childwelfare.gov/topics/preventing/preventionmonth/

National Distracted Driving Awareness Month

National Safety Council
customerservice@nsc.org
www.nsc.org

National Donate Life Month

Division of Transplantation, U.S. Department of Health and Human Services
donation@hrsa.gov
www.organdonor.gov



National Facial Protection Month

American Association of Oral and Maxillofacial Surgeons
American Academy of Pediatric Dentistry
American Association of Orthodontists
inquiries@aaoms.org
www.aaoms.org

Continued on page 32

**National Inter-Professional
Health Care Month**

National Academies of Practice
info@napractice.org
www.napractice.org/Advocacy/
National-Interprofession-
al-Health-Care-Month



National Minority Health Month

Office of Minority Health
info@minorityhealth.hhs.gov
www.minorityhealth.hhs.gov

Occupational Therapy Month

*American Occupational
Therapy Association*
praota@aota.org
www.aota.org



Oral Cancer Awareness Month

The Oral Cancer Foundation
info@oralcancerfoundation.org
www.oralcancer.org

**Sexual Assault
Awareness and
Prevention Month**

*Rape, Abuse & Incest
National
Network (RAINN)*
info@rainn.org
www.rainn.org



**Sexual Assault Awareness
Month of Action**

*National Sexual Violence
Resource Center*
resources@nsvrc.
org
www.nsvrc.org



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Sports Eye Safety Awareness Month

American Academy of Ophthalmology
 media@aao.org
 aao.org/eyesmart



STI Awareness Month

American Sexual Health Association
 info@ashastd.org
 www.ashastd.org

Women's Eye Health and Safety Month

Prevent Blindness
 info@preventblindness.org
 www.preventblindness.org

MAY

Arthritis Awareness Month

Arthritis Foundation
 aforders@arthritis.org
 www.arthritis.org



Better Hearing and Speech Month

American Speech-Language-Hearing Association
 bhsm@asha.org
 www.asha.org/bhsm/



Food Allergy Action Month

Food Allergy Research & Education
 www.foodallergy.org/
 food-allergy-awareness-week#.
 U8QyM140caU



Global Employee Health and Fitness Month

National Association for Health and Fitness
 areobic2@aol.com
 www.healthandfitnessmonth.com







Continued on page 34



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Global Youth Traffic Safety Month

National Organizations for Youth Safety (NOYS)
support@noys.org
noys.org/



Healthy Vision Month

American Academy of Ophthalmology
media@aao.org
aao.org/eyesmart

Hepatitis Awareness Month

Division of Viral Hepatitis, Centers for Disease Control and Prevention
dvhwi@cdc.gov
www.cdc.gov/hepatitis

International Mediterranean Diet Month

Oldways and the Mediterranean Foods Alliance
media@oldwayspt.org
www.oldwayspt.org

Melanoma/Skin Cancer Detection and Prevention Month®



American Academy of Dermatology
mediarelations@aad.org
www.spotskincancer.org

Mental Health Month

Mental Health America
dfritze@mentalhealthamerica.net
www.mentalhealthamerica.net/go/may



National Asthma and Allergy Awareness Month



Asthma and Allergy Foundation of America
info@aaafa.org
www.aaafa.org/page/asthma-and-allergy-awareness-month.aspx

National Osteoporosis Month

National Osteoporosis Foundation
claire.gill@nof.org
www.nof.org/nationalosteoporosis-month

National Physical Fitness and Sports Month

President's Council on Fitness, Sports & Nutrition
fitness@hhs.gov
www.fitness.gov



National Stroke Awareness Month

Centers for Disease Control and Prevention
www.cdc.gov/stroke/stroke_awareness_month.htm



National Teen Pregnancy Prevention Month

HHS Office of Adolescent Health
www.hhs.gov/ash/oah/news/national-teen-pregnancy-prevention-month.html

Preeclampsia Awareness Month

Preeclampsia Foundation
eleni.tsigas@preeclampsia.org
www.preeclampsia.org



Ultraviolet Awareness Month

American Academy of Ophthalmology
media@aao.org
aao.org/eyesmart

JUNE

**June 1 - July 4
Fireworks Safety Month**

American Academy of Ophthalmology
media@aao.org
aao.org/eyesmart

Alzheimer's & Brain Awareness Month

Alzheimer's Association
info@alz.org
www.alz.org/abam



Cataract Awareness Month

Prevent Blindness
info@preventblindness.org
www.preventblindness.org





Men's Health Month

Men's Health Network
 info@menshealthweek.org
 www.menshealthmonth.org

Myasthenia Gravis Awareness Month



Myasthenia Gravis Foundation of America, Inc.
 mgfa@myasthenia.org
 www.myasthenia.org/AboutMGFA/MGFANews.aspx

National Aphasia Awareness Month



National Aphasia Association
 naa@aphasia.org
 www.aphasia.org

National Congenital Cytomegalovirus Awareness Month



National CMV Foundation
 june@nationalcmv.org
 www.nationalcmv.org

National Safety Month



National Safety Council
 media@nsc.org
 www.nsc.org/act/events/Pages/national-safety-month.aspx

National Scleroderma Awareness Month



Scleroderma Foundation
 sfinfo@scleroderma.org
 scfo.convio.net/site/PageServer?pagename=SAW_ias +



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