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Health & Medicine

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IN THIS ISSUE

As we head toward spring, we are pleased to offer you a new selection of informative content in *Lehigh County Health and Medicine* that we hope you find useful. In every issue, we strive to provide a series of articles that touch on a range of health issues that impact our local community. Past issues are available on our website: https://lcmedsoc.org/our-publication.

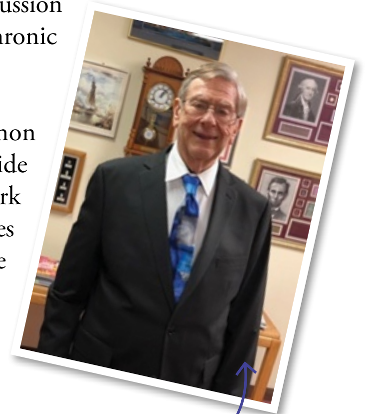
In this issue you'll find an instructive article on stroke, including signs and symptoms, acute treatment, recovery and rehab as well as the future of stroke treatment. We have also included an article on how to help a parent through a stroke, including helpful suggestions on what to be aware of as a caregiver.

With 3.5 million new skin cancer cases each year, information about what to look out for is important. Our article reviews skin cancer basics and definitions, as well as information on Mohs Micrographic surgery. You'll also find an article on Hepatitis A, with information, symptoms and causes as well as the importance of vaccination campaigns.

We have an article on mental illness and important connections to primary care, which is often a first stop for many patients seeking help. You'll find information on how PCPs can assess mental health, and provide individualized treatment and sustained follow-up. The article includes discussion on both reducing the stigma of mental health as well as treating mental illness as a chronic disease (as you would diabetes or heart disease).

We have information on suicide, including the statistics that suggest how common thoughts of suicide really are, and information on the American Foundation for Suicide Prevention, including their efforts to fund research into suicide prevention. And mark your calendars – the AFSP has three awareness walks scheduled locally in 2019, at DeSales University, Cedar Crest College and Lehigh/Carbon Community College. Check the AFSP article for dates and registration details.

We hope you enjoy this issue and wish you a healthy and happy 2019! ✚



Meet the new 2019 LCMS President William A Tuffiash, MD, PC

Lehigh County Medical Society will be holding the following meetings and events this Spring. Members, please look for details coming soon to your mail and email boxes.

April 9th, 2019

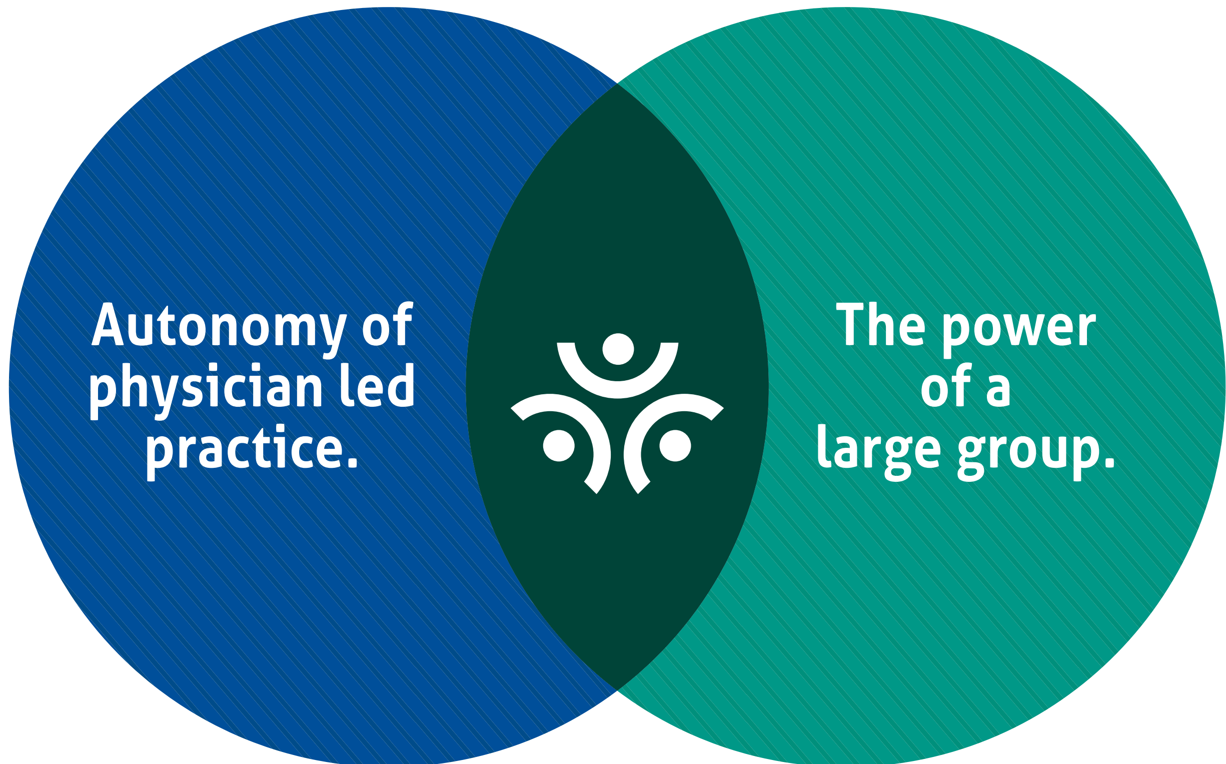
GENERAL MEMBERSHIP MEETING with CME PROGRAM:

"Tools you can use to fight the opioid epidemic"
This program will address the following topics:
Referral to Treatment for Substance Use Disorder Related to Opioid UseApproaches to Address Patients Substance Use Disorder

May 4th, 2019

ANNUAL LCMS SOCIAL MEETING

Yes, you can have the best of both worlds.



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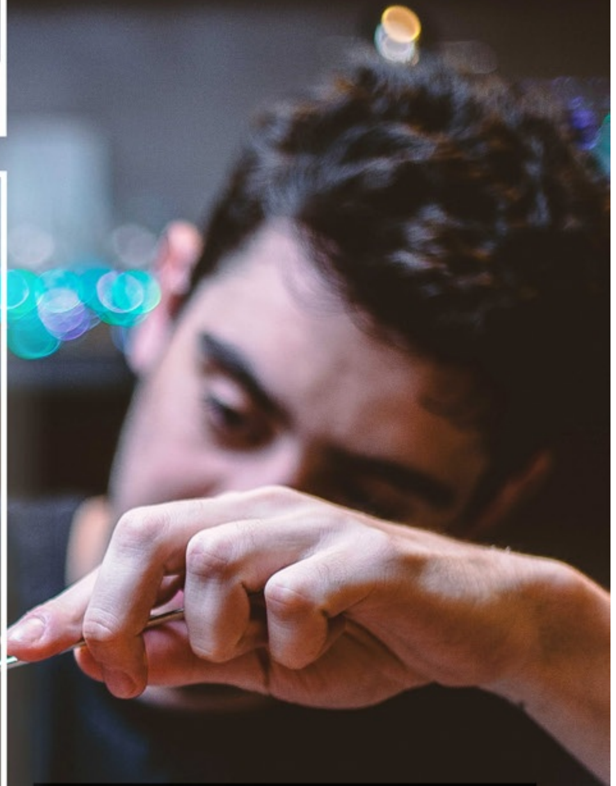

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Hepatitis A

Hepatitis A outbreaks have been on the rise nationally since 2017, occurring primarily in populations whose environment and behaviors adversely affect their health. Factors such as homelessness and drug use make it difficult for typical public health initiatives to succeed. Though Pennsylvania hasn't seen any recent outbreaks, it is important to target these populations with innovative vaccine initiatives to prevent outbreaks from occurring and spreading throughout the state.

The transmission of recent national outbreaks differs significantly from their predecessors. Previous outbreaks were usually attributed to contaminated food products produced commercially, whereas outbreaks occurring over the last two years have been caused by direct person-to-person transmission.

Public health officials can easily identify populations at a high risk for outbreaks. However, conducting outreach is not nearly as simple.

The high-risk populations for Hepatitis A outbreaks include people who use drugs and people who are homeless or live in transient housing. This disease is transmitted by the fecal-oral route, meaning it thrives in certain environments and takes advantage of specific human behaviors. Unsanitary living situations that occur frequently in the homeless/transient housing population can mean poor or even no plumbing. This, combined with poor hand hygiene, allows Hepatitis A to spread with ease.

Using both injectable and non-injectable drugs can cause people to care less about their health and engage in risky sexual activity. This can be due to the high of the chosen drug, as well as users who engage in sex work to support their habit. Drug users may also have other diseases—such as Hepatitis B, Hepatitis C, HIV, or chronic liver diseases—that adversely affect their immune systems, making it difficult to fight off Hepatitis A.

Common symptoms of Hepatitis A include nausea, vomiting, fatigue, fever, loss of appetite, abdominal pain, darkly colored urine, gray-colored stool, joint pain, and jaundice. The average incubation period is 28 days, but the maximum is 50 days. People infected with Hepatitis A can be viremic for up to six weeks and can have the virus in their stool two weeks before they become symptomatic. Although rare, Hepatitis A infection can cause death if an immune-compromised person is infected.

Thankfully, Pennsylvania does not have current outbreaks which grants state and local health departments time to prepare before they occur. Hepatitis A is a vaccine-preventable disease, allowing public health to directly target high-risk populations. Reaching these populations requires great collaboration between state and local health departments, local nonprofits, healthcare professionals, drug and alcohol treatment centers, correctional facilities, and other organizations. Although it seems difficult, it's the only way to prevent an outbreak from happening here. ✚

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https://www.cdc.gov/hepatitis/outbreaks/2017March-HepatitisA.htm

https://emergency.cdc.gov/han/han00412.asp

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LET'S TALK ABOUT SUICIDE

Suicide is a topic that is rarely discussed in our culture and society, but has more than likely impacted so many of us. Whether you have lost a loved one to suicide, or have struggled yourself with suicidal thoughts, it is important to know the warning signs or risk factors to prevent suicide. In 1987, a small group of caring individuals had a vision: establish a private source of support for suicide research and education, and essential suicide prevention efforts could be sustained into the future. These founding families—each of whom had lost someone to suicide—joined with scientists to create what today is the American Foundation for Suicide Prevention, or AFSP.

NORTHAMPTON COUNTY CRISIS LINE: 610.252.9060
LEHIGH COUNTY CRISIS LINE: 610.782.3127

NATIONAL SUICIDE HOTLINE: 1.800.273.8255
NATIONAL SUICIDE TEXT LINE: 741.741

AFSP is dedicated to saving lives and bringing hope to those affected by suicide. AFSP creates a culture that's smart about mental health by engaging in the following core strategies:

- **Funding scientific research**
- **Educating the public about mental health and suicide prevention**
- **Advocating for public policies in mental health and suicide prevention**
- **Supporting survivors of suicide loss and those affected by suicide in our mission**

The American Foundation for Suicide Prevention (AFSP) is the largest private funder in suicide prevention research. Much of what is known about suicide comes from studies that AFSP has funded or supported. From our research we have learned many things, such that suicide is preventable. Through our research we have learned the warning signs and risk factors such as behaviors or moods a person might have. From the research, AFSP has developed evidence-based programs using the latest science on suicide prevention to to provide the local communities. AFSP has developed over 20 different educational programs to offer free to the communities. The programs are built to fit the diverse and different populations that suicide affects within our community. Our programs include training in mental health and suicide prevention for schools, as well as specific populations such as elderly, LGTBQ+ and veterans.

Our Advocacy team gives our volunteers the tools they need to advocate for suicide prevention at all levels. Advocates have won many victories at both state and federal levels, including mandatory suicide prevention programs for schools and landmark legislation like the Excellence in Mental Health Act. AFSP organizes advocacy days in DC and at state capitols to meet with our representatives and encourage them to support suicide prevention policies. Our advocates also meet with local legislators regularly to make an impact at the local level in our communities for mental health and suicide. Nationally we currently have 20,000 field advocates in our database. Being a field advocate means you are notified to contact your local legislators to encourage them to vote on a certain bill. To become a field advocate you can sign up for free at www.AFSP.org/Advocacy.

AFSP offers resources to help loss survivors cope, connect, and heal in time. Our trained peer support volunteers are all suicide loss survivors who know firsthand how difficult it can be to find your way in the aftermath of a suicide. Upon request, they are available to speak with you by phone, in person, by video call, or via email. Our Survivor Outreach team also hosts what is called a International Survivors of Suicide Loss Day, or "Survivors Day." Survivor Day is the one day a year when people affected by suicide loss gather around the world at events in their local communities to find comfort and gain understanding as they share stories of healing and hope. This past year, there were close to 400 Survivor Day events across the globe, including over 30 sites in other countries outside of the US. For the over 6,500 individuals that attended these events worldwide, it may have been the beginning (or continuation) of a journey toward a community that knows intimately the challenges of living with suicide loss. Survivor Day is always held on the Saturday before Thanksgiving and will be held on November 23, 2019 this year.

In order to become the largest suicide prevention organization, we must take time to fundraise for the community. We conduct our biggest fundraiser through college campuses and communities and host "Campus Walks" or "Community Walks." Each year across the country there are over 500 community walks for suicide prevention. These walks are called "Out of the Darkness Walks," as we try to erase the stigma and bring suicide or mental health out of the darkness and into the light.

In 2019 we are hosting three incredible campus walks at 3 local Lehigh Valley colleges. Our first will be a partnership of Desales University and Cedar Crest College on March 23rd. To register, please visit afsp.org/Desales. Our second campus walk will be held at the Lehigh/Carbon Community College (LCCC) campus on April 6th. To register please visit afsp.org/LCCC. Finally our last campus walk will be held at Kutztown University on April 28th. To register please visit afsp.org/Kutztown. These events will provide an outlet for college students and communities to come together to provide support hope and healing.

In 2018, we hosted our 13th annual Out of the Darkness Community walk in Allentown, Pennsylvania on October 7, 2018. We had over 2,000 participants and raised $148,735 dollars! We ranked 35th walk in the entire country out of 500 community walks, beating out large cities like Houston, Charlotte, Dallas, Orlando and Phoenix! When you walk in the Out of the Darkness walks, you join the effort with hundreds of thousands of people to raise awareness and funds that allow the American Foundation for Suicide Prevention (AFSP) to invest in new research, create educational programs, advocate for public policy and support for survivors of suicide loss. We hope that you will join us for our 14th annual community walk in 2019. The walk will be held at Lehigh Parkway in Allentown, PA on Sunday, October 6th. You may register for free at afsp.org/GLVwalk. ✚

We are always looking for more support and volunteers.

Please visit us on facebook at facebook.com/AFSPGreaterLehighValley

Or visit our local chapter website to fill out a volunteer form to get involved at afsp.org/chapter/afsp-greater-lehigh-valley-pennsylvania.

THINK F.A.S.T.

BY CHRISTOPHER MELINOSKY, MD
Neurocritical Care Department of Neurology, Lehigh Valley Health Network

BACKGROUND

Stroke affects over 800,000 people annually in the United States. It is the fifth leading cause of death, and the leading cause of disability in this country, yet many people do not even know what "having a stroke" means. Stroke is divided into two subtypes. Ischemic stroke, or lack of blood flow to the brain, comprises about 85% of all strokes. Hemorrhagic stroke, or bleeding into the brain, accounts for the other 15%. There is no way to determine if a patient is having an ischemic stroke or hemorrhagic stroke without a computed tomography (CT) scan, and the treatment for each type varies. This article will focus on ischemic stroke, which encompasses the majority of the strokes and advancements in the acute treatment.

SIGNS AND SYMPTOMS

Stroke symptoms depend on the blood vessel that is blocked and which area of the brain is lacking in blood flow. Without blood flow, the brain tissue stops functioning and starts to die. If the stroke affects the left side of the brain, there will be right side weakness or numbness, and there may be difficulty with speaking or understanding. If the stroke affects the right side of the brain, there may be left side weakness or numbness. If the stroke affects the base of the brain, there may be dizziness, difficulty with eye movements or swallowing, or even loss of consciousness. The American Stroke Association uses the acronym FAST (Face-Arm-Speech-Time) for the layperson to evaluate for a stroke. Time is key – as soon as there is lack of blood flow to the brain, brain cells start to die and cannot be repaired. Getting to the hospital as soon as possible is vital to having a better outcome.

Acute stroke can be thought of in three phases: (1) Diagnosis and immediate treatment (if eligible) (2) work up for cause of the stroke in order to prevent further strokes (3) rehab/recovery and long term management of stroke risk factors.

ACUTE STROKE TREATMENT

The definition of "acute" stroke has evolved as our treatment options have expanded. Prior to the 1990s, there was no treatment option for acute stroke. Then, tissue plasminogen activator (tPA) was discovered to improve outcomes in stroke clinical trials, and has changed the game in acute stroke care. Tissue plasminogen activator is a substance made by the body to break down clots. In the treatment of acute stroke, a higher dose synthetic version can be administered in order to break up the clot that is causing lack of blood flow and tissue damage. In those studies, it was discovered that the medication is only safe to be given in the first three hours after stroke, so early detection and presentation to healthcare is key. Further studies have expanded this window of treatment to four-and-a-half hours for a certain subset of the population. The medication does carry a risk of bleeding into the brain, but the potential benefit far outweighs this risk as more people that receive the medication end up with better functional outcomes.

What about the patients that present outside of the time window, or those that wake up with symptoms and the time of onset is not clear? More recently, clot retrieval has expanded the window of treatment further for some of these patients, and anyone presenting with symptoms starting within 24 hours is now considered for possible clot removal. Rather than strictly using time to decide on treatment, most centers are using imaging characteristics on CT scan or magnetic resonance imaging (MRI). The blood vessels to the brain are like tree branches – the carotid and vertebral arteries are the main trunks feeding the brain, and there are subsequently smaller branches coming off these arteries. When a blood clot is in one of the larger branches, a clot retrieval device can be threaded up through blood vessels into the brain to remove the clot and restore blood flow. These devices have also evolved over the years, and this second generation of clot retrieval devices has proven to have favorable outcomes in treating what would have been very large strokes. Anecdotally, some of these patients would have been severely disabled and are walking out of the hospital (though this is not always the case). Unfortunately, not all patients are eligible for treatment; if there is already too much injury to the brain on imaging, there is a higher likelihood of having bleeding into the damaged tissue and the procedure cannot be performed.

Many local stroke centers are certified as either Primary Stroke Center or Comprehensive Stroke Center. Primary stroke centers are capable of making immediate decisions on tPA and evaluating for eligibility for clot retrieval. If the patient is determined to be eligible for clot retrieval, they will need to be transferred to a comprehensive stroke center, which has 24/7 access to stroke neurologists, interventional radiology, and a dedicated neuroscience intensive care unit. The Lehigh Valley is fortunate enough to have many primary stroke centers and two comprehensive stroke centers in this region.

When a patient with stroke symptoms calls for medical services, a treatment pathway protocol is initiated. Often, the hospital is notified of a "stroke alert" from the EMS providers in the field, and the stroke treatment team is waiting for the patient. The patient is brought to the Emergency Department where a brief assessment is performed before being taken directly to CT scan. In the meantime, necessary bloodwork and examination are performed and treatment options can be determined at that time. The stroke team works very fast to assess and move to treat as soon as possible to preserve brain tissue. Treatment decisions are often made in under 30 minutes.

STROKE WORK UP

There are many causes for ischemic stroke, and a complete work up is vital since the treatment may vary. About 20 percent of the time, no cause is identified and further long-term work up is required. A very common cause is cardioembolism (about 20-30% of ischemic strokes) often due to atrial fibrillation, which is an abnormal heart rhythm that allows clots to form in the heart, which can then go directly to the brain. This can be detected with a heart monitor during hospitalization, or one placed for discharge for home monitoring.

Continued on page 12

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FEATURE

Other controllable risk factors are associated with stroke and should be investigated. This most commonly includes high cholesterol, smoking, diabetes, diet/obesity, high blood pressure and carotid artery disease. These can be evaluated in the hospital and appropriate treatment can be initiated.

RECOVERY AND REHAB

A vital part of stroke care is rehabilitation. The damaged brain cannot repair itself, but can learn ways to compensate by rewiring. During stroke work up, therapy services including physical therapy, occupational therapy, physiatry and speech therapy typically evaluate for problems and make recommendations for rehabilitation. Recovery from stroke is generally the greatest in the first 3-6 months following the incident, but can take place up to a year from the time of the event. Early rehabilitation has been shown in multiple studies to help with improving functional outcomes, both in restoring function and in learning compensation techniques.

FUTURE DIRECTIONS

Stroke neurologists love to say that “Time is brain.” Early detection of stroke leads to earlier treatment, saving brain cells. Community awareness and education is a vital part of getting to care quickly. The treatment window is expanding for clot retrieval, and now any stroke presenting within 24 hours of onset is treated as an “acute stroke” getting an immediate work up for eligibility for treatment. Decisions are now being made based on the imaging characteristics rather than the time of onset, since every brain is different. Even more patients are being treated for acute stroke under newer protocols.

Another national trend towards early recognition and treatment is the introduction of Mobile Stroke Units (MSU), or ambulances equipped with telehealth equipment and the ability to perform a CT scan. This makes it possible to give tPA pre-hospital, or if hemorrhage is detected, medications can be given to thicken the blood to decrease bleeding. These MSUs have been shown to reduce time from detection to treatment by bringing the neurologist and scanner to the patient, and early treatment has been shown to have better outcomes. The Lehigh Valley is expecting to have its first MSU running this spring. ✚

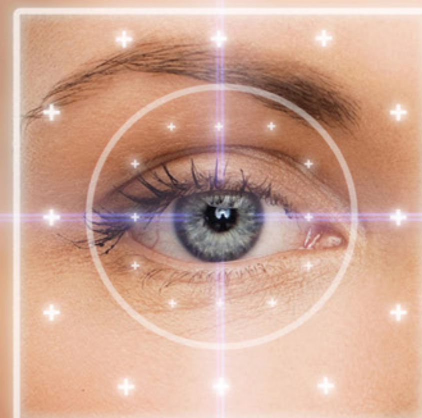
REFERENCES

https://www.strokeassociation.org

https://www.jointcommission.org/facts_about_joint_commission_stroke_certification/

Dr Melinosky is a neurologist and neurointensivist at the Lehigh Valley Health Network Cedar Crest Campus. The neurocritical care team takes care of critical patients with large ischemic strokes, bleeding in the brain, or any neurologic issue requiring ICU care.

Vision Threatening Conditions



BY ELISA GIUSTO, D.O.
Family Medicine PGY-1
PAMPAC Resident Representative

In honor of May being Healthy Vision Month, here is a review of 5 vision threatening conditions.

Ocular Chemical Burns: acid or alkali eye exposure presents with decreased vision, eye pain, blepharospasm, conjunctival redness, and photophobia. Acidic substances include car battery fluid (sulfuric acid), rust remover (hydrofluoric acid), and toilet bowl cleaner (hydrochloric acid). Alkali substances include bleach (sodium hypochlorite), cement (calcium hydroxide), lye cleanser (sodium hydroxide), and dishwasher detergent (sodium tripolyphosphate). Continuous irrigation with water or saline is recommended until the affected eye has a neutral pH.

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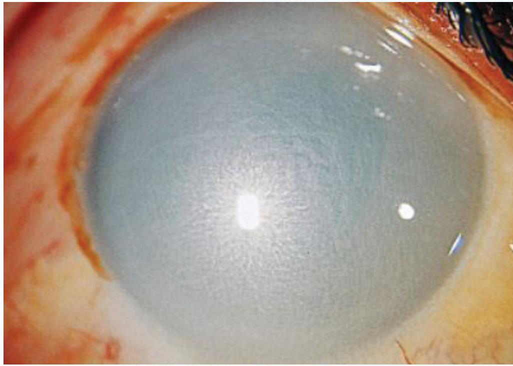

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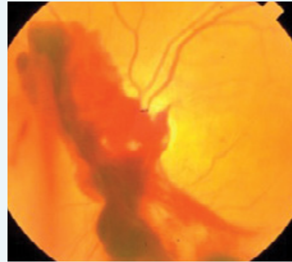
CORNEAL ALKALI BURN

Alkali burn. Significant corneal, conjunctival, and scleral damage occurred after a severe alkali injury. Notice the opacified cornea and the conjunctival and scleral blanching, indicating severe damage to the surrounding blood vessels.



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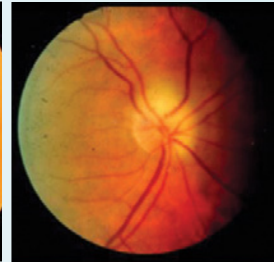
VITREOUS HEMORRAHAGE: APPEARANCE ON FUNDUS PHOTOGRAPH

Color fundus photograph displaying vitreous hemorrhage arising from neovascularization at the disc (NVD).



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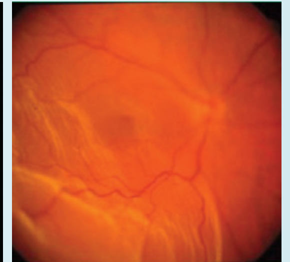
ISCHEMIC OPTIC NEUROPATHY

Ischemic optic neuropathy in a patient with giant cell artertitis who lost vision abruptly four days prior to this examination. The optic disc is swollen and its margins are blurred.



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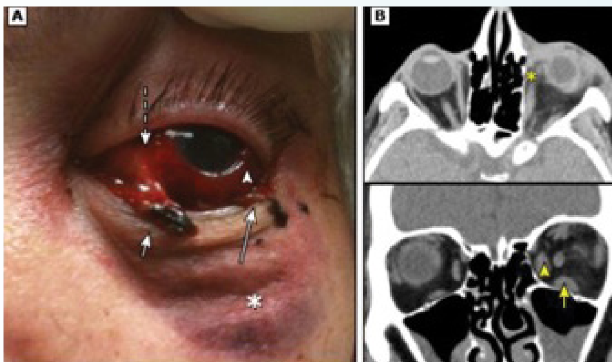
TRAUMATIC RETINAL DETACHMENT

Wide field fundu photograph of an inferotemporal retinal detachment. Note the corrugated appearance of the retina inferotemporally. The focus of the photograph is on the elevated, undulating retinal detachment and thus the optic nerve is out of focus.



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ORBITAL COMPARTMENT INJURY

A 65-year-old man was working in his home workshop when he accidentally caught his left eye on a peg hook. (A) Clinical photo of the eye showing periocular ecchymoses (asterisk), 360 degrees of subconjunctival hemorrhages (arrowhead), a conjunctival laceration (dashed arrow), laceration of the medial rectus muscle with the distal portion rotated anteriorly and temporally (short arrow), and partial laceration of the interior rectus muscle (arrow).

(B). A computer tomography scan of the orbits showing a discontinuity in the left medial rectus muscle (axial scan, asterisk) and marked enlargement of the medial and inferior recti muscle diameters (coronal scan, arrowhead and short arrow respectively).

Orbital Compartment Syndrome: trauma and intraorbital hemorrhage cause rapidly elevated intraorbital pressure causing decreased vision, diplopia, eye pain, and periorbital swelling. Exam findings include afferent pupillary defect, proptosis, decreased retropulsion, and diffuse subconjunctival hemorrhage. Orbital decompression via lateral canthotomy and inferior cantholysis should be performed followed by CT or MRI as determined by an ophthalmologist.

Vitreous Hemorrhage: seen in retinal tear or detachment, abusive head trauma, subarachnoid or subdural hemorrhages causing decreased or hazy vision, black spots, or cob webs. Exam findings include absent red reflex and obscured optic disc, retina, or vessels. An ophthalmologist should guide the need for head CT or orbital ultrasound to identify the underlying injury and provide definitive treatment.

Retinal Trauma: retinal hemorrhage, tears, or detachment result in loss of vision that may be partial, confined to a visual field, or complete. An ophthalmologist should perform a slit lamp evaluation and indirect ophthalmoscopy with scleral depression to fully characterize the retinal injury. Retinal detachment specifically causes light flashes, floaters, and shadowing, which requires bed rest pending urgent surgical repair.

Optic Nerve Injury: also known as traumatic optic neuropathy, causes decreased vision, desaturation of red color, and an afferent pupillary defect. Contusion or avulsion of the optic nerve can be a result of direct lacerating trauma, forceful blow to the temple or brow, optic canal fracture, or abusive head trauma. An ophthalmologist should guide the need for orbit CT to identify the underlying injury and provide definitive treatment. ✚

SOURCE

https://www.uptodate.com/contents/overview-of-eye-injuries-in-the-emergency-department?search=eye%20problems&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

FLOATERS IN MY EYES

BY MARK MORAN, D.O., M.S.H.I., F.A.O.C.O.
Allentown Surgery Center

What are those little black specks or cobwebs that follow along in our line of sight as we look at things? They are floaters. About a quarter of us have seen them, but that number jumps to almost 90% once we hit the age of 80. Floaters or myodesopsia is a very common condition experienced by many of us.

Floaters come in different sizes and shapes. They can appear as hair-like, spots, threads, circles, clumps or cobwebs. Floaters often can take the appearance of objects, just as clouds can sometimes assume the shapes of animals and other objects. Quite often a patient will present to their eye doctor describing objects moving along the wall or floor.

To understand what a floater is, a small anatomy lesson is necessary. Inside the eye are different types of fluids. The main fluid that sits behind the iris, or colored part of the eye, is called the vitreous. As a person ages, the vitreous undergoes degenerative changes called liquefaction. As the term implies, the vitreous gel becomes more liquid. This causes a separation between the vitreous and the retina which leads to a posterior vitreous detachment (PVD).

This separation itself has no serious effect on vision, but it can cause annoying floaters. Liquefaction can cause more ominous problems such as a retinal tear or detachment. Floaters will not typically cause a decrease in vision, but a retinal detachment if not treated can cause blindness. All new onset of floaters (meaning they've originated within 30 days) should be examined by an eye doctor to ensure the PVD has not caused a retinal problem. Signs that the PVD has caused more than just floaters are the onset of a large number of floaters, flashes of light or a greying or missing part of one's vision.

Most floaters resolve on their own, but this resolution can often take months. Floaters can be very annoying and interfere with one's vision. If floaters do not resolve, a vitrectomy could be performed to clear the floaters. A vitrectomy is significant surgery and entails removing the liquefied vitreous. Another option, a minimally invasive in-office technique, is called laser vitreolysis. This technique uses a laser to significantly improve the perception of the floater. This can eliminate the need for a vitrectomy and can improve symptoms in over 90% of the patients suffering from floaters.

Floaters are very common and can signify a serious ocular problem. An examination should be performed on every new onset of floaters. If floaters don't resolve after 2 to 3 months, a consultation should be made to an ophthalmologist with experience in laser treatment. ✚

Mark E. Moran, D.O., M.S.H.I., F.A.O.C.O., is an ophthalmologist serving the Lehigh Valley for almost 30 years. He currently is in private practice in the Bethlehem area caring for patients and working on computers and cybersecurity.

FEATURE

ALL ABOUT ALCOHOL

BY DR. BREANNA HENRY, D.O.

Alcohol is a common part of our culture. Drinking alcohol is often associated with celebrations, social occasions, and relaxing after a long day. While the occasional drink with dinner is acceptable for some people, excessive or prolonged use of alcohol can have negative effects on a person's health. April is Alcohol Awareness Month. Here are some of the important points that everyone should know about alcohol.

HOW DOES ALCOHOL AFFECT THE BODY?

In the Brain: Alcohol slows the rate of communication among various parts of the brain. This leads to slower reaction time, impaired judgement, decreased coordination, and reduced ability to process information. For this reason, drinking alcohol prior to driving a vehicle is dangerous. Alcohol also changes behaviors, especially in persons prone to addiction.

Increases Risk of Cancer: Alcohol use has been shown to increase a person's risk of developing cancer of the head and neck, esophagus, liver, breast and colon.

Digestive system: Alcohol irritates the lining of the stomach and the intestines. This causes heartburn and decreases the body's ability to absorb nutrients from food. Prolonged use of alcohol causes deficiencies of B vitamins, magnesium, calcium, iron, zinc and potassium. Ingesting large quantities of alcohol causes dehydration, leading to stomach cramps and diarrhea.

Heart: But a glass of red wine is good for the heart, right? Actually, heavy or prolonged alcohol use raises blood pressure, which causes the heart to work harder (and therefore wear out sooner). Alcohol is also a toxin to the heart muscle, causing it to stretch out, which ultimately leads to heart failure. In addition, alcohol use increases the risk of developing an irregular heartbeat, which can lead to a stroke and/or heart failure.

Immune system: Alcohol weakens the immune system, making a person more likely to develop infections.

Liver: Alcohol is toxic to the liver. It causes fatty deposits in the liver, inflammation, hepatocellular carcinoma (liver cancer) and scarring or cirrhosis of the liver.

Mental Health: Perhaps you've had a drink to "take the edge off" after a stressful day. While alcohol may help you feel more relaxed in the short term, alcohol is a depressant. Long term use of alcohol changes the neurotransmitters (chemicals) in the brain and how they respond to stress. This reduces a person's ability to cope with stress and increases anxiety. After a stressful day, consider talking to a trusted friend, getting some exercise, or engaging in an enjoyable hobby to help you decompress.

Pregnancy and Fertility: Drinking alcohol during pregnancy affects a developing fetus's brain, growth and development. Babies born to mothers who drank alcohol during pregnancy have lower birth weights and are more likely to have physical deformities at birth. Fetal Alcohol Syndrome, first recognized in 1973, is a condition that results from alcohol damage to the brain of a developing fetus. Children born with fetal alcohol syndrome commonly have learning disabilities, poor coordination, lower inhibitions, poor academic achievement, and problems with attention and/or concentration. These problems may affect them as children, adolescents or adults. According to the United States Surgeon General, women of child-bearing age who are sexually active should avoid using alcohol, as Fetal Alcohol Syndrome is preventable by abstaining from alcohol use while pregnant. In women who are trying to become pregnant, alcohol use may lower fertility rates.

Sleep: A nightcap helps you to fall asleep, right? While alcohol might help you to fall asleep quicker, the remainder of the night of sleep becomes disturbed. Alcohol use increases the time spent in the less restful REM (rapid eye movement) stages of sleep, leading to morning drowsiness. Alcohol is a diuretic, leading to more frequent nighttime awakenings to pass urine. Alcohol also relaxes the muscles in the airways, leading to snoring, which often disturbs sleep.

Weight: Alcohol is made from sugars and has little to no nutrient value. Drinking more than the recommended amounts is a common cause of weight gain. People who drink alcohol excessively may neglect their food intake, which leads to nutrient deficiencies mentioned above.

Continued on page 18

HOW IS A DRINK MEASURED?

A standard drink is equal to 14.0 grams (0.6 ounces) of pure alcohol. Generally, this amount of pure alcohol is found in:

12 ounces of beer (5% alcohol content).

8 ounces of malt liquor (7% alcohol content).

5 ounces of wine (12% alcohol content).

1.5 ounces or a "shot" of 80-proof (40% alcohol content) distilled spirits or liquor (such as gin, rum, vodka, whiskey).

HOW MUCH IS TOO MUCH?

The answer to that question is different for each person. Many factors are involved, including (but not limited to), a person's overall health, age, gender and chronic health conditions. The most important factor is how a person responds to alcohol use.

Certain persons should avoid using alcohol in any amount. These include:

- **persons who are planning to drive or operate heavy machinery**
- **persons who take medications that interact with alcohol**
- **persons with health conditions that are likely to be worsened with alcohol use**
- **persons who are or have been dependent on drugs or alcohol**
- **pregnant women and women who are trying to become pregnant**
- **If you are uncertain about how alcohol might affect your health, talk to your healthcare professional.**

WHAT IS HEAVY DRINKING?

For men, heavy drinking is typically defined as consuming 15 drinks or more per week. For women, heavy drinking is typically defined as consuming 8 drinks or more per week. Binge drinking (see below), on 5 or more days in one month is also considered heavy drinking. Heavy drinking increases a person's chances of developing the health risks discussed above and may be an early sign of alcohol use disorder.

WHAT IS BINGE DRINKING?

According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), binge drinking is defined as a pattern of alcohol consumption that brings the blood alcohol concentration (BAC) level to 0.08% or more. This typically occurs after 4 drinks for women and 5 drinks for men – in about 2 hours. Binge drinking even once per month can lead to the health problems discussed earlier.

WHAT IS ALCOHOL USE DISORDER?

Alcohol use disorder (AUD), commonly called alcoholism, is a chronic relapsing brain disease characterized by compulsive alcohol use, loss of control over alcohol intake, and a negative emotional state when not drinking. AUD affects persons of all ages, genders, races, professions, and levels of intelligence. To be diagnosed with Alcohol Use Disorder, an individual must meet certain criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

To assess whether you or loved one may have AUD, here are some questions to ask.

In the past year, have you:

- Had times when you ended up drinking more, or longer than you intended?
- More than once wanted to cut down or stop drinking, or tried to, but couldn't?
- Spent a lot of time drinking? Or being sick or getting over the aftereffects?
- Experienced craving — a strong need, or urge, to drink?
- Found that drinking — or being sick from drinking — often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
- Continued to drink even though it was causing trouble with your family or friends?
- Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?
- More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
- Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?
- Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?
- Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, irritability, anxiety, depression, restlessness, nausea, or sweating? Or sensed things that were not there?

Answering "yes" to any one of these questions indicates that a person's pattern of alcohol use is dangerous. As the number of "yes" answers increases, the need for change becomes more urgent.

A healthcare professional can complete a formal assessment of a person's symptoms and recommend appropriate and safe ways for a person to make healthy changes.

HOW TO GET HELP FOR YOURSELF

If you have concerns about your pattern of alcohol use, talk to your healthcare professional. There are a variety of treatment options available, and treatment is effective. Research shows that about one-third of people who are treated for alcohol problems have no further symptoms one year later. Many others substantially reduce their drinking and report fewer alcohol-related problems. Treatment options include, but are not limited to, behavioral treatments, mutual support groups, medications, etc. Both inpatient and outpatient treatment options are available.

You may also consider contacting any one of the following organizations for help and support: Alcoholics Anonymous of the Lehigh Valley, Lehigh County Drug and Alcohol Abuse Services, National Institute of Alcohol Abuse and Alcoholism, Physicians' Health Program (for healthcare professionals), Substance Abuse and Mental Health Services Administration. Websites are listed below.

HOW TO APPROACH SOMEONE WHO'S USE WORRIES YOU

If you have concerns about alcohol use in someone else, first talk to your healthcare professional. When you feel ready, ask your loved one if they are willing to reduce or discontinue their alcohol use. If so, ask them to consider some of the suggested resources listed below.

Living with or loving someone with Alcohol Use Disorder is extremely stressful, especially if he or she is not willing to make changes or recognize risky drinking patterns. Remember to take care of your own needs and to confide in trusted friends and family members. You may also consider finding support in Pennsylvania Al-Anon/Alateen Family Groups. Try to be patient with someone who is trying to change his or her pattern of alcohol use. Change takes time and is much easier with support. ✚

WORKS CITED AND SUGGESTED RESOURCES:

https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5409a6.htm

https://www.drinkaware.co.uk/alcohol-facts/health-effects-of-alcohol/

https://www.niaaa.nih.gov/alcohol-health/alcohols-effects-body

https://www.rethinkingdrinking.niaaa.nih.gov/

American Society of Addiction Medicine (ASAM) *https://www.asam.org/*

Alcoholics Anonymous Lehigh Valley (AA) *https://www.aalv.org/*

Centers for Disease Control and Prevention (CDC): Alcohol and Public Health Homepage *https://www.cdc.gov/alcohol/index.htm*

Lehigh County Drug and Alcohol Abuse Services *https://www.lehighcounty.org/Departments/Human-Services/Drug-Alcohol*

National Institute of Alcohol Abuse and Alcoholism (NIAAA) *https://www.niaaa.nih.gov/*

Pennsylvania Al-Anon/Alateen Family Groups *https://pa-al-anon.org/*

Physicians' Health Program (PHP) *https://www.foundationpamedsoc.org/physicians-health-program/php-services*

Substance Abuse and Mental Health Services Administration (SAMHSA) *https://www.samhsa.gov/*

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HEALTHY AGING

In 2018, both Lehigh and Northampton counties were officially accepted into AARP's Age-Friendly Communities Network. The program, based on the AARP Livable Communities model, focuses on social inclusion for seniors. Isolation is more than being alone – it's the result of feeling detached physically or psychologically. More than 8 million adults age 50 and older are affected by isolation and 17 percent of adults age 65 and older are isolated. Sadly, the subjective feeling of loneliness increases the risk of early death by 26 percent. United Way of the Greater Lehigh Valley (UWGLV) aims to combat social isolation and connect seniors to their community.

In addition to preventing social isolation, allowing older people to stay involved in their communities has been found to have significant health benefits, including increased physical function, muscular strength, reduced symptoms of depression and pain, and an increased life expectancy. Recent research on home-based health programs suggests that aging in place can also yield potential cost savings at the individual, state, and federal levels. Individuals, families and communities benefit when seniors stay in their own home.

With the population of Lehigh Valley residents 65 years and older increasing by 10% over the past 4 years, today nearly 110,000 seniors are living in the Lehigh Valley.

COMMUNITY INITIATIVES COMBATTING SENIOR ISOLATION

UWGLV partnered with YWCA of Bethlehem and the Allentown Art Museum last year to host a Take a Senior Out event. Participants in the YWCA Adult Day Services program received transportation to the Allentown Art Museum and had private, guided tours of the exhibit Who Shot Sports: A Photographic History, 1843 to the Present. Following the tours, seniors enjoyed a healthy and delicious lunch at the Museum Café. "Take a Senior Out gave participating seniors an opportunity to spend time in their community, experience

an interesting art show and enjoy a fantastic lunch," said YWCA's Executive Director, Stephanie Hnatiw.

"This is the first in a series of events at local cultural institutions," explained Carmen Bell, Director, Healthy Aging, UWGLV. "The outings offer older adults an opportunity for fellowship with one another and unique experiences lessening the barriers of fear, anxiety, and safe travel." Future destinations include ArtsQuest and the Banana Factory.

Studies show that volunteering among older adults helps to reduce physical disability and loneliness, lower mortality rates, incidence of depression and risk of dementia, and can improve cognitive functions. Engagement helps keep older minds sharp!

With that in mind, UWGLV partnered with Big Brothers Big Sisters Lehigh Valley, Lehigh Valley Children's Center and Valley Youth House for the first annual Senior Day of Action. On President's Day, seniors had the opportunity to get out and lend a hand at area nonprofits through a variety of activities including room painting, arts and crafts, cleaning and organizing classrooms, and special event support. Older volunteers can share important life lessons and valuable experiences and volunteering provides seniors a sense of purpose and accomplishment. Older participants were joined by younger volunteers, including AmeriCorps VISTAS – young adults committed to giving back in their communities. The multi-generational experience benefitted all involved.

Senior Showcase is another step forward in UWGLV's Age-Friendly Lehigh Valley initiative. An engaged, fun day designed to promote healthy lifestyles for older adults through education, fitness and sports, seniors will participate in activities such as chair yoga, balance exercises and tai chi. "Still in the planning phase, Senior Showcase is another UWGLV and Age-Friendly Lehigh Valley approach to combate social isolation and connect older adults to not only one another but also their community," confirms Bell. "In addition, this event encourages healthy lifestyle choices."

UWGLV also works to initiate and provide funding for partner agencies that manage programs to keep seniors safe and healthy in their own homes. Programs include diabetes prevention and management, fall prevention, healthy eating and exercise, and access to healthy food.

Age-Friendly Lehigh Valley complements the work of the United Way's non-profit program providers through advocating (or curating) programs designed to lower the number of older adults suffering from social isolation and ageism as it works toward achieving a community-driven vision for our senior population.

Five years ahead of schedule, UWGLV recently met their Healthy Aging goal to increase the number of dependent seniors who are able to meet their at home basic needs by 50%. Through programs like Take a Senior Out, Senior Day of Action and Senior Showcase, UWGLV is working to keep seniors active and in step with the Age-Friendly initiative to create a community where older adults of all ages can stay active, engaged, and healthy with dignity and enjoyment. ✚

VISIT UNITEDWAYGLV.ORG/SEE-THE-IMPACT/HEALTHY-AGING
to learn more about the organization's healthy aging impact and Age-Friendly Lehigh Valley.

Mohs Micrographic Surgery

for the Treatment of Skin Cancer

BY MARC MITTON, DO, OLIVIA DAHLGREN, and CYNTHIA BARTUS, MD

Skin Cancer Basics

With roughly 3.5 million new cases each year, skin cancer is the most common type of cancer in the United States. It can affect anyone, anywhere, regardless of skin color. The three most common types of skin cancer are basal cell carcinoma, squamous cell carcinoma, and melanoma. One in five Americans will develop at least one of these three types of skin cancer by the age of seventy, and one person dies every hour from melanoma, the deadliest type of skin cancer.

Basal cell carcinoma (BCC) constitutes 80% of all diagnosed skin cancers and results in about 3,000 deaths each year in the U.S. BCCs tend to be slow growing and typically do not metastasize. The lesions most often appear as a pearly pink, non-healing wound on sun-exposed areas of the skin such as the ears, head, and shoulders.

Squamous cell carcinoma (SCC) is the second most common type of skin cancer. There are more than 1 million diagnoses each year in the U.S. Just like BCC, it can develop on sun-exposed areas, but may also develop elsewhere like mucous membranes and genitals. SCC can be identified as a rough, thick, scaly patch or bump or a wound that does not heal. Cutaneous squamous cell carcinoma has a higher propensity to metastasize than basal cell carcinoma, but this is still a rare occurrence.

Melanoma is the deadliest form of skin cancer. Despite constituting only 3% of skin cancer diagnoses, melanoma causes over 75% of skin-cancer related deaths. It originates in melanocytes, or pigment-producing cells that give eyes, skin, and hair their color. Melanomas may develop in a mole (and are often black or brown in color) or can imitate a mole with an unusual shape, color, or surface. These tumors can be found anywhere but are most common on the legs of women or the backs of men.

Limiting ultraviolet exposure is the most preventable way to reduce the incidence of skin cancer. This can be achieved by avoiding tanning beds, seeking shade during peak sun hours, applying generous amounts of sunscreen every two hours when outdoors, and wearing sun protective clothing. It is never too late to practice "safe sun." However, if or when a skin cancer develops, there are a number of successful treatment options.

Cure rates for all three types of skin cancer, including melanoma, are high with early detection and treatment. The treatment options available depend on the tumor size, location, type, and patient comorbidities. These options include curettage, excision, topical chemotherapy or immunotherapy, radiation, and Mohs micrographic surgery. For advanced disease, systemic immunotherapy or chemotherapy may be needed.

Treatment Focus: Mohs Micrographic Surgery

Originally developed by general surgeon Dr. Frederic Mohs, Mohs micrographic surgery, or Mohs surgery, has become the most efficient and advanced method for treating skin cancer. Initially known as microscopically-controlled chemosurgery in the 1930s, the surgery was performed with the use of a zinc chloride paste and subsequent excision of cancerous skin in stages over the course of several days. Over the years, the procedure has been refined significantly to the modern-day technique of full margin examination of fresh frozen tissue all on the same day. Most physicians who perform Mohs surgery today are board-certified dermatologists specially trained to perform the procedure through a post-residency fellowship. During the 1-2 year fellowship, the physician is trained to surgically remove the cancerous

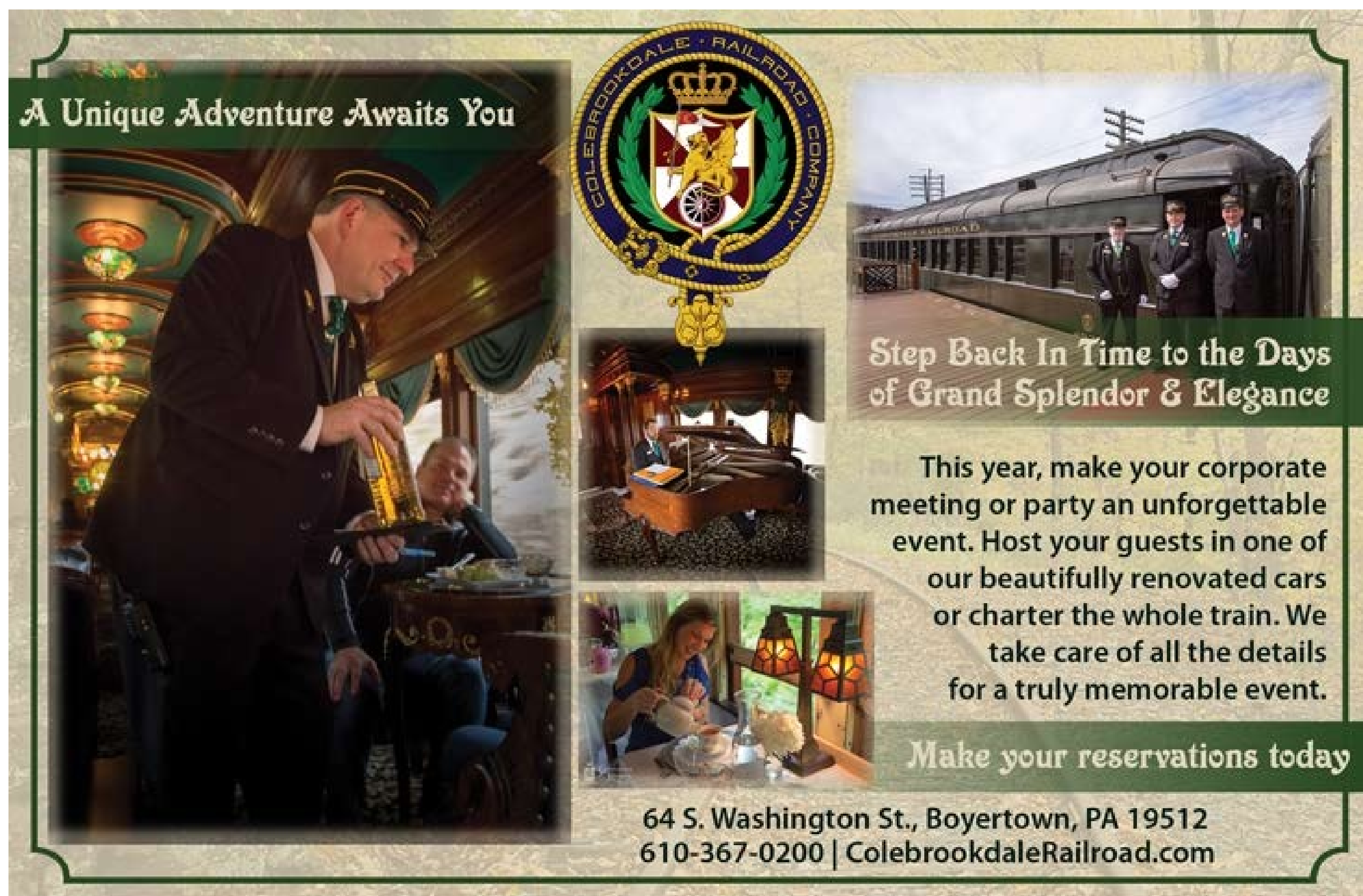
tissue, analyze the laboratory specimen, and surgically reconstruct the defect.

Mohs micrographic surgery differs from a standard skin cancer excision in multiple ways. After inspecting the lesion for its visible borders, the treatment area is anesthetized (local anesthesia) and removed with a scalpel angled specifically to aid tissue processing and allow for full examination of the resected margins. A temporary bandage is placed over the surgical site while the patient awaits the results. The specimen is cut into sections and the edges are inked in different colors. A map is drawn of the surgical site and the colored sections. In the on-site laboratory operated by trained histotechnicians, the specimen is frozen, sliced into extremely thin horizontal pieces, laid flat on microscope slides, and stained so the cells may be examined. Each of the original tissue sections is divided into multiple slices per slide, which the surgeon then evaluates for evidence of cancer at the deep or peripheral margins. If cancer is discovered, the area is marked on the map and the physician then removes another layer of skin specific to the location of the atypical cells. These steps are repeated until the margins are clear. The surgical wound can then be closed. Mohs surgeons are expertly trained to close both simple and complicated surgical wounds. They may perform primary closures, allow the wound to heal without stitches, utilize a flap of surrounding skin, or apply skin graft from another part of the body to aid in the closure. Some cases may require coordinated repair with other specialists such as an oculoplastic surgeon, hand surgeon, or plastic surgeon. In the vast majority of cases, the entirety of the procedure is completed during a single office visit over the course of a few hours.

Mohs surgery is an elegant and effective treatment for skin cancer. It is the gold standard for treating non-melanoma skin cancers (specifically basal cell carcinoma and squamous cell carcinoma) in functionally and cosmetically sensitive anatomic areas where tissue sparing is of utmost importance. Other indications for the use of Mohs micrographic surgery include larger lesions, aggressive cancer features or subtypes, indistinct clinical margins, or recurrent tumors. In cases where the criteria for Mohs surgery are not met, a conventional surgical excision still offers excellent cure rates with pleasing aesthetic results.

Mohs micrographic surgery offers efficient, cost-effective treatment (outpatient under local anesthesia with same day laboratory results), precise results (examination of entire tissue margins, sparing of healthy tissue), and the highest cure rates (94-99%). ✚

ADDITIONAL RESOURCES **www.skincancermohssurgery.org | Skincancer.org**



FEATURE

AMA, Pennsylvania Medical Society and Manatt Health Release First Study of Commonwealth's

EFFORTS TO REVERSE OPIOID EPIDEMIC

Spotlight analysis finds progress made on numerous fronts, recommends next steps for policymakers, insurers, and physicians

BY JEFF WIRICK
Pennsylvania Medical Society

The American Medical Association (AMA), Pennsylvania Medical Society (PAMED) and Manatt Health today released the first in a series of studies of state responses to the opioid epidemic. Focusing on Pennsylvania, the spotlight analysis found that considerable progress is being made to increase access to evidence-based treatment for substance use disorders and to increase oversight and enforcement of state parity laws governing mental health and substance use disorder.

In addition to the continued enforcement and refinement of tools to identify parity violations, the analysis highlights last month's landmark agreement between the governor's administration and the seven largest insurers in the state, fully removing prior authorization requirements for medication-assisted treatment (MAT) to treat substance use disorders.

"We conducted this analysis because it's essential that policymakers know what is working, and where additional progress can be made," said Patrice A. Harris, MD, MA, AMA president-elect and chair of the AMA Opioid Task Force. "There is a long way to go to fully end the epidemic in Pennsylvania and across the nation, but it's clear that Pennsylvania's policymakers are employing multiple strategies that are showing promise."

THE SPOTLIGHT ANALYSIS REVIEWED HOW WELL PENNSYLVANIA IS MAKING PROGRESS IN THREE MAIN AREAS:

1. **Increasing access to high-quality, evidence-based care for substance use disorder**
2. **Providing comprehensive care to patients with pain**
3. **Enhancing access to naloxone**

Based on available data, review of policies, and discussions with key policymakers, the spotlight analysis found that there were four key areas where the Commonwealth was succeeding:

- Comprehensive support for MAT, including removing administrative barriers and establishing 45 Centers of Excellence across the state to expand access to MAT, including mental and behavioral health care services;
- Enforcement of mental health and substance use disorder parity laws through market conduct examinations of health insurance companies;
- Comprehensive naloxone access policies, including a statewide standing order and stakeholder support for increased naloxone access has helped save thousands of lives from overdose in just the past two years; and
- Medically based oversight for Medicaid patients with careful review of care plans for patients with an opioid use disorder as well as for patients with chronic pain, including coverage of non-opioid prescription medications as well as alternative therapies such as physical therapy, occupational therapy and behavioral health services.

"We are pleased to see this study highlight the important progress Pennsylvania is making in our ongoing battle against the opioid crisis," Governor Tom Wolf said. "By expanding access to naloxone and medication-assisted treatment, among the many initiatives of our Opioid Command Center, we are rescuing more people and getting them into treatment and recovery."

"We have worked closely with the Wolf Administration and many other stakeholders for the past several years to ensure that policies have a public health and patient focus," said PAMED President Danae Powers, MD. "We look forward to continuing that close engagement to help make more progress."

The spotlight analysis also found areas where additional progress could be made: 1) In emergency departments and law enforcement by linking efforts to coordinate patients' access to high-quality, evidence-based treatment; 2) In insurer and state policies by examining them so they improve access to non-opioid pain care as well as requiring commercial insurers to post their formularies online, with clear designation of commonly used non-opioid pain alternatives, including non-pharmacologic options; and 3) In working collaboratively to further promote co-prescribing of naloxone to patients at risk of overdose.

"As a former insurance commissioner, we wanted to be sure that the recommendations contained in this report are practical and reasonable but also ambitious and commensurate with the challenge," said Joel Ario, a managing director at Manatt Health Strategies. "Now that so many states have enacted policies designed to reverse the opioid epidemic, it's critical that in-depth analysis of those policies be made available to policy makers." ✚

ABOUT THE AMERICAN MEDICAL ASSOCIATION:

The American Medical Association is the powerful ally and unifying voice for America's physicians, the patients they serve, and the promise of a healthier nation. The AMA attacks the dysfunction in health care by removing obstacles and burdens that interfere with patient care. It reimagines medical education, training, and lifelong learning for the digital age to help physicians grow at every stage of their careers, and it improves the health of the nation by confronting the increasing chronic disease burden. For more information, visit ama-assn.org.

ABOUT THE PENNSYLVANIA MEDICAL SOCIETY

The Pennsylvania Medical Society (PAMED) is a physician-led, member-driven organization representing all physicians and medical students throughout the state. We advocate for physicians and their patients, educate physicians through continuing medical education, and provide expert resources and guidance to help physicians and their organizations navigate challenges in today's ever-evolving health care system. To learn more, visit www.pamedsoc.org or follow us on Twitter at @PAMEDSociety.

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FULL REPORT VISIT END-OPIOID-EPIDEMIC.ORG/PENNSPOTLIGHT OR CONTACT:

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FEATURE

the Missing Piece of Our Health Care Toolkit

BY MEAGAN L. GREGA, MD, AND BONNIE COYLE, MD, MS

There is an epidemic of chronic disease in our country, the majority of which is largely preventable and reversible. These diseases affect millions of Americans, costing billions of dollars yearly for treatments that slow the progression of disease but do not address the root cause of illness. Our current trajectory is unsustainable. The Federal Congressional Budget Office warns that Medicare and Medicaid alone will account for 20% of GDP by 2050 and the CDC predicts that 2 out of 5 Americans will develop diabetes. Approximately 92 million Americans are currently living with coronary artery disease or the sequelae of stroke, with one American dying from cardiovascular disease every 40 seconds. Despite decades of concern and attempts at intervention, our adult obesity rate continues to rise, reaching greater than 39% of the population in 2015-2016; and our children are predicted to be the first generation to live shorter and less healthy lives than their parents.

The cost of health care in the US is reaching a crisis – we pay nearly twice as much per person as the next closest country. We spend an estimated $316 billion dollars every year treating cardiovascular disease and an additional $245 billion in diabetes-related costs. The annual cost of prescription medications for hypertension and hyperlipidemia is increasing at more than double the rate of total health care spending.

This expense might be warranted if we were achieving high levels of health status, but that is not the case. The US scores in the mediocre range on measures of morbidity and mortality when compared to many other countries who spend significantly less on health care. Our life expectancy is shorter, we have higher rates of chronic disease, higher rates of suicide and injury, and significantly worse behavioral health problems. Eighty percent of our health care costs are related to treating chronic diseases such as diabetes, heart disease, stroke, hypertension, cancer, COPD and mental health conditions. Research has demonstrated that 80% of these chronic diseases could be prevented if Americans followed four lifestyle behaviors - not smoking, maintaining a healthy weight, eating five or more servings of fruits and vegetables per day, and exercising for at least 30 minutes five or more times per week. Unfortunately, only 3% of Americans adhere to all four of these lifestyle behaviors.

To effectively curb the high cost of health care, we must treat the cause of health problems rather than just treating the symptoms with medications and procedures. Lifestyle Medicine addresses the triple aim of health care in the US – reduce cost, improve quality/outcomes and improve patient satisfaction. As value-based care becomes the standard in our country, lifestyle medicine is the transformative tool necessary to create true health system reform.

Lifestyle Medicine involves the use of evidence-based, therapeutic lifestyle modifications, such as a predominantly whole food, plant-based diet, regular physical activity, adequate sleep, stress management, avoidance of risky

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LEHIGH VALLEY LIFESTYLE MEDICINE SYMPOSIUM

Saturday, April 6

Kellyn Foundation (www.kellyn.org) and St. Luke's University Health Network (www.sluhn.org) are excited to announce the inaugural Lehigh Valley Lifestyle Medicine Symposium on April 6, 2019, entitled "Discontent is the First Necessity of Progress: Why Lifestyle Medicine is the Missing Piece of our Health Care Toolkit." This inspiring one day event, held at the Llantrisant Retreat and Wellness Center (www.llantrisantretreat.com), will feature nationally-renowned speakers; offering 7.25 CME credits along with delicious, plant-based food for the attendees. The goal is to introduce more members of our health care community to the science and transformative power of Lifestyle Medicine and to start building a cadre of clinicians willing to push forward with disease treatment reversal programs. Lectures will present current evidence for reversal of diabetes and cardiovascular disease, lifestyle medicine prescriptions, Food as Medicine, cultivating resilience, mindfulness stress reduction strategies and the return on investment for Lifestyle Medicine programs in a value-based healthcare environment. This event is intended for physicians, physician assistants, medical students, nurses, nurse practitioners, dieticians, behavioral health specialists, physical therapists, occupational therapists and interested members of the general public. The full speaker line-up and link for registration can be found at www.lvlifestylemedicine.org. We hope to see you there!

substance use, and other non-drug modalities, to prevent, treat, and reverse chronic disease.

Research demonstrates that intensive lifestyle medicine programs are not only clinically efficacious, but also provide an impressive return on investment. Shurney, et al. reported a 1.38:1 return on investment within a six-month period in employees with type 2 diabetes engaged in a comprehensive, workplace-based, lifestyle intervention; with 23.8% of participants able to eliminate one or more of their chronic medications. Savings generated from lifestyle medicine interventions delivered at the appropriate therapeutic dose are more than sufficient to cover the cost of administering the services.

The Department of Community Health and Preventive Medicine at St. Luke's University Health Network has been actively engaged in collaborative efforts to improve the health of our local community, utilizing lifestyle medicine initiatives as the primary strategy. As part of the Community Health Needs Assessment implementation plan, innovative community-based programs have been developed to promote physical activity, healthy diets, improved diabetes management, smoking cessation, mindfulness/stress reduction, and social connectedness. Medical students and family practice residents engage in these programs to expand the skill sets of our future providers.

New residency programs starting at St. Luke's Anderson Campus in summer 2019 will have a significant lifestyle medicine focus, involving residents in St. Luke's Fit for Life activities such as Get Your Tail on the Trail, Walk with a Doc, community supported agriculture programs, and the Healthy Kids, Bright Futures program. Residents will also benefit from extensive experiential learning opportunities via Kellyn Foundation programs such as: Healthy Neighborhood Immersion Initiative; school-based healthy lifestyle education and "Garden as a Classroom" programs; strategies tailored to improve access to nutrient-dense produce via the Eat Real Food Mobile Market and Lehigh Valley Corner Store Initiative; hands-on, plant-based cooking classes in community settings and intensive therapeutic lifestyle change interventions for individuals and families. Residents will be eligible to become board-certified in Lifestyle Medicine at the completion of their training, adding substantial expertise to our local community. ✚

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FEATURE

MENTAL ILLNESS

The New Dimension in Primary Care

BY MARK WENDLING, MD
Family Medicine Physician, Executive Director of Valley Preferred

The primary care physician has long been the starting point for many patients with mental health concerns. It's estimated that 20 percent of all visits to primary care physicians include at least one of the following mental health indicators: depression screening, counseling, a mental health diagnosis or reason for visit, psychotherapy, or provision of a psychotropic drug.*

The role of the PCP continues to expand, in part because value-based payment models support a more holistic approach to health care, with some requiring behavioral health screenings to receive shared savings. This article looks at why mental health and primary care continue to become intertwined, and the logical steps in a comprehensive approach to caring for patients with mental illness in the primary care setting.

Mental illness is a chronic disease. Patients with mental illness appropriately visit their PCP for a number of reasons. Among them: reduced stigma for patients and their families, improved access to care, treatment for comorbidities, improved prevention and detection, and improved follow-up. Some see their family doctor because they simply feel more comfortable talking about mental health with a provider they know, and who is trained to assist. The co-joining of mental health with primary care also correlates to an important outcome of clinical research: An acceptance of mental health disorders as chronic diseases much like diabetes or heart disease.

In my practice, I approach diagnosis without separation between physical and mental health, as the two can be so closely linked. For instance, patients who have had a heart attack and who have depression are twice as likely to have another cardiac event within two years. Author Frank deGruy III, MD, MSFM ("Primary Care: America's Health in a New Era," National Academies Press), puts it this way: "Systems of care that force the separation of 'mental' from 'physical' problems consign the clinicians in each arm of this dichotomy to a misconceived and incomplete clinical reality that produces duplication of effort, undermines comprehensiveness of care, hamstrings clinicians with incomplete data, and ensures that the patient cannot be completely understood."

How does the PCP assess mental illness? PCPs have ready access to evidence-based tools that make diagnosis of mental illness uncomplicated. Recommendations for behavioral health screenings in the PCP office have been generated by numerous entities, from national family medicine, internal medicine, pediatric, and obstetric organizations, to the U.S. Preventive Services Task Force (USPSTF).

According to the USPSTF, PCPs should screen all adults for depression, alcohol abuse, and drug abuse. Along with assessment, PCPs need to discuss mental health disorders with their patients, and if diagnosed, provide as much education on the condition as possible.

INDIVIDUALIZED TREATMENT AND SUSTAINED FOLLOW-UP

The ultimate goal of treatment under a PCP is to render the patient symptom-free and sustain that status for a period of time. The type of treatment recommended will be highly individualized, based on the patient's particular situation. Mild illness can be treated by the PCP alone, while moderate and severe illnesses usually require a multidisciplinary approach, such as with behavioral health counseling. It's up to the PCP to make certain there is appropriate diagnostic follow-up with a behavioral health clinician.

Among avenues for treatment are pharmaceutical and non-pharmaceutical; the latter including things patients can do to help themselves. If pharmaceuticals are determined to be helpful and appropriate, there are groups of medications available that are safe and effective without lots of side effects. I make certain patients understand their role in their own treatment plan, and the risks of not complying – for example, what will happen if they abruptly stop taking their medication. Data supports that not taking medication for the recommended period leads to a high relapse rate. Unfortunately, with every relapse, the disease gets harder to treat.

SEVERE ILLNESS AND CRISIS MANAGEMENT

If one of my patients shows signs of a psychotic illness such as schizophrenia, I will refer that patient to a psychiatrist. A lot of follow-up, possibly including an outpatient treatment program, will be required. Patients who are suicidal (anyone who says they are thinking of harming themselves) should be evaluated in a setting capable of managing this level of illness: Most of the time that means the hospital emergency department.

If a patient comes to my office and is suicidal, I will ask questions about intent: Have you thought about the method you will use? Have you thought about when and where? The more information offered about intent, the closer the patient usually is to realistically taking action. In this case, an immediate, emergency response is needed. Even if patients say they are thinking about suicide, they are emergent. Establishing a safety plan** is recommended. These patients need to be reassured, and the PCP must assist in getting them to a place where they can openly talk to someone who is trained on what to do.

PCPS AND FIGHTING THE STIGMA

As the primary care office continues to be a first stop for patients with mental health concerns, PCPs can be highly influential in outcomes. Screenings in primary care settings can improve quality of life, help contain health care costs, and reduce complications from co-occurring behavioral health and medical comorbidities.*** As PCPs emphasize the significant risk of stopping treatment prematurely, and reinforce the idea that with the appropriate treatment, the chance of recurrence is lower and the chances of comorbidities are lower.

Since a lot of mental illness can be treated by a PCP, it's important for patients to seek this relationship as well as with mental health providers. As PCPs assume the role of "first responder," we have an opportunity for even greater impact by helping to demystify mental illness in our culture. As we reinforce that mental illness is no different than any other chronic disease and provide follow-through on this premise, we can begin to erode the reluctance people have to seek treatment. ✚

**https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6347a6.htm (2010 data)*

*** A safety plan is a prioritized written list of coping strategies and sources of support that people who have been deemed to be at high risk for suicide can use before or during a crisis. The plan is brief, easy to read, and in the person's own words.*

****https://www.ncbi.nlm.nih.gov/pubmed/28948432*

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