

LEHIGH COUNTY

Health & Medicine

Official Publication of The Lehigh County Medical Society

Stop Spring Allergies BEFORE THEY START

plus

A HISTORY OF ALLERGY & ASTHMA

CATARACT SURGERY & NEW OPTICAL TECHNOLOGY

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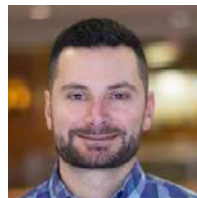
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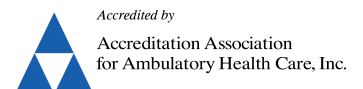
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Hello and welcome to the spring edition with *Lehigh County Health & Medicine*! We hope you made it safely through the winter. In this edition we discuss a range of topics including allergies, diabetes, measles, preeclampsia, and more.

First up, March gives us International Adolescent Health week, so please read on to learn more about it. March is also Save Your Vision Month, so take the time to learn about new developments in eye care, specifically for cataract surgery and diabetic retinopathy.

For many of us, spring is the start of allergy season. May is National Asthma and Allergy Awareness Month. We offer an article on the history of allergy and asthma. Check out the article on ways to stop the allergies before they start. May 22 is World Preeclampsia Day, so we have a timely article on Preeclampsia and Pregnancy. As mentioned in the article, heart disease in women is on the rise, including women in the age range of 35 to 54.

“Lessons learned from a Case of the Measles” points out how dangerous the disease can be and how much the public can be at risk. (Makes me glad I was vaccinated, otherwise I would be calling my doctor.) Lung cancer can be a deadly disease, but the survival rate is improving for those who are diagnosed with it. One of our articles discusses the importance for CT scans for smokers. If you are a smoker or know someone who is, please read this article.

You also will find an article from the United Way of the Greater Lehigh Valley (UWGLV) on making our residents who are 55 and over more aware of diabetes. Did you know that 50% of Americans over 65 are pre-diabetic?

We hope you enjoy this, and past issues, as we add to the conversation about how medicine and wellness can help us form strong communities in Lehigh County. If you are interested in back issues, or just want to read *Lehigh County Health & Medicine* online, please visit our website at <https://lcmehs.org/our-publication>. If you have ideas or suggestions for upcoming issues, please consider using the contact page on our website to submit it to us. Thank you for reading! +

FEATURE

A HISTORY OF **ALLERGY & ASTHMA**

By **WILLIAM A. TUFFIASH, MD,**
Past President of the PA Allergy & Asthma Assoc.
and Philadelphia Allergy Society
Current President of the Lehigh
County Medical Society

Asthma is a very ancient disease. It was first described by Hippocrates in the 5th Century B.C. He also believed that conditions existed where phlegm which originated in the brain flowed down to the lung via the nose. At the time of Julius Caesar in the 1st Century B.C., a Roman scholar wrote that very small animals grow in damp places, so tiny that they cannot be seen by the eye; floating in the air that we breathe, they pass through the nose and mouth into the body where they give rise to serious diseases. Celsus defined asthma as the inability to breathe without making noise. In the year 400 A.D., one of the Roman physicians stated that asthma should be treated by stays at the seaside. We now know that there is less mold in the air when at the beach since sand doesn't support the growth of mold. Ancient Romans also described food allergy with the following sentence: "What is normal food for some can be deadly poison for others."

The ancient Pharaoh Menes, who died in the year 2641 B.C. after the sting of a wasp, was regarded as the first documented case of anaphylaxis. A famous Middle Ages physician known as Maimonides became the personal physician to the Sultan Saladin (1135 to 1204). He wrote a thesis on asthma and presented a concept for treatment which included relaxation, personal hygiene, avoidance of noxious environmental influences, avoidance of opiates (which we now know cause direct histamine release) and intoxicating drugs. He recommended that asthmatics avoid poultry, milk and nuts, while he allowed salad, cauliflower and eggplant. He also wrote that the disorder known as asthma often starts with the common cold, especially in the rainy season, and the patient is forced to gasp for breath day and night.

There were no further advancements until the 1870s when Dr. Paul Ehrlich discovered mast cells, basophils and eosinophils in the tissues associated with pollen exposure. The phrase catarrh and asthma was described by Dr. William Heberden as early as 1802.

A major breakthrough came during the 1870s in England when Charles Blackley deliberately provoked symptoms of hay fever by self exposure to various pollens. He observed that dust stirred up by a passing carriage produced symptoms and that a sample of the dust contained grass pollen. He then applied pollen to his nose, eyes, tongue, lips and throat and inhaled the pollen through his nose and mouth. He also invented five devices for measuring pollens in the atmosphere and was able to study the effects of sunshine, rain, wind and humidity on the amount of pollen in the atmosphere. By the end of the 19th Century it was established that pollen was the cause of seasonal catarrh, although not until the 20th Century was it realized that mechanism was immunological rather than toxic. Dr. Henry Salter in 1860 appreciated the hereditary nature and the fact that there were many triggers for this such as exposure to horses, cats and other animals. The first allergy immunotherapy was started in London in 1911. The first scratch test was described in 1912. In 1908 the skin was tested by intracutaneous or intradermal injections and in 1930 by a puncture test which was a precursor of the prick test. Prick tests have been used since 1959. In 1915 a young physician from Holmdel, NJ named Robert Cooke (1880-1960) went to New York to study and had to drive horse-drawn ambulances. He became allergic to the horses and after that became interested in other allergic diseases. The term atopy was started by Dr. Arthur Coca and Dr. Robert Cooke.

Drs. Coca and Cooke founded the first Allergy Clinic at New York Hospital in February of 1919. It served as an outpatient service for the treatment of allergic individuals and also a center for research and training for allergists. Ironically, Dr. Cooke grew up in Holmdel, 3 miles down the road from where I grew up in a little town called Lincroft. In another ironic twist of fate, one of Dr. Cooke's students was a young man from upstate New York by the name of Dr. William Woodin. Dr. Woodin established the Allergy Clinic at Upstate Medical Center in Syracuse. It

was my attendance at that clinic during a pulmonary rotation where I first became interested and inspired to become an allergist. Allergy treatment has come a long way since all we had at first was the use of small doses of allergic material to immunize or build protective antibodies for allergy patients in 1911. The use of nebulized solutions did not occur until the late 1940s. At that time a glass bulb with a rubber squeeze bulb to atomize the material was used to administer isoproterenol. The use of corticosteroids in asthma did not occur until the 1950's. It was soon discovered that overuse of this drug could result in side effects such as diabetes, hypertension and obesity. No further major advances remain until the introduction of a combination of bronchodilator with inhaled steroids in 2001. This occurred shortly before the tragedy in New York on 9/11/2001.

Monoclonal antibodies for the treatment of asthma occurred around 2003. Since then four other monoclonal antibodies have been invented which have a beneficial effect on asthma. These must be injected at regular intervals and are extremely effective for patients' not responding to more simpler techniques of bronchodilation. Lastly, we are still using hyposensitization which was invented in 1911 to decrease patients reactivity to allergic phenomenon in the air. This is extremely important as it alters the cause of allergic rhinitis and asthma together.

If you are not responding to medications alone or have intolerable side effects to the medications, whether for asthma or allergic rhinitis, then it is time to consult an allergist. +



Stop Spring Allergies before they start

by ANDREW PESCOE, M.D.

Sniffing, sneezing, watery eyes, and congestion are just a few issues that allergy sufferers expect to deal with all season long. And if you don't get a head start on addressing your symptoms, you could be in for a long battle.

Seasonal allergies are caused by an over-reaction in the immune system. When you inhale allergy triggers, such as pollen or mold spores, your immune system mistakenly identifies these particles as harmful substances

and releases antibodies to neutralize the threat. These antibodies attach themselves to mast cells which release histamine, a chemical neurotransmitter that triggers allergy symptoms.

Controlling seasonal allergies often requires a multifaceted approach, and pre-treatment is a crucial step in this process. Pre-treating seasonal allergies turns on your body's defenses so it is already prepared to handle allergens. Pre-treatment also helps

prevent symptoms from compounding and becoming more difficult to treat.

THERE ARE SOME RULES TO FOLLOW WHEN PRE-TREATING SEASONAL ALLERGIES:

- Mometasone furoate (Nasonex) or fluticasone propionate (Flonase) are nasal steroid sprays that can be used in advance. These medications treat more allergy symptoms than other drug classes, but they take a month to reach full effectiveness. Begin using nasal steroid spray once daily beginning one month prior to allergy season.

- Oral antihistamines or antihistamine sprays or drops may also be used in advance, though they are not as effective as steroid sprays. Some antihistamines can cause drowsiness, making them a poor option for older adults at risk of falls.

- Decongestant sprays are only meant to be used for a few days and are not appropriate for pre-treatment. Decongestant pills may be used to prevent nasal congestion, but they are not safe for individuals with hypertension or heart problems.

ONCE THE ALLERGY SEASON STARTS, HERE ARE A FEW STEPS TO MINIMIZE YOUR SYMPTOMS:

- Saline nasal irrigation/lavage can help keep the nasal passages open, reduce post nasal drip and flush out pollens, mucous and debris. Lavage is performed in the comfort of your home and is well tolerated with minimal side effects.

- To minimize exposure to spring time pollens, it is best to keep the windows closed and keep the air conditioner on the “recirculate” setting. The “filter-only” setting can be used if it is not hot outside.

- Pollens can be tracked from the outside into your home from your shoes, clothes, hair and pets, so keep them clean. Washing your hair prior to laying down on your pillow for the night can be helpful. Avoid drying your laundry outside on a clothesline during the pollen season.

There are several treatment options that can help keep your allergy symptoms under control. Schedule an appointment with your doctor to discuss different therapies and develop a complete treatment plan that’s right for you. Taking preventive steps now will keep you breathing easy all season long (Source: Harvard Health). +

Dr. Andrew Pestcoe is a board certified Otorhinolaryngologist(ENT), who has treated allergies and diseases of the Ears, Nose and Throat for the past 30 years in the Lehigh Valley, Pennsylvania area .

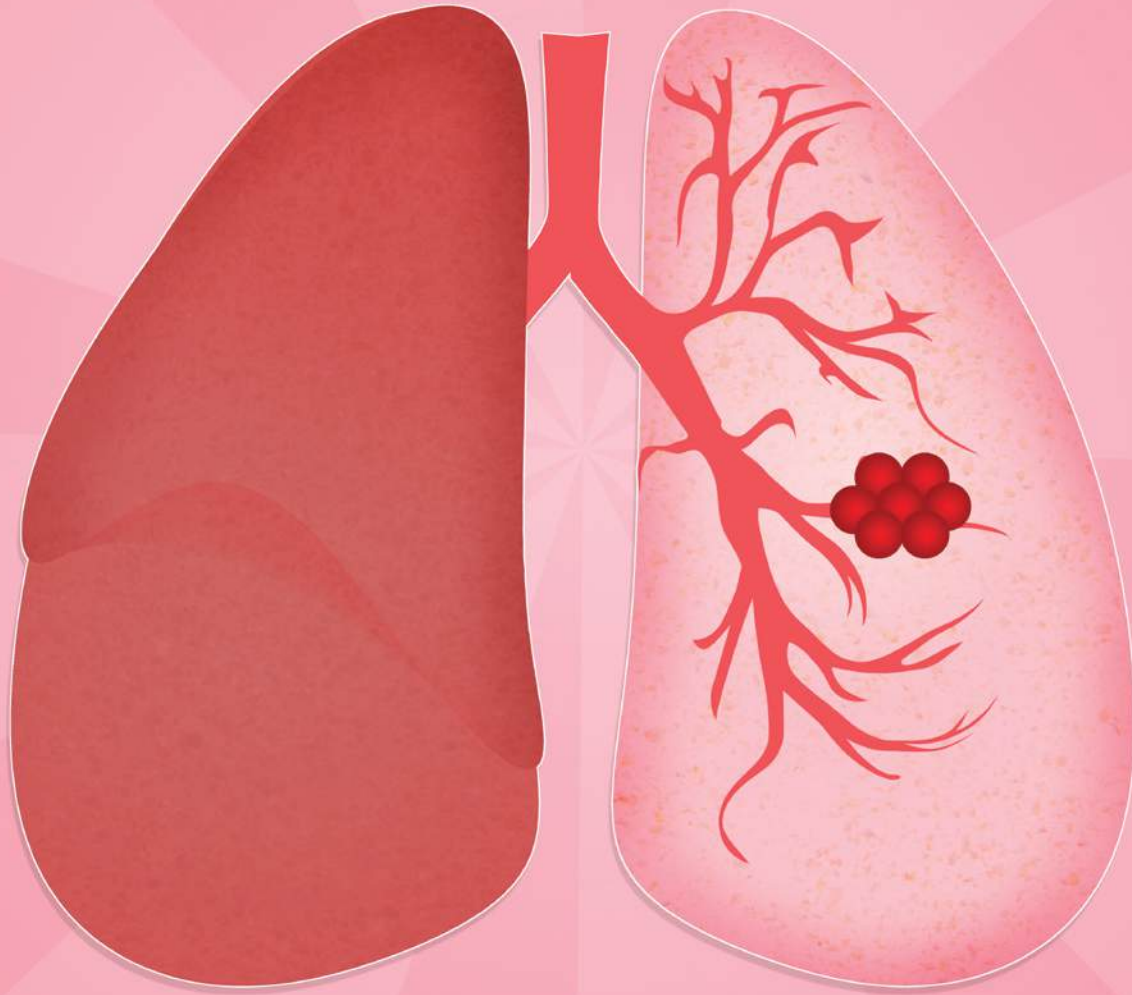
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Making progress against the world's *deadliest cancer*

By **ROBERT KRUKLITIS, MD,
PHD, MBA, FCCP**

The five-year survival rate for lung cancer is now 21.7%, up from 17.2% a decade ago. This is a dramatic 26% improvement over the past 10 years* ... and, along with declines in tobacco use, supports the lifesaving potential of lung cancer screening, which finds the disease at an early stage when it's more curable.

Lung cancer remains the leading cause of cancer deaths among both women and men, according to the American Cancer Society, even though the number of new lung cancer cases is decreasing. That trend has been attributed to the fact that more people are quitting smoking. The other impact has been medical technology's contribution to

early detection. In this latter category, we are seeing encouraging outcomes that could be made even better with increased awareness about the value of screening.

A SLOW ROAD TO DETECTION

Lung cancer is most often asymptomatic in its early stages, which leads to a delayed diagnosis. More than half of patients already have metastatic disease by the time the disease is diagnosed.** After studies showed that the cancer is curable, with a five-year survival rate at 56 percent for cases detected when the disease is still localized (within the lungs) according to the American Lung Association, early detection became of paramount interest for health care researchers and providers. Studies involving the chest x-ray as a scanning tool began in the 1960s, with a large randomized trial conducted in London. Trials in the United States followed in the 1970s at the National Cancer Institute, Memorial Sloan Kettering Cancer Center, and Johns Hopkins. The results were consistent for all of them: cumulative lung cancer incidence and mortality rates were similar between groups, showing no real benefit of chest radiographic screening for the disease.

By the late 1990s, computed tomography (CT) had been introduced and had evolved to the point of producing good images in the span of a single holding of the breath. Its next generation, low-dose CT (LDCT), provided an even better tool as it reduced radiation exposure (to 1.6 millisieverts), and offered high-resolution images of nodules as small as 0.5 cm to 1 cm. Studies that followed through institutions such as Mayo Clinic produced outcomes with LDCT that were far superior to the early attempts at detection with chest x-rays. The most convincing was the National Lung Screening Trial in 2011, which showed a 20% reduction in lung cancer mortality in patients who received LDCT. (Learn more at bit.ly/Lungtrial.) Based on the study, the U.S. Preventive Services Task Force made lung cancer screening with LDCT a public health recommendation in 2013.

LDCT SCREENING: JUST FOR HEAVY SMOKERS

When LDCT scans were introduced as a way to screen for lung cancer, there were some drawbacks. Since the screening itself does not detect cancer, but only nodules in the lungs, further testing needs to be done to determine whether the nodules are cancerous. The initial false-positive rate among patients, and the possibility of causing patients undue worry, gave many providers and institutions pause about wide scale LDCT screening. This led to development of guidelines as to which patients might be most helped; these are endorsed today by the U.S. Preventive Services Task Force, the American Cancer Society, and the Centers for Disease Control and Prevention (CDC), among others (see side bar).

The guidelines focus on heavy smokers. Although non-smokers can develop lung cancer, there is not enough evidence to know whether screening them would be helpful or harmful, according to the American Cancer Society. Statistics show that cigarette smoking is the number one risk factor for lung cancer. In the United States, cigarette smoking is linked to about 80% to 90% of lung cancer deaths as reported by the CDC.

COST STILL A FACTOR IN ACCESSIBILITY

Cost can be a significant detriment to LDCT screening. Patients initially had to bear the cost of the scan, averaging \$300, until major insurers and Medicare decided in 2015 to provide coverage for those patients who meet the guidelines above. However, according to the American College of Radiology, CMS has since slashed Medicare reimbursement to less than half the Medicare provider reimbursement for a mammogram. Such cuts have restricted the number of facilities financially able to provide scans, and have impacted the motivation for providers to recommend screenings.

Medicaid beneficiaries are disproportionately affected by lung cancer, yet standard Medicaid programs are one of the only health care payers not required to cover lung cancer screening. If screening is covered, Medicaid

programs may use different eligibility criteria, require prior authorization or charge individuals for their scans. As of January 2019, 31 state Medicaid fee-for-service programs covered lung cancer screening for those at high risk, 12 did not, and seven had no information available. In states where fee-for-service Medicaid plans covered screening, 4.8 percent of those at high risk had been screened, compared to 2.6 percent in states that did not cover screening.*

EDUCATION, PROGRAMS, AND FOLLOW-UP ARE KEY

While we have made progress, the majority of the estimated 8 million eligible Americans are not enrolled in a screening program.*** Lung cancer screening with low-dose CT scans has been recommended for those at high risk since 2013, but only 4.2 percent of those eligible were screened in 2018.*

These numbers suggest awareness is a formidable obstacle to early detection through screening. Much of the public does not understand the role of lung cancer screening, and CT scans for heavy smokers are not yet embedded in providers' work flows. A patient's primary care physician must approve an LDCT scan for a patient after a shared decision-making visit (unlike breast or colorectal screenings). This will only take place if the PCP is informed and aware of the value of the LDCT, and is willing to recommend the screening with equal encouragement to breast and colon cancer screens.

As more providers and health system administrators are exposed to the statistics, and recognize that today's tools can potentially detect lung cancer early with increased success, there is more movement toward promotion of LDCT as the lifesaver it can be. Many U.S. institutions have been taking steps to create programs and incorporate CT scans into their medical best practices. The same is occurring locally, such as at Lehigh Valley Health Network based in Lehigh County, where currently 20% of adults are smokers.****

Continued on page 12



WHO SHOULD GET A LOW-DOSE CT SCAN?

The U.S. Preventive Services Task Force recommends annual lung cancer screening if:

- You are 55 to 80 years old.
- And you have a smoking history of at least 30 pack years.
- And you still smoke, or you quit within the last 15 years.
- And you are in good health overall. (Having a serious health problem might mean that you couldn't have treatment for lung cancer. The treatment could be too high-risk, and it might not help you live longer.)

Here are actions that have made a difference across the country:

- Start a lung cancer screening program: hire a manager with buy-in from hospital administrators.
- Integrate smoking cessation education with screenings.
- Reach out to high-risk patients pro-actively through their PCPs.
- Engage in relationship building with referring physicians on a regular basis.
- Acquire or designate convenient screening locations within the hospital network (also a space where the radiologist can meet with patients to discuss findings).
- Have scans read centrally by subspecialty-trained radiologists.
- Discuss suspicious findings with a multidisciplinary group (radiology, thoracic surgery, thoracic pathology, interventional pulmonology, respiratory medicine, nuclear medicine, oncology, radiation therapy).
- Market LDCT within the hospital system and the community.
- Balance the cost of the screening with insurance reimbursement so that the cost to the patient is not overwhelming.
- Utilize a navigator to ensure proper order authorization and sign-off, schedule follow-up appointments, reach out to patients by phone, and report back to patients' referring physicians.
- Meet with medical practices that include heavy smokers on their patient panels.
- Promote education of both ordering physicians and patients, such as "Saved by the Scan" quiz from the American Lung Association. +

*<https://www.lung.org/assets/documents/research/ALA-SOLC-2019-Key-Findings.pdf>

** Oken MM, Hocking WG, Kvale PA. Screening by chest radiograph and lung cancer mortality: the prostate, lung, colorectal and ovarian (PLCO) randomized trial. *JAMA*. 2011;306:1865-73. <https://jamanetwork.com/journals/jama/fullarticle/11104579>

*** https://www.acr.org/-/media/ACR/Files/Case-Studies/In-Practice/Nov-2019_IM3_Pub.pdf?la=en

**** <https://www.countyhealthrankings.org/app/pennsylvania/2015/measure/factors/9/map>

YOU NEED TO EDUCATE YOURSELF

Empowering older adults to prevent
and manage Type 2 diabetes

By **LAURA MCHUGH**
United Way of the Greater Lehigh Valley

With a family history of diabetes, Annette Rodriguez of Bethlehem, PA, is determined not to let this chronic disease control her life.

“My paternal grandparents and father have died of diabetes complications. So, when I was diagnosed with pre-diabetes at the age of 40, I remember thinking, ‘I will not be a victim.’ It has not been an easy road, but I embrace the journey and focus on my goal to be healthy and free of diabetes,” said Annette.

Continued on page 14





More than a decade later, Annette's weekly routine involves healthy meals, several days of aquatic fitness classes at the gym and walking whenever the weather allows. The exercise particularly helps manage her stress levels.

"Most people with diabetes don't realize how important it is to keep their stress levels low. You can eat healthy and exercise every day but if you have high stress, your levels will run up and down like a rollercoaster. What I have learned during this journey, is that I am in control of my mind, body and spirit. I have done extensive research on what helps my body stay healthy and what causes my body harm. I have the tools I need to keep me healthy and happy. If you allow it, diabetes will control your life. You need to educate yourself and find ways to allow your body to heal itself the way it was meant to," added Annette.

Limiting saturated fats and staying active are keys to reducing blood-sugar levels and

managing diabetes, but not everyone has access to those resources or knows how to find them.

As volunteer Chair of the Diabetes Coalition of the Lehigh Valley, Annette works with Age-Friendly Lehigh Valley and United Way of the Greater Lehigh Valley to make sure all older adults living in the Greater Lehigh Valley can access the resources they need to prevent and manage diabetes, which affects one in four Americans over age 60. In fact, United Way recently extended diabetes prevention and management programs to adults age 55 and older.

"The Diabetes Coalition strives to lower the rate of diabetes in Lehigh, Northampton and Carbon counties. To do that, we have to make sure we're reaching at-risk adults before it's too late," said Carmen Bell, Director of Healthy Aging, United Way of the Greater Lehigh Valley.

Half of all Americans age 65 or older have pre-diabetes and are at risk for developing type 2 diabetes. According to the Centers for Disease Control and Prevention, there were a total of 1.7 million new total diabetes cases in 2012, and adults aged 45 to 64 were the most diagnosed age group for type 2 diabetes.

"With this shift to include seniors 55-plus, we can assure that we're not just managing diabetes after it's diagnosed, but working with seniors individually to change the lifestyle choices that can lead to diabetes later in life," added Bell.

To provide direct services to older adults, United Way has partnered with YWCA of Bethlehem, Hispanic Center Lehigh Valley, Casa Guadalupe Center, Lehigh Valley Active Life and Greater Valley YMCA.

"Statistics from the Centers for Disease Control and Prevention (CDC) show that 84 million people in the U.S. have pre-diabetes, up from 79 million people in 2010. Without weight loss and moderate physical activity, 15 to 30 percent of people with pre-diabetes will develop type 2 diabetes within five years," said Maribel Tandazo, Director of Pathway Development, Greater Valley YMCA. "Programs like the YMCA's Diabetes Prevention Program have been shown to prevent or delay new cases of type 2 diabetes by 58 percent and as much as 71 percent in adults over the age of 60."

In a community that's aging demographically, Bell says it's important that seniors understand that diabetes does not have to be a part of getting older.

"This is the time of our lives where we still feel young and vibrant and are able to keep ourselves moving by exercising and engaging in healthy activities. Keeping fit in our 50s will only benefit us as we mature into our 60s and 70s," added Annette. +

To learn more about Age-Friendly Lehigh Valley and the Diabetes Coalition of the Lehigh Valley, visit www.agefriendlylv.org.



CATARACT SURGERY AND NEW OPTICAL TECHNOLOGY

By DANIEL ROSS, MD

One of the most exciting advancements of cataract procedures available to medicine is the utilization of software, computer imaging, and laser technology to perform laser-assisted cataract surgery. This allows for better outcomes, fewer complications, and less likely to need glasses after cataract surgery.

A real-time laser image of the cataract is projected on a screen and the laser parameters are adjusted precisely to the individual geometry of the patient. These precise measurements are used to perform the incision in the cornea, make a perfectly circular opening in the anterior capsule then optically etching the cataract. This allows the surgeon to aspirate the cataract with very low phacoemulsification, sound wave energy power. By keeping the energy low and the incisions precise, this minimizes the common complications of traditional cataract surgery. Lower power will result in less corneal edema and avoid complications

Continued on page 16



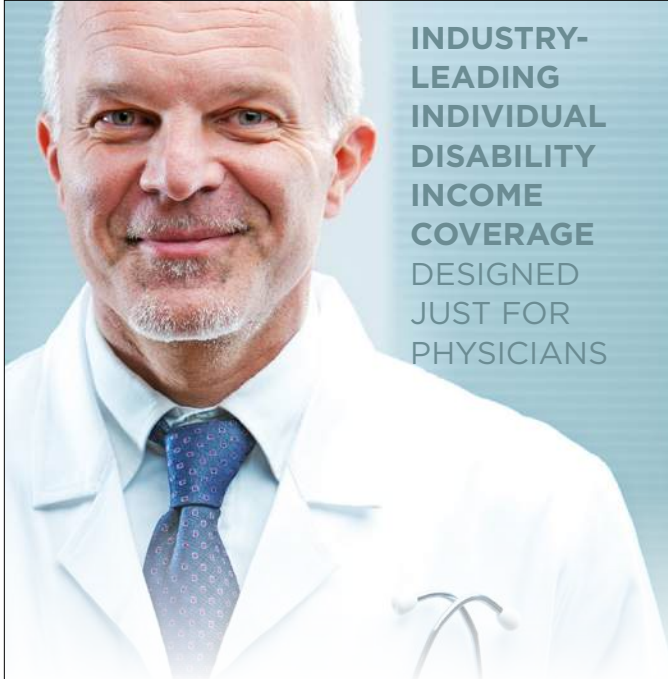
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FEATURE

of capsule extension and capsular tear. At the same time, the laser can make precise corneal incisions to correct astigmatism.

A second key component is the ORA (Intraoperative lens measurement). ORA is an infrared optical device mounted on the operating microscope. It measures the patient's lens implant power, intraoperatively, after the cataract is removed. ORA provides a more accurate measurement of the lens implant placed during the cataract procedure. In the past, it was a challenge to calculate the lens implant following LASIK. Now, ORA helps to more accurately calculate the lens implant.

A third key component is the availability of advanced technology lens implants. Lens implants are now available to allow for correction of distance vision, near-vision as well as astigmatism to allow for spectacle free function after cataract surgery. Traditional lens implants are only focused at one distance. PanOptix lens allows for distance, intermediate, and near correction as well as astigmatism. This may allow the patient to be far less dependent on glasses after cataract surgery.

DIABETIC RETINOPATHY

New therapies for Diabetic Retinopathy can greatly reduce the risk of blindness. A potentially blinding condition can be converted into a chronic care condition, a mainstay of medical control of blood sugar, blood pressure, weight, diet and exercise. New medications can prevent disease progression and, in many cases, cause disease regression. Below includes the most up to date treatments available.

Anti VEGF (Anti-Vascular Endothelial Growth Factor) medications such as Avastin, Lucentis, Eyelea are now available as therapy for all forms of Diabetic Retinopathy. The medications are administered in the office by intravitreal injection every 1-3 months.

Intravitreal steroids (Ozurdex, Iluvien, Retisert) are a second class of medication that may be used in conjunction with Anti VEGF medications listed above. These medications may last 3 months to 3 years depending on which one is used.

Surgical Posterior vitrectomy is a minimally invasive outpatient procedure, under sedation, using sutureless ports to access the vitreous cavity. Vitrectomy removes blood, removes scar tissue from the retina, repairs a detached retina, etc.

The above techniques have vastly improved patients' quality of life through improved vision. +



Piriformis Syndrome

by **ELISA GIUSTO D.O.**,
Family Medicine PGY-2

Piriformis syndrome is often overlooked in clinical settings since its presentation may be similar to that of lumbar radiculopathy, primary sacral dysfunction, or innominate dysfunction. It is estimated that at least 6% of patients who are diagnosed as having low back pain actually have piriformis syndrome. In as much as 96% of the population, the sciatic nerve exits the greater sciatic foramen deep along the inferior surface of the piriformis muscle while in as much as 22% of the population, the sciatic nerve pierces or splits the piriformis muscle predisposing these individuals to piriformis

Continued on page 18

syndrome. Entrapment of the sciatic nerve may develop following a piriformis muscle strain or trauma to the buttocks causing scarring and fibrosis around the nerve. During downhill running or sprinting, the piriformis muscle contracts and can cause similar issues leading to piriformis syndrome. The most common presenting symptom of piriformis syndrome is buttocks pain of gradual onset that increases with sitting for 15-20 minutes. The “wallet sign” is associated with piriformis syndrome and is when patients find they can no longer sit on their wallet without causing symptoms. Piriformis syndrome is however more common in women than men, possibly because of biomechanics associated with the wider quadriceps femoris muscle angle or “Q angle” in their pelvis. Piriformis syndrome occurs most frequently during the fourth and fifth decades of life and affects individuals of all occupations and activity levels.

The diagnosis of piriformis syndrome is considered when the classic signs of a lumbar radiculopathy elicited by provocative testing are absent, neurologic examination is normal, and other causes of gluteal and sacroiliac pain are ruled out. When examining a patient, a contracted piriformis muscle can be seen causing an externally rotated foot on the same side when the patient is relaxed in the supine position. Lasègue sign is localized pain when pressure is applied over the piriformis muscle and its tendon, especially when the hip is flexed at 90 degrees and the knee is extended. Freiberg’s test is localized pain with the hip in extension and internal rotation, and the patient resisting external rotation. Pace sign is localized pain when the patient is in a lateral recumbent position and the examiner internally rotates and adducts the hip by applying downward pressure to the knee. Ultrasound assessment of piriformis thickness and cross-sectional area may assist in diagnosis of piriformis syndrome. When necessary, imaging of the hip and pelvis can be obtained to rule out disc and vertebral pathologic conditions. Nerve conduction studies are rarely positive in piriformis syndrome, but can be useful for eliminating intervertebral disc herniation.

Early conservative treatment is the most effective treatment, with a majority of patients

PIRIFORMIS SYNDROME REHABILITATION EXERCISES

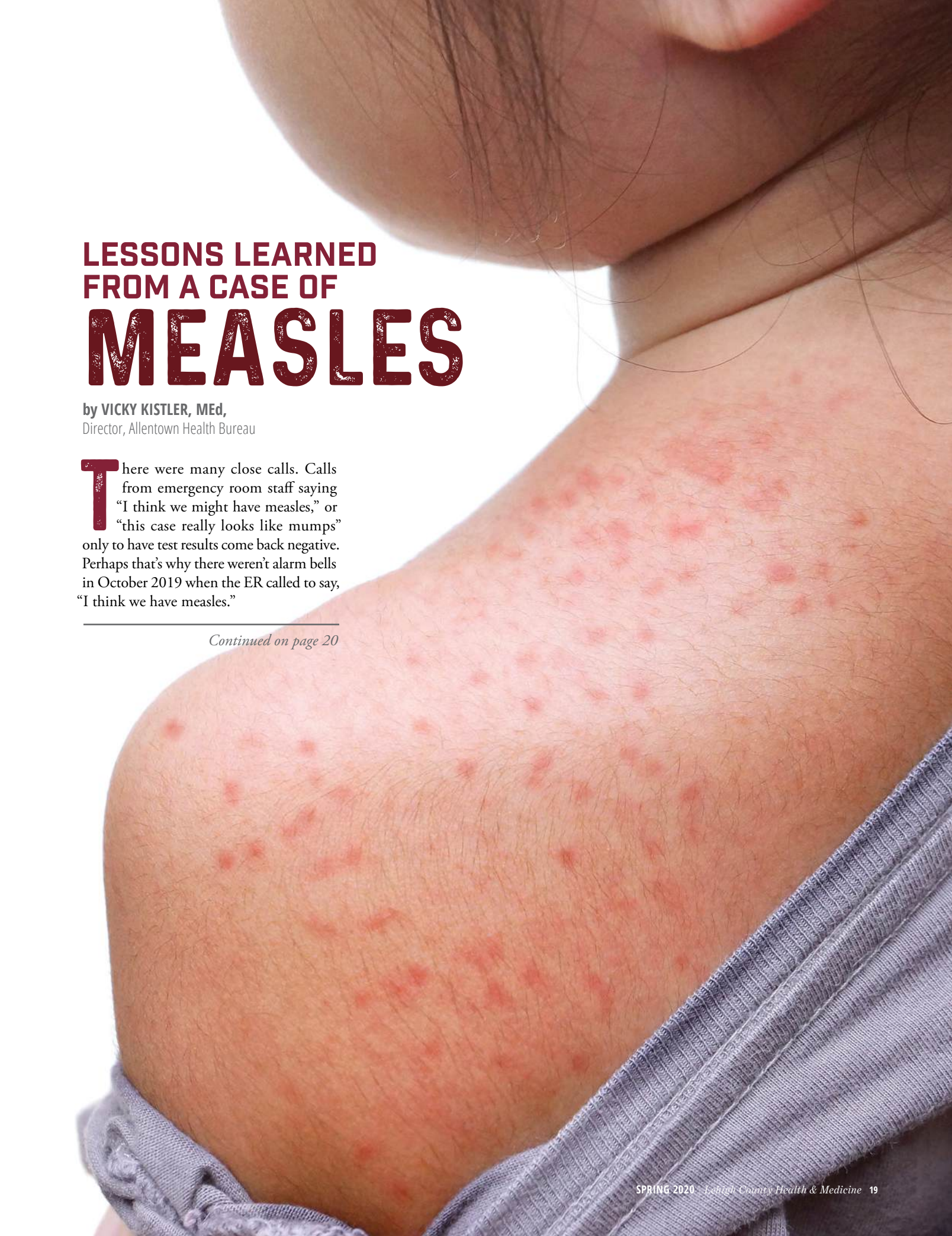


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with piriformis syndrome receiving symptom reduction with the use of nonsteroidal anti-inflammatory drugs, muscle relaxants, ice, and rest. Patients with piriformis syndrome may be treated with physical therapy involving a variety of motion exercises and stretching techniques involving strengthening of the pelvic and hip region. Ultrasound-guided glucocorticoid injections have been beneficial in some cases, and botulinum toxin injections have also been used. Surgery, typically a piriformis tenotomy, may be considered if symptoms are debilitating and persist despite conservative therapy. So while piriformis syndrome may be. +

SOURCES:

- https://www.uptodate.com/contents/approach-to-hip-and-groin-pain-in-the-athlete-and-active-adult?search=piriformis%20syndrome&source=search_result&selected-Title=1-29&usage_type=default&display_rank=1#H59287118 (information and first photo)
- https://www.summitmedicalgroup.com/library/adult_health/sma_piriformis_syndrome_exercises/ (second photo)
- <https://jaoa.org/article.aspx?articleid=2093614> (information)



LESSONS LEARNED FROM A CASE OF MEASLES

by VICKY KISTLER, MEd,
Director, Allentown Health Bureau

There were many close calls. Calls from emergency room staff saying “I think we might have measles,” or “this case really looks like mumps” only to have test results come back negative. Perhaps that’s why there weren’t alarm bells in October 2019 when the ER called to say, “I think we have measles.”

Continued on page 20

As details and travel history of the case became clear, the diagnosis seemed more and more plausible. Unvaccinated individual, recent travel to an area with Measles, symptoms perfectly matching the presentation for Measles, it was all falling into place and then just as the Phantoms were charging towards the goal, my cell rang and I heard the words I dreaded, “we have blood test confirmed measles.”

In my 27 years of working in public health I had not had a case of Measles in the city of Allentown, much less a case that had traveled and spent time in a busy emergency room. Measles being the highly contagious disease that it is was going to prove very interesting to contain, especially since there was still time to protect some of those who were exposed.

Thanks to the very quick action of a physician assistant, the case was isolated from other patients very quickly, minimizing the number of those directly exposed. In the absence of hard facts regarding air exchanges and HVAC systems, in discussion with the Pennsylvania Department of Health it was decided that the definition of exposed included anyone who came into airspace up to two hours after the index case. That significantly increased the numbers of potentially exposed considering time was spent locally at two outpatient laboratories, an employment site and the hospital waiting room.

Quick and efficient response by hospital employee health, hospital infection control, state public health staff and local public health staff resulted in rapid citizen notification which ultimately resulted in many receiving vaccination and/or titers for immunity. Almost from the start we learned many valuable lessons.

STORIES CHANGE

It is very difficult to remember exactly where you were several days before, not to mention exactly where you were at a point in time – and the time made all the difference in the world. Did you enter the lab at 2:00 pm or at 2:15 pm? The answer to that question could put you in or out of the exposed category and could alter

your movement for the next 21 days. We learned that thanks to technology – many of our movements have a time stamp. Many cellphones showed a message that you “checked in” at a particular time or a receipt showed the time you checked out. Despite many folks knowing exactly when they came and went, their receipts or logs said differently, putting them in or out of the exposed group.

GOOD RECORD KEEPING MATTERS

Although many had vivid memories of childhood vaccinations, they couldn’t prove it and if their titers showed a lack of immunity, they needed to isolate for 21 days. Most could remember their parents having a strong box or a shoe box with everyone’s important papers, but few knew what happened to those papers when a parent passed or downsized. Since few doctors’ offices were computerized many years ago, few doctors could produce records for patients over the age of 20 years. Each person exposed and born after 1957 needed to produce a vaccination record or show immunity by blood test. If they couldn’t, they were asked to isolate for 21 days in case they were incubating Measles.

MEDIA – FRIEND OR FOE?

The coverage by local media helped folks self-identify if they were part of the exposure. When the message went out regarding airspace and waiting room exposures, folks were easily able to gather information about relevant exposure times and the availability of testing/immunization. The media, however, failed to use its reach to drive home the point of the importance of immunizations. One unvaccinated person contracting Measles resulted in hundreds of known and probably hundreds more unknown exposures. People isolated for 21 days as a result of shared airspace and the inability to find records.

Luckily, there were no known secondary cases of Measles from this index case. Most of the closest contacts were fully vaccinated, helping to limit the spread. Swift post-exposure work took the necessary precautions since the numbers were in the hundreds but had there been many cases, the youngest and the oldest or the sickest in our community

could have paid the price. The public health system in Pennsylvania would have been ill prepared to handle even dozens of cases if each case had travel history and moved freely through crowded places.

MANY UNDERSTAND

The courts as well as many exposed individuals understood the importance of limiting the possible spread. Older individuals could recall people becoming very ill from Measles. Many even shared stories of serious complications from the disease in their own families. To those exposed it wasn’t just a childhood illness like the common cold. Many made personal sacrifices to protect others and encouraged others to get vaccinated and maintain up to date records.

It is my hope that the availability of electronic medical records and personal health portals will make future communicable disease investigations easier. Finding immunization records in the future should be far quicker and patients now have an active role in accessing their own documentation. The issue of thorough and timely vaccination though remains a challenge. Despite the widespread availability of sound research on vaccine safety, myths continue to thrive, and folks continue to decline vaccinating children at way too high a rate. We saw firsthand in Allentown how many can be impacted by one unvaccinated individual. We need the help of all clinicians, employers and individuals to stress the importance of vaccinations and to encourage those vaccinations through policy and education. Every one of these cases of disease which could have serious complications is preventable and vaccination is the answer. +

Vicky Kistler, MEd, has been the Health Director for the City of Allentown for the past 12 years. Previously she was the Communicable Disease Manager for 14 years. The Allentown Health Bureau has 37 staff and provides services to over 122,000 Allentown residents. Some programs extend into Lehigh and other counties as well.



Preeclampsia and Pregnancy

A Window into Future Cardiovascular Risk

By **PATRICIA MARAN, MD,**

Department of OBGYN, Generalist Division, Lehigh Valley Hospital

and **AMY AHNERT, MD,**

Co-Director of Women's Heart Program, Lehigh Valley Heart Institute

Heat disease is the leading cause of death for women. Although overall mortality from cardiovascular disease among women has been decreasing, alarming trends are being seen among young women. Heart disease is actually increasing in women ages 35-54 years and maternal mortality rates are also increasing. Cardiovascular disease is a significant contributor to maternal mortality. While we think of heart disease and cardiovascular risk in our older women, we need to start paying attention to diseases of pregnancy as a harbinger to future health risk factors.

Continued on page 22

PREECLAMPSIA foundation

Take Heart Take Care

Preeclampsia may lead to heart disease, stroke, and high blood pressure

Know the Facts

- 5% to 8%** One in Every 12 Pregnancies Preeclampsia (including eclampsia and HELLP syndrome) impacts 5% to 8% of all pregnancies
- 2x to 4x** Know Your High Risks Preeclampsia doubles your risk of heart disease and stroke, and quadruples your risk of high blood pressure later in life
- 2x** Heart Disease
- 2x** Stroke
- 4x** High Blood Pressure
- At higher risk...** If you have had preeclampsia and:
 - ✓ delivered pre-term
 - ✓ had low-birth weight babies
 - ✓ suffered from severe preeclampsia more than once
- 2 out of 3** women who experience preeclampsia will die from cardiovascular disease

Take Heart Take Care

You Can Lower Your Risk

A history of preeclampsia doesn't mean you'll definitely develop cardiovascular problems, especially if you take the higher risk to heart and make changes today for a healthier tomorrow

Every Year

- Talk to your healthcare provider within one year after delivery about monitoring your heart-health and blood vessels with extra care
- Get regularly evaluated and treated for cardiovascular risk factors: high blood pressure, blood sugar and cholesterol, obesity, and smoking
- Get adequate physical activity
- Stay at a healthy weight
- Talk to your doctor about taking low-dose aspirin
- Know your numbers for blood pressure, blood sugar, and cholesterol
- Adopt a heart-healthy lifestyle
- Eat a heart-healthy diet
- If you smoke, stop!
- Know your family health history

One of the fundamental diagnoses obstetricians confront on a daily basis is preeclampsia. Preeclampsia is a severe form of hypertension that affects 7% of pregnancies. While women throughout time have experienced preeclampsia, there is no definitively known reason why one woman over another develops this disease. What we know about preeclampsia is that it is associated with new onset hypertension during pregnancy. The disease does not follow an exact pattern, but the pregnant patient may present with vague symptoms of a headache or excessive swelling. While these symptoms may be part of normal pregnancy, in some cases they are a sign of underlying kidney compromise, lab abnormalities, bleeding problems, or neurologic disorders. Depending on the severity of the disease and rapidity of onset, the presenting sign may be an eclamptic seizure, cardiopulmonary collapse or a stroke. Ultimately the only way to abate the manifestation and severity of preeclampsia is to deliver the fetus, regardless of the gestational age.

One of the fundamental diagnoses obstetricians confront on a daily basis is preeclampsia

Preeclampsia also predisposes the woman to needing interventions for a vaginal delivery or an emergency cesarean section. As such, there are fetal and neonatal risks

that accompany a pregnant woman who develops preeclampsia, including poor fetal growth, decreased amniotic fluid reserves, placental compromise and premature delivery. The hypertension of the mother compromises blood flow to the placenta thereby restricting oxygen and nutritional reserves to the fetus. In fact, the newborn may require an extended stay in the neonatal ICU, which is especially difficult for families and something parents don't expect when they imagine the happiness surrounding the birth of a newborn.

Recent data has shown that adverse pregnancy outcomes such as preeclampsia increase a woman's risk of developing heart disease. Women with preeclampsia have an overall 2 fold increased risk of heart disease and stroke. They have a 4 fold increased risk of hypertension. Even the American Heart Association now recognizes preeclampsia, eclampsia, pregnancy-induced hypertension, and gestational diabetes as major risk factors for cardiovascular disease. Unfortunately, many providers and patients are not aware of this link.

The presence of preeclampsia provides an important opportunity for early detection of women at risk for cardiovascular disease. By educating health care professionals and patients about these novel risk factors, we can start to change these statistics. It is imperative that a woman's pregnancy history becomes a part of her documented medical history. Through careful monitoring, aggressive lifestyle modifications and appropriate treatments we can lower a woman's risk of heart disease. +



New Pediatric Intensive Care Unit *Opening Early 2020*

St. Luke's University Health Network is opening an eight-bed Pediatric Intensive Care Unit (PICU) at St. Luke's University Hospital – Bethlehem. This new unit will allow your child to receive advanced care close to home when they need it. The PICU will be equipped with all the very latest technologies and will be staffed with pediatric critical care intensivists, available 24/7. St. Luke's pediatric intensivists and nurses are specially trained to be sensitive to the needs of children and teenagers who are experiencing critical illnesses or injuries.

The department's mission is to provide specialized, high-quality care to critically ill children and their families while continuing the St. Luke's tradition of delivering personalized and compassionate care close to home.

St. Luke's newly designed PICU offers spacious private rooms with homelike amenities for you and your child. Each patient room will have video game connectivity as well as books and toys for children. Children

will be able to request whatever food they like (as long as it's approved for their diet) and will be able to keep snacks or food from home in our in-room refrigerators. St. Luke's provides pet therapy for critically ill children, as well as guest appearances from our favorite clown!

Each room has a sofa so parents can stay overnight, an area for families to charge devices and work in the room, and a separate TV allowing you time to disconnect and rest while your child recovers. A washer and dryer are also available on the unit if needed. Private bathrooms with showers in each room will be available if you want to stay at the hospital.

In addition, for your peace of mind and better clinical care, our nurses are positioned outside of your child's room, so they have the ability to closely monitor your child. For your child's safety, our unit will be locked at all times. +

A close-up photograph of a silver stethoscope and a wooden gavel resting on a wooden surface. The stethoscope is in the upper left, and the gavel is in the lower right. The background is a warm, textured wood grain.

FEATURE

PA Legislative Agency Releases
**STUDY ON IMPACT OF
VENUE FOR MEDICAL
LIABILITY ACTIONS**

By PA Medical Society

A Senate resolution passed in February 2019 directed the Pa. Legislative Budget and Finance Committee (LBFC) to study the impact of venue for medical professional liability actions. The LBFC's study was released on Feb. 3, 2020.

The state's current venue rule, in effect since 2003, provides that a medical professional liability action may be brought against a health care provider only in the county in which the cause of action arose. The current rule was implemented as one part of the state's medical liability tort reforms in 2002-2003.

The Pa. Supreme Court's Civil Procedural Rules Committee is proposing a rule that would significantly expand potential venues.

PAMED REACTION TO THE LBFC VENUE REPORT

The Pennsylvania Coalition for Civil Justice Reform (PCCJR), of which The Pennsylvania Medical Society (PAMED) is a founding member, strongly opposes any change to the current medical liability venue rule. While the group is still analyzing the report, its preliminary review finds that the LBFC report does not support efforts to change the current rule.

"A return to old rules would have profound, real-world consequences on the delivery of health care in Pennsylvania, including increased liability premiums for doctors and hospitals, which in return will impact the

availability of health care services for people who need them," PCCJR and the coalition said in a statement released on Feb. 3.

HIGHLIGHTS FROM THE VENUE REPORT

The LBFC looked at venue from the time period of 1996 through 2018. The study did not reach a definitive conclusion on the impact of the 2003 venue rule.

REPORT HIGHLIGHTS INCLUDE:

- The cost of medical professional liability insurance in Pa. increased significantly from 1996 to its peak around 2007, before decreasing.
- The LBFC acknowledged that a change in the venue rule, coupled with the regionalization of hospital services, would likely have a destabilizing effect on the insurance market, at least in the short term, as insurers will likely have a more difficult time predicting costs.
- The number of medical malpractice filings has decreased by 44.9 percent between the period of 2000-2002 and 2015-2017.
- Compensation for injuries from medical negligence by physicians decreased by 13.7 percent from 2003 to 2018.
- LBFC was unable to reach a conclusion on the impact of venue on patient access to health care. It noted that access to care involves many different variables including health insurance coverage and geographic locations.

WHAT'S NEXT?

During the LBFC's public meeting on Monday, Senator Lisa Baker, a member of LBFC and Chair of the Senate Judiciary Committee, commented that further consideration of the topic may be warranted suggesting the possibility of a public hearing. Additionally, we will work with our PCCJR partners to analyze and respond to the LBFC's report.

Stay vigilant by watching our venue webpage at www.pamedsoc.org/venue-rule for more information and next steps.

In early 2019, when we mobilized our members and other stakeholders to send their comments to the Pa. Supreme Court's Civil Procedural Rules Committee that is proposing this change, nearly 2,600 people responded. If more action is needed, can we count on you? +



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MARCH

Colorectal Cancer Awareness Month

APRIL

Autism Awareness Month

Alcohol Awareness Month

National Face Protection Month

Sports Eye Safety Awareness Month

National Sleep Awareness Week (last week of the month)

World Immunization Week (last week of month)

Sexual Assault and Prevention Month

Testicular Cancer Month

IBS Awareness Month

Child Abuse Prevention Month

Oral Cancer Month

MAY

Arthritis Awareness Month

Better Hearing and Speech Month

Food Allergy Action Month

Healthy Vision Month

Hepatitis Awareness Month

Melanoma/Skin Cancer Detection and Prevention Month

Mental Health Month

National Asthma and Allergy Awareness Month

National Teen Pregnancy Prevention Month

National Physical Fitness and Sports Month

National Stroke Awareness Month

National Osteoporosis Month

DIRECT PRIMARY CARE

Preserving the Patient-Physician Relationship



A new model of primary care is emerging in Pennsylvania and across the country.

It's called Direct Primary Care (DPC), and it's being fueled by independent physicians opening small, private practices. DPC is an innovative, patient-centric, value-based form of healthcare delivery, bringing back distant memories – for those who remember – of the “old-fashioned” family doctor.

This grassroots, physician-led medical movement began over a decade ago, with a spike in the number of practices opening during the past 2-3 years. Independent DPC physicians innovate and respond to the needs of patients who find our current healthcare system broken, expensive and inefficient. DPC physicians do not participate with insurance. This allows DPC physicians to eliminate the red tape, and the middlemen, from the exam room. The results are lowered overhead costs, with savings being passed onto patients. DPC is lowering the cost of primary care while giving physicians more time with their patients to focus on patients' medical issues. Over 1000 practices across the country are providing patients with increased access, attention and affordability. This makes DPC a truly, patient-centric option.

As a subscription-based model (think Netflix or Costco), DPC charges a periodic medical service fee which includes a wide range of primary care services. DPC costs less than a monthly cable or cell phone bill, and eliminates the need for co-pays, co-insurance, and deductibles. Fees range from \$19-\$100 per month, usually age-based, with regional and market variations seen between offices.

While not a substitute for health insurance which covers expenses outside of the scope of primary care, or for catastrophic issue(s), High Deductible Health Plans, employer-sponsored plans, health sharing, and short-term plans all pair well with DPC. Employer groups, in particular, are realizing significant savings and are seeking DPC arrangements with employer-sponsored plans. Medicare and Medicaid patients also find value and join DPC practices. The uninsured are finding DPC which can help them get affordable primary care.

All services are transparently explained in Patient Agreements which patients sign when they join a DPC office. Value-added benefits include:

- deeply discounted prices for laboratory tests
- deeply discounted prices for radiology studies

- generic medications dispensed from the office at near wholesale cost
- same day/next day acute/sick appointments
- prolonged appointments, averaging between 30-60 minutes to discuss multiple medical issues
- the physician's direct email address and cell phone number for after-hours urgent access (most insurances charge extra for this service)
- unrestricted office visits
- joint injections
- nebulizer treatments
- spirometry
- skin lesion removal
- suturing
- EKGs
- pulse oximetry
- rapid strep tests
- urine dips

DPC physicians work hard to keep patients out of the ER/Urgent Care/hospital. Imagine the efficiency and convenience of talking to your own personal physician who knows you and your medical history when needed after office hours - and then get seen the next day in the office if necessary, all for no extra cost. Direct Primary Care is changing the delivery of primary care by providing affordability, access, and attention to patients.

The Pennsylvania Direct Primary Care Association® is a non-profit organization dedicated to representing all independent DPC offices in Pennsylvania. This year, the organization was the proud recipient of the Pennsylvania Medical Society's first annual Practice Innovation Grant to educate about the affordable, attentive, and accessible medical care provided to patients of independent DPC offices.



**PENNSYLVANIA
DIRECT PRIMARY CARE
ASSOCIATION**

If you are a patient, employee or employer and want to learn more about DPC, please reach out to any of the DPC physicians listed on the website of the Pennsylvania Direct Primary Care Association® <https://padpca.com>.

Chelsea C. Giagni wins

**2019-2020
HUMANENESS
IN MEDICINE
AWARD**

from

**LEHIGH
COUNTY MEDICAL
SOCIETY**

LCMS is proud to announce Chelsea Giagni, MD – currently a resident with the Lehigh Valley Health Network Obstetrics and Gynecology Division – is the 2019-2020 recipient of the Humaneness in Medicine Award. This award is presented to a Lehigh County medical resident or fellow who has best displayed the ideals of outstanding compassion in the delivery of care, respect for patients, their families, and health care colleagues, as well as demonstrated clinical excellence.

In describing her reason for nominating Dr. Giagni, Dr. Joanne Quinones, MD, MSCE, Associate Professor of Clinician Education Pathways at the University of South Florida College of Medicine, Lehigh Valley Campus, said: “What struck me since meeting her early in her training was her sincere desire to help her patients, not only completing the tasks necessary to complete the medical evaluation of the patient, but also understanding her patient’s background and social situation which highlighted what needed attention from all the medical team members.”

Dr. Quinones shared examples of how Dr. Giagni goes above and beyond to build relationships with her patients, gaining their trust to help her patients stay on track with their treatment and well care.

Dr. Giagni has spent her time and energy – in addition to her regular care delivery responsibilities – following up personally with young female patients who have had challenging deliveries and complicated courses of care. Gaining trust through patience, persistence and personal outreach, she has enabled women to re-enter the care delivery system, allowing patients to receive improved care as well as the care necessary for their newborns.

Located in Allentown, PA, LCMS represents physicians of all specialties on local issues. In coordination with the Pennsylvania Medical Society, LCMS also works to address health issues at the state capitol. +

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LCMS NEWS

NEW MEMBERS

Abdul Aleem, MD (GE – Resident)
Joshua A Bemporad, MD (NRN)
Suryanarayana Reddy Challa, MD (Resident)
Pamela H Chin, MD (EM)
Andrew Ryan Clark, MD (P)
Jessica Davis, DO (Resident)
Francis Samuel Distefano, II, DO (IM)
Milena Goldshmidt, MD (P)
Mary Catherine Stock Keister, MD (FM)
Suha F Khalifa, MD (FM)
David A Kohan, DO (AN)
Anthony G Messina, MD (AN-Retired)
Antoine Jacques Panossian, MD (OFS)

Laura B Roper, MD (EM)
Jennifer Ann Sadowski, DO (EM-Resident)
Shane Swink, DO (D – Resident)

RE-INSTATED MEMBERS

Elizabeth Anne Flodin, DO (OBG)
Margaret L Hoffman-Terry, MD (ID)
Michael Maher Sidhom, MD (GS)
Daniel Paul Verges, MD (U)

CALENDAR ANNOUNCEMENTS

March 17, 2020

Recognizing and Responding to Children at Risk - Suspected Child Abuse & Neglect (SCAN) Education for Physicians, SCAN is a program of the PA Chapter, American Academy of Pediatrics and is approved for Act 31

April 18, 2020

Annual Lehigh County Medical Society Social meeting

May 7, 2020

Meeting with Dr. Lawrence R. John, vice president of PAMED, speaking on physician wellness

Please see our website, lcmedsoc.org, for more information.

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Jack Smith, MD

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Virginia Commonwealth University Hospital

Certifications

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Sympathetic nerve blocks • Nerve blocks with US guidance
Chemodeneration of nerves with RFA and/or neurolytics
Geniculate nerve RFA for post TKA pain and patients who are not candidates for TKA
Botox for migraines and spasticity • Occipital nerve blocks with US guidance
Spinal cord stimulation trials and implants • Peripheral nerve stimulation
Intrathecal pump management and implantation for primarily cancer pain
Trigger Point Injections • EMG/NCS



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Terrell, age 6, future doctor



St. Luke's Pediatric Intensive Care Unit NOW OPEN!

St. Luke's Pediatric Intensive Care Unit, the region's newest PICU, provides advanced, critical care for children close to home.

St. Luke's PICU offers home-like amenities for children and parents, including:

- Spacious, private rooms and bathrooms
- Couches for families to stay overnight
- Color-changing lights
- TV's, video game connectivity, books and toys



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