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SECD #277180: Travis County Medical Society Journal (ISSN 1054-2597) is the official bi-monthly publication of the Travis County Medical Society and the Seventh District of Texas. Periodicals Postage Paid at Austin, Texas. Subscription price $2.00 per year to members.

Payment of annual membership dues entitles member to a subscription.

POSTMASTER: Send change of address notices to the Travis County Medical Society Journal; 4300 North Lamar Blvd, Austin, Texas 78756. Membership: 3,355
As I begin to compose this column, I am on a plane lifting off from Washington, DC after spending three days speaking to Texas representatives and attending the AMA National Advocacy Conference.

My first trip to our nation’s capital was over 20 years ago to visit with then Central Texas Congressman Jake Pickle about medicine’s issues. I have been back numerous times since, both with organized medicine and on my own volition, to speak about issues that affect our profession and our patients’ access to care. There has been a definite evolution of attitudes on Capitol Hill over these many years. During my first call to Congressman Pickle’s office, I was told that no changes would be made in federal medical policies until they heard complaints from patients. At that time, physicians did not have enough political cachet for their concerns to make a difference.

Today, however, our recent visit to the Hill occurred in the context of a much more open and concerned environment in Washington. Politicians have become a part of medical care and they appear more concerned about our issues. Since federal dollars pay for at least 50 percent of medical care in our own country, it was inevitable that regulation of medicine would occur. Every congressional office visited was concerned about the future of medical care for Americans and were willing to hear the physicians’ point of view. Now, more than ever, it is important for each of us to communicate with elected officials and to let them know our opinions – both the good and the bad – regarding health care policies.

It is easy to become cynical about the increasing governmental regulation and control placed on our profession. But I believe, for the most part, it is being enacted by men and women who are sincere about problem solving and doing the most good they can for the most people possible with the resources they have. I also believe medicine has not been as successful as we would have liked because physicians haven’t been as involved in the political process as our opponents have been. You may see the large lobby brigades and large dollar amounts used to advance agendas adverse to our profession as being insurmountable, and that may have been true in the past. But now, all Americans will be affected by the government’s involvement in medical care and, in my opinion, this change will make the monied interests less powerful. At the end of the day, votes matter more to politicians than money.

This is why it is critical that all physicians become politically active in whatever manner is comfortable for you. Get to know your local, state and/or federal officials – each one would welcome your point of view on medical issues. Make an appointment to visit in their office, or simply send an email or a fax that respectfully states your views on an issue. Personally written correspondence will go much farther than form emails and letters generated from an organization as they are easy to spot by staffers and are not as effective. Whether visiting or writing, keep to no more than three issues and use patient stories to illustrate your point. In addition, consider donating to a PAC (there are many to choose from in medicine) since they can pool smaller dollars to have a large impact. Silence from our side will just about guarantee that those who don’t believe as you do will prevail.

I invite you to participate in First Tuesdays at the Capitol with other Texas physicians. Senior Director of Community and Government Relations Stephanie Triggs makes appointments for TCMS members to visit all of our area’s state officials. This “white coat” invasion has been very effective and one Tuesday out of your practice every other year can have a profound effect on the future of medical practice in Texas.

The day begins with an overview by TMA legislative staff on issues currently in play at the Capitol. Then we make the appointed rounds as a “tribe” so there is always another white coat to support you. This is one of the most effective TMA programs, and I believe it is as valuable as any equipment you buy or CME program you attend.

If you already know a legislator as a patient or friend, or if you care for any of their family members, consider holding a fundraiser for them. Raising money does matter to politicians, but for most, the opportunities these events provide for them to personally interact with constituents and get their input on issues of concern are more important.

We all have valuable points of view to express, and we have expertise in the practice of medicine that our politicians and bureaucrats need. If physicians don’t get involved personally and make our views known, organized medicine’s political action will not be as effective as it could be. We need all hands on deck to assure that medicine has a bright future.

I find it amazing that less than 250 years ago there was no United States of America. In the grand sweep of history that is a couple of blinks of the eye, yet in that brief period of time, our country has established itself as a beacon for the world and has provided much to many. There will always be more that can be done to perfect our union, but with each visit to Washington, DC, I am more in awe of what has been accomplished by imperfect human beings in the pursuit of a better life.
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Physicians working together always achieve more. This truth is at the core of the Travis County Medical Society and its group purchasing program.

While still a relatively young program, TCMS Group Purchasing is already providing members with great value. The program offers clinics the opportunity to access deeply discounted products and services that they already use on a daily basis. Prior to engaging with vendors, participating practices are assured of savings through an individualized “savings profile.”

Using just one approved vendor, a single physician practice is already saving in excess of $30,000 annually.

The program will only get stronger as additional vendors are brought into the fold and the base of participating clinics expands. The program is actively seeking additional quality vendors.

The purchasing program also aids TCMS by generating additional non-dues revenue utilized to support the TCMS mission.

“We have participated in the program since its beginning and have achieved significant savings through the group purchasing program.”

James Eskew, MD
Austin Ear, Nose & Throat Clinic

“My office has participated with the group purchasing program for many years. Currently, as various contracts expire, Central Texas Colon and Rectal Surgeons analyze and (in most cases) have found it beneficial to move to the vendors participating in the program. Not only have we enjoyed better pricing, but we seem to get better responses from these vendors with our service issues. One recent vendor, the Regional Extension Center, was particularly helpful in navigating successfully through the maze of Meaningful Use attestation.”

David Fleeger, MD
Central Texas Colon and Rectal Surgeons

For more information, visit www.tcms.com. To receive a no-obligation savings profile, contact Program Manager Steve Hinojosa at steveh@tcms.com or 512-358-4913.
On February 21, TCMS members gathered at the TMA Thompson Auditorium for an informative discussion on Accountable Care Organizations and the Affordable Care Act.

Happy 100th Birthday Dr. Kermit Fox!
Christopher Chenault, MD

On January 8, 2013, Kermit Fox, MD scampered across the end of his first century. He remains healthy and active and continues to enjoy several hobbies including writing, collecting and organizing his family’s history, reading, keeping up with his farm land and holding discussions with his friends at the Summit in Westlake.

He likes to remember the many changes that have occurred in his life since his birth in the old farmhouse, built of cedar planks in 1855, that is still partially standing. He was delivered by Dr. Suehs, who was the father of Oliver Suehs, MD, a classmate of Kermit’s in medical school, who later came to Austin to practice ENT. In 1913 the house had no running water, no electricity and no inside plumbing. They farmed entirely with horses until after Kermit left for college in 1930.

Kermit attended a one-room schoolhouse and completed his elementary schooling in seven years – speaking only German when he began. Only twelve when he started high school, he spent two years at junior college and one year at UT followed by medical school in Galveston.

Dr. Fox met a nurse, Jewel, who was caring for his ailing father and they were married in 1940, the same year he was activated into the Army. While in practice in Bryan/College station he had taken correspondence courses that elevated his rank to Captain. When assigned to Alaska, he became the head of a 150-bed hospital because of his rank. Since he knew something about managing a farm they thought he could manage the hospital. During those years he and Jewel had two children.

He came to Austin in 1948 to start the Austin Bone and Joint Clinic with fellow resident Larry Griffin, MD. Perhaps a first in Austin, they took call for each other so that even if someone asked for Dr. Fox, they might get Dr. Griffin.

Performing surgeries in outlying towns, they carried almost all of their instruments with them. Starting a bone bank in the early 1950s, they harvested bone, kept it frozen and sterile and had no complications. Dr. Fox practiced 37 years with the clinic, performed the first total hip arthroplasty in Austin, perhaps the first total knee arthroplasty and set a standard of excellence in orthopedic surgery.

He celebrated his 100th birthday by calling the medical school to find that he and Mavis Kelsey, founder of the Kelsey-Seybold clinic in Houston, are the only surviving members of his class. He also had cake with his friends and family.
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The Department of State Health Services (DSHS) has posted the Texas Notifiable Conditions for 2013 at www.dshs.state.tx.us/idcu/investigation/conditions. Chagas disease, also referred to as American trypanosomiasis, is now a reportable condition in Texas.

Chagas disease is named after the Brazilian physician, Carlos Chagas, who discovered it in 1909. Chagas is caused by the parasite trypanosome cruzi and is transmitted to animals and people by insect vectors. If infected with the T. cruzi parasite, triatomine bugs (also called reduviid bugs, “kissing” bugs, assassin bugs, cone-nosed bugs and blood suckers) can transmit the parasite during blood meal. These bugs are present in Mexico, Central America, South America and the southern United States, including Texas. DSHS Health Service Region 7 has documented the presence of the parasite T. cruzi in the triatomine bugs in our area, as noted in the following preliminary data of Table 1.

Triatomine bugs can live indoors, in cracks and holes of substandard housing, but are more commonly found outdoors in a variety of settings. At this time, DSHS, in conjunction with the CDC, provides testing of triatomine bugs for the parasite T. cruzi. There currently is no charge for species identification and testing; due to workload and budget constraints, testing priority is given to direct implication in a human exposure. Not all submissions will be tested. Additional resources on triatomine bug testing can found at www.dshs.state.tx.us/idcu/health/zoonosis/Triatominae.

The most commonly thought of transmission mode for Chagas is vector-borne. The disease can also be acquired through blood transfusion, organ transplant and mother-to-baby (congenital transmission). Blood banks currently screen for Chagas disease. Donors are notified when positive testing is found, and the blood is discarded. The disease process has an incubation period of one to two weeks, acute phase of eight to 12 weeks, indeterminate phase can be years to decades long and chronic lifelong phase. In the acute phase, most patients are asymptomatic or mildly feverish, some display inflammation at the site of inoculation (chagoma) or unilateral swelling of eyelids (Romana’s sign). In rare instances, patients present with severe disease such as myocarditis, pericardial effusion and meningoencephalitis. Trypomastigotes, circulating in peripheral blood, can be seen. The early chronic stage or indeterminate phase is often asymptomatic and prolonged. During this period, few to no trypomastigotes are found in the blood. Chronic disease complications include cardiomyopathy, mega-esophagus, mega-colon and neurological symptoms in immune-compromised patients. Many people remain asymptomatic for life. However, it is estimated that 20-30 percent of infected people will develop debilitating and even life-threatening medical problems over the course of their lives.

Diagnosis of Chagas disease during the acute phase is by microscopic examination of the parasite in a blood smear. In the chronic phase, when there are clinical findings and evidence of exposure, diagnosis is generally made by testing with at least two different serological tests. Patient testing for Chagas is available through the CDC. Health care providers may call Parasitic Diseases at 404-718-4745, email chagas@cdc.gov or go to private laboratories for testing. Treatment for Chagas disease is recommended for acute infections, congenital infections, for those with suppressed immune systems and for children with chronic infections. Adults with chronic infection may benefit from treatment as well. In the United States, medication for Chagas is available only through the CDC. Health care providers can discuss with CDC staff whether and how to treat patients diagnosed with Chagas diseases.

Table 1: Triatomine bugs tested for T. cruzi parasite in Texas Health Service Region 7 Counties

<table>
<thead>
<tr>
<th>YEAR</th>
<th># TESTED</th>
<th>T.cruzi POSITIVE</th>
<th>%</th>
<th>COUNTIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>31</td>
<td>19</td>
<td>61%</td>
<td>Blanco (1), Caldwell (6), Fayette (2), Hays (5), Travis(5)</td>
</tr>
<tr>
<td>2011</td>
<td>18</td>
<td>10</td>
<td>56%</td>
<td>Caldwell (7), Fayette(2), Williamson (1)</td>
</tr>
<tr>
<td>2010</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Bosque (1)</td>
</tr>
</tbody>
</table>

Note: Individuals with possible exposure to the parasite were advised to seek a medical assessment and testing with their health care provider. Of those who sought testing, none tested positive for chagas disease.
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Rodney Schmidt, MD never imagined that in 2012 he would be taking the ride of his life on a sidecar motorcycle through northern China. During an 11-day trip, covering a total of 1,200 miles, Dr. Schmidt developed an unforeseen kinship with the beauty, people and history of the country.

The adventure began when paramedic colleagues John Horrall and Geoff Hughes peaked Dr. Schmidt’s curiosity with an invitation to follow the path of legendary Mongolian warrior Genghis Khan.

“After the initial trip proposition, I found myself taking a motorcycle riding class, which led to getting a license and eventually to buying a starter cycle. Before I knew it, I was packing my equipment and boarding a 12-hour flight to Beijing,” Dr. Schmidt recalled.

Once landing in Beijing, the three men were greeted by friendly trip coordinator Robbie Gilchrist, who treated his participants to fine Chinese cuisine and luxury private rooms for the night. “We almost forgot we were on a ‘cowboy’ adventure motorcycle trip,” Dr. Schmidt said.

The group boarded a flight to Manzhouli, China’s largest most northern city, early the next morning. Sticking out among the crowd of locals, the men arrived at their destination and were introduced to their new ride: Chang-Jiang 750cc sidecar motorcycles.

“We had about 30 minutes to practice and get used to handling the sidecars. We learned how to pack up our food and gear in the various compartments. Then, off we went,” Dr. Schmidt said.

The riders started their journey with a mere 100 kilometers “starter” ride, traversing the grasslands of Inner Mongolia, an autonomous province of China. They happened upon a beautiful herd of Mongolian horses before reaching their first campsite on the plains. There, they learned how to pitch their tents, unload gear and settled down to marvel at the exquisite sunset.

Upon rising, the troop faced a cold and cloudy morning, which turned into a threatening storm by midday. Opting to wait out the rain, they stopped for the night at a nearby town called New Barag Zuoqi. Luckily during the following two days, the men faced fair weather, good roads and beautiful sights of rolling Mongolian prairies with sheep, cattle and herds of wild horses.

The men moved out of the prairie and into the beautiful Ergun forest, filled with white barked birch trees and falling, golden-brown leaves of autumn. As the scenery changed, so did the roads, turning from smooth asphalt to bumpy, graveled paths with numerous potholes. Once they arrived safely at their destination, Dr. Schmidt, John and Geoff explored the town’s market and found an interesting shop that sold furs, jewelry and knives, among other souvenirs.

Dr. Schmidt said, “we managed to do some bargaining and wound up with some nice ivory-handled handmade Mongolian and Russian knives for ourselves, and some beautifully painted porcelain boxes for our spouses back at home.”

The group jumped back on their motorcycles and traveled south toward Xanadu, the summer palace site of Kublai Khan, Genghis Khan’s grandson and founder of China’s notable Yuan Dynasty. Xanadu achieved legendary status as a host to religious debates and
entertainment from foreign travelers, whose writings inspired others throughout centuries.

“The most visible modern day remnants are the mere earthen walls, but the past splendor of the well-designed, square-shaped city is still evident. It’s no wonder it flourished to a population of 100,000 citizens,” Dr. Schmidt explained. “We hated to leave Xanudu, but the lure of the Great Wall of China was calling.”

Just as the motorcycles were beginning to feel more comfortable, and the quality of the roads was significantly improving, the right tire of Geoff’s sidecar hit a particularly steep right shoulder, landing him upside down in an adjacent roadside ditch. Fortunately, Geoff was uninjured, but he was pinned underneath his motorcycle and couldn’t crawl out. The men gripped the rear of the cycle and pulled it up, allowing Geoff to scamper out. The incident occurred on a highway coursing through a small farming town, and all the excitement brought out the locals and their children, who crowded around, laughing and smiling amongst themselves about their strange visitors.

The men were once again on their way, riding through a beautiful mountain range as they neared the Great Wall of China. Through the curving roads, they reached their destination of the Jinshanling portion of the Great Wall. For the first time since their arrival in Beijing eight days earlier, the riders checked into a hotel. The following day, they rode a cable car from the Jinshanling base up to the Great Wall.

“It was very impressive, and easy to understand how for so long, it was not only a protective structure, but also a symbol of the power of the Chinese empire,” Dr. Schmidt reflected. “From its turrets and watchtowers, we imagined ourselves as archers shooting down on helpless invading enemies as they struggled to scale the uphill slopes surrounding the Wall.”

Ready to ride again, the men entered the Hebei Province, which surrounds the municipality of Beijing. Surviving horrible traffic and tolerating the city’s smog, they arrived at their final stop and headed to a victory dinner at an exclusive restaurant. For the last two days of their journey, the adventurers were on their own to explore Beijing, one of the most populous cities in the world and China’s capital.

The men took the opportunity to stop at the Beijing Harley-Davidson store, walk around the city and shop for souvenirs. They also braved the busy subways and set out for Tiananmen Square, where they visited their third World Heritage Site of the trip, the Forbidden City. There, the group marveled at the size of the old palaces and the traditional palatial architecture that was the center of Chinese rule and culture for almost 500 years.

As the trip came to a conclusion, the travelers reluctantly rode back to the Beijing airport for another 12-hour flight to the US.

“We really enjoyed ourselves and would recommend this trip to anyone looking for a great adventure,” Dr. Schmidt said.
The Travis County Medical Alliance “Swanky Affair” gala was held on January 26 at the beautiful home of Dr. John Hogg and Mr. David Garza.

Attendees enjoyed a night of fun and fundraising. Due to our generous sponsors, over $50,000 was raised to benefit the TCMA grant recipients.

All proceeds benefit the 2012-2013 Grant Recipients: Family Eldercare, Lifeworks, St. Louise House and Volunteer HealthCare Clinic.

Special thanks to Gala Chair Elaine Agatston and her committee, Vice President of Financial Development, Kimberly Chassay and Treasurer Tera Ferguson.

Upcoming Events
April 16 - 9:30 am
General Meeting and Awards Ceremony
Lady Bird Johnson Wildflower Center

April 21
TCMA/TCMS Spring Picnic
Mayfield Gardens
Join friends for a fun event for all ages.
More information to follow!

For more information about the Alliance visit our website at TCMAlliance.org, or contact Edie Finch at efinch@ediefinch.com.
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WHAT YOU NEED TO KNOW ABOUT CHIARI MALFORMATION

K. Michael Webb, MD

What is Chiari Malformation?
A Chiari Type I malformation occurs when the cerebellum protrudes through the opening in the skull where the spinal cord exits, which can cause increased pressure on the brain stem, spinal cord or cerebellum. It occurs in roughly one out of 1,000 births, more commonly in females. Even though Chiari malformation is present at birth, symptoms generally do not develop until adolescence or adulthood, and patients can go undiagnosed for years.

What are the Symptoms?
The symptoms of Chiari malformation vary from person to person, and can range from mild to severe or debilitating. Some people have no symptoms at all. The most common symptom is a severe headache, which is usually in the back of the head and can be brought on by straining, coughing, sneezing and laughing. Another common symptom is neck pain which radiates across the shoulders and down the spine.

Other symptoms include difficulty swallowing, trouble speaking or hoarseness, respiratory problems and sleep apnea, frequent urination and/or loss of bladder control, irritable bowel syndrome and/or lack of bowel control, weakness and stiffness in the arms and/or legs, numbness in the hands and/or feet and vertigo and/or trouble balancing.

Chiari malformation can also occasionally lead to syringomyelia, a disorder in which a cyst forms within the spinal cord, which can compress and damage the spinal cord, resulting in weakness or stiffness in the arms, legs and cause chronic, severe pain.

How is the Condition Diagnosed?
Anyone who consistently experiences any of the symptoms described here should receive a neurological examination, including a complete medical history and physical exam. The best diagnostic tool to date for detecting Chiari malformation is magnetic resonance imaging (MRI). Recent advances in MRI techniques, most notably the ability to measure the flow of cerebrospinal fluid (CSF), allow doctors to identify many cases that would otherwise go undiagnosed.

What is the Treatment?
Treatment options vary according to the severity of the disease. Many people who have Chiari malformation experience no symptoms at all and therefore require no treatment. Patients who complain of mild symptoms can sometimes be effectively treated with medication. However, medication can only relieve the symptoms and does not correct the problem.

If the symptoms are severe and debilitating, affecting the patient’s overall quality of life or neurologic function, surgery may be considered. Surgery generally involves removal of the bone over the Chiari malformation to create more room for the cerebellum and brain stem. Additionally, the lining of the spinal cord is usually expanded to further improve the flow of spinal fluid.

What are the Patient’s Long-term Prospects?
Though not everyone experiences the same severity of symptoms, living with Chiari malformation is a life-long struggle that can place a tremendous strain on patients and their families. With proper knowledge of the symptoms, diagnosis and multidisciplinary treatment, Chiari malformation can be managed, allowing patients to achieve their best quality of life.

For more information about Chiari malformation, visit www.shannons-hope.org.

Dr. Webb is a board certified Austin neurosurgeon with extensive experience in Chiari malformation diagnosis and treatment, including decompression surgery.
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Lexus GS 350
More Assertive Design, Better Technology, Improved Handling
Steve Schutz, MD

After three years of getting hammered by concerns about quality, accusations of sudden acceleration, a tsunami in Japan, a flood in Thailand and a strong yen, Lexus is fighting back. Their comeback officially started with a first-ever Super Bowl ad in February, then gathered momentum with the announcement that the 2013 model year would bring all-new, or mostly-new, versions of the GS and ES sedans, LX SUV and RX crossover.

Good thing, because it’s not like the competition has been hanging back waiting for Lexus to catch up. On the contrary, despite a global recession, BMW, Audi, Cadillac and Mercedes have been aggressively expanding their reach into emerging markets, particularly China, and using those big profits to develop new vehicles and engineer a slew of engines and transmissions to go with them. Lexus needed to respond if they hoped to stay competitive, and they have.

The new Lexus GS 350 is certainly competitive, replacing a good-but-not-great sedan that was supposed to give the BMW 5 Series and Mercedes E-Class a run for their money but never did. The 2013 GS shows that Lexus has learned some lessons about how to succeed in this market segment.

The GS now has a more assertive design, better technology and improved handling.

Attractive, Understated Design
Let’s start with the design, which is significantly more interesting visually than it was before. Frankly, I liked the look of the last GS, but intended customers didn’t, so a change was needed. The 2013 GS is the first Lexus with a spindle grille that’s the new face of the company. Lexus hopes you like it because if you don’t, you’re not going to like the 2013 LX 570, the 2013 RX or any other new Lexus launching over the next few years. While the new grille is different enough to draw looks from other drivers, the rest of the GS’ styling doesn’t depart too much from what we’ve come to expect from Lexus designs – they’re attractive but understated.

Inside, the cabin blends a lot of last-gen GS flavoring with hints of the LFA supercar. The dash and central stack, while all-new, will be reassuringly familiar to current Lexus owners. On the other hand, the handsome steering wheel and aluminum-heavy trim mix are clearly modeled after the LFA supercar. It’s an interesting mix.

The new infotainment system has been completely reconfigured and represents a big step forward for Lexus. The most noticeable change is the huge screen that dominates the middle of the dash, however, the mouse-like controller with its cool haptic interface and intuitive graphics make this system, which Lexus calls Enform, best in class. In addition to the usual navigation and other doo-dads, Enform brings in apps from your smartphone such as Pandora and Facebook. (No, you can’t update your status while you’re driving.) Look for more merging of smartphone utilities with car electronics in the near future, by the way. Audi already offers in-car Wi-Fi and Google Earth in many of their models, and Pandora is spreading rapidly into car audio systems. Can Spotify and Reddit be far behind? I doubt it.

Lexus also spent a lot of time on the GS’ suspension. While the prior model was geared more toward comfort than performance, the new version is sportier. Turn-in is sharper than before, steering feel is enhanced, and steering effort, which previously was too easy for a sedan in this category, has been increased as well. On your favorite twisty road, the standard GS handles crisply and with confidence, and the F-sport edition does even better, equaling the benchmark BMW 5 Series in most circumstances.

Many Features Now Standard
I wish the same were true of the engine and transmission. The only non-hybrid engine available in the 2013 GS is the ubiquitous Lexus 3.5-liter V6 coupled with a six-speed automatic gearbox.
Nothing wrong with that - we’re talking 306 HP and a zero-to-60 time of 5.6 seconds, after all - but comparable Audi A6 and BMW 5 Series sedans provide more torque plus either seven-or eight-speed transmissions, which harness horsepower and torque better than the Lexus six-speed. In addition, the BMW and Mercedes offer an optional V8 for those wanting more oomph, something the last-gen GS used to, but the new one doesn’t.

Lexuses tend to come with more standard features than their German competitors, and that’s the case with the new GS as well. We don’t have space here to go through the various options and trim packages available, but rest assured, it’s easy to add to the GS 350’s base price of $49,000. I expect average transaction prices to approach $60,000.

The GS 350 is proof that Lexus has put its recent challenges behind them and is now focused on competing strongly with BMW, Mercedes, Cadillac and Audi. Look for all Lexuses coming in the next several years to sport modern exteriors, high-tech interiors, and all the luxury we’ve become accustomed to from the brand. And don’t be surprised to see Lexus close the gap in the engine/transmission department sooner rather than later, as well.

Steve Schutz, MD, is a board-certified gastroenterologist who lived in San Antonio in the 1990s when he was stationed in the US Air Force. He has been writing auto reviews since 1995.

Retired Membership is granted to those physicians who have retired from the active practice of medicine. Upon nomination from the Board of Ethics, the TCMS Executive Board elected the following to Retired Membership:

Barry Hafkin, MD

Life Membership is granted to those physicians who have been a dues paying member of organized medicine for 35 years, of which 25 years must have been dues paying years in the TMA and who has reached a point of comparative inactivity in the practice of medicine, as determined by the Society. Upon nomination from the Board of Ethics, the TCMS Executive Board elected the following to Life Membership:

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Contact TCMS Auto Program Director Phil Hornbeak at phornbeak@tcms.com or 512-949-5758.
Negligence in Prescribing
TMLT Risk Management Department

The following closed claim study is based on an actual malpractice claim from TMLT. This case illustrates how action or inaction on the part of physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician’s defensibility. An attempt has been made to make the material less easy to identify. If you recognize your own claim, please be assured it is presented solely to emphasize the issues of the case.

Presentation
A 45-year-old woman came to the emergency department (ED) complaining of pain, blurry vision and sensitivity to light in the left eye. Examination confirmed a corneal abrasion. The patient was given an antibiotic eye drop and instructions to follow up with the defendant ophthalmologist.

She was seen the next day in the defendant’s practice. At that time, the history revealed that the patient had not filled the oral antibiotic prescription. She also had not administered the topical antibiotics as instructed by the ED physician.

Physician action
Visual acuity was 20/200 in the left eye. A corneal ulcer with an infiltrate was diagnosed. The defendant started the patient on topical tobradex, a combination antibiotic and corticosteroid medication. The patient was instructed to return the next day for repeat examination. At that visit, she reported less discomfort and improved vision. On examination, the visual acuity had improved to 20/80 and the infiltrate was still present but improved. Tobradex was continued as well as ciproloxan that had been prescribed by the ED physician. A return appointment was made in five days.

On the appointment date, the patient came to the same ED and was instructed to see the defendant as scheduled. She did not keep this appointment, but was seen the next day. The patient reported an increasing foreign body sensation in the affected eye. Visual acuity had decreased to 20/200 and an infiltrate was still noted. A therapeutic bandage contact lens was inserted and the patient was advised to continue ciproloxan and tobradex and return in two days. At this appointment, the patient complained of increased pain and decreased vision in the left eye. She informed the physician that she thought a piece of asphalt had flown into her eye the first day she went to the ED. Visual acuity was 20/400 and the infiltrate was larger, involving the inferior cornea. The bandage contact lens was exchanged and ancef and atropine drops were added to the topical medications.

The patient was seen the next two days (Saturday and Sunday) by the defendant. No improvement was noted. On Sunday, the patient was referred to a corneal specialist. The defendant paged the on-call specialist for the corneal group and that physician agreed to see the patient on Sunday at a medical center. The patient was examined in the ED and appropriate cultures were done. On Monday, the corneal specialist recorded a corneal abrasion 4 mm by 6 mm that had not increased from the earlier measurements. Two days later, the abrasion had decreased in size to 3 mm by 5 mm. The final results of the cultures were determined five days later (April 16), and were positive for a fungal corneal ulcer. Amphotericin B was started and cosopt for increased intraocular pressure.

A return visit with the corneal specialist on April 21 listed amphotericin B, vancomycin, gentamycin and cosopt as the medication regimen. Demerol was also prescribed for pain. The patient reported hand motion vision. Pressure had increased to 42, and the infiltrate was described as light blocking and dense, about 5 mm. The plan was to continue therapy and see the patient in five days. On April 26, the patient described less pain and vision to count fingers. The impression indicated some improvement in the fungal infection, and an order to decrease the anti-fungal medication to every two hours. A return appointment was scheduled in four days.

From April 30 to June 16, the patient was seen 12 times with the indication that the ulcer was responding to treatment and continued therapy recommended. Amphotericin, cosopt and atropine were continued.

At an appointment on June 16 with the corneal specialist, his findings indicated increasing pain despite demerol every three hours, light perception only, pressure of 34, 75-percent hypopyon, filamentary keratitis and continued infiltrate. The fusiform ulcer was not responding to medical treatment. Xalatan was added for pressure reduction. Surgery was scheduled for a corneal graft. The transplant was done on June 18. In spite of aggressive follow up and care, the transplant subsequently failed. She is legally blind in the left eye.

Allegations
The general ophthalmologist was sued and the plaintiff alleged negligence in prescribing both an antibiotic and steroid concurrently as it helped promote the growth of the infection. The plaintiff further alleged that the defendant should have added other antibiotics and an antifungal medication earlier thus causing a delay in treatment and the need for corneal transplant.

Legal implications
Physician consultants for the defense described the ophthalmologist’s care and treatment as reasonable and meeting the standard of care. They felt it was appropriate to treat a mild corneal ulcer without cultures in the
beginning. When the patient’s condition did not respond to treatment, an emergent referral on a Sunday demonstrated the defendant’s concern. The physicians who reviewed this case consistently acknowledged that fungal corneal infections are difficult to detect in their early stages. It was also noted that most ophthalmologists may see only one to two fungal infections in their entire careers.

One reviewer emphasized that there were no apparent signs of fungal infection during the time the defendant treated the patient. He felt strongly that no physician could have identified this infection any sooner, and there was no requirement on the part of the defendant to perform a culture earlier, as alleged by the plaintiff. With regard to causation, the corneal specialist who cared for the patient stated that upon first examining her, the eye did not appear to have a fungal ulcer present. He also agreed that the type of fungal infection the patient had is rare and very difficult to treat. This physician further opined that fusarium is a particularly nasty strain of fungal ulcer and generally results in the outcome this patient experienced regardless of the treatment.

The plaintiff’s expert stated that the standard of care had been breached by the defendant because he prescribed a steroid (Tobradex) in combination with antibiotic drops (Ciloxan). The expert did agree that ophthalmologists may differ in their opinions regarding the use of Tobradex. The Physician’s Desk Reference lists treatment of corneal abrasions with Tobradex as appropriate and its use does not breach the standard of care. During deposition, this expert also acknowledged that fungal infections are rare and the fusarium infection was even more rare. He agreed these infections are generally not diagnosed until the later stages and that patients often lose their eyesight. This physician went on to describe the characteristics of a fungal lesion and admitted to defense counsel that at no time under the defendant’s care were these findings present.

**Disposition**

This case was taken to trial and the jury returned a unanimous verdict in favor of the defendant.

**Risk management considerations**

It is satisfying to present a claim in which the defendant physician is exonerated at trial. It is also noteworthy to add that none of the physician consultants or experts participating in the review of this claim expressed any criticisms about the defendant’s practice protocols or quality of the medical record.
Tuberculosis (TB) is a communicable infection (can be transmitted from person to person) that usually affects the lungs. It is spread by airborne droplets when an infected person coughs or sneezes. It is caused by a bacterium called Mycobacterium tuberculosis. At the time of diagnosis, people with TB usually have a variety of symptoms such as low-grade fever, constant cough with sputum (phlegm), night sweats and unintentional weight loss.

**Classifying TB**

- **Active TB** describes an ongoing infection in which a person develops symptoms and has a positive (abnormal) result on a test for TB.
- **Latent TB** occurs when a person with no symptoms has a positive result on a TB skin or blood test. This suggests that the person was infected with TB in the past but the bacteria are in a dormant or inactive state. Persons with latent TB cannot spread the TB bacteria to others.
- **Multidrug-resistant TB (MDR-TB)** is a form of active TB caused by bacteria that do not respond to the medications most commonly used to treat TB.

**Risk Factors for TB**

- A deficient or weakened immune system, such as in people with diabetes or HIV/AIDS.
- Traveling to or living in countries where tuberculosis is endemic (found commonly).
- Working in health care or refugee camps.
- Living in overcrowded and poorly ventilated residences.

**Evaluation for Suspected TB**

- **Tuberculin skin test** (also called PPD, or purified protein derivative). In response to this injection, if a person has been infected with TB, immune cells will indurate (harden) the area surrounding the injection site. The area of induration is measured 48 to 72 hours after injection and used to determine the likelihood of TB infection.
- **Chest x-ray** may be done to distinguish between active and latent TB.
- **A blood test** may be done to check for cytokines (substances released by immune cells) that are unique to TB infections.

**For More Information**

- Centers for Disease Control and Prevention
  [www.cdc.gov/tb](http://www.cdc.gov/tb)
- National Institute of Allergy and Infectious Diseases
  [www.niaid.nih.gov/topics/tuberculosis/Pages/Default.aspx](http://www.niaid.nih.gov/topics/tuberculosis/Pages/Default.aspx)
- World Health Organization
  [www.who.int/mediacentre/factsheets/fs104/en](http://www.who.int/mediacentre/factsheets/fs104/en)

**Prevention**

- In high-risk health care settings, appropriate precautions should be followed. This includes wearing masks specifically designed to prevent the spread of TB.
- Patients diagnosed as having latent TB may be given medications to kill dormant bacteria and prevent the development of active TB.
- In countries where TB is endemic, people may be given bacille Calmette-Guérin (BCG), a vaccine against TB.

**Treatment**

- Several antimicrobials (medicines that kill microorganisms or interfere with their growth) are used to treat tuberculosis.
- Treatment usually lasts for six months and requires close monitoring by an infectious diseases specialist or other specialist.
- Complete treatment of a person with any form of TB is essential to maintain the person’s health and to prevent the spread of tuberculosis to others.
OPPORTUNITIES

Urgent Care: MedSpring Urgent Care, Austin seeking staff physicians for 6 new urgent care locations in Austin. Gorgeous, centrally located centers featuring 12-hour shifts, no nights, no call and no overhead. MedSpring is dedicated to getting patients ‘back to better,’ and we are looking for doctors who seek to provide outstanding service to every patient. MedSpring is poised to become an industry leader in urgent care and we are looking for doctors to grow with our company. Excellent compensation, annual bonus, benefit package, licensure and CME reimbursement, paid medical insurance and excellent opportunities for leadership.

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OFFICE SPACE

Medical Office: 4207 James Casey #302, across from St. David’s South Austin Medical Center, 1240 sq ft. 3 exam rooms, office, lab, restroom, reception office and waiting room. Contact broker/owner at 512-797-4977 or mpspatients@austin.rr.com.

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Email PracticeOpportunityAustin@gmail.com.

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