

ALACHUA COUNTY MEDICAL SOCIETY

House Calls



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SUMMER 2017

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The Spectrum of Diabetes



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ACMS We Care Physician Referral Network

The We Care Physician Referral Network is a community-based initiative that coordinates volunteer physicians, dentists, hospitals, and ancillary providers to meet the medical and dental needs of uninsured and poor Alachua County residents. It is a partnership of public and private institutions, agencies, and individuals that responds to the health care needs of the community's under-served population. A health care board provides guidance to the program in response to community health issues and evaluates the efficacy of the agency's programs. The initiative started over twenty-five years ago in response to an overwhelming need for medical services for low income, uninsured residents of Alachua County.

Since 1990 the program has received over 25,000 requests for volunteer medical and dental care. More than half of those requests were met by volunteer professionals. The cumulative total of volunteer medical and dental services provided exceeds \$80,000,000.

House Calls

Scott Medley, MD,
Executive Editor
Jackie Owens,
ACMS EVP, Managing Editor

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2017 ACMS AWARDS



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Dr. Ann Hatfield is an obstetrician/gynecologist who joined North Florida Women's Physicians in 2014. Prior to that, she was Assistant Clinical Professor and Medical Director at the University of Florida Generation to Generation Obstetrics and Gynecology in Orange Park, FL. She received her medical degree at Duke University School of Medicine, and completed her residency at the University of Florida College of Medicine Jacksonville.



Scott Medley, MD
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Dr. Scott Medley practiced family Medicine for 20 years before becoming the Chief Medical Officer at NFRMC. He served as President of the ACMS and of the Florida Academy of Family Physicians, and as Chair of the Gainesville Area Chamber of Commerce. He received the Gainesville Sun Community Service Award in 1987 and was chosen Florida Family Physician of the Year in 1992. He currently is retired and Volunteers at Haven Hospice. Dr. Medley has served as Executive Editor of *House Calls* for the past 19 years, and has authored over 80 editorials and articles for this publication.



Janet Silverstein, MD
Pediatric Endocrinology

Dr. Janet Silverstein is a Pediatric Endocrinologist at UF Health. In her years of experience she has held and holds many titles including director, chief, program director, professor, medical director, associate chief, and associate professor, to name a few. She has chaired many national committees including the American Academy of Pediatrics (AAP) Section of Endocrinology, Children's workgroup of the National Diabetes Education Program, the Diabetes in Youth committee, and President of the Pediatric Endocrine Society (PES).



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Dr. Albanese-O'Neill holds BSN, MSN and PhD degrees in nursing science from the University of Florida. She is an expert in the management of pediatric type 1 diabetes, a nationally board certified diabetes educator through NCDDBE and a nationally certified pediatric nurse practitioner through PNCB. Dr. Albanese-O'Neill also holds certifications as an insulin pump and Continuous Glucose Monitor (CGM) trainer.

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From the President's Desk



Matheen A. Khuddus, MD,
ACMS President



As physicians, we have all taken care of critically ill patients at some point in our careers. Our years of medical training have taught us to manage these situations thoughtfully and methodically, but also with a sense of urgency and purpose. We learn to manage multi-organ system failure and work with other members of the team including fellow physicians, nurses, technicians and case managers. We put forth our very best effort and commit all available resources to the care of the patient, no matter how dire the situation may seem. It is through commitment, team work and perseverance that we achieve these goals.

Ironically, the very skills we work to perfect for patient care are the same we need to overcome the multiple challenges facing the medical profession today. Instead of disease or infection, we are combating a never-ending increase in regulations and bureaucracy, reimbursement challenges, certification requirements and other barriers to patient care. These challenges are leading to increasing physician frustration, burn-out and attrition, but more importantly, to a deterioration in our ability to deliver patient care.

Unfortunately, physicians too often deal with these issues in silos, with little to no communication or organization amongst ourselves. Additionally, most of us are unfamiliar with the processes to address our grievances and have little time to commit to learning them. The haphazard and disjointed introduction of the Electronic Health Records (EHR) to our practices is just one of the many examples of how these changes can burden the physician while also contributing to the deterioration of the patient-physician interaction.

The Alachua County Medical Society can and will play a vital role in overcoming the challenges facing physicians today. As the incoming President, I hope to build on the work of those before me to grow the medical society and adapt to the ever-changing landscape so that the ACMS can serve the physician community in meaningful ways. During my term, the ACMS will

continue to focus on social engagement, medical education, advocacy and service to the community. With more frequent social activities, we will allow for greater opportunities to network with colleagues and across health care systems. I continue to believe that when physicians meet and work together, good things happen. We also anticipate our increasing social media presence will lead to greater physician outreach and engagement, particularly with early career physicians. The focus on medical education will include CME activities that are meaningful and pertinent to the practicing physician. We plan to also include opportunities to highlight research contributions and projects by our members, as well as activities specifically directed towards physicians in training at both UF Health and NFRMC. The ACMS also remains committed to its long standing service to the community supporting the Robb House, Weekly Wellness Walks, and community education via HOME magazine, while also increasing our cooperation with local organizations to support community events. Last but certainly not least, the Medical Society will continue the excellent physician advocacy work being done at county, state and national levels. The ACMS is consistently one of the best represented societies at the state level and remains committed to representing the interests of our members and training new physicians to be leaders in the area of advocacy.

I look forward to serving the ACMS and its members over the next two years. The ACMS is only as strong as our membership and having been part of this medical community for the last 20 years, I know that together we have the potential to make great strides towards our common goals.

Helping Hands Clinic

The 2017 Recipient of the
ACMS Health and Wellness Advocacy Award

**Brendan Shortley,
Director**



L to R: Brendan Shortley, Director of Helping Hands Clinic receiving the ACMS 2017 Health and Wellness Advocacy Award from David Winchester, MD, ACMS President.



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Overview of Services

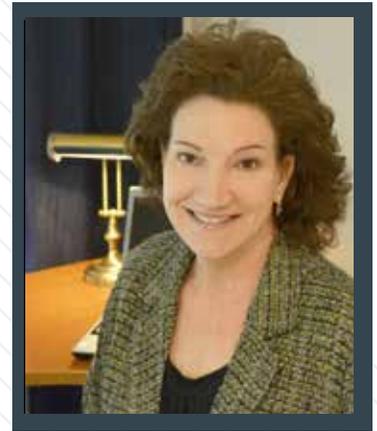
Women's Health Program

- **Medical**
 - Urgent & Primary Care
 - Management of Chronic Conditions
- **Psychiatry**
 - Counseling
 - Medication Management
- **Other services**
 - Acupuncture (Mondays)
 - Massage Therapy (Thursdays)
 - Dental & Eye Care
- **Referral & Payment**
 - Pap smear & Mammogram
 - Pregnancy & STD testing
- **Health education**
- **Other Services**
 - Hair Stylist
 - Nutritional Meal
 - Activities
 - Clothing & Personal Hygiene Items
 - Showers

From the Desk of the EVP

Focus, Fanfare & Fun at the FMA Meeting

Jackie Owens, ACMS Executive Vice President



Returning home from the annual FMA meeting at Universal Studios Orlando, I reflected upon the experience with fond anticipation for next year’s event. I had a great time meeting new people and getting a peek into the process of our physicians’ resolutions becoming legislative content for the next session. This was my first trip in the position of ACMS EVP and I was not expecting this to be fun. I had heard rumors of long days indoors, late nights, early morning meetings, and overpriced breakfasts. Instead, I was met with a beautiful new facility and resort at the largest FMA gathering of physicians to date, with lots of activity and excitement. I’d like to take this opportunity to quell some of those rumors you may have heard and take the mystery out of the FMA meeting for some of you, hoping that you will join us there in the future.

The focal point of the FMA annual meeting involves the submission, review and approval of resolutions for consideration (usually submitted by May) to the FMA House of Delegates (HOD) and the Board of Governors. The HOD is made up of representatives from each county and specialty group in the State of Florida, with delegate counts being assigned based upon the population of each group. Alachua County has the second highest delegate count in the state, and Duval County is eagerly closing in fast

(they made that clear to me). Each medical society sends its list of approved delegates to the FMA and you’re on your way.

There are many activities that you can join while you’re at the FMA meeting, but the most significant is your input on the resolutions (done in the Reference Committee meetings held Saturday) and voting on those resolutions on Sunday.

In the Reference Committee meetings, there is much excitement and energy invested in the resolutions at hand, as delegates openly debate the finer details submitted. The committee arrives at a conclusion as to if, or how to submit the resolution to the HOD for consideration. Resolutions concerning Maintenance of Certification (MOC) issues sparked a heated debate this year and are destined to get even more interesting next year. If you’ve ever watched the British Parliament in session on BBC you know what I’m talking about. Worth watching, even if you

Continued on Page 9

Delegate Positions per County:

Alachua County	27	Escambia County	8	Palm Beach County	20
Brevard County	6	Hillsborough County	23	Pasco County	3
Broward County	18	Indian River	3	Pinellas County	12
Capital Area	11	Lake Sumter	7	Polk County	6
Charlotte County	3	Lee County	13	Santa Rosa County	2
Clay County	3	Manatee County	8	Sarasota County	9
Collier County	8	Marion County	8	Seminole County	5
Dade County	22	Martin County	3	St. Johns County	4
Duval County	25	Monroe County	1	Volusia County	8
Emerald Coast	6	Orange County	30		

FOCUS AT THE FMA MEETING

Continued from Page 8

don't feel like getting in the middle of it.

Saturday evening we celebrated the inauguration of the incoming FMA President, John N. Katopodis, MD. Dr. Katopodis shared the story of his father's escape from Nazi-occupied Greece to the United States and the struggles they faced as a family. Afterwards, we celebrated with a delicious traditional Greek dinner and were entertained with Greek dancing performed by a local group.

Sunday morning it's back to business as you vote on your preferred physician representatives at the state (FMA) and national levels (AMA). These physicians will represent you in the following year. We are fortunate to have excellent representation on the state and national levels with Charles Riggs, MD, as our Board of Governors representative for Medical

District H, David Winchester, MD, as an AMA Delegate, with Mark Panna, MD, as an AMA Delegate Alternate. A special thanks to Carl Dragstedt, DO, who has served as our FMA Delegate Chair for the last two years. He has taken the time to organize our group and keep us informed of the FMA issues, processes and procedures.

There are opportunities for lots of fun before, in-between and after these events, so plan to bring your family. You can pick up a few CMEs, lounge at the pool or take the kids to the Universal theme park. OK, there was still overpriced breakfast, but it's a rare opportunity to have fun while positively impacting medicine in the state of Florida - and we need your future participation at the conference. Consider joining us next year - you won't be disappointed.



Congratulations to the Alachua County Medical Society Delegates for achieving "Outstanding 1000+ Club Membership" of the FMA PAC 1000+ Club! L to R: Joseph Thornton, MD, Jesse Lipnick, MD, Carl Dragstedt, DO, John Hiemenz, MD, Charles Riggs, MD, and Thomas Martinko, MD.

MEET THE NEW ACMS PRESIDENT

MATHEEN A. KHUDDUS, MD



Interview by: Jackie Owens, ACMS EVP

JO: Where were you born and what brought you to Gainesville?

MK: I was born and raised in Ft Pierce, Florida and went to school in Vero Beach. I, like so many others, came to Gainesville to attend the University of Florida. In 1995, I was accepted into the Junior Honors Medical Program and then stayed at the University for my Residency and Fellowships. After completion of my training in 2008, I joined the Interventional Cardiologists of Gainesville, which is now The Cardiac and Vascular Institute.

JO: What prompted you to pursue medicine and specialize in Interventional Cardiology?

MK: As the son of a Cardiologist, I've been exposed to the field my entire life. I joke that I was the only kid in middle school who knew his cholesterol level, but I also witnessed first hand both the per-

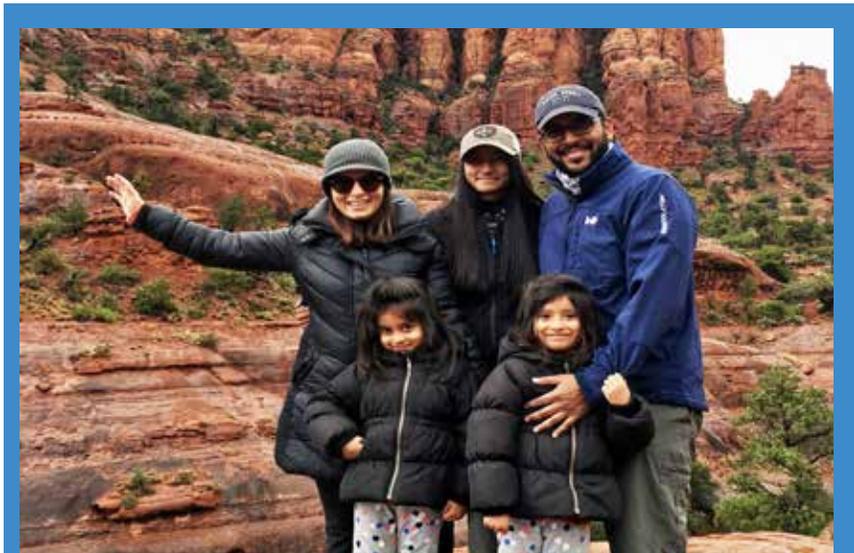
sonal sacrifice and professional satisfaction that comes with the job. Still, it wasn't until medical school and residency that it was apparent to me that Interventional Cardiology was the field for me. I found the subject matter inherently fascinating, but was also drawn to the tremendous innovation related to device development and procedural technique that has transformed the field in recent years while still allowing me to maintain continuity of care and build relationships with my patients.

JO: What do you like best about being a physician?

MK: As an interventional Cardiologist, I get to routinely care for patients that are very sick. Being able to help and comfort patients and their families in those situations and then watch as they recover remains without a doubt the most rewarding part of being a physician for me.

JO: What are your goals for the ACMS in 2017-2018?

MK: I feel very strongly that when physicians meet, share ideas and work together it leads to advancements in patient care and improvement in the ability of our practices to operate and deliver patient care.



From Top Left: Mrs. Sahela Khuddus; daughter Ayesha; Matheen A. Khuddus, MD; and twin daughters Sarah and Maryam.

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Conversely, when physicians isolate themselves due to perceived competition or a lack of time or interest it is detrimental to the health care delivery process and leads to erosion of our field and profession. I've seen the success that comes with physicians working together first hand during my relatively short time in practice, but unfortunately have witnessed more failures than successes.

My primary goal for the ACMS is to increase physician engagement and support the gathering and collaboration of physicians in Alachua County in as many ways possible. This includes not only our regular member meetings but social events such as Tap Room Tuesdays and hopefully the addition of educational events such as journal clubs and research poster competitions. If we can bring physicians together, good things will inevitably occur and I am certain that together we can address the many more important issues we face today.

JO: What do you feel are the challenges facing medicine?

MK: Unfortunately, the challenges facing medicine are too numerous to list. The practice of medicine has changed dramatically in the few years that I have been practicing. While some of that has been good, far too much has been bad.

The ever-increasing-EHR documentation requirements and non-clinical tasks have eroded physicians' abilities to interact with their patients in a meaningful way. Healthcare reform has become a political football resulting in unsettling uncertainty for physicians and their patients.

Collectively, the challenges facing medicine are contributing to increased physician dissatisfaction and burnout. While these challenges can at times feel overwhelming, I believe that they can and will be overcome through advocacy and physician organization. Despite these multiple challenges, the practice of medicine remains the greatest profession.

JO: Why do you believe in supporting organized medicine, especially through your county medical society?

MK: The only solution to address the challenges facing medicine is to support organized medicine. Most physicians dedicate their lives to caring for patients and continuing education. By neglecting advocacy, we have allowed those who don't understand what we do or how we do it to dictate how we practice and more often than not, they get it wrong. Most of us don't have the time or familiarity with the political process to be effective, but the county medical society engages and cultivates physicians with a passion and expertise for advocacy. These individuals are your colleagues. They are known to you, easily approached and have a deep sense of accountability. It is only through organized medicine that we can achieve this degree of representation.

JO: Please tell our readers about your family.

MK: I'm blessed to have quite a bit of family locally. My wife, Saleha and I have been married for 17 years and have 3 amazing girls, Ayesha, who is 14 and starting at Eastside High school in the fall, and twin 5-year-olds, Sarah and Maryam, who are starting Kindergarten. My parents have retired in Gainesville and I have an older brother and sister who are also practicing physicians in Gainesville whom I get to see quite regularly.

JO: How do you spend your free time?

MK: I enjoy spending my free time with family and friends and particularly with my 3 kids. As a family, we enjoy traveling and getting outdoors as much as possible. Skiing, paddle-boarding and fishing are currently favorite activities. We've recently been spending lots of time traveling for my oldest daughter's soccer games as well swimming lessons which is time with them that Saleha and I really cherish.

THE FUTURE IS NOW: TECHNOLOGY & DIABETES



JANET SILVERSTEIN, MD



ANASTASIA
ALABANESE-O'NEILL, PhD

TO PUMP OR NOT TO PUMP?

JANET SILVERSTEIN, MD &
ANASTASIA ALABANESE-O'NEILL,
PhD, ARNP

UF Health Pediatric Specialties

A generation ago, the Diabetes Control and Complications Trial (DCCT) demonstrated that people with type 1 diabetes (T1D), including adolescents, could achieve improved glycemic control through intensive insulin therapy.¹ The Epidemiology of Diabetes Interventions and Complications Study (EDIC), a longitudinal follow up to the ground-breaking DCCT, has shown that achieving a hemoglobin A1c (HbA1c) close to target even for a relatively short period of time early in the disease process can prevent and delay chronic diabetes complications.² However, intensive management is difficult to sustain due to a burdensome regimen, and overall success is limited by the risk for severe hypoglycemia.³ Despite the availability of improved insulins and widespread access to insulin pump therapy, data from the Type 1 Diabetes Exchange clinic registry indicates that fewer than 25% of children and adolescents with type 1 diabetes are able to achieve the recommended target glycosylated hemoglobin (HbA1c) of 7.5%, with the average HbA1c among participants aged 2 to 5 years at 8.2%; 6-12 year-olds at 8.4%; and 9.0% for those aged 13 to 17 years.⁴ HbA1c levels among registry participants with household income <\$50,000/year were even higher, at 8.4% for those aged 2-5 years; 8.9% for 6-12 year-olds at 8.4%; and 9.5% for those aged 13-17 years, indicating a sociodemographic disparity.⁴ These data suggest that achieving recommended HbA1c targets with available therapeutic options remains elusive for most children and adolescents with T1D. Despite these sobering data, an atmosphere of tremendous hope and anticipation surrounds current research on the Artificial Pancreas (AP), an integrated system that would automate both glucose monitoring and insulin delivery to achieve close to normal glycemic levels for people with T1D. Additional studies are underway in pediatrics using an automated "Bionic Pancreas," a bi-hormonal pump both containing insulin and glucagon to attempt to replicate endocrine pancre-

atic function. Both testing by finger-stick and manual use of injections would no longer be required. Indeed, late last year, the FDA approved a "hybrid closed loop," which offers semi-automated insulin delivery and is now available to patients, although there is currently a backlog until fall 2017. Further, with support from the National Institutes of Health and private equity, fully automated or "closed loop" options are being studied in a growing number of pivotal trials in academia and in the private sector. These devices will ultimately allow our pediatric patients with T1D to focus on being children, rather than having to deal with the constant burden of disease management.

The necessary components of these AP systems include an insulin pump, continuous glucose monitor (CGM), and control algorithm. Insulin pumps have been shown to decrease the rate of hypoglycemia compared to intermittent insulin administration by injection. Insulin pumps infuse insulin through a small canula that is inserted subcutaneously by the patient and rotated to a new site every 2-3 days. CGM systems are comprised of a sensor, transmitter, and receiver. CGM provide a glucose reading every 5 minutes and also display real-time trends in glucose. An app on the patient's smartphone can be used in place of the receiver, and this app makes it possible for the patient to share real-time glucose data with parent caregivers. This strategy allows the CGM user to intervene before the development of low blood glucose levels. The Dexcom G5 Mobile CGM system[®] recently received FDA approval for use to make treatment decisions, minimizing the number of daily finger-sticks to check glucose levels. Research on CGM use has also revealed that there is less post-prandial hyperglycemia when insulin is given 20 to 30 minutes before eating rather than immediately before or following the intake of carbohydrates. The newer systems can overcome many of the barriers

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to achieving and maintaining excellent diabetes control.

The first AP system approved by the FDA is the Medtronic Minimed 670G® (a hybrid closed-loop system).⁵ In the 670G pivotal trial, participants not only experienced an overall reduction in HbA1c from individual baseline (7.4% to 6.9%), but also had less hypoglycemia, less glycemic variability, and more time in target glucose range.

Existing barriers to fully automated insulin delivery systems include user factors such as fear of hypoglycemia and device burden; algorithms that are insufficiently robust to accommodate altered physiologic responses to exercise, stress, and variability in meal composition and frequency; inadequacy of currently approved insulin formulations that have universally delayed and non-physiologic action profiles when administered subcutaneously; device inaccuracy, device failure or malfunction, particularly with insulin pump infusion sites; and high cost.⁶

There is tremendous excitement around these systems, and physicians can use the information in this article to have a meaningful and realistic conversation with their patients about the current state of these technologies. However, the importance of managing patient expectations cannot be overemphasized. Many patients may not understand the difference between the newly available Medtronic 670G® device and a fully closed loop system, and have unreasonably high expectations. Others may believe that in the future, using an Artificial Pancreas device will require simply attaching it to their body and turning it on, when in reality, some user oversight will still be required. Any significant disparity between expectations and the reality-based benefits of using the device may contribute to discontinuation of therapy.

Insulin pump use is high among pediatric patients with type 1 diabetes in the United States (63% of 2-5 year-olds, 65% of 6-12 year-olds, and 58% of 13-17 year-olds), and discontinuation of therapy is low, at approximately 3-4%, according to international registry studies. However, available published data on CGM use in pediatrics indicates a low rate of use, with 6% of patients aged <13 years and 4% of teens ages 13-17 years, using CGM, and an overall discontinuation rate of 41% within the first year.⁷ A challenge with these data is that they report patient experiences with older generations of CGM devices, so it is difficult to draw

conclusions on the experiences of patients using newer CGM models. Further research to elicit differences in user-experience and device use is merited.⁸⁻⁹ Over the past year, CGM use in the pediatric population has sky-rocketed due to improved insurance coverage, share technology, and ability to use some CGM data to make treatment decisions. In this vein, recent inquiry has focused on identifying and addressing the modifiable human factors that contribute to device discontinuation. A recent study on adults using CGM, particularly young adults ages 18-25 years, reports “general hassle” and dislike of having a device attached to their body as reasons for discontinuation.¹⁰ Human factors research has been integrated into four pivotal trials of automated insulin delivery devices funded by the NIH, some of which include children as young as 6 years of age.¹¹

Finally, issues concerning the cost of these devices and access to them must be addressed. In the short term, continued federal funding to support this revolutionary area of research is imperative, and is currently provided in part through the Special Statutory Funding Program for Type 1 Diabetes, which is now up for renewal in an uncertain legislative environment.¹¹

Advocacy efforts will be required to ensure that these complex and costly pivotal trials can continue without interruption. Once these systems come to market, it will be imperative to lobby for insurance mandates to ensure all patients with type 1 diabetes have access to these devices, which are expensive. Finally, initial and ongoing training, education, and support is required, much like that currently recommended for successful insulin pump therapy, to facilitate the successful use of this technology.¹²

Physicians who care for patients with diabetes in their practice are partners in this effort and need to remain up to date in order to have meaningful conversations with patient families about treatment options. In addition, these physicians have a central role as advocates so that research funding continues, and to ensure that all people with diabetes have access to technology that automates disease management while simultaneously reducing disease burden.

References available upon request.

DIABETES IN PREGNANCY

Ann S. Hatfield, MD
North Florida Women's Physicians



Case Report:

Ms. X is a 24-year-old Gravida 1 Hispanic female who presents to care for pregnancy at 7 weeks gestation. She has no past medical history other than a Body Mass Index (BMI) of 32. She has a family history of diabetes and breast cancer in her mother, and does not smoke, stopped alcohol with pregnancy, and denies drug use. She takes no medications other than prenatal vitamins. She is concerned about diabetes due to her family history, but is otherwise excited about this pregnancy.

What is this patient's risk of diabetes?

Diabetes is one of the most common medical conditions encountered in pregnancy, and the global rates are increasing due to increasing rates of obesity. It is estimated that nearly 10% of American pregnancies are affected by diabetes, and only 10% of these patients have pre-existing diabetes. This means the vast majority of patients will be diagnosed with diabetes during their pregnancy. Since screening based solely on risk factors may miss many cases, the 2014 US Preventive Services Task Force (USPSTF) recommended screening all pregnant women for diabetes after 24 weeks gestation. Additionally, the American Diabetes Association (ADA) recommends early screening for women at risk for pregestational diabetes. This includes women who are overweight AND have first degree relatives with diabetes, have a history of gestational diabetes or a macrosomic infant with a previous pregnancy, have a history of polycystic ovary syndrome, or belong to a high-risk race/ethnicity.

Ms. X is at risk for pregestational diabetes and should be screened when she has her prenatal labs drawn.

How would you screen this patient for diabetes?

There are two main strategies used to diagnose gestational diabetes.

- A. One-Step: perform 75-g 2-hour glucose tolerance test and check plasma glucose levels fasting and at 1 and 2 hours.
 - Diabetes is diagnosed if any single value is at or above the cutoff (fasting 92 mg/dL, 1-hour 180 mg/dL, 2-hour 153 mg/dL).
- B. Two-Step:
 1. Perform 50-g 1-hour glucose tolerance test and check plasma glucose level at 1 hour.
 - Patient fails the screen if glucose is above 130, 135, or 140 mg/dL, depending on institutional threshold. Patients who fail the screen move on to Step 2.
 2. Perform 100-g 3-hour glucose tolerance test and check plasma glucose levels fasting and at 1, 2 and 3 hours.
 - Diabetes is diagnosed if at least two values are at or above the cutoffs set by the National Diabetes Data Group (NDDG) or by Carpenter and Coustan.
 - Neither the Carpenter/Coustan nor the NDDG thresholds have been found to be superior, so the choice of diagnostic standards should be based on community prevalence of diabetes and availability of resources for treating pregnant diabetic women.

DIABETES IN PREGNANCY

Continued from Page 14

	Carpenter and Coustan (mg/dl)	National Diabetes Data Group (mg/dl)
Fasting	95	105
1 Hour	180	190
2 Hours	155	165
3 Hours	140	145

While neither the One-Step nor Two-Step method was shown to be superior in a 2015 Cochrane review, the American College of Obstetricians and Gynecologists (ACOG) recommends the traditional Two-Step process due to insufficient evidence to support the One-Step method.

In the case of Ms. X, she failed her early 1-hour glucose tolerance test but passed the 3-hour glucose tolerance test. When she was 24 weeks gestation, she repeated the 3-hour glucose tolerance test and failed it.

What is the initial management of gestational diabetes?

Once a diagnosis of gestational diabetes is made, the patient is often referred for Diabetic Education. There, she learns about a diabetic diet and how to monitor her blood sugar. No studies have determined the optimal dietary composition; however, limiting carbohydrates to 30-40% of calories and a preference of complex carbohydrates over simple carbohydrates seem to decrease blood sugars. Diabetic patients, like all pregnant women, should perform at least 150 minutes of moderate-intensity aerobic activity every week.

Diabetic women should monitor their blood sugars fasting and either 1 or 2 hours postprandial. The ADA and ACOG recommend fasting values to be less than 95 mg/dL, 1-hour postprandial values to be less than 140 mg/dL and 2-hour postprandial values to be less than 120 mg/dL. Patients who are routinely hyperglycemic are usually referred to Maternal

Fetal Medicine (MFM) for initiation of medication.

Ms. X was referred for Diabetic Counseling and changed her diet/exercise routines. Despite these changes, her fasting blood sugars were consistently elevated at her 28-week visit and she was referred to MFM.

What are the medical options to treat diabetes during pregnancy?

If a patient's blood sugars cannot be controlled with exercise and a modified diet, patients are usually started on medications.

Insulin has long been the medication of choice since it does not cross the placenta and can be titrated to tightly regulate glucose levels. However, patient compliance and acceptability are common issues. The introduction of long-acting insulin preparations, such as insulin glargine and insulin detemir, has helped decrease some of these concerns.

Glyburide has been used for many years to treat diabetes in pregnant patients. Since it is a sulfonylurea, it cannot be prescribed to women with a sulfa allergy. Additionally, there have been some reports of increased pre-eclampsia, as well as more neonatal complications, such as respiratory distress syndrome, neonatal hypoglycemia and macrosomia.

Metformin has been mostly used in pregnant women with polycystic ovary syndrome and infertility. Oftentimes, women with these conditions are placed on metformin while trying to become pregnant and are continued on it until the end of the first trimester. Metformin is known to cross the placenta, and there have been no long-term studies to prove its safety.

While insulin is still the recommended first-line treatment according to the ADA, many practitioners start with oral antidiabetic medications due to their ease of use. However, none of the oral agents are FDA-approved to treat diabetes in pregnancy.

Continued on Page 16

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Ms. X was started by MFM on nightly glyburide which was able to strictly control her blood sugars.

How are gestational diabetics monitored antenatally?

Most gestational diabetics can be seen according to the routine antenatal schedule (e.g., every 4 weeks before 28 weeks, biweekly starting at 28 weeks and weekly after 35-36 weeks). If the patient's blood sugars are not well controlled, they will often be seen more frequently or will present weekly blood sugar logs for providers to review.

Antepartum fetal testing is recommended in patients with pregestational diabetes and in gestational diabetics who require medication because these women are at increased risk of fetal demise. Testing is usually initiated at 32-34 weeks. The type and frequency of such testing (e.g., biophysical profile, nonstress test, contraction stress test, etc.), is based on institutional practice. Since polyhydramnios is common in diabetic patients, measurement of amniotic fluid is often incorporated in testing protocols.

Ms. X received weekly biophysical profiles starting at 34 weeks as well as growth ultrasounds every month.

What is the optimal timing for delivery in gestational diabetics?

Delivery planning must weigh the risks of prematurity and failed induction (i.e., increased cesarean rates) versus the risks of macrosomia, shoulder dystocia and fetal demise. Diet-controlled gestational diabetics are usually expectantly managed until 39-41 weeks. Gestational diabetics whose sugars are well-controlled with medication are usually delivered between 38 and 39 6/7 weeks. There is no consensus on delivery timing for poorly controlled gestational diabetics, but delivery prior to 37 weeks is typically only mandated if the patient fails inpatient glycemic control or has abnormal antenatal testing.

At her 38 week visit, Ms. X was diagnosed with olig-

ohydramnios and the decision was made to induce labor with pitocin. She had a vaginal delivery of a healthy baby boy weighing 8 lb 5 oz the next day.

What postpartum considerations are there?

Gestational diabetics have a significant risk of developing diabetes later in life. Therefore, screening with the 75-g 2-hour glucose tolerance test 4-12 weeks postpartum is standard. Additionally, the ADA and ACOG recommend repeat screening every 1-3 years for women who have a history of gestational diabetes.

Ms. X happily passed the 2-hour glucose tolerance test 8 weeks postpartum. However, she decided to continue a low-carb meal plan and exercise for her overall health.



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Contact Jackie Owens, Executive Vice President with the Alachua County Medical Society, or Jay Hutto, CPA and Partner at James Moore & Company, to find out more about the Practice Management Network and sign up to be notified about our next luncheon!

Jackie Owens, Executive Vice President
352.376.0715 | acmsassist@acms.net

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DIABETES SPECTRUM

BARIATRIC SURGERY AS THE PRIMARY TREATMENT FOR TYPE 2 DIABETES

William Troy Donahoo, MD
UF Health Division of Endocrinology



The prevalence of obesity worldwide has increased dramatically over the past two decades, and Florida (based on BRFSS self-reported data from the Centers for Disease Control) has not been spared. In 1995, 35% of adult Floridians were overweight (BMI 25–30 kg/m²) and 17% were obese (BMI greater than 30 kg/m²). This has increased to where in 2005, 23% of Floridians were obese and in 2015 over a quarter, or 27%, of Floridians were obese. Specific to the Gainesville area, in 2013, 25% of the population were obese and 32% were overweight. In association with this dramatic increase in obesity there has been a similar increase in diabetes. In 1995, 5.3% of the Florida population “had been told by a doctor” that they had diabetes whereas in 2005 that number had gone up to 8.8%. By 2015, the percentage of Floridians with diabetes was up to 11.3%. In addition, looking at the UF Health population specifically, 32% had a BMI greater than 30 kg/m², 16% had a BMI greater than 35 kg/m² and 8% - a BMI greater than 40 kg/m² (this is a weight of about 250 lbs. for a person 5’-6” tall).

Along with the rising incidence is the medical burden of caring for people with diabetes, and due to this burden, medical costs are dramatically increasing. A very recent systematic review showed significantly increased total, medication-related, inpatient, and ambulatory care costs for patients with both overweight and obesity compared to healthy weight controls as shown in Table 1.¹ Extending these data to

Table 1. Percentage change in healthcare costs relative to healthy weight (Adapted from Kent, et al., Body mass index and healthcare costs: 2017)

	Overweight	Obese
Total	12%	36%
Medications	18%	68%
Inpatient	12%	34%
Ambulatory	4%	26%

diabetes results in similar outcomes, such that obese patients with diabetes have significantly greater health care costs and have significantly greater years of life lost with increasing weight.²

Over the last half century, we have gone from treating many metabolic diseases as “lifestyle failures,” to surgical therapy with true (albeit high-risk) surgical cures, and then finally to potent medications with a very favorable risk-to-benefit ratio. For example, gastric reflux disease was initially treated with weight reduction and a diet emphasizing avoidance of fat, cutting down on sugar, and limitation of tea and coffee and alcohol drinking.³ Subsequently, surgery evolved such that surgical repair of hiatal hernias became the mainstay therapy for many with gastroesophageal reflux disease.⁴ More recently, however, the common therapeutic approach, after a brief attempt at lifestyle therapy, is management with H₂ blockers and proton pump inhibitors (PPIs) with the rare patient being sent for consideration of anti-reflux surgery. Likewise, hyperlipidemia initially was treated with very aggressive diets lowering both fat and cholesterol, often with an argument for lowering carbohydrate instead.⁵ Prior to the advent of statin therapy, surgical management of hyperlipidemia with partial ileal bypass was carefully evaluated and shown to have both mortality and morbidity benefits as data from the POSCH trial has shown.⁶ Despite known morbidity and mortality benefits, due to adverse effects, even patients with familial hypercholesterolemia can almost always be managed on high dose statins and newer lipid-lowering agents such as the PCSK9 inhibitors.

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Perhaps we are now at the stage in treating obesity and diabetes where we were several decades ago with gastroesophageal reflux disease and hyperlipidemia? Although we have many new medications for obesity and diabetes which have very good results, we are not at the level of a PPI or high-dose statin where most can be “cured”. Until such time, should surgical therapy be considered the first-line treatment for diabetes in patients with obesity? Growing evidence from both lifestyle interventions and surgical interventions suggests that surgery is the most evidence-based treatment.

In 2013 the American Medical Association declared obesity a chronic disease.⁷ It is well appreciated that, unlike previous beliefs that obesity was purely a lack of willpower, obesity and diabetes are complex diseases that result from the interaction of genetics, neuro-hormonal factors, environmental factors, and psychology that are based on millennia of evolution to ensure survival during times of famine. The biological basis of obesity and the body's fight to maintain excess weight includes factors such as changes in energy expenditure and changes in hormones such as ghrelin and leptin such that, even following intensive lifestyle intervention, weight is almost universally regained. One topical example comes from a recent evaluation of long-term outcomes from the television show “The Biggest Loser” which revealed these adaptations persist over six years and the majority of weight loss is regained.⁸

In the largest lifestyle intervention study done to date, “The Look AHEAD” study randomized over 5000 overweight or obese individuals with type 2 diabetes to either standard care or intensive lifestyle intervention.⁹ After 10 years, and with successful weight loss as well as improvements in diabetes control in the intervention group versus the control group, there was no significant improvement in cardiovascular outcomes. Thus, although essential to overall health, lifestyle intervention does not seem to be sufficient currently to have a major impact on cardiovascular morbidity and mortality in people with type 2 diabetes.

In contrast to medical therapy, bariatric surgery has been shown to be common, safe, and to have dramatic benefits in people with obesity and diabetes. Data from the American Society for Metabolic and Bariatric Surgery (ASMBS, an organization based here in Gainesville), have documented the dramatic increase in bariatric surgery over the years, such that in 2015 approximately 196,000 surgeries were done. There's also been an evolution in the types of

surgeries being done. Currently the majority of surgeries are vertical sleeve gastrectomy which account for approximately 54% of surgeries nationwide with Roux-en-Y gastric bypass accounting for approximately 23% of surgeries. As with any surgery, there are risks including anastomotic or staple line leak, although this occurs in less than 0.5% of gastric bypass patients and 0.27% of vertical sleeve gastrectomy patients. The risk for death is less than that of similar surgeries such as cholecystectomy and is approximately 0.14% for bypass and 0.06% for vertical sleeve gastrectomy. In contrast to these risks, the benefits are highly significant and include improvements in hypertension, hyperlipidemia, obstructive sleep apnea, type 2 diabetes and mortality. Specific to diabetes, Schauer et al¹⁰ showed in a randomized controlled trial that weight loss, diabetes medication reduction, lipid level improvement, and quality of life were superior with surgical therapy versus lifestyle intervention and were maintained over 5 years. Specific to diabetes, a hemoglobin A1c of <6% occurred in only 5% of the medical arm whereas 29% of those who received a gastric bypass and 23% of those who received a sleeve gastrectomy had such control, often with remission of diabetes. A summary of 11 randomized controlled trials, including earlier results from the trial mentioned above, has shown consistent effects of surgical therapy on remission of diabetes.¹¹ Additionally, it has been known for approximately a decade that bariatric surgery improves mortality with findings from the Swedish Obesity Study¹² as well as the Utah Study.¹³ The Utah study found that after a mean follow-up of 7.1 years the adjusted long-term mortality from all causes decreased by 40%, and the cause-specific mortality in the surgery group decreased by 56% for coronary artery disease, 92% for diabetes, and 60% for cancer.

Given the new appreciation over the last decade or two of obesity and diabetes being due to diverse risk factors including genetics, neurophysiology, regulation of energy expenditure, environment, and lifestyle, it is readily understandable why lifestyle interventions alone have failed to impact on the obesity epidemic and consequent epidemic in diabetes. With modern surgical techniques, bariatric surgery has become the only durable cure for diabetes and obesity. Consideration of this management option while we wait for that effective “statin or PPI” for obesity is certainly warranted.

References available upon request.

THE TERRIBLE SCOURGE OF DIABETES - REVISITED

SCOTT MEDLEY, MD



[Editor's note: The following article first appeared as my editorial in the Fall/Winter 2008 issue of House Calls. We are reprinting it in this edition because (1) it is still pertinent and (2) I am getting lazy in my old age. Unfortunately, as predicted, the prevalence of diabetes in the U.S. and in the world continues to increase rapidly. The number of people with diabetes is projected to almost double by 2030. The Center for Disease Control (CDC) and the American Diabetes Association (ADA) estimate that one in three Americans born after 2000 will develop diabetes in their lifetime.]

Not surprisingly, the epidemic of diabetes coincides with the epidemic of obesity, with the increase in diabetes tracking the increase in average weight across both males and females. Annual costs of this disease are estimated at \$101-132 billion in the U.S. alone.

Finally, to look more closely at the human cost of diabetes, my young lady patient I profiled in paragraph 3 below is now about age 40. She is thankfully, but surprisingly, still alive and still receiving Renal Dialysis. She was admitted to the hospital some ten times during the last calendar year alone – not atypical for someone suffering from “The Terrible Scourge of Diabetes.”]

There are several excellent scientific articles about diabetes mellitus in this issue of House Calls. My column, as usual, will convey a more anecdotal picture of this terrible disease---a disease which is becoming epidemic and even pandemic. When I teach students---at Santa Fe College and at the hospital---about their own health maintenance, I tell them, “Don’t smoke, don’t drink alcohol, don’t do drugs, don’t get HIV, and don’t develop diabetes.” Of course, they yawn and their eyes glaze over because 1) they’ve been told all this before 2) they think that at their young healthy ages they are immortal and 3) what does an old (guy) like me know, anyway? But that last phrase--

-the one about diabetes---usually gets their attention. How can one lump diabetes in with these other significant health risks? Did ole’ Doc Medley just misspeak--again?

Then I explain to them about the multitude of awful consequences that diabetes can wreak upon a body. Diabetes most certainly causes much more pathology in many more body systems than does any other common disease---and it is, unfortunately, becoming much too common much too rapidly. I tell them that diabetes is one of the leading causes of blindness, amputations, heart disease, nerve damage, kidney failure---and this really gets their attention---sexual dysfunction. Sometimes, when explaining diseases to students, one must be quite basic. As for kidney failure (diabetic nephropathy), for instance, I liken the kidneys to a pair of incredibly wonderful chemical factories, performing the myriad of tasks involved in maintaining the body’s chemical balance. But, I warn, these little chemical factories are very fragile, made of something like styrofoam, and that while high blood pressure can pound away at this fragile matrix with each heartbeat, having diabetes is somewhat like slowly but steadily dripping sulfuric acid on the styrofoam, eating it away a little at a time, until these chemical factories are ruined, resulting in renal failure requiring lifelong dialysis or a kidney transplant.

Speaking of kidney dialysis as a result of diabetes, let me tell you a true story from my days in private practice. I first saw this patient two decades ago. She was an obese 10-year old girl who already had elevated blood sugars and elevated lipids. Not surprisingly, both of her parents were obese and both suffered from metabolic syndrome. I counselled them repeatedly that, if they did not provide some profound and significant intervention, their daughter was headed for the dreadful complica-

Continued on Page 21

Contribute to the Robb House Endowment Fund



ROBB HOUSE MEDICAL MUSEUM

This Victorian cottage built in 1878 became the home and medical office of doctors Sarah Lucretia and Robert Robb. Sarah Lucretia was the first woman physician in Alachua County. She practiced medicine from 1884 to 1917.

The Robb House was the home and medical clinic of Dr. Sarah Lucretia Robb and her husband, Dr. Robert Robb, from 1884 until the 1920's. The house was moved from its original location (East University Avenue) to 235 SW 2nd Ave in 1981 and restored in 1983 as the ACMS offices. The moving costs were approximately \$20,000 and restoration costs were \$80,000. The Alliance helped raise funds through various fund-raising efforts and established a Medical Museum with original artifacts from the Robbs.

Over the years, many objects have been donated by local physicians. The museum has been carefully tended by our museum curator, Ms. Florence Van Arnam, for more than twenty years. The Robb House is the only historic house in Florida which has been restored as a County Medical Society. It was also the first recognized Medical Museum in the state.

We have created an endowment through the ACMS Foundation to maintain this precious jewel. Our goal is a \$100,000 endowment. The tentative plan is to draw a sum on an annual basis for maintenance purposes (e.g. paint, roof repairs, restoration projects, appliances).

Thank you to all who have contributed!

Robb House Endowment Donors

A Special Thank You to our Generous Donors below!

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Congratulations to:

Southeastern Integrated Medical

The 2017 Recipient of the
ACMS Outstanding Clinical Practice Award



L to R: David Winchester, MD, ACMS President honoring Oscar DePaz, MD, and Daniel Duncanson, MD, of Southeastern Integrated Medical with the 2017 ACMS Outstanding Clinical Practice Award.



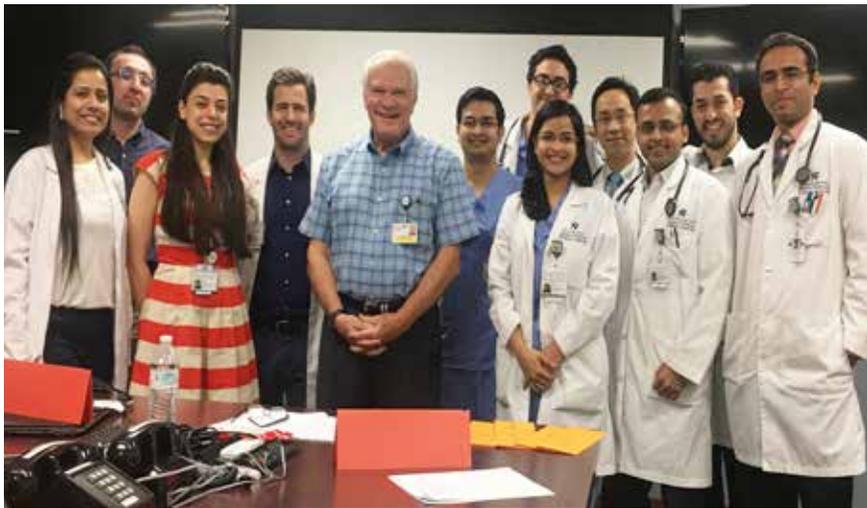
HAPPENING

ACMS

NFRMC Residents in Training



Mrs. Barbara Noble and Howard Noble, MD.



Scott Medley, MD, with Residents in training at NFRMC.



L to R: John Sousa; Lindsay McCullough, MD, UF Resident Physician Representative; and Lindsey Johnson.

ACMS Tap Room Tuesday

Loosey's Haile

June 27, 2017



L to R: Emily Welch; David Winchester, MD; ACMS past President; and Chris Libby.



L to R: Mr. John Roberts, VP, Commercial Banking at Community Bank & Trust of Florida; Mr. Jeff Sims; and Ronald Jones, MD.



L to R: David Winchester, MD, ACMS Past President; Jarrod Fowler, MHA, FMA Director of Health Policy and Innovation; and Matthew Crowley, Chief Operating Officer, Florida Medical Association.



L to R: Mrs. Roslyn Levy; Norman Levy, MD ; Erin Connor Werner, MD; Eduardo Marichal, MD; and Caroline Rains, MD.



NFRMC Resident Physicians Pritam Brar, MD; and Priyanka Kapoor, MD.



L to R: David Winchester, MD, ACMS Past President; Matheen A. Khuddus, MD, ACMS President; John Katopodis, MD, FMA President-Elect; and Matthew McKillop, MD.

**ACMS Tap Room Tuesday
Loosey's Haile, July 18, 2017**



L to R: Harry Meisenbach, MD; Ronald Jones, MD; Illie Barb, MD; Joe Kim, MD; Matheen A. Khuddus, MD, ACMS President; and Brandon Bodlak, DO.

HAPPENINGS

ACMS



L to R: Joseph Thornton, MD; Jesse Lipnick, MD; Carl Dragstedt, DO, ACMS Secretary/Treasurer; and Charles Riggs, MD.

FMA Annual Meeting
Loews Sapphire Falls Resort
Universal Orlando®, August 4-6, 2017



L to R: Jackie Owens, ACMS EVP; Charles Riggs, MD, and Mrs. Chris Riggs; Jesse Lipnick, MD; Carl Dragstedt, DO; and Ms. Corinne Gelfand Lipnick.



David Winchester, MD, ACMS Past President.



Opening ceremonies at the FMA House of Delegates meeting.



David Winchester, MD, ACMS Past President addressing the House of Delegates.



L to R: Jackie Owens, ACMS EVP; Chris Riggs; Charles Riggs, MD; and Carl Dragstedt, DO, ACMS Secretary/Treasurer.

**FMA Annual Meeting
Loews Sapphire Falls Resort
Universal Orlando®, August 4-6, 2017**



Jesse Lipnick, MD; and
Carl Dragstedt, DO, ACMS Secretary/Treasurer.



Karen Humphreys, UF Health Regional Manager, Oncology and Dana Nemenyi, Director of Business Development, UF Health Shands at the FMA Vendor Show.

HAPPENINGS



L to R: Jesse Lipnick, MD, ACMS Board Member; Joseph Thornton, MD; John Hiemenz, MD; Charles Riggs, MD, ACMS Board Member; Karen Harris, MD; David Winchester, MD, ACMS Past President; and Matheen Khuddus, MD, ACMS President.



Greek Dancers at the FMA President's Installation Celebration "A Taste of Greece."



Mark E. Panna, MD addressing the House of Delegates.



John N. Katopodis, MD, incoming FMA President at the FMA President's Installation Ceremony.

**FMA Annual Meeting
Loews Sapphire Falls Resort
August 4-6, 2017**



David Winchester, MD, AMA Delegate Candidate Speaking at the Gator Caucus Breakfast.



L to R: Charles Riggs, MD; John Hlomez, MD; and Matheen Khuddus, MD, ACMS President.



FMA ANNUAL MEETING 2017

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Charles E. Riggs, Jr., MD, FACP,
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David E. Winchester, MD,
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AMA Delegate

SPECIAL THANKS TO:



Carl Dragstedt, DO,
2017 FMA Delegate Chair.

Save the Date for Upcoming ACMS Dinner Meetings:

Tuesday Evenings 6pm Social; 7pm Dinner

September 12th - Cardiology - Mitral Disease

Dr. Charles Klodell and Dr. Mark Tulli,
North Florida Regional Medical Center

October 10th - Maintenance of Certification

Dr. Timothy Flynn
UF Hilton Conference Center (Vendor Show)

November 14th - Prevention of Medical Errors

Haile Plantation Hall

A Note from our **Editor**



MEDICAL MARIJUANA "THE REST OF THE STORY" - SO FAR

SCOTT MEDLEY, MD

House Calls Executive Editor

Dr. Medley is currently retired and
Volunteers at Haven Hospice

{Editors note: While continuing to teach classes at Haven Hospice and to the Residents at NFRMC, I find great ongoing interest in the subject of Medical Marijuana. Tapping into that interest, I wrote an article in the Winter 2017 issue of House Calls entitled "Medical Marijuana Initiatives in Florida." I closed that article with the words "Stay Tuned". Well, as expected, there have been extensive developments in this arena in the past few months – herein lies a summary.}

CLOSE TO HOME

The first Medical Marijuana (MM), "Cannabis Clinic" in Gainesville opened on SW 34th Street on May 19, 2017. At the time it opened, this was one of seven clinics licensed in Florida, but this number is, no doubt, already rapidly increasing. At this Gainesville clinic, patients who have "an approved physician's certification" can receive "high CBD" – the "medical component", "low THC" – the "psychoactive component" cannabis for various debilitating conditions which will be listed below. These patients must have failed other treatments by "qualifying physicians" before being eligible to receive MM. At the time of the opening of this clinic, there were seven physicians in Gainesville who were "qualified" to "certify" patients for MM. This number will also, undoubtedly, increase. All drugs at the clinic are referred to as "Medical Cannabis", and nowhere to be found are the words "POT", "WEED", OR "GRASS".

THE LEGISLATURE FINALLY ACTS

"Amendment 2" passed in November 2016 authorizing the use of MM in Florida and requiring the Florida State Legislature to establish laws governing MM by July 3rd, 2017 to be enacted by October, 2017. During its Spring 2017 regu-

lar session, the Legislature was unable to agree on a bill regarding this contentious issue. It was not until "the eleventh hour", on the last day of a special session on June 9, 2017, that the MM bill was passed overwhelmingly – by a vote of 103-9 in the Florida House and 29-6 in the Senate. Some features of the law include:

- A cap of 25 dispensaries, 17 marijuana growers
- 4 more new dispensaries per 100,000 patients in the future
- Patients/caregivers must be age 21 and over and have ID cards
- Patients may receive three 70-day supplies between physician visits
- Patients must be "recertified" every 30 weeks
- Patients no longer must be under the care of a physician for 90 days to be "certified"
- Certification courses for physicians are reduced from 8 hrs to 2 hrs
- Seasonal residents ("snowbirds") who meet certain criteria are eligible

QUALIFYING DEBILITATING CONDITIONS

Patients must have one of the following ten "qualifying debilitating conditions" to be eligible to receive MM. (1) Terminal Conditions, (2) Cancer, (3) Epilepsy, (4) HIV/AIDS, (5) Glaucoma, (6) Post Traumatic Stress Disorder (PTSD), (7) Crohn Disease, (8) Parkinson Disease, (9) Amyotrophic Lateral Sclerosis (ALS), and (10) Multiple Sclerosis (MS).

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It is currently estimated that about 16,600 Floridians “qualify” for MM, and that by 2022 some 470,000 will qualify, producing about \$542 Million in sales.¹ There is no sales tax on these “medicines”. The considerable perils of using marijuana were detailed by our EVP, Jackie Owens, and by myself in the Winter 2017 issue of House Calls.^{2,3}

NOT YOUR AVERAGE “GUMMY BEAR”

Approved delivery methods include oils, sprays, tinctures, and “vaping” (“inhaling and exhaling the vapor produced by cannabis in an inhalation device”) MM is also formulated as “edibles”...but “as a food product not appealing to or marketed to children”. (In some states edible marijuana is packaged similar to kids’ snacks. In fact, in California there is a cannabis product “intended for medical use only” which, indeed, is packaged as “Gummy Bears”. This product contains 5mg. of THC-the psychoactive component-per “Bear”, with no mention on the package of CBD-the medicinal component. Also in California, one can purchase “for medical use”, “cannabis infused” edible “Peanut Budda Buddha”, each serving containing “20.2 mg. of active THC” and 0.00 mg. of CBD!)



Medical Marijuana Edibles

- Cookies, gummies, beverages, chocolate bars and more
- Delicious and yummy way of medicating
- Effects start between 30 and 60 mins after consuming, and can last 4 to 12 hours
- All items preserved using proper storage conditions

SMOKING – FOR THE PEOPLE!

It is interesting that, except for patients with “terminal conditions,” smoking medical marijuana remains prohibited by law in Florida. It is also interesting that John Morgan, whose Personal Injury law firm, Morgan and Morgan (for the people!), financed about one-half of the \$12.5 million Amendment 2 effort, has filed a lawsuit against the state of Florida to allow smoking MM. Go figure!

More than half of the states in the U.S. have now passed laws legalizing MM. Many are considering completely legalizing the recreational sale of marijuana.

On July 1, 2017, the sale of recreational marijuana became legal in the state of Nevada. Is Florida next? As stated before—Stay Tuned!



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