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Dr. Brar, MD, a University of Florida graduate, earned her medical degree at the Xavier University School of Medicine in Bonaire. She completed her Internal Medicine Residency at Rochester General Health System in Rochester, New York and a Fellowship in Rheumatology at Brown University in Providence, Rhode Island. Dr. Brar is Board Certified in Internal Medicine and is currently practicing at SIMED Health Arthritis Center in Gainesville, Florida.

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Dr. Rozboril, MD earned his Medical Degree at the University of Illinois, Abraham Lincoln School of Medicine. He completed his Internship and Residency in Internal Medicine at the University of Michigan and went on to complete a Fellowship in Rheumatology at the University of Michigan. He began private practice in Gainesville, FL in 1985 where he continues today at SIMEDHealth Arthritis Center. Dr. Rozboril is a Diplomate of the American Board of Internal Medicine and is Board Certified in Rheumatology.

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GrayRobinson, PA

Rupa Lloyd is a Shareholder at GrayRobinson, PA and an elected member of the Executive Council of Florida Bar Health Law Section. With over 16 years of experience, she specializes in healthcare operational, corporate, transactional and regulatory matters. She advises clients in privacy and data security, fraud and abuse, corporate governance, labor relations, licensure and discipline, quality improvement, and healthcare risk management. She routinely conducts due diligence, including the preparation and negotiation of agreements in connection with telehealth, software licensing, EMR, practice sale and acquisition.

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Retired Family Physician

After graduating from the University of Kentucky College of Medicine, Dr. Scott Medley served in the U.S. Army, completing his Residency in Family Medicine and attaining the rank of Major. Dr. Medley entered Private Practice in Gainesville, establishing Gainesville Family Physicians. He spent 20 years in Private Practice before becoming a Hospitalist and later acting as 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 was given 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, where he was named Volunteer of the Year for 2017. Dr. Medley has served as Executive Editor of HOUSE CALLS for the past 20 years, and has authored over 85 editorials and articles for this publication.

Eric Rush , MD

SIMED Rehabilitation Medicine

Dr. Rush was born in Pittsburgh, PA and began his pilgrimage south with his undergraduate degree at North Carolina State University where he obtained a BS in Biomedical Engineering. He then continued on to medical school at American University of the Caribbean School of Medicine on St. Maarten. He has completed a residency in Physical Medicine and Rehabilitation at East Carolina University in Greenville, NC where he was the Chair of the Resident and Fellow Council. He has joined the team at SIMED Health in the Rehabilitation Medicine department, and is also currently the Director of the Spinal Cord Injury inpatient rehabilitation program at UF Health Shands Rehabilitation. His passions lie in spinal cord injury recovery, amputee care, and musculoskeletal medicine.

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UF Health Division of Nephrology

Dr. Alquadan is an Assistant Professor in the UF Division of Nephrology, Hypertension and Transplantation. Her clinical interests include transplant nephrology and chronic kidney disease in patients with solid organ transplants. Her published research includes uric acid's role in AKI and its relationship to kinetic GFR, ambulatory blood pressure monitoring and autonomic dysfunction, and post transplant lymphoproliferative disorder in kidney transplantation. Dr. Alquadan is Board certified in Internal Medicine and Nephrology and is a member and a fellow of the American Society of Nephrology and a member of the American Society of Transplantation.

(Dr. Alquadan's Biography was omitted from the Winter House Calls issue and is presented here as the co-author of the article titled "Belatacept - The 'New Kid on the Block' In Kidney Tranplants." We apologize for this omission and have credited Dr. Alquadan in the revised online publication at acms.net.)

House Calls is a quarterly publication of the Alachua County Medical Society, Inc., Gainesville, Florida.

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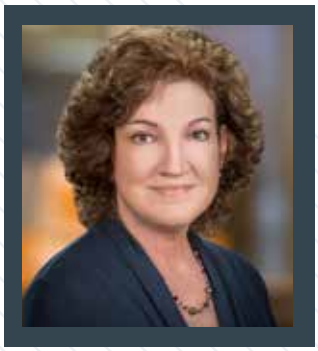

Gout – A Brief History

Jackie Owens, ACMS Executive Vice President

Gout is a highly painful form of inflammatory arthritis and the most common type of inflammatory arthropathy worldwide. It is associated with increased risk of diabetes, cardiovascular disease, renal disease, morbidity and mortality. [1, 2, 3]

Originally associated with an affluent lifestyle, gout can affect anyone, including athletes who have an active and healthy lifestyle. Many famous people throughout history have reported episodes of gout, including King Henry VIII, Ludwig Van Beethoven, Charles Dickens, Queen Anne, Benjamin Franklin, Thomas Jefferson, John Hancock and Queen Victoria. More recent reported cases include Ansel Adams, Luciano Pavarotti, Dick Cheney and Emmitt Smith. [4,5,6,7]

First identified by the Egyptians in 2640 BCE, gout was later recognized by Hippocrates as "the unwalkable disease." Hippocrates referred to gout as an "arthritis of the rich," as opposed to rheumatism, an "arthritis of the poor." Gout was originally associated with a lifestyle of debauchery and intemperance, but was also occasionally mentioned as a hereditary trait.[5, 8] Many medical cartoons have been devoted to gout over the years, including the three shown below (Figures 1 & 2).

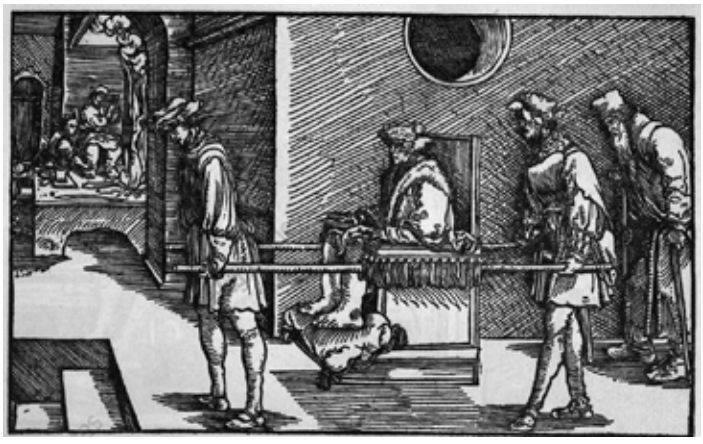

Figure 1: Image titled "Von dem Ziperlin oder Podagra" by Hans Weiditz, 1572

"The gout generally attacks those aged persons who have spent most of their lives in ease, voluptuousness, high living, and too free a use of wine, and other spirituous liquors, and at length, by reason of the common inability to motion in old age, entirely left off those exercises which young persons commonly use. And further, such as are liable to this disease have large heads, and are generally of a plethoric, moist, and lax habit of body, and withal, of a strong and vigorous constitution, and possessed of the best stamina vitae."

----Thomas Sydenham (English physician and discoverer of Sydenham's Chorea) [9]

Gout played a considerable role in American history. The British statesman William Pitt the Elder and his disabling gouty arthritis was a major factor in Britain's loss of the American colonies. Being an Englishman who considered the Americans to be "the sons, not the bastards, of England," he defended the colonies in various parliamentary proceedings. During one of his absences from Parliament due to an episode of gout, Lord Townshend persuaded Parliament to levy a heavy duty on colonial imports of tea to raise needed revenues. This action precipitated the Boston Tea Party in 1773! [5,10].

Ben Franklin, the only colonist to have signed all three of the following: the founding Document of the American Revolution, the Declaration of Independence, and the ratification of the Constitution – suffered from severe gout, as well as did Thomas Jefferson and the Comte de Vergennes, a French nobleman who was integral in obtaining the money to finance the Revolution. Ben Franklin had to be carried in a sedan chair to the Constitutional Convention as his gout would not allow him to walk. Diet was originally considered the primary contributing factor to the development of gout – too much red meat, shellfish, beer and liquor. [11] In other words, if it tastes good, don't eat or drink it!

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GOUT - A BRIEF HISTORY

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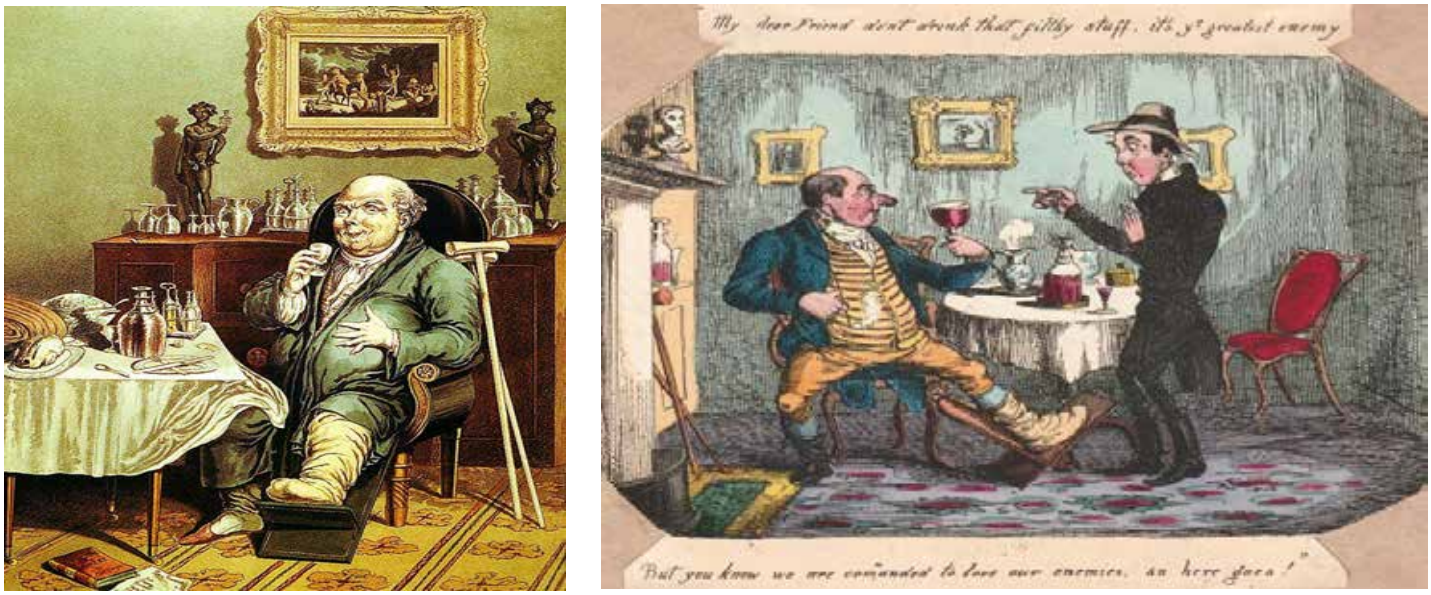

Figure 2: A caricature of Ben Franklin circa 1780 titled "An Exquisite Taste, with an Enlarged Understanding" (left) and an unrepentant port drinker with gout, ignoring advice from the vicar – unknown artist circa 1800 (right).

Colchicine, an alkaloid derived from the autumn crocus, was one of the first medicines employed to treat gout, and was used by Byzantine physicians in the 6th century ACE. [5] Allopurinol, a uric acid lowering agent, has been the most widely used gout medication over the last 60 years. More recently, febuxostat (Uloric ®) has proven to be effective in reducing uric acid levels without many of the side effects of Allopurinol.[12,13,5] These medications help alleviate the pain associated with gout, but nothing exists at this point to totally cure the underlying condition. Non-steroidal anti-inflammatory drugs (NSAIDS) and corticosteroids are used for acute attacks.

Chronic kidney disease (CKD) is often present in patients with gout. Studies have shown that gout is not a cause of CKD, but that the common association of hyperuricemia with CKD is solely attributed to the retention of serum uric acid that is known to occur as the glomerular filtration rate falls.[14] Elevated serum uric acid levels are also associated with an increased risk of developing type 2 diabetes. A recent study of Chinese adults in Singapore shows that individuals with gout have a 36% increased risk of developing diabetes – dependent upon the baseline BMI and hypertension status – surprisingly, those with normal weight and free of hypertension were most likely to develop type 2 diabetes. They concluded that hyperuricemia may causally lead to both gout and diabetes and that obesity and hypertension were not causal factors of gout. [15]

The National Kidney Foundation (NKF) recommends lifestyle and dietary modifications along with appropriate pharmacologic treatments for gout and reducing the risk of worsening CKD.[3] Nonpharmacologic methods used to address these conditions include:

- Losing weight to achieve a healthy body mass index
- Exercising to achieve physical fitness
- Quitting smoking
- Staying well hydrated

Good advice for everyone, really.

Today, relief is available for the pain associated with gout. However, additional clinical trials are needed to research the role of uric acid in relation to gout, CKD and metabolic syndrome. Much is still unknown about hyperuricemia and its underlying effect on the human system. Perhaps even someone with the intellectual curiosity of Ben Franklin would have difficulty figuring it out!

References available upon Request

Non-operative Management of Chronic Knee Osteoarthritis

Eric Rush, MD,
SIMED Rehabilitation Medicine

Background:

Arthritis is the leading cause of disability in the US with an estimated 52.5 million adults suffering from this condition.[2] The CDC denotes arthritic joint pain that severely impacts a person's quality of life as severe joint pain (SJP) and found that of the 52.5 million adults with documented arthritis over 27% of them suffered from SJP.[2] Finding ways to help our patients to live with osteoarthritis (OA) and SJP is of paramount importance, especially in our home of Alachua County which has a median age of 31.3.

Diagnosis and Workup of Arthritic Knee Pain

The beginning of an arthritis diagnosis like any other medical condition starts with a thorough history and physical examination. Ruling out inflammatory conditions (gout, pseudogout, etc.) and systemic spondyloarthropathies (RA, ankylosing spondylarthrosis etc.) is important when first making the diagnosis of primary knee OA. "Red-Flag Symptoms" that should make you think of other causes of knee pain include, fever, weight changes, many joints involved, erythema, swelling, warmth, prolonged morning stiffness (> 1 hour), and rapid onset of knee pain. Knees which are swollen, erythematous and red should always be considered for infection and gouty arthropathies, and fluid analysis on the synovial fluid is critical in those diagnoses.

A classic OA picture will present as a gradual worsening of symptoms, initial stiffness in the AM (usually < 30 minutes), worse after rest but improving somewhat with moderate exercise, and can be provoked by prolonged activity. The patient may report clicking or popping, but it is uncommon for the joint to lock or become "stuck" with just OA. The pain is usually aching and deep in nature, but can have some occasional sharp pains reported. Typical OA will develop worse in the medial compartment of the knee with a slight valgus (knees buckled in) appearance. In younger patients (<55 years old) primary patellofemoral arthritis can cause severe pain which remains localized deep to the patella and is worse with extension type activities.

Before moving forward with treatment, it is important to perform a thorough physical exam. Inspection is often overlooked but is vitally important, as deformities of the knee will cause uneven stresses and can lead to more rapid progression of the arthritis and more severe symptoms. Palpation along the joint lines of the knee as well as range of motion (ROM) of the knee can give insight into general function and localization of pain symptoms. Testing of the ligaments of the knees should include varus and valgus stress testing, both in full extension and at 20-30°/of flexion, as well as anterior and posterior stability testing with either an anterior and posterior drawer test or Lachman test. Gait observation including limp and comparative stride length can give insight into the impact arthritis may be having on your patient.

Further testing with laboratory studies and imaging can be beneficial when first making the diagnosis of primary knee OA. Weight bearing XR of the knee in AP, lateral and non-weight bearing "sunrise" views gives the best images of the knee in its functional state and can better help to establish progression of disease. Routine laboratory studies with CBC, CMP, sed-rate and/or CRP may be warranted if the patient has any of the red flag symptoms above, or say you are considering pharmacologic interventions for his/her pain. However, lab testing is usually not necessary for diagnosis of OA.

Non-pharmacologic Management

The first steps for managing OA knee pain are lifestyle changes with an emphasis on diet and exercise. Moderate intensity exercise of at least 150 minutes per week has been shown in several studies to have beneficial effects on slowing the progression of and disability from knee OA.[4] Also, BMI of higher than 35 carries a very sharp rise in the risk of infection post joint replacement, and thus it is important that from the first sign of joint pain a push is made to combat obesity.[5] Physical Therapy with strengthening programs targeting the adductors and knee extensor muscles will help to stabilize the knee and assist in OA pain deriving from patellofemoral component arthritis. Regular stretching to preserve full ROM is also important as one of the most predictive factors of knee ROM post-replacement is knee ROM pre-replacement. Complementary and alternative medicines such as acupuncture, heat and ice modalities, and herbal supplements have also been shown to have benefits in small studies.

Pharmacologic Management

Acetaminophen should be considered first line for oral pharmacologic treatment. Doses of 650mg up

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CHRONIC KNEE OSTEOARTHRITIS

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to four times daily can be effective in most early cases of OA. Prolonged use of acetaminophen should prompt the physician to check liver transaminases for possible adverse events with the medication. Oral NSAID or topical NSAIDs should be considered second line. Chronic use of either should prompt a physician to check renal function every 3-6 months as well as considering placing the patient on an antacid medication to reduce risk of gastrointestinal complications. Topical agents either via gel, patch or liquids carry less risk of the systemic side effects, but have been less effective in overweight patients. Use caution in using oral NSAID or selective COX inhibitors in patients with known coronary artery disease as there is a significant increased risk of cardiovascular events with prolonged use.

Interventional Management

If pain continues despite pharmacologic and non-pharmacologic treatments, the next step in management is interventional modalities. There are several types of injections and a multitude of mechanisms of action that can lead to reduction in arthritic pain and morbidity. Arthrocentesis should be considered for every patient on their first injection to allow for fluid analysis to rule out concomitant gout or pseudogout, which may play a role in worsening the patient's prognosis. Depending on the severity of the arthritis and the level of effusion within the joint it may be beneficial to the patient to first perform an arthrocentesis, as the amount of fluid in the injection can lead to increased intraarticular pressure and discomfort.

After simple arthrocentesis the next most common injection includes intraarticular steroid injection with or without local anesthetic. I recommend using local anesthetic when injecting steroids as it can limit some of the discomfort from joint capsule stretch from injection of all the fluid. While more recent studies show that there may be some increase in the rate of cartilage degradation post-corticosteroid injection, and that long-term the injections do not delay or prevent joint replacement, patients often report improved symptoms and less impairment with these injections.[1,3] Alternative injections with hyaluronic acid or viscosupplementation has shown benefits in the management of OA, however results seem to be very patient-specific and at this point no clear predictive indices currently exist for who will be a responder and who will not.[3] For these injections improvement of symptoms >50% at 2 weeks and continued benefit past 6 months is considered a successful treatment, and you could consider repeat viscosupplementation injections. They come in various options for injection including single-dose up to 5 sequential weekly injections.

The newer options for interventional management of knee OA pain include geniculate nerve blocks, which operate on a principle like medial branch rhizotomies on the back. First the patient will have a diagnostic block or two to identify if the formal rhizotomy is likely to provide relief. Then if patients report >50% reduction in their pain symptoms which wears off appropriately for the anesthetic, they will be brought back for a radio-frequency ablation of the geniculate nerves, thus denervating the articular surfaces of the knee. No motor function is lost in this procedure as all motor branches have been given off prior to the site of the lesion. The remaining two options include platelet rich plasma (PRP), or stem cell injections in which the patient has cells harvested from autologous tissue and then injected into the knee. The mechanism of action of this is an inflammatory process and thus patients are instructed to stop all NSAIDs and steroids prior to injections. Both of these last two options are still classified under investigatory by most insurance carriers and thus are usually the performed as self-pay interventions.

Ultimately, the goal of the physician in treating chronic knee OA pain is to limit pain symptoms which impair the patient's quality of life. Doing so in the least invasive way possible is the ultimate goal. There is no treatment currently that has been shown to prevent the progression of OA or reverse damage that has already been done, and our goal should be to delay replacement as far into life as possible to prevent the need for revision and to set patients up for success post-replacement with strengthening, ROM, and weight loss strategies, if they do end up needing to undergo total knee replacement.

References Available Upon Request

TELEREHABILITATION INNOVATION AT THE NORTH FLORIDA SOUTH GEORGIA VETERANS HEALTH SYSTEM

Charles Levy, MD
Chief of the Physical Medicine and Rehabilitation Service at the North Florida/ South Georgia Veterans Health System (NF/SG VHS), Co-Director, CINDRR Gainesville.

It is not surprising that access to top quality rehabilitation care becomes more difficult to obtain the further one resides from comprehensive medical centers. Yet the Veterans Health Administration has a mission of delivering high quality care to Veterans regardless of where they reside. This is the challenge faced by the North Florida/South Georgia Veterans Health System (NF/SG VHS) centered in Gainesville, which serves Veterans in a catchment area the size of West Virginia. As part of the response, the Physical Medicine and Rehabilitation Service has turned to telehealth through two programs, the Low Activities of Daily Living Program (LAMP) and the Rural Veterans TeleRehabilitation Initiative (RVTRI).

LAMP was born in 2001, when the VA's Office of Telehealth (now VA Telehealth Services) issued a call for innovative demonstration projects. William Mann, PhD, who at that time was the Chair of the Department of Occupational Therapy at the University of Florida, teamed up with Charles Levy, MD, the Chief of Physical Medicine and Rehabilitation at the NF/SG VHS, to take advantage of the opportunity. Dr. Mann had done research that demonstrated that provision of appropriate rehabilitation equipment (items such as canes and walkers, adapted utensils, toilet, bathroom and shower equipment) could prolong home independence for frail elders. With this new opportunity, Mann and Levy created a program with the following components:

1) Veterans in need of support to maintain home independence are referred to LAMP.

2) After screening for eligibility, they receive a home visit by a technician and an occupational therapist, who perform a comprehensive home assessment.

3) The LAMP team returns to deliver and install the needed equipment, which could also include ceiling or floor lifts, communication devices, adapted computers, environmental control units, and indoor and exterior ramps and rails (the team has discovered plenty of previously ordered equipment sitting in closets because the equipment is the wrong size or needed assembly/installation to be useful). The team also provides training and education to the Veteran and caregivers.

4) the LAMP team encourages self-management of chronic conditions through a rehabilitation-based disease management protocol (DMP) delivered either by a low-tech home messaging device which runs on a standard telephone line; or a more customizable protocol delivered to a personal computer, tablet, or phone. Both of these methods rely on secure encryption technology.

In order to receive LAMP service the Veteran/caregiver must agree to engage with the DMP on a daily basis, The DMP will ask questions pertinent to the Veterans health status ("Did you take your prescribe medicines?," "Did you get any exercise today?," "Are you experiencing any falls?," etc.,) allowing the Veteran to respond by selecting an answer from a menu. The computerized version allows the Veterans to fill in free text responses. The team reviews the responses of each Veteran each day. Most of the time, most Veterans are doing fine, and don't need active interventions, but when their responses indicate it, the therapists are there as care coordinators to help navigate the system to get the Veterans the assistance they need, from prescription refills, to referrals to VA and community resources, to facilitating urgent medical care.

The LAMP team consists of two occupational therapists, one technician, and one program support assistant. They are able to manage a caseload of up to two hundred Veterans. LAMP enrollment has resulted in an increase in clinic visits and home equipment, with a reduction of nursing home bed-days of care.[1-3] LAMP earns high marks in patient satisfaction, with comments such as "I am sure you have been told this before, but my daily chores have been made easier since making contact with this new program. Thanks to you all.," and "Just want to thank you for what you have done for me. I can now get soup to my mouth without spilling. All the other utensils are great also. Must go now. GOD BLESS YOU." In 2017 the LAMP Team (two occupational therapists, one technician, and one program support assistant) provided ongoing service to 216 Veterans, with 2032 encounters.

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TELEREHABILITATION

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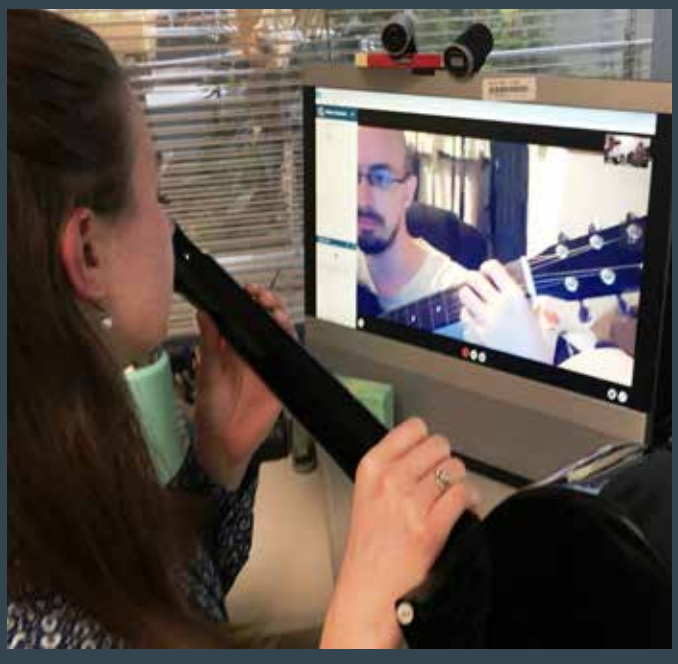
The RVTRI was founded in 2009, when Dr. Levy was alerted to a second call for demonstration projects, this time from the VA's Office of Rural Health. Despite the success of the LAMP program, Dr. Levy had noticed that the occupational therapists were busy with care coordination, and could not personally offer ongoing occupational therapy beyond the home assessments. Dr. Levy had heard of streaming televideo (i.e. Skype) and thought this might be a viable method to bring therapists into Veterans' homes, saving the Veterans the time, inconvenience and expense of travelling to the medical center. He was awarded funding to launch the RVTRI: fortunately, it turned out that the VA had established an Enterprise Video Network, which was a perfect vehicle for this project-which started with physical therapy, occupational therapy, and recreational therapy. In this model, Veterans are seen initially in person to determine what their needs are, whether they are amenable to treatment at a distance and to see if they are interested in telerehabilitation. If the treatment demands hands-on joint mobilization, telerehabilitation won't work. However, a large portion of rehabilitation therapies involves education and coaching, which works well through a computer-enabled telehealth to provide live streaming video. The Veteran performs the exercises at home while the therapist at the medical center evaluates the performance and gives immediate feedback. Web cameras on dedicated devices, personal computers, tablets and even smart phones can carry the video. RVTRI patients receiving home PT showed significant improvements in cognition, walk times, quality of life, and functional independence, while saving hundreds of miles of travel, and travel-related time and expense. Veterans were highly satisfied with their treatment.[4] Over the years, the RVTRI has expanded to include speech/language therapy, creative arts and dance/music therapy as well as supported employment services.



Diane Garrison Langston, NMT, MM, MT-BC conducting music therapy via telehealth. Photo Credit: Bobbie O'Brien/WUSF Public Media.

The RVTRI has been so successful that it has been chosen as a VA Enterprise Wide Initiative (EWI). As an EWI, funds are available for the other VA centers to join the RVTRI and to be mentored by the NF/SG VHS team to set up similar programs in their own catchments. Current expansion sites include Phoenix and Show Low Arizona; Richmond, Virginia; and Bonham, Texas. This body of work has led to the inclusion of the NF/SG VHS in Creative Forces: NEA Military Healing Arts Network, which serves the special needs of active duty service members and Veterans who have been diagnosed with traumatic brain injury (TBI) and psychological health conditions, as well as their families and caregivers. Made possible by a unique collaboration between the National Endowment for the Arts, the Departments of Defense and Veterans Affairs, and state arts agencies, Creative Forces is funding a music therapist to join the RVTRI team. In turn, members of the RVTRI team are mentoring therapists at the National Intrepid Center of Excellence (NICOE) in Telerehabilitation. NICOE, a directorate of Walter Reed National Military Medical Center, helps active duty, reserve, and National Guard members and their families manage their traumatic brain injuries and accompanying psychological health conditions through diagnostic evaluation, treatment planning, outpatient clinical care and TBI research.

In 2017, 1411 unique Veterans were served through 3631 encounters.

Both the LAMP and the RVTRI benefit from being VA programs, where the first priority is getting services to Veterans. These progams set a great precedent for the private sector of patient-centered medicine, which will hopefully ease the way for similar programs for civilians.

References Available Upon Request

ADVANCES IN THE MANAGEMENT OF PSORIATIC ARTHRITIS

Tina Brar, MD
SIMED Health Arthritis Center

Introduction

Although psoriasis has been described since the time of Hippocrates, psoriatic arthritis was identified as a separate disease entity in the 1960s by what is now the American College of Rheumatology (ACR). Initially thought to be benign, it is now recognized as a member of the spondyloarthropathies and is a debilitating, progressive illness with a comparable impact on functional ability and quality of life as rheumatoid arthritis (RA). Early diagnosis is imperative to prevent long-term disability and ensure optimal management of the disease and its comorbidities.

Psoriatic arthritis (PsA) is a complex affliction with musculoskeletal involvement- including arthritis, dactylitis, enthesitis and/or axial involvement as well as skin and nail disease. Although the exact pathogenesis is not known, it is thought that genetic, immunologic and environmental factors play a role. The prevalence of PsA in the United States is around 0.25%, however about 30% of patients with psoriasis also have psoriatic arthritis, affecting men and women equally. It is therefore prudent to screen all psoriasis patients for PsA. Varying patterns of the disease mimic different inflammatory conditions, such as gout and RA. Approximately 15% of patients develop arthritis prior to skin involvement, making the diagnosis difficult. Generally, laboratory tests are unhelpful as there is no specific test for PsA and systemic inflammatory markers may be elevated in only half the cases. The genetic marker HLA-B27 is not a diagnostic test as no more than 2% of people born with this gene will eventually develop a spondyloarthropathy. A multidisciplinary approach between dermatology and rheumatology is helpful in analyzing many cases. Recognition of this disease process has increased with the introduction of the classification criteria, CASPAR, as well as the development of several screening tools that allow for timely intervention.

Treatment

Anecdotally, treatment options for PsA were limited to non-steroidal anti-inflammatory drugs (NSAIDs) and conventional disease-modifying anti-rheumatic drugs (DMARDs). Initially developed to treat rheumatoid arthritis, these medications have varying benefits in treating inflammation and the vast manifestations of PsA as well. Multiple systematic reviews have determined that the effect size of these DMARDs such as methotrexate, sulfasalazine and leflunomide are not very high and cyclosporine is seen as toxic. Corticosteroids can be used both locally as injections and systemically, although not supported by evidence-along with the concern of rebound psoriasis upon withdrawal of the drug.

Spanning the past decade, the availability of targeted synthetic and biologic DMARDs has revolutionized treatment. Given these advances, a "treat-to-target" approach towards management has been proposed, following its favorable application in other rheumatic conditions. The ultimate objective of therapy is to procure the lowest possible level of disease activity in all aspects of the illness. Despite a lack of cure, there are now effective treatments.

Tumor necrosis factor inhibitors (TNFi), which block the inflammatory mediator TNF-α, have been around for over two decades and have established breakthrough efficacy in patients with PsA. Five TNFi are now available, including adalimumab, etanercept, infliximab, golimumab and certolizumab. Along with improvement in clinical signs and symptoms, these treatments also decrease radiographic evolvement of disease. All TNF-α blockers have been studied in randomized control trials as well as in observational studies with consistent evidence supporting their efficacy and safety in PsA. Currently, trial data is limited in regards to switching from one inhibitor to another, although clinically it is a successful strategy. The choice of agent is based upon patient preference as well as regulatory and payor requirements and/or limitations

In recent years, new biologics with alternative modes of action have also been tested and approved in PsA. Ustekinumab is an FDA approved IL 12/23 inhibitor with evidence in treating arthritis, skin, enthesitis and dactylitis. Guselkumab, an IL-23 blocker, is currently FDA approved for psoriasis only and is under investigation for the management of PsA with promising data.

Research now highlights the importance of the TL-17 pathway and a number of therapies targeting this pathway are being studied. FDA approved anti-IL-17 therapies include secukinumab and ixekizumab. Currently brodalumab is FDA approved for psoriasis only, but has shown efficacy in trials for PsA as well.

Tofacitinib is an oral inhibitor of Janus kinase that

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has demonstrated efficacy in the treatment of PsA in several randomized trials including patients with both an inadequate response to conventional DMARDs and TNFα(alpha) to inhibitors.

Abatacept, a selective T-cell costimulation modulator used in the treatment of rheumatoid arthritis, has also shown benefit in patients with PsA in limited published randomized trials and therefore became FDA-approved last year.

Apremilast, a phosphodiesterase 4 inhibitor, is a newly targeted synthetic DMARD that induces suppression of several inflammation mediators including IL-2, IL-12, TNF-α, IFN-γ and inducible nitric oxide synthase. Efficacy and safety in PsA has been demonstrated through four multi-centric, randomized trials (PALACE Trials) compared to placebo in patients who failed other biological options.

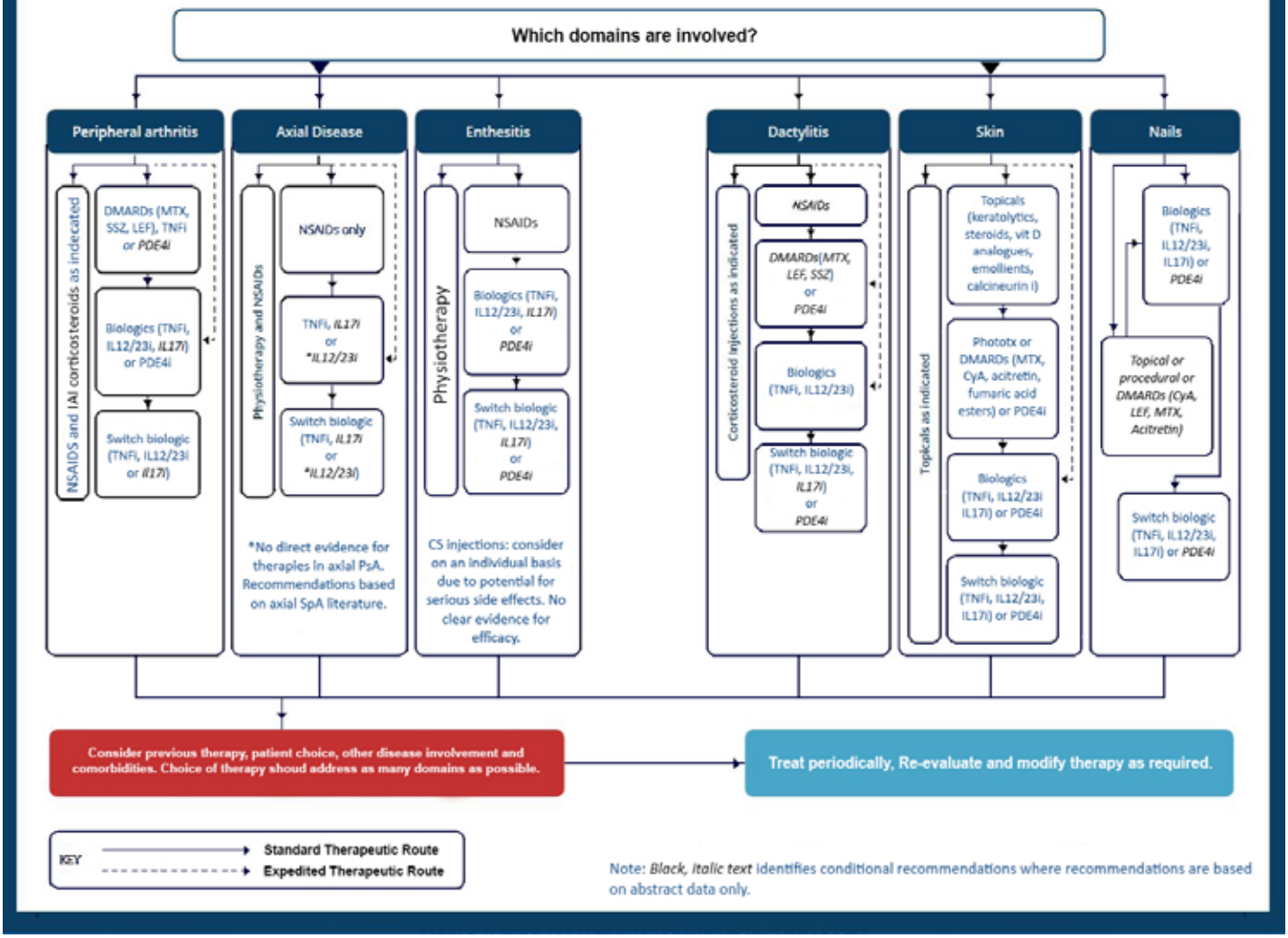
Unfortunately, evidence-based guidelines to navigate how these therapies should be used are lacking. Several international and national recommendation sets are created such as GRAPPA (figure 1) and EULAR, with the aim to help rheumatologists in everyday clinical practice management. At this time, drug choices are made according to available safety data, presence of extra-articular manifestations, cost and patient's preference. Information directly comparing all biological drugs and assessing the efficacy of treatment options specific for PsA is urgently needed.

Conclusion

The hope is that in the future PsA patients will be treated earlier and more aggressively with targeted drug therapies to escape marked progression of joint damage. Moreover, with effective management of the skin and joint disease as well as the consideration of risk factors for comorbidities, it will be reasonable to expect to improve the quality of life and function in these patients.

References available upon request.

Figure 1. GRAPPA Treatment Schema for Active PsA



RHEUMATOID ARTHRITIS – A 36 YEAR PERSPECTIVE

An Interview by Scott Medley, MD, with Michael Rozboril, MD, of the SIMED Health Arthritis Center

I have known Dr. Mike Rozboril for some 33 years. Recently I had the opportunity to talk with him about a very confounding disease – Rheumatoid Arthritis.

Editor (Dr. Scott Medley): Please tell us a little bit about your educational background.

Dr. Rozboril: College at Harvard University. Medical School at University of Illinois – Chicago. Then Internal Medicine Residency, Rheumatology Fellowship and Faculty Member all at the University of Michigan.

Editor: Does that mean you're still a big University of Michigan fan?

Dr. Rozboril: Absolutely! I even have a pair of Jim Harbaugh pants!

Editor: (laughing) That's interesting – who is Jim Harbaugh?

Dr. Rozboril: As you well know, he is the Head Football Coach at the University of Michigan!

Editor: So how did you wind up in Gainesville?

Dr. Rozboril: We came to Florida to visit Dr Larry Edwards – then on the UF faculty. On our return trip north we stopped in Atlanta for the American College of Physicians (ACP) meeting. Alachua General Hospital had a presence there – they were recruiting a Rheumatologist – so we moved here in 1985.

Editor: During those early years, you probably had to do some General Internal Medicine practice.

Dr. Rozboril: Yes, I did that as I established my Rheumatology practice.

Editor: How has your practice evolved over the years?

Dr. Rozboril: Of course, now I practice primarily Rheumatology. But I still enjoying seeing some Internal Medicine patients that I have taken care of for 20-25 years. I still like the variety – some patients with hypertension, some with diabetes, etc.

Editor: About what percentage – ball park estimate – of your practice is now devoted to the various Rheumatology disorders?

Dr. Rozboril: Probably about 40% osteoarthritis, about 25% fibromyalgia and related disorders, and about 20% rheumatoid arthritis (RA), with gout and other arthritis diseases making up the rest.

Editor: You completed your Rheumatology fellowship in 1982. I assume that you've seen lots of changes in the treatment of RA in these past 36 years.

Dr. Rozboril: Oh yes, we've seen tremendous advances. At first, about the only drug we had was aspirin – we placed patients on 8-10 aspirin tablets a day and gradually increased it until they developed tinnitus (ringing in the ears). Other options came along like the NSAIDS (nonsteroidal anti-inflammatory drugs)--Indocin, Motrin, and Naprosyn, but they all have significant side effects, especially in elderly patients. And they weren't that effective for RA.

Editor: I was always fascinated that many RA patients received GOLD injections.

Dr. Rozboril: Indeed, we had 'gold injection clinics', but the gold was not terribly effective either, and had lots of side effects.

Editor: So along came the DMARDS (disease-modifying antirheumatic drugs)?

Dr. Rozboril: That's right. Methotrexate is the standard, but there is also Azulfidine, Plaquenil, even minocycline, and others.

Editor: What about what I call the 'mab' drugs - Humira (adalimumab), Remicade (infiximab), Simponi (golimumab), and others?

Dr. Rozboril: These are the 'biological drugs' and they have made a great deal of difference in treating RA. In fact, we almost always start patients on 'combination

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therapy' with a DMARD and prednisone. This approach has greatly improved the effectiveness of our therapy. If there is no response then we add a 'biological'. Some of the 'biologicals' are given subcutaneously and some, like REMICADE, must be given IV. And these drugs can be extremely expensive.

Editor: Tell me more about the efficacy of these 'new' drugs.

Dr. Rozboril: Joint replacements for RA patients have decreased some 30%, while joint replacements for osteoarthritis patients have doubled over the past several years. Our RA patients are experiencing much less pain and they are living longer. They used to die at earlier ages from side effects from NSAIDS such as GI hemorrhages and renal failure. In the past, we could never say that our RA patients were truly 'in remission', but with the major inroads with combination therapy and biologicals we can now often place our patients 'in remission' or, as we prefer to say, 'with low disease activity.

Editor: That's wonderful. So there is still a place for steroids like prednisone in the treatment of RA?

Dr. Rozboril: Sure. I'm a fan of low-dose prednisone, carefully monitored, when patients have 'flares' of their disease. It works quite well.

Editor: Do lab tests and x-rays help in your diagnoses and treatments?

Dr. Rozboril: Not too much. As you know, the 'sed rate' is often unreliable and as many as 20% of RA patients are 'RA factor' negative. As for x-rays, we used to judge the severity of RA by the number and severity of joint erosions, whereas now – with early combination therapy or biologicals– we can PREVENT those joint erosions.

Editor: Of course, you're familiar with the current 'opioid crisis'. Do many of your patients require opioid medicines?

Dr. Rozboril: I may have a bit of a different take on that. Many of my patients I have taken care of for decades. I know them well. They have a very low 'drug-abuse' potential. If we cannot control their severe pain otherwise, as a last resort we may carefully prescribe small amounts of opioids. These drugs still have their place in Medicine.

Editor: Thank you, Mike, for this fascinating perspective on a very difficult disease.

Dr. Rozboril: Thank you!

In Memoriam

It is with much sadness that we report that a beloved member of our medical family passed away….

Sey Park, MD

(1989 – 2018)

Dr. Sey Hee Park, age 28, passed away on January 9, 2018 in Gainesville, FL. Sey was born in Orlando and attended the University of Florida for undergraduate studies and medical school. He continued his medical training at UF in the Community Health and Family Medicine program and was in his second year of residency. Sey aspired to improve the interface between medicine and technology, which combined his love of technology and patient care. He was widely known at UF Health and was very popular among not only his resident-mates and classmates from the class of 2016, but also many of the current students and faculty across the college of medicine. Sey, meaning "enlightenment to the world", never met a stranger. His jovial personality, easy laugh, kindness and compassion for all was infectious. His passing is a profound loss for all of us.

Sey is survived by his parents, Hoon and Young Park, and his sister, Ki Park.

The Sey Park Memorial Fund for Resident and Student Education and Resiliency Outreach has been established in his honor. This fund aims to provide support to programs focused on caring for underserved populations and to promote programs and initiatives to highlight the importance of maintaining resilience and to promote resident well-being.

Opioid Prescribing Law: Quick Facts

Rupa S. Lloyd, JD
Shareholder, GrayRobinson, PA

In March, Florida signed into law a Controlled Substances bill which addressed the ongoing opioid-crisis. Going to effect on July 1, 2018, we have outlined the following changes that healthcare providers should be aware of.

1 Prescription Limits (3-Day Limit)

Prescriptions of a Schedule II opioid to alleviate acute pain are limited to a 3-day supply.

If a prescriber writes a prescription for a Schedule II opioid not related to treating acute pain, "nonacute pain" must be written on the script.

7-day supplies are allowed if:
- "Acute pain exception" is documented on script
- Basis for deviation documented in patient's record
- Medically necessary

Does not apply to pain for:
- Cancer
- A terminal illness
- Palliative care
- Serious traumatic injury

Must maintain patient data including:
- Complete medical record
- Controlled substance agreement
- Driver's License

2 CMEs on Controlled Substance Prescribing

- All healthcare practitioners authorized to prescribe controlled substances must complete a 2-hour mandatory CME course before January 31, 2019.
- Course to be completed at each subsequent license renewal.
- The Florida Medical Association and the Florida Osteopathic Medical Society meet the criteria to offer the course.

3 DOH Increasing Regulations for Acute Pain Treatment

- The DOH will adopt rules establishing guidelines for prescribing controlled substances for acute pain. Physicians and Practitioners must remember to follow these upcoming rules.
- Additional rules will address patient evaluations, treatment plan regulations, consent and agreement for treatment, treatment plan reviews, consultations, record review, and legal compliance.

4 Certificate of Exemption

Pain management clinics must either be registered with the DOH as a clinic or hold a certificate of exemption by January 1, 2019. The following is more information regarding the exemption:

- Under the law, there is no fee for the certificate of exemption.
- Certificate is not transferrable and a new one must be issued if the clinic changes addresses.
- 60 days notice for the following:
  - Change of ownership
  - Name Change
  - Relocation
- 3 days notice if the certificate holder becomes aware of any ineligibility.
- Must be renewed biennially.

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5 Prescription Drug Monitoring Program (PDMP)

The Prescription Drug Monitoring Program has expanded to include the following:

- Mandatory Consultation: Prescriber or dispenser must consult the PDMP to review a patient's controlled substance dispensing history, for patients age 16 and older.
- PDMP is now required to purge information more than 4 years old
- Controlled substances for Schedule II through Schedule V prescriptions must be reported.
  - Schedule V non-opioids are excluded.
- Penalties: Failing to consult the system will result in a nondisciplinary citation to the healthcare practitioner for the first offense. Any subsequent offense will result in disciplinary action against the practitioner's license.

6 Controlled Substances Additional Regulations

- Addition of Controlled Substances: The new law aligns Florida's Controlled Substance Act with federal schedules of controlled substances, adding numerous substances to all Florida schedules. Please consult updated schedules for a more a full list of added substances.
- Criminal Penalties Heightened: For intentionally providing prescribing medically unnecessary controlled substances, it is now raised from a third-degree felony to a second-degree felony.
  - It is now a crime to possess, purchase, deliver, or sell a tableting machine, encapsulating machine, or controlled substance counterfeiting material for illegal disbursement of controlled substances.

Questions?

Contact: rupa.lloyd@gray-robinson.com

July 1, 2018

All Changes Take Effect

CME Course Schedule for 2018-2019:

Controlled Substance Prescribing course (All specialties) **August 3, 2018 - Orlando FL**
at FMA meeting (Free to FMA members and ACMS Delegates attending the Annual Meeting)

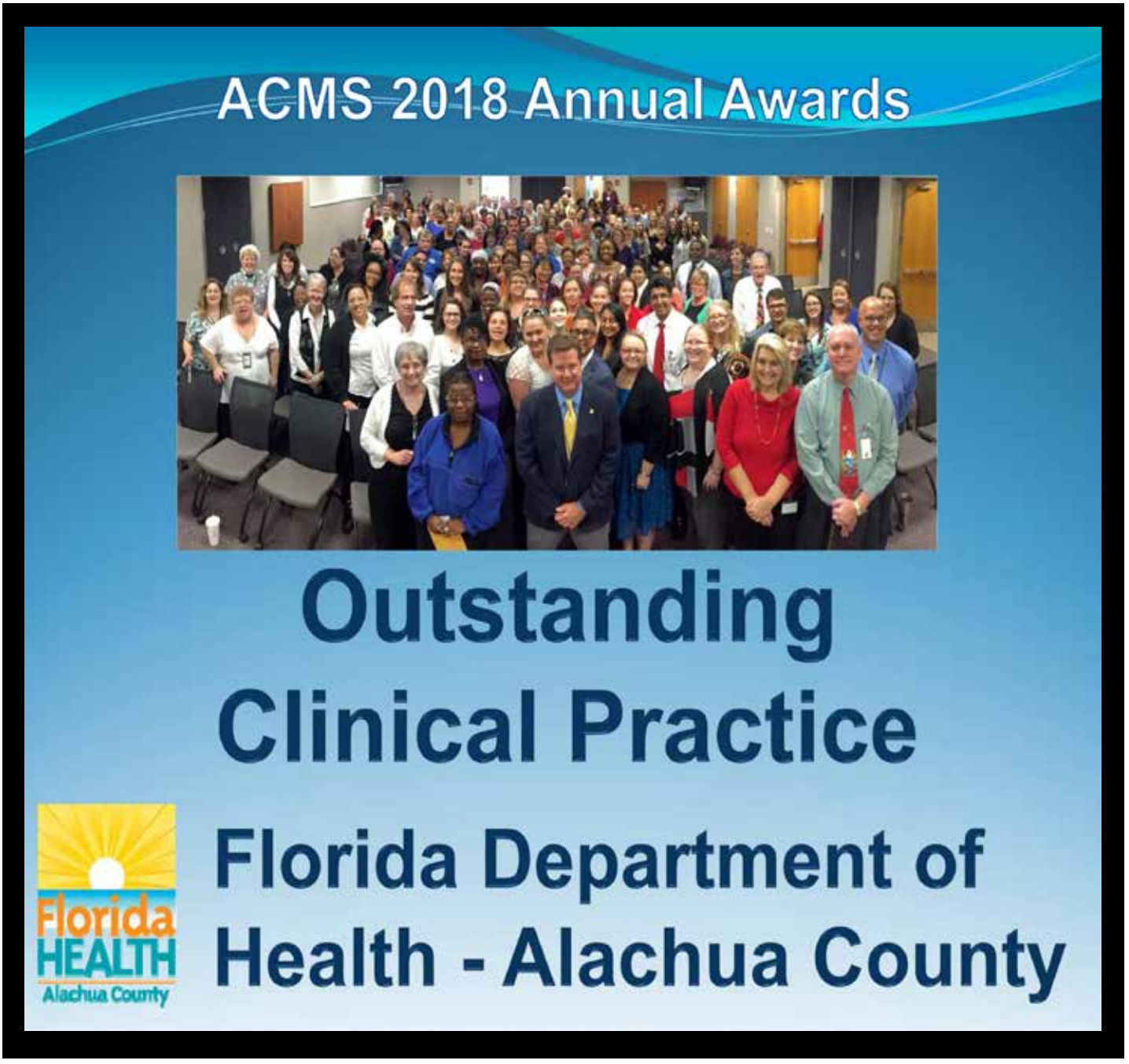
Prevention of Medical Errors **November 13, 2018 at Haile Plantation**

Domestic Abuse **January 15, 2019 location tbd**

All courses will be free to ACMS members

Congratulations to the Florida Department of Health - Alachua County Recipient of the 2018 Outstanding Clinical Practice Award!

The Clinical Team of the Florida Department of Health in Alachua County (DOH-Alachua) constantly strives to improve their ability to provide a real-time response to the health needs of the residents and visitors of Alachua County - as those needs emerge and change over time. The original scope of services focused on mosquito-borne disease over 100 years ago and today has expanded to include various communicable diseases such as HIV, AIDS, STD, TB and even lifestyle health threats such as obesity and diabetes. Working together, staff members are consistently providing service excellence on the front lines of health care delivery, primarily focused on the uninsured and under-insured in Alachua county. Paul D. Myers, Administrator, DOH-Alachua and John Colon, MD, Medical Executive Director, accepted the award on behalf of the DOH-Alachua.



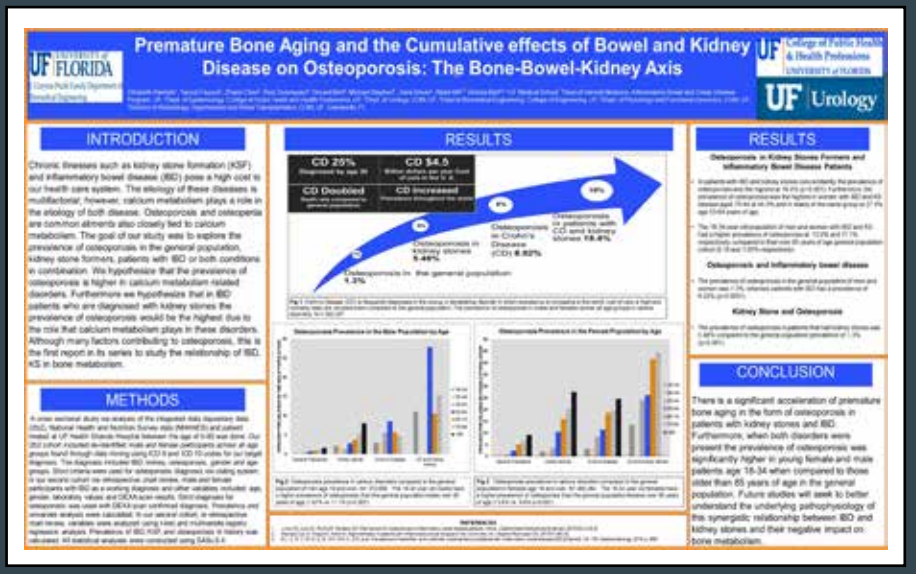
Congratulations to Tony Campo, We Care Program Director and the Recipient of the 2018 Health, Wellness & Advocacy Award

Tony Campo has worked with the We Care Physician Referral Network program for over 25 years, becoming Program Director in 1998. We Care is a community-based initiative that coordinates volunteer physicians, dentists, hospitals, and ancillary providers to meet the medical and dental needs of uninsured and low-income 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 We Care model represents the best efforts of volunteer professionals, social services agencies, State and local governments, collaborating to provide for the less fortunate in a dignified and effective manner. Over the last 25 years, Tony Campo has been an integral part of the program's success and is the recipient of the ACMS 2018 Health, Wellness and Advocacy Award.

Congratulations to the Winners of the

ACMS 2018 RESEARCH POSTER SYMPOSIUM

1st Place Winner & Recipient of the Sey Park, MD Award of Excellence : Elizabeth Kwenda



2nd Place Winners (Tie)

Fan Ye, MD

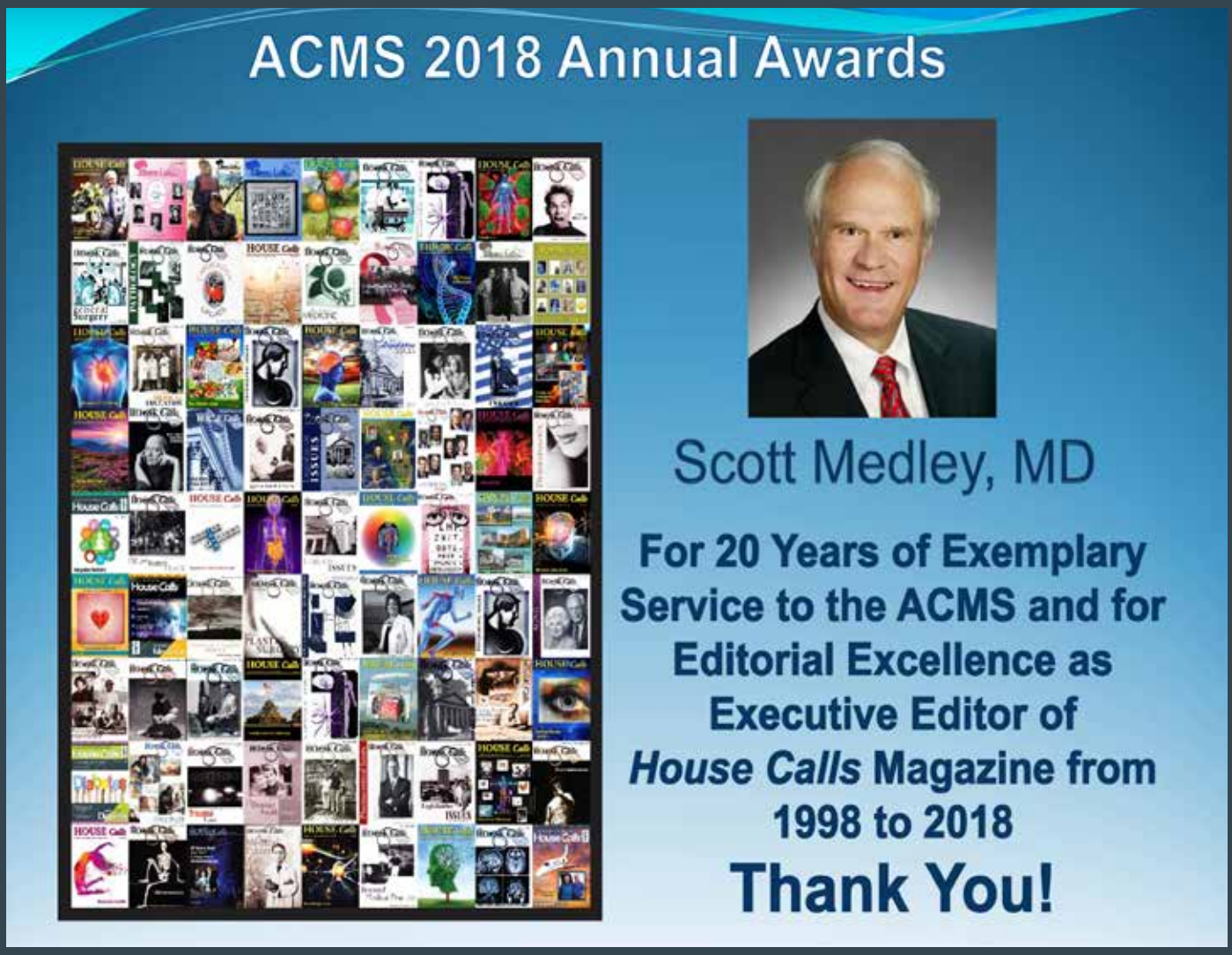
Jodi-Anne Wallace, MD

Special Thanks to our Scientific Committee and Judges:

Juan Aranda, MD
Christopher Bray, MD
Chris Cogle, MD
John Colon, MD
Javariah Fatima, MD
Lucio Gordan, MD
Karen Harris, MD
Matheen Khuddus, MD
Jennifer Li
Charles Riggs, MD
Consuelo Soldevila, MD
Madison Szar
Hale Toklu, PhD
David Tyson
Siddharth Wayangankar, MD
Ann Weber, MD
Joseph Whelihan
David Winchester, MD

Congratulations to Scott Medley, MD

for 20 Years of Editorial Excellence!



Join the ACMS Today!

The Acms is working to promote organized Medicine: advocating for Physicians, providing CME programs and professional development opportunities. Your efforts as ACMS Members provides medical services for the underserved populations of Alachua County through the We Care Physician Referral Network. Get involved with you community, join the ACMS today at acms.net

ACMS HAPPENINGS

L to R: Arlene Colon, ACMS Alliance President; John Colon, MD, ACMS Past President; and Mary Aplin, MD.

L to R: Michael Dillon, MD; Keynote Speaker Stacy Joyner, CPA; and Jay Hutto, CPA with James Moore Company.

ACMS March Dinner Meeting at Sweetwater Branch Inn

March 13, 2018

L to R: Jackie Owens, ACMS EVP; Dale Taylor, MD, ACMS Board Member; and Scott Medley, MD, Executive Editor of House Calls Magazine.

Matthew Ryan, MD, PhD, ACMS Vice President; and Matheen Khuddus, MD, ACMS President.

Cindi Larimer, MD; and Elias Sarkis, MD.

Forrest Clore, MD and Leonard Furlow, MD

Front Row: Connie Caranasos; George Caranasos, MD;
Back Row: Arthur Mauceri, MD; and Mrs. Ann Marie Mauceri.

L to R: Mark Barrow, MD; Mary Barrow; and
Thomas Lau, MD.

ACMS March Dinner Meeting

at Sweetwater Branch Inn
March 13, 2018

L to R: Rogers Bartley, MD; Cherise Bartley; Barbara Noble; and Howard Noble, MD.

Priyanka Vyas, MD; and Himesh Vyas, MD.

Jackie Owens, ACMS EVP; and
Mrs. Roslyn Levy, Alliance Past President.

Alachua County Doctors Day Proclamation
March 30,2018

HAPPENINGS

L to R: David Tyson, ACMS Medical Student Representative; Madison Szar; and Dana Nemenyi, UF Health.

Medical Students enjoying the Spring Vendor Show

ACMS Spring Vendor Show

April 17, 2018

Hilton UF Conference Center

L to R: Ronald Jones, MD; Evelyn Jones, MD; Carl Dragstedt, DO, ACMS Secretary/Treasurer; and Victoria Bird, MD.

L to R: Robert Vasquez, MD; Pritam Brar, MD; and Pryanka Kapoor, MD.

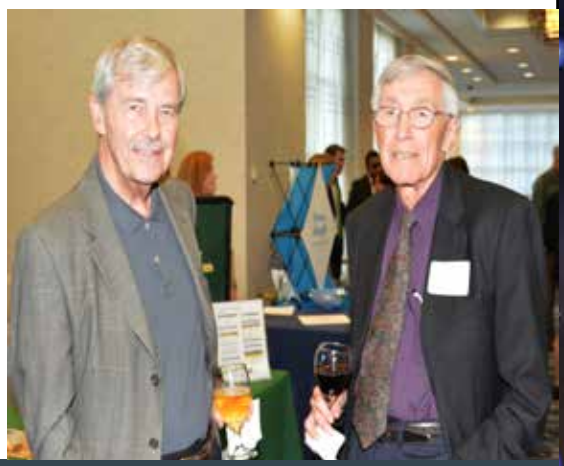
Howard Noble, MD; and Madeleine Mills, with Community Bank and Trust of Florida.

Matthew Ryan, MD, ACMS Vice President; and Rupa Lloyd, JD, with GrayRobinson, PA.

Sandy Fackler and Jackie Jackson, MD.

L to R: Tim Deardourff and Rick Cain, with FrontStreet Realty; and Greg Grooms with Charles Schwab

Medical Students



Edward J. Wilkinson, MD; and Ira Gessner, MD.

L to R: Scott Medley, MD, *House Calls* Executive Editor; Sally Lawrence of Edward Jones; and Carl Dragstedt, DO, ACMS Secretary/Treasurer.

L to R: Panelists SA Robert Reilly, Matthew Ryan, MD, ACMS Vice President; Circuit Judge Phillip Pena; and Rupa Lloyd, JD; and Jason Hunt, MD.

Ilene Silverman Budd and Commissioner Harvey Budd, Mayor Pro-temp.

ACMS HAPPENINGS

Practice Management Network Luncheon
May 2, 2018
Napolatanos Restaurant

L to R: Kip Harrison, President, Capital City Bank; with Greg Grisson; and Bill Bechtol (seated) and Jay Hutto, CPA, James Moore CPAs

L to R: Jay Hutto, CPA, James Moore CPAs; Guest Speaker Gabriel Paulian, MD; with Daniel Duncanson, MD, CEO, SIMED.

ACMS 2018 Research Poster Symposium
North Florida Regional Medical Center,
May 15, 2018

Ann Weber, MD, Chief of Medical Officer, NFRMC addressing the Audience.

L to R: Matheen Khuddus, MD, ACMS President; Jodi-Anne Wallace, MD; Elizabeth Kwenda; Fan Ye, MD; and Hale Toklu, PhD, Division Director of Research GME, HCA North Florida.

Research Poster Symposium Scientifc Committee, Presenters and Judges.

Research Symposium assistants Blanca Millsaps and Samantha Whyte.

L to R: Jodi-Anne Wallace, MD; David Tyson, Madison Szar, Elizabeth Kwenda and Jennifer Li awaitng the competition results.

David Dojcsak, NFRMC GME Director; with Karen Harris, MD.

L to R: David Winchester, MD, ACMS Past President; Norman Levy, MD, PhD; and Matheen Khuddus, MD, ACMS President.

Charles Riggs, MD, discussing a research poster with Vaibhav Rastogi.

A group reviewing one of the submissions.

ACMS HAPPENINGS

Scott Medley, MD, receiving an award for 20 Years of Editorial Excellence from Ronald Jones, MD.

Matheen Khuddus, MD, ACMS President presenting Paul Myers of the Florida Department of Health - Alachua with the Outstanding Clinical Practice Award.

ACMS Annual Awards Dinner Meeting

May 22, 2018

Mark's Prime Steakhouse

Susan Edmonds and Ronnie Lamb with SunTrust Bank.

Bruce Stechmiller, MD, presenting the Health, Wellness & Advocacy Award to Tony Campo, We Care Program Director.

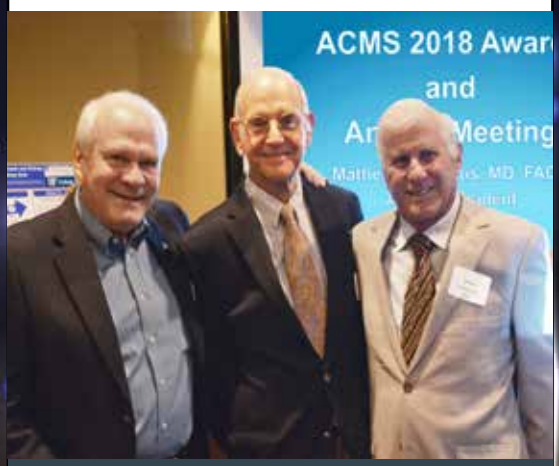
L to R: Clockwise Mrs. Cherise Bartley; Rogers Bartley; Arthur Mauceri, MD; William Driebe, Jr., MD; and Mrs. Ann Marie Mauceri.

2018 ACMS Annual Awards Dinner Meeting
Tuesday, May 22, 2018
Mark's Prime Steakhouse

L to R: Paul Ryan with the Florida Health Department; John Colon, MD; Mrs. Arlene Colon; and Mr. Roger Dolz with the Florida Health Department.

L to R: Mrs. Ellen Gershow, Mrs. Ann Marie Mauceri; and Arthur Mauceri, MD.

L to R: Elizabeth Kwenda receiving 1st Place in the Research Poster Competition and the Sey Park Award of Excellence from Carolyn Carter, MD.



L to R: Scott Medley, MD, Executive Editor of House Calls; Norman Levy, MD, PhD; and James Gershow, MD.

ACMS Gator Angioclub
Shula's Steakhouse

ACMS Gator Angioclub presentation on Alternative Arterial Access for Transcatheter Aortic Valve Replacment

ACMS Gator Angioclub presentation on Techniques for Endovascular Aortic Graft Implantation.

FMA ANNUAL MEETING 2018

August 3-5, 2018

Enjoy a weekend with your colleagues and family!
Make an impact on the Future of Medicine in Florida

Fullfil your Opioid Prescribing Course on Friday, August 3rd - Free of charge to ACMS Delegates and FMA members)

Contact Dr. Carl Dragstedt (carldragstedt@gmail.com) or Jackie Owens (evp@acms.net). Travel to Universal Studios - Orlando for two nights August 3-5, with discounted hotel rates and theme park passes.

Universal Aventura Hotel - Opening in August!

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, January 2, 2018

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, January 2, 2018 at The Cardiac and Vascular Institute

Secretary's Report: Dr. Dragstedt presented the following names for membership: F. Kayser Enneking, MD; Amita Kathuria; MD, along with medical students: Celeste A. Rousseau, David A. Tyson, Neha Malik and Joseph Whelihan. Dr. Jones moved approval of the new members, seconded by Dr. Taylor.

Treasurer's Report: Dr. Dragstedt presented the 12/31/2017 Balance Sheet and P & L statement for the ACMS and the ACMS Foundation. ACMS Foundation Revenues were largely derived from the Robb House Endowment, We Care donations and the FAFCC Grant, with expenses primarily related to the upkeep of the Robb House and distributions to We Care Clinic. Dr. Colon moved approval of the report, seconded by Dr. Grow.

President's Report: Dr. Khuddus updated the Board on the status of the ACMS Gator Angioclub (next meeting Feb. 28, 2018), and the New Member Benefits Program. The ACMS Awards Committee for the 2018 Awards will consist of Dr. Dragstedt, Dr. Ryan and Dr. Colon. Dr. Khuddus also discussed the ACMS Research Poster Symposium that will be held at NFRMC on May 15th.

EVP Report: Ms. Owens discussed the January Board Table Challenge and noted that Dr. Norman Levy has sponsored a table of 8 guests. The group discussed the option of adding a "donate" button to our website and social media sites for a medical disaster relief fund. These funds would be used for medical help to disaster areas by either a mission trip sponsored by the ACMS or a Board-approved mission trip by other physicians. The website has been updated with the "New Member Highlight" and the "Member Highlight" which will be an ongoing rotating post for members. Ms. Owens also discussed the Leadership Gainesville program.

The Board discussed the topics of upcoming Dinner Meetings and a potential panel discussion on the Opioid Epidemic in April.

In Memoriam

It is with much sadness that we report that a beloved member of our medical family passed away…

James E. McGuigan, M.D.

(August 20, 1931 – April 18, 2018)

James Edward McGuigan, M.D., died in Gainesville, Florida, on Wednesday, April 18, 2018, after a brief illness. Dr. McGuigan earned his medical degree from St. Louis University School of Medicine in 1956, graduating with Alpha Omega Alpha honors. In 1969, he accepted the position as Chief of the Division of Gastroenterology at UF College of Medicine.

In 1976, he became Chairman of the Department of Medicine, stepping down in 1997. He resumed practice in gastroenterology, retiring in 2013. He then received emeritus status. Among his awards and honors were: continuous funding for his research for 31 years, from the National Institutes of Health ('NIH'); an honorary doctorate from Uppsala University in Sweden for his research; identification and citation by Citation Index as one of the 1,000 most frequently cited research scientists in the world; and publishing over 250 times.

Dr. McGuigan is survived by his wife, Nancy McGuigan. He is also survived by his sister, Elizabeth Dean; Mary McGuigan, the mother of his three children, Sheila McGuigan, John McGuigan, and Maura McGuigan Vash (Jeffrey); his grandson Collin; and his niece, Maureen Johnson, and nephew, Edwin Glueck, as well as his four great nephews (one of whom was just accepted to medical school).

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, February 6, 2018

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, February 6, 2018 at The Cardiac and Vascular Institute.

New UF Student Representative: Michael Dangl introduced the new UF Student Representative, David Tyson, who will be taking over for Mr. Dangl starting next month. The Board welcomed Mr. Tyson.

Special Request: Dr. Mark Barrow presented a special request to move the facade of an historic concrete lintel beam from Alachua General Hospital to the grounds of the Robb House to be installed as a bench. The request was approved by the Board.

Approval of Minutes: The minutes of the January 2, 2018 meeting were presented. Dr. Colon moved approval, seconded by Dr. Jones to approve the minutes. The minutes were approved by the Board.

Secretary's Report: Dr. Khuddus presented the following student names for membership: Madison Szar and Julia G. Buddendorff. Dr. Jones moved approval of the new members, seconded by Dr. Colon.

Treasurer's Report: Ms. Owens presented the 1/31/2018 Balance Sheet and P & L statement for the ACMS and the ACMS Foundation. ACMS Foundation Revenues were largely derived from We Care Contributions. Expenses were due to the We Care Clinic. Dr. Jones moved approval of the report, seconded by Dr. Ryan.

President's Report: Dr. Khuddus updated the Board on the status of the Members Benefits program and the upcoming ACMS Research Poster Symposium, sponsored by NFRMC on May 15th

EVP Report: Ms. Owens reported on the ACMS Awards Program 2018 and the presentation at the Annual Meeting on May 22. The group discussed the upcoming April Dinner Meeting on the Opioid Epidemic and the panelists that will be involved. James Moore CPAs will be making a presentation at the March Dinner Meeting on Tax Reform and How It Affects You and the presentation on women's cardiovascular care (Dr. Ki Park) will be moved to a fall program.

Alachua County Medical Society - Board of Directors Meeting Minutes, March 6, 2018

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, March 6, 2018 at The Cardiac and Vascular Institute.

We Care Update: Mr. Campo updated the Board on the status of the We Care program including Funding, Personnel and the Program Data for volunteer hours and patients served. The We Care referral completion rate is 78% with over $2.6 million in medical services provided to uninsured Alachua County residents in 2017.

Approval of Minutes: The minutes of the February 6, 2018 meeting were presented. Dr. Jones moved approval, seconded by Dr. Riggs to approve the minutes. The minutes were approved by the Board.

Secretary's Report: Dr. Dragstedt presented the following names for membership: Lucio Gordan, MD, and Grace Thompson (UF medical student). Dr. Levy moved approval of the new members, seconded by Dr. Jones.

Treasurer's Report: Ms. Owens presented the 2/28/2018 Balance Sheet and P & L statement for the ACMS and the ACMS Foundation. Overall, revenues are on par with total revenues in the previous fiscal year with Net Income increasing 18% overall for 2018. ACMS Foundation Revenues were largely derived from We Care Contributions with expenses resulting from the We Care Clinic. Dr. Jones moved approval of the report, seconded by Dr. Levy.

President's Report: Dr. Khuddus updated the Board on the status of the meetings with the Gainesville Sun on presenting fair and balanced reporting with respect to cases involving physicians. Discussions have been favorable and are ongoing with The Sun.

Dr. Khuddus asked the Board to consider naming the ACMS Research Poster Symposium in the memory of Dr. Sey Park. The Board unanimously approved the request.

EVP Report: Ms. Owens reported on the ACMS Awards Program 2018 and the presentation at the Annual Meeting on May 22. The Board discussed adding an Addiction Specialist to the panel at the April Dinner Meeting on the Opioid Epidemic. The September dinner meeting was discussed as a possible date for the Candidate's Debate.

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, April 3, 2018

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, April 3, 2018 at The Cardiac and Vascular Institute.

Approval of Minutes: The minutes of the March 6, 2018 meeting were presented. Dr. Ryan moved approval, seconded by Dr. Carter to approve the minutes. The minutes were approved by the Board.

Secretary's Report: Dr. Khuddus presented the following names for membership: Mark B. Sherwood, MD, and Robert J. Hall (UF medical student). Dr. Ryan moved approval of the new members, seconded by Dr. Carter.

Treasurer's Report: Ms. Owens presented the 3/31/2018 Balance Sheet and P & L statement for the ACMS and the ACMS Foundation. Overall, revenues are on par with the previous fiscal year with expenses down 10% for the 8 months recorded. ACMS Foundation Revenues were largely derived from We Care Grant Contributions with expenses resulting primarily from Grant Disbursements. Dr. Carter moved approval of the report, seconded by Dr. Ryan.

President's Report: Dr. Khuddus discussed the nominations for FMA Delegates with plans to meet the June 8th deadline for filing with the FMA. Also discussed was the crafting of a Resolution to be presented at the FMA meeting on implementing a meningococcal vaccine to protect children and adults from the disease.

EVP Report: Ms. Owens reported on the status of the Research Poster Symposium and the Sey Park, MD Award of Excellence. The highest scoring entry in the Research Poster competition will receive this award. The Annual Awards Dinner Meeting will be held on May 22nd at Mark's Prime.

A course on the recently required Opioid Prescribing CME will be offered to members in the Fall of 2018, along with courses on Domestic Violence and Prevention of Medical Errors.

We Care Participation Form

Join your colleagues and make a difference! Complete and submit your participation card today. Earn CMEs. Support the ACMS.
Please call Melissa Laliberte at (352) 334-7926 for more information.

Alachua County Medical Society
We Care Physician Referral Network

- ☑ Yes! I will see We Care Patients
- ☐ I will see 6 patients per year.
- ☐ I will see We Care patients by rotation for my specialty.

Physician Name | Practice Name if Different

Office Address Where Patients are Seen | Telephone Number | Fax Number

First Specialty | Second Specialty

Physician Signature

☐ Please check if current member of Alachua County Medical Society

Please fax to (352) **334-8844** or mail to:
We Care Physician Referral Network
224 SE 24 Street
Gainesville, FL 32641

A Note from our **Editor**

THE OPIOID "CATACLYSMIC" CRISIS – FROM HIPPOCRATES TO TOM PETTY

SCOTT MEDLEY, MD
House Calls Executive Editor

Dr. Medley is a retired Family Physician
Volunteers at Haven Hospice

The OPIUM POPPY has been cultivated for some 5,000 years. It is speculated that HIPPOCRATES used opium in CIRCA 400 B.C.E. in some of his treatments and teachings[1]

I prescribed OPIATES dozens if not hundreds of times – hopefully judiciously – during my 40 years practicing medicine (1972-2012). I can only hope that "the Father of Medicine" would have been proud of me!

The current "OPIOID ADDICTION CRISIS" has been ongoing for several years. But just in recent months, the news coverage of this disaster has exploded, and rightly so. I thought it might be helpful to distill some of this coverage for our readers. What follows is information from 17 different "news" sources – not one of which seems to be "fake" news.

PROLOGUE – SUMMERS OF 2016 + 2017.

-The Cover of Medical Economics – in huge 1 ⅓ inch **BOLD** type "OPIOID CRISIS".[2]
-The Cover of the AARP Bulletin – "The OPIOID MENACE". [3]
-USA TODAY – OPIOIDS killing 150 Americans per day, or about 55,000 deaths per year – about the capacity of Yankee Stadium or Dodger Stadium.[4]

FALL 2017

-THE GAINESVILLE SUN – Gainesville native and Rock Icon TOM PETTY found dead. [5] His autopsy and toxicology reports later revealed that he had died of "an accidental OVERDOSAGE of OXYCODONE, sedatives, and FENTANYL" which he had been taking for "an undiagnosed hip fracture" and for other pain. FENTANYL, which is 50-80 times more potent than morphine and heroin and is usually prescribed only for end-of-life care, is becoming more widely abused. Often "laced" into other drugs, it is flowing into the U.S. from Mexico and China. (Even more scary is CARFENTANYL—said to be 10,000 times stronger than morphine. Small doses are used to sedate elephants!)

-Family Practice News- "Deaths from heart disease, stroke, and cancer are declining while OPIOID deaths and related suicides are surging". Suicide rates are up 25% from 2000 to 2015, with "one suicide every 12 minutes." "The U.S. spent only $1 billion over two years for the OPIOID CRISIS, but $15 billion in 3 days for Hurricane Harvey." [6]

-The Jacksonville Times Union- "Jacksonville is planning to file a lawsuit against the makers and distributors of prescription pain killers that would allege the businesses are partly responsible for the spike in OPIOID OVERDOSE DEATHS that have been a scourge in Jacksonville...responding to more than 1,000 more overdose calls in 2016 (than 2015) and expecting to administer 3 times as much Naloxone (Narcan®)—a drug that reverses OPIOID OVERDOSES-- in 2017 compared to 2015." "The cost of transporting OVERDOSE patients is expected to cost the city $4 million this year." [7] As noted below, Alachua County plans to file a similar lawsuit.

The New Yorker- Featured a much lengthier expose' about Purdue Pharmaceuticals, the maker of OXYCONTIN®--containing OXYCODONE, which is 1 ½ to 2 times more potent than Morphine. OXYCODONE is found in the U.S. combined with aspirin in Percodan ® and with acetaminophen in Percocet®. "When OXYCODONE becomes too expensive or too difficult to obtain, the addict often turns to HEROIN. In fact, 4 out of 5 heroin users started with synthetic OPIOIDS." OXYCONTIN could be "abused when it is ground up and snorted or dissolved and injected." When the pills were "made more difficult to grind up, the addict would suck off the pill's coating, once again enabling it to be ground up and snorted or injected."

The statistics are astounding:

-The U.S. accounts for 1/3 of the global market for OPIOIDS.

-OPIOID O.D.'s are now the leading cause of

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death for Americans under age 50—more than guns and motor vehicle accidents.

-11 million people in the U.S. abused prescription OPIOIDS in 2016 alone.

-In Ohio in 2016, one in five adults received a prescription for OPIOIDS.

-More Americans are now dying annually from OPIOIDS than died during the entire Viet Nam war.

In August 2015, in rural Pike County in my home state of Kentucky, "29% of the population knew someone who had died from OXYCONTIN®. 70% said the effect of OPIOIDS on the community had been 'devastating'". "Of the 1997 Pikeville High School football team, almost half died of O.D.'s or were addicted."

-Fall DEA Alert on OPIOID Use-Directive to physicians: Use non-opioids for chronic pain lasting more than 3 months. If opioids must be used, "start low (dosage) and go slow". Reserve opioids for 1) acute post-operative pain, 2) active cancer treatment, 3) palliative care, and 4) end-of-life care. [8]

-The Wall Street Journal- "Massachusetts considers mandatory 3-day rehab" for opioid O.D. patients. "One in ten Mass. patients who initially survived after first-responders treated them with naloxone died of an OVERDOSE within a year. About 8,000 people in the state died from OPIOIDS from 2010-2017."[9]

WINTER 2017-2018

-House Calls- "Startling Statistics"

Percent increase in death rate 2014-2015: from synthetic OPIOIDS other than Methadone, up 72.2%; from HEROIN, up 20.6%. [10]

-The Weekly Standard- "OPIOIDS In The Suburbs"-

Dispelling the notion that OPIOIDS and HEROIN are abused only by the "lower socioeconomic classes,"..."In nine days in early December,2017, eight young people died of OVERDOSES in Fairfax County, Virginia, the second-richest of the 3,007 counties in the U.S." "13.5 % of people prescribed eight days of OPIOIDS were still using them a year later." [11]

-The Journal of Family Practice – "Immunoassay urine drug screens for detecting OPIOIDS show a.....sensitivity of 92% and a specificity of 93%." This test allows physicians to use random urine drug testing to determine whether their patients are really abusing OPIOIDS, using them as prescribed, or abstaining from them as directed during the rehab process.[12]

-American Family Physician - "Medication – assisted treatment with BUPRENORPHINE is effective as METHADONE in terms of treatment retention and decreased OPIOID use." "From 2000 to 2015, more than 500,000 (1/2 million) people died from OPIOID OVERDOSES". [13]

-House Calls – In her excellent article, "Organ Transplants and the Paradox of the OPIOID Epidemic", Jackie Owens, ACMS EVP, points out the terribly bittersweet fact that "this increase in (young) organ donors coincides with increased deaths from the OPIOID epidemic." And "donors who die from drug overdoses typically have no medical comorbidities that would preclude donations, thus making them good candidates for organ donations."[14] This passage by Jackie was later quoted in an article in the Gainesville Sun (May 3, 2018), which noted "the sharp increase in organ donations which come from OVERDOSE DEATHS ". The article stated that hundreds of more (healthy) livers were available for transplantation "because of DRUG OVERDOSE DEATHS." Most of these deceased young donors have healthy organs. In other words, if not for the O.D., they would likely live long healthy lives!

SPRING 2018

-The Weekly Standard-"...the OPIOID EPIDEMIC." "...the economic burden of the opioid epidemic hit $95 billion in 2016, with the vast majority coming from losses in workforce due to OVERDOSE DEATHS. Another $12.4 billion of the cost stemmed from lost productivity. A separate study found that the OPIOID EPIDEMIC is responsible for 20% of the drop in men's labor force participation."[15]

-The Gainesville Sun- "Gov. Scott Signs Bill To Combat OPIOID Addiction." The bill limits prescriptions for OPIOIDS for acute pain to 3-7 days, and enhances use of the Prescription Drug Monitoring Program (PDMP). (See more details below.) "Florida had 5,725 OPIOID-RELATED DEATHS in 2016, up 35% from 2015."[16]

-The Wall Street Journal – President Trump signs into law the new U.S. budget bill, increasing the outlay for OPIOID PROGRAMS from $2 BILLION to $5 BILLION . The article predicted that " some will praise this increase, while critics will say that it is not enough". [17]

-The Gainesville Sun – (Indeed, critics say that it is not enough) "STATES: Need more to fight OPIOIDS": In recommending more money be budgeted to fight the problem, former U.S. Rep. Patrick Kennedy stated "We still have lacked the insight that this is a crisis, A CATACLYSMIC CRISIS". The story goes on to state "the U.S. is spending more than $7 billion annually on domestic funding on AIDS, an epidemic with a death toll that peaked in 1995 at 43,000", and is rapidly declining. More individual states are spending more and more money to "address the (OPIOID) crisis." [18]

- Spring DEA Alert on OPIOID use – Per the CDC there were

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63,632 total drug O.D.s in the U.S. in 2016. This is 174 deaths per day and one death every 8.28 minutes. About 2/3 of these, 42,249, are due to OPIOIDS. [19]

- The Louisville Courier Journal – U.S. Surgeon General Dr Jerome Adams issues the first "Surgeon General's Advisory" in 13 years, stating that "people at risk for an OPIOID OVERDOSE, as well as their family and friends, should keep naloxone (Narcan®) on hand"...since "over half of these OVERDOSES are occurring at home." Many states are now allowing pharmacists to dispense naloxone without a prescription. The drug, which can cost as much as $100, is being provided by some states at low-or no –cost. Kentucky "lost more than 1400 people to drug overdoses in 2016, and Louisville lost 364." [20]

Naloxone temporarily reverses the effects of OPIOIDS, and is available as an intranasal spray, or by injections-intramuscular, subcutaneous, or intravenous.

-USA Today – On the second anniversary of the death of "music superstar PRINCE" his county attorney stated that he died of an overdose of "the common painkiller VICODIN (Hydrocodone plus acetaminophen) when, unbeknownst to him, it was laced with deadly FENTANYL." He reportedly "did not know he had become addicted to FENTANYL." [21] But yet another tragic OPIOID death.

-AARP Bulletin- "The OPIOID-Medicare Connection" "Medicare ID numbers have been abused to fuel the ongoing OPIOID CRISIS. Shady doctors are writing prescriptions for OPIOID painkillers, using Medicare numbers that have been stolen or bought from their holders. The pills are then sold on the streets for huge profits." "One in three Medicare Part D beneficiaries received at least one prescription OPIOID in 2016." In this same issue, U.S. Attorney General Jeff Sessions was interviewed about this problem. He stated that these fraudulently obtained "powerful pain pills sell for as much as $80 a pill on the street."[22]

Indeed, OPIOIDS usually sell "on the street" for "about a dollar a milligram," and OXYCONTIN® "extended release tablets" are formulated from 10 mg. to 80 mg. per tablet.

-ACMS April Meeting- Closer to home, this meeting featured an excellent panel discussion about the OPIOID EPIDEMIC. Among the revelations:

-Life expectancy for young Americans has decreased for the first time since the AIDS epidemic.

-An extra Medical Examiner has been hired in South Florida to deal with the increased number of OPIOID-related deaths.

-Alachua County, like Jacksonville, has plans to file a lawsuit against the pharmaceutical companies.

-In 2016 1390 people in Florida died of FENTANYL overdoses—11 in Alachua County

-In a very frightening development, some FENTANYL is becoming Naloxone-resistant

-OPIOID hospitalizations have increased 39% from 2011-2016.

-Many young mothers become addicted to OPIOIDS during and after the Labor and Delivery process.

-The PDMP can be very effective, but as yet is not very user-friendly for physicians[23]

-FMA Magazine-"Florida's New Law On Controlled Substance Prescribing"- The new law "imposes a number of legal requirements on healthcare practitioners who prescribe controlled substances, particularly OPIOIDS. This new law encompasses 205 pages and imposes new obligations on practitioners that carry penalties for noncompliance."[24]

The article provides a summary of the law. (See the "New Opioid Prescribing Law" elsewhere in this issue.)

-The St. Augustine Record-"Drugmakers Push Back Against Lawmakers Call To Tax OPIOIDS." "Bills introduced in at least 15 states would impose taxes or fees on prescription painkillers," such as OPIOIDS. One of these states is tiny Delaware, "where there were 282 fatal overdoses from all drugs in 2016, a 40% increase from the year before." Of course, the drug companies are fighting back, stating "we do not believe levying a tax on prescribed medications that meet legitimate medical needs is an appropriate funding mechanism for a state's budget." "Makers of OPIOIDS and their allies spent about $880 million on politics and lobbying from 2006 through 2015."[25]

-The Gainesville Sun- "Florida Sues Drug Industry For OPIOID EPIDEMIC". "Florida AG Pam Bondi sued opioid manufacturers and distributors ...claiming the addiction crisis...stems from the industry's 'strategic campaign of misrepresentations' about painkilling medication." "...the same day AGs in" 5 other states "also sued in their state courts." "...several Florida cities and counties have sued and were rolled into a massive lawsuit against the industry now underway in federal court in Cleveland, Ohio." "We are in the middle of a national OPIOID CRISIS", Bondi said. "I think you'd have to be living under a rock not to know that now." "We can't put a monetary value on loss of life." [26]

The dilemma now faced by many physicians was summarized well by a practicing doc during the Q and A session after the panel discussion at our ACMS April meeting. To paraphrase this frustrated physician, " A few years ago, I was a 'bad doctor' if I did not liberally treat my patients' pain—now I'm a 'bad doctor' if I do adequately treat their pain with OPIOIDS. What are we to do?"

Indeed, perhaps Hippocrates could tell us.

References Available Upon Request

Savvy Caregiver for Families Program

For information about these classes in Alachua County, please call:

Ana M. Robles-Rhoads at (352) 692-5265

To find out about classes in other counties call:

Tom Rinkoski at (352) 692-5226

Savvy Caregiver is a six week training designed for caregivers who assist persons with Dementia and/or Alzheimer's Disease.

The Savvy Caregiver Program is a unique approach to family caregiver education. The program offers ideas gathered from many disciplines and sources. Throughout the series caregivers are urged to learn, develop and modify approaches they can use to lessen their own stress and improve their particular caregiver situation

This course is ***free*** to all family caregivers, but you need to register! Those completing this course will:

- Increase skills and knowledge for caregiving
- Understand dementia and its progressive cognitive losses
- Gain confidence to set and alter caregiver goals
- Learn effective ways to increase family involvement
- Reduce adverse impacts of caregiving

ELDER OPTIONS

2018 Class Start Dates	Location
Tuesday, February 6, 2018	Clermont, FL
Tuesday, February 6, 2018	**Ocala, FL**
Wednesday, February 7, 2018	The Villages, FL
Thursday, February 8, 2018	**Gainesville, FL**
Monday, March 5, 2018	Chiefland, FL
Tuesday, April 10, 2018	Homosassa, FL

2018 Class Start Dates	Location
Tuesday May 8, 2018	Trenton, FL
Wednesday, May 9, 2018	Trenton, FL
Tuesday, May 22, 2018	**Gainesville, FL**
Monday, July 9, 2018	Chiefland, FL
Thursday, August 2, 2018	**High Springs, FL**

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