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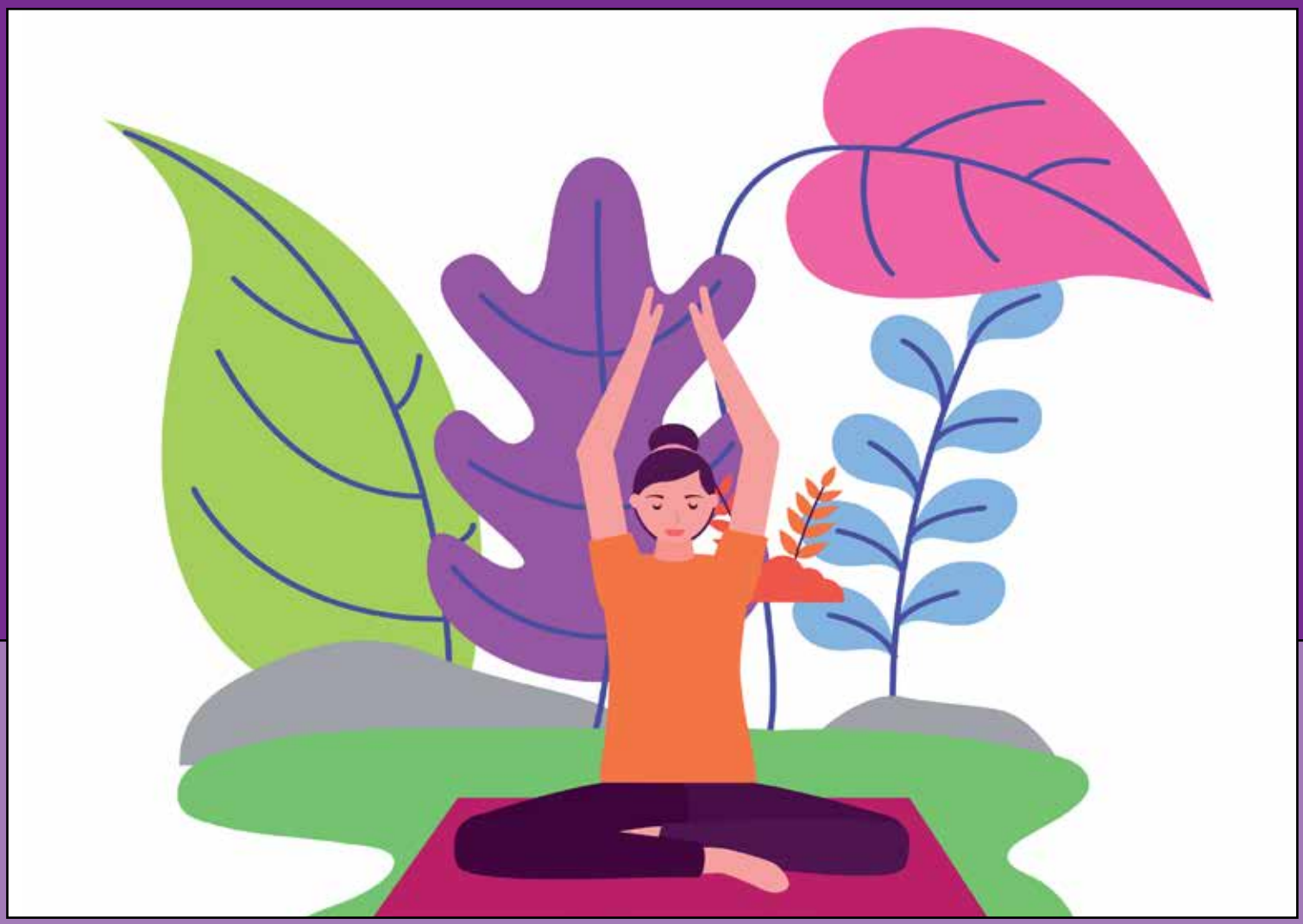
ALACHUA COUNTY MEDICAL SOCIETY

House Calls

WINTER 2020



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ROBB HOUSE MEDICAL MUSEUM

The Robb House Medical Museum was built in 1878 and became the home and medical office of doctors Sarah Lucretia and Robert Robb. Sarah Lucretia Robb was the first female physician in Alachua County. She practiced medicine from 1884 to 1917.

The Robb House was renovated by the Alliance and ACMS Community in 1981 and the roof is once again in need of replacement. We are kicking off a Raise The Roof Campaign this spring inviting you and the community to help us replace the roof on this historic treasure. Stay tuned for more next issue!

CONTENTS

CONTRIBUTING AUTHORS

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Austin Chen, M.D. practices Gynecology at SIMEDHealth's Women's Health Clinics in Gainesville, Chiefland and Ocala. She completed her undergraduate and medical education at the State University of New York at Stoney Brook, and was at Columbia Presbyterian College of Physicians and Surgeons, Harlem Hospital for her Obstetrics and Gynecology residency. After eleven years of solo practice in New York City, she embarked on a three-year program at Schuylkill Medical Center in Pennsylvania to further develop her minimally invasive women's health surgery skills. Dr. Chen relocated to Gainesville in March 2019 and is on medical staff at HCA/ North Florida Regional Medical Center and HCA/West Marion Community Hospital.

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Dr. Patrick is a Maternal Fetal Medicine physician at North Florida Perinatal Associates. She received her undergraduate degree in Biology from Vanderbilt University and then became a true Gator, completing her medical school, OBGYN residency, and Maternal Fetal Medicine fellowship training at the University of Florida. Although she grew up in Kansas City, she has been a Gainesville resident since 2008. She is board certified in Obstetrics and Gynecology and board eligible in Maternal Fetal Medicine.

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Olgert Bardhi

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Olgert Bardhi is a 2nd year medical student at the University of Florida. He completed his undergraduate studies in Biology and Psychology at UF and went on to finish a master's degree focused on discovering therapeutic approaches for neurodegenerative diseases. He has been a volunteer for the Alachua County Crisis Center for the past 3 years. As a medical student, Olgert volunteers as an Operations Coordinator for the Equal Access Clinic Network, a student-run free clinic for the underserved in Alachua. He is a Global Health Trip Leader for Project HEAL, a yearly medical mission trip to Ecuador.

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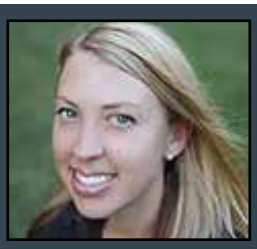
House Calls is a quarterly publication of the Alachua County Medical Society, Inc., Gainesville, Florida.

Human Trafficking in Our Area

Guest Column by:
Robyn Hoelle, MD, FACEP, NFRMC Emergency Medicine
Ashley Barash, DO, Resident, NFRMC Emergency Medicine GME



Robyn Hoelle, MD

Ashley Barash, DO

About a year ago, a woman presented to the Emergency Room with vague abdominal pain. She was jumpy, gaunt in stature, older-appearing than her stated age, and had extremely poor dental hygiene and an uninterested partner at bedside. Nothing turned up on her medical evaluation and we suspected drug use and severe anxiety explained her presentation. She was discharged. Twenty minutes after her discharge, a special state investigator turned up at the nurses' station, looking for a young woman who he suspected was a victim of human trafficking. Hoping she would be in the ER, he showed printouts of old Facebook posts featuring a young, vibrant, happily smiling woman. I barely recognized her but my heart sank... she was the same woman I had discharged moments before. She had been missing for four years and had a two-year old child when she disappeared.

We missed it... we missed it. Thankfully, the officer found her, still in the hospital, squatting in a corner of the waiting room and waiting for her ride. Had it been any longer, she probably would've disappeared again as human traffickers move victims up and down the state of Florida, peddling their wares and always on the move. We missed it, but thankfully, he found her.

With human trafficking, there isn't a lab value or an image reading that will identify that piece you are missing. It requires an awareness of the issue and an ability to identify red flags, which are often quite subtle.

According to the United Nations Conventions against Transnational Organized Crime, human trafficking is defined as: "The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude, or the removal of organs."

Human trafficking is a $150 billion industry worldwide and $9.5 billion in the United States (Polaris Project). There are 40.3 million victims (that is 140.3 times the population of Alachua County) of human trafficking worldwide (Polaris Project). Seventy-five percent of these victims are women and girls, while 25% are children. These numbers are even more astounding when we recognize that it is occurring right in our backyard and we are on the front lines. Human trafficking occurs in all 50 states and Florida is 3rd to California and Texas (Polaris Project). And, with a quick internet search of "Human Trafficking in Gainesville" there are an astounding number of articles regarding recent arrests related to human trafficking.

As Emergency Department providers, we are on the front lines. Of 173 survivors of trafficking in the United States, 68 percent were seen by a health care provider while trafficked, with 56 percent seeing emergency or urgent care providers (Chisolm). Nearly 88 percent of human trafficking survivors surveyed reported accessing care at least once while trafficked (ACEPNow). Sixty-three percent of those who accessed care did so in a hospital emergency department (ACEPNow).

Victims of trafficking present with an inconsistent history. They are hesitant to answer questions; sometimes visitors do all the talking; there is evidence of a controlling relationship; they avoid eye contact, appear fearful or nervous, are unaware of currently location, time or date, do not know their addresses, or are not in control of their own time or money.

In cases of human trafficking, our goal is never to obtain a disclosure or carry out a rescue. As physicians, we seek to rescue our patients often with quick fixes, so approaching a human trafficking patient can be challenging. When approaching a potential victim of human trafficking, it is important to speak with the patient alone, but also to avoid asking outright if the patient has been trafficked. Instead, asking broad and open-ended questions allows the patient to feel safe, keeping in mind that if the patient does not disclose anything during this visit, they must feel safe and secure to return on another occasion. Assuming the patient is a consenting adult, they must always be engaged in any discussion and their consent must be sought prior to involving law enforcement.

If patients disclose that they are victims of human trafficking, they can call the National Human Trafficking Hotline (1-888-373-7888) from a private and safe space. You may call on the patient's behalf. However it is important to discuss how much personal information the patient wants disclosed.

We missed it. You don't have to.

References available upon request.

Improving Outcomes in Women's Health

Jackie Owens, ACMS Executive Vice President

Women's health has traditionally referred to women's reproductive health. Today, Women's health refers to "the branch of medicine that focuses on the treatment and diagnosis of diseases and conditions that affect a woman's physical and emotional well-being", focusing on all aspects of a woman's life cycle.[1] Women were often excluded from clinical trials in the early-mid 1900s, as researchers were concerned about the potential risks concerning pregnancy and infertility. Recent research has found, however, emerging differences in sex/gender, and age on the health of women, emphasizing the necessity of including sex as a variable in clinical research.[2]

The US trails behind other countries in many key health indicators, especially for women. Although women live longer than men in most industrialized countries, they experience earlier and more advanced disease with poorer outcomes.[2] Figure 1 shows the life expectancy in years at birth for males by country of birth for similar industrialized nations. Figure 2 shows this data for the female population in those same countries.

In both male and female analyses, the US is lagging behind its peers in terms of life expectancy, especially when compared to those countries that lagged far behind us in 1980. The advancements in women's life expectancy are even less promising. The overall bad performance of the United States over the last 37 years is unexpected, given that we spend far more on health care than other nations, both in total and as a percentage of gross national product.[3]

There are several clinical categories including depression, cardiovascular disease, diabetes, Alzheimer's/dementia and stroke, where women experience significantly different outcomes than men.

Alzheimer's / Dementia

Nearly two-thirds of the population living with Alzheimer's disease (AD) are women. Emerging evidence suggests there may be unique biological reasons beyond longevity for these differences. The Alzheimer's Association has established the Sex and Gender in Alzheimer's (SAGA) grant funding program to support scientific research that addresses these differences.

In addition to AD, there are many causes of dementia – genetics, neurological diseases, heart disease, trauma, and others. While stroke incidence and prevalence rate is higher in men, the rate of subarachnoid hemorrhage is higher for women, and due to the differences in age at stroke occurrence, stroke tends to be more severe in women.

Women with cardiovascular disease have more strokes than men. In many cases, women have been less aggressively treated than men with blood thinners, drugs that can decrease the risk of stroke by as much as 80%. With blood thinners, the survival rate for stroke is 97% compared with 85% for those not given the correct dose. The problem is that women are less likely to be given blood thinners at all.[4]

Depression

Studies documenting differential vulnerability to risk factors for depression find a 10.4% higher risk of depression for women than for men across all socioeconomic conditions. One-fifth

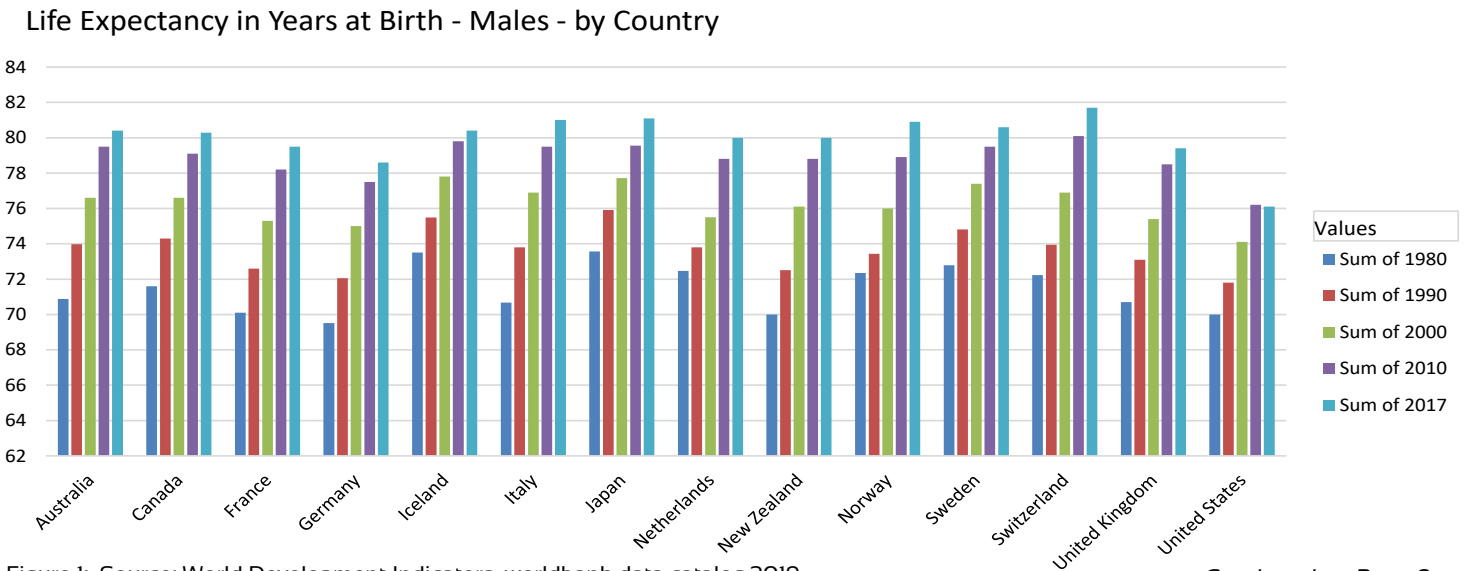


Figure 1: Source: World Development Indicators, worldbank data catalog.2019

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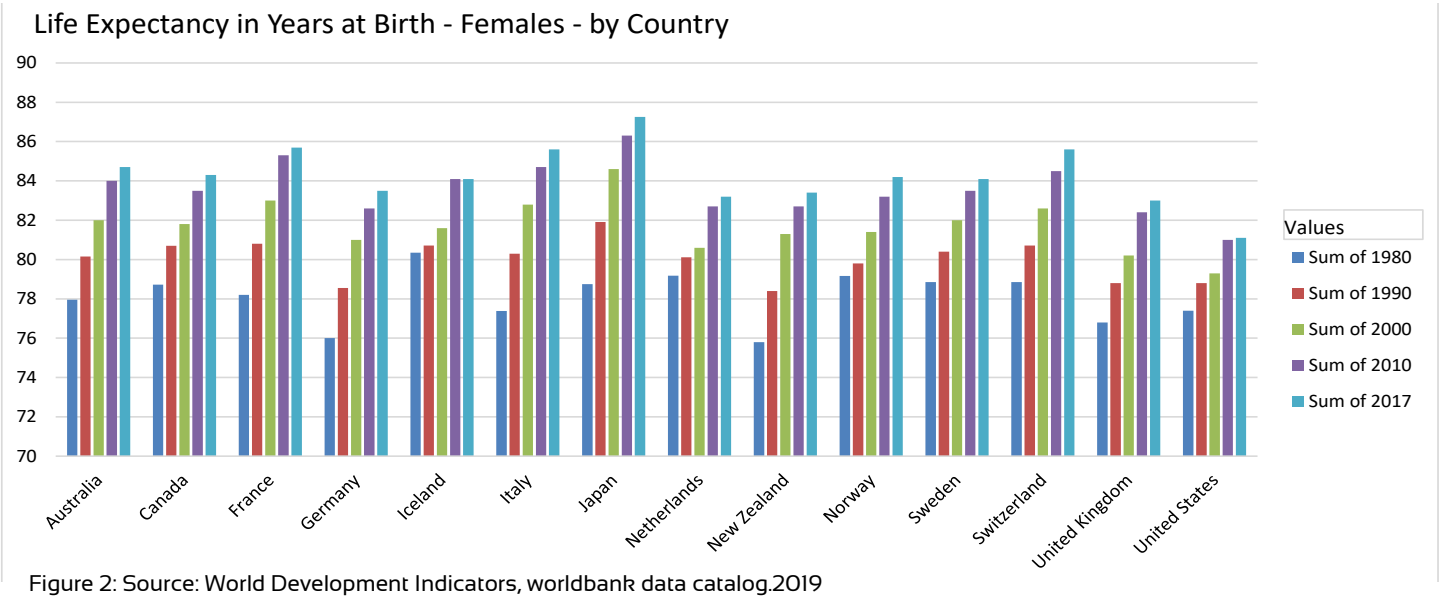

Figure 2: Source: World Development Indicators, worldbank data catalog.2019

of the elevated risk of depression among women is attributed to exposure to interpersonal violence. Childhood and adult exposures to adversity contributed more to depression in women than in men and was linked to an increased rate of suicide during military deployment.[5]

Cardiovascular Disease (CVD)

Among all people affected by heart attacks, women have greater fatality rates compared to men. Cholesterol plaque in women may not build up into major artery blockages as it does in men, instead spreading evenly throughout the artery wall, causing a condition which is more difficult to diagnose. These women may not have outright symptoms of a myocardial infarction, but are still at high-risk. Women are less likely than men to receive early medical therapy and invasive cardiac procedures. Women are more likely to have hypertension and less likely to have coronary artery disease. Women have more brain injury after cardiac surgery compared with men. They also have more small-vessel or microvascular disease in the heart arteries and possibly in the brain than men, which may contribute to their increased rate of dementia. It takes women longer to restore the flow of blood to a previously ischemic tissue or organ, resulting in higher mortality rates with ST-segment-elevation myocardial infarction. This area clearly requires more research to fully understand the sex differences in CVD.[5,6]

Diabetes

Diabetes is a stronger risk factor for coronary heart disease (58%), and all causes of mortality (13%) in women than in men. Risk of stroke is 8% higher for women with diabetes than for men, and there is a 30% increased risk of CVD mortality in women. This study included analysis of CHD, CVD, cancer, infectious disease and respiratory disease and points to an urgent need to develop sex/gender-specific risk assessment strategies and interventions to target diabetes management.[7]

There is evidence that women are less likely to have their risk factors assessed by physicians when they present in primary care. Women with diabetes or CVD are diagnosed later and have a lower frequency of statin therapy, aspirin use, ACE inhibitors and Beta-blocker use than men, thereby exacerbating the sex differences. Implicit bias may play a role is these diagnoses, delaying the proper diagnosis. Recent research measuring implicit bias in a healthcare environment with respect to race, gender, age and weight found a positive relationship between the level of implicit bias and lower quality of care. Measures need to be taken by physicians and hospitals to raise awareness of implicit bias and the potential conflict of holding negative attitudes towards certain patients/characteristics. [8]

What Next?

Continued research in areas of notable sex/gender differences need to focus on both male and female subjects to further unlock the reasons behind some of the differences in patient outcomes. The National Institute for Health (NIH) is seeking to improve those outcomes by encouraging the inclusion of women in biomedical research and supporting the advancement of women in the industry. The introduction of the "Sex as a Biological Variable" (SABV) policy by NIH Office of Research on Women's Health, has contributed to closing the gap across sex and gender issues by promoting the use of sex as a variable in clinical studies and thereby elevating the standards for the health of women. The policy requires that researchers embed SABV in their scientific approaches and study both sexes unless there is a strong scientific justification not to do so. Supplemental funding has been provided to NIH grantees to address the health of women of Understudied, Underrepresented and Underreported populations (U3 program). These strategies have the potential to reverse the trend towards shorter life expectancy and poorer health for women in the U.S. and hopefully in the entire population as a whole.

References available upon request.

Building Awareness About Infertility And the Transition To Early Pregnancy Care: A Case Based Example

Alice Rhoton-Vlasak, MD, UF Health Obstetrics & Gynecology
Michelle Larzelere, MD, UF Health Obstetrics & Gynecology

Alice Rhoton-Vasak, MD

Michelle Larzelere, MD

Case Presentation:

A 34-year-old female presents to her primary care physician for her annual checkup. She reports she has not used birth control for 2-1/2 years, and wonders if she should be checked for infertility. She has irregular cycles, acne, and excess facial hair growth, and was told she has polycystic ovarian syndrome. She tried using ovulation predictor kits that were rarely positive for an LH surge. They have regular unprotected intercourse, and her partner has no children. She asked if they should be checked for infertility and wonders how early pregnancy obstetrics care would be handled.

Part One – The Infertility Side of the Story

Infertility can be devastating, and in order to recognize the problem, practitioners must first be aware of the current definitions. Infertility is defined as a failure to achieve a pregnancy within 12 months of unprotected intercourse or therapeutic donor insemination in women younger than 35 years, or within 6 months in women older than 35 years. If a woman presents over 40 years of age, more immediate evaluation and treatment is often warranted, since advancing age is an important but often unrecognized factor that can significantly impact female fertility. It is critical to recognize that women over 35 should receive an expedited evaluation and undergo treatment after 6 months of failed attempts to get pregnant or earlier, if clinically indicated.

Infertility may affect up to 15% of couples. In many cases, an infertile woman will initially broach the topic and seek care from her obstetrician-gynecologist or primary care physician. It is appropriate for an infertility evaluation to be offered to any patient, who by definition has infertility or is at high risk of infertility. The list of reasons for infertility includes anovulation, tubal blockage, age-related, uterine factor, endometriosis, male factor, and unexplained infertility. In about 30% of cases, there may be an issue with the man, in another 30% the concern is with the woman. In the remainder of couples, there could be overlapping male and female factors, as well as unexplained infertility.

It is important for a woman's health provider to recognize potential known causes for infertility, in which an immediate evaluation would be considered. Once infertility has been recognized, the primary care or any provider making this connection could offer referral to an Obstetrician Gynecologist or Reproductive Endocrinology/ Infertility (REI) specialist. UF Health has both types of practitioners in one location at the Springhill office location. Both would be appropriate starting points for the investigation. Complex cases should be referred to the REI for advanced workup and treatments, such as In Vitro Fertilization (IVF) and other types of Assisted Reproductive Technologies (ART). Potential indicators for early evaluation include oligomenorrhea or amenorrhea, known or suspected uterine or tubal disease, advanced-stage endometriosis, and possible male infertility. During the first visit, where pregnancy desires are revealed, there should be pre-pregnancy counseling and evaluation. Pre-pregnancy counseling is important to reduce the risk of adverse health effects for the woman and her baby by optimizing pre-pregnancy health and addressing modifiable risk factors. This measure should include brief counseling on a healthy diet and lifestyle, striving to achieve a normal pre-pregnancy weight, and avoiding excess use of alcohol, tobacco, and drugs. There should be a review of current vaccinations and updates as indicated. It is common to offer universal genetic carrier screening as part of pre-pregnancy care, but this could be deferred to the Obstetrician. It is important to educate women about methods to maximize fertility, including timing and frequency of intercourse.

Once a diagnosis of infertility has been established, a targeted workup can be initiated. The medical history should include items relevant to potential etiologies of infertility and should be obtained from the patient and the partner, if the patient has a partner. The physical examination should be performed with a focus on vital signs, and include a thyroid, breast, and pelvic examination with attention to physical findings which may impact fertility.

Additional testing for infertility includes laboratory and imaging tests. For the female partner, tests will focus on ovarian reserve and egg quality, ovulatory function assessment, and structural abnormalities. It is critical to recognize that certain fertility tests

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have a low yield in identifying a modifiable diagnosis, do not distinguish women who will and will not become pregnant, add significant expense, and/or are associated with harms that outweigh demonstrable benefit. (See Table 1 and Table 2).

Table 1 Basic Infertility Evaluation*

Female	Male
History	History
Physical	Physical deferred to PCP, or Urologist if there is male infertility
Pre-pregnancy counseling	Pre-pregnancy counseling
Tubal Factor -Hysterosalpingogram (gold standard) -Transvaginal bubble sonography	**Semen analysis** (Performed at UF Health Reproductive Medicine at Springhill)
Ovarian reserve (egg quality) -Antral follicle count -Basal FSH, estradiol, and AMH	**Normal Semen Parameters (lower limit) Per WHO Standards, 2010** -1.5mL -15million/mL -39 million total motile -32% progressive motility -4% on Strict Morphology
Ovulatory Factor -Serum progesterone > 3ng/mL -TSH -Prolactin	
Uterine Factor -Transvaginal ultrasound -Hysterosalpingogram -Office hysteroscopy -Saline infusion sonography	

*Adapted From Infertility Workup for the Women's Health Specialist

The most common cause of female infertility is ovulatory dysfunction, which often manifests as irregular periods. A serum progesterone value > 3ng/mL is considered evidence of ovulation. Polycystic ovary syndrome is the most common cause of ovulatory infertility. Additional testing with a TSH and prolactin level should be completed to rule out thyroid disease and hyperprolactinemia, which can cause ovulatory dysfunction. Ovarian reserve or egg quality testing is completed with a menstrual cycle day 2, 3, or 4 transvaginal ultrasound with antral follicle count, basal follicle stimulating hormone (FSH), basal estradiol, and anti-mullerian hormone (AMH) level. Tubal patency and uterine anatomy are typically evaluated with a hysterosalpingogram (HSG). A transvaginal bubble study could also be attempted, but is not as widely used for this purpose. Office hysteroscopy or transvaginal ultrasound will allow for uterine cavity and wall assessment. The gold standard for evaluating tubal patency is the hysterosalpingogram.

While the female partner may be the first one recognized for broaching the delicate topic of infertility, one must not forget the male evaluation. A semen analysis is the quantitative microscopic evaluation of sperm parameters. 2-5 days of abstinence is optimal before undergoing a semen analysis. Abnormalities on semen analysis warrant repeat testing and further investigation. Normal values are listed in Table 1. Despite a thorough investigation, unexplained infertility occurs when the basic evaluation is performed with all normal test results. Fortunately, even in cases of unexplained infertility, there are many treatment options available.

Case Follow-up: Our couple was found to have a low serum progesterone, with remainder of her workup being normal. A referral was made to a Reproductive Endocrinologist. They elected to start letrozole for ovulation induction and conceived a singleton pregnancy during her first month of treatment. She had many questions about the transition to early pregnancy care with an Obstetrician. Specifically what are the important factors to consider in preparation for early pregnancy?

What Happens Once I Get Pregnant?

Once the excitement of a positive pregnancy test wears off, many women begin to wonder what happens next. If they conceived under the care of a reproductive specialist, they will choose an Obstetrician or Midwife for pregnancy care. Typically, the first appointment occurs between 6-10 weeks of pregnancy. An ultrasound may be performed to confirm viability of the pregnancy. The first visit involves counseling, patient education, labs, and a physical examination.

Before the first visit, a patient may experience nausea and vomiting. The first step in treatment is doxylamine and pyridoxine/vitamin B6 (or combination Diclegis). These are preferred over other anti-emetics as they are available over-the-counter and have fewer side effects.

A common, but potentially more urgent concern in early

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Building Awareness About Infertility

Table 2
Infertility Tests That Should Not Be Routinely Performed From ABIM Choosing Wisely Campaign*

Laparoscopy for Unexplained Infertility – May be indicated if symptoms or findings of endometriosis present
Advanced sperm function testing , such as DNA integrity
Postcoital testing
Thrombophilia testing
Immunologic testing or treatments
Karyotype
Endometrial biopsy
Prolactin (unless cycles irregular)

*Adapted from Infertility Workup for the Women's Health Specialist and American Society For Reproductive Medicine Choosing Wisely

Table 3 Antenatal Genetic Testing*

	First trimester screen	Quad Screen	Cell free fetal DNA
What it detects?	Trisomy 18, 21	Trisomy 21, 18, Neural tube and abdominal wall defects	Trisomy 13, 18, 21, sex chromosome aneuploidies
When is it done?	11-14 weeks	15-22	After 10 weeks
Detection rate for T21?	82-87%	81%	99.9%

Adapted from Doubilet PM, Benson CB, Bourne T, et al. Diagnostic criteria for nonviable pregnancy early in the first trimester

pregnancy, is when the women calls the office with vaginal bleeding or abdominal pain. It is important for them to be evaluated to check for a potential miscarriage or rule out an ectopic pregnancy. Important testing includes physical examination, transvaginal ultrasound, beta-hCG, CBC, and blood type and screen. A physical examination is important to determine the severity of her bleeding as well as to see if her cervix is dilating. Heavy bleeding with a dilated cervix can indicate an inevitable spontaneous abortion or miscarriage. An ultrasound can show a potential viable intrauterine pregnancy or abnormal pregnancy. In a typical patient the beta-hCG should rise by 53% every 48 hours in early pregnancy. Once a threshold of 3,000 mIU/mL is reached, a normal pregnancy should be seen by transvaginal ultrasound [3]. If there is a plateau in b-HCG it can indicate a possible ectopic pregnancy or an abnormal intrauterine pregnancy. If the patient has had a miscarriage, typically there will be a decline in the hCG. Any patient with bleeding should also have a type and screen. Rhogam should be given to any patient who is Rh negative within 72 hours of onset of bleeding in order to prevent Rh isoimmunization.

Once a viable pregnancy is confirmed, several additional tests will be ordered. At any initial pregnancy visit, a CBC, type and screen, rubella immunity status, full STD panel, and urine culture will be ordered. A patient will be offered and may wish to undergo additional genetic testing. Today, we offer several different tests to screen for trisomies 13, 18 and 21 (Table 3, Reference 4). An additional test can also confirm the gender of the fetus. If a patient has not previously had genetic carrier screening, this will be offered.

Once the first pregnancy visit is complete, the woman will continue with routine scheduled care with her Obstetrician or Midwife throughout the pregnancy and postpartum period. Hopefully, this vignette will allow for better awareness of infertility, the workup, and the smooth transition that occurs from Reproductive Endocrinology and Infertility treatments and conception, to the day of the much-awaited graduation to Obstetrics care. These services are offered by Dr Larzelere and Rhoton-Vlasak, at the UF Health clinics in Gainesville and Ocala Heathbrook locations.

References Available Upon Request

What Really Is a High Risk Pregnancy? – An introduction to the subspecialty of Maternal Fetal Medicine

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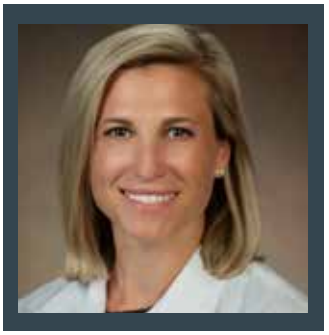

Kathryn Patrick, MD, FACOG

As physicians and community leaders, there is a high likelihood that we are familiar with someone who has had a "high risk pregnancy." Over the years, I have heard the term "high risk pregnancy" used to describe a vast spectrum of pregnancies. From a next door neighbor who was eating too much canned tuna, to a sister who had elevated blood pressure during pregnancy, to a co-worker who had a baby with a congenital heart defect. It seems that any pregnancy affected by the unusual or unique, is coined "high risk." But what really makes a pregnancy "high risk," and who manages high risk pregnancies?

Maternal fetal medicine (MFM) specialists, or perinatologists and high risk pregnancy physicians, care for pregnant mothers and their unborn fetuses. MFM specialists complete an additional three-year fellowship following a four-year obstetrics and gynecology residency program. MFM fellowship training focuses on performing and interpreting obstetric ultrasound as well as the diagnosis and management of obstetric, medical, and surgical complications of pregnancy.

The extent to which an MFM specialist is involved in a woman's pregnancy varies. A MFM specialist may be a consultant to the primary obstetric provider, providing specific prenatal, delivery, and postnatal management recommendations during a single consultation. A MFM specialist may also provide consultation prior to pregnancy on preexisting maternal medical conditions, obstetric history, or family history issues.

A MFM specialist may co-manage a pregnancy with the primary obstetric provider. Certain pregnancy conditions such as gestational diabetes are very nicely managed this way. The MFM specialist may see a woman on regular intervals to perform ultrasound evaluations, review blood glucose logs, and provide medication recommendations while the primary obstetric provider continues to provide prenatal, delivery, and postnatal care.

Sometimes it is necessary to transfer all care of a pregnant woman to a MFM specialist. This practice model is particularly useful for pregnancies complicated by fetal congenital anomalies, in which a multidisciplinary team is needed to optimally counsel and care for the pregnancy and neonate.

Many MFM specialists are also involved in basic science and clinical research as well as medical education.

A MFM specialist manages the medical, surgical, obstetric, fetal, and genetic complications of pregnancy. When considering the maternal medical complications of pregnancy, it is helpful to think of two different scenarios: when a pregnant woman gets sick and when a sick woman gets pregnant. Certainly healthy women get sick during pregnancy with conditions such as infections, cardiac issues, thromboembolic events, and cerebrovascular accidents. On the other hand, with advanced medical care, delayed child bearing, and increasing rates of pregnancies achieved through assisted reproductive technology, older and more medically complicated women are getting pregnant. In fact, according to the Centers for Disease Control, the two leading causes of maternal mortality in the United States are cardiovascular disease and other medical non-cardiovascular complications, many of which are diagnosed prior to pregnancy. In these women, the importance of a preconception consultation with a MFM specialist is of paramount importance. Reviewing medications, optimizing medical conditions, and working in concert with reproductive specialists are important components to preconception care in women with preexisting medical conditions.

Perhaps one of the most important concepts of managing women with medical conditions during pregnancy is that no woman should be denied appropriate medical care for the sole reason that she is pregnant. One of the many benefits of involving a MFM specialist in the care of a sick mother is to reassure these women and referring physicians that appropriate medical treatment is not only beneficial, but also not harmful, to the fetus. In fact, appropriate resuscitation and treatment of a sick mother often improves the status of the fetus and the pregnancy.

On the contrary, there are times when medical treatment can be altered or delayed until a later gestational age or the postpartum period following careful consideration of

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Maternal Fetal Medicine

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the risk-benefit profile. Additionally, there are certain medications and treatments that should be avoided in pregnancy, women who are attempting pregnancy, and breastfeeding. In all of these scenarios, a MFM specialist can help counsel and guide the patient and other healthcare providers with regards to the optimal, safe, and individualized treatment of medical conditions in the perinatal period.

MFM specialists also participate in the management of surgical complications of pregnancy. Placenta accreta is a very serious pregnancy condition characterized by an abnormally adherent placenta and can result in life-threatening hemorrhage. These women often require hysterectomy following cesarean delivery. Prompt antenatal diagnosis and referral to a Level III or IV maternal care center for delivery have been some of the only interventions shown to improve the outcomes of these women. Diagnosis of placenta accreta can be facilitated by ultrasound imaging, but remains imperfect. It is of utmost importance to maintain a high index of suspicion in the setting of risk factors (i.e. prior cesarean delivery, placenta previa). MFM specialists are directly involved in the antenatal diagnosis and surgical planning of women with suspected placenta accreta. On occasion, MFM specialists also participate in the surgery alongside other pelvic surgery specialists.

Perhaps some of the most well recognized indications to see a MFM specialist are related to the obstetric and fetal complications of pregnancy. Conditions such as gestational diabetes, hypertensive diseases in pregnancy (i.e. gestational hypertension, preeclampsia) and their related complications, preterm labor, preterm prelabor rupture of membranes, and amniotic fluid abnormalities (i.e. polyhydramnios, oligohydramnios) are all obstetric indications for management by MFM specialists. Furthermore, women with a history of pregnancy complications often receive counseling by a MFM physician in the preconception period or early in pregnancy regarding specific screening, prophylaxis, and intervention recommendations with the goal of preventing a similar adverse pregnancy outcome.

Pregnancies affected by fetal complications are also followed by MFM specialists who perform detailed fetal anatomic ultrasounds to primarily screen for or evaluate the suspicion of a congenital birth defect. The roles of MFM specialists in these pregnancies include diagnosis or confirmation of a fetal anomaly, monitoring of fetal growth and well-being, and delivery planning. Fetal complications may include congenital birth defects, chromosome abnormalities, and aberrant growth. Although they may be uncomplicated, multiple gestation pregnancies are also typically monitored by a MFM specialist due to the increased risk of fetal and maternal complications.

In addition to diagnosing and monitoring pregnancies complicated by fetal birth defects, MFM specialists play a role in coordinating and performing intrauterine fetal therapies for complicated fetal issues. Fetal therapies include percutaneous umbilical cord blood sampling (PUBS), intrauterine blood transfusion for fetal anemia related to Rh and other red cell antigen alloimmunization, ex-utero intrapartum treatment (EXIT procedure) for fetal critical airway restriction, fetoscopic endotracheal occlusion (FETO procedure) for congenital diaphragmatic hernia with impaired lung development, fetoscopic laser surgery for twin-to-twin transfusion syndrome (TTTS), and fetoscopic myelomeningocele repair.

Lastly, MFM specialists have the unique role of genetic counselor in many pregnancies. Important indications to see a MFM specialist include a personal history, family history, or previous child with a genetic abnormality. MFM specialists counsel women on genetic abnormalities and how they may affect the patient, her current pregnancy, and future pregnancies. MFM specialists are well versed in the constantly evolving field of prenatal genetic screening and diagnostic genetic testing including chorionic villus sampling and amniocentesis. MFM specialists are responsible for counseling patients on the most appropriate genetic screening or testing modality for one's pregnancy and performing diagnostic genetic testing procedures. Another important element of genetic screening involves the genetic ultrasound. MFM specialists perform specialized first and second trimester obstetric ultrasounds that aid in screening for chromosome abnormalities and congenital birth defects.

Indeed, MFM specialists play a special role in a woman's pregnancy. Women with an indication to see a MFM specialist have some degree of a "high risk pregnancy." It is not surprising that for many women referral to a MFM specialist involves an elevated level of anxiety and concern. For others, seeing a MFM specialist may elicit or reinvigorate undesirable feelings about a previous pregnancy. As such, it is not uncommon for the visit with a MFM specialist to involve extensive counseling, perhaps reassurance, and thoughtful planning. Even if the role of a MFM specialist is primarily consultative, there can be a high level of continuity of care during a single pregnancy and between multiple pregnancies of the same woman. All of the above factors facilitate an important and special relationship between a woman and her MFM specialist anchored on the prevention, mitigation, follow-up, and improvement of the various risks and complications of pregnancy.

References Available Upon Request

Becoming a Reproductive Health Champion

Austin Chen, MD
SIMEDHealth Women's Health Clinic

Unfortunately, reproductive health is too often not considered in the treatment of common patient presentations. Improving the reproductive health of our patients can be, and should be, a focus of our medical practices. In this article I selected three topics to educate and hopefully energize readers' ongoing efforts to be reproductive health champions. These topics appear in the American Board of Obstetrics and Gynecology (ACOG) recertification reading list, representing the areas of physicians' focus from ACOG.

Expedited Partner Therapy for Sexually Transmitted Diseases

- Vignette –

Recently, I encountered a young couple with no medical insurance. She was diagnosed with a Chlamydia infection. I prescribed antibiotics for my patient, and discussed the importance for her partner to receive simultaneous treatment. Her partner asked me for a prescription and I prescribed antibiotics to the partner. When the partner took the prescription to the pharmacy, the pharmacist declined to fill the prescription, and called me to state there was general concern that I should not be prescribing to the partner, sight unseen.

Untreated partners of sexually transmitted disease (STD) patients can result in re-infection of the original patients as well as expose any of the partners other sexual partners to STDs. STD infections can spread to the uterus and fallopian tubes resulting in pelvic inflammatory illnesses and infertility. As long ago as 2006 the Centers for Disease Control (CDC) initiated expedited partner therapy (EPT) guidelines. By 2016 EPT achieved full support from ACOG and the American Bar Association. Gradually, the state legislatures, including Florida, passed statutes allowing clinicians to prescribe, and pharmacists to dispense, treatment to partners. Currently South Carolina is the only state where EPT is prohibited.

To date, only 11% of physicians practice EPT. EPT tends to be more prevalent in larger cities and in academic settings. EPT is less common in community practices and in rural settings. Lack of EPT awareness and not understanding the importance are the dominant reasons for the low implementation rate.

Good public health policy and full consumer support can't take off without our healthcare providers' "boots on the ground." STD treatment is effective only when the partner is treated, and doing so follows evidence-based guidelines as well as having the protection of state regulations.

What is Expedited Partner Therapy (EPT)?
EPT seeks to increase the rate of treatment for partners of patients with sexually transmitted infections through patient-delivered therapy, without requiring the partner to receive a medical evaluation or professional prevention counseling.

What are common fears or concerns of practicing EPT?
EPT disrupts certain long-standing teachings in medical ethics. This list is not complete, but the common fears and concerns are: the standard of informed consent prior to treatment, the lack of continuity of care, and the medical liability of treating without adequate evaluation of the patient.

Florida legislature's support of physicians, advanced care providers, and pharmacists in implementing EPT?

Florida Statute §384.27 (effective July 1, 2016):

A health care practitioner may provide expedited partner therapy if the following requirements are met:

1. The patient has a laboratory-confirmed or suspected clinical diagnosis of a sexually transmissible disease;

2. The patient indicates that he or she has a partner with whom the patient has engaged in sexual activity before the diagnosis of the sexually transmissible disease;

3. The patient indicates that his or her partner is unable or unlikely to seek clinical services in a timely manner.

Are sexually transmitted diseases still a problem?
The incidence of STDs has increased sharply since 2013. In 2017 alone, twenty million of the US population were diagnosed with STDs. The three most common STDs are Gonorrhea, Syphilis, and Chlamydia. STDs are not just illnesses for OB/GYN physicians. They affect men and women, young and old, and even babies. With access to

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Becoming a Reproductive Health Champion

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treatment all STDs are completely treatable.

Accessing treatment?

On both the patient's and the partner's side the perceived stigma attached to STDs lead to self-imposed silence. This fact combined with the barriers to effective partner treatment lead to further delays and lost opportunities for treatment. It is estimated that 46-75% of partners are NOT treated.

Budget cuts have slashed traditional default points of access for many with STDs including local health departments, Planned Parenthood and other free or reduced-cost health clinics, resulting in reduced points of access for STD patients and their partners. These health access points are often considered places where there is less drama and stigma associated with the diagnosis and losing these access points is unlikely to slow the rising STD incidence. Consequently, timely diagnosis and timely EPT is essential for the rest of us in healthcare who are now the primary resource for these patients.

Optimize Thyroid Hormone among Women with Reproductive Desire

Evaluation of thyroid function is commonly done by laboratory measurement of the thyroid stimulating hormone (TSH). The TSH is considered "normal" if the result falls within a range between 0.5 – 5.0 mIU/L. Endocrinologists will tell us this is a very wide range and patients are often unable to feel the difference between the low to mid-range, or the mid to high-range results.

TSH optimization for women with reproductive desire has evolved and become more nuanced. TSH testing should be part of the screening process for women expressing desire for procreation or women reporting infertility. The American Thyroid Association guidelines call for infertile women with TSH > 4 mIU/L to be treated with levothyroxine to maintain their TSH levels below 2.5 mIU/L. It is also considered safe to treat pregnant women with hypothyroidism with levothyroxine to maintain TSH levels below 2.5 mIU/L.

PAP Testing and Adolescents

The prevalence of Human Papilloma Virus (HPV) infection in sexually active adolescents is approximately 30%. However, the incidence of cervical cancer in women younger than 21 years is approximately 1 case in a million. Essentially all HPV infections in this age group are transient and do not require intervention.

Since 2002 the cervical cancer screening guidelines raised the minimum age of screening from 18 to 21 years of age, regardless of previous sexual activity. This position has been reaffirmed over the years since initially adopted.

Despite these long-standing and accepted guidelines, many young women continue to have screening tests. Abnormal results can occur, but are not a reflection that the guidelines are inadequate, as these transient inflammatory abnormalities are very unlikely to result in any long-standing problems. However, testing earlier than the guidelines call for can be a gateway for potential over-treatment, which can introduce harm to fertility and pregnancy experiences later in life.

The following algorithm is recommended for women younger than 21 years of age who are inadvertently screened with PAP smears and their results return with abnormal cytology or HPV results:

- Restrict colposcopy only to the most severe, high-grade abnormalities (ASCUS-H, HGSIL);

- With high-grade abnormalities (ASCUS-H, HGSIL, or LGSIL for 2 consecutive years), perform or refer to gynecologist for colposcopy exam and biopsy;

    - If colposcopy biopsy is positive for CIN 1 – repeat PAP smear with only cytology in 1 year;

    - If colposcopy biopsy is positive for CIN 2 or 3 – refer to gynecologist.

Key Points:

- Most HPV infections in adolescents are transient and will regress spontaneously.

- Because HPV infection is common in adolescents, HPV testing is not indicated.

- Treatment of CIN 1 is not indicated in women under the age of 21 years.

- Excisional and ablative therapy of CIN may result in future obstetric risks.

- It is recommended that CIN 2 be followed rather than treated in adolescents.

(Sources: The American Cancer Society, US Preventive Services Task Force, ACOG, CDC)

We Did It!

How We Started an OB/GYN Residency Program

Parker Long, DO
Women's Group of North Florida

Residency, post-graduate training for medical physicians, can be challenging and stressful regardless of the field of medicine. Coming into a brand-new residency program adds more challenges than an established program. Reflecting on my interview with our Program Director, Dr. Karen Harris, I immediately felt at ease. I was finishing a successful tour as a flight medical officer in the US Navy and was looking for a program where I could continue my training in OB/GYN, after having already completed my residency intern year through the Navy. When I found out about the opportunity to bring my real-world experience to a brand-new residency program as a second-year resident, it seemed like the perfect match.

Before the program had even started, there were significant challenges that we faced. The office moved a few weeks before the program began. The program and office had to hire a completely new staff. And, the office protocols were not yet in place. It seemed like an overwhelming task to begin this program and there were certainly some growing pains to work through. Impressively, within one year, a group of four interns and one second year resident have transformed this practice into a flourishing OB/GYN residency program that can barely keep up with the patient load.

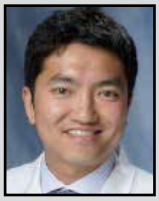
The first month the doors were open, we received only three service patients on Labor & Delivery. Flash forward one year, we are now delivering approximately 50 plus patients per month. Certainly, we had no scheduled gynecologic surgeries to start, and now we are booked up four weeks in advance. And the momentum only continues to build within our program.

A unique aspect of our program is that we have combined a private practice office with a resident-run clinic. This unusual setting for a residency program created many administrative obstacles at first. It was necessary to solve problems that normally are above a resident's level of practice. We had to establish a detailed list of protocols for the clinic to function. We all had to learn how to communicate effectively and how to get triage notes from Labor & Delivery to the office. We had to determine how to get a patient to the operating room without an attending physician or senior resident present. We have rewritten policies on Labor & Delivery, in the Emergency Room, and in the operating room. We all feel that we have helped improve patient care in every aspect in which we are involved- even despite the initial fear of having new residents at a private hospital. The attending physicians, the residents, the nurses and the office staff are all very proud of how much our practice has grown.

The most important part is how we are improving patient care in North Central Florida and the greater Gainesville area. Our patient population has been underserved for far too long and needed relief from a shortage of treatment options and physicians in our community. Time and time again, we hear stories from women and the difficulties they have had finding a physician in a reasonable amount of time. Time and time again, we have been honored to have a positive impact in these women's lives. We are all far from being perfect, but all the residents here have been humbled and feel a sense of pride in establishing a new standard of care. We have wholeheartedly cared for each patient who has walked through our doors.

Starting this program was a big risk for all of us. I am happy to say that this risk has paid off tremendously, not only for our education and personal and professional growth, but also for the wellbeing of the Gainesville community.

Welcome New Members



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Welcome to the ACMS Physician Community!

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David R. Nelson, MD
Health Affairs UF Health

Laurie A. Solomon, MD
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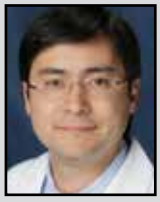

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Orthopaedics

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Welcome New Members - continued

Welcome to the ACMS Physician Community!

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UF Health
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The Cardiac & Vascular Institute

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North Florida GME
Internal Medicine

Katherine Choi, MD
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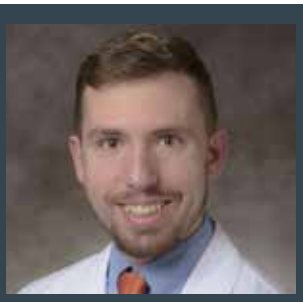
Alexis Hanlon
UF College of Medicine

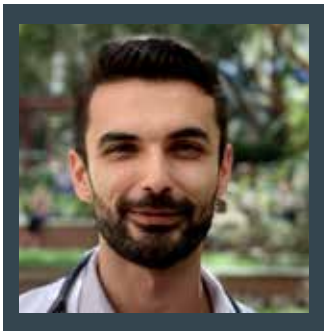
Thomas C. King
UF College of Medicine

"It's Time to Bring Safe Syringe Exchange to Alachua County"

By David Tyson and Olgert Bardhi,
UF College of Medicine



David Tyson



Olgert Bardhi

One of the most significant victories of scientific research and health care has been that of finding effective diagnosis and treatment for persons with HIV/AIDS, thanks to the global response to this epidemic. These efforts have shown remarkable success, with reduction in HIV/AIDS incidence of more than 4% from 2008 to 2013 [1]. The United States is one of the nations leading the effort to prevent the spread of HIV and develop more effective treatments. Despite all of our efforts, 1.1 million people are living with HIV today in the U.S. and about 15% of them are unaware they are infected and more than 38,000 were newly infected with HIV in 2017. The Southern U.S. accounts for 52% of those diagnoses. Furthermore, according to the CDC, Florida led the country with the highest number of new cases of HIV at roughly 4800 new diagnoses in 2017 [2]. More than 5% of these new diagnoses occurred from injection drug users (IDUs) [3]. One of the reasons the spread of HIV is high among IDUs is the lack of access to clean needles. Syringe sharing and improper disposal rates are high, with 34% of IDUs reporting that they used a syringe after someone else had used it and 41% giving their used syringe to another after they had used it. Only 18% used their syringe safely [3]. This CDC data is alarming, and it should be noted that the numbers are likely underreported. Naturally, the question becomes: how do we stop the spread of HIV among IDUs and improve health outcomes?

"Syringe Exchange" or "Needle Exchange" programs have long been at the cornerstone of HIV prevention programs, with a long successful record of reducing mortality and morbidity as well as the incidence of infectious diseases among IDUs. Providing sites with safe and sterile injection equipment to people who inject drugs has been proven to be an effective way of reducing the spread of HIV/AIDS, as well as Hepatitis C. These sites are cheap and effective: they provide access to sterile equipment, and educational resources, and they connect community members to health care resources. Studies have repeatedly shown that the introduction of syringe exchange programs in the United States have reduced the transmission of HIV. For example, in New York, their introduction was associated with a sharp decrease of HIV incidence from 4% per year in the early 1990s to 1% per year [4]. Similarly, this reduction is cheap to implement, as cost per person has been estimated by the United Nations Programme on HIV/AIDS to be $23-$71 annually [4]. Because of the specifics of Florida state law, local or state funds cannot be used, but other funding is available through private sources.

This success is evident in our own state with the Miami Infectious Disease Elimination Act (IDEA) Exchange program-- the first in Florida. This pilot program began in 2016 and has since collected 302,702 used syringes and distributed 290,344 new sterile syringes—collecting 12,000 more syringes than they have given out. They have distributed over 2,000 boxes of Narcan®, an overdose reversal drug, and effectively had 1,208 reported overdose reversals as of April 2019. Despite their effectiveness, these programs have also faced significant backlash due to political, legal and moral objections from community members. It is not difficult to see why this is the case. However, in July of 2019, a major shift occurred when the Florida legislature approved the Infectious Disease Elimination Act (IDEA), giving each county the option to start a Syringe Exchange program in its community.

We now have an opportunity to reduce harm right here in Alachua County. In 2017, according to the Florida Department of Health there were 56 new HIV diagnoses in Alachua County [5]. Furthermore, in 2017, 151 people living in Alachua county are HIV positive and identified IV drug use as a risk factor. 182 Alachua county residents were Hepatitis C positive and used IV drugs. These numbers are unacceptably high and pose a tremendous risk to public health. Furthermore, this situation poses a huge cost to the healthcare system. One study in Miami, Florida found the total cost for

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treatment for injection drug use-related infections to Jackson Memorial Hospital over the 12-month period was $11.4 million [6]. These costs were high in part because 92% of these patients were found to be either uninsured or publicly insured. There are additional costs to government at the local, state, and federal level. For example, a 2012 study of long-term costs of Hepatitis C infection estimated the cost per patient at over $64,000 [7]. Reducing rates of infection is a smart investment in the future and poses a huge opportunity to reduce healthcare costs. When it comes to HIV/AIDS and Hepatitis C, truly the best treatment is prevention. We propose that offering syringe exchange right here in Alachua county would reduce costs and save lives.

Syringe exchange also poses an opportunity to address the opioid crisis in North Central Florida. In 2017 there were 27 drug-related deaths in Alachua county related to opioid use. We plan to offer Narcan® along with syringe exchange services. Finally, funding has already been secured to offer anonymous HIV and Hepatitis C testing to individuals utilizing syringe exchange services. Narcan® and clean syringe distribution offers an opportunity to provide valuable counseling, HIV/Hep C disease screening, and can assist with ongoing efforts to direct patients to care.

Syringe exchange has been proven to work. The time is right to act. Let's bring harm reduction through syringe exchange to Alachua County.

References Available Upon Request

[*Editors note: We are pleased to occasionally present controversial subjects in House Calls. Opinions expressed in articles appearing in House Calls do not necessarily imply approval or endorsement by the Alachua County Medical Society*]

In Memoriam

Hal G. Bingham, MD

(October 22, 1925 – September 19, 2019)

Dr. Bingham graduated from the Medical School at Kansas University in 1954, completing his Residencies at the University of Iowa and the University of Kansas in General Surgery and Plastic and Reconstructive Surgery. He joined the faculty at the University of Missouri in 1962 where he started plastic surgery programs and trained residents. In 1964, he began a private practice in Tulsa, OK, returning to the University of Missouri Medical Center in 1966.

In 1972, he joined the faculty of the University of Florida as Chief of Plastic and Reconstructive Surgery and Director of the Burn Unit at Shands Teaching Hospital. Dr. Bingham also served at the Veteran's Administration Hospitals in Iowa City, IA, Columbia, MO, and Gainesville, FL until he was 80 years old. He enjoyed playing the clarinet in the Gainesville Community Band and with the Docs of Dixieland for many years.

Dr. Bingham was preceded in death by his wife, Mary Ann Beal Bingham in 2005, and a granddaughter, Candace in 2019. He is survived by his children Steven Lee (Trudy), Catherine Jo Bingham-Borde, Lynn Ann Bingham-Cox (Emory), Mary Shaun Bingham-Dindial (Hans), and John Eric; eight grandchildren, Ceri, Rachael, Marissa, Jace, Martin, Austin, Nathan, and Jacob.

Thomas Finley Newcomb, MD

(June1927 – September 2019)

Dr. Newcomb moved to Florida in 1959 to join the Hematology Department at the University of Florida. In 1968 he became the Associate Chief of Staff for Research and Education at the Gainesville Veterans Administration Hospital. In 1972 he accepted a position in Washington, D.C. as Director of Medical Research Service for the Veterans Administration Central Office. He served both V.A. Headquarters and the Gators until moving to Texas in 1978.

Dr. Newcomb moved to Chapel Hill in 1985 after serving as Chief of Staff at the Audie L. Murphy Memorial V.A. Hospital in San Antonio. He was also a Professor of Medicine and Associate Dean for Veterans Affairs for the University of Texas. He served as the Chief of Staff at the V.A. Medical Center Durham and as Associate Professor of Medicine and Associate Vice Chancellor Health Affairs for Duke University. For two years he was the Acting Director V.A. Medical Center Durham and from 1988-1995 served as the Director, Regional Medical Education Center, Durham.

Dr. Newcomb became Associate Professor Emeritus of Medicine at Duke in June 1998 and retired from the Veterans Affairs Medical Center Durham in 1999, but continued to serve Veterans as 'just a Doc' performing exams at a V.A. Clinic until the age of 81, retiring from government service in 2008. While in Washington and for years afterwards, Dr. Newcomb testified numerous times before Congress advocating for hospital and research budgets targeted for Veteran's health care regardless of service connection.

ALACHUA COUNTY MEDICAL SOCIETY HEALTH INSURANCE CO-OP

Now Available to Members:

ACMS Health Insurance Co-Op Plan

Underwriten by

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ACMS HAPPENINGS

Keynote Speaker Francisco I. Macedo, MD.

L to R: Scott Medley, MD, *House Calls* Executive Editor; Ann Weber, MD; Joseph Parra, MD, Chief Medical Officer at NFRMC.

ACMS September Dinner Meeting

at NFRMC South Tower Conference Room, September 10, 2019

L to R: Carl Dragstedt, DO, ACMS Vice President; Matthew Ryan, MD, PhD,
ACMS President; and Matheen Khuddus, MD, ACMS Past President.

Evelyn Jones, MD and Patricia Hess, MD

L to R: Future Medical Students Tim Silber; Daniel Galloza; Nathaniel Ma; and Annie Hu.

Lloyd Alford and Judith Lightsey, MD.

ACMS September Dinner Meeting

at NFRMC South Tower Conference Room, September 10, 2019

Carl Dragstedt, DO, ACMS Vice President; and Forrest Clore, MD. Photobomb by: Matthew Ryan, MD, PhD; ACMS President.

L to R: Chef Christy Angerhofer and the catering Crew at NFRMC: Gene Belcher, Chef Christy Angerhofer, Tony Pagliara, Lauren Coleman, Abron Demps. Thanks for the amazing cuisine!

L to R: Tom Haeseker, NFRMC Physician Relations, Blanca Millsaps, ACMS Graphic Designer and Keynote Speaker Francisco I. Macedo, MD.

L to R: Cherise Bartley; Mack Tyner, MD; and Rogers Bartley, MD.

L to R: Steven Reid, MD; Jeffrey Schulman, MD; Karen Harris, MD; Mary Aplin, MD; and Cynthia Cromer, MD.

HAPPENINGS

ACMS

ACMS/CBTFL Gator Tailgate Breakfast

at Roberts Stadium Club September 21, 2019

L to R: Doug Rains; Madeleine Mills, CBTFL; Norman Levy, MD, PhD; Roslyn Levy, Alliance President; and Hugh Dailey, President CB&TFL.

Cris Rawls and Misty Barnett

L to R: Jeff Sims; Caroline Rains, MD; and Doug Rains

Carl Dragstedt, DO, ACMS Vice President and Madeleine Mills With CB&TFL.

L to R: Ira Gessner, MD; Norman Levy, MD, PhD, Carl Dragstedt, DO, ACMS Vice President and Roslyn Levy, Alliance President.

David's BBQ making an omelette for Brian Berryhill of CB&TFL.

HAPPENINGS

ACMS

ACMS October Dinner Meeting & Vendor Show

UF Hilton Conference Room, October 15, 2019

L to R: Roslyn Levy, ACMS Alliance President; Norman Levy, MD; Madeleine Mills, CB&TFL; Justin Head, CB&TFL; and Florence Van Arnam.

L to R: Charles Riggs, MD; Matthew Ryan, MD, PhD, ACMS President; Jackie Owens, ACMS Executive Vice President; and Keynote Speaker Joshua Lenchus, DO.

Jeff Sims and Jesse Lipnick, MD.

L to R: John Leibach, MD; Cherylle Hayes, MD; and Dean McCarley, MD.

Rogers Bartley, MD and Richard King, MD

L to R: Jay Hutto, CPA, Stacey Dreher; and Stacey Joyner, CPA with James Moore, CPAs; and UF Medical Students Sierra Blashock; and Thomas King.

Marie Carmelle Elie, MD and Harvey Rohlwing, MD.

Dana Nemenyi, UF Health and Carolyn Carter, MD.

L to R: Scott Medley, MD, *House Calls* Executive Editor; Sally Lawrence; and Matthew Ryan, MD, PhD, ACMS President.

ACMS October Dinner Meeting & Vendor Show

UF Hilton Conference Room, October 15, 2019

Caroline Rains, MD and William Hamilton, MD.

L to R: Melinda Ryan; Rhonda Gillion Means; and Katie Comfort, at the ACMS Registration Desk.

At the podium is Carl Dragstedt, DO, ACMS Vice President with Jeff Sims assisting with door prizes from our sponsors.

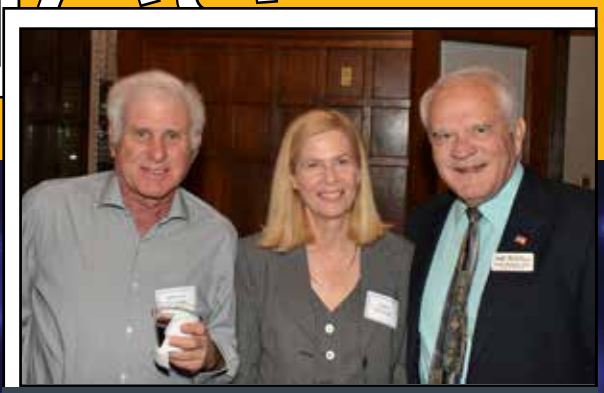
L to R Alliance Members: Ellen Gershow; Lorraine Pardi; Roslyn Levy, Alliance President; and Florence Van Arnam.

HAPPENINGS

ACMS

ACMS November Dinner Meeting
at The Thomas Center, November 12, 2019

L to R: MD; Matthew Ryan, MD, PhD, ACMS President; Harvey Rohlwing, MD; and Brian Fitzgerald, MD.



L to R: James Gershow, MD; Ellen Gershow; and Scott Medley, MD, *House Calls* Executive Editor.

Ann Mauceri and Arthur Mauceri, MD.

At the podium is Keynote Speaker Matthew Graham, CPHRM, LHRM.

Meera Nair, MD.

Jackie Owens, ACMS Executive Vice President and Shelley Hakes, with The Doctors Company.

Brad Nesmith, MD and Matthew Ryan, MD, PhD, ACMS President.

Anthony Ackerman, MD.

L to R: Norman, Levy, MD, PhD; Thomas Lau, MD; and Jeffrey Schulman, MD.

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, May 7, 2019

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, May 7, 2019 at The Cardiac and Vascular Institute.

Approval of Minutes: The minutes of the April 2, 2019 meeting were presented. Dr. Ryan moved approval, with a second by Dr. Meisenbach. The minutes were approved by the Board.

Secretary's Report: Dr. Dragstedt presented the following name for membership: Gerald Hazouri MD with North Florida Cataract Specialists. Dr. Ryan moved approval of the new member, seconded by Mr. Tyson.

Treasurer's Report: Dr. Dragstedt presented the Year to Date Balance Sheet and P & L statement (9 months) for the ACMS and the ACMS Foundation. Total grant disbursements were $55.8K for the ACMS Foundation and a Net Loss of $1K for the ACMS for the same period. The report was motioned for approval by Dr. Ryan, seconded by Mr. Tyson, and approved by the Board.

President's Report: Dr. Khuddus discussed the results of the ACMS Research Poster Symposium and gave an update on the status of the ACMS Health Insurance Co-op. Dr. Khuddus announced the Women's Health Initiative event at UF and participating in a panel discussion. Dr. Ki Park is interested in moderating the panel discussion and will follow up with the EVP for further planning.

Committee Reports: Dr. Carl Dragstedt discussed the upcoming FMA meeting and the ACMS Delegates. Dr. Ryan finalized the results of the ACMS Awards Committee and the honorees for 2019: Nancy Hardt, MD, will be recognized for the Health, Wellness and Advocacy Award; and the Florida Heart and Lung Institute will be recognized for the Outstanding Clinical Practice Award.

EVP Report: Ms. Owens discussed a possible picnic social to be sponsored by HCA this summer, a Fund Raiser for Dr. George Buchanan and the upcoming Robb House Dedication on June 1st. An ACMS Summer Board Retreat was discussed to focus on the future direction of the ACMS.

Alachua County Medical Society - Board of Directors Meeting Minutes, September 5, 2019

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, September 5, 2019 at The Cardiac and Vascular Institute.

We Care Report: Mr. Campo presented an overview of the We Care Physician Referral Network program including volunteer medical services, funding for 2020 and updates on medical clinics/tests they administer. The value of medical services provided by physicians and hospitals exceeds $90 million with services provided from July 2018 through June 2019 of $5.9 million.

Approval of Minutes: The minutes of the May 7, 2019 meeting were presented. Dr. Levy moved approval, with a second by Dr. Dragstedt. The minutes were approved by the Board.

Secretary's Report: Dr. Dragstedt presented the following names for membership: Markus Agito, MD; Manuel Amaris, MD; George J. Arnaoutakis, MD; Brittany Beel, MD; Roniel Cabrera, MD; Virginia C. Clark, MD; Peter Draganov, MD; Tara Dyson, MD; David Estores, MD; Rosemarie Fernandez, MD; Roberto J. Firpi-Morell, MD; Brian C. Fitzgerald, MD; Matthew J. Gray, MD; Anand Gupte, MD; Alpna R. Limaye, MD; Tiago N. Machuca, MD, PhD; Eddie W. Manning, III, MD; Giuseppe Morelli, MD; Marcus Muehlbauer, MD, PhD; David R. Nelson, MD; Nakechand Pooran, MD; Joel Rowe, MD; Andre Spiguel, MD; Amitabh Suman, MD; Brian C. Weiner, MD; Dennis J. Yang, MD; Ellen Zimmermann, MD; Sonja Knittel-Hliddal, MD; Sai Sudha Mannemuddhu, MD; Andrea Ramirez, MD; Andrew Moore Slater, DO. Dr. Carter moved approval of the new members, seconded by Dr. Rosenberg.

Treasurer's Report: Ms. Owens presented the Fiscal Year End Balance Sheet and Profit & Loss statement (12 months) for the ACMS and the ACMS Foundation. Membership in the ACMS increased in 2019 by 14 new members, net of retiring members. Sponsorship income declined during 2019 and was offset by a reduction in expenses for the same period, resulting in a break even net income for the 12 months of $213. Total Grant income was $77K for the ACMS Foundation, with disbursements of $76K, resulting in a Net Income of $1K for the 12 month period. The report was motioned for approval by Dr. Dragstedt, seconded by Dr. Rosenberg, and approved by the Board.

President's Report: Dr. Ryan and the Board discussed possibilities of raising funds for the Robb House to replace the leaking roof. The Board decided that an onsite event should be scheduled to familiarize members with the history of the building and raise funds for the project. The Board discussed the Acorn Clinic and questioned why the decision was made to close the clinic on the State level. The ACMS will refer patients, when contacted, to the We Care program to help close the void in medical services in the Acorn Clinic area.

EVP Report: Ms. Owens announced an open Board position for the NFRMC Resident program and asked that any Residents interested email their resume. The 2019-2020 Dinner meeting schedule was discussed with the Board suggesting potential alternate venues to consider if needed. Ms. Owens discussed planned construction on the lot adjacent to the Robb House. The site is to become a six-story apartment building. The current streetlight that illuminates SW 2nd Terrace and the Robb House parking lot is located on the adjacent lot and is scheduled to be removed. The Board decided to wait until construction is complete to see what level of lighting is provided by the façade of the building to determine if additional street lighting will be required.

Vaping and Marijuana Use in Pregnancy - A Very Dangerous Intersection -

By Scott Medley, MD

We have strived to bring you informative and timely information in this issue of HOUSE CALLS featuring "Women's Health". I would like to update you on two additional timely topics—vaping and marijuana use during pregnancy—and their unfortunate intersection.

VAPING

"'Vaping' is an informal term for inhalation of aerosolized cannabis (marijuana) components and water vapor. Vaporizers do not heat cannabis to the point of combustion; therefore they provide less exposure to smoke-related toxicants while providing similar (rapid) time of onset."[1] In other words, a quick "high" without the smoke. And this dangerous (as we shall see later) habit is on the rise. "In just one year from 2017 to 2018 marijuana 'vaping' increased more than 50% in all ages surveyed."[2] Vaping products are "some of the fastest growing segments of the legal marijuana industry."[3] Now there are very recent reports of a mysterious severe and sometimes fatal lung disease associated with vaping nicotine or marijuana products. The lung illnesses apparently resemble a severe inhalation injury. At the time of this writing these illnesses prompted two states where recreational marijuana is legal to take action: California "issued an advisory urging people to stop all forms of vaping."[3] and Massachusetts issued a four-month ban on vape sales. As a result of these mysterious lung maladies, vape sales—which were booming—are finally suffering.

MARIJUANA USE IN PREGNANCY

Meanwhile, public interest in recreational and medical marijuana continues to explode. Marijuana was the cover story topic in at least two widely-read publications in September 2019 [1], [4], and TIME Magazine devoted an entire 96-page special issue to marijuana in July, 2019. Medical marijuana is now permitted in 33 states, while 11 states allow recreational marijuana use. With all this publicity and availability, it is not surprising that marijuana use in pregnancy has almost doubled, from 4% to 7% from 2009 to 2016. But these figures are for self-reported use, and most experts believe that actual use is much higher.

As one would expect, there are not a lot of research studies on marijuana use during pregnancy. In fact, "the most recent policy statement of the American Academy of Pediatrics reflects this paucity of data."[1], [5]. There is some evidence of lower birth rates, developmental delay, and difficulty in executive functioning in infants exposed to marijuana in utero.[6] The American College of OB-GYN (ACOG) does advise physicians to screen for marijuana use in pregnancy and to encourage users to quit—even when used for medicinal purposes—during pregnancy and while breast feeding.

Confounding these few research studies are the facts that: 1) Many of the studies are old and 2) the amount of THC—the most problematic and psychoactive component of cannabis—in marijuana strains is rapidly increasing and 3) many marijuana products have a multitude of possibly harmful unknown additives.[7]

Continued on Page 32

VAPING & MARIJUANA USE IN PREGNANCY

Continued from Page 31

So why would an expectant mother use marijuana? Some of them feel that, with the recent widespread acceptance and utilization of marijuana, using it "must be all right." Others have been using cannabis regularly prior to their pregnancy, and find it difficult to stop. Still others actually start using the drug during pregnancy to try to prevent or treat morning sickness or other maladies of pregnancy. Furthermore, some surveys show that 69% of cannabis dispensaries market marijuana for morning sickness and 36% tell expectant mothers that marijuana is safe during pregnancy.[8]

In my articles, in addition to scientific references, when possible I like to include anonymous anecdotal "off the cuff" comments from some of our local physicians. So on the subject of marijuana use during pregnancy—From an OB-GYN physician: "We know that marijuana affects the mother's brain. We know that it crosses the placenta and probably affects the fetal brain. We've advised against smoking cigarettes during pregnancy for decades—smoking marijuana may be infinitely worse. We know that THC can be transmitted to the newborn through breast milk. So why in the world would anyone want to use this drug during pregnancy?" From an Emergency Medicine Physician: "It doesn't make sense. A pregnant woman might take this substance to treat hyperemesis gravidarum (vomiting in pregnancy). Then there's a good chance that she'll develop severe cyclical vomiting associated with marijuana use, which can be much worse, not to mention the risks to the fetus." And from a marijuana "prescriber": "Oh, I would never certify medical marijuana to be taken during pregnancy—the risks to the fetus are too high."

So vaping marijuana is a bad idea. Using marijuana during pregnancy is a bad idea. When the two intersect it is a very bad idea!

References available upon request

In Memoriam

Stanley I. Cullen, MD

(1933 - 2019

It is with great sadness that we note the passing of our dear friend and colleague Stanley Cullen, MD.

Dr. Cullen was the first practicing Dermatologist in the Gainesville area and one of the first Dermatology Faculty at the University of Florida, engaging in clinical research, giving lectures, holding clinics and providing consultations, in addition to maintaining his busy private practice. He Graduated from the University of Miami School of Medicine in 1959 and completed his Residency at Jackson Memorial Hospital in 1965. Dr. Cullen was a member of the Florida Society of Dermatology and Dermatologic Surgery and Past-President of the Alachua County Medical Society in 1974-75.

Dr. Cullen and his wife Jodi have been active and devoted members of our community for many years. Married for over 60 years, their partnership of life and family is a legacy of love. Stan was a friend to all who knew him. His humor, thoughtful participation, generous spirit, and tremendous intellect will be missed.

Family has asked that donations be directed to Congregation B'nai Israel. We send our condolences to Jodi along with children Jackie (Rick), Mary K. (Dan), Gerald, Stuart (Liza), Steve, Rebecca (Bill), and Elana (Joel) and grandchildren (Leslie, Finale, Russell (Katy), Miranda, Elliot, Lily (JT), Oli, Will, Emily and David).

Dr. Cullen as ACMS President in 1974

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Haven cares for over 90 percent of patients in their home or wherever they call home. But when there is a need for short-term inpatient care for pain control or symptom management that typically cannot be provided in a patient's home, Haven offers hospice care centers in Gainesville, Chiefland, Lake City, Orange Park and Palatka. Originally built in 1996, the E.T. York Hospice Care Center in Gainesville was recently expanded to 30 private rooms to meet the growing needs of hospice patients and their families in the Gainesville area. Family members and friends, including children, are welcome 24 hours a day. Haven also welcomes visits from family pets.

Other Haven Programs

In addition to providing comfort through compassionate delivery of hospice services to adults and children, Haven offers Transitions, Palliative Care Consultations and Advance Care Planning with a patient-centric focus.

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