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PETER SNYDER, PhD
to head Statewide Committee on Neuroscience Research

SOUTHCOAST PRESIDENT
KEITH HOVAN
to chair Mass. Hospital Assn. Board of Trustees

DONALD COUSTAN, MD
appointed to committee of American Diabetes Association

KENT, MEMORIAL
recognized for Quality Stroke Care

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honored at White House for RI Defeats Hepatitis C

LIANNA KARP, MD
received the Rakatansky Prize at Alpert Medical School

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The Misperceived Curmudgeon

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I was talking to an older colleague recently who mentioned that he was a fellow when I was a medical intern at the same hospital. He worked with Dr. B., a very famous, but no so well liked, neurologist. In fact, Dr. B. was usually considered the most unpleasant neurologist on earth. Of course, to my colleague, he was a pleasant, very supportive person underneath the crusty façade, although my friend was well aware of the professor’s reputation. I don’t think I hear about curmudgeons nearly as much as I did during training. I don’t know if this represents a change, brought about by limited work hours, women making up half the classes in medical school, the realization that a military attitude is out of date, or, worrisome to me, that I’m possibly one of these crusty old troglodytes so no one says anything in my presence.

“Yes,” he said, “he was often very nasty to the residents, but, to be fair, also to the attendings. However, if someone was in trouble, he was always willing to help and he tried to be supportive.”

I countered with my own experience, limited to a single teaching conference. As a medical intern, I knew I was going into neurology, and that I’d be at a different program than where I was a medical intern. Every Saturday, Dr. B. had his famous, and highly regarded “Phenomenology Rounds.” What could excite a budding neurologist more than a conference focused on exhibiting the arcane abnormalities of the neurologically afflicted? So, after I completed a Friday night on call early enough to attend the Saturday morning conference, I did. What I observed is still embedded in my memory, although not the phenomenology or the teaching points. After the first patient was presented, Dr. B., a man of about 60, looked at the audience of about 20 doctors, and the resident, gave a clear indication of having had his time wasted, and asked, “Why did you bring her?” Although I was an intern, it seemed clear that he thought the patient a “crock” who was simply crazy, and not only wasting his and all the other doctors’ time, but that the resident was a fool for giving credence to her symptoms. The patient was clearly offended. He didn’t care.

The second patient experience was even more catastrophic. He was a German-born Jewish man with the tattooed numbers from a concentration camp on one arm. I do not recall his symptoms, nor do I recall how Dr. B treated him, but I certainly recall the patient’s response. “I haven’t been treated this badly since I left the camp 34 years ago. You should be ashamed.”

Even in New York City this is a stunning accusation. When I mentioned this to my colleague, he nodded and admitted that, while the second case was quite extreme, even by Dr. B’s standards, it was believable.

My colleague then mentioned that he also worked with the Neurology Department chair, Dr. M. I noted that Dr. M, from my very few and brief interactions, seemed to have been cut from the same mold. Shortly after I started working as an attending, in RI, I called Dr. M about a case that was in his area of expertise. He didn’t know me, and, although he took the call, his level of interest was non-existent. “Never heard of this.” No advice. No sympathy or encouragement from the world famous Dr. M. to the neophyte. Two years later I was first author on a paper in JAMA, describing the clinical syndrome, no thanks to him. On another occasion he joined a small group conversation I was in at a research investigators’ meeting, and stunningly ignored the women who were in the group. It was as if he had special glasses that produced negative hallucinations, even after I introduced the female neurologists.

It is difficult for me to imagine compensatory behaviors that might offset these Paleolithic behaviors. Can one justify such behaviors by saying, “Oh, that’s just his gruff exterior. Inside he’s really a softie.” I doubt it.

One can never know how one is truly perceived by others, but we certainly
get some inkling. A transformative experience for me came many years, unfortunately, into my attending career. I was home and answered a page from a medical house officer about a patient with a neurological problem. I thought the call irrelevant and a waste of my time, but, perhaps more importantly, an invasion of my privacy and time, which was unwarranted, because the problem could easily have been handled without my input. I didn’t yell at the poor resident but I was cool and unsympathetic, clearly indicating my displeasure. My daughter, then a medical student, was visiting and heard my end of the conversation. “Dad, you were terrible. If I was on the other end of the phone, I’d probably be crying.” I certainly have tried to always be nice to anyone who calls or pages me. I always think that my daughter could be on the other end of the phone. I take solace in having heard from one of my neurology colleagues in Florida, with whom I never worked, that long before this episode, her husband, then a fellow in a medical discipline at Rhode Island Hospital, once paged me about a case of his, and was so impressed by my demeanor that he still talks about how nice I was.

I hope I’m not perceived as one of those, “Gruff on the outside, soft on the inside” sort of old person. I know that I do not broadcast a “warm and fuzzy” personality. I don’t smile a lot. I hope that I’m nice, supportive, friendly to those I know. At least I think about it. But the point of this article is not that we, as physicians, need to be warm and open, although that would be nice, but that we do need to not be the opposite. We do not burnish our reputations by cultivating an aura of unapproachability based on fear of humiliation. Fear is not respect. It is not necessarily a good thing that, as an older doctor, you can look back and say, “Dr. X made me think. I’d never ask him a question unless I’d researched it in advance so he wouldn’t make me feel like an idiot. I learned not to waste his time.”

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ROME, ITALY

Paula Coro, RN, a nurse in the Post Anesthesia Care Unit (PACU) at Women & Infants Hospital, paused to view RIMJ while visiting Rome.

The dramatic Fontana di Trevi dates from 1732 and features statues of Neptune in the center, Abundance on the left, and Health (or Hygieia) on the right. Hygieia, the daughter of Asclepius, god of medicine, and is the goddess/personification of health and cleanliness, or hygiene. Hygieia has been depicted in the RI Medical Society seal for more than a century, and is carved over the entrance of RIMS’ former Francis Street headquarters, built in 1912.

The imposing Arco di Constantino spans the Via Triumphalis and is situated between the Colosseum, seen on the right, and the Palatine Hill. At 70 feet in height, it is the largest of the Roman triumphal arches, and was dedicated in 315 CE to honor the victory of Constantine I at the Battle of the Milvian Bridge. By defeating Maxentius, Constantine I became the sole ruler of the Roman Empire. Attributing his victory to the Christian god, Constantine I subsequently legalized Christianity throughout the Empire the following year.
Willingness of Rhode Island Dentists to Provide Limited Preventive Primary Care

CATHERINE TUYET MAI DANG, BA; RENEE R. SHIELD, PhD; DONALD B. GIDDON, DMD, PhD

ABSTRACT
In response to the shortage of primary care physicians and the need for greater intercollaboration among health professionals, dentists with sufficient medical and surgical training are an untapped resource to provide limited preventive primary care (LPPC), such as chairside screening for chronic diseases. The objective of this study was to determine attitudes of Rhode Island dentists toward becoming more involved in the overall health of their patients.

Using a 5-point scale (1 being highest), a pretested survey was administered to 92 respondent RI dentists who were asked to indicate their willingness to become more involved in patients’ overall health, and undergo additional training to provide LPPC. Their moderate level of willingness was offset by great concern for liability, with older dentists being significantly more willing to assume these additional responsibilities than younger dentists (p<.05). Rank order of designation of oral health providers among dentist, dental physician, oral physician, odontologist, stomatologist, and stomiatrist was still dentist first, but with no significant difference between the mean ranks of dentist and oral physician.

KEYWORDS: health care delivery, primary care, terminology, oral health, oral physician

INTRODUCTION AND BACKGROUND
Sixty-five million Americans live in areas with a shortage of primary care physicians.1 The 2013 deficit of 8,200 primary care physicians will grow by 2025 to an estimated shortage of 12,500-31,000.2 Despite these projections, medical schools are currently training only one-half the primary care physicians needed, with the majority of physician assistants and nurse practitioners choosing better paying, less demanding specialty positions other than primary care.3 In 2013 there were approximately 195,000 practicing, licensed dentists in the United States4 who were already sufficiently trained in medicine and dental surgery to be considered de facto oral physicians.5 Because patients see their dentists more often than their primary care physicians,6 there is an opportunity for dentists to provide limited preventive primary care, including chairside screening for chronic diseases such as diabetes, hypertension, hypercholesterolemia, osteoporosis, domestic/child/substance abuse, and developmental disorders; and counseling for obesity and substance abuse; while monitoring patient compliance with prescribed and over-the-counter medications.

Moreover, the recognition of the reciprocal relation between oral and systemic health and disease, together with the increased need for more intercollaboration among health professionals, has fostered the reaffirmation that the mouth is part of the body.7 As such it is essential for survival, socialization, and self-actualization.8,9 Given some of the bases for these expanded roles, the insistence on continued use of the term “dentist” is too restrictive, referring to only the structure and function of the teeth, and does not connote what dentists can and should do as part of the health care team. Despite the intransigence of dentists who prefer their unaccountable business model, the term oral physician is being considered to better indicate their actual and potential scope of practice.

OBJECTIVE
Based on the need and opportunity for dentists to become more involved in the overall health care of their patients,10 the objective of this study was to determine the willingness of dentists in Rhode Island to undertake chairside screening for chronic disease.

METHOD
A 48-question plus demographics survey was developed to determine the attitudes of Rhode Island dentists toward being involved in LPPC. Following pretesting with California dentists, the questionnaires were emailed to a convenience sample of Rhode Island dentists. A one-to-five scale was used to indicate the importance of medical screening in the dental office, confidence in medical knowledge, willingness to be involved in the overall health of patients, and concern with liability and related insurance issues. Respondents were also asked to rank order their preferred titles for oral health professionals: dentist, dental physician, oral physician, odontologist, stomatologist, and stomiatrist.

RESULTS
Of 520 surveys distributed, 92 (17.7%) were returned by dentists, of whom 75% were male and 25% female, with a
The results of this study are consistent with those of several other studies looking at the acceptance of expanded roles for dentists by physicians and patients. From a political and business point of view, most dentists prefer the status quo, in which they are unaccountable for appropriateness and quality of their treatment. However, much change is expected with the advent of the Affordable Care Act, and in another study it was found that dentists recognized the importance of medical screening and were even willing to consider providing it in their practices. Patients see no problem regardless of whether dentists were called oral physicians or dentists. Similarly, patients were also willing to have medical screening for chronic disease done by dentists and to pay $20 for it. In a study of physicians, they were found to have no objection to dentists doing limited preventive primary care screening in a dental setting. The observation that the older Rhode Island dentists are more willing than younger dentists to become involved may reflect their greater personal and professional security than the younger dentists, who may well be paying off debts associated with their expensive training.

CONCLUSION
Although most dentists preferred the status quo, they acknowledged the importance of medical screening as well as its potential liabilities. Older dentists expressed less concern than younger dentists about additional responsibilities with more willingness to receive additional training. Moderate support for the term oral physician was also noted.

Acknowledgment
Thanks are due to Dr. Shirley Freedman, Clinical Associate Professor, Department of Surgery, The Warren Alpert Medical School of Brown University, who introduced the authors to the Rhode Island Dental Association and played an integral role in helping collect responses from Rhode Island dentists.

References


Disclaimer
The views expressed herein are those of the authors and do not necessarily reflect the views of Brown University or Harvard University.

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Geriatric Issues in Older Dialysis Patients
MANOJ BHATTARAI, MD

ABSTRACT
Geriatric syndrome is common among older patients on dialysis. Basic knowledge about its prevalence and management is crucial for nephrologists to provide standard patient care. In busy clinical settings, up-to-date and holistic medical care can be delivered to elderly dialysis patients by collaboration of nephrology and geriatrics teams, or in part by training nephrology fellows the basics of geriatrics.

KEYWORDS: geriatrics, nephrology, palliative care, dialysis

INTRODUCTION
Approximately 46.2 million people (14.5 percent of the total population) aged 65 and older lived in the United States in 2014 [1]. According to US census projections, this number is expected to follow an upward trajectory in the coming years. The likely consequence of this trend is that the prevalence of Chronic Kidney Disease (CKD) among the Medicare population—which was 10.4 percent in the 2012 report, will surge [2].

The United States Renal Data System, 2014 Annual Data Report, stated that close to half of all dialysis patients are 65 years and older. About 17 to 45 percent of patients accepted for dialysis are older than 75 years [3]. Functional decline, cognitive impairment, depression, and malnutrition are common features of this dialysis population [4].

This article reviews basic geriatrics principles as applied to kidney disease care by briefly describing the major geriatric components in patients with kidney disease. These core components are frailty, functional status, cognition, falls, palliative care, polypharmacy, and depression. Each of these is discussed below.

FRAILTY
The prevalence of frailty can be as high as 73% among patients initiating dialysis and is an independent and strong predictor of mortality and multiple hospitalizations [5]. Dialysis initiation among nursing home residents has been shown to accelerate the progression towards loss of dependence in daily activities of living [6]. A systematic comprehensive geriatric assessment (CGA) provides the best estimate of a patient’s physiologic reserve, estimating future decline and vulnerability, and even residual life expectancy.

Frailty screening tests can be helpful in selecting patients who may benefit from dialysis treatment, or exclude vulnerable patients at risk of adverse health outcomes. The information derived from a CGA may help to determine dialysis outcomes and help trigger shared decision-making conversations with the patient and family.

Conservative care has become the standard alternative for dialysis in elderly frail patients with advanced kidney disease to improve the quality of life [7]. The single most effective intervention to improve functionality and quality of life in these frail patients is exercise. Familiarity with Medicare programs such as Program of All-inclusive Care for the Elderly (PACE) and Acute Care for Elders (ACE) can help frail elderly adults in improving and maintaining functioning.

PACE is an outpatient model in which an interdisciplinary team delivers primary care to community-dwelling older adults. ACE, on the other hand, is a model of care targeted to acutely ill hospitalized patients to prevent functional decline or help improve independence if the patient has already declined. Since PACE and ACE can help frail elders maintain functioning within their communities at a low cost, thus likelihood of institutionalization is minimized.

FUNCTIONAL STATUS
Activities of daily living (ADL) and instrumental activities of daily living (IADL) scores generated from a CGA provide prognostic information in older adults. Studies have shown an association of ADLs to survival of elderly dialysis patients [8]. In a group of nursing home residents who underwent dialysis between June 1998 and October 2000, only 13 percent were able to maintain functional status to predialysis levels; 58 percent of these patients died over the next 12 months of follow-up [6].

Similar results were recorded in Jassal et al [2009], a single-center study of people who were 80 years or older [9]. At the onset, 78 percent of the participants were independent as measured by their ADL scores. After starting dialysis over a one-year period, the independence level of these individuals dropped to 23 percent. It is therefore important to identify those patients who could benefit from physical therapy in a timely manner and make the appropriate referrals to minimize these precipitous declines.
There are no well-designed studies available to compare functional decline in younger patients initiating dialysis.

COGNITION

CKD is an independent and significant risk factor for cognitive impairment [10]. Cognitive impairment worsens as kidney function declines. The prevalence of cognitive impairment in dialysis patients is at least two times higher than that of age-matched controls. The pathophysiologic mechanism postulated for cognitive impairment is vascular injury and direct neuronal toxicity of uremic toxins. Both the kidneys and the brain are low resistance end organs with a high volume of blood flow with low susceptibility to vascular damage. Thus, dementia related to vascular causes is more likely to be present than Alzheimer’s disease in a dialysis population.

Understanding the basics of pathophysiology involved helps minimize the future risk. Not all the tests that are routinely used in geriatric assessment are designed to detect mild cognitive impairment related to vascular damage in dialysis patients. Relatively quick tests such as Mini-Cog [3 words recall and clock drawing] may be offered for quick screening in busy practice. When prompted, more reliable Montreal Cognitive Assessment (MOCA), which has good sensitivity and specificity for executive function, can be utilized [11]. If indicated, referral for neuropsychological tests is warranted.

Often times, patients’ declining cognition goes unrecognized even by close family members. Therefore, careful scrutiny and the recommendation of cognition tests should not be delayed. The practitioner should be alert to warning signs, such as when a patient is demonstrating new behavioral changes, non-compliance with medications and dialysis procedure; and is repeatedly asking the same questions. Poor hearing should be ruled out before making this determination, however.

FALLS

The incidence of falls in elderly non-dialysis patients aged 75 years and above is 0.32 falls per patient-year [12]. This number increases to 1.60 per patient-year on initiation of dialysis, thus putting dialysis patients at four times higher risk of falls compared to the age-matched non-dialysis population [13].

In a study of hemodialysis patients with falls who were followed for two years, there was a two-fold increase in the number and duration of hospitalizations, a 3.5 fold increase in risk of nursing home admission, and a 2.13 fold increased risk of mortality [14]. When a hip fracture occurs, these patients are at a four times higher risk of hip fracture and a two-fold higher risk of 1-yr mortality.

Given these dire and preventable consequences, basic knowledge of screening dialysis patients at risk of fall is everyone’s responsibility. Asking about a history of falls and conducting simple tests for gait and balance such as the Get Up and Go test and the Functional Reach test can identify most older adults who are susceptible to fall hazards. Such adults can benefit from timely referral for comprehensive geriatric evaluation.

HOSPICE AND PALLIATIVE CARE

The majority of nephrologists do not feel they are sufficiently well-trained to make end-of-life treatment decisions [15]. Discussions on the patient’s goals of care and advanced care preferences are a crucial part of the older adult encounter, this is even more crucial in frail older adults with multiple comorbidities in imminent need of dialysis who may not do well on dialysis.

Respecting patients’ values and preferences while keeping them comfortable and providing spiritual, psychosocial, and practical support both to patients and their family caregivers in such situations are key tenets of the palliative care approach. Helpful tools such as ePrognosis can estimate life expectancy and weigh the risks and benefits of proposed interventions to establish appropriate goals in a vulnerable patient.

Patients aged 75 and older who have CKD stage 5 with advanced neurodegenerative disease, high comorbidity scores (modified Charlson Comorbidity Index score of 8 or greater), significantly impaired functional status [ Karnofsky Performance Status Scale score of less than 40], or severe malnutrition [serum albumin level less than 2.5 g/dl] do poorly with dialysis [16]. In these patients, physicians should recommend a time-limited trial of dialysis treatment. Dialysis can also be offered to address specific patient goals, such as living long enough to see a grandchild’s birth, or a child’s graduation. However, if such patients decide to continue treatment, the physician has little or no support yet for withholding dialysis. In this scenario, the physician should continue to review the treatment tolerance with patients and their families at specified intervals. Better understanding of the dialysis burdens and benefits with a trial of dialysis enables patients and their families to make informed decisions. Guidelines for shared decision-making in the appropriate initiation and withdrawal from dialysis are available [16].

POLYPHARMACY

Dialysis patients take 10-12 daily prescribed and over-the-counter medications on average. It is necessary to understand physiologic changes that occur with aging, such as decreased hepatic and renal function and altered fat distribution, which can result in inappropriately high serum drug levels even with appropriate equivalent doses for younger individuals. This basic understanding can help make treatment safe, convenient, and effective. Helpful tools such as Screening Tool of Older Persons’ potentially inappropriate Prescriptions (STOPP), Screening Tool to Alert doctors to Right
Treatment (START) and the Beers criteria list of medications can be of significant value in guiding treatment decisions.

**DEPRESSION**

Depression affects dialysis patients of all ages. Studies comparing its prevalence, course and treatment outcome to younger patients is lacking in older dialysis patients. However, given that the majority of dialysis patients are older than 65, it is an indication that older adults are at higher risk of developing depressive symptoms, which is usually due to high symptom burden. The prevalence of depression in CKD stage 5 in some reports is as high as 39 percent, although this number varies based on the method used to diagnose depression. Depression in CKD is further associated with increased mortality, lower treatment compliance, increased health-care utilization, and lower self-rated quality of life. Depression in dialysis patients may be a result of poor dialysis tolerance, inadequate pain control, and other unfavorable social situations. Frequent assessment of dialysis patients for depression is mandated. The Beck Depression Inventory for depression is a validated tool in cancer patients and can be used in dialysis patients [17]. Treatments for depression exist and can be extremely effective.

**DISCUSSION**

The treatment decisions in elderly patients with advanced kidney disease are complicated by the interaction between various treatment domains. In order to improve medical care for elderly patients with kidney disease in general, collaborative care between nephrologists and geriatricians is needed.

However, an alarming shortage of geriatricians exists across the country. To further complicate matters, the number of medical graduates interested in pursuing nephrology training is decreasing. The limited resources create a formidable barrier for physicians to provide the best medical care possible for these patients.

One solution to this problem is to integrate geriatrics and palliative care into nephrology training. This approach will not only minimize the demand for collaborative care, it will also provide added skills to nephrologists that are necessary to provide state-of-the-art care to these vulnerable individuals. While the ultimate goal of this approach is not to produce geriatric nephrologists, it instead aims to train graduating nephrologists to recognize the risk that patient frailty poses to the health and overall well-being of a patient.

Notwithstanding that nephrologists are generally incredibly busy physicians, the development of a focused exam tailored to specific patient symptoms and needs, to conduct a quick assessment within a few minutes, is needed. This assessment can equip nephrologists to make informed decisions about whether to transfer a patient to a geriatrician for comprehensive geriatric assessments (CGA) by which a multidisciplinary team diagnoses and treats medical, functional and psychosocial issues in a coordinated and integrated plan for an elderly patient. For an extremely busy nephrology practice, this model of co-management can help identify patients at risk and refer them for CGA.

Many nephrology fellowship programs in the country have recognized the need to train their fellows in geriatrics and palliative care as a part of holistic nephrology care, but most of them are able to do the bare minimum because of limited resources. Professional societies, such as the American Society of Nephrology, the American Geriatrics Society, and the National Kidney Foundation have taken steps to address the issue of inadequate geriatrics skills in the nephrology workforce.

Medical schools have started integrating geriatrics into medical school training courses. Similarly, nephrology associations have been incentivizing their residents and fellows to travel to national conferences; they are also providing research scholarships for their young physicians. Nonetheless, these positive steps remain inadequate given the widening gap between the increasing need and demand and the static number of nephrologists. Since the American Board of Internal Medicine Nephrology certification exam does not include geriatrics content and only fewer than 2 percent of ethics and palliative care content [5], this issue remains unsolved at the present time.

Important discoveries and refinements have been made as a result of better awareness of the intricacies involved in the association of aging and kidney disease. It will be illuminating to see nephrology trainees develop into professionals who are able to handle the challenges of caring for an aging population with kidney disease through enhanced exposure to geriatrics content and pertinent clinical experiences. The need to prepare all nephrology trainees to successfully manage the care of older adults can be addressed by a singular commitment of education leaders to incorporate relevant geriatrics content as well as clinical experiences within all nephrology courses.

**Acknowledgment**

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**References**


Influence of Medical Student Debt on the Decision to Pursue Careers in Primary Care

Joseph A. Gil, MD; Gregory R. Waryasz, MD; Dorothy Liu, BS; Alan H. Daniels, MD

ABSTRACT

PURPOSE: To determine if medical student debt has an effect on medical student specialty choice.

METHODS: A cross-sectional survey was distributed to students at 12 medical schools across the United States to assess the effect of debt on specialty choice.

RESULTS: In total, 415 students responded to the survey; 98 medical students reported that they were pursuing a primary care residency (PCR) and 250 reported that they were pursuing a non-primary care residency (NPCR). There was no significant difference in average student loan debt anticipated by medical students pursuing PCR and NPCR ($142,217 vs $150,784; P>0.46). Medical students pursuing a PCR reported lower estimated salaries on average than medical students pursuing NPCR ($137,711 vs $241,804; p<0.01). Of the surveyed students, 62% of students who are pursuing PCR and 77% of the students who are pursuing a NPCR would not have pursued medicine as a career if residents were responsible for paying tuition.

CONCLUSION: This study revealed no significant difference between the student debt of medical students pursuing PCR compared to those who are pursuing a NPCR. However, a large majority of medical students would not pursue a career in medicine if faced with the responsibility of paying tuition for residency.

KEYWORDS: medical student debt, residency tuition, primary care salaries, careers

INTRODUCTION

The cost of medical school attendance and the level of medical student debt has substantially increased over the last decade with individuals’ debt levels sometimes approaching $350,000.1-4 According to the Association of American Medical Colleges (AAMC), medical school tuition continues to increase annually.4,5 A major concern is that the increasing levels of medical student debt are contributing to the decline in medical student interest in pursuing a primary care residency due to the relatively lower reimbursement of primary care physicians compared to subspecialists.2,7 Previous investigations have demonstrated that medical student debt has a variable influence on career choice; some studies suggest that this influence plays a major role in career choice while other studies suggest that debt has no influence.8-14

Although the impact of medical student debt on career choice is not clear, the rate of medical student debt growth is unsustainable.1 The purpose of this study was to assess the influence of medical student debt on career choice. Our hypothesis is that medical student debt has a strong influence on career choice. Additionally, in 2014, a report from the Institute of Medicine Committee on the Governance and Financing of Graduate Medical Education considered options for potential funding sources for Graduate Medical Education.15 One source they considered was to require residents to pay tuition. Given our hypothesized influence of medical school debt on career choice, we hypothesize that if residents would be required to pay for residency, a career in the medicine would be less desirable.

METHODS

After obtaining approval from our institutional review board, we designed and distributed a cross-sectional survey for allopathic medical schools in the United States. Medical students were asked if they planned a career in a primary care or non-primary care specialty, what their anticipated salary was within their first 5 years of practice, and if they would have pursued medicine as a career if residents were required to pay tuition.

The survey was initially piloted with six PGY-1 residents in the Brown University orthopaedic department to assess survey comprehension. The survey was then distributed to the deans of student affairs in medical school in the United States requesting them to distribute the survey to their medical students. The survey was distributed via the REDCap (Research Electronic Data Capture) program (Vanderbilt University, Nashville, TN), which is a tool provided by the Lifespan Biostatistics Core. Study data was also collected and managed using the REDCap program. REDCap program is a secure, web-based application designed to support data capture for research studies. REDCap program does not record IP addresses.

For statistical analysis, anticipated medical student debt and anticipated level of annual income were compared with a two tailed t-test with a cutoff of p<0.05 for significance. Comparison of categorical data was performed with Chi-square analysis. Statistical analysis was performed

RESULTS
In total, 12 medical schools distributed the survey [n=12] with a response rate of 6.6% [n=415]. When asked about career plans, 98 medical students reported that they were pursuing a primary care residency [PCR], 250 reported that they were pursuing a non-primary care residency [NPCR], and 67 reported that they were undecided.

There was no significant difference in average student loan debt that was anticipated by medical students pursuing PCR ($142,217) compared to medical students pursuing a NPCR ($150,784) (P>0.46). There was a significant difference between the residents pursuing a PCR ($137,711) and between those pursuing a NPCR ($241,804) in the estimated salary that the students anticipated on earning annually in the first 5 years of their practice (p<0.01) [Figure 1].

Overall, 62% of students who planned to pursue PCR and 77% of the students who are pursuing a NPCR would not have pursued medicine as a career if residents are required to paying tuition for post-graduate training (p<0.01) [Figure 2].

DISCUSSION
The cost of medical school attendance and medical student debt has increased over the last decade, and according to the Association of American Medical Colleges [AAMC], medical school tuition continues to increase annually. 4-6 Rising medical student debt may be contributing to the simultaneous decline in medical student interest in pursuing a career in primary care. 2 Phillips et al performed an analysis of medical student debt and its effect on intentions to pursue careers; it revealed that medical students from middle income families who anticipated more debt were less likely to pursue residencies in primary care. 2

Schwartz et al demonstrated that in comparison to 1990, medical student interest in general internal medicine decreased in 2007, and medical students were also graduating medical school with higher levels of debt. 7 Grayson et al surveyed first- and fourth-year medical students to determine the influence of economic factors on career choice. 16 They found that medical students with higher levels of debt reported a higher value for the importance of income and anticipated to earn more than medical students with less debt. Medical students who reported a higher value for the importance of income were more likely to switch from pursuing a primary career to a high paying non-primary care career. This switch was associated with a higher anticipated medical student debt and higher anticipated income.

Gil et al calculated the total increase in medical student debt after medical school in hypothetical cases of an orthopaedic surgery resident and an internal medicine resident with $180,000 of debt that is a result of unsubsidized Stafford loans which currently have a 6.8% interest rate. 17 They reported that for an orthopaedic resident at a six training year program with one year of subsequent fellowship who chooses forbearance for all loans during residency and fellowship, the total interest accrued depends on the post-training repayment program chosen. They reported that a Standard Repayment plan will result in a total repayment of $383,302, representing a 113% increase in debt after medical school. Alternatively, if the resident chooses the Extended Repayment plan, this will result in a total repayment of $577,940, representing a 221% increase in debt after medical school. In the case of an internal medicine resident, a Standard Repayment plan will result in a total repayment of $311,284, representing a 73% increase in debt after medical school, while an Extended Repayment plan will result in a total repayment of $469,355, representing a 161% increase.

Figure 1. Comparison of anticipated medical student debt and anticipated annual income during the first five years of practice.

Figure 2. Comparison of the number of medical students who would or would not pursue a career in medicine if residents were required to pay tuition.
in debt after medical school. Therefore, medical students ultimately pay far more than the estimated cost of their education while lenders make a significant profit on loans.

Although medical school tuition continues to rise, medical schools still face substantial financial pressure. In 2014, a report from the Institute of Medicine Committee on the Governance and Financing of Graduate Medical Education considered options for potential funding sources for Graduate Medical Education. One source they considered was to have residents pay tuition. Of the respondents of this survey, 62% of students who are pursuing PCR and 77% of the students who are pursuing a NPCR would not have pursued medicine as a career if residents were responsible for paying tuition. Therefore, if residents are required to pay for residency, highly qualified students will decide against careers in medicine due to unreasonable financial pressures associated with physician training.

A substantial limitation of this is study is the low response rate despite the authors repeated attempts to recruit medical schools to assist in the goal of understanding the influence of medical student debt on career selection. Medical schools often cited policies regarding the distribution of surveys from outside of their own institutions and they noted that the AAMC Graduation Questionnaire (GQ) addressed similar questions we sought to answer in our study. A significant limitation of the GQ is that it is only distributed after medical students already are committed to a residency. Therefore, conclusions regarding the selection of career are significantly limited by selection and recall bias. The advantage of our survey is that it captures perceptions of medical students as they advance through their education. Therefore, it may more accurately capture the factors that influence career selection.

CONCLUSION

The results of our study suggest that there is no difference between the student debt of medical students pursuing PCR compared to those who are pursuing a NPCR. However, the salary the students anticipated on earning annually in the first 5 years of their practice was significantly different between these two groups. Additionally, the majority of medical students would not pursue a career in medicine if faced with the additional financial burden of being responsible for paying for tuition to be in residency. Student debt appears to affect career choice in today's medical school trainees. Efforts to minimize student debt and encourage career choice based on factors other than debt burden are needed.

References

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Disclosures
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ABSTRACT

Malaria and Dengue are some of the common infections occurring in persons traveling to countries endemic for these infections. Chikungunya virus infection is another illness that can occur in people who have travelled to areas endemic for chikungunya virus infection. Herein we report cases of malaria, dengue, and chikungunya in Newport Hospital, The Miriam Hospital and Rhode Island Hospital between January 1, 2010 and December 31, 2014.

KEYWORDS: Travel-related infections, local transmission, mosquito-borne infections

INTRODUCTION

Approximately 1,500 to 2,000 cases of malaria are reported yearly in the United States, almost all in recent travelers [1]. Although dengue rarely occurs in the continental United States, it is endemic in Puerto Rico and in many popular tourist destinations in the Caribbean, Latin America, Southeast Asia and the Pacific Islands [2]. Beginning in 2014, cases of chikungunya virus infection were reported among U.S. travelers returning from affected areas in the Americas and local transmission was identified in Florida, Puerto Rico, and the U.S. Virgin Islands [3]. With a large number of foreign-born individuals in Rhode Island (13.1%) [4], herein we report cases of malaria, dengue, and chikungunya in our hospital system between January 1, 2010 and December 31, 2014.

METHODS

After Institutional Review Board approval, a list of patients diagnosed with malaria, dengue, or chikungunya between January 1, 2010 and December 31, 2014 at Newport Hospital, The Miriam Hospital and Rhode Island Hospital was obtained using the Theradoc software program in the Rhode Island Hospital Department of Epidemiology and Infection Control. Once these patients were identified, their medical records were reviewed to assess details regarding their acute illness.

RESULTS

Of 35 identified cases, 51% were reported in 2014 [Figure 1]. We identified 23 cases of malaria, 22 caused by Plasmodium falciparum and one by P. vivax/ovale. All cases were diagnosed by thick and thin smears [Table 1]. The majority of cases had recent travel to Africa. All cases of P. falciparum were hospitalized, 16 were treated with atovaquone and proguanil, 2 with quinine sulphate and clindamycin, 2 with quinine sulphate and doxycycline, 1 with chloroquine, and 1 with atovaquone, proguanil and doxycycline. The time interval from return to the U.S. until diagnosis of malaria ranged from 2 to 30 days. The one case of P. vivax/ovale occurred in a patient who had traveled to Ethiopia seven months earlier. This patient was hospitalized and treated with mefloquine.

Table 1. Demographics of patients with travel-related infections

<table>
<thead>
<tr>
<th>Country of recent travel, n (%)</th>
<th>Malaria</th>
<th>Dengue</th>
<th>Chikungunya</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria 6 (26%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominican Republic 5 (62.5%)</td>
<td></td>
<td></td>
<td>2 (50%)</td>
</tr>
<tr>
<td>Liberia 5 (22%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haiti 1 (4%)</td>
<td></td>
<td>1 (25%)</td>
<td></td>
</tr>
<tr>
<td>Guinea 2 (9%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other 9 (39%)</td>
<td>3 (37.5%)</td>
<td>1 (25%)</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. Travel-related infection diagnosis at time of diagnosis

Table 1. Demographics of patients with travel-related infections
There were 8 cases of dengue, all diagnosed by serology. One had past dengue infection, 1 had probable past infection, 2 had equivocal values for IgG and IgM, 2 had elevated IgM levels, and 2 had elevated IgG and IgM levels. Most cases had recent travel to the Dominican Republic. Six of the 8 cases were hospitalized. The time interval from return to the US until diagnosis of dengue was 7 to 45 days.

Four cases of chikungunya were diagnosed; all were diagnosed serologically. The time interval from return to the United States until diagnosis of chikungunya was 8 to 45 days.

**DISCUSSION**

Most of the cases reported herein were detected in 2014. This may indicate greater awareness of these diagnoses among practicing physicians, greater incidence of these diseases in endemic countries visited by our patient population, or additional, unknown reasons. Although the male to female ratio was similar in cases of malaria and chikungunya, there was a strong male preponderance with dengue diagnosed in our hospital system, as previously reported [2]. Most dengue cases reported travel to the Dominican Republic in September, coinciding with the rainy season.

Some of the limitations of this study reflect the fact that chikungunya is not a reportable disease to the Rhode Island Department of Health and it may be underreported in this study. Data from only 3 hospitals were collected. Data on whether the patients infected with malaria were using anti-malarials was not collected. Data on how many of the people infected with malaria were visiting Africa for medical reasons (teaching, research, etc.) was not studied.

Chikungunya virus is most often transmitted by the *Aedes aegypti* and *Aedes albopictus* mosquitoes, which are the same species that transmit dengue virus [5]. These mosquitoes are found throughout much of the Americas, including parts of the Southern US. Since chikungunya is new to the Americas, most people in the region are not immune and infected travelers could spread the virus to mosquitoes upon their return home, leading to local transmission and further infections [6] as in infrequent reports of autochthonous cases of chikungunya and dengue in the US [7]. Although most cases of chikungunya infection are self-limited, chronic arthritis affects a small number of infected cases [8]. Our experience suggests that these patients’ symptoms can wax and wane and may present with joint pain weeks after their initial onset of symptoms leading to an extended period of time from infection to diagnosis.

In conclusion, of the approximately one million people residing in Rhode Island, we identified 35 cases of malaria, dengue or chikungunya over five years with the largest number of cases identified in 2014. Travelers returning from areas with mosquito-borne infections, including dengue, chikungunya and Zika virus, are recommended to take steps to prevent mosquito bites for 3 weeks to prevent local transmission [9]. We believe that by making travelers aware of mosquito-borne infections and reducing their risk by use of insect repellents, mosquito netting, screened windows and access to a pre-departure travel clinic would reduce the risk of these and other travel-related illnesses in our patient population. Nevertheless, it is likely that we will see greater numbers of these infections in our state based on the large number of people who vacation or have families in the Caribbean.

**Acknowledgments**

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**References**


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Atypical presentation of infective endocarditis
KARUPPIAH ARUNACHALAM, MD

ABSTRACT
The HACEK group of organisms are one of the infrequent causes of infective endocarditis. Infective endocarditis should be recognized and treated promptly to prevent excessive morbidity and mortality associated with the disease. Sometimes the diagnosis is delayed due to vague and subtle presentation. Through this case report, risk factors of Cardiobacterium hominis endocarditis and its atypical presentation is illustrated to increase the recognition of infective endocarditis as one of the differential diagnosis.

KEYWORDS: infective endocarditis, HACEK, cardiobacterium hominis, atrial fibrillation

INTRODUCTION
In the United States, an estimated 10,000 to 15,000 new cases of infective endocarditis (IE) are diagnosed each year. To date, less than 100 cases of Cardiobacterium hominis (C. hominis) endocarditis have been reported in the English medical literature. The HACEK group of bacteria (Haemophilus species, Aggregatibacter species, Cardiobacterium hominis, Eikenella corrodens, and Kingella species) are a small, heterogeneous group of fastidious, gram-negative bacteria that frequently colonize the oropharynx and have long been recognized as a cause of infective endocarditis. These organisms have been historically reported as causing infection in <5% of patients of IE. This case report describes the atypical presentation of infective endocarditis due to a rare organism.

CASE PRESENTATION
An 80-year-old man with St. Jude’s prosthetic mitral valve replacement done in 2009, with a history of Alzheimer’s dementia and stroke, presented with bright red blood per rectum and palpitations. He was fatigued and felt unwell for nearly 6 weeks before the presentation. He lives with his wife at home and had a dental procedure 2 months before the presentation. He was given prophylactic amoxicillin for 5 days after the procedure. In the emergency room, he was found to be diaphoretic, pale and drowsy. He was hypotensive to systolic blood pressure of 70 mm Hg and tachycardic to 150/min. On exam, he was pleasantly confused and oriented to person and place only. Oral examination revealed grossly poor dentition with dental caries. Cardiovascular exam showed a holosystolic murmur in the left 5th intercostal space medial to the nipple area. Initially the EKG looked like supraventricular tachycardia and after adenosine therapy the atrial fibrillation was clearly evident.

He was resuscitated with intravenous fluid boluses; the laboratory tests showed severe anemia with a hemoglobin of 6.4 g/dl and supratherapeutic INR of 5.4. He was transfused with 3 units of fresh frozen plasma and 3 units of packed red blood cells. During the hospitalization, he had a temperature of 102 degrees Fahrenheit; the blood culture was done which showed gram-negative bacteria in two bottles. He was started on intravenous ceftriaxone empirically.

The microbiology studies showed specific characteristics like cluster of gram negative bacilli and a waxy growth on the blood culture bottle. [Figure 1] Biochemical tests showed specific indole positivity which differentiates from other HACEK group of organisms.

The transthoracic echocardiogram done initially showed a normal ejection fraction without any obvious vegetations. The trans-esophageal echocardiogram done due to high suspicion for IE showed a mobile vegetation of approximately 1 cm in size adherent to atrial surface of the mitral valve. But the patient didn’t have any significant mitral regurgitation and there was no evidence of valve dehiscence.
The patient was treated for 6 weeks with intravenous ceftriaxone and surgical treatment was not indicated. He recovered well in a rehabilitation facility.

**DISCUSSION**

IE with Cardiobacterium hominis, a member of the HACEK group of microorganisms, is usually insidious in onset, with a prolonged subacute course characterized by leukocytosis, anemia, splenomegaly, embolic phenomena, congestive heart failure and weight loss.

C. hominis endocarditis is known for a spectrum of unusual clinical presentations, non-specific symptoms and protracted clinical course. It has been reported to occur after dental procedures, upper GI endoscopy and colonoscopy. Incidence among elderly patients are higher due to the above risk factors and increased use of prosthetic valves and devices implants. Other rare presentations include septic arthritis, mycotic aneurysm, congestive heart failure and acute coronary syndrome.

C. hominis produces indole and is oxidase positive. It ferments glucose, sorbitol, mannose, sucrose and, in most cases, maltose and mannitol. It does not demonstrate urease, catalase, nitrate reductase, phenylalanine deaminase, beta galactosidase, lysine decarboxylase, ornithine decarboxylase or arginine dihydrolase activity. These characteristics help distinguish it from other members of the HACEK group.

Although C. hominis is of relatively low virulence, endovascular infection complicates 95% of all cases of bacteremia, with the aortic valve being most commonly affected. Peripheral and central nervous system emboli occur frequently in C. hominis endocarditis, noted in 51% and 21% of cases, respectively, especially when the aortic valve is involved. Prognosis is generally favourable, with a 93% cure rate for both native and prosthetic valve infection.

A third-generation cephalosporin is the drug of choice for infection with HACEK organisms.

Most often this disease has a chronic clinical course and requires prolonged antibiotic therapy. Association of atrial fibrillation with C. hominis endocarditis is rare and can be present either at the time of presentation or develop after hospitalization. This case report illustrates the atypical presentation of rare case of C. hominis subacute bacterial endocarditis (SBE) and also stresses the recognition of important risk factors like poor dentition, prosthetic valves in elderly patients for prompt diagnosis of prosthetic valve endocarditis.

**References**


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A case of Ochrobactrum anthropi-induced septic shock and infective endocarditis

FARHAN ASHRAF, MD

ABSTRACT
Ochrobactrum anthropi is a gram-negative rod of low virulence. Infections due to this organism are uncommon; however in immunocompromised hosts it can cause severe infections. Among the many infections it can cause, infective endocarditis is very rare. Even rarer is infective endocarditis of the native valves, as Ochrobactrum anthropi affects damaged or prosthetic valves almost exclusively. This case describes native valve endocarditis due to Ochrobactrum anthropi.

KEYWORDS: infective endocarditis, sepsis, Ochrobactrum anthropi

CASE REPORT
A 58-year-old woman with a past history of atrial fibrillation not on anticoagulation, end-stage renal disease with a failed kidney transplant, now on dialysis, coronary artery disease, moderate aortic stenosis, and pacemaker for 3rd degree heart block came in with chest pain for 2 days. She described the pain as substernal, sharp, non-radiating and 8/10 in intensity. She denied any difficulty breathing, fevers, chills or palpitations. She was a smoker in the past, and denied drug use.

Her vitals were: Temperature 98.1 degree Fahrenheit, heart rate 90/min, blood pressure 128/61 mmHg, respiratory rate of 16/min and oxygen saturation was 100% on room air. On examination she had a regular heart rate and a 2/6 systolic murmur was heard in the aortic area, consistent with her history of aortic stenosis. No other murmurs were heard, and her lungs were clear. The rest of the examination was remarkable for a dialysis catheter in internal jugular vein and a scar at the site of the kidney transplant. Laboratory work-up showed hemoglobin of 8.1 mg/dl which was her baseline. Her white count was not elevated, creatinine was 6.7 mg/dl, and electrolytes were within normal range. The 1st troponin was negative. Electrocardiogram [EKG] showed ventricle-paced rhythm, Sgarbossa score was 0. The chest X-ray showed cardiomegaly which was stable compared to previous X-ray. Her pain responded to nitroglycerine and she was admitted to rule out acute coronary syndrome due to septic shock. She was monitored on telemetry without any significant events. Her chest pain remained under control. The 2nd troponin was negative, however 3rd was very mildly elevated at 0.034 ng/ml. A stress test was scheduled for the next day after an inpatient cardiology consult. However, the next day around midnight she became confused and hypotensive, with a blood pressure of 60/40 mm Hg. The heart rate at that time was 120/min, and she remained afebrile. She was initially given normal saline and then albumin, but there was minimal improvement of the blood pressure. She was also noted to have a fever of 103 Fahrenheit on a repeat set of vital signs. Examination at that time did not reveal anything new: there was no obvious skin infection, her dialysis catheter site was clean, and no new murmurs were heard. Work-up at that time included complete blood count, troponin and blood culture drawn from periphery and her dialysis catheter. EKG was unchanged from previous. She was treated empirically for hospital-acquired infection with vancomycin and piperacillin/tazobactum due to persistently low blood pressure she was started on phenylephrine drip. Her blood pressure responded to phenylephrine, and her mental status also improved very quickly. Within 24 hours she was weaned off the phenylephrine drip. Her blood pressure remained stable, and she did not have a fever again. Her troponin continued to trend up and peaked at 0.5 ng/ml. In the absence of chest pain and EKG changes, this was considered demand ischemia due to septic shock. Her white cell count was never elevated throughout this process.

The blood culture from her dialysis catheter and periphery grew Ochrobactrum anthropi sensitive to Meropenam and resistant to Beta Lactams. Subsequently, Meropenam was started and previous antibiotics were discontinued. The dialysis catheter was also replaced, the tip of original catheter was found to have a thick biofilm. The tip was also sent for culture, and it also grew the same organism. Repeat blood cultures remained negative. Considering the fact that she had a pacemaker, a transthoracic echocardiogram was performed, which did not show any vegetation. A transesophageal echocardiogram was then done, which showed 1 cm vegetation on Mitral Valve [Figure 1]. She subsequently had her pacemaker leads removed, given the presence of vegetation, and semi-permanent epicardial pacemaker leads were placed. She was treated with antibiotics for 6 weeks without any further complications.
DISCUSSION

Ochrobactrum anthropi is an aerobic gram negative rod of low virulence which is widely distributed in aquatic environment. In many ways it bears resemblance to Pseudomonas. Due to its low virulence, Ochrobactrum anthropi rarely affects immunocompetent hosts, but can cause a variety of infections in immunocompromised hosts. It is thought to be associated with central lines, catheters and other foreign objects. It has binding abilities similar to those of Staphylococcus epidermidis and Staphylococcus aureus, which would explain its association with central lines and other foreign bodies. In our case the internal jugular dialysis catheter was the most likely portal of entry. Transplant-related infections due to contaminated pharmaceuticals have also been reported.

Even though Ochrobactrum anthropi has been reported to be a cause of various infections more frequently over the last 20 years, it still remains a very rare cause of endocarditis. In almost all the reported cases of endocarditis, the affected individuals had a prosthetic valve or rheumatic valve disease. This case though, describes undamaged native valve endocarditis. To our knowledge, only 1 case of undamaged native valve endocarditis has been reported previously.

Ochrobactrum anthropi is resistant to most beta lactams, and usually needs treatment with carbapenem, ciprofloxacin, trimethoprim/sulfamethoxazole or gentamycin. The resistant to beta lactams is due to production of AmpC β-lactamase by the organism. This β-lactamase is chromosomal, inducible, and is resistant to inhibition by clavulanic acid.

Even though it is considered to have low virulence, Ochrobactrum anthropi can cause severe infections in immunocompromised hosts. Therefore it is important to consider this bacterium in immunocompromised hosts who deteriorate suddenly. Similarly once the organism is identified, antibiotics should be switched to carbapenem, ciprofloxacin, trimethoprim/sulfamethoxazole, or gentamycin to cover it appropriately, even before sensitivities are available. It is uncertain whether every patient with positive blood culture for Ochrobactrum anthropi should be screened for endocarditis, but patients who have any hardware in their heart (prosthetic valves, pacemakers, defibrillators), which was true in our case, should get a transthoracic echocardiogram, and even a transesophageal echocardiogram to rule out infective endocarditis. As described in our case above, transthoracic echocardiogram can miss vegetation, which can result in a shorter duration and insufficient treatment of the endocarditis.

References


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Figure 1. Transesophageal echocardiogram showing vegetation, marked with blue arrow. The vegetation is about 1cm x 0.7cm in size, and adherent to mitral valve annulus.
The pharma-fever that almost got away

XIAO CHI ZHANG, MD, MS; MATTHEW SIKET, MD; WILLIAM BINDER, MD

From the Case Records of the Alpert Medical School of Brown University Residency in Emergency Medicine

DR. XIAO CHI ZHANG: A 68-year-old man was brought into the Emergency Department by his family with chills and altered mental status. Two days prior to his ED presentation, the patient had an episode in which he “spaced-out” and was unable to comprehend or acknowledge his wife. She reported that he did not have any signs of seizure activity and did not have any focal weakness. The episode lasted approximately 30 minutes and he returned to his baseline. Today he had another episode, but this time associated with chills and rigors. His past medical history was significant for chronic back pain due to bony metastasis from Stage IV non-small cell lung adenocarcinoma, requiring palliative gamma knife radiation, as well as a daily oral chemotherapy agent, erlotinib, an oral tyrosine kinase inhibitor. Additional medications included sertraline and methadone, which had recently been increased from 2.5 mg to 5 mg three times daily. Review of systems was negative for any recent travel, exposure to sick contacts, or pulmonary, abdominal and urinary complaints. Of note, the patient had developed a stable and unchanged truncal rash ever since he was started on erlotinib, 15 months prior to presentation.

On arrival to the ED, the patient’s vital signs were 106.2 F (41.2 C), blood pressure 137/78 mm Hg, pulse rate of 109, respiratory rate of 20, with an oxygen saturation of 90% on room air. His physical exam was notable for normal reactive pupils without papilledema, a supple neck without menin-gismus, mild oral thrush, tachycardia with regular rhythm and a diffuse, blanchable, papular rash along the trunk and proximal extremities He was alert and oriented x4, fully conversant, with 3+ patellar reflexes bilaterally and mild clonus, but otherwise had a normal neurological and memory exam.

Initial laboratory studies including a complete blood count (CBC), a comprehensive metabolic panel (CMP), a lactate level, a urinalysis, and a point of care rapid strep and influenza were normal. A non-contrast CT of the brain was unremarkable, and a chest x-ray revealed an apical lung mass consistent with the patient’s known lung cancer. An abdominal CT scan demonstrated an incidental pathologic acetabular fracture, but did not reveal any sources of infection.

DR. SARAH GAINES: A fever greater than 41.0°C is quite elevated and unusual. Is this dangerous? What was your differential?

DR. MATTHEW SIKET: Humans generally tolerate temperatures below 41°C [105.8°F]. In contrast to hyperthermia, in which an imbalance between heat generation versus dissipation occurs without up-regulation of the hypothalamic set point, fever as a host defense against infection rarely reaches dangerous levels in neurologically competent individuals. Very high temperatures can be related to urosepsis, intraabdominal sepsis, C. difficile colitis, meningitis, and central venous catheter infections. Hyperpyrexia, defined as temperature > 41.5°C [106.7°F] is an uncommon result of infection and usually implies central fever, neurologic malignant syndrome, malignant hyperthermia, adrenal insufficiency, or a drug related cause.1 Our patient was hyperpyrexic, suggesting either a limited spectrum of infectious diseases or a medication-related disorder.

DR. ELIZABETH GOLDBERG: What were your next steps in diagnosis and management of this patient?

DR. ZHANG: Our patient had a change in mental status as well as a remarkably elevated temperature. Our initial concern was for encephalitis or meningoencephalitis as delay in treatment can result in devastating morbidity and mortality. A lumbar puncture was performed with an opening pressure of 15cm H2O, 500+ RBCs in tube 4, 1 nucleated cell, 71% PMN, 17% lymphs, and normal glucose and protein. The patient was empirically treated for encephalitis of unclear etiology with IV cefepime, acyclovir, and vancomycin and was admitted to the floor for additional workup. Of note, his fever defervesced to 38.6 °C with 1g of IV acetaminophen.

DR. BRUCE BECKER: I have two questions. First, why did you obtain a CT of the brain prior to the lumbar puncture? Second, why was this patient treated with antiviral medication and antibiotics?

DR. ZHANG: While all patients with suspected encephalitis or meningitis should have a lumbar puncture for CSF evaluation, a computed tomography (CT) of the brain is not necessarily indicated as it can lead to a delay in appropriate treatment. A retrospective study in Sweden showed that...
patients who underwent immediate LP without CT received antibiotics 1.6 hours earlier than those who had a CT. The treatment delay resulted in a relative increase in mortality of 13 percent per hour of delay.\(^2\) If an LP is delayed or contraindicated (such as thrombocytopenia, history of epidural abscesses, or concern for herniation), the providers should obtain peripheral blood cultures and give empiric antibiotics.

The reasons for obtaining brain CTs prior to LPs are to assess for potential mass lesions or increased intracranial pressure, which may lead to a fatal cerebral herniation during removal of CSF. The indications for obtaining brain CTs include a history of immunocompromised states, malignancy, seizures, abnormal level of consciousness, focal neurologic deficit and papilledema.\(^3\) Since our patient has a history of metastatic cancer with altered mental status, we felt that a CT prior to performing the LP was indicated.

HSV encephalitis is a fatal disease process if untreated, especially in patients presenting with diffuse cerebral edema or intractable seizures.\(^5\) Prompt acyclovir therapy for HSV encephalitis can decrease one year mortality from 70% to approximately 14% although persistent neuropsychiatric and epileptic sequelae will persist in well over 20 percent of the surviving population.\(^6\) Consequently, empiric IV acyclovir was initiated while awaiting confirmation from CSF studies, including CSF cultures, PCR, and viral serologies.

We administered empiric antibiotics prior to obtaining our CSF results because bacterial meningitis is a devastating disease with significant mortality despite appropriate and timely administration of antibiotics. The overall case fatality rate is 16.4%, with mortality increasing linearly with age, from 8.9% (age 18-34) to 22.7% (age 65+).\(^7\) A delay in antimicrobial treatment for pneumococcal meningitis of more than 3 hours significantly increases mortality and results in greater neurologic deficits at discharge.\(^8\)

**DR. WILLIAM BINDER:** Would empiric antibiotics have affected the gram stain and CSF cultures?

**DR. ZHANG:** Administration of antibiotics can reduce the yield of gram stain and cultures, but the pathogen can still be cultured from the CSF for several hours after antibiotics.\(^9\) However, a special consideration should be made for patients with meningococcal meningitis, as one study demonstrated that three out of nine CSF cultures, obtained within one hour prior to LP, were negative.\(^10\) This is in contrast to pneumococcal meningitis in which 4 to 10 hours were required before the CSF cultures were sterile after antibiotics.\(^11\)

**DR. ANDREW NATHANSON:** It appears that you have covered the patient for infectious organisms. However, given the elevated temperature, was there further concern for a non-infectious cause of the hyperpyrexia?

**DR. ZHANG:** On admission, the patient was afebrile with unchanged repeated blood work. His blood, urine, and CSF (HSV, CMV) cultures and PCR were negative, his respiratory viral studies were normal, and consequently his antibiotics were discontinued. A careful review of the patient's medication revealed that his methadone dose was recently increased from 2.5mg TID to 5mg TID two weeks prior to hospital admission due to increased back pain. This coincided with the patient's initial febrile episode. In the setting of hyperpyrexia, hyperreflexia, and clonus, the patient was diagnosed with serotonin syndrome secondary to opiate dose increase. Sertraline was subsequently discontinued and he remained alert, oriented, and afebrile for the remainder of his hospital stay.

**DR. JEFF FEDEN:** How did methadone use lead to serotonin syndrome?

**DR. ZHANG:** Serotonin syndrome is a potentially dangerous condition associated with increased serotonergic activity in CNS, \(i.e.\) autonomic hyperactivity, neuromuscular abnormalities, altered mental status, due to synergistic drug-drug interaction or intentional overdoses of serotonin reuptake inhibitors (SSRI or SNRI). It is usually more acute in onset (<12 hours) than neuroleptic malignant syndrome (NMS), which occurs over 1–3 days and is associated with akinesia and rigidity, decreased levels of consciousness, and mutism.\(^12\) Additionally, the creatinine kinase (CK) level is usually markedly elevated (typically, greater than 1000 IU/L, and up to 100,000) in NMS. 13 Our patient’s CK was 206 IU/L.

Serotonin syndrome is often associated with multiple medications which increase serotonin release. Co-intoxication with CNS stimulants (cocaine, amphetamine, MDMA) can also precipitate serotonin syndrome both increasing the release and impairing serotonin reuptake, while CNS depressants (opiates) can act as direct serotonin agonists. Approximately 8% of Caucasians are deficient in the cytochrome P450 2D6 enzyme and are more susceptible to serotonin toxicity if taking medications such as venlafaxine, paroxetine, tricyclics, dextromethorphan, and methadone.\(^14\) There are no data to suggest that erlotinib is related to serotonin syndrome. However, erlotinib inhibits the cytochrome enzyme CYP3A4, which can result in the accumulation of serotonergic drugs such as methadone, and consequently may have contributed to this patient’s syndrome.\(^15\)

**DR. ILSE JENOURI:** Are there any specific diagnostic criteria for serotonin syndrome?

**DR. ZHANG:** Serotonin syndrome is diagnosed through clinical exam findings and detailed history consistent with worsening autonomic symptoms in the setting of known exposure to serotonergic substances. Common serotonin syndrome physical findings include agitation (or altered mental status), hyperthermia, hyper-reflexia, akathisia, tremors, diaphoresis, and muscle rigidity.\(^16\) In the absence of additional medical co-ingestions, cerebral infections or mass effects, clinicians can use the Hunter Toxicity Criteria Decision Rules 17 to diagnose serotonin syndrome. The Hunter Criteria is 84% sensitive and 97% specific when compared with a diagnosis of serotonin syndrome made by a medical.
toxicologist if a patient has taken a serotonergic agent and meets one of the following conditions:

- Spontaneous clonus
- Inducible clonus PLUS agitation or diaphoresis
- Ocular clonus PLUS agitation or diaphoresis
- Tremor PLUS hyperventila
- Hypertonia PLUS temperature above 38ºC PLUS ocular clonus or inducible clonus

There are no specific confirmatory laboratory tests to confirm serotonin syndrome; however, one may consider ordering CBC, CMP, CK, UA, drugs of abuse, coagulation studies, as well as radiographs, brain CT and/or lumbar punctures to narrow the differential diagnoses.

**DR. EDWARD RUHLAND:** What is the management of serotonin syndrome?

**DR. ZHANG:** The primary management of serotonin syndrome is discontinuation of the offending agent (i.e. serotonergic agents) and supportive care. Patients should be placed on placed on continuous cardiac monitoring, while receiving supplemental oxygen to maintain SpO2 > 94 percent and IV fluids for volume depletio. Benzodiazepines can be used to control agitation as well as elevated blood pressures and heart rates. While antipyretic agents, such as acetaminophen do not typically have a role in controlling for fever, as the increase in body temperature with serotonin syndrome is due to an increase in muscular activity as opposed to an alteration in the hypothalamic temperature set point, it is interesting to note that our patient defervations after one dose of acetaminophen. Patients with persistent fever above 106°F (41.1°C) can be considered for sedation, paralysis and intubation. Cyproheptadine, a histamine receptor antagonist, may be considered if the patient continues to exhibit agitation and abnormal vital signs despite conservative supportive care and benzodiazepine.

**DR. LAURA MCPAKE:** How did the patient fare after discharge?

**DR. ZHANG:** The patient returned to his psychiatrist two weeks after hospital discharge for additional therapeutic recommendations for treating his depression. After a long discussion, both physician and family agreed that prescribing additional antidepressants may result in recurrence of serotonin syndrome, especially in the setting of an expected increase in opiate prescription over time. Fortunately, the patient had great support from family and friends and demonstrated a realistic, yet positive view on his prognosis; he elected to seek alternative methods for managing his depression with palliative care and has not had any recurrent serotonin syndrome symptoms.

**References**


**Authors**

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Fax 401-444-4307
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Rhode Island Monthly Vital Statistics Report
Provisional Occurrence Data from the Division of Vital Records

<table>
<thead>
<tr>
<th>VITAL EVENTS</th>
<th>JANUARY 2016</th>
<th>12 MONTHS ENDING WITH JANUARY 2016</th>
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<tr>
<td></td>
<td>Number</td>
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<tr>
<td>Live Births</td>
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<tr>
<td>Deaths</td>
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<td>Infant Deaths</td>
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<td>Under 20 weeks gestation</td>
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<tr>
<td>20+ weeks gestation</td>
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* Rates per 1,000 estimated population
# Rates per 1,000 live births

<table>
<thead>
<tr>
<th>Underlying Cause of Death Category</th>
<th>JULY 2015</th>
<th>12 MONTHS ENDING WITH JULY 2015</th>
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<tr>
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<td>Number (a)</td>
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<tr>
<td>Diseases of the Heart</td>
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<td>Malignant Neoplasms</td>
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<td>Cerebrovascular Disease</td>
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<tr>
<td>Injuries (Accident/Suicide/Homicide)</td>
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<tr>
<td>COPD</td>
<td>33</td>
<td>546</td>
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</tbody>
</table>

(a) Cause of death statistics were derived from the underlying cause of death reported by physicians on death certificates.
(b) Rates per 100,000 estimated population of 1,055,173 (www.census.gov)
(c) Years of Potential Life Lost (YPLL).

NOTE: Totals represent vital events, which occurred in Rhode Island for the reporting periods listed above.
Monthly provisional totals should be analyzed with caution because the numbers may be small and subject to seasonal variation.
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THIRD ANNUAL RIMS MEMBERS

CONVIVIUM

SAVE THE DATE

SEPTEMBER 23
The new tradition continues. Members and guests are invited to schmooze, graze, and relax with colleagues while enjoying live music and watching the sun set over Narragansett Bay.

205TH ANNUAL MEETING
Inauguration of Officers and award presentations:
Dr. Charles L. Hill Award
Dr. Herbert Rakatansky Award
Dr. John Clarke Award

EAT, DRINK, BE CHUMMY
Nosh and mingle waterside at the Squantum Association.
Entertainment by Alpert Medical School’s own Chords of Bilroth.
6:30pm

WATCH FOR YOUR INVITATION LATER THIS SUMMER!
Working for You: RIMS advocacy activities

June 1, Wednesday
Meeting with Chairman Miller, Senate Health and Human Services Committee, at RI Urological Society: Mark Sigman, MD
Legislative Hearings
Meeting to discuss legislation: Michael Migliori, MD

June 2, Thursday
Warren Alpert Medical School Dual Degree Program Seminar: Josiah Rich, MD; Thomas Bledsoe, MD; Steve DeToy, staff
Rhode Island Diabetes Council: Newell Warde, RIMS staff

June 3, Friday
Meeting with PhRMA regarding opioid issues, Washington, DC

June 6, Monday
RIMS Council Meeting

June 7, Tuesday
RIMS Physician Health Committee: Herbert Rakatansky, MD, Chair
Legislative hearings
Senator Kettle fundraiser

June 8, 2016, Wednesday
Board of Medical Licensure and Discipline meeting
Governor’s Opioid Taskforce: Gary Bubly, MD, Past President, Taskforce member
Legislative hearings

June 9, Thursday
SIM Steering Committee: Peter Hollmann, MD

June 10–15, Fri–Wed
AMA House of Delegates Meeting, Chicago: Peter Hollmann, MD; Alyn Adrain, MD; Sarah Fessler, MD; RIMS staff

June 14, Tuesday
Legislative Hearings
RIMS member special event: Grilled Pizza Class

June 15, Wednesday
Primary Care Physician Advisory Committee
Reach Out and Read RI, Board of Directors: Steven R. DeToy, Board Member
Legislative Hearings

June 16, Thursday
Legislative Hearings

June 17, Friday
Diabetes Prevention Stakeholder Network: Newell Warde, RIMS staff
Legislative Hearings

June 18, Saturday
Legislature Adjourns

June 20, Monday
Blue Cross Blue Shield of RI; meeting with new President, Kim Keck

June 21, Tuesday
Conference call AMA, Department of Health, and Department of Behavioral Health, Developmental Disabilities and Hospitals regarding SAMSHA opioid grant
OHIC Health Insurance Advisory Committee meeting

June 22, Wednesday
Rhode Island Medical Journal: centennial planning

June 23, Thursday
Lifespan Resident Orientation: Presentation by Herbert Rakatansky, MD, and Kathleen Boyd, MSW, LICSW, Physician Health Program; new member recruitment, Diane R. Siedlecki, MD, Co-chair, Membership Committee

June 27, Saturday
Legislature Adjourns

June 20, Monday
Blue Cross Blue Shield of RI; meeting with new President, Kim Keck

Grilled Pizza Class
RIMS hosted this special event for members at the Easy Entertaining Café on June 14. Members and RIMS staff enjoyed an evening of culinary fun, learning to throw dough and grill pizza to perfection.
THE RHODE ISLAND MEDICAL SOCIETY HOSTS
DATA BREACH AND YOUR PRACTICE:
NEW REGULATIONS AND THEIR IMPLICATIONS

WEDNESDAY, AUGUST 31, 2016
RHODE ISLAND MEDICAL SOCIETY
405 PROMENADE STREET, SUITE A
PROVIDENCE, RI 02908

AGENDA

7:30 am—8:00 am: Continental Breakfast
8:00 am—9:00 am: Expert Panel Presentations
   I) 2016 regulations and some of the latest breaches
       Jeffrey F. Chase-Lubitz, Esq., Donoghue Barrett & Singal, PC
   II) A case study and compliance audit for a medical practice
       Chris Sheehan, Compliance Agent, Shred-it
   III) Insurance options for your practice
        David White, Partner, Butler & Messier Insurance
             Robert Anderson, Jr., President, RIMS Insurance Brokerage Corporation

9:00 am—9:30 am: Question & Answer

This Event is Free to the Members of the RI Medical Society and their staff.
Please visit www.rimed.org for further registration information.

Senior Physicians: Addressing Age, Ability and Acumen
… exploring challenges and opportunities for senior physicians as well as implications for healthcare systems, regulatory agencies, and medical practices

Friday, September 30, 2016
8:00 am to 4:00 pm
Crowne Plaza, Warwick, RI

This conference is made possible through an educational grant from the Coverys Community Healthcare Foundation. Program agenda and registration details may be found here or at www.rimed.org

MILE AND A QUARTER
334 South Water Street, Providence

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385 South Main Street, 2nd Floor, Providence

THURSDAY, SEPTEMBER 8, 2016
5:00–6:30 pm  Mingle at Mile and a Quarter
6:50–8:30 pm  Teams participate in one of three games
   The Study      21% success rate, record time 34:22
   The Gallery    15% success rate, record time 39:10
   Ex Machina    12% success rate, record time 45:29

FOR RIMS MEMBERS AND THEIR GUESTS
$60 per person
Limited space availability. RSVP by September 1
Reserve via the Member Portal on www.rimed.org or contact Megan Turcotte at 401-331-3207

RIMS Special EVENT

PUZZLE CHALLENGE
Mingle with your colleagues over a bite to eat at the Mile and a Quarter, then walk to Escape Rhode Island where your team will try to escape a mysterious room by solving a series of puzzles.
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Care New England was founded in 1996 and is the parent organization of Butler, Kent, Memorial and Women & Infants hospitals, the VNA of Care New England, The Providence Center, CNE Wellness Center and Integra, a certified Accountable Care Organization. Care New England includes 970 licensed beds and 216 infant bassinets. Through Butler, Memorial and Women & Infants, Care New England has a teaching and research affiliation with The Warren Alpert Medical School of Brown University. Kent is a teaching affiliate of the University of New England College of Osteopathic Medicine.

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Doctor’s Choice provides no cost Medicare consultations. Doctor’s Choice was founded by Dr. John Luo, a graduate of the Alpert Medical School at Brown University to provide patient education and guidance when it comes to choosing a Medicare Supplemental, Advantage, or Part D prescription plan. Doctor’s Choice works with individuals in RI, MA, as well as CT and helps compare across a wide variety of Medicare plans including Blue Cross, United Health, Humana, and Harvard Pilgrim.

john@insurehealthgroup.com

Neighborhood Health Plan of Rhode Island is a non-profit HMO founded in 1993 in partnership with Rhode Island’s Community Health Centers. Serving over 185,000 members, Neighborhood has doubled in membership, revenue and staff since November 2013. In January 2014, Neighborhood extended its service, benefits and value through the HealthSource RI health insurance exchange, serving 49% the RI exchange market. Neighborhood has been rated by National Committee for Quality Assurance (NCQA) as one of the Top 10 Medicaid health plans in America, every year since ratings began twelve years ago.

www.nhpri.org

RIPCPC is an independent practice association (IPA) of primary care physicians located throughout the state of Rhode Island. The IPA, originally formed in 1994, represent 150 physicians from Family Practice, Internal Medicine and Pediatrics. RIPCPC also has an affiliation with over 200 specialty-care member physicians. Our PCP’s act as primary care providers for over 340,000 patients throughout the state of Rhode Island. The IPA was formed to provide a venue for the smaller independent practices to work together with the ultimate goal of improving quality of care for our patients.

www.ripcpc.com

The Rhode Island Medical Society continues to drive forward into the future with the implementation of various new programs. As such, RIMS is expanded its Affinity Program to allow for more of our colleagues in healthcare and related business to work with our membership. RIMS thanks these participants for their support of our membership.

Contact Megan Turcotte for more information: 401-331-3207 or mturcotte@rimed.org
RIMS gratefully acknowledges the practices who participate in our discounted Group Membership Program.

For more information about group rates, please contact Megan Turcotte, RIMS Director of Member Services.
Why You Should Join the Rhode Island Medical Society

The Rhode Island Medical Society delivers valuable member benefits that help physicians, residents, medical students, physician-assistants, and retired practitioners every single day. As a member, you can take an active role in shaping a better health care future.

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RI Foundation awards $480,000 for medical research

PROVIDENCE – The Rhode Island Foundation has awarded more than $480,000 in seed funding for 20 promising medical research projects ranging from reducing heart failure among people who are overweight to developing stress-reduction techniques to prevent pre-term births.

The grants are intended to help early-career researchers advance projects to the point where they can compete for national funding.

A review panel made up of scientists and physicians assisted the Foundation in reviewing the medical research proposals. The grants are:

- $25,000 to Brown University Department of Neuroscience for the research project entitled “Multiple functions of the cell adhesion molecule TAG-1 in motor circuit development” led by ALEXANDER JAWORSKI, PHD.
- $25,000 to Brown University Department of Cognitive, Linguistic, and Psychological Sciences for the research project entitled “Examining How Autism Spectrum Disorders Affect Social Causal Learning” led by JOSEPH AUSTERWEIL, PHD.
- $25,000 to Brown University School of Engineering for the research project entitled “Temporal Geometric Control of Stem Cell Chondrogenesis for Osteoarthritis Therapy” led by ANITA SHUKLA, PHD.
- $25,000 to Brown University for the research project entitled “Regulation of human neural stem cell function by the pro-longevity FOXO transcription factors” led by ASHLEY WEBB, PHD.
- $25,000 to Brown University School of Engineering for the research project entitled “Microscopic in vivo imaging of cerebral dynamics in ischemic stroke” led by JONGHWAN LEE, PHD.
- $25,000 to Miriam Hospital for the research project entitled “Addressing sexual networks and the burden of sexually transmitted diseases in Providence, Rhode Island” led by PHILIP CHAN, MD, MS.
- $25,000 to Miriam Hospital for the research project entitled “Fecal Microbiota Transplant by Enema in Severe Clostridium difficile Infection” led by COLLEEN KELLY, MD.
- $24,334 to Miriam Hospital for the research project entitled “Mindfulness-based Stress Reduction to Prevent Preterm Birth” led by MARGARET BUBLITZ, PHD.
- $24,758 to Ocean State Research Institute, Inc. for the research project entitled “Magnesium Supplementation for Primary Prevention of Heart Failure in Obesity” led by SIDDIQUE ABBASI, MD.
- $25,000 to Rhode Island Hospital for the research project entitled “Targeting aspartate-beta hydroxylase as a chemoprevention for cholangiocarcinoma” led by CHIUNG-KUEI HUANG, PHD.
- $25,000 to Rhode Island Hospital for the research project entitled “IRE1 branch of the unfolded protein response and arrhythmias” led by MAN LIU, PHD.
- $25,000 to Rhode Island Hospital for the research project entitled “Elucidating How Matrilin-3 Prevents Accelerated Osteoarthritis” led by CHATHURAKA JAYASURIYA, PHD.
- $25,000 to Rhode Island Hospital for the research project entitled “miR-146a prevents cartilage degeneration in mouse osteoarthritis model” led by YINGJIE GUAN, MD, PHD.
- $22,222 to Rhode Island Hospital for the research project entitled “Home Blood Pressure Monitoring to Track Post-Discharge Blood Pressures In At Risk Individuals” led by ELIZABETH GOLDBERG, MD.
- $22,000 to Rhode Island Hospital for the research project entitled “Caenorhabditis elegans as a host model to study multi-drug resistance in Candida glabrata” led by DIMITRIOS FARMAKIOTIS, MD.
- $15,000 to Rhode Island Hospital for the research project entitled “Merging a National Hospital Trauma Registry with Post-Acute Care Data in Older Adults with TBI” led by MARK ZONFRILLO, MD, MSCE.
- $24,947 to URI Foundation for the research project entitled “Improving influenza vaccine efficacy in the elderly with a novel physical adjuvant” led by XINYUAN CHEN, PHD.
- $23,695 to URI Foundation for the research project entitled “Use of Gold Nanoparticles to Enhance the Effect of Radiation on Cancer” led by MICHAEL ANTOSH, PHD.
- $24,598 to Women & Infants Hospital for the research project entitled “Initiating metformin after delivery in post-partum women at high risk for diabetes mellitus: A Pilot Study” led by ERIKA WERNER, MD.
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Pediatric Anxiety Research Center moves to Bradley campus

Clinical and research branches united in one collaborative setting

EAST PROVIDENCE – Bradley Hospital’s Pediatric Anxiety Research Center (PARC) has relocated its clinical and research services to the hospital’s main campus in East Providence. The move unifies and expands its pediatric obsessive-compulsive disorder and anxiety treatment programs, leading research and education/training in one central location. PARC’s services – previously located at the Coro West Building – are offered in Bradley’s newly expanded outpatient building in a patient- and family-centered environment optimized for milieu-based therapy.

PARC treats children ages five to 18 who experience significant impairment in their daily lives due to anxiety and obsessive-compulsive (OC) spectrum disorders. It is home to the Intensive Program for Obsessive Compulsive Disorder, one of many nationally-recognized programs that brings families to Bradley Hospital. PARC is led by a team of child behavioral experts who specialize in the assessment and treatment of OCD and anxiety disorders, including social anxiety, phobias, panic disorder, illness anxiety and OC spectrum disorders, such as Tourette syndrome, tic disorders, body dysmorphic disorder, skin-picking, and trichotillomania (hair-pulling).

“Centralizing our services in one convenient, modern facility allows us to easily access the latest treatment options and various levels of care to help children with complex anxiety disorders,” said JENNIFER FREEMAN, PhD, director of research and training. Freeman leads the program with ABBE GARCIA, PhD, clinical director, and BRADY CASE, MD, medical director.

PARC is a nationally recognized, leading research group in pediatric OCD and anxiety, continually receiving National Institute of Mental Health research funding since 1998. The center focuses on developing and evaluating treatment protocols, improving understanding of psychological and biological factors in pediatric OCD, anxiety, and tic disorders; and training providers in the community to deliver evidence-based treatment. PARC was one of three sites in the U.S. for the Pediatric OCD Treatment Studies, the largest federally-funded treatment outcome studies for youth with OCD.

“Approximately one in eight children is affected by an anxiety disorder, which if left untreated can lead to school avoidance, withdrawal from family and friends, loss of interest in activities, substance abuse and problems eating and sleeping,” Freeman added.

PARC’s patients benefit from the center’s research by receiving the latest, proven treatments and therapies. Patients with OCD or anxiety participate in exposure and response prevention (ERP), a specific form of cognitive behavioral therapy (CBT) proven to be the most effective form of treatment for anxiety.

The move to Bradley’s campus and expansion of PARC’s services enabled the program to grow its research opportunities and clinical services for children and adolescents with tics – sudden, uncontrollable body sounds or movements. Tics occur in approximately one out of five school-age children and may persist into adolescence and adulthood. Tic Talk is PARC’s 8-week group program that utilizes Comprehensive Behavioral Intervention for Tics (CBIT), a research-based therapy aimed to help reduce tics and improve overall functioning for youth. ✷

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NIH awards Brown $11.5M for computational biology research

Brown University will launch a Center for Biomedical Research Excellence in Computational Biology of Human Disease to expand its research using sophisticated computer analyses to understand and fight human diseases.

PROVIDENCE — With a new five-year, $11.5 million grant from the National Institutes of Health, Brown University will expand its research in computational biology and launch a new Center of Biomedical Research Excellence (COBRE), which will support five early career faculty members as they tackle the genomics underlying diseases such cancer, preeclampsia and severe lung infections.

“There’s data and then there’s information,” said DAVID RAND, director of the new center and chair of the Department of Ecology and Evolutionary Biology (EEB). “Turning data into information you can use for something is what computational biology is all about.”

The new center will bring together diverse teams of researchers to generate new insights to advance medicine and health, said DAVID SAVITZ, Brown’s vice president for research.

“Brown scientists and students from a number of departments around the University – from computer science and applied mathematics to biology, medicine and public health – have been working collaboratively to understand and realize the benefits of advanced genomics,” said Savitz, who is also a professor in the School of Public Health. “This new COBRE will expand those programs to help move Brown to the forefront of this exciting, promising field of research.”

South County Health opens Medical & Wellness Center in Westerly

WESTERLY – After three years in planning and construction, the South County Health Medical & Wellness Center in Westerly welcomed its first patients May 23.

The 32,000 square foot Center, located at 268 Post Rd. (Rt. 1) in Westerly, is home to more than a dozen medical services, including primary care physicians, OB/GYNs, dermatologists, orthopedic surgeons, cardiologists, podiatrists, a general surgeon, diabetes management, urgent/walk-in care, lab, x-ray, ultrasound, and 3-D mammography among the array of services available.

The urgent/walk-in center is open seven days a week.

Fatima opens Long-Term Behavioral Health Unit

Will assist with state waiting list

PROVIDENCE – CharterCARE Health Partners and Our Lady of Fatima Hospital recently opened a Long-Term Behavioral Health Unit, where beds will be immediately available to patients on the waiting lists for long-term psychiatric care at the state’s Eleanor Slater Hospital.

The new 20-bed unit offers the following:

• Dedicated open community spaces;
• Several acres of outdoor space for walking;
• An evidence-based care model that offers a variety of individual, family, and group modules, and that incorporates principles of rehabilitation and recovery;
• The opportunity for patients to develop positive coping and daily living skills that will enhance patient autonomy and individual decision-making;
• A multi-disciplinary team with Psychiatry, Nursing, CNAs, Licensed clinicians, Milieu Therapists, and Occupational Therapists who routinely receive training for best practices in the treatment of patients on the new long-term unit.

REBECCA PLONSKY, LICSW, CharterCARE Vice President of Integrated Behavioral Health, worked in partnership with the Rhode Island Executive Office of Health and Human Services, the Department of Behavioral Healthcare, Disabilities and Hospitals, and the Rhode Island Department of Health to reach the agreement to create the dedicated long-term unit.
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Appointments

Dr. Albert Woo Named Chief of Pediatric Plastic Surgery at Hasbro Children’s Hospital

PROVIDENCE—Hasbro Children’s Hospital has appointed ALBERT S. WOO, MD, as chief of pediatric plastic surgery and director of its Cleft and Craniofacial Center. Woo is a board-certified plastic and reconstructive surgeon who treats children and adults affected by a variety of facial and body malformations. He also serves as a faculty member in the department of surgery at the Warren Alpert Medical School of Brown University.

Woo most recently served as chief of pediatric plastic surgery at St. Louis Children’s Hospital.

“Dr. Woo has more than a decade of clinical experience and is nationally recognized for his skills in complex craniofacial reconstruction,” said PAUL LIU, MD, chief of plastic surgery at Rhode Island Hospital and its pediatric division, Hasbro Children’s Hospital. “Because pediatric plastic surgery can be an understandably emotional process for families, we are fortunate to have Dr. Woo who is not only innovative and technically skilled but brings compassionate care to his patients and their families.”

Woo’s clinical interests include craniofacial surgery, cleft lip and palate, facial reconstruction, cosmetic procedures, treatment of moles and vascular malformations, hand surgery, trauma reconstruction and facial paralysis. He is an expert in the field of endoscopic craniosynostosis and craniofacial reconstruction. He has pioneered a new technique for cleft palate repair that improves speech outcomes in both primary and secondary operations.

Published in more than 40 peer-reviewed publications, Woo’s research interests include cleft lip and palate, velopharyngeal insufficiency, craniosynostosis (endoscopic and open), robotic plastic surgery and 3D printing technology.

He earned his medical degree at the Warren Alpert Medical School of Brown University and completed his residency in plastic surgery at Rhode Island Hospital. He also completed a fellowship in craniofacial surgery at the University of Washington School of Medicine in Seattle.

Woo currently is a member of the American College of Surgeons, the American Society of Maxillofacial Surgeons, the American Cleft Palate-Craniofacial Association and the American Society of Plastic Surgeons. He is the recipient of numerous awards including Best Doctors in America since 2011.

Peter Snyder, PhD, to Head Statewide Committee on Neuroscience Research

Panel will guide partnership of Lifespan, Brown, URI, Care New England and Providence VA

PETER J. SNYDER, PhD, senior vice president and chief research officer at Lifespan, has been named the inaugural chairman of the Rhode Island Neurosciences Leadership and Steering Committee, the panel responsible for leading a collaboration of Rhode Island’s most prominent research institutions engaged in the brain sciences.

STEVEN RASMUSSEN, MD, chair of the department of psychiatry and human behavior at the Alpert Medical School of Brown University, and representing Care New England on the committee, will serve as vice chair.

The new 10-member committee also announced at its first meeting last month that the collaboration has $200,000 in seed money. The committee is working on a thorough assessment of the organizations’ resources and capabilities, and identifying shared interests in the neurosciences.

A memorandum of understanding was signed last year by leadership from Lifespan, Brown University, the University of Rhode Island, Care New England and the Providence VA Medical Center.

The five institutions will focus on identifying causes and potential treatments for a wide range of diseases and disorders, including Alzheimer’s disease, epilepsy, stroke, traumatic brain injury and autism.

“The neurosciences are a broad area of study, one in which we have the potential to effect some real advancements in our lifetime,” said Snyder. “It is not commonplace for academic and medical institutions to collaborate, rather than compete. The sharing of mutual goals by these institutions will allow us to maximize our resources, in terms of personnel, physical research space, and, of course, funding. I am honored to have been chosen as the first leader of this exciting endeavor.”

Along with creating a critical mass in attracting large grants, Snyder says the partnership has started exploring initiatives like research opportunities for students of the neurosciences and planning a statewide research conference around brain sciences.
Appointments

Southcoast Health President & CEO Keith Hovan to Chair Massachusetts Hospital Association Board of Trustees

KEITH HOVAN, President & CEO of Southcoast Health in Southeastern Massachusetts was recently named the 76th Chair of the Massachusetts Hospital Association Board of Trustees. In his inaugural address, Hovan noted the unique responsibilities of healthcare institution and organization leaders.

“As executives, we have a special role within healthcare,” Hovan said. “We do not diagnose disease. But we ensure that our hospitals and clinics are staffed with the highly skilled clinicians who can. We do not remove tumors or set bones. But we help provide the operating rooms and high-tech equipment for those who do. And we do not deliver infants. But we help provide the best settings for our obstetrics professionals to usher in new life. We work every day to make sure that our hospitals, clinics and health centers deliver safe, high quality care at a cost that patients, businesses and, indeed, society can bear.”

Dr. Donald Coustan appointed to committee of American Diabetes Association

PROVIDENCE – DONALD R. COUSTAN, MD, of Jamestown, director of the Division of Maternal-Fetal Medicine’s Diabetes in Pregnancy Program at Women & Infants Hospital of Rhode Island and a professor of obstetrics and gynecology at The Warren Alpert Medical School of Brown University, has been appointed to serve a two-year term of the Professional Practice Committee of the American Diabetes Association.

Dr. Coustan was chairman of the Department of Obstetrics and Gynecology at Women & Infants and the Alpert Medical School from 1991 to 2008. He is a past president of the Society for Maternal-Fetal Medicine, past board member of the American Diabetes Association, and has held numerous other national positions.
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Kent, Memorial Recognized for Quality Stroke Care by American Heart/ American Stroke Association

PROVIDENCE – Kent and Memorial hospitals have been recognized by the American Heart Association/American Stroke Association for their commitment to quality stroke care.

Kent Hospital has received the American Heart Association/American Stroke Association’s Get With The Guidelines®-Stroke Gold Plus Quality Achievement Award with Target: StrokeSM Honor Roll. Memorial Hospital has received the American Heart Association/American Stroke Association’s Get With The Guidelines®-Stroke Gold Plus Quality Achievement Award. These awards recognize the hospitals’ commitment and success in ensuring stroke patients receive the most appropriate treatment according to nationally recognized, research-based guidelines based on the latest scientific evidence.

Hospitals must achieve 85 percent or higher adherence to all Get With The Guidelines-Stroke achievement indicators for two or more consecutive 12-month periods and achieve 75 percent or higher compliance with five of eight Get With The Guidelines-Stroke Quality measures to receive the Gold Plus Quality Achievement Award.

To qualify for the Target: Stroke Honor Roll, hospitals must meet quality measures developed to reduce the time between the patient’s arrival at the hospital and treatment with the clot-buster tissue plasminogen activator, or tPA, the only drug approved by the U.S. Food and Drug Administration to treat ischemic stroke. If given intravenously in the first three hours after the start of stroke symptoms, tPA has been shown to significantly reduce the effects of stroke and lessen the chance of permanent disability. Kent Hospital earned the award by meeting specific quality achievement measures for the diagnosis and treatment of stroke patients at a set level for a designated period.

Lynn E. Taylor, MD, accepts certificate honoring the program she created, Rhode Island Defeats Hepatitis C, from Karen B. DeSalvo, MD, acting assistant Secretary for Health, U.S. Department of Health and Human Services (HHS), at a White House event in May, the first time HHS presented awards for hepatitis testing. The 12 non-profit organizations honored were selected based on their success in reaching out to underserved populations and getting people tested and linked into care. Dr. Taylor developed and directs Miriam Hospital’s HIV/Viral Hepatitis Coinfection Program.

Lianna Karp, MD ‘16, shown with Herbert Rakatansky, MD, received the Herbert Rakatansky Prize at the Alpert Medical School in May. The award was endowed by the Rhode Island Medical Society in 2012 and is given to the graduating senior medical student who has done the most to promote the well-being of her/his fellow medical students.
Recognition

Dr. Andrew Cohen, Chief of Nephrology at the Providence VA Medical Center, right, gives a tour of the new dialysis facility's state-of-the-art water treatment plant to Dr. Michael Mayo-Smith, director of the VA New England Healthcare System, Wednesday, June 15, 2016.

Providence VA Dialysis Unit Wins ICARE Award

PROVIDENCE – DR. MICHAEL MAYO-SMITH, director of the VA New England Healthcare System, visited the Providence VA Medical Center June 15th and presented an ICARE award to the Providence VAMC’s Dialysis Unit for their exceptional service to veterans.

For the past two years, the unit was one of a select group of recipients of a National VA Renal Disease and Dialysis Office of Specialty Care Award.

Dialysis at the Providence VAMC has also achieved an infection rate of zero for several years, and implemented a Ticket to Ride program to seamlessly transition patients from their hospital bed to hemodialysis treatment.

ICARE awards are presented to a VA employee, or group of VA employees, who through their outstanding service, exemplify VA’s core values of integrity, commitment, advocacy, respect and excellence.

Dr. Susan MacKenzie, director of the Providence VA Medical Center, Dr. Satish Sharma, chief of staff, far left, and Dr. Paul Pirraglia, chief of Primary Care, second from left, present Dr. Monty VanBeber with the VA Secretary’s Hands and Heart Award Monday, June 13, 2016. The award recognizes VA employees whose dedication to Veterans is marked by the highest standards in patient care. Dr. VanBeber oversees primary care at all of the Providence VAMC’s community outpatient clinics. In addition to his administrative duties, Dr. VanBeber works tirelessly to personally deliver care to Veterans as the primary care physician for many clinic patients in Hyannis and New Bedford, Mass., and Middletown, R.I., as well as on Martha’s Vineyard and Nantucket islands.
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Southcoast Centers for Cancer Care earns national seal of accreditation from the American College of Radiology

NEW BEDFORD, MASS. — The Southcoast Centers for Cancer Care, part of Southcoast Health, has been awarded a three-year term of accreditation in radiation oncology as the result of a recent review by the American College of Radiology (ACR). The ACR seal of accreditation represents the highest level of quality and patient safety.

“American College of Radiology certification for radiation oncology has been the gold standard in our field for quite some time, yet has historically not been achievable by many institutions – even some of the most renowned,” said Sheri Weintraub, MS, DABR, Director and Chief Physicist of Radiation Oncology for Southcoast Centers for Cancer Care. “Certification requires an organized, systematic, and well-documented adherence to published best practices. As simple and reasonable as this sounds, there are many ways to follow best practices and it took a lot of focused teamwork to develop standard operating procedures that utilized the best of what each of us brought to the table. Developing those procedures was one thing, and holding ourselves accountable was another. We spent countless hours tracking and evaluating data to determine where our weak areas were and what was being done effectively to improve not only quality, but the patient experience.”

Blood and Marrow Transplant Program reaccredited by FACT

PROVIDENCE – The Roger Williams Medical Center Blood and Marrow Transplant program, the only unit of its kind in the state, has been awarded renewed accreditation from the Foundation for the Accreditation of Cellular Therapy (FACT) for demonstrating compliance with the FACT-JACIE International Standards for the full scope of bone marrow transplant programming. The accreditation is effective January 2016 for a period of three years.

“Patients with leukemia, lymphoma or other life-threatening disease or other blood disorders need the most effective care to improve and prolong their lives,” said Dr. Todd F. Roberts, Program Director of the Blood and Marrow Transplant Unit and Section of Hematologic Malignancies. “FACT reaccreditation for the program at Roger Williams confirms the excellent care and treatment we are delivering to patients in need of transplant services.”

The FACT accreditation process involved an on-site inspection, which took place in December 2015 and was conducted by inspectors qualified by training and experience in cellular therapy. FACT accreditation is embraced by the overwhelming majority of transplant programs. More than 90% in the United States are FACT accredited.

A dedicated unit located in the hospital is supplied with high-efficiency particulate air-filtration systems that provide protection to patients who cannot resist infection. Patients are monitored through a centralized intensive care patient monitoring system, which includes highly skilled nurses who have expertise in high-dose, anti-tumor chemotherapy administration and management of transplant-related side effects.

The unit is a full-service program, which provides compassionate care to patients diagnosed with acute and chronic leukemia, lymphoma, multiple myeloma, aplastic anemia, and myelodysplastic syndrome.

This voluntary accreditation is based upon compliance with the most comprehensive standards in the field, verified by rigorous peer-reviewed inspections. FACT-accredited organizations voluntarily seek and maintain FACT accreditation through a rigorous process, demonstrating their belief that patient needs are paramount.

The accreditation includes adult allogeneic and autologous transplantation, hematopoietic progenitor cell transplantation, marrow and peripheral blood cellular therapy product processing with minimal manipulation, and cellular therapy product processing with minimal manipulation.

Obituary

DR. LOUIS VINCENT SORRENTINO died on June 12, 2016. Born February 19, 1923 in Providence, he was predeceased by his wife, Rosemary Pierrel Sorrentino. Surviving are his brother, Stanley Sorrentino, daughter, Kathy Lytle [Rev. Bern] of Fishers, IN, son, Rev. Dr. Paul Sorrentino [Karen] of S. Deerfield, MA. He also leaves behind four grandchildren and eight great-grandchildren.

Military service in World War II shortened his Princeton studies. After the war, he graduated from Boston University Medical School. After his residency, he served for five years as a medical missionary in Japan. Upon returning from Japan, he completed his psychiatric training at Boston State Hospital.

His psychiatric practice began in Rhode Island in 1960. He was a member and Past President of the RI Psychiatric Society, the American Medical Association and the RI Medical Society. He was active for many years on the RI Medical Society Physician Health Committee and the RI Group Psychotherapy Society of which he was a founder. He was on the staff of RI Hospital and Butler Hospital and a Clinical Assistant Professor of Psychiatry at the Brown University Medical School.

In lieu of flowers, please contribute to the Dean of Pembroke College Endowed Visiting Professorship | Brown University, Gift Cashier, Box 1877, Providence, RI 02912, Butler Hospital | Foundation Office, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906) or the charity of your choice.
The Eleanor Slater Hospital (ESH), with campuses in Cranston and Burrillville, Rhode Island, is seeking physicians either board certified or board eligible in Internal Medicine or Family Practice interested in working with our patient population who suffer from acute and long term medical illnesses. The hospital provides care to patients with both medical and psychiatric disorders. At ESH physicians serving the psychiatric and medical populations work together in a collegial environment. Applicants must be licensed by the State of Rhode Island Department of Health.

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Recognition

Dr. Jennifer Gass serves as international breast cancer resource

PROVIDENCE – JENNIFER S. GASS, MD, surgeon-in-chief and co-director of the Breast Health Center at Women & Infants Hospital of Rhode Island, a Care New England hospital, continues to be recognized as an international resource in the field of oncoplastic breast cancer surgery and cancer survivorship issues and was recently invited to participate in two key groups.

Dr. Gass completed a one-month sabbatical at the Paris Breast Center in 2011 in the novel surgical procedure that combines the best techniques from plastic surgery with oncologic surgery to remove breast cancer, and then brought oncoplastic surgery to Women & Infants, making it the first facility in New England to use it.

Dr. Gass – who has also served as a surveyor for the National Accreditation for Breast Centers, directs the breast fellowship at Women & Infants, and serves as a clinical associate professor at The Warren Alpert Medical School of Brown University – was recently invited faculty to the Internationale Senologische Society in Warsaw, Poland. There, she presented on oncoplastic surgery and served on the Global Breast Health Initiative working group.

“As we gain a greater appreciation of the cancer survivorship journey, we better catalogue patient reported outcomes in survivorship. Oncoplastic surgery is one technique surgeons can provide that may empower women who want to preserve and reconstruct their breasts in the most natural looking way at the time the cancer is removed,” Dr. Gass says.

In addition, she was the invited co-chair of the American Society of Breast Surgeon’s survivorship pre-conference course at the group’s recent annual meeting. As such, she was asked to submit a manuscript for the course offering.
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Graduation day exercises were held on Friday, June 17, 2016, for residents and fellows completing their training at Memorial Hospital of Rhode Island. Family Medicine graduates, pictured left to right, were: kneeling front row, Jeremy Stricsek, MD, Jeffrey Sorokin, MD, Samantha Greenberg, MD, Sarah Phillips, MD and Susan Boisvert, MD. Standing, back row, left to right, David Dick, DO, Rachel Trippett, MD, Gabriel Pleasant, MD, Katherine Jarrell, MD, Jessica Heney, MD, Laurie Garabedian, DO, Bridget Marvinsmith, MD and Michael Chen-Illamos, MD.

Internal Medicine graduates, pictured left to right, were Omair Tahir, MD, Umama Gorsie, MD, Armea Hodarkar, MD, Rachana Sedhai, MD, Jae Young Lee, MD, Nicole Yang, MD, Muhammad Shafi, MD, Anum Saeed, MD, Arman Uzunyan, MD, Mervat Saleh, MD and Fady Marmoush, MD.
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1915: Poison Pies on the Fourth of July Create Panic in Westerly & Stonington, CT.

MARY KORR
RIMJ MANAGING EDITOR

Francis T. Brightman, 72, and his wife, Georgiana, 68, were returning home from the First Baptist Church in Westerly on Sunday, July 4th, 1915 when they stopped for lunch at Alexander Ray Gavitt’s restaurant. Known for its homemade pies, the restaurant was located on the bridge spanning the Pawcatuck River between Westerly, RI, and Pawcatuck, CT. For dessert, they each had a slice of pie.

Three days later, the Civil War veteran and his wife were dead. The holiday weekend proved deadly for two others who had also consumed the restaurant’s pies. Timothy J. Sullivan, 49, was the first fatality. He exhibited symptoms of severe food poisoning seven hours after eating the pie and died 36 hours later. Two family members who had eaten the pie became very ill; his young daughter was in a coma for several days, while four other family members who had not eaten the pies were fine.

The fourth victim, Horace Rodman, lingered for three weeks before succumbing. In addition, more than 60 people in southern Rhode Island and bordering Connecticut, all suffering from acute gastroenteritis, violent vomiting and nausea, and severe stomach pain, kept area physicians busy making house calls.

It didn’t take long for the panic to spread throughout southern Rhode Island and over the border. Physicians called it an epidemic and sprung into action to determine the cause.

Investigators, both medical and legal, stated the following facts which local newspapers reported:

- Gavitt’s pastry chef, Thomas Fantano, mixed the dough for the holiday pies on Friday, July 2.
- On Saturday, July 3rd, he made 11 coconut pies, six custard, six squash, four lemon, three blueberry, four chocolate and eight apple pies.

Dr. M.N. Scanlon, medical examiner for Washington County, which includes Westerly, later testified to attending to several patients about midnight on July 4, all of whom had eaten the custard pie at Gavitt’s.

On the morning of July 5th, Alexander Gavitt himself came to Dr. Scanlon’s office with gastroenteritis and leg cramps. Later that day, Dr. Scanlon went to Gavitt’s restaurant and ordered him to stop selling the pies. He took samples of everything used for cooking in the restaurant and sent them to Providence for analysis by bacteriologists.

At first, Dr. Scanlon and area physicians thought that arsenic or mercury had gotten into the pies or that ptomaine poisoning had resulted from bacteria present in one or more of the pie ingredients. The food samples were initially tested for heavy metals and alkaloids, with negative results.

A court inquiry was held in Connecticut, where many of the victims, as well as Gavitt himself, lived. As physicians and those who had recovered sufficiently to testify, a startling fact emerged – those who ate only the pie filling did not become sick. But those who ate the pie and crust did.
Pathologists **HARRY S. BERNSTEIN, MD**, and **EZRA S. FISH, MD**, of the Rhode Island Board of Health, conducted the investigation which ultimately concluded the outbreak was due to the organism *bacillus paratyphosus B* which their lab isolated from the pie crust and from samples provided from an autopsy of one of the victims, as well as a dozen blood sera provided by physicians tending those seriously ill who had eaten the pies.

In a report published in *JAMA* the following January, Drs. Bernstein and Fish noted striking similarities in a food epidemic resulting from pork pies which occurred in 1910 in Wexham, England: 107 persons in 56 families became seriously after eating pork pies, five of them died. The pork pies all came from the same bakery. Health authorities were able to detect *bacillus paratyphosus B* in two of the specimens of the pies eaten, and it was also found in the “agglutins for the organism in five persons who had eaten the pies in question.”

The Rhode Island doctors concurred with their English colleagues that “parathyphoid carriers may cause infection not only directly but also by contaminating sound food.”

They emphasized the importance of protecting public food supplies from “disease carriers.”

In the Westerly pie epidemic, the disease carrier was not identified in the medical literature or general press of the day, nor were there any reports of the restaurant staff being tested.