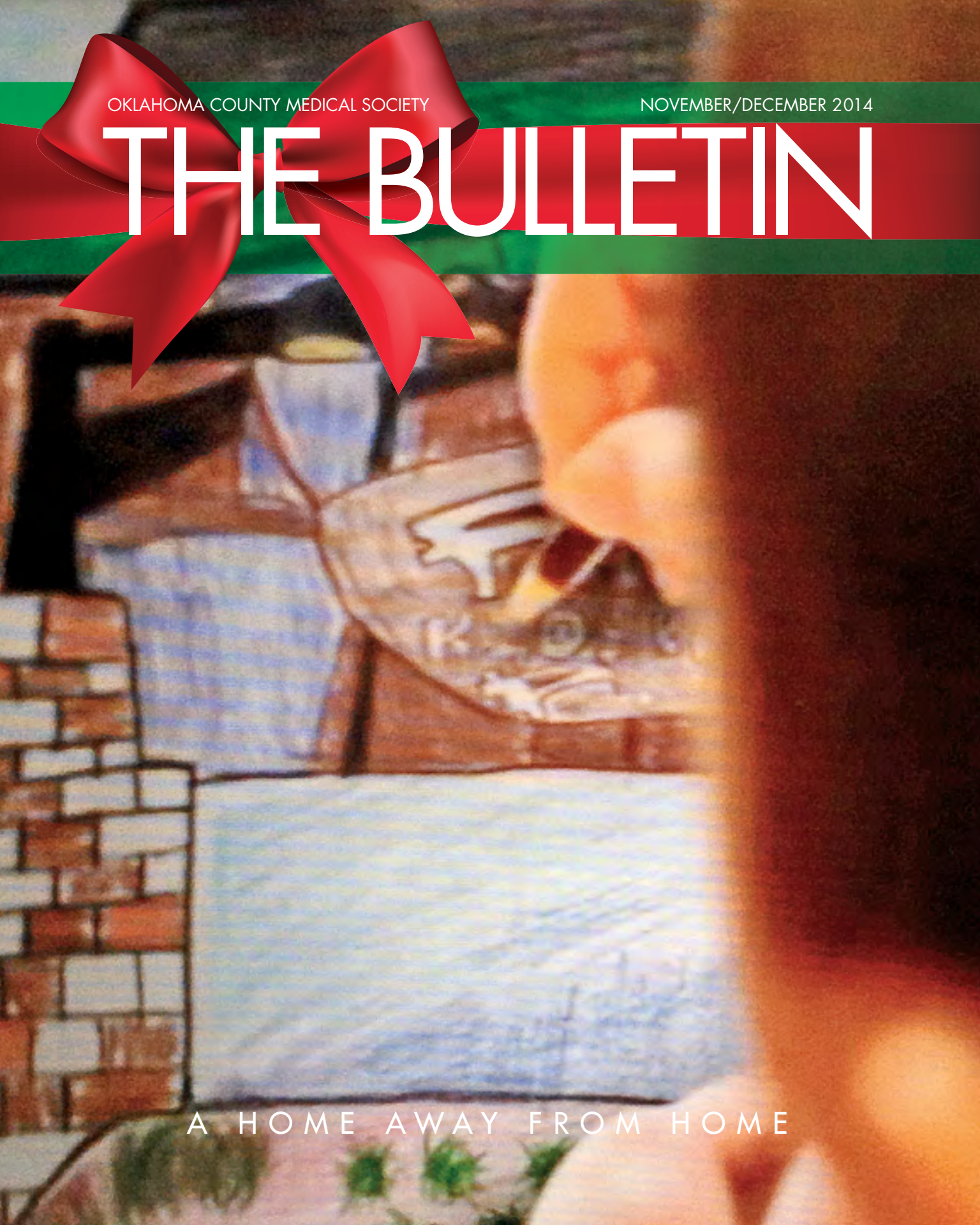
OKLAHOMA COUNTY MEDICAL SOCIETY NOVEMBER/DECEMBER 2014

THE BULLETIN



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Vice President

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Vice President

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OKLAHOMA COUNTY MEDICAL SOCIETY

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THE BULLETIN

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ABOUT THE COVER

The last months of the year are a time for us to reflect on the meaning of family and home. Our cover art is a drawing of the OK Kids Korral in Oklahoma City. This was being drawn by Tristan, age 12, from Pawnee, who lived at the OK Kids Korral for several months while he was receiving treatment for a brain tumor. For Tristan and many other Oklahoma children with cancer, the OK Kids Korral is a home away from home, a haven for the entire family while their children are receiving life-saving treatment.

The OK Kids Korral opened in January 2014 as a project of the Toby Keith Foundation. Many pediatric cancer patients in Oklahoma must travel hours a day to receive treatment. For families, the toll of traveling to and from treatment can be overwhelming, both emotionally and financially. The OK Kids Korral provides a cost-free, convenient and comfortable home for pediatric cancer patients receiving treatment at The Children's Hospital at OU Medical Center, Peggy & Charles Stephenson Cancer Center and other nearby facilities.

The art above is by Shane Smith, age 6. He drew the OK Kids Korral, which he calls "Toby's House." His family is on top of the castle/Korral and some of the staff is there, too. Shane is the blue one with an "S" on his shirt; he also included his port.

This is from 10-year-old Trevor, who was asked to draw a picture about his family. He titled this one "Picnic." Trevor is a quiet boy and the only one of his age at the Korral right now. He relies heavily on his family and this project came easy for him.

THE BULLETIN

ADDENDUM

In the last issue of the Bulletin, a portrait was used of the former Dean Robert Montgomery Bird, which hangs in the OU Health Sciences Library named for him, with the support of the Robert Montgomery Bird Society. Dean Bird joined OCMS in 1953 and served as Vice President in 1964. The portrait's artist is Carol Castor from Vinita, OK, who has a BFA from OU and studied at the Art Students League of New York. She painted the posthumous portrait in 1991. Her portraits are in permanent collections from Texas to New York.

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

PRESIDENT'S PAGE

By Julie Strebel Hager, MD

"The Oklahoma County Medical Society will be the leading advocate to improve the health of our citizens and to enhance, nurture and improve the well-being of its physicians."

The Oklahoma County Medical Society was created in 1900 by a group of physicians who wanted to promote the art and science of medicine and the betterment of public health. Today, we comprise greater than 1,200 Oklahoma County physician members, and we unite with other county medical societies in Oklahoma to create the Oklahoma State Medical Association. Our mission statement is above, and our vision statement can be found in its entirety on our website. At its core, we aim to provide a forum for community physicians to come together for advocacy and communication, and to promote wellness for the county's residents.

Historically, OCMS has done amazing things. In 1972, the leadership of the society began studying the problems with our local blood supply. It took several years of planning, but after dedicated Oklahoma County physicians signed personal financial notes, the Oklahoma Blood Institute was formed. It is now recognized as a national leader in blood banking and has recently opened its stem cell and cord blood research center. In 1975, OCMS recognized the need for a community emergency transport system. AMCARE (now EMSA) was created one year later without any government funding but with a personal financial commitment from OCMS. In 1990, the County Medical Society established Hospice of Oklahoma County, a local nonprofit hospice which currently functions with support from Integris.

More recently, OCMS leadership along with Deaconess Hospital and the Free Methodist Church opened a free clinic in northwest Oklahoma City. The Open Arms free clinic operates today with the assistance of the Butterfield Foundation, and several OCMS primary care physician members and residents volunteer their time and provide medical care. A bit later, Schools for Healthy Lifestyles was started. The OCMS Community Health Committee partnered with the Oklahoma City-County Health Department and the Oklahoma State Health Department to create a program concentrating on education, injury prevention, nutrition, physical fitness, and prevention

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 Continued from page 5 ...

of tobacco use. Physician members may participate by becoming the 'Adopt-a-Doc' for a school included in the program. In 2005, OCMS president Dr. R. Murali Krishna had a vision for a coordinated health care delivery system for the uninsured in Oklahoma County. The Health Alliance for the Ininsured now fulfills that vision. Physicians may volunteer their time, as hospitals volunteer their resources to provide primary care and surgical services through this very important organization.

Today, OCMS leadership has been integral in creating the city's trauma call rotation and publishes that schedule on its website. Dr. Larry Bookman, former OCMS president, started the OCMS Leadership Academy, which models its curriculum after Leadership Oklahoma City. In a small group, young physician leaders, both members and nonmembers, have access to powerful community resources as educators. The Academy has graduated a number of young physician leaders into this community.

In the future, we will continue the work of our mission statement. Soon, we will be creating a series of webinars on a variety of topics to assist physicians, their families, and patients with current medical issues and challenging clinical scenarios. We will include resources directed at the business climate in today's clinical practice models, and financial resources from the city's trusted local authorities. These will be available on our website. We will use local media to provide medical resources to the physicians and residents of Oklahoma County via interviews and editorials. Look for a large-scale community wellness project organized by our young physician graduates of the Leadership Academy. Finally, we are committed to providing advocacy to all Oklahoma County physicians, politically and personally, here in the communities where we work. THAT is who OCMS is- it is ALL of us, uniting to make Oklahoma County a healthier community.

DEAN'S PAGE

By M. Dewayne Andrews, MD, MACP

"Big Data" – interesting term – what does it mean and what does it have to do with medicine? All of us are increasingly surrounded by and immersed in a tremendous overload of information on a daily basis. Some of this information, or data, comes from digital images, from electronic medical records, from laboratory analyzers and countless other sources in the health care world. Just think of the explosion of information at our disposal through the Internet and the smartphone held in our hands. The term Big Data generally refers to large and complex sets of information requiring computerized techniques for storage, sorting and analysis. It's important for now and for the future. The NIH has established a new program called Big Data to Knowledge (BD2K) to help deal with the massive datasets in medicine and biomedical science that have emerged and to give researchers assistance in extracting meaning from the vast amount of raw information that is generated each week.

The BD2K initiative has four major goals: (1) to facilitate broad use of biomedical digital assets by making them discoverable, accessible, and citable; (2) to conduct research and develop the methods, software, and tools needed to analyze biomedical Big Data; to enhance training in the development and use of methods and tools necessary for biomedical Big Data science; and (4) to support a data ecosystem that accelerates discovery as part of a digital enterprise. While all this may sound disconnected from day-to-day practice, there is tremendous potential here for intensive data analysis of large clinical data warehouses to better inform our understanding of clinical presentations, improve diagnostic approaches, and improve treatment outcomes. This seems especially relevant to population health management, which is becoming increasingly important in the health care reform changes occurring in the United States.

The OU College of Medicine, along with many other medical schools, is pursuing these big data avenues along several lines. Researchers are working on new bodies of information that include but are not limited to the genome (our entire DNA 'catalog'), proteome (the collection of proteins produced by the genes within cells), epigenome (composite group of chemical and physical modifications to DNA structure), microbiome (the entire collection of microorganisms that live in or on the body), transcriptome (the collection of RNA that provides the templates for our genes, and bioinformatics. Bioinformatics is the scientific field that allows researchers to create and utilize highly sophisticated computer-based tools and methods to analyze biologic data in depth. Computational structural biologists are working on computer-based methods to match all known chemical compounds with their potential binding partners in the human proteome. This could lead to better understanding of drug-protein interactions and ultimately much better drug design and the potential to personalize drugs for an individual.

Biomedical research continues to advance in ways only dreamed of a few years ago. Big Data is a key component of some of the likely advances in the next few years.

OCMS 2015 OFFICERS & NEW BOARD MEMBERS

C. Douglas Folger, MD

Don L. Wilber, MD

David L. Holden, MD

Sam S. Dahr, MD

The Nominating Committee has submitted its slate of 2015 officer candidates:

President: C. Douglas Folger, MD
President-Elect: Don L. Wilber, MD
Vice President: David L. Holden, MD
Secretary-Treasurer nominee: Sam S. Dahr, MD

The Committee is offering one nominee for the Secretary-Treasurer position. Other board members may opt to be placed into nomination for this position before the Nov. 17 membership meeting. If there is a contested election, members will be asked to cast their ballots as they check in at the meeting.

The new OCMS board members for 2015 are:

Renée H. Grau, MD
Jason S. Lees, MD
R. Kevin Moore, MD
James A. Totoro, MD

Many thanks to the four members going off the board:

Anureet K. Bajaj, MD
Thomas H. Flesher, III, MD
Paul J. Kanaly, MD
David C. Teague, MD

Renée H. Grau, MD

Jason S. Lees, MD

R. Kevin Moore, MD

James A. Totoro, MD

WELCOME NEW MEMBERS!


Jason S. Breed, MD


Carlos A. Garcia, MD


Theresa Garton, MD


Justin M. Davis, MD


David W. Lam, MD


Kristin B. Lam, MD

JASON S. BREED, MD, is a board-certified family medicine physician. He completed medical school at the OU School of Medicine and completed a residency at the Integris Baptist Great Plains Family Medicine Residency Program.

CARLOS A. GARCIA, MD, is a board-certified dermatologist. He completed medical school at Anahuac University School of Medicine in Mexico City, an internship at Hospital General in Zacatecas in Mexico, a residency at Hospital General Dr. Manuel Gea González in dermatology, and a fellowship at Duke University School of Medicine in dermatology and Mohs micrographic surgery.

THERESA GARTON, MD, is a board-certified psychiatrist at the OU Health Sciences Center. She completed medical school at OUHSC, an internship at the University of Texas Health Sciences Center – San Antonio in psychiatry, a residency at OUHSC in psychiatry, and a fellowship at the University of Mississippi Medical Center in Jackson, MS, in psychiatry.

JUSTIN M. DAVIS, MD, is a board-certified anesthesiologist with Affiliated Anesthesiologists LLC. He completed medical school at the OU Health Sciences Center, and completed an internship and residency at the University of Texas Medical Branch in Galveston, TX.

DAVID W. LAM, MD, is a practicing physician in hematology/oncology and internal medicine. He completed medical school at the OU College of Medicine, and a residency at the OU Health Sciences Center.

KRISTIN B. LAM, MD, is a board-certified pediatrician. She completed medical school at the OU School of Medicine, and an internship and residency at the University of Oklahoma – Pediatrics in Oklahoma City.

OCMS
OKLAHOMA COUNTY MEDICAL SOCIETY

WELCOME NEW MEMBERS!


Kashif A. Mufti, MD


Florina Neagu, MD


Betsy M. Nolan, MD


Terrell R. Phillips, DO


David N. Roberts, MD


Thomas Stasko, MD

KASHIF A. MUFTI, MD, is a board-certified rheumatologist practicing at McBride Orthopedic Hospital Clinic. He completed medical school at King Edward Medical College in Pakistan, an internship at Jinnah Hospital Lahore Pakistan in medicine, a residency at St. Louis University in internal medicine, and a fellowship at the University of Arkansas for Medical Sciences in rheumatology.

FLORINA NEAGU, MD, is board-certified in allergy and immunology and practices at the Oklahoma Allergy & Asthma Clinic in Oklahoma City. She completed medical school at the University of Medicine and Pharmacy at Timisoara in Romania, an internship and residency at Weiss Memorial Hospital in Chicago, and a fellowship at Rush University Medical Center in Chicago.

BETSY M. NOLAN, MD, is a board-certified orthopedic surgeon practicing at the Veterans Administration Medical Center in Oklahoma City. She completed medical school at the University of Texas Health Sciences Center in San Antonio, an internship and residency at LAC+USC Medical Center in Los Angeles in orthopedic surgery, and a fellowship at Balgrist Hospital at the University of Zurich and at William Beaumont Hospital in shoulder and elbow surgery.

TERRELL R. PHILLIPS, DO, is a board-certified anesthesiologist. He completed medical school at the Oklahoma Osteopathic College of Medicine, an internship at the Dallas/Fort Worth Medical Center, and a residency at OU Medical Center.

DAVID N. ROBERTS, MD, is board-certified in internal medicine. He completed medical school at the OU School of Medicine, an internship and residency at the University of Alabama - Birmingham in internal medicine, and a fellowship at the University of Oklahoma in gastroenterology.

THOMAS STASKO, MD, is a board-certified dermatologist. He completed medical school at the University of Texas Health Sciences Center in San Antonio, an internship at USAF Medical Center at Scott Air Force Base in Illinois, a residency at the University of Texas Health Sciences Center in San Antonio, and a fellowship at the New England Medical Center in Boston.

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Detailed Hospital Checklist for Ebola Preparedness

The U.S. Department of Health and Human Services (DHHS), Centers for Disease Control and Prevention (CDC), and Office of the Assistant Secretary for Preparedness and Response (ASPR), in addition to other federal, state, and local partners, aim to increase understanding of Ebola virus disease (EVD) and encourage U.S. hospitals to prepare for managing patients with EVD and other infectious diseases. Every hospital should ensure that it can detect a patient with ebola, protect healthcare workers so they can safely care for the patient, and respond in a coordinated fashion. Many of the signs and symptoms of EVD are non-specific and similar to those of many common infectious diseases, as well as other infectious diseases with high mortality rates. Transmission can be prevented with appropriate infection control measures.

In order to enhance our collective preparedness and response efforts, this checklist highlights key areas for hospital staff -- especially hospital emergency management officers, infection control practitioners, and clinical practitioners -- to review in preparation for a person with EVD arriving at a hospital for medical care. The checklist provides practical and specific suggestions to ensure your hospital is able to ***detect*** possible EVD cases, ***protect*** your employees, and ***respond*** appropriately.

While we are not aware of any domestic EVD cases (other than two American citizens who were medically evacuated to the United States), **now is the time to prepare,** as it is possible that individuals with EVD in West Africa may travel to the United States, exhibit signs and symptoms of EVD, and present to facilities.

Hospitals should review infection control policies and procedures and incorporate plans for administrative, environmental, and communication measures, as well as personal protective equipment (PPE) and training and education. Hospitals should also define the individual work practices that will be required to detect the introduction of a patient with EVD or other emerging infectious diseases, prevent spread, and manage the impact on patients, the hospital, and staff.

The checklist format is not intended to set forth mandatory requirements or establish national standards. In this checklist, healthcare personnel refers to all persons, paid and unpaid, working in healthcare settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, or contaminated environmental surfaces.[1]

This detailed checklist for hospitals is part of a suite of HHS checklists currently in development.

CDC is available 24/7 for consultation by calling the CDC Emergency Operations Center (EOC) at 770-488-7100 or via email at eocreport@cdc.gov.

[1] Healthcare personnel includes, but is not limited to, physicians, nurses, nursing assistants, therapists, technicians, laboratory personnel, autopsy personnel, students and trainees, contractual personnel and persons not directly involved in patient care (e.g., house-keeping, laundry).

HEALTH CARE PROVIDER PREPAREDNESS CHECKLIST FOR EBOLA VIRUS DISEASE

The following checklist provided by the Centers for Disease Control and Protection (CDC) highlights some key areas for health care providers to review in preparation that a person with EVD arrives for medical care.

- ❑ Stay up to date on the latest information about risk factors, signs, symptoms, and diagnostic testing for EVD (www.cdc.gov/vhf/ebola/index.html)
- ❑ Be alert for patients with signs and symptoms of EVD or who may have traveled recently to one of the affected countries (www.cdc.gov/vhf/ebola/symptoms/index.html)
- ❑ Review facility infection control policies for consistency with the CDC's Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected EVD in U.S. Hospitals: (http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html)
- ❑ Promptly apply standard, contact, and droplet precautions for any suspected or confirmed EVD patients before transport or upon entry to the facility, and triage using the facility plans (e.g., place in private room) for evaluation: (http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html)
- ❑ Know how to report a potential EVD case to your facility infection control leads.
- ❑ Know the points of contact within your facility responsible for communicating with state and local public health officials. Remember: EVD is a nationally notifiable disease and must be immediately reported to local, state, and federal public health authorities.
- ❑ Know who to notify in your facility after an unprotected exposure (i.e., not wearing recommended PPE at the time of patient contact or through direct contact with blood or body fluids) to a suspected or confirmed EVD patient.
- ❑ Know how and where to seek medical evaluation following an unprotected exposure.
- ❑ Do not report to work if you become ill after an unprotected exposure (i.e. not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with EVD.

IN MEMORIAM

Raymond J. Dougherty, MD
1922-2013

Marco A. Paliotta, MD
1964-2014

Please plan to attend the annual OCMS Presidential Inaugural Dinner on Friday, Jan. 23, 2015, to honor our 2015 president, C. Douglas Folger, MD.

The event will include dinner, awards and recognition, and dancing afterwards at the Oklahoma Golf & Country Club. Dress is black-tie optional. Tickets are $95 each and may be paid online at www.o-c-m-s.org or by check. Dinner guests may order a vegetarian and/or a gluten-free meal in advance.

If your organization is interested in sponsoring an inaugural table, please call Tracy Senat at 702-0500.

Invitations to this special event will be mailed to all members in early December with an RSVP card, which should be mailed back by Jan. 9, 2015.

SAVE THE DATE!

MEMBER **NEWS**

Dr. John Bozalis and his wife, Sharon, have been named 2014 Treasures for Tomorrow by the Oklahoma Health Center Foundation. They were honored as Dedicated Community Volunteers at the 15th annual Treasures for Tomorrow celebration in September at the Skirvin Hilton Hotel. Treasures for Tomorrow pays tribute to individuals whose passion for life, courage and inspiring actions serve as a model for quality values and goodness in our community. Dr. Bozalis co-founded the OU Medical School Evening of Excellence, and founded and is chairman of the board for Schools for Healthy Lifestyles, which was started at OCMS.

THE BULLETIN

Looking For **Physician Authors** for 2015

The Bulletin is looking for physicians who are interested in writing articles for the 2015 Bulletin. Specifically we need authors to write clinical articles for 'The Pearl,' and younger physicians who would like to write articles from the 'Young Physician' perspective. We publish six Bulletins a year and authors may write one article or more if they wish. Columns are generally 500-1,000 words.

If you are interested, please contact Tracy Senat, 702-0500, tsenat@o-c-m-s.org, and we can discuss the topic you are interested in and your timeframe.

MUCH ADO ABOUT TESTOSTERONE ADVERSE EVENTS

THE PEARL

By Johnny B. Roy, MD

Testosterone is an important hormone and plays an important role in both men and women's physiopathology. My focus here will deal with its role in men.

Hypogonadism is characterized by low libido, impotence, irritability, depression, decreased muscle mass, obesity, lack of stamina, osteoporosis, and gynecomastia.

Replacement therapy may rectify most of these symptoms. Reports show improvement in BMI from 31 kg/m² to 29 kg/m², waist circumference declined at least 10cm. This in addition to providing higher quality of life!

Testosterone therapy has increased to an extent that it is the second fastest growing medication in the country. This could be attributed to better awareness of our growing, better educated aging population.

Currently, we are inundated with solicitous blanket downgrading of the proper use of this hormone. This followed a report by the FDA evaluating the risk of heart attack and stroke in two publications, one in November 2013 and the other in January 2014.

The adverse events reported in these articles is contrary to the accumulated evidence for decades showing the cardio-protective effect of testosterone. Investigators worldwide have shown low testosterone contributes to diabetes, hypertension, metabolic syndrome, Alzheimer's, and 2.6 times greater risk of dying within two years from the diagnosis.

The two articles implicating testosterone in cardiovascular risk have caused an international uproar among investigators in this field. The first article had grave errors, including in an all-male data, 9% women. A letter co-signed by more than 160 leading figures from 32 countries including 60 professors & nine journal editors asked the AMA to retract the article. A similar letter requested the FDA to retract their warning. Their response was that they never implicated testosterone to MI in stroke, but just reported the journal articles and would monitor & evaluate the safety of testosterone.

Incidentally, in June 2014, the FDA approved two new testosterone products!

Shooing Halluc

BY HANNAH SADDAH, MD

It happened unexpectedly, like a lightning bolt in fair weather. But 1971 was that kind of a year: the Vietnam War was raging, I was new to America, and I had never heard of DTs.

In Lebanon, we watched the Vietnam conflict explode on the black-and-white screens, but the war remained distant from our hearts and misunderstood by our minds. We had our own social problems then, our own wars to comprehend, and our own defeats to accept. America, on the other hand, was our El Dorado, the open-armed land from whose bosom all knowledge flowed, and from whose breasts all humanity fed. It was the mighty beacon of science where we all flocked to specialize after finishing our medical training at the American University of Beirut.

Alcoholism in Lebanon was socially contained. Every town had its few 'drinkers' who were sheltered by their families and friends. Moreover, it was legal for families to make their own distilled alcohol, arak, and there was plenty of it. It was also sold everywhere, even in the minutest grocery stores, and there was no age limit for buying it. Kids were allowed to drink it and often did so on festive occasions. Because it was so widely available, alcoholics never ran out of drinks, DTs were unheard of, and the term was unfamiliar to my ears.

As a first-year resident in medicine, I was assigned to the Oklahoma City VA Hospital and my first day on the service was also my first night on

inations

call. I was busy admitting two new patients when my pager screamed, "Doctor, you're needed on 5-North. Immediately." I darted out of the emergency department, ran up the stairs, and when I reached 5-North, I found the Head Nurse pacing in front of the elevators awaiting me.

"Oh, you used the stairs."

"It sounded urgent."

"You're the resident on call?"

"Yes, ma'am."

"I hope you can handle this situation because we can't."

On the way to Room 505, the Head Nurse went over the details and handed me a chart.

"He's a Vietnam veteran who took to heavy drinking after he returned and has been at it for several months. His wife and two daughters finally gave him the ultimatum and told him that if he did not quit, they were going to leave him. He stopped drinking five days ago and started to go crazy on them the day before yesterday. He was admitted at four o'clock today and has all the right PRN orders but we can't get to him to start an IV or to administer his Valium and Thorazine."

"And why can't you get to him?"

"He's in DTs, pretty bad, and thinks that a pack of dogs is after him."

"DTs?"

"Yes!"

"What are DTs?"

The Head Nurse rolled back her eyes as she exclaimed, "Oh God, don't tell me…"

"No need for alarm, Ma'am." I interrupted. "I can handle it if you will just tell me what the initials stand for."

"Delirium Tremens."

"What's that?"

The Head Nurse lowered her eyeglasses down her nose, took one piercing look at me and, with a patronizing tone, inquired, "How old are you, son?"

"Twenty-five," I mumbled, feeling a bit intimidated.

"And you've never heard of DTs?"

"We must not have them in Lebanon," I sheepishly answered.

"Lebanon? You've no alcoholics over there?"

"Oh, we have some, for sure."

"And what happens to them when they stop drinking?"

"They don't stop drinking. In my hometown, Amioun, there are three 'drinkers'— that's what we call them over there — and they're always drunk. I've never known any of them to stop drinking."

 Continued from page 19 …

I surveyed the room. There was an IV pole with a liter of intravenous fluid hanging from it. I looked at all the stunned faces for a hint, a tacit suggestion, but all I saw were the blank looks of astonishment and awe.

My innocent answer must have touched a motherly nerve in the Head Nurse's heart. Slowly, her frowns gave way to a faint gleam that glowed underneath her concerned aspect. I could almost hear her heart whisper, "What's this poor little man from Lebanon going to do when he sees what awaits him in 505?" Walking toward 505, she took my arm and began teaching me.

"When heavy drinkers stop drinking suddenly, they develop an alcohol-withdrawal syndrome with agitation, confusion, hallucinations, body shakes, rapid heart, high blood pressure, etc. They basically go temporarily mad but after we hydrate them and sedate them for a few days, they come out of it and go back home."

"What do you sedate them with?"

"His admitting doctor's orders say to give him IV fluids, IV Valium, and IM Thorazine but, in case you didn't hear me say it, we're unable to get close enough to him to be able to treat him."

"And why's that?"

"Because he's combative and thinks that the dogs are after him. That's why I paged you."

That was the last thing she said to me before we entered Room 505. In spite of feeling profoundly ignorant, my state of mind when I walked in and surveyed the scene was inappropriately comfortable. It was merciful that youth had endowed me with an exaggerated sense of aptitude. Consequently, I took immediate charge of Operation Dogs without having the necessary knowledge to guide me. All that propelled me at that most strained moment were sheer confidence and blind faith.

During my last year in Beirut, I had amputated limbs, injected adrenalin into arrested hearts, intubated lungs, and gone without sleep for 48 hours at a time. Casualties arrived in droves, it seemed, when I was on emergency call. So, what could be worse, I thought.

But here, in America, people are giants. The man stood like a colossus twice my size, holding the room's corner with his back, thrashing like a bear at anyone that dared come close to him. His eyes were bulging, red, and paranoid. He was drooling at the mouth

and barking at the top of his lungs, "Get away from me, you bastards. Go away. Go on. Shoo. Shoo." I had never seen a more massive man in my life. He looked like he could bite a tree in half and use it for toothpicks. Other orderlies and nurses hugged the walls, wearing frightened aspects and serrated lips. Chaos flickered everywhere like the lights of a police car in a crowd.

When I walked in, for some reason, everyone stood still. I must have looked ridiculously minute before that mad giant. Nevertheless, even he stood still, as if at attention, and waited for me to say something. At that eerie instant, the last words of my mother echoed in my ears,"Go on to America, my son. I have prayed for you and know that God will take good care of you. Just listen to him when you are in trouble and he will guide you."

"God's on my side," I thought, as I approached Goliath with not even a sling in my hand. When our eyes met, I could see dread in his and he must have seen kindness in mine because he did not seem to mind the fact that I had gotten too close to him. Stopping at about five feet away, I asked, "What's bothering you, sir?"

"These damn hounds," he barked, pointing at the empty corner to the left of the door. "They're rabid and aim to bite me. Just don't let them get any closer. Shoo them away. They're mad. Mad dogs. All seven of them."

I surveyed the room. There was an IV pole with a liter of intravenous fluid hanging from it. I looked at all the stunned faces for a hint, a tacit suggestion, but all I saw were the blank looks of astonishment and awe. I was a little man, alone, unarmed, in the middle of an arena, with seven rabid dogs and a mad giant glaring at me. The only thought that came to my mind at that most strained moment was Dr. William Osler's adage, "Listen to your patients and they will hand you the diagnoses and tell you what to do." Suddenly, the giant's words came back to me like an epiphany. "These damn hounds. They're rabid and aim to bite me. Just don't let them get any closer. Shoo them away. They're mad. Mad dogs. All seven of them."

My external calm and small stature belied the aggression that I was about to evince. With sudden, ostentatious might, I grabbed the tall IV pole, shook off the dangling liter of IV fluid, and charged the rabid pack of dogs like a Roman gladiator with a long spear. I thrashed and darted, parried, and lunged, emitting fierce battle cries, and scoring one fatal stab after another. "One out of seven, two out of seven, three out of seven," I shouted as I battled the rabid pack single-handedly, until I had exterminated all seven of them. When I said, "Seven out of seven," I threw the IV pole onto the floor as if it were a bloody sword and, dripping with sweat, looked to the giant for approval. He began screaming again, "Doc. Doc. There's one more behind you. One more. Get him. Get him. Get him before he gets you and me." I quickly picked up the IV pole and darted again and again at where he was pointing until his screams died down. Then, still holding the IV pole in my hand, I looked to him again for approval. This time, his red eyes were no longer bulging and he had the hint of a smile on his exhausted face. I approached him with an extended hand, which he shook with gratitude. Then, leading him to his bed, I said, "The nurses need to start your IV treatment so that you can get well and go home."

The next morning, as my team and I were making rounds with our attending, the Goliath actually waved at me as we passed Room 505. He looked calm, was eating breakfast, and his eyes were no longer red. Nurses in the halls giggled as we passed them. Our attending seemed a bit annoyed and asked, "What's going on? Did something happen that I don't know about?"

"Nothing of significance, sir," I reassured. "Last night I had to shoo away a hallucination and the Head Nurse must have reported the incident in her nurse's notes."

"How interesting?" he smirked. "Shoo away a hallucination? What on earth do you mean by that?"

"It's nothing but silliness, sir. The patient had DTs last night and believed that rabid dogs were after him."

"And, what did you do?"

"I shooed them away."

"And how did you do that?"

COMMUNITY PREPAREDNESS REPORT AVAILABLE

The 'Special Report: Community Preparedness' was released by the United Way of Central Oklahoma earlier this year. This report is a great resource for the community and the information comes from experts in the field. It covers disaster preparedness and recovery, including financial preparedness and the nuances of federal assistance. United Way is offering copies of this report free for physicians to place in their waiting rooms or other locations as suitable. For your free copies, please call Laura Trent at the United Way at 523-3509 or ltrent@unitedwayokc.org.

SHOOING HALLUCINATIONS *Continued from page 21 …*

"With an IV pole."

"Shooed them away with an IV pole?" He repeated as he shook his head with disbelief. "Is that what you normally do in Lebanon?"

"No, sir. In Lebanon our 'drinkers' don't have DTs because they never stop drinking."

"Perhaps you could enlighten your team and me as to why the Lebanese drunks don't ever stop drinking."

"Could I do that some other time, sir?" I pleaded with a blush as I glanced at my watch. "I have six new patients to present to you before the ten o'clock resident's conference begins."

The next time I was on call, the Head Nurse approached me with a grin and said, "I don't quite understand how you knew what to do when you had never seen DTs before? So many of those who were present are wondering the same thing."

"I really didn't know what to do when I walked into that room. The patient was the one who gave me the clue."

"I was there, remember? I heard everything he said and he never said anything sensible."

"Oh, yes he did, but you must have failed to comprehend it."

"And what was it that I had failed to comprehend, Doctor?"

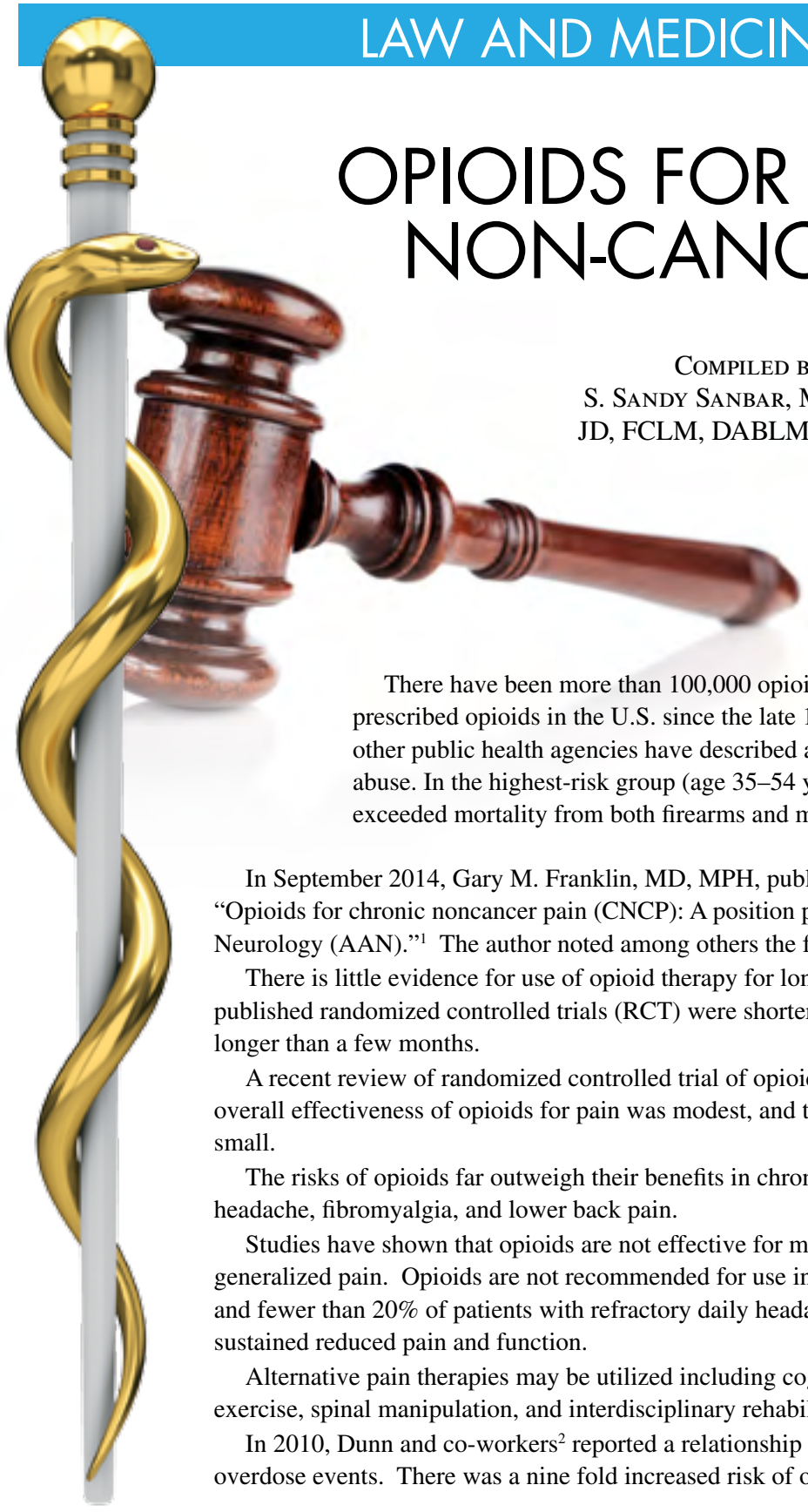
"He said, 'These damn hounds. They're rabid and aim to bite me. Just don't let them get any closer. Shoo them away. They're mad. Mad dogs. All seven of them.' And so I did exactly as he said."

"He was babbling, Doctor, and you did exactly as he said? What on earth did he exactly say?"

"He said, 'Shoo them away,' and that's exactly what I did."

OPIOIDS FOR CHRONIC NON-CANCER PAIN

Compiled by
S. Sandy Sanbar, MD, PhD,
JD, FCLM, DABLM, DABFM



There have been more than 100,000 opioid-related deaths from prescribed opioids in the U.S. since the late 1990s, which the CDC and other public health agencies have described as an epidemic of opioid abuse. In the highest-risk group (age 35–54 years), these deaths have exceeded mortality from both firearms and motor vehicle accidents.

In September 2014, Gary M. Franklin, MD, MPH, published a policy statement regarding, "Opioids for chronic noncancer pain (CNCP): A position paper of the American Academy of Neurology (AAN)."[1] The author noted among others the following:

There is little evidence for use of opioid therapy for longer than 16 weeks. Most of the published randomized controlled trials (RCT) were shorter than 4 weeks, and none was longer than a few months.

A recent review of randomized controlled trial of opioids for CNCP indicated that the overall effectiveness of opioids for pain was modest, and that the effect on function was small.

The risks of opioids far outweigh their benefits in chronic pain conditions such as headache, fibromyalgia, and lower back pain.

Studies have shown that opioids are not effective for migraine, other types of headache, or generalized pain. Opioids are not recommended for use in treating tension-type headaches, and fewer than 20% of patients with refractory daily headache are likely to improve in sustained reduced pain and function.

Alternative pain therapies may be utilized including cognitive-behavioral therapy, exercise, spinal manipulation, and interdisciplinary rehabilitation.

In 2010, Dunn and co-workers[2] reported a relationship between prescribed opioid dose and overdose events. There was a nine fold increased risk of overdose at doses exceeding 100

mg/d MED compared to doses below 20 mg/d MED (morphine equivalent dose) in patients with CNCP. For each fatal overdose in the study, more than 7 nonfatal overdoses were observed. The majority of opioid overdose deaths occur in the home, and a minority appear to be intentional.

Franklin noted, "The most crucial best practices would be as follows:

- Track pain and function at every visit using a brief, validated instrument, so that the practitioner is aware of the effectiveness of opioids at every step.
- Document the daily MED in mg/d from all sources of opioids at every visit.
- Access the state PDMP (Prescription Drug Monitoring Program) data (a) at the time of a first prescription for opioids, particularly if that visit is to an emergency department; (b) at the time of a decision as to whether to institute COAT (Chronic Opioid Analgesic Therapy); and (c) periodically during monitoring of COAT, with a frequency according to risk of abuse.
- Screen for past and current substance abuse and for severe depression, anxiety, and posttraumatic stress disorder prior to initiation of COAT.
- Use random urine drug screening prior to initiation of COAT and periodically during monitoring of COAT, with a frequency according to risk.
- Use a patient treatment agreement, signed by both the patient and prescriber, that adequately addresses the risks of COAT and the responsibilities of the patient, at the initiation of COAT and annually.
- Avoid escalating doses above 80–120 mg/d MED unless sustained meaningful improvement in pain and function is attained, and not without consultation with a pain management specialist."

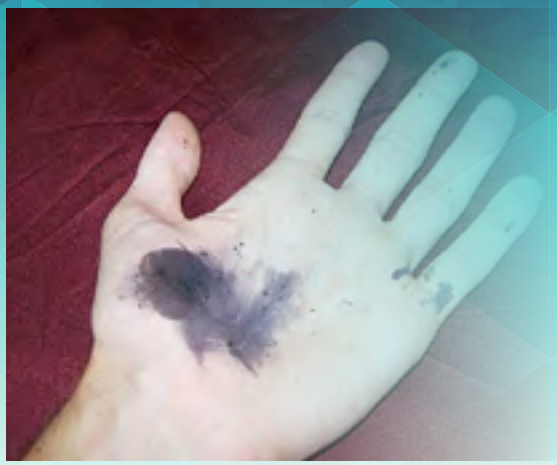
In 2014, clinicians appear to be tempering their use of opioids in CNCP patient. They are increasingly seeking the opinion of pain specialists before prescribing opioids, and they are taking into consideration alternative treatment modalities to alleviate pain.

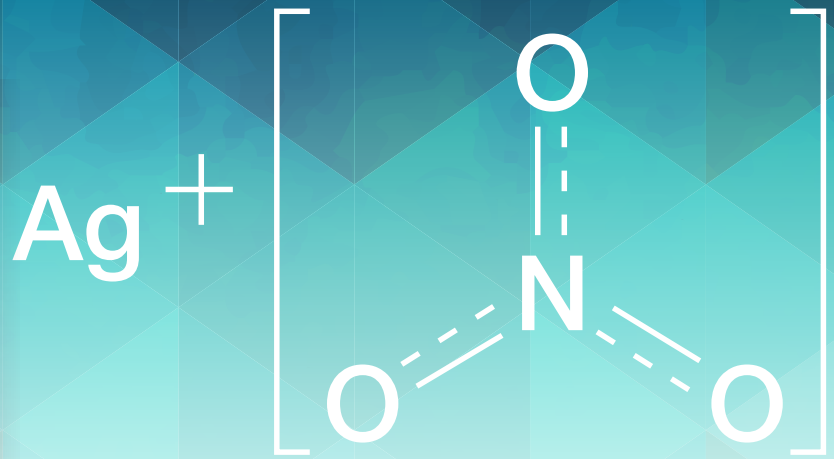
[1] http://www.neurology.org/content/83/14/1277.full.html

[2] Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med 2010; 152:85–92.

BY DAVID W. FOERSTER, MD

While in my first year of plastic surgery residency, I noticed that the renowned Barnes Hospital Group of Drs. Brown, McDowell, Byars and Fryer (with whom I worked) did primarily reconstructive head and neck cancer surgery, as well as a few cosmetic procedures.





Silver Nitrate

Burn cases were handled by the general surgeons headed by Dr. Carl Moyer. He had just developed a new treatment regimen consisting of wet 0.5% silver nitrate soaked dressings. At this concentration, the silver nitrate would coagulate and kill all bacterial species but not harm the unburned underlying tissue, including new skin regenerating from remnants of hair follicles and sweat glands. Even some full thickness burns could resurface without grafting brought about by these remnants, which were protected from destructive infection.

I left Barnes after one year and finished my training with Drs. Cronin and Brauer in Houston in order to get cleft lip, hand, and cosmetic experience. (Dr. Cronin had just developed the silicone breast implant). I then returned to Oklahoma City in 1965 and went into private practice. Here, burn patients requiring hospitalization were treated by the plastic surgeons and so I became actively involved in such cases.

I remembered Dr. Moyer's 0.5% silver nitrate soak therapy and the thought occurred to me that if the concept could be incorporated into a hydrophilic crème then this would result in a more soothing and humane treatment. The crème could gently be washed off in contrast to the soaked dressings, which often became adherent and painful to be removed.

I was sharing an office with my father, Hervey Foerster, MD, a dermatologist, so I went to him asking advice for such a hydrophilic product. He recommended Velvachol, a soothing preparation used often by fellow dermatologists as a carrier for other medications. Taking his advice, I went to the pharmacy at Mercy Hospital and had them compound a 0.5% silver nitrate concentration using Velvachol as the carrier.

Over the next five years, I treated my hospitalized burn patients with this preparation. Several of my plastic surgery colleagues also began to use this method and we eventually accumulated a series of 50 patients. This study was then published in the Oklahoma State Medical Journal.

Let me preface our results by stating that burns severe enough to require hospitalization carried a significant mortality risk during this time period. If the patient's age were added to the percentage of 2nd- and 3rd-degree burn areas and the total exceeded 70-75 points, then the prognosis for survival was very poor. For example, a 40-year-old with 30-35% body surface burns fell into this category, as well as a 60-year-old with 10-15% burns. Needless to say, more than a few of the burns that we treated in that period fell into this fatal category.

It is with great pride that, of the 50 patients so treated with the silver nitrate crème, we only had two deaths with a survival rate of 96%.

Whether or not this was a factor, I don't know, but in the early 1970s Jay Henry, CEO of Baptist Medical

Continued on page 28 …

BEFORE SILVADENE *continued from page 27…*

Center, became enthusiastic about setting up a burn center. Dr. Paul Silverstein, who had recently worked at the Army Burn Center at Brooke General Hospital in San Antonio, was recruited by Dr. Ed Dalton to come to Oklahoma City and was consequently hired by Mr. Henry to head up a new Burn Center at Baptist.

It was about this time that a new burn crème called Silvadene had been developed (I believe Dr. Silverstein had something to do with this) and so burn care and treatment was handed over to Paul, who incidentally did a superb job in establishing a first-class facility. He also enlisted some of the local general surgeons to participate. Eventually they took over the Burn Center and now continue to run it in a pristine manner.

With the advent of Silvadene, which incidentally did not stain bedclothes and everything else black as did the 0.5% silver nitrate crème, there was no further need for the latter and so like an old soldier it just faded away. It had done an excellent job but was no longer needed!

One other thing about the silver nitrate crème is worth mentioning. An unexpected attribute was its ability not only to kill pathogens but to render full thickness burned skin into a soft chamois-like covering. One of the problems with circumferential extremity burns was the tendency of the burnt skin to contract and constrict into a hard, non-pliable hard leather-like eschar, which could cause severe blood flow problems to the distal hands or feet. Surgical splitting of such eschar to relieve pressure was often necessary and thus exposed large strips of underlying raw tissue to potential damage or infection.

Using the silver nitrate crème, such escharotomies were never necessary. I recall a young boy, age 10, with 90% 2nd- and 3rd-degree burns (from a gasoline

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2014 **KITCHEN** TOUR

The OCMS Alliance Kitchen Tour was held at five houses in Nichols Hills in October. The proceeds benefited the Regional Food Bank of Oklahoma and Schools for Healthy Lifestyles.

Co-chairs for this year's event were Marni Sigmon and Berna Goetzinger. The committee members included Amy Bankhead, Deanna Carey, Cara Falcon, Karen Gunderson, Natasha Neumann, Christina Nihira, Suzanne Reynolds, Jeary Seikel, Jennifer Tortorici and Mucki Wright.

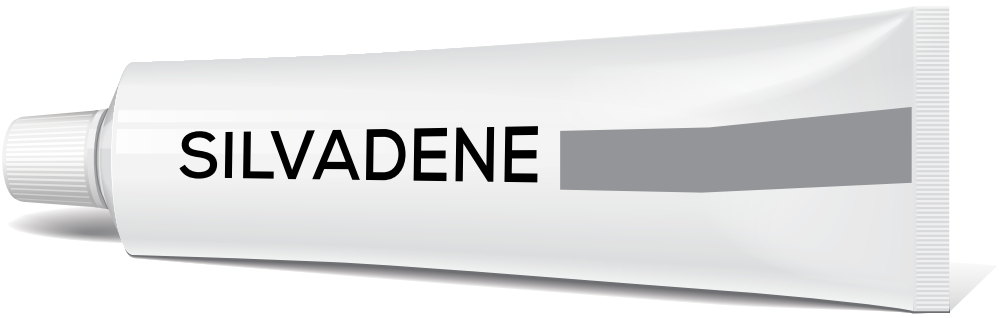
Sponsors for the event included Integris, Freede Foundation, Clearwater Enterprises, Intrust Bank, OU Physicians, St. Anthony, Digestive Disease Specialists, MidFirst Private Bank, Deaconess, OCMS and Dr. Roy Bankhead.

A special thank you goes out to AC Dwellings, Culinary Kitchen, Liberte, Lime Leopard, Lush Blow Dry Bar, Luxe Objects, New Leaf Florist, On A Whim, the Wood Garden & Everything Barbeque for their participation.

explosion in a small closed bathroom) who did not require surgery for the first two months. During this period, the silver nitrate crème allowed about 45% of the burned area to regenerate and thus be available for graft donor sites. Consequently I was able to systematically peel off strips of the soft chamois-like eschar and graft onto the smooth underlying raw surface. No homografts were needed and I was eventually able to cover all areas that had not spontaneously regenerated. Shortly after leaving the hospital, he and his parents moved away and he was lost to follow-up. His case was chronicled in the Oklahoma State Medical Journal.

The modern treatment of burns has changed considerably. Tangential excision of deep burned areas with mesh grafting is done as early as possible while the patient is still in good physiological condition. Perhaps Dr. Silverstein can give us an update.

In conclusion, may I saw that with our 'dirty' old silver nitrate crème and slow-to-operate system, we didn't do too shabby!



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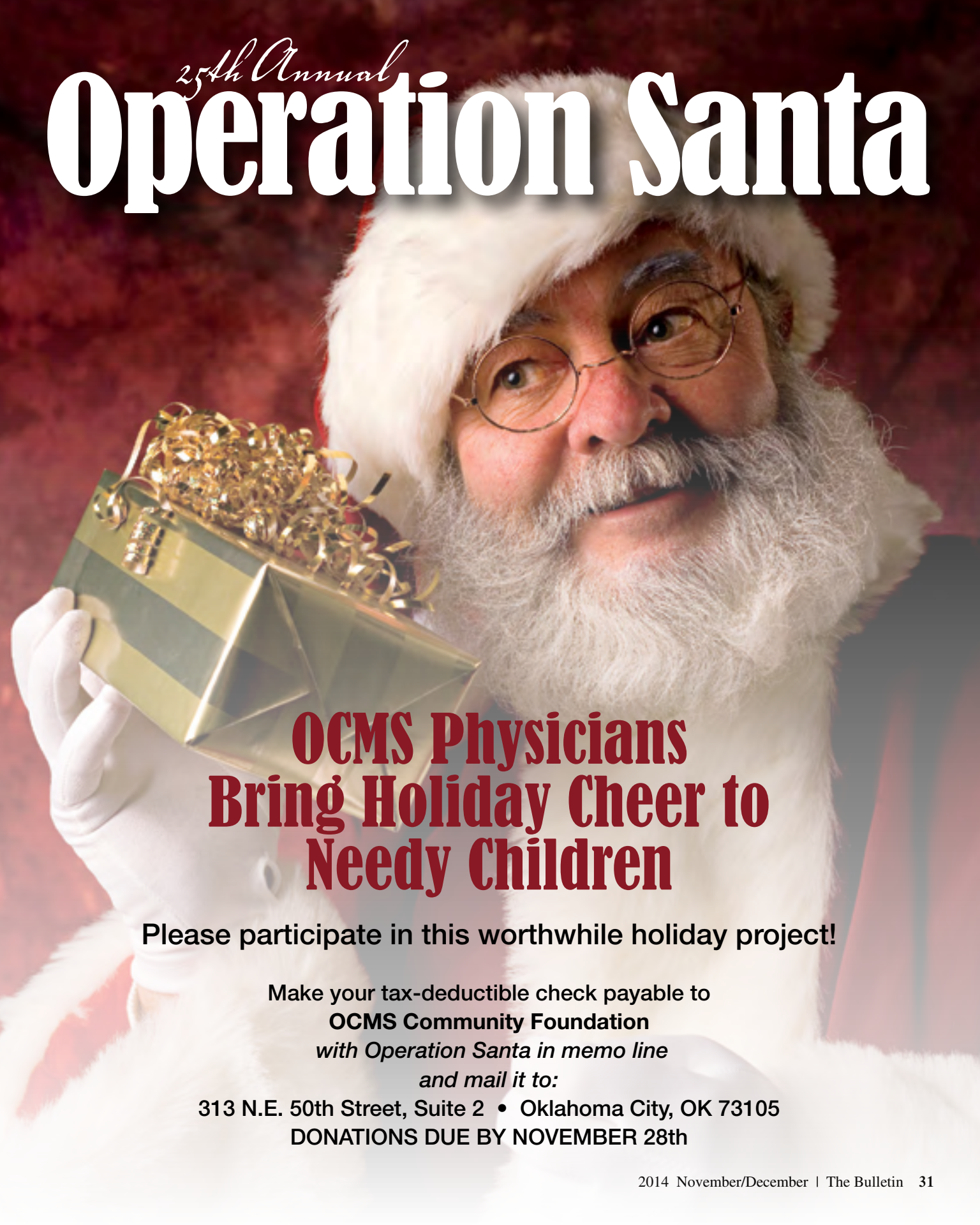
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DIRECTOR'S DIALOGUE

By Jana Timberlake, Executive Director

ANOTHER YEAR ... **WHAT HAPPENED???**

Is this year coming to a close much faster than the ones before it? Time seems to be traveling at warp speed, and sometimes I want to "stop the world so I can get off" to catch my breath! As I write this article, many good things are happening at the Society that we hope will translate into success. This year's Board of Directors has devoted many hours to define the value of this organization, and there are plans to offer additional services to our members. Dr. Julie Strebel Hager, the Executive Committee, and the Board made a commitment this year to effect change, and they have succeeded! Be sure to thank them for their work and dedication.

While the Society's leadership has governed well, I want to thank the staff for advancing the Board's goals and strategies. In some organizations, great ideas disappear into a dark hole, never to be seen or heard from again. That is not the case with our talented staff – give us a challenge and we will do our best to tackle it. It is a pleasure to work with Tracy Senat and Eldona Wright every day, and they make me a better director. I appreciate their skills, knowledge and their "can do" attitude! And thank you for giving me the opportunity to work for this incredible organization and its members. I often tell people this is the best job anyone could ask for because I work for physicians – the best and the brightest!

In this season of thanksgiving, troubling events are unfolding each day. It also seems many people discredit others – either because of race, religion, politics or sexual orientation. Is it because in order to feel better about oneself that the other person must be marginalized? Or because "they are not like me" that their attitudes and opinions are worthless? The author Michael P. Watson stated, "Strong people don't put others down...They lift them up."

I believe the greatest gift we can give our fellow man is that of respect and try my best to treat others the way I want to be treated. You know...it's a version of that Bible quote some of us learned in Sunday School: "Do to others as you would have them do to you." Every person is valuable whether rich, poor, educated or uneducated. When someone speaks, listen – they might have something interesting to say even if you don't agree. If you encounter a homeless person, be mindful not to judge because you do not know that person's circumstances.

In conclusion, I offer for reflection the following quote by Ogor Winnie Okoye, author of Awaken and Unleash Your Victor:

"The biggest piece in respecting and loving others is an acknowledgment of their individuality which makes them susceptible to views, opinions, perspectives and beliefs that may differ significantly from ours and sometimes even shake the foundation of our very own core belief systems."

Wishing everyone a beautiful holiday season that is filled with understanding and respect ...

THE POET'S SPOT

Retirement is painful, but is also necessary when we suddenly realize that we have arrived at the end of our professional journey. The whistle blows, the train stops, we dismount, we look back, we wave goodbye, then we walk away into the noble night.

By Hannah Saadah, MD

The Goodbye Sonnet

Two scores and more at sea, my time is nigh
To dock my ship and wave my last goodbye;
My morn and afternoon will sunset soon
A gentle night awaits me, and her moon.

Life does not end when we depart and fly
Our separate routes into our nights and days;
Our works live on and serve in sundry ways
Long after we have breathed our final sigh.

Life always will recycle life, and we
Are but atoms errant, much like the bee
That samples flowers on her way to hive
Where age defers to youth that comes alive.

One after one we tire and retire
Back to the hearth of life to fuel its fire.

C.diff to the Rescue, The alter-after-osis

by Cliff Wlodaver, MD

When despair sets in for lack of diagnosis —
Frustration roiling in patient, family, doctor and payor alike,
Antibiotics get called for whatever-osis —
All hope for the best,
cares to C. diff, resistance and reactions put to rest.
When successful, great —
Alas, no response.
If C. diff takes over, we're likewise grateful —
Now we've at least an alter-after–osis!

Corollary:
When to stop antibiotics no one knows,
'til the answer C. diff shows!

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