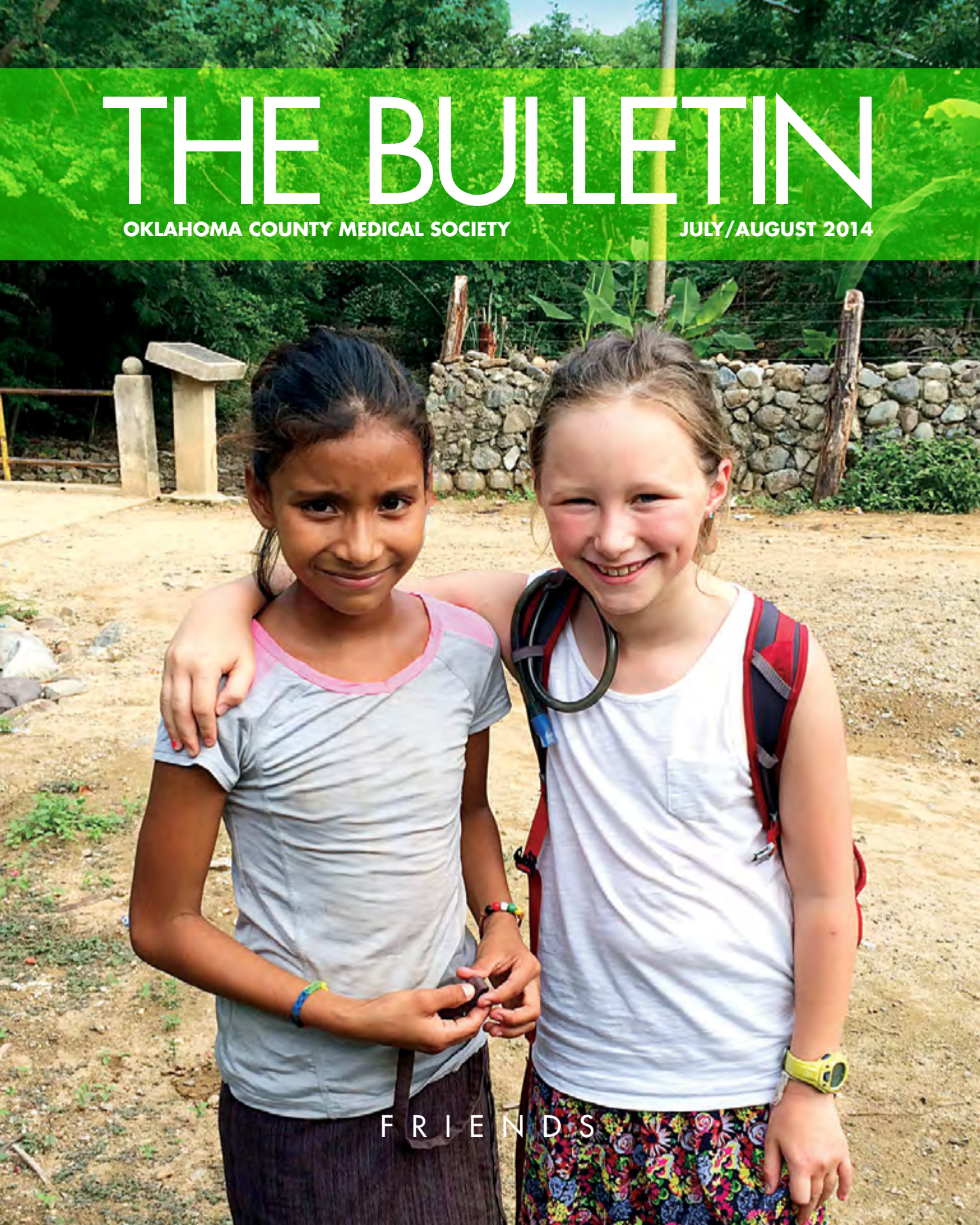
THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY JULY/AUGUST 2014



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THE BULLETIN

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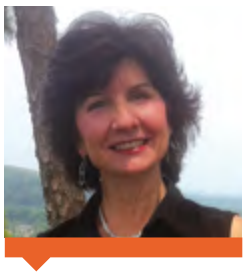

DR. LINDA WORLEY

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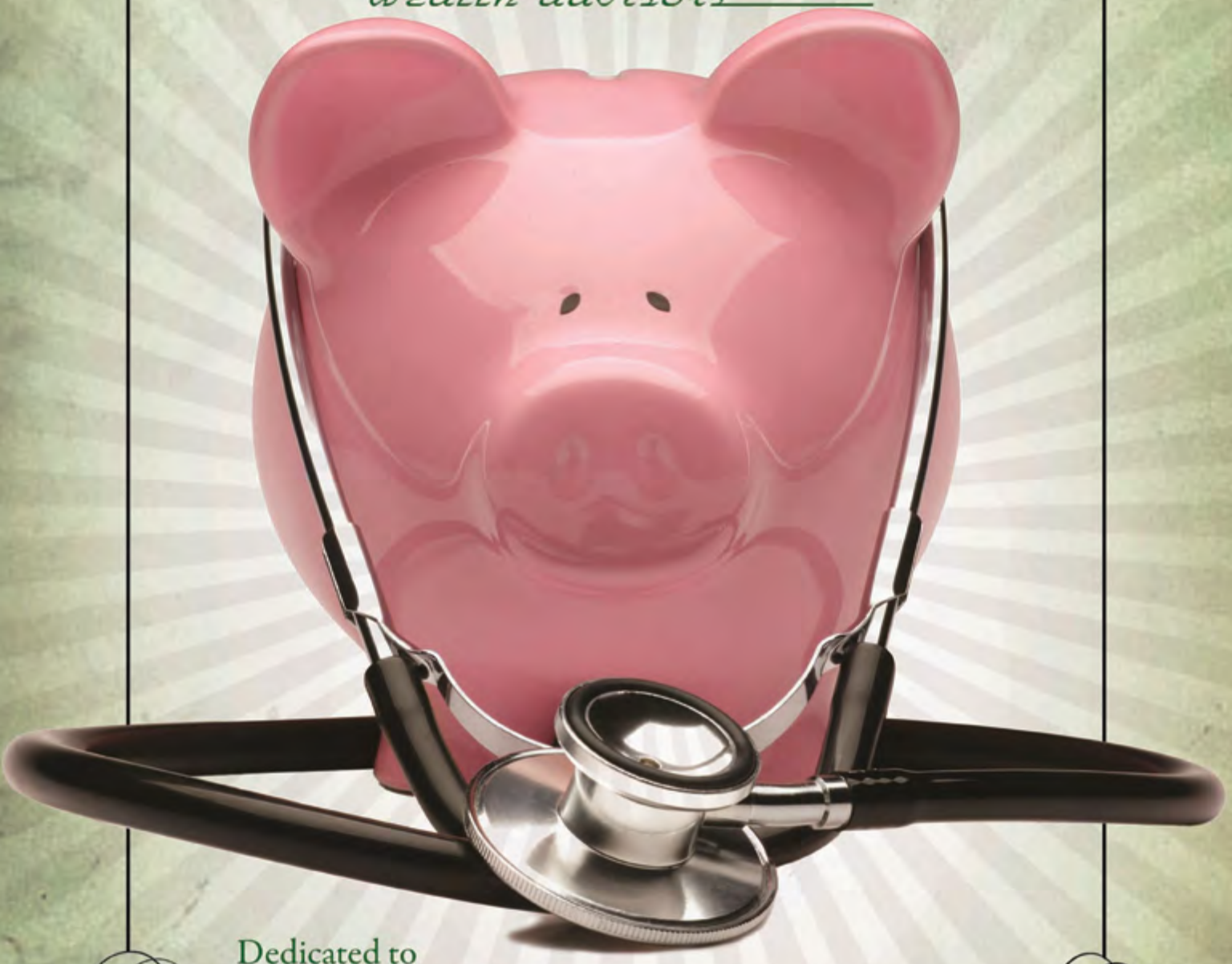
ABOUT THE COVER

A number of Oklahoma doctors spend their 'off time' on international medical trips, helping people who do not have access to appropriate medical care. Dr. Thomas Lewis, a pediatrician with OU Children's Physicians specializing in pediatric orthopedics, is one of these. Since 1999 he has traveled to Mexico, Guatemala, Honduras, Haiti, St. Vincent, Nicaragua and Uganda to serve those in need. His story, which starts on page 14, talks about his trips, what he has learned from them, and how they have helped him become a better doctor. On the cover is Dr. Lewis' daughter Emma with her new friend Xochil in Los Jobitos, Nicaragua, near the Honduran border.

IN MEMORIAM

Ralph C. Wilson, MD
1921-2014

Wilshire-Pennington
wealth advisors



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PRESIDENT'S PAGE

By Julie Strebel Hager, MD

As I write this President's Page, we have just passed the one-year remembrance of horrific tornadoes that tore through the state of Oklahoma last May. And as I recall the vivid memories from a year ago this month, it is impossible for a few examples not to stand out. Some have called it "Oklahoma Strong."

You may wonder why I have selected to write about this since this is a medical journal. The reason is simply this - this was a community crisis, a medical crisis, and rebuilding effort that included absolutely all of us.

Several communities were affected by the tornadoes of May 2013. I am most familiar with the monster that barreled over I-35 in Moore, Oklahoma. It leveled a medical center, a cinema, and countless neighborhoods. We all saw the pictures of those affected, whose lives will forever be changed. We all mourned the precious lives that were lost that spring. They will never be forgotten. What also won't be forgotten is the sense of community, responsibility, reactivity, and resilience that the individuals, medical staffs and communities nearby exhibited through that tumultuous time.

I was both fortunate and unfortunate enough to serve on a volunteer crew that went back into the Moore community on Memorial Day to search for things that were still missing that might comfort those whose lives were touched, and also to assist in the cleanup of the debris that would last for several weeks. What I saw changed me as a medical professional and as a human being for the rest of my life.

We entered three neighborhoods that were variably affected by the storms. What was common in all of them, however, was the feeling that we were all there to help. This was not about us. It was all about them. The mobile medical communities vaccinated hundreds of Oklahomans as they searched through debris. The public health workers distributed masks to protect everyone's lungs from toxic substances that lay underneath the rubble. The mental health providers canvassed neighborhoods seeking those that were quiet and might need some help - someone to talk to or even just someone to hug. Neighbors walked by with wagons of food and water and kind words that kept everyone working. It was a humbling and beautiful view of the goodness in humanity.

It is now one year later. The scenery has changed but the memories will always remain. I am amazed that occasionally someone will come to my office that I did not realize lost a home that storm season and have rebuilt or are in that process. I see photos of families that survived, some of the young ones whom I was lucky enough to witness entering the world. I recollect doctors and nurses and psychologists who answered the call when needed. These are our colleagues. These are our patients. This is our community. This is "Oklahoma Strong." And we will promise never to forget.

DEAN'S PAGE

By M. Dewayne Andrews, MD, MACP

What's happening at the College's Tulsa campus? That's a question I get asked periodically, because in fact several changes are in the works for the branch campus in Tulsa. This month I would like to provide a brief historical and future overview for you.

The College of Medicine-Tulsa was created as a branch campus of the University of Oklahoma College of Medicine in 1972, by act of the Oklahoma State Legislature, and began operations in 1974. Known as the "Tulsa option," each year up to 25 percent of the second-year class of medical students could select the option to continue their third and fourth years of medical education at the Tulsa campus. Over the past 40 years, this selection process has worked as planned: no student has ever been denied the opportunity to continue in Tulsa, nor has any student ever been forced to transfer to Tulsa. The clinical years education program in Tulsa is based in three large Tulsa community hospital systems (Hillcrest, Saint Francis, St. John) affiliated with the College, each of which also serves as the base for two or more of the College's Tulsa residency training programs.

In 2000, the Tulsa branch consolidated its operations at the newly developed OU-Tulsa Schusterman Center campus, located at 41st and Yale. By 2007, the leaders at the Tulsa campus forged a new vision for the college branch located there emphasizing "community medicine." This did not mean just primary care, rather it was all of the medical specialties represented taking a new approach to education and training focused on the community itself, especially the underserved whether rural or urban. To reflect this new vision and direction, in 2008 the University's Board of Regents officially renamed the Tulsa branch of the College the "School of Community Medicine." Significant philanthropy in Tulsa, especially the George Kaiser Family Foundation, made it possible to develop new programs and positions. Still an integral part of the College of Medicine, and operating under the College's accreditation by the LCME as an approved educational track, the School of Community Medicine (SCM) developed a plan for expanding its programs and student numbers. Initially, the concept promoted in Tulsa was to create a new, separate four-year medical school. However, for a variety of reasons it became clear that plan was probably too ambitious for the current times. Ultimately, the plan evolved to expanding the Tulsa SCM to include all four years of the College of Medicine's medical education program, including first and second year students from the start of medical school.

While all details are not yet completed, beginning in the fall of 2015 the College of Medicine admissions board will admit up to 25 students per year specifically to the Tulsa SCM program. These students will spend all four years in Tulsa, rather than spending the first

Continues on page 8 …

Continued from page 7 …

two years in Oklahoma City. The educational program will be delivered by both distance education technology and onsite faculty presence. The SCM will hire some basic science faculty in a special affiliation program with the University of Tulsa. The LCME has approved proceeding with this plan. Eventually, the SCM would like to increase its class size to 50 students per year.

While there are many more facets and details about the SCM development, this is a general summary. What does this mean for the total number of students admitted to the College? We will continue to admit 165 students per year but with the growth at the SCM that number will increase. We will keep a total of about 140 students at the Oklahoma City campus, with more of the growth occurring at the Tulsa campus in the future. Across public medical schools, we are a large medical school now when measured by the average number of students at most medical schools.

MEMBER NEWS

DOCTORS OF RECOGNITION

Gordon Deckert, MD

Gordon Deckert, MD, was recognized with a Physicians' Campaign for a Healthier Oklahoma Prevention in Practice Award by the Oklahoma State Medical Association at its annual meeting this spring. This award recognizes those who have taken a proactive leadership role and responsibility working with patients and colleagues regarding healthier lifestyle choices and improving the health of Oklahomans. Among other achievements, Dr. Deckert created the first 'State of the State's Health Report.' He also helped start Turning Point, which works with community partnerships on health improvement initiatives. Today there are more than 70 Turning Point coalitions in Oklahoma.

R. Murali Krishna, MD

R. Murali Krishna, MD, recently was recognized with a national mental health award for his efforts to educate and improve access to care. He was selected for the 2014 National Alliance on Mental Illness Exemplary Psychiatrist award. Dr. Krishna is president and COO of Integris Mental Health and the James L. Hall Jr. Center for Mind, Body and Spirit. The award is given to psychiatrists who make substantial contributions to alliance activities in their communities. Dr. Krishna was honored at a reception in New York City in May.

WITH MEDENCENTIVE, PHYSICIANS WIN

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For more information, please visit **www.medencentive.com.**

WELCOME NEW MEMBERS!

Tabitha D. Danley, DO

Tabitha D. Danley, DO, is a board-certified family medicine/obstetrics physician at St. Anthony Physicians North. She completed medical school at the West Virginia School of Medicine, an internship and residency at St. Anthony Family Medicine in family medicine and a residency at Spokane Family Medicine in obstetrics.

Andrew N. Dentino, MD

Andrew N. Dentino, MD, is a board-certified internal medicine physician with OU Physicians with a secondary specialty of geriatric medicine. He completed medical school at the Mount Sinai School of Medicine in New York, an internship and residency in internal medicine and psychiatry at West Virginia University Hospitals in Morgantown, and a fellowship in geriatric medicine at Duke University Medical Center in Durham, NC.

LOOK FOR THE OCMS ENEWS IN YOUR EMAIL!

It's a monthly email newsletter that we send to all of our members with news and information. It's short and easy to read, just right for our busy members. It is distributed in the middle of the month, so if you don't remember seeing it, please check in your spam email folder!

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Gregory G. Eppard, MD

Gregory G. Eppard, MD, is an OB/GYN at Oklahoma Laborists and Women's Services in Oklahoma City. He completed medical school at the University of North Carolina School of Medicine, and an internship and residency at Mountain Area Health Education Center in North Carolina in obstetrics/gynecology.

Brian L. Robinson, MD

Brian L. Robinson, MD, is a board-certified internal medicine physician and hospitalist at St. Anthony. He completed medical school at OU College of Medicine, and a residency at Case Western Reserve University/MetroHealth Medical Center in Cleveland, OH.

Thomas A. Singletary, MD

Thomas A. Singletary, MD, is a board-certified anesthesiologist at Integris Southwest Medical Center. He completed medical school at the University of Texas at Galveston, an internship at John Peter Smith Hospital in Fort Worth, TX, and a residency and fellowship at the University of Texas Southwestern Medical School in Dallas.

ANNOUNCEMENTS

2015 Board Nominees Announced

Nominees to stand for election on the 2015 OCMS Board of Directors are:

Position I: Deaconess/Baptist
R. Kevin Moore, MD
Troy A. Tortorici, MD

Position II: Edmond/Mercy
Mark F. Kowalski, MD
James A. Totoro, MD

Position III: OU Medical Center
Jason S. Lees, MD
Robert C. Salinas, MD

Position IV: St. Anthony
Anureet K. Bajaj, MD
Renee H. Grau, MD

The official ballot will be mailed to each OCMS voting member on or before Sept. 15, 2014. Completed ballots must be received by OCMS postmarked no later than Sept. 30, 2014.

Thank you to the members of the OCMS Nominating Committee for their work this year: Tomás P. Owens, MD; Mukesh T. Parekh, MD; Ann Parrington, MD; Apple Rice, MD; and David Teague, MD.

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PHYSICIANS PRACTICING WITHOUT STATE BORDERS:

Mutual Recognition Agreement and Interstate Medical Licensure Compact

By S. Sandy Sanbar, MD, PhD, JD

Since the late 19th century, state licensure of physicians in the U.S. has been widespread. Licensure laws were ostensibly enacted to protect the public from medical incompetence and to control the unrestrained entry into the practice of medicine that existed during the U.S. Civil War of 1861-1865. Physician licensing is controlled by both federal and state regulations. Federal standards govern medical training and testing. Federal licensing is mandatory for prescribing controlled drugs. Every state has its own licensing board(s); few states have separate boards for allopathic and osteopathic physicians. Doctors must procure a license for every state in which they practice medicine, with few exceptions: during emergencies, for physicians from bordering states, and for consultations.

In the 21st century, the physician's practice is becoming increasingly borderless. Evidence-based medical standards apply nationally. Practice guidelines for medical training are set nationally through the Accreditation Council for Graduate Medical Education, the Centers for Medicare and Medicaid Services' Graduate Medical Education standards, and the Liaison Committee on Medical Education. All U.S. physicians must pass either the United States Medical Licensure Examinations or the Comprehensive Osteopathic Medical Licensing Examination. The basic standards for initial physician licensure are uniform across states.

Specialist shortages in rural areas are endemic. Patients often travel long distances and endure lengthy waits in order to be seen by an urban specialist. To alleviate physician shortage and provide quality care to patients at their locale, mutual recognition agreements have been utilized successfully by the Veterans Administration, the U.S. military, the Public Health Service and adopted in Europe and Australia. Similar mutual recognition agreement called the Nurse Licensure Compact for registered nurses and licensed practical/vocational nurses have

been signed on to in 24 states. Mutual recognition agreements will impact telemedicine and stimulate its growth. They could potentially benefit (1) patients by lowering the cost of care, increasing access, and improving health outcomes, (2) providers by lowering administrative costs and reducing barriers to relocating and (3) payers by exerting downward price pressure on providers. Mutual recognition agreements may arguably compromise patient safety or reduce the revenues that states derive from licensure fees.

As of 2008, 18 states did not permit exemption from licensure or expedited licensure for volunteer physicians during disasters. Mutual recognition agreements would ameliorate physician shortages during public health emergencies, allow treatment by out-of state-doctors and diminish harmful disaster consequences. Out-of-state private practitioners whose license is recognized will be allowed to render voluntary aid and practice medicine without fear of potentially placing themselves at risk for civil and/or criminal penalties.

The Federation of State Medical Boards (FSMB) has endorsed and taken steps toward implementing a system of "expedited endorsement," which offers qualifying doctors a simpler and more standardized licensure application process. In January 2014, 16 U.S. senators publicly commended state medical boards and the Federation of State Medical Boards (FSMB) for attempts to streamline the licensing process for physicians who wish to practice in multiple states by proposing an Interstate Medical Licensure Compact. The latter would expedite licensure in all states participating in the Compact and ensure that physicians are under the jurisdiction of the state medical board where the patient is located at the time of a medical interaction. Participation in the Compact would be voluntary, for both states and physicians. The state medical boards would retain their licensing and disciplinary authority, but would agree to share information and processes essential to the licensing and regulation of physicians who practice across state borders.

Physicians Serving
LOCALLY AND ABROAD

A team of three Oklahoma City doctors averaged seeing about 200-250 patients a day in the rural village of Namwiwa, Uganda.

By Thomas Lewis, MD

Physicians entering practice face many different stressors related to billing, scheduling, electronic health records, office staff, etc. These virtually all serve as detractors from the main reason that many of us entered into the field of medicine - caring for people in their time of need. Throughout my medical school, residency training and now early into my practice, I have been rejuvenated by the time I have carved out to travel and serve those in need in various countries. Many of my partners at OU and colleagues in the state participate in similar efforts around the world.

Since 1999, I have been blessed to be a part of medical mission efforts in Mexico, Guatemala, Honduras, Haiti, St.Vincent, Nicaragua and Uganda. Being able to visit these places and serve these people

in desperate need continually reinvigorates my love for medicine and makes me a better doctor upon returning home. I also learn new lessons and on many occasions have been able to partner with local physicians there to teach and provide continuity for their patients.

My first trip was to San Raymundo, Guatemala, in 1999 for two weeks. This was during my senior year of college and I worked with a group from First Baptist Church in Texarkana, TX. We saw patients in general clinic/pharmacy and also set up an operating room suite with three tables and performed 10-15 surgeries a day ranging from simple ganglion cyst excisions to open cholcystectomies and hysterectomies.

I was given the opportunity to scrub into the surgical cases as an assistant and also served as a recovery nurse as the cases were completed. I gained valuable experience in starting IVs and being introduced to perioperative patient care. This experience cemented my calling to medicine and to consistently serving. I repeated this trip two more times, the last coming during my intern year of residency. I had the opportunity to apply some of the rudimentary surgical skills I had obtained and grow as a part of the team.

Later, in my fourth year of residency, I was invited to travel to Honduras with one of my mentors and attendings, Andy Sullivan. Dr. Sullivan has served with the CURE International group in several countries but by this time had built a relationship with the CURE hospital and orthopedic team in San Pedro Sula, Honduras. It was inspiring to work with him and really apply the knowledge and skill that I had been gaining over the previous four years.

Six Oklahoma physicians and their families served the physical and spiritual needs of the community of Somotillo at the Clinica Medica: Ministerios de Jesus in Nicaragua in June 2014. The team received certificates for their service during the week.

The conditions were not ideal for the OR suites but that allowed us to improvise, using our creativity and higher level problem solving. I also learned the value of teaching and developing relationships; seeing Dr. Sullivan interact with orthopedic surgeons and nurses that he had been with many times impressed upon me the value not only of the cases that we were performing but of the teaching that he was doing that would touch many more children through the hands of the local healthcare providers.

In any medical mission setting, but particularly in surgical care, being able to ensure well-educated and caring follow up for the patients is integral in providing a true service. Otherwise, we run the risk of serving only ourselves while we are there and creating the potential for complications and hardships of post-operative care that then burdens the patients.

Continues on page 16 …

In January 2014, a group of Oklahoma City doctors, attorneys and business executives partnered with their friend, Pastor Henry (unlettered), to paint a school in Jinja, Uganda.

PHYSICIANS SERVING

Continued from page 15 …

Perhaps the most memorable and educational trip I have been on was to Haiti shortly after the devastating earthquake in 2010. I was in my fellowship at the time and felt myself trained uniquely to be an asset in the areas of both adult and pediatric orthopedic trauma of which there was an abundance.

By divine intervention, I found myself in the Hôpital Sacré Coeur in Milot, Haiti, two weeks after the earthquake, taking handoff from some of the team members who had been there on the day and facing the immediate aftermath. I was joined by some truly amazing doctors, nurses and logistical personnel as we endeavored to care for the nearly 500 earthquake victims that were transported to the 35-bed hospital in northern Haiti. I learned many valuable lessons that serve me well to this day.

I employ dressing techniques in my current pediatric trauma practice that I developed during my two weeks there. My daily rounding on the 50+ patient pediatric trauma ward gave me unique insight into the daily struggles faced by kids in such a situation. I was joined in their care by amazing nurses and a physical therapist who worked tirelessly with these children as well as with the adults in the hospital. I learned that kids can really be their own best therapist and that play and laughing in the midst of pain and suffering is often the best treatment.

Dr. Lewis and his wife, Julie, visit with Keny and Maria Aguilar and their children during a trip to Los Jobitos in April 2014. Katerine Aguilar (second from right) had a right elbow reconstruction in February at OU Children's Hospital. Dr. Lewis traveled back to Nicaragua in April for a post-op visit.

Dr. Lewis with his translator, Kevin, "Thundering Up" at Masaya Volcano in Nicaragua during the NBA playoffs this spring.

Seeing the resilience of the children, many of whom were amputees or orphaned, or both, opened my eyes to how amazingly we are created; and experiencing the community that formed from parents caring for children not their own touched my heart in a way I cannot fully describe.

Now three years into my practice, I continue to travel and serve internationally. I continue to learn, grow, teach and build relationships myself as I revisit the same people and places. I am currently planning a trip with some of my travel partners for us to take our older children to Nicaragua to give them a taste of serving in a developing country.

Medical missions give me an opportunity to bless others physically and spiritually, be blessed myself by the people I meet and use the gifts that I have been given in a way that reenergizes my daily efforts at OU Children's Hospital. The parabolic principle of "to whom much is given, much is expected" is very much true and guides me in my medical service both here and abroad.

"STEWARDS OF TECHNOLOGY"

By Ryan F. Wicks, MD

The pace that medicine has advanced in the last century has been exponential. Much of the change can be attributed to new technology that has altered small strides in medical care into giant leaps. But with the revolution of an increasingly complex and hi-tech world there also arise new risks and questions that will confront the practice of medicine. As has ever been the case, physician leaders will have to push the boundaries of what is possible while acting as responsible stewards for our profession as well as the nation's wellbeing.

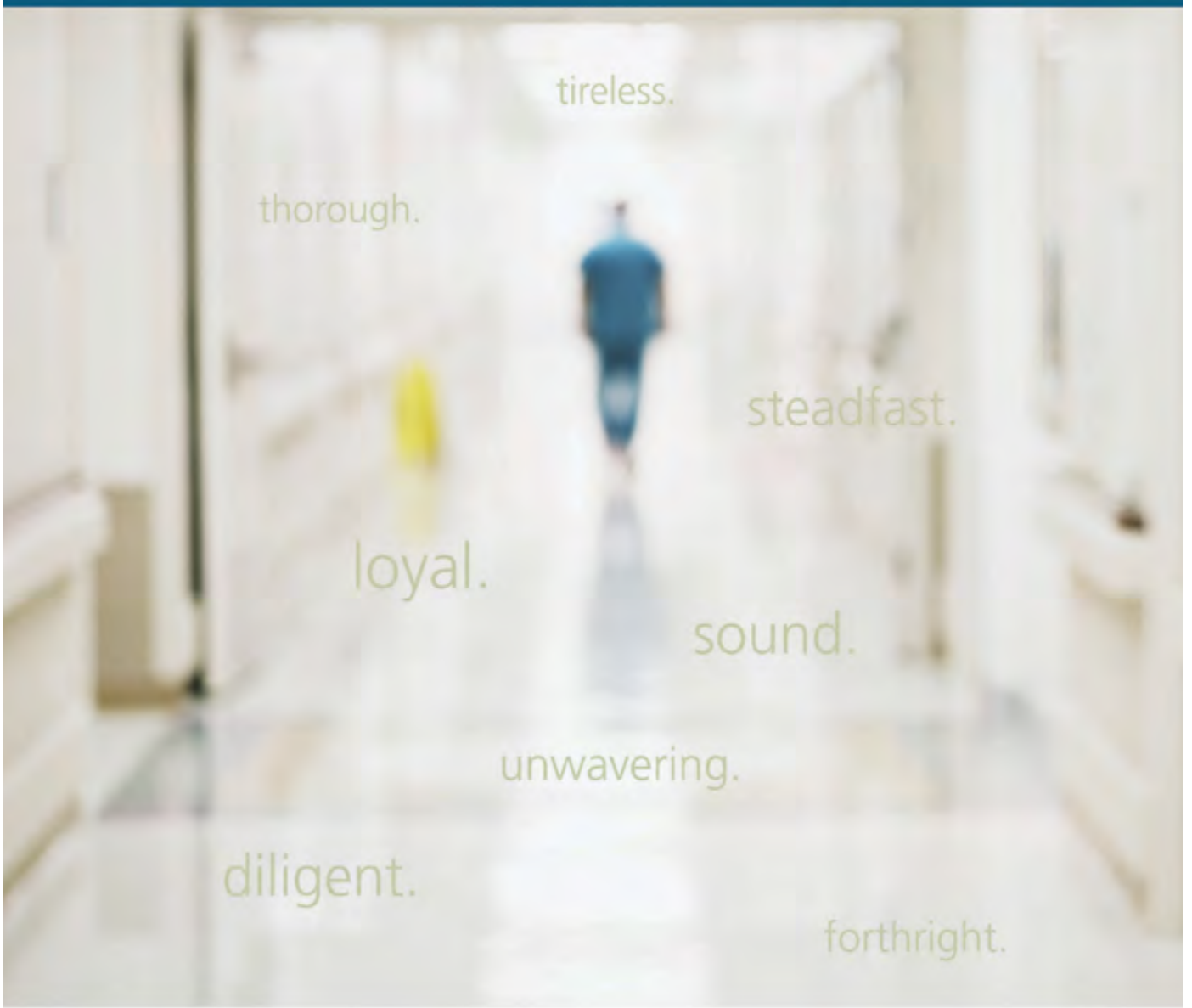
Technological advancements have led to countless steps forward in medicine. Past generations' remarkable achievements, such as the discovery of the double helix and parenteral nutrition, have yielded to laparoscopic and robotic surgery and gene targeted therapies that have not only increased patient's longevity but have greatly improved their quality of life. This is part of the reason that according to the CDC the average life expectancy in the US in 1900 was 49.24, in 1950 was 68.07, and in 2007 was 77.9.

But with these strides, new and ever-changing questions arise for both physicians and society as a whole. What if any limits should be placed on genetic research? Does the next patient really benefit from the newest gadget? Is the cost justified? If so, who should pay for it? Is there any point at which we must stop patients and the technology we've spear-headed? The physician will increasingly be asked by patients, government and society not only, "Can you do this?" but 'Should we do this?"

New technology brings new industry. While that produces millions of jobs, countless new and effective medicines and endless new instruments, it also can raise questions of conflict of interest that can tangle up physicians. New technology brings new interactions. The telephone and fax machine have given way to email and Facebook. The speed at which information can pass is measured in the nanosecond. Images can be uploaded across the state instantly. Patients in small communities can interact with great physicians hundreds of miles away. Lab results can be sent immediately via email.

But with that comes the risk of new "viruses" and hackers that can expose personal information to the world with a few clicks of the mouse. Identifying and sometimes graphic pictures can be spread to the community at large rather than a select few in a controlled and academic setting. New technology brings new cost. From tailored chemotherapy regimens to infection resistant biologic meshes for hernias the possibilities seem endless. But unfortunately those possibilities also have bottom lines that must be accounted for. It is this dual edged sword of technology that physicians are uniquely capable of and responsible for mastering safely. It is through our training and our experience that gives insight into both the good and bad of advancing technology. At our very heart we are scientists who pursue knowledge to new heights, but we take care of the human being as our greatest calling. And we all took an oath to do no harm. Physicians remain tied to each individual community and can help the overall health while keeping those values in mind.

Choose your health coverage from people who share your idea of what it means to truly, passionately want to make a difference.



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COMMUNITY FOUNDATION

Your Donations Help Those In Need!

You became a physician because you wanted to help people. And you do, every day.

You help by practicing medicine and also by supporting other community organizations that help people in need. The OCMS Community Foundation has been raising money to help community-based organizations since 1966. Last year's donations helped support a number of important programs, including:

Health Alliance for the Uninsured
Schools for Healthy Lifestyles
CARE Center
Daily Living Center
ITN Central Oklahoma
Integris Hospice
Special Care

Your generous donation to the OCMS Community Foundation by Sept. 5, 2014, will make a world of difference to those in our community who need it the most. Thanks to your support and generosity, these organizations and others will continue to touch the lives of thousands of people for years to come. Remember, every penny of your donation goes to an Oklahoma County organization and is tax-deductible.

All OCMS members will receive a letter in the mail that includes a return envelope for your donation. Or you may make a donation online at www.o-c-m-s.org/members/pay-dues/online-dues, with your donation amount in the 'OCMS Community Foundation Contribution' field. Please call 702-0500 if you have any questions. Thank you again for your generosity!

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OKLAHOMA COUNTY MEDICAL SOCIETY alliance

The 128 active members of the OCMS Alliance sponsored a number of activities beginning in the fall of 2013. These activities included:

- Fall Fashion Show
- Two boats in the Komen Paddle for the Cure
- Kitchen Tour in Nichols Hills, which raised $20,000 for the community
- New Member Reception, held jointly with OCMS
- Holiday Auction
- Assisted with Bart and Nadia Fitness and Health Fair
- Spring Luncheon at the OKC Symphony Show House

Scheduled activities for the remainder of 2014 include:

- Kitchen Tour
- Komen Paddle for the Cure, jointly with OCMS

For more information, please contact Suzanne Reynolds, OCMSA President.

Email Suzanne Reynolds Here

THE BULLETIN

THE PEARL

SPECIAL CARE FOR WOMEN WITH EPILEPSY

Divya Singhal, MD,
and
James R. Couch, MD

Epilepsy affects about 2 million people in the United States (based on CDC records) and has a 1:1 gender prevalence. However, being a woman with epilepsy brings along with it a unique set of challenges affecting various aspects of life, including menstrual cycle, choices of contraception and fertility, as well as reproduction.

Comprehensive care of women with epilepsy during their reproductive years must include effective pre-conceptional counseling and preparation for improved quality of life.

Menstrual Cycle, Epilepsy, and Fertility

The diagnosis of epilepsy and the use of antiepileptic drugs (AEDs) present women of childbearing age with many problems; both the disease and its treatment can alter the menstrual cycle and fertility. Reproductive steroid hormones can affect neuronal excitability and hence alter a woman's seizure susceptibility. Estrogen has been shown to be pro-convulsant while progesterone is anticonvulsant, resulting in cyclical monthly fluctuations in seizure control or changes at menarche, during pregnancy, at menarche and at menopause.

Catamenial epilepsy refers to a reliable pattern of seizure exacerbation (typically twofold increase) that occurs during a

particular time of menstrual cycle and is attributed to mid-cycle increase in estrogen levels. Catamenial epilepsy is more common in women with intractable epilepsy –for these women, empiric treatment with acetazolamide (along with AEDs) is recommended.

Contraception in Epilepsy

There are no contraindications to the use of non-hormonal methods of contraception in women with epilepsy (WWE). Several AEDs can reduce the efficacy of hormonal contraceptives, notably hepatic microsomal-inducing AEDs such as phenytoin, barbiturates, valproate, carbamazepine, oxcarbazepine and topiramate [dose above 200 mg/day]. Nonenzyme-inducing AEDs (lamotrigine, levetiracetam) do not alter the efficacy of combined oral contraceptive pill (OCP). It is important to note, however, that lamotrigine efficacy is decreased when taken in conjunction with hormonal birth control pills.

Highly effective contraceptive methods for WWE include intrauterine device, barrier method and IM Depot medroxyprogesterone (unaffected by concomitant AED use).

Infertility

Women with epilepsy have lower than expected fertility; multifactorial reasons include: impact of AEDs (side effects, teratogenicity), neurologic and psychiatric comorbidities (such as intellectual impairment), psychosocial issues (isolation, fear of child with epilepsy), as well as reproductive dysfunction (Polycystic ovarian syndrome affects up to 20% of WWE).

Preconception Counseling

Preconception counseling should be readily available to all women with epilepsy who are considering pregnancy. It is important that a woman with epilepsy be made aware of unique challenges relating to her future pregnancy, including methods and consequences of prenatal screening, genetics of their seizure disorder(s), teratogenicity of AEDs, folic acid and vitamin K supplements, labor, breast feeding, and childcare.

Most commonly encountered teratogenic effects of AEDs include cardiac defects, neural tube closure defects, urogenital malformations and cleft lip and palate. Incidence of these defects is 2-3 times higher in WWE compared to the general population. All WWE of childbearing age are recommended to take folic acid 1 mg daily to minimize the teratogenic effects. As the rate of teratogenicity in WWE on no AED is similar to that of the general population (2 to 3 percent), if clinically feasible, AEDs should be discontinued before a woman attempts pregnancy. However, the primary goal during pregnancy is seizure freedom as convulsive seizure places mother and fetus at risk for physical as well as cognitive injury.

Pregnancy

The lowest effective dose of the most appropriate AED should be used, with the ideal goal of monotherapy where possible. Although no antiepileptic medication is entirely safe in pregnancy, recent pregnancy databases/registries suggest that the most teratogenic drugs, in descending order, are valproate, combination of valproate sodium and lamotrigine, oxcarbamazepine and topiramate. Most pregnancies in WWE are uneventful (especially those women that have been seizure-free for one year prior to pregnancy), and most babies are delivered healthy with no increased risk of obstetric complications in women.

It is important to monitor serum AED levels during pregnancy and adjust dose to maintain seizure control. A goal is to keep the number of drugs and the dose to the minimum necessary to control the seizures.

Breastfeeding

Postpartum period is a vulnerable time for WWE due to medication alterations, disrupted sleep, increased stress of a newborn, and the challenges of breastfeeding. All women with epilepsy should be encouraged to breastfeed their babies due to benefits of child-mother bonding, improved cognition, reduced infant mortality and reduced infant infection. Impact of AEDs via breast milk on infant health and development is unknown, however, as drug elimination mechanisms are not fully developed in early infancy. Babies should be monitored for excess sedation, irritability and failure to thrive, any of which may necessitate discontinuation of breastfeeding.

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The Care of Children of Mothers With Epilepsy

Although there is much anxiety about the potential risks to a child from the mother's epilepsy, there is little published evidence. The risk of the child being harmed depends on the type and frequency of seizure, and this risk is probably small if emphasis is placed on training mothers and caregivers in safety precautions.

Menopause

During menopause, about 40% of women report worsening of their seizure disorder, 27% improve, and a third had no change. Hormone replacement therapy is significantly associated with an increase in seizure frequency during menopause, especially in women with a history of catamenial epilepsy.

Bone Health

Women with epilepsy are at increased risk of fractures, osteoporosis, and osteomalacia due to use of AEDs. Hence, Dual Energy X-ray Absorpiometry screening and considering vitamin D and/or calcium supplementation in WWE is recommended. Lamotrigine and leviteracetam may have less adverse effect on bone health than other AEDs.

Pearls for Effective Management of Women With Epilepsy

- Counseling WWE contemplating pregnancy is highly recommended, including evaluation of AED choice and dose, medication compliance
- Best contraceptive methods for WWE include intrauterine device and IM Depot medroxyprogesterone with backup of barrier methods
- Seizure freedom for at least one year prior to conception increases likelihood of seizure freedom during pregnancy
- If a patient on teratogenic AEDs becomes pregnant, changing AEDs during pregnancy can result in breakthrough seizures
- Ideally WWE should be treated with AED monotherapy during pregnancy
- Counseling physician must have knowledge of the issues to enable an honest discussion and appropriate decision-making in partnership with the patient

- Daily folate intake of 1 mg is highly recommended
- Monitoring serum AED levels during pregnancy and post-partum period is imperative due to fluctuation of levels
- Known benefits of breastfeeding should be weighed with unknown small risks of avoiding breastfeeding
- Pre-emptive education about newborn safety has a positive psychosocial impact on the expectant mother

For additional information, please refer to:

Management issues for women with epilepsy--focus on pregnancy (an evidence-based review). CL Harden et al. Epilepsia. 2009 May; 50(5):1229-55.

AUTHORS:/ References

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THE BULLETIN

THE POET'S SPOT

Only Words Are Free

By Hanna Saadah, MD

Before I come to you
Before I pretend that I do not pretend
I need to love you freely
With my words.

Most days
Words are all I have
And all I can have
With you.

But words, my love, endure
Live longer than life
Longer than death
Longer than love
So, when I love you with my words
You might reflect and say
He loves me all the way.

THE BULLETIN

A GROUNDBREAKING CASE

By David W. Foerster, MD

In the fall of 1966, one year after returning to Oklahoma City where I began my practice in plastic surgery (mostly reconstructive in those days), I received a call from a GP concerning one of his patients. He had been totally puzzled by this patient's bizarre history and request, in so much as the patient appeared to be a male, small in stature, but stated he had been born a female and since early childhood had been totally convinced that he had been born into the wrong body and was really a male!

As an adult, he took on a male name, dressed and worked as a male, but became more and more depressed over his female body, especially his breasts. He pleaded for the GP to surgically remove his breasts in order to correct this 'mistake of nature.'

After much soul searching and consultation with the Sister Administrator of Mercy Hospital, the GP was given permission to carry out such surgery. (Some GPs in those days had rather extensive surgical privileges.)

Consequently, a bilateral mastectomy was done and the patient (I will call him LH) was greatly relieved of his anxiety. Stimulated by this success, LH wanted to proceed further and have male genitalia constructed and thus be fully physically transformed. It was of this request that I was called, in the hope that I could carry out such a procedure.

In 1966, the new familiar words of 'transsexual,' 'transgender' and 'gender dysphoria' did not exist. There was nothing in the surgical literature about changing female into male genitalia. However, I did find

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in a textbook by Sir Harold Gillies (a famous British plastic surgeon) a case where he reconstructed a male soldier's lost phallus from a war injury by using a tube pedicle inside a larger tube pedicle from the abdominal skin and fat, needing multiple steps, then 'flip flopped' it onto the penile stump. After the blood supply had become established, he released the other end from the abdominal attachment, thus creating a 'neopenis.'

It seemed to me that something like this might work on LH, with the inner tube pedicle anastamosed to the female urethra and the other tube pedicle embedded in the surrounding external female genitalial tissue in order to pick up a new blood supply.

I explained this in detail to LH and told him that it would be a calculated gamble to achieve a successful outcome, as to the best of my knowledge this had never been attempted. With tears in his eyes, LH said he was willing to risk anything, even his life, to become a 'man' and no longer look upon himself as a woman. And so with his permissions, the die was cast.

The Sisters of Mercy were consulted and gave permission to proceed. The multi-stage procedure was carried out over a two-month period and (with great anxiety on my part) the final release from the abdomen was done. Lo and behold, the new phallus remained pink all the way to the free end and healed nicely.

When the catheter was eventually withdrawn, LH was able to urinate standing up, something he had always hoped to be able to do. Elation, however, was short-lived as LH developed a urinary leak at the innertube-urethral anastomatic site. He did learn that by holding finger pressure at the leak, he could still urinate standing (although a little messy). For several months he got along fairly well, but as time passed he returned wanting a better solution.

It was at this time I consulted with Dr. Charles Reynolds, a talented urologist with considerable surgical experience. Working together we were able to close the fistula and we eventually buried a firm silicone rod inside the shaft of the neopenis. LH now had the ability not only to urinate like a man, but also to function sexually. He could now go out into the 'dating' world and look for a female companion and possibly find love, something he had dreamed about but never thought possible.

To make a long story short, he did find a lovely wife, a widow who had lost two husbands. Several years later she told me that LH was by far the kindest and most considerate of all her husbands and that their sex life was most compatible and satisfying. LH was in his 40s when we began his surgeries, married in his 50s and lived into his 60s.

Other plastic surgery groups had also begun work in the area of sexual transformation in the late 1960s, including Dr. Milton Edgerton, chief of the plastic surgery department at Johns Hopkins, and Dr. Donald Laub, chief at Stanford. By the early 1970s, a society was formed of surgeons, psychiatrists, gynecologists, urologists and many other health-related professionals dedicated to the treatment of those individuals who are now known as 'transsexuals.'

Even so it was, and still to this day, difficult for some of the general public as well as religious groups to fully understand why surgical conversion is necessary and often life-saving for these desperate souls, whose suicide rate was around 50% prior to the availability of surgical conversion.

For many years, Dr. Reynolds and I, with our team members, worked on such patients, both female to male and male to female at Baptist Medical Center and later at the Oklahoma Health Sciences hospitals. Dr. Laub and I gave many teaching seminars at the annual national plastic surgery convention concerning surgical techniques including advancements and improvements.

In conclusion, thanks to LH and hundreds of other patients, conversion surgery is now an accepted procedure for qualified gender dysphoric patients and is available at many major plastic surgery centers. The suicide rate has been greatly reduced and many lives saved. To the best of my knowledge, LH was the first fully functional female to male conversion. I feel honored to have been a part of his success.

DIRECTOR'S DIALOGUE

By Jana Timberlake, Executive Director

"Leave all the afternoon for exercise and recreation, which are as necessary as reading. It will rather say more than necessary because health is worth more than learning."

~Thomas Jefferson

PADDLE FOR THE CURE

Let's get ready to paddle!!! We all know that exercise is good for both the body and mind so here's your chance to improve your physical and mental health while providing financial support to the Susan G. Komen Paddle for the Cure Central and Western Oklahoma Affiliate. This exciting event is set for Thursday, Oct. 2, on the Oklahoma River. It is a dragon boat competition that will feature teams of 20 paddlers and one drummer.

The Oklahoma County Medical Society and OCMS Alliance are recruiting physicians, spouses and friends to join their teams. The cost is $650 per team – about $31 per person. I even have some advance information that the Alliance is printing "team" t-shirts!

No excuses like "I've never rowed before" or "It's been so long since I really exercised," because prior to the event each team is allowed two 60-minute practice sessions. And with the three-month notice, this gives you ample time to begin getting ready for this competition by doing push-ups, a little weight-lifting and strengthening your legs. If you cannot participate by rowing, then consider sponsoring a member of one of these teams and attending to cheer them on!

At past events co-sponsored by the Society and the Alliance, several have commented, "This was a lot of fun. Why don't we get together more often?" So here's your chance! This is a great opportunity for both organizations to work together on a health project and maybe there will be a celebration afterwards at a nearby Bricktown restaurant.

Have I peaked your interest and your competitive spirit? If so, please send your name, phone number and email address to me: jtimberlake@o-c-m-s.org or contact the OCMS staff at 702-0500. Send your commitment today! Happy summer...

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The Oklahoma County Medical Society is sponsoring the publication of a comprehensive history of medicine in Oklahoma County. Tentatively titled Building on the Legacy, the book will be a hard-cover, well-illustrated account of the development and medical contributions to Oklahoma City, Oklahoma and the nation, covering more than 100 years.

Highlighted in the book will be medical pioneers from the founding days of Oklahoma City to current practitioners using the most high-tech, innovative techniques.

The author is Gayleen Rabakukk, an award-winning writer who is the author of Art of the Oklahoma Judicial Center. The publisher is John Compton, who has previously published medical histories in Nashville, TN; Raleigh, NC; and Charleston, SC, among others.

If you are interested in providing information for the book, please contact **John Compton at the OCMS offices, 702-0500.**

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If you would like to be a BULLETIN author, for one article or more, please let us know! You can share information on new clinical findings, business practices, or other topics you feel are important.

We look forward to hearing from you!

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