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District Visits Complete

I have finished my 12 district visits. It is during these visits where I have had an opportunity to meet the members of the South Dakota State Medical Association (SDSMA) from the various geographic regions of the state. I have been to the Hub City of Aberdeen and braved an early-season blizzard to visit Brookings. In Brookings I sat with two family physicians who completed the same residency in Idaho; drove to Rapid City just after the October blizzard and saw first-hand the death and damage that will affect the ranchers for some time. I have been to Dallas and ate at Frank’s Bar and Grill. I discovered the origins of Mobridge over lunch; met old friends in Watertown and Mitchell, and in Vermillion I was able to greet a medical pioneer who is in his mid-90’s and still loves to come to the district meetings. In Huron I ate dinner at the airport, and sadly did not see many pheasants on the trip there. I also had dinner with several legislators at the Pierre visit. I ended my visits with the Seventh District, my home district. There were many of my mentors and teachers in attendance.

The common thread to all these meetings was the chance to meet the diverse and dedicated doctors of South Dakota, who make up the SDSMA. It was a pleasure to meet them, and an honor to represent them. We were able to talk with many local newspapers at these meetings to inform your patients what the SDSMA is doing for you and for them.

Legislative Session

We are in the midst of the legislative season. As your advocate, the SDSMA either supports, monitors or opposes legislation that could impact the practice of medicine in South Dakota.

A topic list includes expanding Medicaid, the death penalty, the sale of raw milk, e-cigarettes, autism spectrum disorder, abortion, medical school expansion, loan repayment programs for rural family doctors, insurance credentialing, insurance reform, texting while driving, epinephrine pens in schools, and mental health care. Despite this list, it’s been a quieter year. The SDSMA has a great group to advocate in Pierre. Our Legislative and Executive committees continually monitor and inform leadership about the issues, and together they determine a course of action. Members can stay informed by reading the SDSMA’s weekly InSession newsletter.

Get Involved

My year as president of the SDSMA is flying by and has been a truly amazing experience. We will be choosing new leaders in the coming months.

I want to encourage you to consider becoming more active and to look for new ways to become involved in your association. The SDSMA is always looking for physicians to seek membership on our various committees. The committees develop a lot of the policies that our Council then debates and adopts. Consider becoming a Councilor or Alternate Councilor for the organization. If you are a Councilor, consider becoming an Executive Committee member or an officer. The SDSMA needs involved leaders to assure that we are patient focused and physician supportive in everything we do.

Please join your colleagues at our Annual Meeting in Rapid City May 30-31 and have some fun, make new and visit with old friends, and help us celebrate our successes.

Book Recommendations

Rocket Man: The Epic Story of the First Men on the Moon by Craig Nelson

Three Cups of Tea: One Man’s Mission to Promote Peace One School at a Time by Greg Mortenson and David Oliver Relin

Final Rounds: A Father, a Son, The Golf Journey of a Lifetime by James Dodson
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Every year on March 30 we honor our physicians with their very own day. This year, the Health Project Committee is encouraging all Alliance members to consider making a donation to the Cribs for Kids state health project in honor of a physician of their choice to celebrate Doctors’ Day. Stephanie Lehmann and Cathie Calhoon, State Health Project Committee co-chairs, explain it best:

“The Cribs for Kids program addresses the serious problem of infant mortality in South Dakota. Our infant mortality rate is higher than the national average and that of surrounding states. The Cribs for Kids program educates parents on the importance of safe sleep practices and provides cribs to families who cannot otherwise afford a safe space for their babies to sleep.”

Each Crib Kit costs only $80 and includes a Graco Pack ‘n Play crib, crib sheet, sleep sack, pacifier and a safe sleep educational message. Alliance members can donate any amount to the program in honor of a physician of their choice as a meaningful way to celebrate Doctors’ Day this year. Doctors’ names will appear in an upcoming issue of South Dakota Medicine.

Last year, the SDSMA Alliance received the first place National Health Awareness Promotion Award from the American Medical Association Alliance for our efforts in addressing the infant mortality rate in South Dakota through the Cribs for Kids program. As a State Alliance, we were able to raise $16,000 and buy over 200 Crib Kits. This year we hope to get participation from more districts and individuals as we continue to focus our efforts on decreasing unnecessary infant deaths in our state.

Honor your favorite physician in a very special way and help alleviate the problem of infant mortality in our state by sending your tax-deductible donation to Grace Wellman, 2309 S. Holt Ave., Sioux Falls, SD 57103.

Checks must be written out to South Dakota Community Foundation. In the memo, please write Cribs for Kids 718. Please remember to include the name of the physician you are honoring.

Contact Cathie Calhoon at 605.484.3105 or Stephanie Lehmann at 605.381.1567 if you have any questions. We thank you wholeheartedly in advance for your generous participation in the Cribs for Kids State Alliance health project and wish you and your doctor the very best this Doctors’ Day 2014!

Your State Health Project Chairpersons,
Cathie Calhoon and Stephanie Lehmann

As spouses and partners of physicians, we all recognize the time and dedication doctors bring to their patients and communities. This is a wonderful way to recognize them, and help correct a serious health problem in our state. All districts will benefit from this program by receiving cribs, which will be distributed to those who can best use them. I want to join Cathie and Stephanie in encouraging Alliance members to make a donation to the Alliance’s health project, Cribs for Kids in honor (or memory) of your favorite hardworking physician. The Alliance has already promoted the Cribs for Kids health project at our 2014 Day at the Legislature. On Feb. 6, several Alliance members joined with first-year medical students to serve ice cream sundaes to legislators and inform them of our Cribs for Kids project.

Last month we discussed the creation of a Political Action Committee (AMPAC) by the American Medical Association (AMA) in the early 1960s. Although it has gone through a few name changes, the South Dakota State Medical Association’s Political Action Committee was formed soon after in 1963 (SoDaPak). This month we spotlighted the fact that physicians are honored every year on their own national day of recognition, March 30. It was on March 30, way back in 1842, that a young 26-year-old doctor first used ether as an anesthetic to painlessly remove a neck tumor from a patient. Do you know the name of this caring, young physician and what year Congress first proclaimed March 30 as National Doctors’ Day?
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Scott McPherson, MD

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Measles is likely the most contagious human viral disease. Prior to the measles vaccination era, pre-1960s, measles was universal and ubiquitous. For those of us who grew up in the 1950s and early 1960s, measles was a common childhood illness of rash and fever, a menacing rite of passage.

We must never forget that in the pre-vaccination era, three per 1,000 children with measles died with respiratory and neurologic complications, and measles encephalitis caused brain damage in approximately one in every 1,000 measles cases. Fifty years ago, in the early 1960s, there were approximately a half-million cases and 500 measles deaths reported annually in the U.S. In South Dakota we experienced waves of measles with over 10,000 cases reported during peak years prior to the 1960s. Today in the developing world, where malnutrition is common and vaccination is uncommon, up to 25 percent of children with measles die and measles is a leading cause of blindness.

Measles is not a theoretical or historical threat. I had measles as a child growing up in South Dakota, as did my brothers and sisters. We all survived. My coworker’s sister had measles in 1967, developed permanent brain damage, and lives in a total-care institution to this day. In the U.S. we have had as many as 220 measles cases reported as recently as 2011, and 13 cases had already been reported as of Feb. 1, 2014.

South Dakota’s most recent measles outbreaks were in 1990 among University of South Dakota students and in 1997 in Hughes and Hyde counties. We have, however, been dodging the viral bullet for the past 17 years. In 2011, a North Dakota resident became sick with measles while staying in a Rapid City motel and received care in a local clinic. Also in 2011, a measles outbreak in a Minneapolis immigrant community exposed several South Dakota children. In 2010, a group of Sioux Falls school children were exposed to measles while on an Omaha field trip. In 2007, a group of South Dakota students were exposed to measles while attending a science fair in New Mexico. We have been lucky, but it’s not all luck. It is primarily good prevention by maintaining strong vaccination coverage.

The measles vaccine was licensed in 1963. Today South Dakotans are well immunized. Our 2-year-old children have a 93.3 percent MMR (measles, mumps, rubella) vaccination coverage rate, and our kindergarteners have a 97.9 percent MMR2 vaccination rate. Measles vaccination is required for school entry and child daycare attendance, and two MMR shots are mandated for college entry in South Dakota. However, we should not be complacent.

Some 1,100 of South Dakota’s 2-year-old children are not vaccinated, not protected, and very vulnerable. Although herd immunity partially protects our unvaccinated population, the risk of measles persists from imported cases who might expose those who are not vaccinated. During the past few days, measles cases have been reported from Texas, Massachusetts, California, Oregon, Canada, Finland, Russia, United Kingdom, Africa, Asia, Indonesia and Australia.

Some unvaccinated children are not able to be vaccinated due to medical contraindications, but the vast majority have not had the MMR shot due to parental misguidedness or negligence, or worse yet, failings of our medical and public health systems. The real menace of measles remains. We all have a responsibility to encourage, facilitate and insist on prevention by vaccination.
Your #1 Priority

Colorectal cancer is the second leading cause of cancer death in South Dakota. Yet it is one of the most treatable and preventable when caught early. Talk to your patients about the importance of getting screened.

Know the facts. getscreenedsd.org
Undifferentiated Carcinoma of Pancreas: A Rare Entity with Aggressive Behavior and Possible Genetic Link

By Kabir Ahmed, MD; Douglas Lynch, MD; Kimberlee Tams, MD; Gary Timmerman, MD; Kristin De Berg, MS; Manoop Bhutani, MD; Philip Tanner, MD; and Muslim Atiq, MD

Abstract
An aggressive undifferentiated carcinoma of pancreas is a rare tumor, especially with a strong personal and family history of malignant melanoma. Limited literature review and few case reports described a genetic association between distinct types of pancreatic cancer and malignant melanoma.

Case Report
We present an uncommon case of an aggressive undifferentiated carcinoma of the pancreas in a 50-year-old Caucasian female. Initially, she presented with intermittent epigastric postprandial pain and mild nausea. A computed tomography scan of the abdomen showed a 5 cm heterogenous pancreatic tail mass, which on biopsy was found to be a poorly differentiated non-small cell carcinoma. Past medical history included malignant melanoma, with extensive family history of pancreatic cancer and malignant melanoma. However, not genetically confirmed, a hereditary pancreatic linkage was highly suspected. A week later, repeat computed tomography demonstrated tremendous enlargement of the pancreatic tail mass. Within a few weeks, the patient developed aggressive metastasis in various organ systems, followed by multiple surgeries. An emergent first round of chemotherapy was started, followed by an intensive care unit stay, and she eventually died.

Conclusion
Our case exposes the aggressive behavior of undifferentiated carcinoma of pancreas, along with possible hereditary link between pancreatic cancer and malignant melanoma.

Introduction
Pancreatic cancer (PC) is the fourth leading cause of cancer related death in the U.S. with a five-year survival rate of only 5 percent.\textsuperscript{1} We present a unique case of an aggressive undifferentiated pancreatic carcinoma in association with personal and family history of malignant melanoma.

Case Report
A 50-year-old Caucasian female presented with intermittent epigastric postprandial pain and mild nausea for a few months. Persistent symptoms prompted gallbladder ultrasound and hepatobiliary iminodiacetic acid scan with unremarkable findings. A trial of proton pump inhibitor was started, but without much relief, followed by an esophagogastroduodenoscopy (EGD) without any significant abnormality. Persistently progressive symptoms such as nausea, vomiting and severe epigastric pain prompted a computed tomography (CT) of the abdomen, which showed a 5 cm heterogenous pancreatic tail mass, splenic vein thrombosis, and a 10 mm hepatic hypodensity area suspected for metastasis (Figure 1). An endoscopic ultrasound guided fine needle aspiration (EUS-FNA) was...
performed and showed poorly differentiated non-small cell carcinoma, positive for pankeratin, S-100, CK7, and CAM 5.2, negative for HER2/NEU, MART-1, HMB-45, CD56, HepPar-1, CK20, CD-2, and synaptophysin. CA 19-9 levels were normal. Histopathology was suggestive of undifferentiated carcinoma of pancreas (Figure 2a, 2b).

Pertinent past medical history included malignant melanoma diagnosed four-and-a-half years ago. Family history was significant for malignant melanoma in her father, uncle, cousin and PC in her paternal uncle at the age of 74. A possibility of hereditary pancreatic cancer was highly suspected, but not confirmed genetically with CDKN2A/p16 mutation testing. Genetic counseling was offered to other family members.

After a week, the patient presented with sudden onset of worsening abdominal pain. A CT scan demonstrated a large pancreatic tail mass with interval increase in size (Figure 3). An urgent exploratory laparotomy was performed with resultant distal pancreatectomy, liver biopsy, intraoperative microwave ablation of a metastatic hepatic lesion and splenectomy. Within a few weeks, the patient developed intermittent, sharp left upper quadrant pain. Repeat CT revealed ascites, a small pleural effusion, small bowel obstruction, and a large mass in the left upper quadrant, consistent with carcinomatosis.

She underwent another exploratory laparotomy, which included lysis of adhesions and resection of a recurrent large left upper quadrant tumor. An emergent first round of chemotherapy was initiated. Her intensive care stay was complicated with neutropenia, respiratory failure requiring ventilatory support and she eventually died.

Discussion

This case highlights two important aspects. First, it illustrates the aggressive nature of undifferentiated carcinoma of the pancreas. Second, it points towards a possible hereditary link between this aggressive histological grade of PC and malignant melanoma.

Association between PC and melanoma has been reported. Patients diagnosed with malignant melanoma before age 50 years have been found to have a nearly two-fold increased risk of subsequent carcinoma of the pancreas; with the greatest estimated risk in young white females. Genetic association with pancreatic cancer is well established, as Table 1.1 lists frequently associated genes in pancreatic cancer.

In 1968, Lynch and Krush first reported an association between pancreatic cancer and multiple nevi and melanoma. Later, named familial atypical multiple mole...
Two out of three asymptomatic individuals were found to have pancreatic cancer syndromes. However, there are no established guidelines as of yet to mandate screening in kindreds with hereditary pancreatic cancer. Howev er, there are no established guidelines as of yet to mandate screening in kindreds with a known CDKN2A mutation has been documented. In addition, Table 1.2 outlines the genetic syndromes associated with familial pancreatic cancer. However, there are no established guidelines as of yet to mandate screening in kindreds with hereditary pancreatic cancer syndromes.

Earlier age of onset of PC is seen in patients with familial pancreatic cancer syndromes, which makes surveillance of high-risk individuals and early aggressive surgical options, an inevitable approach. In a Dutch family with FAMMM, two out of three asymptomatic individuals were found to have pancreatic ductal adenocarcinoma on screening EUS. However, genetic testing continues to be controversial in cases of FAMMM syndrome, but high-risk individuals can be guided towards clinical research programs on screening and prevention of pancreatic cancers. In high-risk individuals with known genetic syndromes, EUS and multi detector dynamic-phase computed tomography are front-runners for screening for pancreatic cancer in clinical research.

Most pancreatic cancers associated with FAMMM syndrome are conventional ductal adenocarcinoma. Undifferentiated carcinoma of the pancreas with osteoclast-like giant cells is considered a rare variant of ductal adenocarcinomas, characterized by the presence of reactive multinucleated osteoclast-like giant cells. One case of undifferentiated carcinoma in a patient with FAMMM syndrome has been reported in a Dutch patient. Although, we do not have convincing evidence that our patient had FAMMM syndrome, the association of personal and strong family history of malignant melanoma and the aggressive nature of this undifferentiated carcinoma of the pancreas is noteworthy. Since undifferentiated carcinoma of pancreas may represent a variant of ductal adenocarcinoma, it would be interesting to note if pancreatic cancer in patients with a history of melanoma have osteoclast-like giant cell features. Furthermore, if this subset of pancreatic cancers has a more aggressive biological behavior, is not well studied.

Ideally, high-risk individuals with a family history of melanoma are carefully monitored with skin screening every six months, starting at the age of 10. Genetic testing for mutations in the CDKN2A and CDK4 genes are options to be considered. The Melanoma Genetics Consortium recommends genetic testing to be rarely performed outside of a clinical research setting; however, genetic counseling might be beneficial.

In conclusion, it is a possibility that personal and family history of melanoma could result in a more aggressive PC. Large-scale prospective studies are needed to investigate the biological behavior of PC in patients with personal and family history of melanoma. A high vigilance in suspecting pancreatic cancer and prompt need to further investigate symptoms of dyspepsia and/or abdominal pain is warranted in this subgroup of patients.
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Remember...AA&R Ask. Advise. Refer.
Hyperparathyroidism: A Rare Mediastinal Presentation of an Ectopic Adenoma

By Meredith Meyer, MSIV; Gary L. Timmerman, MD, FACS; John C. VanderWoude, MD, FACS;† and Fred C. Lovrien, MD

Abstract
The aortopulmonary window is a rare location of an ectopic parathyroid gland, but one that must be considered in persistent primary hyperparathyroidism despite previously attempted parathyroidectomy. Multiple diagnostic studies, including nuclear scans and anatomical imaging techniques, are crucial for identification of a parathyroid gland in the mediastinum and prevention of unnecessary exploratory surgical intervention. This case report presents a 55-year-old female patient with persistent hyperparathyroidism following a neck exploration and thyroidectomy for a parathyroid adenoma. Serial sestamibi scans and CT imaging over the subsequent few years were suggestive, but not diagnostic, of a mediastinal adenoma. Four years after the initial surgery, however, imaging studies identified the development of a soft tissue mass with increased uptake in the aortopulmonary window. A median sternotomy was performed at that time. An ectopic parathyroid gland was identified during surgery between the aortic arch and the bifurcation of the pulmonary artery, as demonstrated on imaging and confirmed by frozen section. Two years following the sternotomy, the patient remains symptom free with calcium and parathyroid hormone (PTH) levels within reference ranges.

Introduction
With the advent of today’s new imaging technologies including ultrasound, nuclear parathyroid scans with subtraction imaging, Spect/CT scans, MRIs and PET scans, the surgical mystique and storied skill sets required to identify the location of an abnormal parathyroid gland appear to have diminished in the last twenty five years. Preoperatively localizing parathyroid adenomas is a common (often expected) occurrence today leading to minimally invasive operative techniques (“focused parathyroidectomy”) and outpatient surgery. However, finding an elusive ectopic parathyroid gland remains a formidable endeavor requiring considerable knowledge of parathyroid embryology and migration along with deliberate and confident surgical intervention. We report a patient with persistent hypercalcemia following unsuccessful neck exploration for hyperparathyroidism.

Case Report
A 55-year-old female with a single episode of left-sided nephrolithiasis and primary hyperparathyroidism presented with persistent elevation of calcium and parathyroid hormone levels despite a neck exploration with left superior parathyroidectomy and left thyroid lobectomy performed at another facility one year prior.

At the first facility, following a single episode of left-sided nephrolithiasis, she was diagnosed with primary hyperparathyroidism with elevated urinary and serum calcium levels, elevated parathyroid hormone (PTH) levels and preoperative nuclear parathyroid imaging studies suspicious for a parathyroid adenoma in the region of the left thyroid lobe. An appropriate neck exploration was performed with intraoperative PTH sampling demonstrating higher concentrations on the left than right, and calcium levels elevated at 11 mg/dL (normal 8.4 to 10.2 mg/dL). A normal-sized left superior parathyroid gland was excised and found to be mildly hypercellular on biopsy; the left inferior parathyroid gland was not definitively found; the right superior parathyroid gland was normal; and the right inferior parathyroid gland was within thymic tissue. Thyroid tissue included two benign thyroid nodules in the left lobe, and a left thyroid lobectomy was performed at that time. The PTH level remained elevated at 77 pg/mL (normal 8-72 pg/mL) at the conclusion of the procedure, despite a complete and thorough cervical exploration. Post-operatively, it was believed the thyroid nodules likely
lead to the false-positive scan for a parathyroid adenoma in the region of the left lower thyroid lobe.

A sestamibi parathyroid scan performed at the same facility following the operation suggested a possible thoracic parathyroid gland in the left mediastinum, although this imaging did not provide a definitive diagnosis. A non-contrast CT of the chest was indeterminate. The patient continued to deny symptoms such as weakness, fatigue, depression, intellectual weariness, abdominal pain, or muscle pain. Although additional studies were recommended, at the patient’s request, care was transferred to our practice one year following the exploration.

Upon our initial visit with the patient, PTH and calcium levels were 107 pg/dL and 10.7 mg/dL, respectively. A repeat sestamibi scan was performed at that time and did not indicate any convincing evidence of a lesion with clear uptake that would definitively represent an ectopic parathyroid adenoma. Because the patient remained asymptomatic and imaging studies did not provide a clear diagnosis, the patient was advised to repeat the sestamibi scan in six months to a year and follow PTH and calcium levels every four months. Observing the patient in this manner would monitor the suspected ectopic parathyroid gland if any growth or changes occurred allowing for a definitive localization.

However, due to the patient’s concerns for cost and adequate financial coverage, follow-up was sporadic and inconsistent. At one year following our initial visit, a sestamibi parathyroid scan demonstrated the subtle increased uptake in the pretracheal region (yet remained non-diagnostic) and a thoracic CT scan failed to identify any abnormality. The patient did not return until two years later (four years from the initial surgery), where a sestamibi parathyroid scan now identified increased uptake in the pretracheal region to the left, just superior to the carina (Figure 1). A CT angiogram performed shortly afterward demonstrated a 9 mm soft tissue mass posterior and inferior to the aortic arch and superior to the

Figure 1. This sestamibi scan was performed four years after the neck exploration and two months prior to the sternotomy. It demonstrates very subtle increased uptake in the pretracheal area to the left, just superior to the carina. This is increased from the previous scan, indicating a possible ectopic mediastinal parathyroid adenoma.

Figure 2. This CT angiogram (transaxial and sagittal views) was performed four years after the neck exploration and six weeks prior to the sternotomy. It demonstrates a 9 mm mass in the aortopulmonary window correlating with increased uptake on the parathyroid scan.
bifurcation of the pulmonary artery (Figure 2). This lesion correlated with the area of increased uptake on the sestamibi scan. This correlation strongly supported the mediastinal parathyroid adenoma hypothesis. Her calcium and PTH levels had been monitored since she established care at our facility and ranged from 10.5-11.7 mg/dL and 68-136 pg/mL, respectively. She had remained symptom-free during this period.

A median sternotomy and parathyroidectomy with autotransplantation was then performed. The space between the aorta and pulmonary artery was exposed, and a 1.5 cm abnormality on the posterior aspect of the aortic arch was identified, superior to the pulmonary artery bifurcation and just right of the ligamentum arteriosum, which correlated with the preoperative scans (Figure 3).

An intraoperative 99mTc sestamibi probe indicated an uptake of 5,000 counts over the heart with the uptake in the upper mediastinum at 1,000. Counts directly over the mass were 3,000. This was consistent with a parathyroid adenoma, and it was resected (Figure 4). The specimen was sent for frozen section, with a 20 mg portion excised and retained for potential autotransplantation pending the pathology results. The frozen section confirmed a greater than 195 mg parathyroid adenoma.

With positive identification of the specimen as parathyroid gland, the remaining 20 mg portion was minced for autotransplantation in the left forearm. The small slices of parathyroid gland were inserted into an incision through the brachioradialis muscle. PTH levels were then collected at 10, 20 and 30-minute intervals and compared to the concentration immediately prior to the procedure. Levels measured 104 pg/mL, 66 pg/mL, and 52 pg/mL, respectively, as compared to 136 pg/mL before surgery.

Two years later, both her calcium and PTH levels have remained in the normal range at 9.6 mg/dL and 40 pg/mL, respectively, and she continues to be symptom free.

**Discussion**

Further diagnostic testing for ectopic parathyroid glands is crucial in patients with persistent primary hyperparathyroidism, defined as sustained hypercalcemia in the first six months following parathyroidectomy. The most common cause of persistent primary hyperparathyroidism is a missed ectopic gland.

Twenty percent of the population has an ectopic inferior parathyroid gland that may be found in the true sheath of the thymus, an intrathyroidal location, the anterior
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Steven Dean, DO, The Ohio State University Medical Center, Columbus, Ohio
Bruce Gray, DO, University Medical Center, Greenville, S.C.
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mediastinum, a submandibular location, the tracheoesophageal groove, the retroesophageal space, or the carotid sheath.1,4

Familiarity with the embryological development and descent of parathyroid glands facilitates an understanding of potential sites of ectopia.

Inferior parathyroid glands originate from the third pharyngeal pouches, along with the thymus, while the superior glands develop from the fourth branchial pouches.5,6 The latter migrate a relatively short distance during embryological development, resulting in minimal variation of final location. Superior parathyroid glands typically rest on the posterior aspect of the thyroid lobes just above the intersection of the inferior thyroid artery and recurrent laryngeal nerve in more than 80 percent of individuals.1,2,8

The inferior parathyroid glands form a complex with the thymus early in development and therefore migrate together before typically separating and resting in their final positions superior to the thymus.1 The most common presentation of inferior parathyroid glands is at the level of the inferior lobe of the thyroid, although this occurs in only half of individuals. As the thymus originates at the level of the mandibular angle and descends to the pericardium, inferior parathyroid glands may be found anywhere along this path. They are more likely to be ectopic than their superior counterparts owing to increased migration distance.3,6,9,10

When migration of the parathyroidic complex is arrested early, the inferior parathyroid glands may be found with thymic tissue above the thyroid and superior glands along the carotid sheath, above or adjacent to the carotid bifurcation, in the tracheoesophageal groove, in the retroesophageal space, or adjacent to the angle of the mandible. Ectopia above the superior parathyroid glands occurs in 1 to 2 percent of individuals.1,4,8,11,12 In 1 to 3 percent of individuals, the inferior parathyroid gland is intrathyroidal and found within the lower pole of the thyroid, with a higher frequency in hyperfunctioning glands.1

When separation of the inferior glands from the thymus is delayed, the glands descend into the anterior mediastinum, occurring in 4 to 5 percent of ectopic cases. They may be found within or adjacent to the retrosternal thymus or in contact with the innominate vein and ascending aorta, the pleura, or the pericardium.1 Approximately 5 percent of extrathyroidal ectopic parathyroid glands exist in the aortopulmonary window.11 Even more rarely, they may be found outside the thymus adjacent to the aortic arch and origin of the great vessels.1 While 70 percent of inferior glands are symmetric, this percentage decreases in cases of ectopia, such that only one gland may be ectopic.1

Though rare, extrathyroidic glands located in the mediastinum must be considered as potential adenomas.

In this case, the initial exploratory surgery demonstrated unconvincing evidence of the left inferior parathyroid gland in the expected anatomical location. Because only three glands were evident yet lab values were still elevated, it would be reasonable to infer that a fourth gland existed in a more remote location, necessitating further testing. As this case demonstrates, it is crucial to employ nuclear and anatomic imaging studies to locate a mediastinal mass and confirm it to be an ectopic parathyroid gland before performing an invasive procedure, such as a sternotomy.14

The threshold for neck exploration in removing a parathyroid adenoma is significantly lower than that of a sternotomy. Ectopic parathyroid adenomas below the aortic arch typically indicate a median sternotomy for excision, which is generally planned as a second procedure after neck exploration is unsuccessful in identifying the parathyroid adenoma. While this approach is effective, its use should be limited due to significant invasiveness and morbidity and be employed only after confirmation of the adenoma by localization studies such as MRI, sestamibi scan, or selective venous angiography.14,15

This patient’s initial imaging studies were suggestive of a mediastinal parathyroid adenoma, but not diagnostic. Due to her stable clinical presentation (contributing to her reluctance for follow up) and lack of definitive evidence on imaging, surgical intervention was not indicated, and a more conservative route of observation and monitoring was employed. After three years of monitoring at our facility, a definitive soft tissue mass in the left mediastinum was identified on CTA, which correlated with increased uptake on the parathyroid scan. At this point, we had reasonable evidence to indicate a median sternotomy was appropriate intervention to remove the adenoma and cure the patient of hyperparathyroidism.

In the U.S., more than 75 percent of patients with this disease do not present with the classical symptoms of “stones, bones, groans, and psychiatric overtones.” New guidelines published in 2009 suggest surgery for those asymptomatic patients meeting the following criteria: 1) serum calcium more than 1 mg/dL above the reference limit; 2) creatinine clearance less than 60 cc/min; 3) markedly reduced bone
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density at any site (T score less than 2.5 or fragility fracture); and 4) age less than 50 years. This patient’s only symptom included nephrolithiasis. According to the guidelines above, she qualified for parathyroid excision based on the elevation of serum calcium 1.2 mg/dL above the reference range (highest serum calcium level measured 11.7 mg/dL, with a reference range of 8.4-10.5 mg/dL).16

As this case demonstrates, a mediastinal location should be suspected in patients with primary hyperparathyroidism who undergo a negative neck exploration. It is crucial to obtain reasonable evidence of the specific location of a mediastinal parathyroid adenoma from imaging studies before performing a sternotomy due to its significantly invasive nature and associated morbidities. These studies improve the chances of a successful sternotomy and definitive cure for the patient.

† Deceased July 9, 2012.
Recently the Food and Drug Administration (FDA) reaffirmed its recommendation that health care professionals discontinue the prescribing and dispensing of medications that contain more than 325 mg of acetaminophen, citing an increased risk of severe liver injury from inadvertent overdose. In fact the statement urges pharmacists who receive a prescription for a combination product with more than 325 mg of acetaminophen per dosage unit call the prescriber and request a change. This statement comes after a January 2011 statement requesting that drug manufacturers voluntarily limit the amount of acetaminophen to no more than 325 mg in each dosage unit by Jan. 14, 2014. Over half of the drug manufacturers have complied with this request, but there are still a number of products available with more than 325 mg of acetaminophen per dosage unit.  

With the increased focus on possible acetaminophen overdose, one drug manufacturer, Zogenix, recently received FDA approval for an extended-release, single-entity hydrocodone product – Zohydro ER. The first ever FDA-approved medication of its kind, Zohydro ER is indicated for the management of pain severe enough to require daily, around-the-clock, long-term treatment with an opioid for which alternative treatment options are inadequate. The FDA approved Zohydro ER in October 2013 and Zogenix announced soon after that they expected the medication to launch in approximately four months – meaning it should hit the market soon.  

Zohydro ER comes in strengths ranging from 10-50 mg, is available only as a capsule, and is to be taken every 12 hours. Opioid-naive and opioid non-tolerant patients should start with a dose of 10 mg every 12 hours. Prescribers can then increase the dose by 10 mg every 12 hours, every three to seven days as needed to achieve adequate analgesia. The manufacturer has provided approximate oral conversion factors when transitioning a patient from another oral opioid (Table 1). When converting a patient, add up the total daily dose of the opioid, multiply that number by the appropriate conversion factor, and then divide that dose in half for administration every 12 hours.  

In clinical trials, Zohydro ER had a similar side effect profile to most opioid medications – constipation, nausea, somnolence, fatigue, headache and dizziness. Zohydro ER is contraindicated in patients with significant respiratory depression, with acute or severe bronchial asthma or hypercarbia, who have or are suspected of having paralytic ileus, or who have a known hypersensitivity to hydrocodone. In addition, Zohydro ER has a pregnancy category of C, and should be with caution in patients with severe hepatic impairment or renal impairment.  

With concerns about possible abuse and misuse, Zohydro ER is a Schedule II controlled substance under the Controlled Substances Act. This obviously means that Zohydro ER will have stricter prescribing and dispensing rules than current hydrocodone combination products, such as hydrocodone with acetaminophen, but that may become a non-issue due to the recent FDA recommendation that all hydrocodone containing products be reclassified as Schedule II medications. Zohydro ER will comply with the new labeling requirements recently approved by the FDA for all extended-release and long-acting opioid analgesics, and will complete a postmarket study to assess the known serious risks of misuse, abuse, increased sensitivity to pain, addiction, overdose, and death associated with use beyond 12 weeks.  

### Table 1 – Approximate Conversion Factors to Zohydro ER

<table>
<thead>
<tr>
<th>Prior Oral Opioid</th>
<th>Approximate Oral Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocodone</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>2</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2.67</td>
</tr>
<tr>
<td>Morphine</td>
<td>0.67</td>
</tr>
<tr>
<td>Codeine</td>
<td>0.1</td>
</tr>
</tbody>
</table>
Zohydro ER is the first of what might be several new opioid single entity opioid products that come to the market due to the increased concerns with acetaminophen toxicity and the benefits of an easier dosing schedule. Other drug manufacturers have long-acting, single-entity hydrocodone products in various stages of clinical trials, including Teva Pharmaceuticals and Egalet.6,7 Interestingly, both of those products too are expected to have abuse-deterrent technology, potentially lowering the risk of abuse. As these new products come to the market, it will be important for health care practitioners to decide exactly where they fit in the pain management toolkit.

**REFERENCES**


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Q: If the patient is present and has the capacity to make health care decisions, when does HIPAA allow a health care provider to discuss health information with the patient’s family, friends or others involved in the patient’s care or payment for care?

A: Even though HIPAA requires health care providers to protect patient privacy, in most cases, providers are permitted to communicate with the patient’s family, friends, or others involved in their care or payment for care. If the patient is present and has the capacity to make health care decisions, a health care provider may discuss the patient’s health information with a family member, friend or other person if the patient agrees or, when given the opportunity, does not object. A health care provider may also share information with these persons if, using their professional judgment, he or she decides the patient does not object. In either case, the health care provider may share or discuss only the information that the person involved needs to know about the patient’s care or payment for care.

Q: If the patient is not present or is incapacitated, may a health care provider still share the patient’s health information with family, friends or others involved in the patient’s care or payment for care?

A: In short, yes. If the patient is not present or is incapacitated, a health care provider may share the patient’s information with family, friends, or others as long as the health care provider determines, based on their professional judgment, that it is in the best interest of the patient. Of note, when someone other than a friend or family member is involved, the health care provider must be reasonably sure that the patient asked the person to be involved in his or her care or payment of care, and the health care provider may discuss only the information that the person involved needs to know about the patient’s care or payment. To be further noted, a health care provider cannot tell a family member, friend or other person about a past medical problem that is unrelated to the patient’s current condition.

It is important for health care providers to know that while they are allowed to share patient information in certain situations when the patient is not present or is incapacitated, health care providers are not required by HIPAA to share the patient’s information, and can choose to wait until the patient has an opportunity to agree to the disclosure.

Generally, parents of a minor or the guardian of a minor or adult are deemed to be “personal representatives” of the patient; however, the HIPAA privacy rules provide for situations wherein parents or guardians do not have a right of access to the protected health information of un-emancipated minors. Specifically, when a minor has authority to act for himself without parental consent, the minor may direct the protected health information be withheld from a parent or guardian. For example, if a minor seeks an abortion without parental consent (which may be permitted with a court order), and if the patient asks that a parent or guardian not be informed, the health care provider may withhold the information from the parent or guardian.

Additionally, a health care provider may elect not to disclose information if the health care provider believes the patient has been or may be subject to domestic violence, abuse or neglect.

Psychotherapy notes are also subject to the written authorization requirements for use other than treatment of the patient.

Q: Does HIPAA require a health care provider document a patient’s decision to allow the provider to share his or her health information with a family member, friend or other person involved in the patient’s care or payment of care?

A: No. HIPAA does not require that a health care provider document the patient’s agreement or lack of objection. However, a health care provider is free to obtain or document the patient’s agreement, or lack of objection in writing, if he or she prefers.
Congress recently enacted two changes to estate tax laws that can make life easier. The first increases the "exemption amount." In 2014, individuals can now transfer $5.34 million without triggering estate tax. Married couples, using both spouses' exemptions, can potentially transfer $10.68 million. The Congressional Research Service predicts this change should limit estate tax liability to only the wealthiest 0.14 percent of Americans\(^1\), but this assumes the remaining 99.86 percent plan properly.

The new law effectively creates three tiers of estate plans. Estates under the single exemption amount ($5.34 million) should be able to avoid federal taxes fairly easily. Those over twice the exemption amount ($10.68 million) will likely always face a hefty estate tax. Those in between have real planning opportunities because with work, they can significantly reduce federal estate taxes.

Consider a married couple, John and Sharon, each owning $4 million of assets. Their plan is simple – whoever dies first gives everything to the surviving spouse, and when the survivor later dies, the children inherit everything. Unfortunately, this very common plan creates a tax trap.

If John dies and leaves his $4 million outright to Sharon, his estate will incur no tax because the law allows unlimited transfers between spouses. Later when Sharon dies, her estate will have $8 million (her $4 million plus the $4 million she received from John). However, she has only her $5.34 million exemption so of the $8 million estate, $2.66 million will be taxed. The effective estate tax rate is 40 percent so she will end up paying over $1 million in tax.

With a little planning the couple could eliminate this tax. Historically, estate planners did so by creating a “bypass,” or family trust. So, instead of giving Sharon outright ownership of the assets, John’s $4 million is placed in trust which helps support Sharon while she lives and is later distributed to their children at Sharon’s death. John’s $4 million transfer to the trust triggers no tax because he has his $5.43 million exemption.

Later when Sharon dies, John’s trust assets bypass Sharon’s estate because she technically never owned them. Her estate transfers her $4 million to the children free of tax using her $5.34 million exemption, and the children receive the full $8 million without triggering estate tax. The trust structure might be cumbersome, but by utilizing both exemption amounts it saves $1 million in tax.

The other change Congress made grants “portability” which gives surviving spouses access to their deceased spouse’s unused exemption amount. In our case using portability, John could avoid the trust structure. Instead, Sharon receives John’s assets (without tax as part of that unlimited spousal transfer). At her later death, all $8 million are included in Sharon’s estate but she can utilize both her exemption and John’s unused exemption. No tax is due because the $8 million estate now has $10.68 million of exemption available.

Portability is a great tool providing estate tax savings and simplicity, but it requires some careful planning. A timely-filed election must be made on IRS form 706 at the death of the first spouse. There are other technical aspects to consider. Regardless of your wealth level today, you should strongly consider meeting with your attorney to re-evaluate your estate plan and explore if you might benefit from portability.


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The information and material provided in this article is for informational purposes and is intended to be educational in nature. We recommend that individuals consult with a professional advisor familiar with their particular situation for advice concerning specific investment, accounting, tax and legal matters before taking any action.
Few cancers are preventable. Screening efforts for most cancers concentrate on early detection to begin treatment. Colorectal cancer screening tests can be grouped as cancer prevention or cancer detection tests. CRC screening, specifically colonoscopy, is one of the few screens that can detect precancerous lesions and polyps thus preventing cancer.

In South Dakota, colorectal cancer is the third most common type of cancer. HEDIS data from 2011 indicated that nearly 54 percent of South Dakotans over 50 years of age had not been screened for CRC. A recent study of South Dakota providers suggested some screening practices were inconsistent with current guidelines.

Colorectal cancer screening guidelines have been endorsed by the American Cancer Society, the National Colorectal Cancer Roundtable, the U.S. Preventive Services Task Force, the American College of Gastroenterology and others. While there are subtle differences among guidelines, major components are congruent. The U.S. Preventive Services Task Force recommends three tests for CRC screening: colonoscopy, stools tests including fecal occult blood test (FOBT) or fecal immunochemical test (FIT), or sigmoidoscopy. Guidelines are consistent with those of the other agencies.

**Cancer Prevention**

Cancer prevention tests should be offered first. For people with no significant risk factors, colonoscopy is recommended starting at 50 years of age, though evidence suggests that age 45 may be appropriate for African Americans. Colonoscopy screening is no longer recommended for those over age 80 unless there are specific indications for an individual.

**Cancer Detection**

If a person declines colonoscopy; the preferred detection test is the FIT test since it is specific to human hemoglobin while guaiac-based tests react to all hemoglobin, including that resulting from digestion of red meat. While it is slightly more expensive than a number of the FOBTs, it is more specific with fewer false positives. Patient adherence with FIT has been reported to be higher than FOBT, but that may be due to the dietary and medication restrictions required by FOBT. FOBT is recommended as a screening, but modern, high-sensitivity forms of guaiac-based tests should be used such as Hemoccult Sena. Older tests such as Hemoccult II are no longer recommended. Both FIT and FOBT samples should be collected at home. FIT and FOBT should be used annually. Positive tests should be followed by a colonoscopy.

Flexible sigmoidoscopy remains an option for those patients who decline colonoscopy or for whom colonoscopy is unavailable or not feasible. This and other options such as computed tomography, CT and colonography should be offered every five to 10 years.

Digital rectal examination guaiac testing is no longer recommended. Studies have shown that guaiac-based FOBT obtained on a single specimen obtained during an office visit may miss up to 95 percent of cancers and adenomas.

**Presenting Options**

The American College of Gastroenterology recommends clinicians use a “preferred” strategy rather than providing a “menu of options.” Use of preferred strategies can shorten and simplify discussions with patients and may increase the likelihood of the patient consenting to screening. It is important to check with insurance companies for proper coding of procedures to assure screening colonoscopies, even those resulting in diagnostic procedures, are reimbursted appropriately.

**Other Considerations**

Screening for risk factors that increase risks of CRC including heavy cigarette smoking, obesity and family history is important. People with first-degree relatives with CRC or advanced adenoma diagnosed at an age less than 60 years should be screened every five years beginning at age 40, or 10 years younger than the age at diagnoses of the youngest affected relative. Those with a family history of familial adenomatous polyposis or hereditary non-polyposis cancer should undergo additional testing, genetic counseling and genetic testing.

March is colorectal cancer screening month, a good time to review evidence-based guidelines. Diligence is required throughout the year to increase CRC screening rates and to prevent colorectal cancer in South Dakota.

**REFERENCES**

Please note: Due to limited space, we are unable to list all references. You may contact South Dakota Medicine at 605.336.1965 for a complete listing.

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“Quality Focus” is a monthly feature presented by SDFM, South Dakota’s Quality Improvement Organization. For more information about the SDFM, visit their website at www.sdfmc.org or SDSMA’s website at www.sdsmca.org.
SDBMOE Board News

By Margaret B. Hansen, PA-C, MPAS, Executive Director
South Dakota Board of Medical and Osteopathic Examiners

SDBMOE Member Update
Gov. Dennis Daugaard has re-appointed Mary S. Carpenter, MD, and appointed Laurie B. Landeen, MD, and Ms. Deborah Bowman for three-year terms as members to the Board of Medical and Osteopathic Examiners.

Renewal Cycle for South Dakota Medical Licenses Continues Until March
If you are experiencing difficulties with your online renewal application, please contact the SDBMOE staff for assistance. The staff is also collecting feedback regarding the renewal application in an effort to make improvements in the future. The following information was published in last month’s article and is being reprinted as it contains helpful renewal material.

The South Dakota Board of Medical and Osteopathic Examiners (SDBMOE) is requesting additional data with licensure renewal applications this year. This effort is part of a state and nationwide effort to identify information about health care professionals including academic training history, where and what services are provided to patients as well as other demographic information. Gov. Dennis Daugaard made improving the availability of health care providers in rural South Dakota a key provision of his South Dakota Workforce Initiative (SD WINS). This effort has been approved by the South Dakota Legislature.

A recent Associated Press story also highlights the problem in South Dakota. Nineteen of South Dakota’s 66 counties lack a primary care physician. Information gathered by the SDBMOE from the new questions on the renewal applications may provide assistance in determining how effective the rural recruitment efforts have been, and how to adjust those efforts to meet anticipated needs. The SDBMOE will ask the questions of all their regulated professions to provide a more detailed look at which health care personnel are available to serve the needs of South Dakotans.

Frequently Asked Questions (FAQ) that the Board Staff is fielding this year:

Q: You already have my medical school information. Why do you need it again?
A: The academic training information is not yet available in an electronic format; therefore, for this year, licensees will need to provide the month and year of completion for medical school and post graduate training.

Q: How do I answer the “how many weeks worked” question?
A: Use the actual number of weeks worked. For example, if you took two weeks of vacation, the answer would be 50 weeks.

Q: The “Please provide more details…” box comes up after one of my answers. If I made a mistake, can I type: “I hit the incorrect answer” in the explanation field?
A: Yes, that would be an appropriate response. If more details are needed for this or any other explanation, you will be contacted.

Q: The individuals that I supervise are not correctly listed. What do I do to change this?
A: Please send an email with the necessary corrections and the board staff will assist you. You can see who you are supervising at any time by doing a Licensee Look-Up on the Board website.

Q: Why are you only asking about the American Board of Medical Specialties (ABMS) board certification? Shouldn’t the American Osteopathic Board (AOA) certification be asked as well?
A: At this time, only the ABMS is being requested as it is the only board certification organization mentioned in the South Dakota medical practices act. Also, this question was already part of the information technology (IT) system so it was relatively easy to include in the renewal application. Next year the ability to ask about AOA certification may be available.

REFERENCES
2. SDCL 34-12G.
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Clinical Trials: The Days of Whine and Roses

By E. Paul Amundson, MD, DAKOTACARE
Chief Medical Officer; and Jacque Cole, RN, MS, CNOR, CPHQ,
CMCN, CHC, Director of Compliance and Quality

As I’m sure you are well aware, the Patient Protection and Affordable Care Act (PPACA) has changed, and will continue to change, the health care payment landscape. One of the many less-understood areas is how costs for patients who are part of a clinical trial will be covered by private (i.e., not Medicare or Medicaid) health plans. At times there has been a difference of opinion on which costs should be covered by a health plan versus responsibility of the sponsoring research body. To add further confusion, an individual’s plan benefit structure (grandfathered versus non-grandfathered status) now will play a bigger part in determining what is/isn’t covered. This year will be confusing as there will be much overlap in this area. Below is our attempt to briefly explain this matter to all physicians.

An important provision [Section 10103(c)] of PPACA enacts requirements on group health plans and health insurance issuers offering individual or group health insurance products to provide for coverage of routine patient costs associated with approved clinical trials. The provision, a new section 2709 of the Public Health Service Act, provides as follows:

a. Prohibition on denials of coverage and/or on discrimination.
b. Defines a “qualified individual” under the law as an individual who is enrolled or participating in a health plan or coverage and who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition.
c. Defines the term “routine patient costs.” This is a very important point to fully understand. With some important exceptions, routine patient costs generally include all items and services consistent with the coverage provided under the plan (or coverage) for a qualified individual who is not enrolled in a clinical trial. However, costs associated with the following are excluded from that definition; therefore, the plan is not required under federal law to pay for the following:

1. The cost of the investigational item, device or service.
2. The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management.
3. The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

A few additional key definitions:

Approved Clinical Trial is defined in the statute as a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition (please note this limitation) and is one of the following:

1. A federally funded or approved trial.
2. A clinical trial conducted under a Food & Drug Administration (FDA) investigational new drug application.
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Life-Threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Routine Care Costs is too lengthy to fully describe in this brief article. There are many inclusions and exceptions, so please review the references listed below or contact us directly at 605.334.4000.

In summary, we are asking that you study this matter in more depth if it applies to the care you provide to patients. DAKOTACARE has developed a Medical Coverage Policy to review all requests for coverage within the above-defined rules for clinical trials.

Claim Filing Note: If you submit claims for members participating in any clinical research trial, please utilize ICD Code V70.7 to facilitate proper payment.

REFERENCES

1. SEC. 2709. [42 U.S.C. 300gg–8] COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.
2. Compilation of Title XXVII-Public Health Services Act (and Related Provisions) (As Amended through May 1, 2010) pages 23 through 26
4. Compilation of Patient Protection And Affordable Care Act (As Amended through May 1, 2010) (pages 52 to 54)

General References:

1. Listing of Clinical Trials and Patient Resources
   a. Website: www.clinicaltrials.gov
2. Clinical Trials Guidance Documents
   a. Website: www.fda.gov/RegulatoryInformation/Guidances/ucm122046.htm
3. FDA Drug Approval and Clinical Trials
Exhenuating Circumstances

William Osler and Stonewall Jackson:
A Footnote to History

By Henry Travers, MD, FACP

In April 1913, Dr. Sir William Osler, then a baronet and Regius Professor of Medicine at Oxford University, presented the Silliman lectures on the history of medicine for a lay audience at Yale University. Osler, perhaps the best known physician of the past 150 years, was an internationally heralded historian whose lectureship complemented previous years’ presentations by physician Charles Sherrington, physicist Ernest Rutherford and chemist Svante Arrhenius. Osler’s Silliman lectures were set in type and the galleys sent to Osler for revision, but World War I and the death in Flanders of his son, Revere, in 1917 overtook his energies and he died in 1919 without finishing the revisions. The incomplete galleys were edited by Dr. Fielding Garrison, Dr. Harvey Cushing and others, and The Evolution of Modern Medicine was posthumously published in 1921.1

The book traced the history of medicine from ancient times through triumphs in Cuba and Panama by Leonard Wood and Walter Reed over malaria and yellow fever. The text contained a six-page section on “Astrology and Divination” in which Osler illustrated the impact of astrology on medieval medical practice with the title page of Culpepper’s 1658 treatise, An Astrological Judgment of Diseases, and detailed astrology’s effect on medical prognostication.

Within this section was a startling footnote, a footnote that seemed oddly out of place in comparison to other footnotes in the text. Typically, Osler’s footnotes were immediately related to his topic and were usually quotations, poems or suggestions for additional reading. Footnotes added by editors were declared as such. This remarkable footnote, in contrast, presented – as fact – a strange story about a famous Confederate general who died two months before Osler’s 14th birthday. Adding to the footnote’s intrigue, the story’s author and Osler’s son were respectively grandson and great-great grandson of Revolutionary War hero Paul Reveres.

The footnote began an historical odyssey through three questions. First, was it Osler who wrote it? Second, was the story true? And finally, if the story was not true, what compelled its author to tell it?

The Footnote

The opening sentence of the footnote reads: “It is not generally known that Stonewall Jackson practiced astrology.” The footnote quotes Keel and Saddle, a book written in 1872 by Joseph Warren Revere, a grandson of Paul Revere. Revere had served 20 years in the Navy until 1850 and then spent two years as a colonel in the Mexican army. Returning from military service in Mexico, Revere related meeting Lieutenant Thomas J. Jackson on a steamer bound from New Orleans in early 1852. Over a two day period, the two men spent considerable time discussing metaphysics. As part of their conversation quoted by Revere in detail was this summary of Jackson’s astrologic philosophy: “Not a living being, not even a flower, but has its patron and guide on high in one of those orbs suspended in ether.” The two men parted at Pittsburg, Mississippi, with Jackson promising Revere a horoscope. The latter, according to Revere, was duly conveyed by letter after a few months and contained an ominous prediction: “It is clear to me that we shall both be exposed to a common danger at the time indicated.” The “time indicated” by Jackson’s calculations: May 1863.

Later in Keel and Saddle is an account of a May 2, 1863 incident on the Chancellorsville battlefield in which Revere, then a Brigadier General commanding the Excelsior Brigade, described following on horseback the sounds of musketry, encountering a riderless horse, and coming upon a badly wounded Confederate soldier surrounded by several officers.

The footnote ends with the following sentence: “At the battle of Chancellorsville, May 2, 1863, Revere saw Jackson mortally wounded!”

Did the Footnote Originate with Osler?

Beyond the observation of features distinguishing this footnote from others (it was not temporally related to the subject matter; it added nothing to understanding an historical topic), it appears that Osler had only a passing familiarity with the American Civil War. There is no evidence, at least in Osler’s writings, of an interest in American military topics other than some aspects of military medicine.
That is not to say that the Osler household library had no volumes on the subject. The footnote’s source was the second cousin of Osler’s wife, Grace Revere Osler (Grace’s grandfather and General Revere’s father were brothers), so it is conceivable that a copy of Keel and Saddle had its place in the family library. Bolstering this possibility is the reported deep interest of Lady Osler’s father in the Civil War and the gift of a copy of Keel and Saddle to George Brigham Revere, her father’s distant cousin.

It seems unlikely, however, that Osler would have used Revere’s book either in preparation for a series of lectures on medical history or during his editing of the galley proofs, since the subject of the footnote is completely at odds with the lectures’ content. Could Lady Osler herself, after her husband’s death, have added the footnote to the unfinished galleys, an anecdote in praise of her second cousin? While Lady Osler helped organize Osler’s library after his death, she was not an active participant in his writings, nor was there mention of her assistance in Garrison’s introduction to The Evolution of Modern Medicine.

The only other possible source of the footnote was the editors. Fielding Garrison, the lead editor, was a colonel in the Army, a physician who became an historian and librarian at the Army Medical Library, the forerunner of the National Library of Medicine. Garrison was a close friend of John Shaw Billings, himself an internationally known bibliophile, who was “warmly attached” to Hunter McGuire, Stonewall Jackson’s surgeon. While Osler knew Billings and wrote fondly of him after his death, Billings did not discuss much of his Civil War experiences outside a circle of colleagues who had shared it. His close collaboration with fellow army officer Garrison, however, very likely permitted the discussion of such experiences. While it seems more plausible that the footnote was inserted by Garrison rather than Osler, it is surprising that Garrison would have uncritically accepted it as established fact.

**Was the Story True?**

Revere’s account of the events surrounding Jackson’s death contained a quotation from the Richmond Enquirer of May 12, 1863 which he reported seeing two weeks after the events at Chancellorsville. The newspaper article, a description of Jackson’s wounding and death, mentioned an unknown horseman in the clearing where Jackson lay wounded. Together with his own recollections, Revere, in his book, concluded: “These left no doubt in my own mind that the person I had seen lying on the ground was that officer [Stonewall Jackson], and that his singular prediction – mentioned previously in these pages – had been verified.”

On the page following this statement, Revere paradoxically appeared to disavow astrologic predictions, observing: “Jackson’s death happened in strange coincidence with his horoscopic prediction made years before: but the coincidence was, I believe, merely fortuitous; and I mention it here only to show what mysterious ‘givings-out’ we sometimes experience in life.”

Some authors, contemporaneous with General Revere, accepted the account as true or, at least, did not question it. Sarah Randolph’s biography of Jackson records the Revere tale as “too curious and too authentic to be omitted from a life of Jackson...” Nonetheless, aside from her biography and one or two book reviews in 1873, Revere’s story of Jackson does not seem to have gained much historical traction and is today repeated most often in quotations of Osler’s work. It does not appear in any of several biographies of Jackson.

In 1873, retired Confederate General Jubal A. Early published a refutation of Revere’s story. Early produced a letter from General Francis H. Smith, superintendent of the Virginia Military Institute (VMI) who, then a colonel, invited Stonewall Jackson to join the VMI faculty as professor of natural and experimental philosophy and artillery tactics. Smith confirmed that, at the time of Revere’s alleged encounter with Lieutenant Thomas J. Jackson, Stonewall Jackson was an active member of the faculty of VMI and that Jackson did not travel further south than Charlotte, North Carolina until the commencement of the Civil War in April 1861.

With respect to the scene of Jackson’s shooting, Early provided eyewitness documentation that only two individuals attended the fallen Jackson, not the group of “several persons” reported by Revere. The eyewitness, R.E. Wilbourn, pointed out that the Richmond Enquirer story was “…changed, however, so as to make it appear more like a romance than reality.” Of the lone horseman mentioned by Revere, found in newspaper accounts, and as part of his own official report, Wilbourn said he appeared to be a courier and Wilbourn directed him to investigate the identity of Confederate troops in the vicinity. The man rode off with these instructions and his identity was never determined.

Regarding Jackson’s belief in astrology, neither Early nor contemporary Jackson biographer Robert Dabney reported any evidence that the devoutly Presbyterian Stonewall Jackson harbored beliefs in astrology. Smith, writing to Early, stated: “I never heard General Jackson allude to astrology, nor have I been able to find any one among his former associates who had.”

William Chemerka’s recent biography of General Revere mentions Early’s critique. He agreed with Early that Revere was “mistaken” in both the 1852 encounter on the...
Mississippi and in the Wilderness at the Battle of Chancellorsville in 1863, but declined to suggest the mistakes were intentional. Chemerka mentioned the possibility, found in Early’s refutation, that the “Jackson” Revere encountered at New Orleans was Lieutenant Thomas K. Jackson, an army officer who graduated from West Point two years after Stonewall Jackson. The 1852 letter from Jackson to Revere is not referenced in Chemerka’s exhaustively researched book and Mr. Chemerka did not find it during his research.

Why Would Revere Have Written This Account?

After the battle of Chancellorsville Revere was court-marshaled for marching his command “an unnecessary distance to the rear” while it was engaged with the enemy. He was found guilty of the specification, but not of the specific charge itself (misbehavior before the enemy). He was also found guilty of “conduct to the prejudice of good order and military discipline.” The court sentenced him to be dismissed from the military service of the U.S. and on Aug. 10, 1863, by General Order 282 of the War Department, the sentence was carried out.

The court’s judgment was controversial. Revere supporters harshly criticized the factual findings of the court marshal and the legality of its proceedings, and in spite of his limited abilities as a commander of a large field force, testified to Revere’s virtues as a soldier. Revere himself wrote a lengthy rebuttal. Many of those who fought in the campaign, though, were inclined to agree with the court. In a history of the Excelsior Brigade, Sutherland makes the following observation:

“It [dismissal from the army] came as a severe blow to the man who had entered the United States Navy in 1828 as a fourteen-year-old midshipman, who had raised and organized the Seventh Regiment of New Jersey Volunteers at the beginning of the war and had fought with them since Williamsburg, who had two brothers in the Federal service and who was a descendant of the Revolutionary War hero, Paul Revere, yet the verdict could hardly have been otherwise.”

Efforts by Revere, his relatives and highly-placed friends to reverse the court marshal’s sentence were unsuccessful until late in 1864 when Lincoln approved the War Department’s Special Order 302. This order revoked General Order 282 dismissing Revere from the Army and accepted Revere’s resignation effective Aug. 10, 1863.

Revere, for the rest of his life, actively tried to remove the stain on his reputation from the events at Chancellorsville whenever the matter was discussed. This crusade for basic fairness also occupied the energies of his two sons during their lifetimes. Revere’s autobiographical Keel and Saddle may have been a response to the disgrace of dismissal from the armed forces of the U.S., particularly for an act that could be interpreted as cowardice. Through a celestially-ordained connection with the highly respected General Jackson, he may have sought to claim supernatural sanctification as a warrior. Revere was not a braggart, though, and genuinely believed in the truth of what he had written. He had not been, however, entirely forthcoming about aspects of his life that would adversely affect his reputation. He omitted from Keel and Saddle the reason for his 1850 resignation from the Navy. A court of inquiry, convened in California in 1849, found evidence Revere, himself married at the time, was deceitful in his actions surrounding a love affair with another man’s wife. The court recommended a court marshal, an outcome Revere avoided by resigning.

Could the story have been simply the union of two “mistakes;” Revere confusing an amateur astrologer named Jackson on a Mississippi riverboat for Stonewall Jackson, and then a wounded soldier encountered during his twilight ride in the bewildering circumstances of the Wilderness battlefield for the same person? With his certainty solidified by a report in a Richmond newspaper, simple confusion is plausible. Indeed, Keel and Saddle contained other inaccuracies attributable to inexact recollection. On the other hand, the descriptions in Keel and Saddle of two days with Jackson on the riverboat and quotations from Jackson’s letter to him seem too precise for unassisted memory. Were documents not readily at hand during the writing, the detailed quotations recounted in the book certainly must be the product of imagination.

Revere’s motivation remains conjecture, as is his story’s inclusion as a footnote in The Evolution of Modern Medicine. It is more probable than not that the footnote was inserted by Garrison and not Osler himself. The content of the footnote was certainly not true. Moreover, the events in Keel and Saddle were more likely than not a convergence of fallacious memory with a selfish desire to highlight a fateful connection with a storied military leader, a convergence that could not have been entirely unintentional.

Such conclusions, Osler himself would probably remind us – given his well-known sense of humor – illustrate the Hippocratic maxim that experience is fallacious and judgment difficult, even among those generally revered.
While I was in college, and at a pre-med club meeting, plans were made to invite a speaker to tell us what’s required for getting into medical school. Guess who volunteered to find the expert?

After calling the medical school, I was connected to Dr. Karl Wegner because he was one willing to do such a thing. I must say, I have never before or since met a more gracious man, and that evening he presented to our little premed group the details of applying to medical school with a helpful and thoughtful way. It was there I heard for the first time one of the great lecturers of my lifetime experience.

A few years later after acceptance into medical school, I was one of a group of innocent, empty-headed, sophomore students trying to absorb everything about pathology from Dr. Wegner and his wondrous crew of physician teachers. Up to that class, we had learned about normal healthy anatomy and physiology, but it was in pathology we learned about the cause for each and every illness; basically what can go wrong in the human body.

At the time, Karl Wegner was the chair of the Department of Pathology, and later became the dean of the school, serving during the tough transition time when our med school moved from a first-two-year program to a full four-year MD degree-granting school. There was some heavy lifting during that time, and the people of the State of South Dakota owe a great deal to Dr. Wegner, and other grand leaders who had the foresight to get that done. But he did it with his usual graciousness. Grace is a word that reflects not only elegance in movement, but also in kindness, politeness and goodwill shown for others.

Each of you certainly can name a few teachers that made a difference in your life. Perhaps it was one or both parents who gave you a sense of worth and of the value of honesty, or a third grade teacher who showed you how “you can do it” and how to help others, or a high school teacher who taught you toughness and not to give up, or a college professor who helped you achieve a creative and academic challenge.

Dr. Karl Wegner was, and still is, a teacher who has made a big difference in my life, and many lives, teaching not only what can go wrong with the human body, but also how to face difficulty with grace.

Dr. Rick Holm wrote this Prairie Doc Perspective for “On Call,” a weekly program where medical professionals discuss health concerns for the general public. “On Call” is produced by the Healing Words Foundation in association with the South Dakota State University Journalism Department. “On Call” airs Thursdays on South Dakota Public Broadcasting-Television at 7 p.m. Central, 6 p.m. Mountain. Visit us at OnCallTelevision.com.

The Patient Education Page is a monthly feature sponsored by the Healing Words Foundation. For more information, visit www.prairiedoc.com.
Black Hills District Medical Society President Jennifer May, MD, lives and practices medicine in the same town in which she grew up. She received her bachelor’s degree from Augustana College in Sioux Falls and her MD from the University of South Dakota School of Medicine. After completing an internal medicine residency at the Medical College of Wisconsin and a rheumatology fellowship at the Mayo Clinic, Dr. May returned to her hometown of Rapid City. Her philosophy of medicine is to “treat the patient, not the test or number,” focusing on quality of life as opposed to metrics. “…Sometimes less is more,” she says.

As an active member of the South Dakota State Medical Association (SDSMA), Dr. May serves on the Council of Physicians for District 9, and has been a member of the SDSMA since 2005.

Q: What do you love about practicing medicine?
A: I love it when I make the diagnosis. In rheumatology, sometimes people have been to several doctors before they make it to our office. It is very gratifying to know the answer to the problem and have a solution that will improve how the patient is functioning. Good days have lots of hugs as people come in and are moving and feeling better.

Q: What frustrates you about the profession?
A: As part of a cerebral specialty, the productivity demands can burn you out. It takes time to think about the problems, review records, and discuss with other physicians if necessary. It is frustrating that the time and energy required for those tasks is not valued.

Q: What do you think is the most critical health care issue facing South Dakota today?
A: Physician shortage statewide and the Medicaid expansion issue.

Q: What are you listening to?
A: Lately the Zac Brown Band

Q: What are you reading?
A: I just finished the Game of Thrones series and the novel Big Brother by Lionel Schriver. The latter, a very interesting reflection on obesity and society.

“A Doctor’s Story” is a quarterly feature that highlights physicians throughout South Dakota who are contributing to the quality of health care and the overall good of the community. The goal of this feature is to connect the faces and work of these doctors with the South Dakota State Medical Association (SDSMA).
REGISTER NOW!

2014 ANNUAL MEETING

WHAT: 2014 SDSMA Annual Meeting

WHEN: May 30-31

- Friday, May 30 - Educational sessions, exhibitors, Young Physician Mixer, Celebrating Medicine Reception, Presidential Banquet, Awards & Scholarships
- Saturday, May 31 - SDSMA PAC Breakfast, Council of Physicians meeting

WHERE: Ramkota Hotel & Conference Center, Rapid City

And don't miss the golf tournament and the SDSMA Alliance Medical Student Scholarship Fundraiser on Thursday, May 29!

We hope to see you there – register today!

To register, please return the form you received in the mail, or visit www.sdsma.org.

Tips and Time-savers for Talking with Parents about HPV Vaccine

Recommend the HPV vaccine series the same way you recommend the other adolescent vaccines. For example, you can say “Your child needs these shots today,” and name all of the vaccines recommended for the child’s age.

Parents may be interested in vaccinating, yet still have questions. Taking the time to listen to parents’ questions helps you save time and give an effective response. CDC research shows these straightforward messages work with parents when discussing HPV vaccine—and are easy for you or your staff to deliver.

**CDC RESEARCH SHOWS:** The "HPV vaccine is cancer prevention" message resonates strongly with parents. In addition, studies show that a strong recommendation from you is the single best predictor of vaccination.

**TRY SAYING:** HPV vaccine is very important because it prevents cancer. I want your child to be protected from cancer. That’s why I’m recommending that your daughter/son receive the first dose of HPV vaccine today.

**CDC RESEARCH SHOWS:** Disease prevalence is not understood, and parents are unclear about what the vaccine actually protects against.

**TRY SAYING:** HPV can cause cancers of the cervix, vagina, and vulva in women, cancer of the penis in men, and cancers of the anus and the mouth or throat in both women and men. There are about 26,000 of these cancers each year—and most could be prevented with HPV vaccine. There are also many more precancerous conditions requiring treatment that can have lasting effects.

**CDC RESEARCH SHOWS:** Parents want a concrete reason to understand the recommendation that 11–12 year olds receive HPV vaccine.

**TRY SAYING:** We’re vaccinating today so your child will have the best protection possible long before the start of any kind of sexual activity. We vaccinate people well before they are exposed to an infection, as is the case with measles and the other recommended childhood vaccines. Similarly, we want to vaccinate children well before they get exposed to HPV.

**CDC RESEARCH SHOWS:** Parents may be concerned that vaccinating may be perceived by the child as permission to have sex.

**TRY SAYING:** Research has shown that getting the HPV vaccine does not make kids more likely to be sexually active or start having sex at a younger age.

**CDC RESEARCH SHOWS:** Parents might believe their child won’t be exposed to HPV because they aren’t sexually active or may not be for a long time.

**TRY SAYING:** HPV is so common that almost everyone will be infected at some point. It is estimated that 79 million Americans are currently infected with 14 million new HPV infections each year. Most people infected will never know. So even if your son/daughter waits until marriage to have sex, or only has one partner in the future, he/she could still be exposed if their partner has been exposed.

**CDC RESEARCH SHOWS:** Emphasizing your personal belief in the importance of HPV vaccine helps parents feel secure in their decision.

**TRY SAYING:** I strongly believe in the importance of this cancer-preventing vaccine, and I have given HPV vaccine to my son/daughter/grandchild/niece/nephew/friend’s children. Experts (like the American Academy of Pediatrics, cancer doctors, and the CDC) also agree that this vaccine is very important for your child.

**CDC RESEARCH SHOWS:** Understanding that the side effects are minor and emphasizing the extensive research that vaccines must undergo can help parents feel reassured.

**TRY SAYING:** HPV vaccine has been carefully studied by medical and scientific experts. HPV vaccine has been shown to be very effective and very safe. Like other shots, most side effects are mild, primarily pain or redness in the arm. This should go away quickly, and HPV vaccine has not been associated with any long-term side effects. Since 2006, about 57 million doses of HPV vaccine have been distributed in the U.S., and in the years of HPV vaccine safety studies and monitoring, no serious safety concerns have been identified.

**CDC RESEARCH SHOWS:** Parents want to know that HPV vaccine is effective.

**TRY SAYING:** In clinical trials of boys and girls, the vaccine was shown to be extremely effective. In addition, studies in the U.S. and other countries that have introduced HPV vaccine have shown a significant reduction in infections caused by the HPV types targeted by the vaccine.

**CDC RESEARCH SHOWS:** Many parents do not know that the full vaccine series requires 3 shots. Your reminder will help them to complete the series.

**TRY SAYING:** I want to make sure that your son/daughter receives all 3 shots of HPV vaccine to give them the best possible protection from cancer caused by HPV. Please make sure to make appointments on the way out, and put those appointments on your calendar before you leave the office today!

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www.cdc.gov/vaccines/teens | PreteenVaccines@cdc.gov
For Your Benefit:

Your SDSMA Member Services and Programs

Your membership is voluntary, and we appreciate it. As a member of the SDSMA, you have access to valuable member services and programs. Those include:

- Member advocacy and physician representation;
- Legislative;
- Legal;
- Regulatory;
- Peer-to-peer networking events;
- Leadership development;
- Personal and professional education; and
- Medical practice management services.

Want to know more? Call us at 605.336.1965 or visit www.sdsm.a.org.

SDSMA Membership Services works hard to ensure that you have the programs and services you want and need, as well as marketing the association to potential new members. We want to hear from you if you have questions, concerns or ideas on how we can serve you better, or if you know of a potential new member. It’s your association and we'll work with you to make it the best it can be.

Again, thank you for your membership in SDSMA.

"For Your Benefit" is the SDSMA’s monthly update on programs and services available to physicians through their affiliation with the SDSMA.

Medical Record Privacy – Patient Right of Access

A patient has a right of access to his or her medical records, subject to limited exceptions. Practitioners may withhold records under certain circumstances, including when the practitioner believes the release of records could harm the patient or others.

A provider may refuse to provide the patient access to records, and the patient has no right to seek a review of that denial if:

- The records are excluded as described above;
- The records relate to an inmate in a correctional institution and obtaining such records would jeopardize the health, safety, security, custody, or rehabilitation of the individual or any other at the institution;
- The records relate to research and the patient agreed to suspension of access rights prior to participation in the research; or
- The records were received by the practitioner from a third party under a confidentiality agreement.

Under some circumstances, a provider may refuse to provide the patient access to records, but the patient has a right for the denial to be reviewed in the following situations:

- When the practitioner believes that access would be likely to endanger the life or physical safety of the patient or some other person;
- If the record makes reference to another person other than a health care provider and the practitioner believes that such access is likely to cause substantial harm to the other person; or
- If the request is made by a patient’s personal representative and the practitioner believes that such access is likely to result in substantial harm to the patient or another person.

For more about medical records privacy, download the SDSMA legal brief Medical Record Privacy – Patient Right of Access at www.sdsm.a.org. Through the SDSMA Center for Physician Resources, the SDSMA develops and delivers programs for members in the area of practice management, leadership and health and wellness.

SDSMA 2014 Annual Meeting Set for May 30-31 in Rapid City

The 2014 SDSMA Annual Meeting heads to the Ramkota Hotel & Conference Center in Rapid City Friday, May 30 through Saturday, May 31.

With presentations, discussions, networking opportunities and social and fundraising events, the SDSMA Annual Meeting is a great time to share ideas and learn from fellow SDSMA members, including medical students and residents and active physicians and honorary members.

Don’t miss the exciting lineup of presentations and speakers scheduled for May 30!

An upcoming email will have all the details about presentations and registration.

The Annual Meeting is a benefit of your SDSMA membership; most events are included with annual SDSMA dues. Stay tuned for more details about exciting events taking place during the 2014 SDSMA Annual Meeting!

A booklet with more information and a registration form was sent in the postal mail. For more information or to find a registration form online, visit www.sdsm.a.org.

Source: SDSMA staff

March 2014 123
Meaningful Use
Attestation Date Extended

The Centers for Medicare and Medicaid Services (CMS) announced that the original planned date by which all physicians who are attesting for Medicare Meaningful Use in 2013 has been extended from Feb. 28 to March 31.

CMS said they delayed the date because the attestation system has been experiencing a number of problems which have precluded some physicians from submitting their attestation data. Concerns were raised that physicians would miss the attestation deadline and the opportunity for an incentive unless more time was given. Physicians who are seeking to attest should visit the CMS registration and attestation system at www.cms.gov. The EHR Information Center can be reached at 888.734.6433 CMS has provided the following tips on attesting:

• Ensure that your payment assignment and other relevant information is up to date in the Medicare payment system PECOS.
• Make sure to include a valid email address in your EHR program registration.
• Consider logging on to use the attestation system during non-peak hours such as evenings and weekends.
• Log on to the registration and attestation system now and ensure that your information is up to date and begin entering your 2013 data.
• If you experience attestation problems, call the EHR Incentive Program Help Desk and report the problem.
• If your organization has more than 1,000 providers assigned to a proxy user, use the PECOS system to designate additional proxies to facilitate attestation.
• Physicians participating in the Physician Quality Reporting System (PQRS) must still meet that program’s deadline of Feb. 28.

Source: CMS and AMA

SDSMA Annual Meeting is a Great Advertising Opportunity!

The SDSMA Annual Meeting is a perfect opportunity for organizations of all sizes to market their products and services to physicians and develop working relationships with potential customers. The 2014 Annual Meeting will be held on Friday, May 30, 2014 at the Best Western Ramkota Hotel & Conference Center in Rapid City. As a sponsor or exhibitor, you will have the opportunity to display your technologies, services, pharmaceuticals and other products. This is a valuable opportunity to reach key health care leaders from across South Dakota and enjoy face to face interaction.

A networking lunch on Friday will give exhibitors a chance to visit with potential customers and be a part of a program that will highlight products and services.

An exhibitor registration form is available at www.sdsm.org. Make plans now to attend the 2014 SDSMA Annual Meeting by completing the form.

Additional information about the meeting and those with questions may contact Laura Olson, Director of Administrative & Member Services, at 605.336.1965 or lolson@sdsm.org.

Source: SDSMA staff

National Doctors’ Day is March 30 – Honor a Physician!

Each year, the SDSMA Foundation celebrates National Doctors’ Day on March 30 by honoring our dedicated physicians who serve our communities. This is a national day set aside to recognize physicians for their passion and commitment. Please honor a friend, family member, or colleague with an SDSMA Foundation donation.

Making a donation to the SDSMA Foundation provides you with the opportunity to honor a physician of your choosing in celebration of National Doctors’ Day. Your gift is a meaningful way to say thank you to a friend, relative, or colleague. A personal acknowledgement will be sent to your honoree informing them of your generosity with this gift.

Your tax-deductible gift will provide scholarship assistance to medical students at the Sanford School of Medicine of the University of South Dakota and support health improvement programs that address the SDSMA’s public health priorities.

To make your National Doctors’ Day donation, please visit www.sdsm.org and complete a donation form. If you would like to receive a donation form by email, contact Laura Olson, Director of Administrative & Member Services at 605.336.1965 or lolson@sdsm.org.

Honorees will be recognized in an upcoming issue of South Dakota Medicine. Be sure your friends, family members, and colleagues get recognized on this special day. Donations must be received no later than March 28 to be recognized in South Dakota Medicine.

Source: SDSMA staff

“The Issue Is” is the SDSMA’s monthly update on key policy issues of importance to physicians.
South Dakota PDMP Update

In October 2013, the South Dakota Prescription Drug Monitoring Program (SD PDMP) sent notification letters to 111 prescribers to notify them of patients who have used/visited more than six prescribers and filled prescriptions at more than six different pharmacies within the last 90 days. This was done in an effort to assist prescribers in identifying patients who may be “doctor shopping.”

Upon notification, prescribers are encouraged to check the patient’s data to verify the patient and prescription information to ensure the prescriptions and/or the physician’s signature were not forged. Prescribers can sign up for online access to the SD PDMP by completing an online request at www.hidinc.com/sdpm or contacting the South Dakota Board of Pharmacy at 605.773.3361.

Of note, reports (notification letters) will be sent quarterly and are generated and mailed in the months of January, April, July and October. Providers are also encouraged to regularly review all controlled substances (CS) prescriptions to prevent forgeries and to ensure that their prescriptive authority has not been compromised. Requests for CS prescription information can be directed to Kari Shanard-Koenders, director, SD PDMP at kari.shanard-koenders@state.sd.us or 605.362.2737.

Forty people die every day in the U.S. due to drug overdoses – most of which are due to the intake of prescription controlled substances (primarily opiates). In South Dakota, 10 residents die each year to prescription drug abuse and drug overdose.

Only by working together can we stop the epidemic of prescription drug misuse, abuse and diversion while ensuring proper treatment for those who need it.

Source: SD PDMP

Controlled Substances

Drug use for medicinal purposes is controlled by state law. State law categorizes controlled substances (CS) based on their characteristics and effect on the patient.

The prescription of a controlled substance requires a license and compliance with all applicable state and federal laws and rules. Regulations differ depending on CS category in which a drug falls. In addition to prescription regulations, physicians must follow record-keeping and handling requirements.

South Dakota law also provides for a drug monitoring program that requires “dispensers” (the person or entity who delivers the drug to the end user) to file certain reports, and allows for access by physicians for the purpose, among others, of determining if a patient is “doctor shopping” to obtain multiple subscriptions for the same drug.

For more about CS, download the SDSMA legal brief Controlled Substances at www.sdsma.org. Through the SDSMA Center for Physician Resources, the SDSMA delivers programs for members in the areas of practice management, leadership and health and wellness.

Source: SDSMA staff

SAVE THE DATE

2014 SDSMA Annual Meeting

FRIDAY, MAY 30 – SATURDAY, MAY 31
Best Western Ramkota Hotel & Conference Center
Rapid City, South Dakota
For more information, go to www.sdsm.org.
CME Events

Continuing Medical Education events which are being held throughout the United States (Category 1 CME credit available as listed)

March 2014

March 5-8
Internal Medicine Recertification Course
The Westin Gaslamp Quarter
San Diego
AMA PRA Category 1 Credit(s)” available
Register online: www.mayo.edu/cme

March 6
Pediatric Grand Rounds: “Preparing and Maintaining a Curriculum Vitae”
8-9 a.m.
Sanford USD Medical Center
Schroeder Auditorium
Sioux Falls
AMA PRA Category 1 Credit(s)” available
Register online: www.usd.edu/cme

March 11
Pathology Conference: “Common Pediatric Tumors”
7:30-8:30 a.m.
Sanford Health Pathology Clinic
Conference Room 1513
Sioux Falls
AMA PRA Category 1 Credit(s)” available
Register online: www.usd.edu/cme

March 12
Pathology Conference: “Dermatopathology Conference”
7:30-8:30 a.m.
Sanford Health Pathology Clinic
Conference Room 1513
Sioux Falls
AMA PRA Category 1 Credit(s)” available
Register online: www.usd.edu/cme

March 14
April 24-25
“Ethics Problem Solving and Consultation: The Mayo Approach”
Leighton Auditorium, Siebens Building, Mayo Clinic
Rochester
AMA PRA Category 1 Credit(s)” available
Register online: www.mayo.edu/cme

April 25
“FARM: Preparing Planting and Growing”
11 a.m.-4 p.m.
Sanford School of Medicine HSC
Room 106
Sioux Falls
AMA PRA Category 1 Credit(s)” available
Register online: www.usd.edu/cme

Is South Dakota medicine In Your Advertising Budget?

If not, contact us to reach over 2,000 physicians!

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