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Family Doctor

A JOURNAL OF THE NEW YORK STATE ACADEMY
OF FAMILY PHYSICIANS



FEATURE ARTICLES:

- Albany Report
- Two Views
- Prenatal Genetic Screening Tests
- Women's Healthcare in Correctional Facilities
- Providing Healthcare for the Midlife Woman

Focus:
Women's Health





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¹ United States Department of Agriculture Food and Nutrition Service: School Breakfast Program. <http://www.fns.usda.gov/cnd/breakfast/>. Accessed 9/17/10.z

² Gleason et al. School Breakfast Program but Not School Lunch Program Participation Is Associated with Lower Body Mass Index. *J Am Diet Assoc.* 2009;109:5118-28.

³ Hunger Solutions New York. Academics & Breakfast Connection Pilot: Final Report on New York's Classroom Breakfast Project.

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2016

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January 25-29

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Articles

| | |
|--|----|
| Sexual Assault and the Three C's By Natalie Hinchcliffe, DO | 13 |
| Cervical Cancer Screening in Low Resource Settings By Zachary Davidson; Jonah Mink, MD; and David Levitz, PhD..... | 16 |
| Cytomegalovirus Infection: A Treatable Cause of Progressive Hearing Loss in Newborn Infants By Roberto P. Santos, MD, MSCS, FAAP, AAHIVS and Martha Lepow, MD, FAAP..... | 19 |
| Women's Health Care in Correctional Facilities By Sara Baird, MD, Amanda Harris, MD, MPH, and Ross MacDonald, MD..... | 21 |
| Survey of New York State Family Physicians Regarding Natural Family Planning Beliefs and Practices By Jeanine Morelli, MD; Katherine Callaghan; and Marguerite Duane, MD, MHA, FAAFP | 24 |
| Providing Healthcare for the Midlife Woman By Rodika Coloka-Kump, DO | 26 |
| Non-Hormonal Contraception: A Case Based Approach By Kelita Fox, MD; Ruth Hai, MD; and Vanessa Mervyn-Cohen, DO..... | 29 |
| Prenatal Genetic Screening Tests: Understanding the Options and Current Recommendations By KrisEmily McCrory, MD, FAAFP | 33 |
| The Expanded Menu of Intrauterine Devices By Kathleen Bernard, MD; Patrice Thorpe-Jamison, MD, MS; Joyce Robert, MD and Rachel Rosenberg, MD | 36 |
| Caregiver Strain: an Emerging Women's Health Issue By Rebecca Stetzer, MD..... | 39 |

Departments

| | |
|--|----|
| Upcoming Events | 4 |
| From the Executive Vice President: Vito Grasso..... | 6 |
| President's Post: Robert Ostrander, MD, FAAFP | 8 |
| Advocacy: Marcy Savage | 10 |
| Two Views: Communication..... | 14 |
| View One: FPs and OBs: Communication is Key – By David M. Newman, MD | |
| View Two: FPs and Communication – By Manal Soliman, MD | |
| In the Spotlight..... | 42 |

Index of Advertisers

| | |
|---------------------------------|-----|
| American Dairy Association..... | IFC |
| Atlantic Health Partners | 11 |
| Core Content Review..... | 4 |
| Crouse Hospital | 9 |
| Fidelis Care | 3 |
| Marley Drug..... | 7 |
| MLMIC | 47 |
| Saratoga Hospital..... | 12 |



From the Executive Vice President

By Vito Grasso, MPA, CAE

Women's Health

The variety of topics in this issue reflect the breadth of women's health issues and offer insight into the unique perspective and skills of family physicians as primary care partners for women.

Women are the principal caregivers in our society and in most cultures. The health of women is significantly affected by this critical and fundamental role. The demands and stress associated with caregiving exact a significant toll in depression and anxiety. Furthermore, many caregivers neglect their own health and defer their own comfort and interests to devote their attention to the needs of others. Beyond the personal consequences of such behavior, the impact of women as caregivers has profound implications for health care policy.

As informal and uncompensated caregivers, women are the primary source of care management and patient advocacy. To some degree, this may distort the perceived value of these important functions to payers and architects of health care systems. The movement toward value based payment, driven by the desire to restrain costs,

assumes that there is value in managing and coordinating care across a spectrum of medical and non-medical services. Toward that end, new "value based" payment (VBP) models may offer a vehicle for enhancing the partnership between family caregivers and the formal primary care provider. An ideal of VBP is that primary care practices will have more time and more revenue to support care coordination and management activities that have historically been uncompensated. Many of the functions contemplated by proponents of VBP will, naturally, involve informal caregivers and have the potential to significantly, and materially improve the environment in which the patient receives care.

The Academy has long been a leading and persistent advocate for women's health. Our policy manual is replete with positions on issues of particular concern to women.

NYSAFP has consistently supported: access to emergency contraception, authorization to provide prescriptions for contraception with refills for a year, gender equality in prescription coverage, mandatory insurance

coverage of contraception, OTC access to contraception, protection of providers of reproductive health care services from unreasonable restrictions on their ability to practice, the Women's Health Protection Act, and access to long acting reversible contraception.

We are a routine source of resolutions for the AAFP Congress on issues of importance to women including our recent resolutions to oppose mandatory drug testing of pregnant women and to assure that incarcerated women have access to comprehensive reproductive health care.

As you peruse this issue and consider the opportunities for your own practice to expand and enhance your commitment to your female patients please take a moment to also reflect upon the unique and invaluable role which the Academy has played, and is committed to continuing, as a powerful advocate for the rights of women in our health care system.

As always, thank you for all that you do for your patients and for family medicine.

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President's Post

By Robert Ostrander, MD, FAFPP

As president, one of my priorities for this year is to have the New York State Academy play a central role in the evolution and implementation of value based payment programs, especially here in New York. Additionally, I am hopeful that the insight and experience we gain will allow us to influence the AAFP position on a national level. As we all know too well, a misshapen payment system produces a distorted and ineffective health care delivery system. We must do all we can to be sure that the “new and improved” system aligns incentives and removes barriers, rather than replaces one dysfunctional system with another. No matter how well-intentioned legislators, analysts, insurance executives, business owners, and even consumers are, a workable system is, in my opinion, unlikely to result without a strong input from the practical knowledge and experience of primary care physicians.

To this end, I have assembled a task force on advanced primary care and value based payment, chaired by Bob Morrow. Our initial steps are to develop some broad principles and priorities, and then engage leaders both in the public payer and private payer domains for real dialogue. It seems to me that for a long time we have talked about insurers instead of with them. A primary care physician directed health care delivery system that moves toward the quadruple aim, benefits insurers, physicians and most importantly patients.

In no particular order, here of some of my thoughts:

ASKS:

1. Processes that don't require a consultant or extra staff, especially for small practices where patient care and not administration are the primary function of every employee. Too many of the enhanced payment programs already implemented channel money through primary care physicians to consultants for small practices and additional professional management staff for larger ones.
2. Recognition of all the extra work beyond RBRVS face-to-face care, whose relative value for primary care is no longer really appropriate, having been set based on a system of care that no longer applies. We need to be paid for the administrative tasks we do (right now for free!) for the insurers--prior authorization, appeals, medication changes for formulary for non-medical reasons. We need to be paid for administration/paperwork and supervision of ancillary things like PT, school health, visiting nurses, DME, etc.--that is a key part of APC/Care coordination.
3. Default enhanced payment for chronic condition management for patients whose problem list essentially means they are getting it if the team is doing their job. As an example of a flawed precedent, right now the CMS process requires a written care

plan that no one in my practice has found useful (since that information is always part of the visit and visit summary), and documentation by the minute. The payment is paltry if the real life useful concept of several 2-10 minute phone calls is what happens, especially if you go much over the 20 minute threshold for reimbursement. And contractors are gaming this right and left, taking a cut for doing a cookie cutter care plan for everyone with 2+ diagnoses and making a 20 minute phone call that does not serve the patient. I don't think we can fix CMS, but maybe other payers will see the value of getting this right.

4. Look at practice systems that produce good outcomes for a reasonable cost and with high patient satisfaction. Be sure that the processes that are in place support those systems. For example, there is some evidence that small private practices regularly perform very well based on these criteria, but struggle to meet metrics. It is important that the systems that are put in place not be inadvertently designed to exterminate the very practices we would like to thrive.

The devil will be in fair, simple metrics that assure performance. Lazy, manipulative colleagues are not our friend in this.

PROBLEMS:

1. Largely alluded to above, but also more generally, removing piecemeal payment schemes, as Excellus has in our market for after-hours calls. You can bill \$19 for a 5-minute clinical phone encounter, but by the time you get consent from the patient because of the copay and endure their wrath, document and bill, it clearly leaves almost no pay for the actual work. This is especially since the whole fee will be copay for many, and they won't pay. This work needs to be paid as part of the global management fee.

2. The insurers need to take some of the heat for the need for any cost sharing for VBP. They need to inform and educate members, since now it comes across as us asking for money for what has always been free. Patients have no notion of the behind the scenes work we have to do now compared with 10 years ago.

3. Do not require meeting flawed recognition criteria like PCMH as the sole avenue to VBP (I think this will be an issue with DSRIP, and some payers.) As we all know, PCMH, for example, uses a lot of resources, has a lot of no-value-add work, distracts everyone from important things and often requires a paid consultant. However, I am not suggesting it cannot be one avenue for practices that have already made the effort.

4. Eliminate all the useless variability. Encourage payers to have a single approach/metric/standard to the extent they are willing. But do not necessarily have private payers mirror the public system if the public system, as usual, is overly bureaucratically complex.

Finally, I have a few thoughts on the AAFP and MACRA. Despite the CMS avowed goal to move 50% of payments to value based payment not linked to fee for service, most of the value and quality based schemes provided for by MACRA (e.g. MIPS) link

rewards as percentage increases on fee for service work done in the office. I think this completely defeats the purpose of developing true advanced primary care, where office visits are fewer, longer and richer; and much of the work of wellness and chronic condition management is done differently. I am quite concerned that the AAFP is focusing so much of its effort on creating tools so that we might possibly thrive (survive?) under the system and on negotiating details,

instead of being forthright with insistence on a payment system that will really result in transformation. I fear that if we go down the road we are currently on that we will indeed be trading one dysfunctional system for another.

I and the task force welcome any ideas, comments and stories. Please feel free to email me at president@nysafp.org.

Our initial steps are to develop some broad principles and priorities, and then engage leaders both in the public payer and private payer domains for real dialogue.



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Albany Report

By Marcy Savage



2016 SESSION WRAP UP



The New York State Legislature wrapped up its 2016 legislative session in the early morning hours of Saturday, June 18. It was a challenging session overall for physicians with proposals to:

- cut the excess medical malpractice program by \$25 million;
- change the statute of limitations for medical, dental and podiatric malpractice from two and half years to a “Date of Discovery (DOD)” law;
- increase the cap on attorney contingency fees for malpractice actions;
- require new continuing medical education (CME) requirements for physicians for pain management, addiction, and palliative care; and
- limit the initial prescription for an opioid to treat acute pain.

All of the major medical liability issues were resolved in favor of physicians with the defeat of: excess medical malpractice cut; DOD change; and attorney contingency fees.

The CME mandate and initial opioid prescription limit passed both houses as part of a comprehensive proposal to address the heroin/opioid crisis put forward by Governor Cuomo in the final days of the session. Some concessions for physicians were added to the Governor’s bill by physicians to eliminate mandatory counseling of patients by prescribers when ordering controlled substances and to provide for some exemptions to CME. Also the opioid limit was changed from 5 days, as originally proposed, to 7 days.

A variety of legislation was passed in the areas of women’s health, insurance coverage and other bills which the Academy has been advocating for several years. This includes legislation to regulate health insurer use of step therapy protocols, and bills to ease

mandatory e-prescribing requirements when a physician uses one of the allowed exceptions or in cases where a pharmacy may be out of stock of the prescribed product.

A summary of women specific and other legislative proposals of particular interest to the Academy is provided below.

Mammography Screening & Coverage (S8093 Flanagan/A10679 Barrett)

Governor Cuomo put forward a new proposal in the final days of the session to increase screening mammography. **A portion of the proposal that would have required extended hours of operation for mammography screening in over 400 private offices was removed from the bill by the Legislature after strong opposition by physician organizations.** The final bill provides for the following:

- Puts the requirements for extended hours for mammography screening for hospitals and extension clinics in the public health law.
- Eliminates annual deductibles, co-payments, and co-insurance payments (“cost-sharing”) for screening and diagnostic imaging for the detection of breast cancer. This includes mammograms, breast ultrasounds, and MRIs covered under a patient’s insurance policy.
- Eliminates cost-sharing for all screening mammograms, including those provided to women who may not meet current federal screening guidelines but need screening.
- Provides four hours of paid annual leave for breast cancer screening for public employees in New York City.

This bill passed both houses and on June 27th the Governor signed it into law (Chapter 74 of the laws of 2016).

Information on Dense Breast (S7369-A Hannon/ S5510-B Jaffee)

Legislation was introduced to require NYS DOH to conduct an educational program on breast density. The bill was later amended to delete language that overstated the risk of cancer for women with dense breasts, as recommended by the American College of Radiology.

The final bill requires NYS DOH to conduct a program relating to breast density which must include educational information regarding the meaning and potential health consequences of having dense breast tissue, the impact of dense breast tissue on mammographic and supplemental screening, and access to other educational websites and literature on this topic.

This bill passed both houses. It has not yet been transmitted to the Governor.

Statute of Limitations for Medical, Dental, and Podiatric Malpractice: Date of Discovery (S6596-B DeFranciso/A10719-A Weinstein)

At the start of the 2016 session in January, all three Leaders, Governor Andrew Cuomo, Senate Majority Leader John Flanagan, and Assembly Speaker Carl Heastie, declared their support for a change in the statute of limitations for medical, dental, and podiatric malpractice from two and half years to a “date of discovery” law or DOD. Last year the Assembly passed a DOD bill by a wide margin of 120 to 5.

After much debate, the Republican Senate withdrew their support for the bill in the waning hours of the 2016 Session. The Academy weighed in with strong opposition to the bill with key members of the NYS Legislature through meetings and phone calls. In addition, we worked in coalition with MSSNY, HANYS, GNYHA, malpractice insurance carriers, and other physician specialty societies to defeat the bill.

Opioid/Heroin Package (S8137 Ortt/A10725 Rules-Steck, S8138 Amedore/ A10726 Rules-Cusick and S8139 Murphy/A10727 Rules-Rosenthal)

Legislation to require physicians to complete mandatory CME courses in pain management, addiction, and palliative care has been pending for several years. These proposals were sought by the parents who lost children from opioid overdose.

The Academy has worked for the last several years to defeat this legislation. This year, the Legislature agreed to passage of a CME mandate as part of a comprehensive proposal to address the heroin/opioid crisis. The bill requires all prescribers in possession of a DEA registration number to complete a 3 hour course every 3 years in addiction, pain management and palliative care beginning on July 1, 2017.

Earlier versions of the Governor’s bill would not have provided for any exemptions to the CME mandate. However, the final bill allows

for the NYS DOH to grant an exemption where a prescriber can demonstrate that the course is not needed; or that they have taken a CME course equivalent to what the state has approved. Provisions of the Governor’s original bill that required physicians to counsel and provide treatment referral for patients when prescribing an opioid were removed from the bill by the Legislature prior to passage.

Other key provisions of the bills require insurers to cover inpatient services for the treatment of substance abuse without prior authorization and without the imposition of service denials for the first 14 days of treatment; require insurers to cover naloxone; require hospitals to provide discharge planning services to connect at-risk patients with treatment options; and change the limit on initial prescriptions for an opioid for acute pain from 30 days to 7 days. The Academy also opposed the opioid limit proposal for which an earlier version put at a 5 day limit. Unfortunately, based on the Governor’s own experience as cited in news reports where one of his children received a 30 day supply for tonsil removal, there was an insistence to include a limit on the initial prescription of an opioid for acute pain in the package.

These bills passed both houses and on June 22nd. The CME mandate requires all DEA registration holding prescribers to take the course by July 1, 2017 and every three years after. The opioid limit of 7 days took effect on July 22, 2016.

continued next page



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HIV Changes "Ending the Epidemic" (S8129, Hannon/A10724, Rules-Gottfried)

In the final days of the Session, legislation was introduced as a Governor's Program bill to implement the "Ending the AIDS Epidemic" recommendations. This legislation would:

- Remove requirement for informed consent from an individual prior to performing an HIV related test. The bill would require that the individual be advised that an HIV related test is going to be performed, and that any objection by the individual be noted in the individual's medical record;
- Eliminate the existing upper age limit (64) for purposes of the required offering an HIV related test;
- Authorize a physician to issue a non-patient specific order for registered nurses to screen persons at increased risk for syphilis, gonorrhea and chlamydia and to allow a registered nurse to do such screening; and
- Authorize a physician or nurse practitioner to prescribe and order a patient specific or non-patient specific order to a pharmacist for dispensing a seven day starter kit of post-exposure prophylaxis (PEP) for the purpose of preventing HIV. Also it would allow a licensed pharmacist to dispense the seven day starter kit of PEP pursuant to such an order.

This bill passed both houses. It has not yet been transmitted to the Governor.

Timeline for Health Care Plan Credentialing (S2545D Lanza/A501-E Cusick)

This bill shortens the time frame from 90 days to 60 days for a health plan to approve a fully complete credentialing application submitted by a health care professional who is part of a physician group. In addition, in instances where additional time is needed because of a lack of necessary documentation, a health plan must make a final determination within 21 days of receiving the additional information.

This bill passed both houses. It has not yet been transmitted to the Governor.

Licensure of Pathologists' Assistants (S7932 LaValle/A10408 Harris)

This legislation would create a new licensure category for pathologists' assistants in the education law. It would require clear standards for their scope and practice to be enforced by the State Education Department (SED).

This bill passed both houses. It has not yet been transmitted to the Governor.



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Sexual Assault and the Three C's

By Natalie Hinchcliffe, DO

The idea that I could be sexually assaulted or raped is never far from my mind. I think about it when I walk home. I think about it when the doorbell rings. I think about it when I get dressed. For many women, this is not abnormal. The fear of sexual violence is one of the millions of thoughts that flood our thinking as we move through our day, similar to wondering about the weather.

I am a board certified physician who has very intentionally directed my training towards sexual health. I have counseled sexual assault survivors in the federal qualified health center in lower Manhattan where I worked and trained. I have advocated for women's rights for more than half of my short life. I remember "Take Back the Night" walk in college, hearing a friend's story of sexual assault in high school, and first understanding what rape was while in elementary school. Yet, with all my awareness, it was not until I read a piece detailing the alleged rape of a college student by a now famous movie producer, that I recognized what had happened to me was rape.¹

There is a culture in the United States that allows us to overlook instances of rape where one or both parties have been drinking, and the victim is blacked out. This ability to look past these all too common events is present in many young adults minds. It was there that night in my rapist's mind, it was there the next morning in my friend's mind as she informed me of what she had walked in on, and it was there in my own mind as I heard her words and immediately began an internal dialogue of shame and self-blame.

The first patient I treated in clinic following a sexual assault was Sarah*. She was 18, had taken extra time to complete high school, and was perhaps my kindest patient. When she told me of the rape the tone of her voice was steady, her eye contact did not waver. I told her I was sorry this had happened to her and that it should never happen to anyone. She simply said, "It's OK," and shrugged her shoulders. After declining counseling services, she agreed to return the following week. I realize now, this was for my own comfort as well so that we could follow the appropriate windows for pregnancy and STD testing and follow up (she was asymptomatic and declined presumptive treatment). I was worried about her. The assailant was a friend, as is the most common case. She did not want to report it, as is the most common outcome. How could anyone blame her, when we know there are thousands of backlogged rape kits sitting unopened, all across this country?²⁻⁴ As her provider, I wanted to be able to do something. But what else could I do?

**Name changed for privacy*

There was something about her story that will never leave me-- acceptance. She accepted that the assault had happened, and thought that it was "OK." Ten years ago, I had done the same.

I do not know what she was wearing when she was assaulted. I do not know if she was drinking. I do not know if she had consented to intercourse with her rapist prior to the assault. I do not know how many partners she has had-- all points frequently used in court to slut-shame the victim and encourage the illusion that she "asked for it," "wanted it," or "deserved it." All I knew was that she did not consent and he had sex with her. Why would we ever need to know more than that?

Blame is a dangerous slope on which to start. We can begin in any direction and find momentum. In my own rape—was I to blame for drinking so much? Was he to blame for disregarding my intoxication and my male friend's attempt to dissuade him, in recognition of that level of intoxication? Was the whole party of young adults, binge drinking and using drugs, to blame for creating the circumstance that led to that assault?

I believe acts of sexual violence against women by men sit on a cultural foundation of acceptance. This is not unique to the United States. Programs in Kenya aimed at reducing incidence of rape have found the most important place to start was with the attitude of young boys.⁵⁻⁷ Not surprisingly, teaching women self-defense and safety was shown to not be nearly as effective as teaching boys not to rape. By empowering young men to speak openly about rape among their peers, to speak up and stop language and actions that lead to sexual violence, and helping them recognize rape is never justifiable—they reduced the incidence of rape.

When I ask teenagers about alcohol use, I practice harm reduction. This is how I was trained in residency, and what has been shown to be effective in studies.⁸ I do not tell women not to drink more than one drink a day, nor do I tell men not to have more than two. I don't say "Don't ever do drugs," just as I never tell young adults not to have sex. Try to know your limit when drinking and don't exceed it. Blacking out can be dangerous for many reasons including accidents, theft, and assault. Try to be with people you trust and have someone who stays sober. Know when you can come in for care without providers notifying your parents or guardians, as well as when we have to. These are the points I make sure to discuss.

Conversations with patients about sex also follow an open question, harm reduction model. We always talk about condoms, no matter what gender expression or partner gender, and I make sure they know how to correctly place one (yes, condoms are relevant for women with female partners too). Near the end of my residency training, I started adding the "second C", consent, to this conversation. This allowed me the opportunity to explore the importance of consent with my patients, by emphasizing it every time

continued on page 20

VIEW ONE

FPS AND OBS: COMMUNICATION IS KEY

By David M. Newman, MD

We share our patients with lots of other people, from physical therapists to oncologists, but it is our relationship with our colleagues in obstetrics and gynecology that can be particularly fraught.

As I see it, OB / GYN's really have three different relationships with women, and their PCP's:

First and most important, they are surgical sub-specialists. In that role, we send them patients for a specific problem and, like any other specialist, they take care of the problem and send the patient back.

There are certain things that I expect of my surgical specialist colleagues. First, I want the operative report. I am responsible for keeping the longitudinal patient record. When the patient moves or transfers, the chance that they will ask for records from the OB is small compared to the chance that the new doc will want records from me.

In addition, I expect the initial consult note, a note regarding the decision to operate (if different), and the note when the surgeon releases the patient from their care. I need to know about any complications and any medications prescribed.

Of course, they have the right to expect that we will send them information about the patient and our expectations – what the problem is and what they might consider doing about it.

Second, they take care of pregnancies. While a more intimate and long-term relationship, obstetrics is really another surgical sub-specialty. I expect a copy of the initial evaluation, with EDC, and, when the baby is 8 weeks old, I expect the patient to come back to me with a copy of the operative report / discharge summary and any relevant labs. (This includes pathology of the placenta if other than routine.)

Third, and most complex, is the relationship with women who choose to see the OB for ongoing screening and gynecologic care. This puts both of us in a difficult situation.

During the rise of the HMO, gynecologists were allowed to be “alternate PCP’s” so that women could choose both a GYN and a family doc. Thus began the myth that women only needed a GYN and that their “annual” GYN visit could replace the preventive care that we did. Some gynecologists are comfortable dealing with thyroid

One



Two



VIEW TWO

FPS AND COMMUNICATION

By Manal Soliman, MD

As family physicians we expect the same from all specialists, including obstetricians. Communication is key for any provider’s relationship when it comes to patient care. As primary care providers we expect a postoperative discharge summary including any complications, as well as consult notes, medication adjustment recommendations, and laboratory or imaging testing. Having mentioned that, I don’t see any difference in the relationship between family physicians and obstetricians versus any other provider or specialist.

Obtaining information can sometimes be a struggle. If a patient changes their primary care physician, getting records can be as hard as it is with any other specialty. I think the focus should be on communication between providers in general and not with a single specialty.

I don’t know if requesting the operative report is necessary as it has details regarding who assisted, who performed which portion, which stitches and what kind of sutures were used, and so on. Some operative reports are as long as 4 to 5 pages. I would expect the operative discharge summary instead of the report and would keep it as part of the patient’s medical record. Most patients should have that upon discharge.

Obstetricians are no different; having an uncomplicated vaginal delivery is all that I need to know after a normal delivery. I also need the patient’s prenatal labs, including blood type (most people will ask their PCP, not their OB regarding their blood type). On the other hand I would like to know if there were any complications during or after delivery, such as sepsis, fever, depression, diabetes or high blood pressure. There is no need to ask about specifics like how long each stage of labor lasted, unless we are planning to take over the next pregnancy and delivery.

If a patient chooses to have her GYN exam done by a gynecologist, all we need is to document the gynecologist’s name and the encounter. Having all the records sent to us may create higher liability. I am not sure I would like to go over 10-20 patients’ lengthy records on a daily basis. As a physician and a primary care physician, when you receive any abnormal testing results on a patient, you become responsible regardless of whether you are the ordering physician or not.

By default, obstetricians continue to practice as family physicians, if the patient chooses this. Our responsibilities start when the patient

continued on page 15

continued on page 15

view one, continued

disease, or cholesterol, or even diabetes, but most are not – that is our job.

Some of us are more comfortable dealing with gynecologic issues than others. Gray areas abound – contraception, peri- or post-menopausal hormone therapy, pelvic pain, UTI, breast disease (pain, lumps or discharge). IUD and Nexplanon insertion and removal. Warts anyone?

Who is responsible for immunization – Gardasil, Tdap, MMR, PPD, Pneumovax? How do we assure that the other one knows when a shot has been given or a lab test for immunity obtained? There is currently no system and we are all responsible for wasteful duplication. (Why do we not have a “Prenatal Profile – Primip” that is different from the “Prenatal Profile – Multip”?? Once we know blood type and rubella immunity and CF gene analysis, why do we need to check it again?)

99% of what the GYN does with my patient is of interest to me. A chunk of what I do is of interest to the GYN. Communication and collaboration have, for the most part, been haphazard and ineffective – perhaps most seriously when we expect the patient to be the courier and transmitter of information.

We need to ask the GYN to copy us on *all* the labs they order, especially the things on which our quality scores depend (*e.g.*, pap, chlamydia, mammogram). We need to be sure to copy them when we order those things and anything else that is relevant.

I think that family docs, internists, and, to a certain extent, pediatricians should be having more formal discussions of this relationship with our colleagues in gynecology.

Thus, I plead with you – the family doc in private practice or in a large group, employed or independent, or in positions of leadership in our community – work to make these relationships more clear, improve our communication, and establish systems that bring us closer together. Our patients will benefit, as will our professional lives.

Let the conversation begin.

David M. Newman, MD has been a family physician in Brockport for 33 years, 10 of those years in solo practice. He delivered babies, collaborated with midwives, and did D&C's until 4 years ago when the local hospital closed. He still incorporates gynecology and contraception and refers out as little as he can get away with.

view two, continued

walks through our doors, and most young, healthy women will not require annual testing other than their Pap smear, and that usually can be done every 3-5 years.

Immunizations are a shared responsibility between all providers. My recommendation would be to document patients' immunizations on NYSIIS (New York State Immunizations Information System) whether adult or child, whether given by a pediatrician, a family physician, or a geriatrician. This information would be accessible to all.

I agree that we need to improve communication with our colleagues in obstetrics and gynecology, but we shouldn't stop there. Clear communication between all providers will best serve our patients.

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Cervical Cancer Screening in Low Resource Settings

By Zachary Davidson; Jonah Mink, MD; and David Levitz, PhD



Fig. 1A - Seiler- Colposcope Model 985 LED
Typical commercial colposcope, courtesy of Seiler Instrument, Inc. (www.seilermicro.com)

proficiency in the colposcopy procedure due to lack of experience, and space needed to store the large piece of equipment.

Colposcopes are the primary tool used to visualize the cervix and have been around for nearly a century. Colposcopes consist of an optical head that allows the clinician to visualize the cervix at a working distance of approximately 30 cm, with a magnification of 4x-15x (Fig. 1A). Recently, the miniaturization, simplification and low cost of mobile phone enabled video colposcopes have greatly reduced the barriers to providing colposcopy services in primary care settings. The revolution of telecommunications and digital imaging, and the abundance of smartphones in particular, allow new ways to visualize the cervix. These “mobile colposcopes” have been focused primarily on resource constrained areas of the developing world, but hold promise to change the existing paradigm for primary care in the US. With simple hardware modifications, phones and digital cameras can provide colposcopy-quality imaging at a fraction of the size and a fraction of the price of traditional colposcopes. In the developing world, however, doctors are scarce, and the bulk of cervical examinations have shifted to nurses. A parallel clinical model could be applicable to primary care clinics in the US, using smart phone enabled telemedicine technology.

Earlier attempts at implementing tele-colposcopy have demonstrated mixed success and the most cited studies are almost 15 years old.^{4,5,6} In these studies, the consultation sessions were saved on VHS,^{6,7} and

Cervical cancer is the 3rd leading cause of cancer in women worldwide.¹ As such, prevention remains a top public health priority. In the United States, the majority of cervical cancer screening happens in the primary care setting but diagnostic colposcopy is generally performed in specialty gynecology clinics or academic centers. Only 15.6% of surveyed American Academy of Family Physicians (AAFP) members perform colposcopy in the office setting² and refer screen positive women to specialists. This geographic and temporal disconnect between primary screening and follow up care leads to inadequate follow up for many patients³ and is a lost opportunity for family physicians to help their patients consolidate their care. There are a number of reasons that family doctors do not perform colposcopy in their clinics including startup cost of buying a colposcope, lack of



EVA System is a low-cost cervical cancer-screening tool built around a smartphone that provides a magnified view of the cervix similar to a standard colposcope. Currently, the system is undergoing comparative testing against a traditional video-colposcope and has been successfully field tested in Africa and Latin America. Since the device has an optical design that mimics a standard video colposcope, similar levels of sensitivity/specificity are expected (.95 and .47 respectively).^{14,15,16} In addition to imaging the cervix, it also enables documentation of clinical impression, sharing with geographically distant experts for remote consultation and quality control, and provides a platform for integrating advanced imaging techniques onto both the hardware and software.^{17,18}

When used in clinics in the developed world, the EVA system could enhance point of care screening by combining and improving upon existing methods. As an anchored, connected device at the point of care, the EVA System integrates the information flow between the patient, clinic, and specialists to enable a cost-effective and cohesive cervical cancer screening. Utilizing the device, a family practitioner can take an image of the cervix, receive feedback from experts, and then determine next steps. Utilization data generated by users performing the procedure can provide a means of assessing wider trends, including over-diagnosis.¹⁹ This constellation of features improves the efficacy of screening compared to standard visualization methods while addressing cost, training and size barriers.

A readily-available mobile colposcope in the family medicine setting presents a new revenue source while also further enabling family doctors to create the medical home for their patients that is so crucial to achieving and maintaining health. While some family physicians may have concerns about adding colposcopy to their practice due to premiums charged by their malpractice

phone modems were used to transmit images.⁵ None of these efforts led to a significant breakthrough that altered how care is delivered to patients. In subsequent years, very few studies on tele-colposcopy have been conducted, particularly in the US. Today's technology however, gives clinicians the ability to share high-resolution images in near real time, enabling a level of tele-colposcopy that was not possible until very recently. Currently, there are several efforts by the private and public sectors in Africa and Asia that are particularly promising.^{7,8,9,10} The most advanced effort is by Parham et al., who developed a digital cervicography program in Zambia, using digital SLR camera technology. Laying down critical groundwork, they have outlined the technical requirements needed to obtain high quality images that can be assessed by a remote supervisor/consulting doctor. Also, Yeates et al.,¹¹ have used smartphone imaging of the cervix for ongoing training of health workers in Tanzania. In Asia, Nessa et al., have developed a score to evaluate the cervix through a pocket-sized colposcope that they recently tested in Bangladesh.^{12,13}

One commercial product that has integrated all of these features is MobileODT's EVA System (Fig. 1B). The

providers, plans vary on a case-by-case basis and physicians should consider their unique situation accordingly. As more attention is paid to cost containment and value based care,²⁰ remotely driving expert screening and diagnosis into the primary care space has the potential to significantly lower healthcare costs, improve the health of populations and improve the patient experience.



Fig. 1B - The EVA System
www.mobileodt.com

continued next page

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David Levitz, PhD, is the co-founder and Chief Technology Officer of MobileODT, where he leads the company's technical R&D efforts in advanced imaging technologies and their clinical deployment. He received a bachelor's degree in biomedical engineering/optics from the University of Rochester in 2002 and his master's at Lund University. Dr. Levitz joined a research group in biomedical optics at Oregon Health & Science University, where he continued his innovation and research.



CYTOMEGALOVIRUS

INFECTION: *A Treatable Cause of Progressive Hearing Loss in Newborn Infants*

By Roberto P. Santos, MD, MSCS, FAAP, AAHIVS and Martha Lepow, MD, FAAP

INTRODUCTION

Cytomegalovirus (CMV), a member of the Herpes virus group is ubiquitous in the community. It is spread through saliva and other bodily fluids, most frequently from toddlers without symptoms. In women 14-40 years of age, 50% are susceptible to primary infection. Up to 1% of pregnant women may become infected and 0.2%-2.2% of maternal infections can result in an infant infection. As many as 30,000 infants can be infected yearly in the United States. It is the most common congenital viral infection. 10% will have multi-organ disease including hearing loss, although hearing loss may occur without other symptoms. CMV is the second most frequent cause of congenital hearing loss after genetic causes. Hearing loss can be progressive post-natally.¹ In a study in Israel of 149 infants who had symptomatic congenital CMV, 12 (8%) had significant hearing loss as the only finding.²

Valganciclovir, an anti-viral medication with specific activity against CMV has been used for treatment of symptomatic congenital viral disease with multi organ involvement.³ It was shown to improve hearing in 35% of infants after six months of oral treatment. At twenty-four months neurodevelopmental milestones have also improved. Infants with hearing loss as the only symptom also improved or did not progress.³ Neutropenia is a side effect that is dose related and can be controlled.

In the spring 2016 issue of Family Doctor, we discussed the diagnosis and treatment of one of our own medical student's twins who were affected with congenital CMV.⁴ We recommend that all physicians who care for pregnant women should educate their patients about CMV in pregnancy. It is important to emphasize good hand washing when exposed to saliva or urine of toddlers, especially those in day care centers.

LOCAL EXPERIENCE – Albany Medical Center

At Albany Medical Center (AMC) the Division of Pediatric Infectious Disease implemented the following quality improvement program in June of 2015. Starting in January 2015, we collaborated with the major stakeholders at AMC (Medical Director, Chair of Pediatrics, Chief of Pediatric Infectious Diseases, Chief of Nursery ICU, Chief of General Pediatrics & staff, Chief of Pediatric ENT, Charge Nurse & staff – Newborn Nursery, Supervisor & staff – Audiology) and collectively agreed on a targeted screening program as the standard of care for congenital CMV infection presenting at birth with hearing loss.

All mothers receive a letter of information about CMV screening for babies who fail an initial hearing test. The hearing screeners notify a pediatric infectious disease attending physician regarding babies who have failed two hearing screens and also notify the parents that they need to be referred for a third hearing test. The primary care physician for the baby is contacted and asked to tell the parent that because the baby has failed two hearing screens, a voided urine sample will be collected to be sent to the lab for a CMV polymerase chain reaction (PCR) test. Congenital CMV infection can be confirmed in the newborn period usually at <2 weeks of age.

If the urine CMV screen is positive the baby should be referred to pediatric infectious disease at Albany Medical Center (518-262-5332) for evaluation and possible valganciclovir treatment. If the screen is negative, no further follow up is needed. The screening test and cost of medication will be covered by most forms of medical insurance. Further information can be obtained during office hours through the above office number.

Other hospitals in the 22 counties in upstate New York are establishing similar screening programs including St. Peter's Hospital in Albany, Bellevue Hospital in Schenectady, The Birthing

continued next page

Center at Samaritan Hospital in Troy, and Saratoga Hospital in Saratoga Springs. In the first year we screened approximately 50 babies who failed initial hearing tests from offices of pediatric and family practices in the region. Thus far, all have been negative for CMV.

FUTURE DIRECTIONS

Studies and quality improvement projects are under way for universal screening of all newborns by urine or saliva tests for CMV, so that all infants can be evaluated for valganciclovir treatment. In May 2016, we included HIV exposed infants in the targeted screening program in our efforts to keep up to date with rapidly evolving approaches to the early identification of congenital CMV infection.^{5,6} There is also an ongoing discussion locally regarding inclusion of preterm infants ≤ 34 weeks gestation in the targeted screening program, a recommendation from the recently concluded 2016 Pediatric Academic Societies annual meeting in Baltimore, Maryland.⁵

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we spoke about sex. Partially because I exhibit type A personality traits, and partially due to my years of studying and knowledge of memory tricks, I wanted to think of a “third C.” During a conversation about safe sex with a 13 year-old girl and her mother, we tried as a group to think of a third C. The teen had wanted her mother to stay in the room for the conversation, and before having mom step out for a private check in, we put our heads together. After a moment of quiet, the young teen exclaimed “Communication!” Brilliant. By encouraging communication between our patients and their partners, we create a space where barrier protection, contraception, personal boundaries, and sexual desires can and should be talked about.

Condoms, consent, and communication. I challenge us all—providers, parents, aunts, uncles and friends—to speak openly with young adults and teens about the three C’s. The slippery slope of blame and culture of acceptance may not be remedied overnight, but by encouraging our patients to prioritize consent and openly communicate with potential sex partners—in addition to using condoms consistently and correctly for unwanted pregnancy and STD prevention—perhaps we can begin to create a culture where we all know sexual assault is never OK.

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WOMEN'S HEALTH CARE IN CORRECTIONAL FACILITIES

By Sara Baird, MD, Amanda Harris, MD, MPH, and Ross MacDonald, MD



An estimated 1.2 million women were under the supervision of the criminal justice system in the United States in 2014; of these, approximately 215,000 women were incarcerated in jails, and in state and federal prisons, representing a 700% rise since 1980.¹ While the vast majority of detainees are male, the female population has steadily increased in the face of a declining male population. In jails nationwide, the number of female inmates grew 10.9% from 2010 to 2013 (an increase of 10,000 inmates) while the number of male inmates declined 4.2% (a decrease of 27,500 inmates)² with similar trends in New York State.³ By comparison, New York City's

jail system, which houses inmates on much shorter stays, sees roughly 1,400 new female admissions every quarter and maintains an average daily population of 625 women.⁴

With both the rate of incarceration and total number of women incarcerated rising over the past two decades, the jails are an increasingly important venue for delivering women's health care to a historically marginalized and vulnerable population who may lead unstable lives and find access to community care difficult.

Most incarcerated women are of reproductive age, however reproductive health services remain absent or insufficient in many jails for a variety of reasons—short, unpredictable lengths of stay; absence of emphasis on preventive services; relatively small number of women compared to men and thus less attention given to women's needs; and inadequate resources.⁵ Federal law prohibits Medicaid and Medicare billing for outpatient care delivered in jails and prisons, leaving localities to directly fund healthcare for incarcerated women. High rates of sexually transmitted infections, pregnancy, substance use disorders, chronic disease and complex social and psychological stressors (including sexual victimization), strain under-funded localities.^{6,7} Reproductive health can easily be considered non-essential in this context.

As recently as the last few years, there have been reports of women in US jails and prisons being denied or delayed abortion care, shackled during childbirth, and forced to obtain sterilization procedures.⁸⁻¹⁰ Other women have reported being ignored by correctional and medical officers when suffering complications of pregnancy including miscarriage or preterm birth.¹¹ Although women are legally entitled to reproductive health care in New York State, access to care is highly variable and often lacking.⁹ In this historical context, there is often more medical distrust in correctional settings than is already present in the community and many patients may also refuse care or treatment. For providers, it can also be difficult to address women's health care needs in settings which can be chaotic and complicated by a high number of chronic and acute medical illnesses including acute intoxication.¹² Finally, institutional barriers including limited access to patients, scheduling conflicts with court, and unclear durations of stay also make it difficult to provide high quality care in correctional settings.

In the NYC jail system, a qualitative study demonstrated that women were interested in getting reproductive health care while incarcerated and believed that contraception is a fundamental part of women's health care which should be provided upon request, but were also skeptical and suspicious of healthcare provided while in jail, and fearful that they will not have access to follow-up care after leaving custody.⁷

continued next page

correctional facilities, continued

Informed by early results of this qualitative analysis, Correctional Health Services (CHS), which is responsible for all aspects of medical and mental health care in the NYC jail system, sought to create a freestanding reproductive health clinic responsive to the complex historical and social context of the jail. This effort required redirecting funding from elsewhere in the jail health service and seeking clinical leadership with the skill set necessary to implement such a clinic in a challenging setting.

The clinic, opened in August 2014, was designed to increase utilization of current contraceptive methods (oral contraceptives, Depo Provera) and expand access to long-acting devices (Nexplanon, IUD). Outreach was initially done via presentations directly to women in the housing areas, relying on the robust word-of-mouth network among the women. As the clinic has become more established, referrals come from providers at intake as well as from other specialty physicians, nurses, civilian staff, and corrections officers who are approached by inmates requesting a referral. We have since been collecting data to evaluate contraceptive services uptake and embarked on a study of the clinical training and prescribing of emergency contraception by intake providers.

Since its inception, the clinic, which is open two days per week, has served over 250 women and provided contraception to over 200 of them, including approximately 80 who chose long-acting reversible contraception. Each woman is counseled on all available options, given information to review independently, and then provided the chosen method (barring contraindications) at follow up. Patients are also provided with a list of family medicine FQHC clinics in the community where they may go after release should they require assistance or advice with their chosen method or if they choose to wait to start a method until released. These clinics also provide prenatal and obstetrical care as well as early term abortions, primary care, mental health, and substance abuse services.

Because the jail system tends to concentrate a population of people with complex medical and social problems who may move back and forth between incarceration and the community many times before their lives stabilize, it is important for all family physicians to be sensitive to the possibility that women with a history of incarceration may have both a greater need for reproductive health services and a greater mistrust of medical care when it is offered. Community physicians and health clinics can help to meet the needs of this population first by simply being aware of and sensitive to the many challenges formerly incarcerated women face. In addition, partnering with local community based organizations or with a transitions clinic (if one exists in your community) to become a referral center for women after release would help women find prompt linkage to appropriate community healthcare.¹⁵

As physicians, it is our responsibility to stand up for patients' rights, including rights to access high quality women's health care when incarcerated. The NYSAFP recently passed a resolution in support of women's health care in correctional settings. We believe expanded contraceptive options can be provided in other jails across New York and the country, and multiple models for this have been successful in the last few years. Family physicians, with both reproductive health and general medical training, are uniquely qualified to provide

comprehensive care in correctional facilities. In model programs where physicians split their time between correctional facilities and the community, continuity of care is improved and recidivism decreases.^{14,15} In the absence of such a program, community physicians should understand the barriers that women face during and after their incarceration, and use that knowledge to improve their community-based post-incarceration care.

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Sara Baird, MD is a family physician who helped start and staff the reproductive health clinic at Rikers Island Correctional Facility from August 2014-June 2016.

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Ross MacDonald, MD is Chief of Medicine for the NYC Health + Hospitals Division of Correctional Health Services.

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| | THURSDAY, 1/26 | FRIDAY, 1/27 | | | SATURDAY, 1/28 | | | SUNDAY, 1/29 | | |
|---------------|------------------------------------|--|--|--|---|--|-----------------------------------|--|--|---------------|
| Rooms: | | | | | | | | | | Rooms |
| 7:00 - 7:30 | | Breakfast & Vendors | | | Breakfast & Vendors | | | Breakfast | | 7:00 - 7:30 |
| 7:30 - 8:00 | | Breakfast & Vendors | | | Breakfast & Vendors | | | Breakfast | | 7:30 - 8:00 |
| 8:00 - 8:30 | | Updates from the US Preventive Services Task Force - Dr. John Epling | A New Look at Contraceptive Options Counseling - Drs. Olivia Perlmutter & Aisha Williams | Osteopathic Track - hands-on workshop | Choosing Wisely - Dr. Colleen Fogarty | pending | Hands-on Workshop (student track) | Enhancing the Quality of Healthcare for Patients & Providers through Integrative Team Model - Lisa | Careers in Family Medicine (student track) | 8:00 - 8:30 |
| 8:30 - 9:00 | | | | | | | | | | 8:30 - 9:00 |
| 9:00 - 9:30 | | | Attention Deficit Hyperactivity Disorder - Dr. Deepan Singh | | | pending | | Exercise, Diet & Vitamins: What Does the Evidence Say? Dr. Rebecca Stetzer | | 9:00 - 9:30 |
| 9:30 - 10:00 | | | | | | | | | | 9:30 - 10:00 |
| 10:00 - 10:30 | | Preop Clearance, Evidence Based Update - Drs. Josh Steinberg & Scott Hartman | pending | | MSK - Dr. Todd Shatynski | pending | | Don't We Already Do Value Based Practice - Dr. Bob Morrow | Leadership Training for Residents & Students - pending | 10:00 - 10:30 |
| 10:30 - 11:00 | | | | | | | | | | 10:30 - 11:00 |
| 11:00 - 11:30 | | Contraception - Dr. Lee Stetzer | pending | | Best OB Articles of the Past Year - Dr. Josh Steinberg & Scott Hartman | Static Electricity - Dr. John Ruiz | Adjourn | | | 11:00 - 11:30 |
| 11:30 - 12:00 | | | | | | | | | | 11:30 - 12:00 |
| 12:00 - 12:30 | pre-conference workshops - pending | Lunch on own | | | Lunch on own | | | | | 12:00 - 12:30 |
| 12:30 - 1:00 | | Lunch on own | | | Lunch on own | | | | | 12:30 - 1:00 |
| 1:00 - 1:30 | | Lunch on own | | | Lunch on own | | | | | 1:00 - 1:30 |
| 1:30 - 2:00 | | Lunch on own | | | Lunch on own | | | | | 1:30 - 2:00 |
| 2:00 - 2:30 | | pending | Updates in Medication Abortion - Drs. Martha Simmons & Cynthia Calixte | Evaluation & Management of Young Athlete Injuries - Dr. Krishna Khanal | Improving Asthma Control Through Home-Based Environmental Assessment - Dr. David Johnson | Medical Marijuana: the Evidence, the law and the New Guidelines - Dr. David Johnson | pending | | | 2:00 - 2:30 |
| 2:30 - 3:00 | | | | | | | | | | 2:30 - 3:00 |
| 3:00 - 3:30 | | Uterine Cancer: Risk Reduction, Diagnosis, & Mgt for the FP - Dr. Heather Paladine | My Baby is Crying & Won't Shut Up - Dr. Dan Young | Adolescent Medicine - Dr. Sam Sandowski | Hepatitis C in FM, We Can do it & the Cure is Here - Dr. Russ Perry & Jenna Butner | Addiction Medicine - Dr. Charles Morgan | pending | | | 3:00 - 3:30 |
| 3:30 - 4:00 | | | | | | | | | | 3:30 - 4:00 |
| 4:00 - 4:30 | | Breakfast & Vendors | | | Free time | | | | | 4:00 - 4:30 |
| 4:30 - 5:00 | | Writer's Workshop | | | Free time | | | | | 4:30 - 5:00 |
| 5:00 - 5:30 | | | | | Free time | | | | | 5:00 - 5:30 |
| 5:30 - 6:00 | | | | | Poster Presentation & Cocktail Reception | | | | | 5:30 - 6:00 |

January 26 – 29, 2017

Survey of New York State Family Physicians Regarding Natural Family Planning Beliefs and Practices



By Jeanine Morelli, MD; Katherine Callaghan; and Marguerite Duane, MD, MHA, FAAFP

INTRODUCTION: Natural family planning (NFP), also known as fertility awareness based methods (FABMs), have no medical side effects and may appeal to a variety of patients due to health or environmental reasons, or religious beliefs. There are a variety of different methods such as the symptothermal method, sympto-hormonal method, standard days method and lactational amenorrhea method.¹ Studies of individual methods show that their effectiveness rates are comparable to commonly used forms of hormonal birth control. With typical use, unintended pregnancy rates range from 2-14 per 100 woman years.¹ However, FABMs may not be routinely offered to patients by their family physicians exploring contraceptive options for a few of reasons.²

First, there is a misconception that FABMs are less effective. The failure rate of 24% that has been reported is based on surveys of women who were asked to recall what family planning method they were using at the time they became pregnant and adjusted further based on the assumption that abortions were underreported.³ Rates for all the different natural methods were combined and 86% of these users surveyed identified the calendar rhythm method—a much older and less effective method—as their primary form of contraception.⁴ Quoting a combined typical use effectiveness rate for all FABMs masks important differences and would be akin to quoting a combined effectiveness rate for all forms of hormonal contraception. Family physicians may hold the belief that these methods are outdated, probably because studies show physicians are mostly familiar with the rhythm method developed in the 1920s.^{5,6} However, newer methods have been developed and refined from the 1960s to the present day.

Additionally, proper training in FABMs may not be available to medical students, residents and physicians.⁷ The Centers for Disease Control and Prevention (CDC), American Academy of

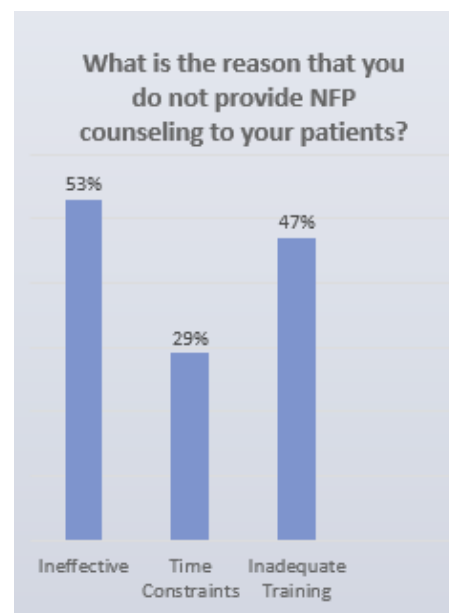
Family Physicians (AAFP), and American College of Obstetricians and Gynecologists (ACOG) have all recommended incorporating family planning and preconception counseling into routine primary care visits since 2005.⁸ The CDC specifically advises contraceptive counseling to include all contraceptive methods in discussions, presenting the most effective options first with subsequently less effective options to follow.⁹ However, to fulfill these all-inclusive recommendations, physicians must be adequately and appropriately informed about all family planning methods, including FABMs. The purpose of this study was to assess whether physicians feel adequately prepared to counsel patients about FABMs and if they provide this counseling.

Methods: In June of 2015, surveys were emailed to all members of the New York State Academy of Family Physicians. Physicians were asked to anonymously complete the survey. Of the 8910 emails sent among members of the NYS Academy of Family Physicians, 1695 emails were opened and 224 physicians responded, making our response rate 13.2%.

RESULTS: More than 90% family physicians provide contraception counseling, but less than half offer counseling on Natural Family Planning, mostly because of a lack of training and a belief that NFP is an ineffective method of contraception.

Counseling in NFP: About 45% of family physicians indicated they do provide counseling on NFP, however, 53% of respondents are interested in learning about NFP.

Reasons behind a Lack of NFP Counseling: About half of participants indicated that they did not counsel patients about NFP because they did not have adequate training and/or they thought it was ineffective. A third of respondents indicated that they did not have sufficient time to counsel patients about NFP.



DISCUSSION: Patients may be interested in FABMs for a variety of reasons and should be educated on all methods of contraception that cater to their individual needs. FABMs are safe, effective, inexpensive and morally acceptable forms of family planning. There are many different options that include Billings Ovulation Method, Creighton Model, Sympto-Thermal method, Marquette Model, and others.¹⁰ Despite empirical evidence that FABMs can be an effective, safe method for family planning, they are not likely included in routine contraceptive discussions due to the stigma of being outdated, ineffective and too time consuming. We suggest this bias may stem from lack of adequate training in counseling about FABMs. Of those with knowledge, the majority gained an understanding through their church, community or family, and not from a formal educational setting. Several respondents expressed a complete lack of knowledge, either never hearing of these methods or recording vague, incorrect definitions. By introducing FABMs into standard curriculum at the medical school and resident level, future physicians will gain a cohesive understanding of contraceptive options and be able to fully counsel patients as recommended by the CDC. We suggest courses should be offered for current family physicians to broaden their understanding and provide guidance about how to effectively incorporate FABMs into family planning discussions. To learn more, please visit FACTSaboutFertility.org.

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Marguerite Duane, MD, MHA, FAAFP is a board certified family physician, is co-founder and Executive Team Leader of FACTS – the Fertility Appreciation Collaborative to Teach the Science, a project under the umbrella of the Family Medicine Education Consortium (FMEC). Dr. Duane is also an Adjunct Associate Professor at Georgetown University. She received her MD degree with recognition in primary care from the State University of New York at Stony Brook and completed her family medicine residency at Lancaster General Hospital in Lancaster, PA.



By Rodika Coloka-Kump, DO

PROVIDING HEALTHCARE FOR THE MIDLIFE WOMAN

Women in midlife, ages 45-64, comprise approximately 43 million or 26.4% of the female population of the United States according to the Census Bureau.¹ The average age of menopause in American women is 51 years, with an age range of 45-55, making this transitional phase particularly challenging for both the woman and her physician.^{2,3} Adequate training in menopausal management is an essential component of the clinical curriculum for the family medicine physician to address the unique set of healthcare and psychosocial needs of the midlife woman which may have potential short and long-term health consequences.

The family medicine physician serves as a potential excellent resource for answers to questions about this stage of a woman's life, including aging, weight gain, menopause, sexuality, depression, anxiety, heart disease and wellness and preventive care.

Opportunities to address midlife issues can be initiated during health maintenance appointments and extended to follow-up visits. The use of tools such as women's quality of life questionnaires can provide an individual needs assessment and facilitate discussion of many personal and sensitive concerns. The quality of life scales (UQOL, MENQOL, Women's Health Questionnaire) are self-reporting and therefore based on individual perception influenced by status, culture and personal expectations.

The Health Maintenance Visit

The midlife woman's annual exam should start with the question, "What are the questions or concerns that you would like addressed today?"

An update of medical history, surgical history, family history, medication (including OTC, supplements and herbs) and allergies to medications, foods and environment is routinely done along with a physical exam. The interview must be expanded to include a detailed social history that provides information about stressors and stress management, personal habits (diet, exercise, tobacco use, alcohol consumption, drug use, caffeine intake) and intimate partner abuse.

A thorough gynecologic, obstetrical and sexual history is essential to identify the common health concerns that occur during this phase of life. Many women in midlife are looking for answers on wellness and preventive care with the goal of becoming healthier. Clinicians are obliged to educate their patients about normal aging changes, both physical and emotional, and long term health risks associated with menopause.

Preventive Care

Counseling regarding disease prevention, especially cardiovascular disease, obesity and diabetes should include lifestyle modifications, such as healthy diet, exercise, weight loss and smoking cessation.

Screening tests should be discussed and ordered based on age and risk assessment. (Table 1)

TABLE 1

MIDLIFE WOMAN HEALTH MAINTAINANCE VISIT - Age 45-64 years

DISCUSSION POINTS:

- Lifestyle and Stress
- Diet/Exercise
- Work Satisfaction
- Screening for Tobacco/Alcohol/Drugs
- Relationship Satisfaction
- BMI
- Intimate Partner Violence
- Screen for Depression/Anxiety
- Advanced Directives

SCREENING:

- Assess Risk for STDs
- Dyslipidemia
- Contraception Need
- Hypertension
- Abnormal Uterine Bleeding
- Diabetes Mellitus
- Urinary Incontinence
- HIV
- Sexual Function
- Hepatitis C
- Sleep Disturbance
- Skin Cancer Risk
- Cognitive Impairment
- Osteoporosis Risk
- Vasomotor Symptoms of Menopause
- Chlamydia, GC, Syphilis (high risk))
- Genitourinary Syndrome of Menopause (GSM)

PREVENTIVE CARE:

- PAP Smear
- Tdap
- Mammogram
- Influenza Vaccine
- Colonoscopy
- Herpes Zoster Vaccine (age 60+)
- Low Dose ASA (55-79, benefit >risk)

Clinical Issues and Concerns

Menopause and normal aging are associated with midlife body changes which may be associated with negative body image and decreased self-esteem and should be addressed if this is an area of concern for the woman.

Weight Gain:

The average weight gain with menopause is 5lbs and is generally related to sedentary lifestyle and aging, rather than loss of estrogen.⁴ Weight gain in menopause is associated with more severe vasomotor symptoms and an increased risk of cardiovascular disease and other comorbidities.

Weight loss through lifestyle modifications of regular exercise and a heart healthy diet should be encouraged and supported but information regarding pharmacologic and surgical options should also be provided if warranted based on BMI.

Pharmacologic agents (phentermine HCl, liraglutide, phentermine/topiramate, orlistat, lorcaserin, naltrexone/bupropion HCl) may be considered as a part of a weight loss program in women with a BMI greater than 30 or BMI greater than 27 with comorbidities, if there are no contraindications.⁴

Surgical options may be considered if the BMI is greater than 40 or greater than 35 with comorbidities.

Skin Changes:

Changes in skin appearance related to menopause include, wrinkling, loss of elasticity and collagen, dryness and dyspigmentation. Decreasing sun exposure and smoking cessation along with a daily skin care regimen of gentle cleansing, removal of make-up before bed, moisturizing, and regular use of sunscreen may minimize the signs of aging.

Vasomotor Symptoms:

Hot flashes occur most commonly in the late menopausal transition and occur in 65-75% of women.^{2,3}

The sudden feeling of intense warmth over the face, neck and chest lasts an average of 4 minutes and be accompanied by profuse sweating. Some women may experience vasomotor symptoms for 10 or more years but most women experience them for 6 -24 months.⁴ The vasomotor symptoms (VMS) may disrupt sleep, causing fatigue and memory loss and impair quality of life.

50-80% of women use non-hormonal therapies for VMS, some of which may not be shown to be effective by the level of evidence.⁵ (Table 2)

Custom-compounded bio-identical hormones are not recommended due to lack of evidence supporting superiority over conventional hormone replacement therapy and their variable potency, purity, and lack of safety and efficacy testing regulation.

TABLE 2

EVIDENCE-BASED TREATMENT OF MENOPAUSAL VASOMOTOR SYMPTOMS^{4,5}

North American Menopause Society (NAMS)

RECOMMENDED:

Cognitive-behavioral therapy
Clinical hypnosis

RECOMMENDED WITH CAUTION:

Weight loss
Mindfulness-based stress reduction
S-equol derivatives of soy isoflavones
Stellate ganglion block

NOT RECOMMENDED:

Paced respiration
Relaxation
Yoga
Cooling techniques
Exercise
Avoiding triggers
Supplements/herbal therapies
Acupuncture
Chiropractic intervention

RECOMMENDED NONHORMONAL PHARMACEUTICALS:

Paroxetine salt- 7.5mg/day (only FDA approved for VMS indication)
Paroxetine -10-25mg/day
Citalopram -10-20mg/day
Escitalopram -10-20mg/day
Desvenlafaxine -100-150mg/day
Venlafaxine -37.5-150mg/day
Gabapentin -300mg TID
Pregabalin -150-300mg/day
Clonidine -0.1 mg transdermal

RECOMMENDED HORMONAL REPLACEMENT THERAPY:

Estrogen (oral, transdermal, vaginal)
Progestogen (oral, vaginal)
Combination (oral sequential, oral continuous, transdermal continuous)
Estrogen, conjugated/bazedoxifene (Duavee)

NOT RECOMMENDED:

Bioidentical hormone

Hormone therapy is the most effective treatment available for moderate to severe vasomotor symptoms which negatively impact quality of life, and may be considered in younger menopausal women without contraindications.

MenoPro, is a free app provided by the North American Menopause Society, that can be used to calculate the individual risk assessment for hormone therapy and can be used to facilitate the decision making process regarding treatment options. This tool has a version for physicians and one for patients. For more information go to www.menopause.org/for-professionals/-i-menopro-i-mobile-app.

continued next page

Sexual Function:

Sexual dysfunction is a common concern for the midlife woman and it is the result of physiological, psychological and interpersonal factors. Decreased sexual desire is the most common complaint, but low levels of arousal and infrequent orgasms are also reported. Dyspareunia due to vaginal atrophy and decreased lubrication can also contribute to sexual dissatisfaction.

Counseling with focus on partner communication, modifying sexual techniques and cognitive behavioral therapy may improve the sexual satisfaction of the midlife woman.

The genitourinary syndrome of menopause (GSM) which may include vaginal dryness, irritation and burning; dyspareunia due to diminished lubrication and vulvovaginal atrophy; dysuria and urgency and recurrent UTIs, can be treated with vaginal estrogen, lubricants, vaginal moisturizers (Replens) and ospemifene (Osphena). Treatment options are based on patient preferences and contraindications.

Vaginal estrogen and ospemifene (an estrogen receptor modulator), although very effective, are contraindicated in patients with undiagnosed vaginal bleeding, estrogen-dependent carcinomas, pregnancy, breast cancer, severe active hepatic disease, and thromboembolic disorders.

Sleep Disturbance:

The midlife woman may have a diminished feeling of overall well-being due to chronic sleep disturbances as a result of interrupted sleep by hot flashes and reduced sleep quality. Also common are primary insomnia, obstructive sleep apnea, restless leg syndrome and sleep disturbance as a symptom of depression. Treatment of hot flashes with hormonal or nonhormonal medication results in self-reported improved sleep quality.

Identifying the condition attributing to poor sleep quality is essential to treatment option decisions. Behavioral therapy such as cognitive behavioral therapy and sleep hygiene are effective. Pharmacologic sleep aide use, although effective, should be limited.

Treating the midlife woman, requires a commitment to communication, establishing trust, allowing for the patient-centered visit, building a history and making quality of life concerns a priority. It requires a commitment of time for follow-up visits and support and disease prevention and maintaining wellness.

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Non-Hormonal Contraception: A Case Based Approach

By Kelita Fox, MD; Ruth Hai, MD; and Vanessa Mervyn-Cohen, DO

INTRODUCTION:

Although combined oral hormonal contraceptive pills (COCs) are the most commonly used contraception in the United States, the risks are relatively higher than other contraceptive methods. Use of hormonal contraception is absolutely contraindicated in certain medical conditions for which pregnancy prevention is equally as important (see Table 1). Studies show that patients who are provided with comprehensive contraceptive options and allowed to make their own decisions have higher adherence and satisfaction rates.^{1,2} A patient decision making tool (see Figure 1) can be used to highlight important points in counseling and contraceptive choice. Depending on desired ease of use, side effect profile and personal preference, patients may choose a contraceptive method with lower efficacy compared to hormonal methods. As any form of contraception is more effective than none in the goal of preventing pregnancy, support and adequate counseling on proper use can be given no matter which method is chosen and lower efficacy methods may be safely augmented with oral emergency contraception. The Cu-IUD is the only non-hormonal emergency contraception, and it is the most effective.



TABLE 1 - WHO Medical Eligibility Criteria for Initiating Contraceptive Methods^{3,4}

| Condition | | Combined Hormonal Contraceptives LNG-IUD | Progestin-only Contraceptives | | | |
|------------------------------|--|--|-------------------------------|------|------|---|
| | | | Implant | DMPA | Pill | |
| Breast cancer | Current | 4 | 4 | 4 | 4 | 4 |
| | Past and no evidence of current disease for 5 years. | 3 | 3 | 3 | 3 | 3 |
| Liver Disease | Severe cirrhosis | 4 | 3 | 3 | 3 | 3 |
| | Hepatocellular adenoma | 4 | 3 | 3 | 3 | 3 |
| | Malignant (hepatoma) | 4 | 3 | 3 | 3 | 3 |
| Systemic lupus erythematosus | Positive (or unknown) antiphospholipid antibodies | 4 | 3 | 3 | 3 | 3 |
| Ischemic heart disease * | | 4 | 3 | 3 | 3 | 3 |
| Stroke/CVA * | | 4 | 2 | 3 | 3 | 3 |

* Data for continuation of contraceptive method only

(1= method can be used without restriction; 2= advantages are greater than the risks; 3= risks (theoretical or proven) are greater than the advantages; 4= unacceptable health risk, this method should not be used)

continued next page

non-hormonal contraception, continued

ILLUSTRATIVE CASES:

1. A 36 year old G1P0010 who has a history of breast cancer treated 2 years ago, now in remission, and who is BRCA1 positive wants to discuss contraceptive options.

The risks of pregnancy within 5 years of cancer remission are high due to the risk of recurrence of breast cancer. This patient with a history of breast cancer should only be given non-hormonal methods for contraception (however there is a small subset of women in breast cancer remission on tamoxifen who can use the levonorgestrel IUD).⁵ Desire to retain future fertility should be discussed with this nulliparous patient in addition to the importance of a high efficacy contraceptive method. The copper IUD is 99% effective thus the most effective reversible non-hormonal option. If she picks this method it should be available the same-day.⁶ She should be counseled that it may cause heavier periods with more cramping, which may improve after 6 months and can be easily treated with NSAIDs and heating packs. It can last 10-12 years⁷ and women should be aware that it can be removed at any time. Patients should be able to easily return to the same facility for an IUD removal visit or contraceptive method change at their discretion to avoid feelings of reproductive coercion. If clinicians are not equipped to do complicated IUD removals (no strings visible, excess traction required) when requested, they can refer to local family planning health centers with these capabilities.

Copper IUD

Counseling Pearls

Same day insertion in the office is standard of care,³ requires no preparation by the patient, and takes 10-15 minutes. As many women may fear the pain of insertion, ibuprofen 800 mg 30 minutes before the procedure, a paracervical block, a heating pack, music, or a support person during the procedure may reduce discomfort.

Limitations

Many misconceptions still prevail on IUD insertion. The only contraindications for the copper IUD are listed in Table 2. A Copper IUD may be placed after a pelvic infection resolves. Gonorrhea and chlamydia testing can be done at the time of insertion based on CDC guidelines: 25 years old or younger and those with multiple or new sexual partners. Patients who test positive for gonorrhea and chlamydia do not need to have the IUD removed while they are treated. (IUD placement animation: <https://www.youtube.com/watch?v=FuPFbgSm0QQ>)

Table 2- Contraindications to copper IUD placement:⁸

- Severe distortion of the uterine cavity such as bicornuate uterus, fibroids which distort uterine anatomy.
- Active pelvic infection
- Known or suspected pregnancy
- Wilson's disease or copper allergy
- Unexplained abnormal uterine bleeding

2. A 29 year old G3P3003 who is 6 weeks postpartum, breastfeeding, and wants to start contraception. She is adamant that she does not want any hormones.

For this multiparous patient, the discussion might start with the desire to have more children. If future fertility is definitely not desired then male or female sterilization are options and 99% effective.³ If she is in a monogamous relationship vasectomy might be preferable over tubal ligation because it can be performed in an office setting with less anesthesia and less recovery time. Most states require consent forms be signed at least one month before a sterilization procedure, so bridging with another contraceptive method should be offered. Transabdominal female sterilization has the benefit of working immediately whereas vasectomy might take 1-3 months until sperm are absent from ejaculate (100,000 or less non-motile sperm per mL). Hysteroscopic female sterilization can be an option for women who are poor candidates for general anesthesia but can take up to 3 months for the fallopian tubes to occlude. If she chooses a less effective option such as condoms, diaphragm, cervical cap, or withdrawal, then emergency contraception (EC) should be prescribed at the same visit along with adequate counseling on how and when to use EC. According to the WHO, no medical condition exists in which the risks of hormonal EC outweigh its benefits.⁴ Before the 6 week postpartum visit the diaphragm and cervical cap are not recommended because uterine involution is typically not complete.

Male Sterilization

Counseling Pearls

Men must be absolutely sure no future children are desired as reversal of vasectomy can be difficult, expensive, and even unsuccessful. Anyone with even a small desire for future children should choose other forms of contraception. Counseling is important to counter popular misconceptions on safety, recovery time, and pain as vasectomy is one of the most effective contraceptive options and is generally considered safer than tubal ligation.⁹ Vasectomy is an outpatient, minimally invasive procedure requiring only local anesthetic. Recovery time is short, about 1-2 days. NSAIDs and good support are adequate for pain management.

Female Sterilization

Counseling Pearls

Only women who are absolutely sure no future children are desired are candidates for tubal ligation. As high as one out of five women regret their choice of sterilization (higher risk in younger age).

3. A 21 year old GPO with systemic lupus erythematosus (antiphospholipid positive) who had unprotected sex 4 days ago presents for emergency contraception as well as ongoing contraception. Last menstrual period was 2 weeks ago and her BMI is 23kg/m².

This patient is at high risk for pregnancy since this episode of unprotected sex may have occurred during ovulation. STI testing (including HIV) and pregnancy testing should be done today. Due to the high false negative rate of pregnancy tests this close to the episode of sex, another pregnancy test should be done in 1-2 weeks. The copper IUD and ulipristal are her best options for emergency contraception up to 5 days from the episode of unprotected sex. The copper IUD is 99% effective throughout this time frame and will provide contraception for up to 10-12 years.¹⁰ If she dislikes the idea of an IUD or the possible side effects, ulipristal may be prescribed. This should optimally be taken in the office. If electronically prescribing to a pharmacy the prescriber should verify that ulipristal is in stock. Counseling for ongoing contraception must focus on nonhormonal methods as she is antiphospholipid antibody positive (see Table 1). If she picks a method with potential high failure rates and user error such as condoms, the diaphragm or the cervical cap counseling should be comprehensive and include hands on or visual guidance on proper use. The diaphragm must be fitted in the office where the diameter size corresponds to the space between the posterior fornix and the pubic bone, measured intravaginally¹¹ (patient information video on the diaphragm: <https://www.youtube.com/watch?v=1-iOyZvd8qI>). The cervical cap requires no fitting. Use size 22 mm if nulliparous, 26 mm if history of c-section or termination or 30 mm if history of vaginal delivery (patient information video on the cervical cap: <https://www.youtube.com/watch?v=K-5W8Xznf9I>. <https://www.youtube.com/watch?v=WJanOsLVtrU>).

Diaphragm and Cervical Cap

Typical Use Efficacy

Diaphragms are 88% effective.¹²

Cervical caps are 84% effective (higher in nulliparous women).¹²

Counseling Pearls

The diaphragm and the cervical cap must be used with spermicide all of the time. Once the cap and diaphragm are inserted sex can occur multiple times. One must wait six hours after the last episode of intercourse to remove the device. The cap can be left in for 48 hours and the diaphragm 24 hours. Both methods need to be replaced every one to two years due to colonization with fungal organisms and material breakdown. Diaphragm and cervical cap use is contraindicated in patients who are at high risk of acquiring or transmitting HIV (sex workers, HIV positive, partners who are HIV positive) because spermicide may cause irritation and abrasion of the cervix which can increase STI transmission.^{4,12} There is a small increase in urinary tract infection rates with use of these methods.⁴

Condoms

Typical use efficacy

Male condoms are 82% effective.³

Female condoms are 79% effective.³

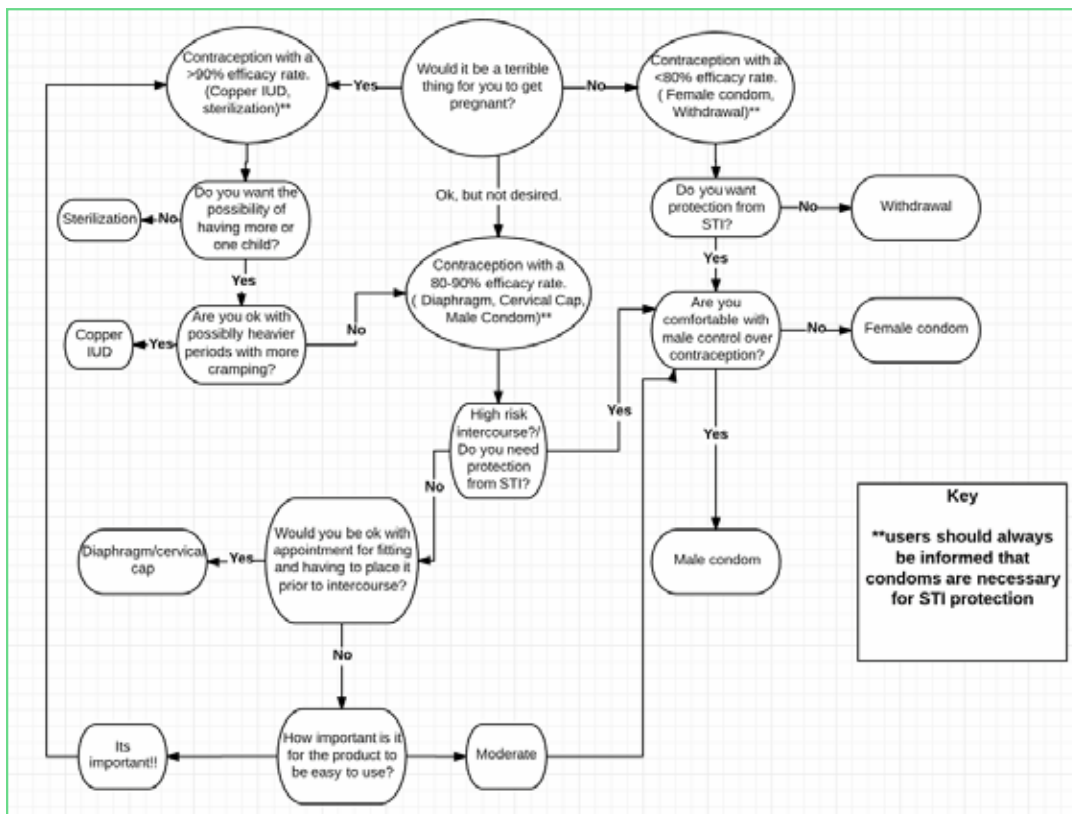
Counseling Pearls

Male condoms require space kept at the tip beyond the end of the penis for the semen to collect without breaking the condom. Removal of the penis while still erect is also recommended to prevent leakage of semen into the vagina. Failure of female condoms may occur in discordantly sized partners (larger vagina and smaller penis than average).

Limitations

The female condom is more expensive than the male condom and may require lubricant if either partner is bothered by excessive noise or sensation.

Figure 1 - Non-Hormonal Contraceptives Patient Decision Making Tool ^{3,4,13,14}



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SUMMARY

Primary care doctors need to feel comfortable in their ability to counsel and guide patients in non-hormonal contraception whether for medical contraindication to hormones or for personal preference. Education on proper use, efficacy rates and potential side effects improves success rates of each contraceptive method. Counseling optimally is patient-centered by matching contraceptive choices to patient's personal needs.

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The American College of Obstetricians and Gynecologists (ACOG) recommend that all pregnant women who seek prenatal care prior to twenty weeks gestation should be offered prenatal genetic screening.¹ Since the introduction of prenatal genetic screening in the 1980s, more and more options to identify potentially severe genetic conditions have become available. These tests can be difficult for physicians and patients alike to understand but can provide an early opportunity to discover serious fetal anomalies.

Fetal aneuploidies occur in approximately one out of every 500 live births, with a higher prevalence during pregnancy, as many of these disorders are incompatible with life and account for a large

limitations that should be carefully discussed with patients before making decisions about such testing.

Patient counseling should focus on understanding which disorders the screening test looks for, the patient-specific risk for aneuploidy based on maternal age and family history, as well as the screening options available. Patients must understand that regardless of the screening method, the results are not diagnostic. A positive screening test merely indicates an increased risk of having an affected fetus and must be confirmed with diagnostic testing. Additionally, a negative screening result is not a guarantee that a fetus will not be affected with a chromosomal abnormality. It only identifies a lower post-test

Prenatal Genetic Screening Tests: Understanding the Options and Current Recommendations

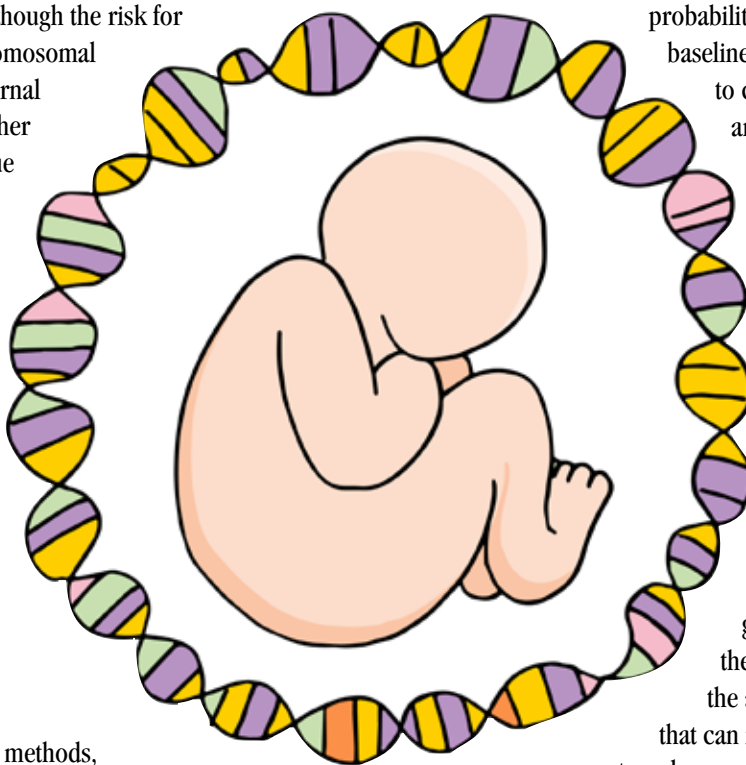
By KrisEmily McCrory, MD, FAAFP

portion of pregnancy losses.² Although the risk for carrying a fetus with such a chromosomal abnormality increases with maternal age, younger women carry a higher proportion of affected fetuses due to having the higher pregnancy rates.

The goal of identifying these anomalies early is to permit patients an opportunity to make decisions with regard to continuation of the pregnancy, prepare for a special needs child including potential transfer to a tertiary center for delivery or possible need for perinatal hospice services for an affected infant.

Current methods for identifying abnormalities include screening methods, which calculate maternal risk of carrying an aneuploidy affected fetus as well as diagnostic tests, such as chorionic villous sampling (CVS) or amniocentesis, which can provide more definitive answers. Although any pregnant woman may opt to defer screening testing for diagnostic testing, the risks of miscarriage or fetal injury often lead those desiring prenatal genetic testing to choose screening as an initial step.

There are a variety of screening methods available in both the first and second trimester. The majority of traditional testing uses maternal serum analytes, sometimes with ultrasound data, to calculate risk of aneuploidy. Newer screening tests focus on free cell fetal DNA circulating in the maternal serum. Each of these tests has



probability of having a condition. Finally, a baseline ultrasound should be considered to confirm viability, number of fetuses, and gestational age.

Maternal risk for aneuploidy in traditional methods looks for evidence of trisomy 21, 18 and often neural tube defects. Through measurement of various maternal serum analytes (Table 1), a multiple of the mean (MoM) is calculated by dividing the patient's serum value by the median concentration for a normal, singleton pregnancy of the same gestational age. A calculation using the MoM and maternal age determines the aneuploidy risk. Other factors

that can influence the risk profile include maternal race, weight, diabetes status, and use of donor eggs. Correction factors are used to adjust for these.

Since gestational age is a major component of the calculating MoM, a correct estimated due date is vital and incorrect dating is a common reason for false positive screens.

In addition to the measurement of maternal serum analytes, an ultrasound measurement of the fluid-filled space at the back of the fetal neck, known as a nuchal translucency measurement is often incorporated. A soft marker for trisomy 21, an enlarged nuchal translucency is associated not only with aneuploidy but also other structural malformations. The accuracy is user dependent and even a small miscalculation can lead to incorrect interpretation.

continued next page

Table One: Maternal Serum Analytes

| Analyte | Origin | Implication |
|--|--|---|
| Maternal Serum Alpha-fetoprotein (MSAFP) | Blood protein produced by fetus | Elevated in NTD/ventral wall defects Decreased in Trisomy 21 |
| b-HCG or total hCG | Hormone produced by embryo and placenta following implantation | Increased in Trisomy 18, 21 |
| Estriol (uE3) | Hormone secreted by fetal adrenal glands and metabolized by placenta | Decreased in Trisomy 18, 21 |
| Dimeric Inhibin A | Secreted by placenta and corpus luteum | Increased in Trisomy 21 |
| Pregnancy Associated Plasma Protein A (PAPP-A) | Synthesized by placenta | Decreased in Trisomy 18, 21 |

Single screening options review risk with one analysis. Early screening in the first trimester occurs between 10 and 13+6 weeks gestation. This identifies an increased risk for trisomy 18 and 21 only using PAPP-A and bHCG with nuchal translucency. If the first trimester is not utilized, during the second semester the quad screen can be done which uses b-HCG, AFP, dimeric inhibin-A, and uE3 to calculate risks for trisomy 18, 21 as well as neural tube defects. Since these tests are not designed to be used together, one must weigh the benefit of early detection of potential abnormalities with the need for additional testing for neural tube defects if opting for first trimester screening. The first trimester screen, as well as the quad screen have similar detection rates of about 80%.¹

Combination testing has become more common in practice and offers higher detection rates compared to the one step testing. There are three combination tests available. Although they use the same analytes for testing, the timing for reporting results and the follow up of results vary between them. Like the single step tests, these tests screen for trisomy 18 and 21. Neural tube defects are only assessed during the second portion of the test so if this portion is omitted then additional testing specific to neural tube defects are necessary. All of these tests have similar sensitivities of 91-93%.¹

Integrated testing can be done with or without the nuchal translucency and uses a first trimester PAPP-A value as well as a second trimester AFP, hCG, uE3, and inhibin A value to calculate a risk profile. Even though blood work is drawn in both the first and second trimester, results are only reported after receipt of the second trimester analysis. The downside is a delay in abnormalities until later in the pregnancy potentially limiting the options if a woman desired to terminate the pregnancy. Additionally, failure to return for the second portion of the testing invalidates the test.

Sequential screening is available using either a step-wise or a contingent methodology. Although the detection rate is similar to the integrated testing, sequential testing identifies elevated risks in

both the first and second trimester. Both methods use measurement of nuchal translucency as well as maternal serum levels of PAPP-A and hCG during the first trimester. During the second trimester both tests analyze serum levels of AFP, hCG, uE3, and inhibin A. The main difference in the two methods lies in how an elevated risk in the first trimester is managed.

In step-wise screening, women are given a positive or a negative screening result. Positive results do not go on to the second step and instead are offered either cell free DNA testing or diagnostic testing. Women with negative first trimester results go on to have the second trimester testing and are given a second screening result at that time. Again, positive results are offered cell free DNA or diagnostic testing.

Contingent testing breaks the first trimester risk profiles into low, intermediate, and high. Women receiving a high-risk profile are managed the same as a positive first trimester screening in the step-wise screening. Those identified as intermediate continue on to second trimester screening with subsequent results of either positive or negative and managed accordingly. Women who are judged to be low risk during the first trimester screening do not undergo second trimester screening.

In either methodology, women who do not go on to the second trimester testing still need to have a maternal serum AFP drawn during the second trimester to screen for neural tube defects.

In 2011, cell free fetal DNA (cffDNA) screening for fetal aneuploidy became available for clinical use. Unlike the traditional methods described previously, cffDNA relies not on analysis of maternal serum analytes but from detection and evaluation of fetal DNA circulating in maternal serum. Cell free fetal DNA derives primarily from the placenta and is detectable in the maternal serum from about nine weeks of gestation. It increases from that point and ultimately makes up 3-13% of the total cell free DNA circulating and can be extracted and subsequently analyzed. The fetal fraction, or percentage of circulating DNA that is fetal in origin, influences the

ability to produce a result. Many labs require a minimum of four percent to provide an interpretation and between 1-8% of results are considered uninterpretable, or “no call results,” due to low fetal fraction. Maternal weight of greater than 250 pounds increases the likelihood of a low fetal fraction. Additionally, having a fetus affected by aneuploidy has an increased association with a “no call results.” For this reason, women who do not receive an interpretable result should undergo genetic counseling as well as be offered both a comprehensive ultrasound and diagnostic testing. Repeating the cell free DNA in hopes of a result is not recommended. Only about 50% of repeat testing produces a result and there is a potential delay in diagnosis by waiting to undergo more definitive testing.

Several of these tests are available commercially, including MaterniT21™, Harmony™, Qnata™, and Paramore™; they have been heavily marketed to the general public and are increasingly covered by insurance companies. These tests routinely screen for trisomy 13, 18, and 21. The sensitivities for trisomy 18 and 21 are both 99% while the trisomy 13 screening sensitivity is 80-90%.³ In addition to these three disorders, some companies offer additional testing for trisomy 16 and 22, sex chromosome aneuploidies, as well as some microdeletion syndromes. Patients should be counseled, however, that screening for microdeletion syndromes is not currently recommended by ACOG as these screening tests have not been validated so sensitivity and specificity is not fully known. Test results are generally available in 7-10 days.

When counseling women regarding cffDNA testing it is imperative to understand this test is not diagnostic. It has both false negative as well as false positive results. False positive results can be attributed to vanishing twin, placental mosaicism, or rarely, maternal malignancy. Any abnormal result needs to be confirmed with diagnostic testing. One lab found that 6.2% of women who had received a positive screen opted to terminate without obtaining any diagnostic testing,⁴ so educating a patient beforehand regarding the potential need for diagnostic testing is important. It is also vital patients understand that even highly sensitive tests have varying positive predictive values based on the prevalence of the condition being tested. This can have profound implications when interpreting positive screening results. For example, in detection of trisomy 21, the positive predictive value of a positive screen is 87% for a forty-year-old woman but the same result in a 25-year-old woman would have a positive predictive value of only 33% due to the lower prevalence of trisomy 21 in that age group. With the more rare aneuploidies, the positive predictive values are even lower.

In a low risk population, trisomy 13, 18, and 21 actually comprises a smaller proportion of chromosomal abnormalities, and thus traditional analytes testing may trigger diagnostic testing that can uncover abnormalities that may not have been detected by cffDNA screening. Due to this limitation, as well as the cost effectiveness of serum analyte testing, ACOG recommends that traditional serum testing be considered first line in low risk individuals.³

Additionally, cffDNA testing does not identify neural tube defects, ventral wall defects, or other chromosomal/genetic abnormalities.

One benefit for cffDNA, however, is as an adjunct when a traditional screen is negative for those women who would like to avoid more invasive diagnostic testing. The residual risk of having an abnormal fetus with a positive serum analyte screen that was followed by a negative cffDNA screen is approximately 2%, which may be reassuring enough for some women.

Prenatal genetic screening offers women a chance to identify the risk for having an infant with an abnormality that may be incompatible with life or require increased care upon birth. Having this information early affords parents the opportunity to make decisions regarding the continuation of a pregnancy or prepare for a special needs child. Those providing maternity care need to be aware not only of these benefits, but also of the limitations of the available tests in order to help families make the most appropriate choices for them.

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The Expanded Menu of Intrauterine Devices

By Kathleen Bernard, MD; Patrice Thorpe-Jamison, MD, MS; Joyce Robert, MD and Rachel Rosenberg, MD

Introduction

The use of intrauterine devices (IUDs) in the US has risen quickly over the past several years – it is estimated that more than 4 million American women now use the IUD for contraception.¹ For women whose main priority is the effectiveness of a contraceptive, nothing beats long-acting reversible contraception (LARC), which includes the IUD and the birth control arm implant. Many experienced family physicians may remember with trepidation early iterations of the long-acting reversible contraceptives, such as the Dalkon Shield® IUD and the Norplant® arm implant, which were associated with various adverse outcomes and were both removed from the market. Happily, today's LARC options are both safe and effective. In fact, LARC is more than 99% effective, while the effectiveness of the user-dependent birth control methods drops to between 75% and 91% with typical use. The arm implant that is available today, Nexplanon®, is a single rod that is inserted subdermally, releases progesterone only, and is effective for at least 3 years. There are currently four types of IUD available in the US, two of which were FDA-approved within the past three years. With the use of IUDs on the rise, it is important for family doctors to be able to use evidence-based information to counsel patients on the types of IUD available, and to be able to manage side effects of the IUDs.

What Do the New IUDs Add?

For many years, the two IUDs available in the US were the copper IUD (Paragard®) and the 52-mg levonorgestrel IUD (Mirena®). In 2013, the FDA approved a 13.5-mg levonorgestrel IUD (Skyla®). Though robust research has shown that any of the IUDs are safe and effective in nulliparous women and teens, Skyla® is the first IUD to have that data available at the time of FDA approval, so it is the only IUD that is FDA-approved to be used in adolescents and nulliparous women. The Skyla's® frame and insertion tube are also slightly smaller than those of the other IUDs, and some evidence suggests that this can make Skyla® insertion slightly more comfortable for the patient and easier for the provider.² Most women continue to get periods with Skyla®, but these periods are generally lighter and less crampy. Unlike its predecessor, the Skyla® is only effective for 3 years. Because of this shorter time frame, many providers are suggesting that Skyla® be used as a second-line IUD option, specifically for women who want to keep getting periods but want them to be lighter, or for whom the smaller frame and insertion device would be beneficial.

In 2015, another 52-mg levonorgestrel IUD (Liletta®) was approved by the FDA. Though it contains the same amount of levonorgestrel as Mirena®, it uses a different insertion device. It is only FDA-approved to last for 3 years, but research is currently taking place to see if it in fact is effective for 5 or even 7 years, like the other 52-mg levonorgestrel IUD. The main benefit of the

Liletta® is its cost. Its manufacturers have made Liletta® available through the 340B Drug Pricing program, which means that it will be accessible to many of the patients of family doctors who provide care to low-income women.

See Table 1 for a comparison of IUDs.

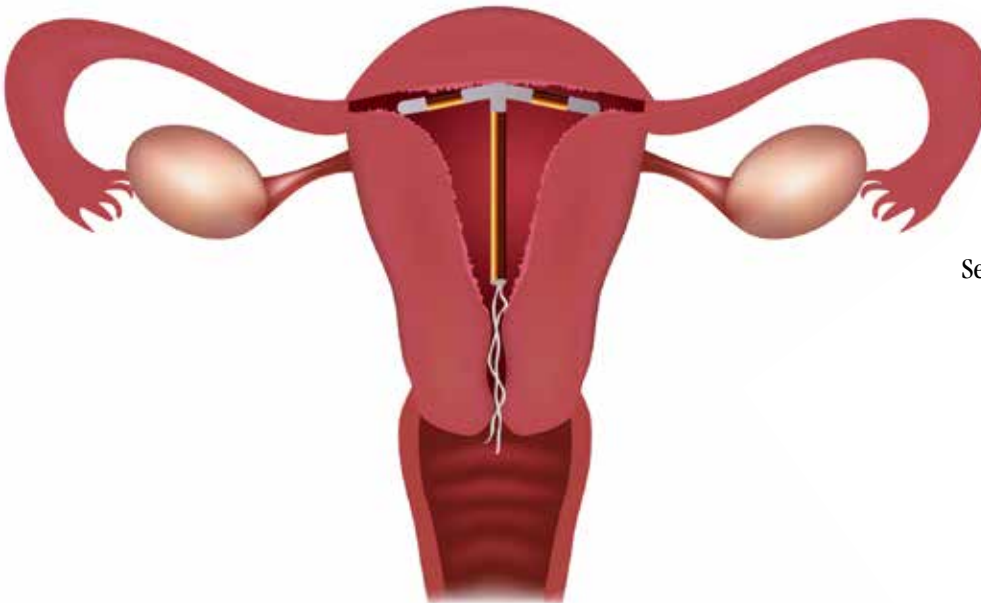


Table 1: Comparing the IUDs^{3,4}

| Type of IUD | Paragard® | Mirena® | Liletta® | Sklya® |
|-------------------------------|--|---|--|---|
| What's It Made of? | Copper IUD frame | Plastic frame with reservoir of 52 mg levonorgestrel | Plastic frame with reservoir of 52 mg levonorgestrel | Plastic frame with reservoir of 13.5 mg levonorgestrel |
| How Long Does it Last? | 10-12 years | 5-7 years | 3 years | 3 years |
| Important Features | -Works immediately -Can be used as Emergency Contraception when inserted within 5 days of unprotected sex | -Lighter periods with less cramping -May not have any periods after several months | -Lighter periods with less cramping -May not have any periods after several months -Available through 340 B Drug Pricing Program | -Lighter periods with less cramping -Smaller IUD size and insertion device -Most women continue to get monthly menses |

Who Can Get IUDs?

The vast majority of women are good candidates for one or any of the IUDs. Except in the case of uterine anomaly or active gynecologic cancer, there are almost no absolute contraindications to all IUDs. Detailed information about which IUDs are safe for women with medical conditions can be found in the CDC's Medical Eligibility Criteria for Contraceptive Use.⁵ See Table 2 for IUD Myths vs. Facts.

What Are the Non-contraceptive Uses for IUD's?

There are many benefits to IUDs beyond their excellent contraceptive effectiveness.⁶ Consider offering an IUD to your patients...

-With pelvic pain: The levonorgestrel IUDs can treat pelvic pain in women with endometriosis, adenomyosis, dysmenorrhea and idiopathic chronic pelvic pain.

-With abnormal uterine bleeding (due to fibroids, hemostatic disorder, obesity, dysfunctional perimenopausal bleeding and idiopathic menorrhagia):

The levonorgestrel IUDs reduce the amount of menstrual blood loss due to endometrial suppression, improving symptoms of heavy or abnormal uterine bleeding and increasing hemoglobin concentration in women at risk for anemia.

-At risk for endometrial hyperplasia: The levonorgestrel IUDs render the endometrium atrophic and inactive, making them a first-line treatment for endometrial protection.

-Seeking emergency contraception: The copper IUD is the most effective form of emergency contraception available, preventing pregnancy >99% of the time. For use as emergency contraception, insertion is recommended within 5 days of unprotected intercourse.⁷

How Can I Manage the Side Effects of IUDs?

Unfortunately, all contraceptive methods have some potential side effects. But most common IUD side effects can be managed without removing the IUD:⁸

-Uterine Cramping: Women with levonorgestrel IUDs can be reassured that cramping is common within the first few months of IUD insertion, but generally resolves by 6 months. Women with the copper IUD may experience increased cramping with their periods throughout the duration of the IUD. Both NSAIDs and heat packs are effective for relieving cramps in women with IUDs.

-Heavy or Irregular Bleeding: NSAIDs and oral contraceptive pills can be used to treat heavy or irregular bleeding, which is most common in the first few months after IUD insertion.

-Partner Can Feel the Strings: Generally, the IUD strings protruding from the external os become tucked around the cervix and are not felt by the patient's partner during intercourse. If the partner can feel the strings, they can be trimmed to a shorter length such that the ends are within the cervical canal. Patients should be advised that this may make IUD removal slightly more challenging.

-Missing IUD Strings: The most common cause of IUD strings not being seen on speculum exam is that the strings have migrated inside the cervix or uterus. Rarely, unnoticed IUD expulsion or uterine perforation is the cause. A transvaginal ultrasound is the first step in the work-up for missing IUD strings, and can safely and accurately assess whether the IUD is still in place. If the IUD is intrauterine and the patient wishes to continue using the IUD for contraception, no further intervention is needed. If she desires IUD removal, an experienced provider can use safe, non-traumatic techniques to remove it.

continued next page

Table 2: IUD Myths vs. Facts ^{9,10}

| Common IUD Misconception/Myth | Facts |
|--|--|
| IUDs can lead to infertility | Extensive research shows no increased risk of infertility with modern IUDs |
| Nulliparous women and teenagers shouldn't use IUDs | IUDs are a first-line option for women of any age or parity |
| IUDs are contraindicated in patients at risk for sexually transmitted infections (STI) | IUDs can be used in women with risk factors for STIs and do not cause STIs or pelvic inflammatory disease |
| IUDs increase the risk of ectopic pregnancy | IUDs actually lower the risk of ectopic pregnancy. However, if a pregnancy occurs while an IUD is in place, the likelihood that it is an ectopic pregnancy is higher than if the patient did not have an IUD |
| Getting an IUD placed is painful | Cramping can occur with insertion but there are multiple techniques that have been shown to reduce discomfort with insertion |

Endnotes

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Caregiver Strain: an Emerging Women's Health Issue

By Rebecca Stetzer, MD



“Informal” or “family” caregivers provide unpaid assistance with daily activities and medical tasks to someone with a disability or illness. Despite the fact that they provide 90% of the long term care in the United States,¹ family caregivers are largely invisible.² They are frequently not consulted as the care team partners that they are, and the profound impact of this role on their lives is underestimated or unrecognized. Caregiver strain is increasingly becoming a women's health issue: the majority of caregivers are women, the bulk of direct care is provided by women, and the negative financial and medical consequences impact women more profoundly.

Who are the Caregivers?

There are 40 million unpaid (“family”) caregivers in the U.S., approximately 16.5% of the population.³ New York states ranks 3rd in the nation for number of caregivers: over 2.2 million provide more than 2 billion hours of care yearly.⁴ The majority of mid-life caregivers are taking care of a parent, many while still caring for their own children.^{5,6} There are more men taking on caregiving activities, and they now comprise 40% of family caregivers. However, women provide a far higher proportion of direct-care hours.

What Does it Mean to be a Family Caregiver?

Providing care to family and friends can be an expression of love, a source of pride, and deeply rewarding.⁷ However, the role frequently becomes a dominant and defining part of the family caregiver's life. The average number of hours spent per week increases with caregiver age, from 14.8 hours for 15-24 year olds, to 34.5 hours for those over 75.⁸ Most family caregivers have no formal training, and learn how to provide care for daily living needs as they arise. Almost half perform nursing and medical tasks.⁵ Many serve as advocates within the medical setting, assist with coordination of care, and help navigate complex medical decision making² and this is all done within the context of increasing social isolation. Adding to this stress is a feeling of being invisible; although caregivers are intimately involved in care recipients' health and lives, their role, and ability to perform it, is frequently an afterthought to the medical team.²

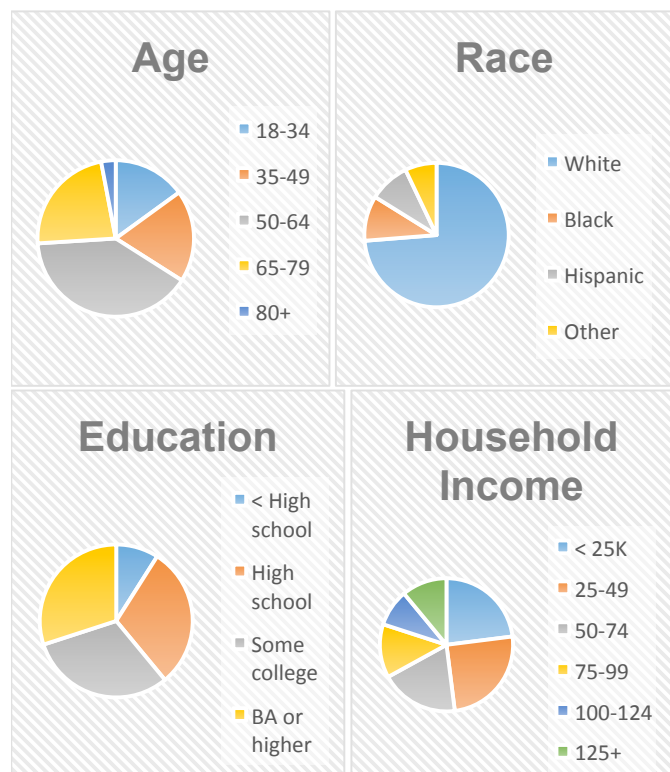
Gender Differences in Caregiving

Studies have found that men and women tend to respond to caregiving responsibilities differently. Women spend an average of 50% more time providing care, resulting in decreased time at work, within the community, and attending to self-care. Men are more likely to contribute financially, resulting in increased working hours and retirement delays.^{9,10} Caregiver strain affects women more profoundly; they have reported lower levels of physical and mental health and overall well-being.^{11,12}

Financial Strain

The estimated economic value of caregiving services was at \$470 billion in 2013 – just shy of Walmart's revenue for that year!² However, that money is not finding its way into caregiver's pockets. The combination of decreased work hours and care supplies can be financially devastating. Compared to non-caregiver counterparts, women caregivers are more likely to decrease work hours, miss or refuse promotions, retire early or simply resign.¹³ The result is that women caregivers are two and half times more likely to live in poverty and five times more likely to receive Supplemental Security Income (SSI) than non-caregivers.¹⁴ The future implications are profound, as these women will not have financial reserves for their own care needs.

Caregivers are a diverse group:



Source: Reinhard S, Levine C, Samis S. Home Alone: Family Caregivers Providing Complex Chronic Care. AARP. October 2012

continued next page

Impact on Mental health

Caregivers have reported feelings of inadequacy, helplessness, anger and guilt. They have admitted to feeling a loss of self-identity and self-esteem.¹⁵ Women frequently become socially isolated.¹⁶ Over 40% of caregivers have clinically significant symptoms of depression.¹⁷ Symptom severity is higher when care recipients have dementia or declining functional status,¹⁸ and in women providing more than 35 hours per week of care.¹⁹ In response to this stress, caregivers are more likely to abuse alcohol and drugs, and in some cases become abusive.²⁰

Impact on Physical Health

The increases in stress, mental and emotional strain, and limited free time all contribute to a decrease in overall health status for caregivers as well. Studies have found caregivers to have higher levels of stress hormones, lower levels of antibody responses, and slower wound healing.^{21,22}

A number of studies have demonstrated that time dedicated to caregiving frequently results in decreased self-care,²³ ranging from preventive care such as diet, exercise²⁴ and screening tests²⁵ to fulling prescriptions²⁶. This is largely due to caregivers prioritizing family and care-recipient needs²⁷.

25% of women report problems with physical health due to caregiving duties.²⁸ Caregivers suffer from nearly double the rate of chronic conditions such as coronary artery disease, diabetes, arthritis and cancer.²⁹ The physical labor involved in personal care can result in injuries, especially to the back.

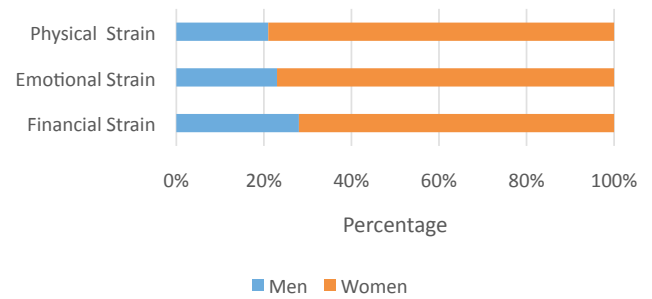
Understanding the financial, mental and physical toll on caregivers suggests areas where targeted intervention will be most helpful. Caregivers are less likely to come into the doctor's office for themselves, making it imperative to reach out when they accompany care recipients to the office. Ask about self-care, support network, service gaps, sources of stress and coping success. As they come in for their own appointments less frequently, screening for common conditions should be included in all visits. When the caregiver and care recipient are patients in the same office, coordinated visits can help caregivers gain access to the medical care they need.

Support Services

Interventions designed in response to an assessment of caregiver needs will be the most effective. Illness-specific education and skills training, support groups, and guidance with navigating the health care system are frequently high-need areas. Commonly available services include home health aides, adult daycare, respite programs, meal services, home modification assistance, support groups, education and ombudsman services. Establishing a relationship with your local office of aging (directory accessible via the first link) will facilitate connecting your patients with the services they need.

Caregivers are a significant and growing part of the population, and the associated burden is still significantly carried by women. Combining attention to caregiver-associated health risks with support services can help ease the burden associated with this vital role.

Gender distribution of caregivers who reported feeling "very strained" by caregiving duties.



Adapted from Center on Aging Society. (2005). *How Do Family Caregivers Fare? A Closer Look at Their Experiences*. (Data Profile, Number 3). Washington, DC: Georgetown University.

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Caregiver Office Visit:

Screen for

- Depression and anxiety
- Substance abuse
- Stress management techniques and resources

Review

- Modifiable cardiac risk factors (smoking, diet, activity level)
- Health care maintenance: routine age-appropriate screening tests, vaccines, advanced care planning

Examine

- Blood pressure and weight
- Musculoskeletal system for injuries, mobility issues
- Lab work: lipid panel, serum glucose

Refer

- Appropriate support services (see page 41)

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- Caregiver Resources:**
Association on Aging in New York: <http://www.agingny.org/AboutUs/AAADirectory.aspx>
- Directory of county offices; “Elder Services” link with core services and explanation of state and national programs.
- New York State Office for the Aging Resource Guide:**
<http://www.aging.ny.gov/Caregivers/Index.cfm>
- Offers a list of resources addressing a variety of potential caregiver needs, including daily care support, legal questions, communication guides for transitions in care, and at-risk driving.
- NY Connects:** <https://www.nyconnects.ny.gov/> or 1-800-342-9871
- Directory of services and supports to help maintain independence in the community setting, searchable by zip code and specific service desired.
- New York State Department of Health:** <http://www.nyhealth.gov/>
- Offers information on higher levels of care and advocates for these facilities.
- Family Caregiver Alliance New York Navigator:** https://www.caregiver.org/state-list-views?field_state_tid=91
- Provides information and links to available caregiving services (including eligibility), housing, homecare, legal help and advocacy. Larger website with caregiver education and connections.
- For dementia patients:** **Alzheimer’s Association** at www.alz.org or 1-800-272-3900
- Extensive information and resources specific to dementia care, searchable by local chapter.
- For veterans:** **VA Caregivers Support** at <http://www.caregiver.va.gov/> or 1-855-260-3274
- Well-organized website offers information about veteran-specific issues, connection to resources, and caregiver support webinars and a support line.
- VeteranAid.org** at <http://www.veteranaid.org/about.php> or 1-866-584-7191
- Information about the Aid & Attendance benefit, which provides financial assistance for care needs of veterans and their spouses, as well as links to other resources and a blog.
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Rebecca Stetzer, MD is a family physician who has been practicing in upstate New York since 2005. She completed a fellowship program in geriatric medicine at Baystate Medical Center/Tufts University School of Medicine in June. She has recently joined the Geriatric Medicine Department at the Stratton VA in Albany.



Good News! Family Doctor is now worth more CME credits.

In an effort to evolve away from time-based credit as well as align with AMA policies, the AAFP Credit System has changed how journal credit is calculated. Effective immediately, the maximum number of credits will be based on the number of eligible articles within each issue with each article worth 1 CME credit. We will no longer require a post-test specific to a CME article, but instead have a short evaluation available for you to provide feedback which will help us improve future issues of Family Doctor.

For example, our summer 2016 issue is worth up to 8 CME credits and members can now claim credits commensurate with their participation. Like always, CME is claimed at the session level by logging in to your account and searching for the journal, selecting the issue, and inputting the number of credits based on the number of articles you read, up to the maximum allowed for that issue. Depending on the necessary approval time for each issue, there may be a delay in seeing credits for each issue, so check back frequently.

We hope that this change will enhance your learning experience with Family Doctor! If you have questions, please contact AAFP's CME Department at 800-274-2237.

NYSAFP is very pleased to share with our readers the winning entries from our second annual writing contest, "Family Doctors Telling our Stories". Our first place winner was "Priceless" by Dr. Dan Way. We hope you enjoy his and our three runners-up stories.

Priceless

By Daniel Way, MD

Taking night call for medical emergencies is never a fun thing under any circumstances. Even after thirty years, when my beeper jars me awake from a sound sleep at 2 AM and I see the ER's number glowing on its message screen, a wave of emotions washes over me. First there is confusion and disorientation, followed by anger and frustration, which gives way to resignation and determination. If, as I quietly walk out the back door I am met with subzero cold or falling snow, it only adds to my self-pity. Usually the experience is something to be endured.

It proved more than that very early one April morning in 2003 when I was asked to come in and evaluate a 48 year-old woman named Winnie I had never seen before, who was a patient of one of my Hudson Headwaters Health Network colleagues. The emergency physician told me she was suffering from severe diabetic ketoacidosis, and although I had treated many cases before, I knew at the very best I would be up all night in the intensive care unit near the patient's bedside ordering various combinations of IV fluids, insulin, sodium bicarbonate and other electrolytes while monitoring hourly blood tests until the patient's metabolism and been restored to a safe balance. I didn't want to think about the very worst.

After wiping the sleep from my eyes I got up and dragged myself into the Glens Falls Hospital ER where I came upon a frail-looking, desperately ill black woman who was moaning and restless, but otherwise unresponsive. She smelled like Wrigley's Juicy Fruit gum from the acetone on her breath. Her sister Judy, looking very worried, was at her bedside. From her I learned that Winnie was a native of Albany who lived in Granville with her husband and three children. She added that Winifred had no health insurance and had not been a Hudson Headwaters patient for over four years. "Then who prescribes her insulin?" I asked. "She got a bottle at the Albany Medical Center three months ago and she's been trying to make it last ever since," Judy answered. As I pondered the significance of this fact she looked up at me with a look of desperation and asked softly, "Can you help her doctor?" As I returned her gaze, I didn't have the heart to tell her that, technically, I was not responsible for a patient who had not been seen by one of my group's physicians within the past three years. It would have been easy to walk away and tell the ER doc to call the MD who was responsible for unassigned patients that night, but I couldn't. Instead I nodded yes, and explained to Judy that her sister had gotten this sick because she wasn't getting enough insulin and was critically ill, and that I knew what needed to be done and would do all I could for Winnie. Her relief was palpable. "Thank you sir", she said earnestly.

After six hours, four liters of IV fluid, over eighty units of insulin, two ampules of bicarbonate and a lot of work by a team of dedicated nurses, Winnie began to come out of her coma. I watched from her bedside as she opened her eyes and began looking around, trying to orient herself. As weak as she was, there seemed nonetheless an intangible sense of grace about her. Perhaps it was the sincerity and concern her sister had shown on her behalf that made

me notice. Finally her eyes locked on me and she asked, "Are you my doctor?" "Yes", I answered. "What's your name?" "My name is Daniel Way. It's good to see you feeling better." With all the strength she had left she whispered "I am feeling better. God bless you Daniel Way." She then fell asleep.

Her simple words uplifted me, as if a window had been opened, letting in a draft of fresh air. A moment before, I had been exhausted and in need of a large infusion of caffeine to prepare for the morning's rounds, but now I felt inexplicably energized. Winnie had reminded me that it was a blessing to be able to heal the sick and help make peoples' lives better. That was why I went into medicine in the first place. Rarely in my experience as a physician had one so ill expressed her appreciation so sincerely, with such effort and effect. This was a special lady I thought, as I shuffled pensively down the hall.

By the time I came back to check on her in the afternoon she was already out of bed and walking around. She didn't even remember our earlier meeting, yet she greeted me with a warm smile and a friendly handshake. I reintroduced myself to her, and she replied "I'm Winnie". I was able to learn that she had been diabetic for over half her life, yet had never suffered any significant organ damage. She beamed when I suggested it was her positive attitude. "My Momma gave that to me when I was very young. She always told me to love myself and see the beauty in other people. Did you know that you are beautiful?" I glanced over my shoulder to see if someone else was standing behind me while she continued. "Everyone is beautiful in some way." The most amazing thing was that this was no act by some burned-out flower child. She was utterly sincere.

The next day, as our conversation shifted from educating Winnie on the dangers and management of her insulin-dependant diabetes to the barriers her self-employed husband was encountering in his attempts to find affordable health insurance, her two sons appeared with their aunt. The respect and affection they lavished on their mother was touching and refreshing. I learned from Winnie that her ancestors were among the first five black families to settle in the city of Albany in the 1880's, and her sense of family pride was obvious. Suddenly I knew I had to try and capture the grace of Winnie's character and the strength of her family's love on film. Although she had only known me for a couple of days, she freely consented to let me take some pictures of her enjoying the company of Judy, Gabriel and Robert on the day she was to go home. Meanwhile we continued discussing the support that would be coming from the hospital's nutritional, case management and social services departments.

Soon the day came when she was to be discharged back to the care of her outpatient physician, who had not seen her in almost four years. As I framed Winnie and her family in my viewfinder, I pondered the events of the past few days, starting with the unwelcome buzzing of my pager in the middle of the night. The amount of time I had spent providing medical care to Winnie? Perhaps six hours. Cost of her four-day stay in Glens Falls Hospital for the treatment of diabetic ketoacidosis? \$6,489.37. Value of meeting and briefly knowing a charming and, yes, beautiful human being whom I was able to help survive a difficult situation? Priceless.



Winnie with sons Gabriel and Robert and sister Judy.

Daniel Way MD, a native of Glens Falls, New York, has practiced rural family medicine in the Adirondack Park for thirty-five years as a member of the Hudson Headwaters Health Network. He is also a noted photographer and author, having published three books of illustrated patient vignettes that venerate the doctor-patient relationship and describes the joys and frustrations of practicing rural primary care in Upstate New York's Adirondack Park. He lives with his wife Dr. Harriet Busch, also a Family Doctor for HHHN, in Glens Falls, New York. He can be reached through his website at www.danielway.com.

Frontline Stories: When You Do Everything Right

By Sheila Ramanathan, DO

My eyes flitted down to the electronic medical record in front of me. I was conducting a physical assessment of a patient new to my clinic and the area. The forty-five year old male sat down before me and I noticed immediately that he was morbidly obese and sweating profusely. I tapped away as he rattled off his various diagnoses which included: cervical radiculopathy, depression, chronic low back pain with radiculopathy, and insulin dependent diabetes, to name a few.

I reviewed his medication list and immediately noticed the prescription for oxycodone. For the second time that day, I patiently explained that I would need his prior medical records, a urine drug screen, and a signed controlled substance agreement prior to prescribing any controlled substance. Expecting anger, frustration, impatience, and indignation over accusing him of inappropriate use, I was instead met with ready compliance. It was such a surprise, and it warmed my heart. My patient congenially stated that it would be fine. He was one of the few patients that had set up an initial appointment soon after moving, as he knew the snail's pace at which the medical system runs. Knowing that medical records can take months to

work through health systems, I prepared myself for the long wait for his medical chart. With the extra time I offered him osteopathic manipulative therapy, which he accepted. It was able to reduce his pain by a few points in his neck and low back. I was ecstatic to avoid the compulsory twenty-minute lecture on tolerance, escalation, and dependency to narcotics and actually spend my time focusing on pain management. I refilled his non-controlled medications and scheduled a follow-up appointment in six weeks. I also ordered a urine drug screen. I make a point of being very strict about narcotics.

I experience scenarios like this at least three times per day, sometimes more. I expect that it will become more frequent, especially as the number of Americans on controlled substances rises and the expectation is to be chronically maintained or escalated despite changes in age, functional ability, and drug interactions. While steps are being taken to avoid dependency, no efforts have been made to address the underlying misconception that a tablet can solve a patient's problems. Direct marketing, along with physicians uneducated to the current standard, have led to this public health nightmare. A nightmare that plays out in office rooms across the country as patients demand sedatives, hypnotics, opioids, and stimulants without realizing the long-term effects. These demands contribute to physician burnout and lead to emotional exhaustion, depersonalization, and a sense of low personal accomplishment.

Six weeks later and no closer to obtaining medical records, my patient hastily handed me a patient summary note from his previous pain management clinic. It corroborated his diagnosis and verified that his medication dosage was appropriate. This clinic was in another state and I had no way to review his controlled prescription history. I couldn't help but reflect on the ineffective regulations for statewide prescription drug monitoring, especially in areas where state lines are a mere stone's throw away. I looked up at him, clearly in pain and sweeter than usual. Since his last urine drug screen was consistent with his current medications and I had some semblance of a medical record, I refilled his last oxycodone prescription and had him plan to follow up at our local pain clinic to get surgical intervention.

As I was finishing up notes from earlier in the week, a nurse poked her head in and alerted me that a counselor at a drug rehabilitation facility would like to speak to me concerning my patient. Startled, I picked up the phone to hear that my patient had met with a counselor to discuss his feelings of opiate addiction and suicidal ideation. He notified me that my patient had been checked into a drug rehab facility for snorting heroin in the past and was concerned he would start using again. Horrified by this realization, I felt shamed by my inappropriate prescribing. I emphatically told the counselor that I would not be prescribing my patient any further narcotics and that the remainder of his prescription would be tapered.

My heart was in my throat. How had this patient slipped through my stringent system? How had I failed to screen appropriately? The controlled substance agreement was a stack of paperwork detailing mental health, prior abuse history and a series of agreements between the patient and

myself. My patient had lied to my face and manipulated me into providing him something that could kill him. I felt betrayed and terrified that I had so easily been complicit in my patient's twisted addictive spiral. My compassion and sense of humanity had backfired spectacularly. Dark thoughts swirled in my mind, making me wonder as to the competency of my medical training which failed to prepare me for the depth of patient diversion, misuse, abuse and noncompliance. The experience led me to a state of hypervigilance and feelings of unwarranted mistrust toward my other patients.

Two weeks later my patient returned to my clinic. My anger and frustration had welled up. I dread these types of visits. Visits during which I spend the majority of the time drawing a picture of the neuromuscular junction and explaining why I cannot prescribe scheduled substances to them. My patient explained that he was in constant pain and had only snorted heroin a few times over a year ago. He demanded medication to assist with his pain control and I calmly stated that I could only treat with neuropathic agents. I empathized with him and though I understood that he was in legitimate pain, I would not treat him with narcotics due to his history of abuse and the potential risks. After a thirty-minute conversation, my patient walked out, muttering angrily and threatening that he was either going to the emergency room or would find something off the street. His comments only added to the overwhelming emotional fatigue that I felt about whether I was even making a difference by standing up to the wave of addiction moving through the community. I sighed with a heavy heart but mentally prepared for my next patient. I tended to be strict about illicit drug use.

I read through messages from my patient in the electronic medical record. After three months of waiting he was finally placed in a rehabilitation facility in another state. Most local community resources are completely overrun when it comes to the management of pain or mental health. I perused the affiliated hospital records to check if he had been to our emergency department. He had not. I spotted a nurse's note stating that he had successfully completed his sixty-day stay and had scheduled a follow-up appointment with me. As I walked into the small room, my patient was seated calmly. I congratulated him for completing his time in rehabilitation. My patient smiled and happily expounded on his extensive time there. He relayed how he had wanted to get narcotics at the emergency room, just like he had threatened during his last visit; however, he resolved not to do so since I had refused to give him a prescription for oxycodone. He stated that his mental health had finally stabilized after extensive time in rehab and that he received the counseling help that he had needed. After increasing his non-narcotic pain medication and completing the visit punctuated with my delighted congratulations, my patient stood up and a little sheepishly asked if he could hug me. My arms were as wide as my smile. I am strict about hugs.

Sheila Ramanathan, DO graduated from Lake Erie College of Osteopathic Medicine and trained in rural family medicine in Watertown, NY at Samaritan Medical Center. She is currently board certified in family medicine and continues to practice rural healthcare in Keene, NH as part of the Dartmouth Hospital System.

She Was 85

By Patricia Hermogenes, MD

She was 85. I have been Edit's and her family's physician for 12 years. She lost her only son at age 48. She had not seen her 2 grandchildren since her son died. All her family lived in Hungary. Her only niece lived in Ohio. All she wanted was to go the grave and bring her son flowers and balloons. But he was buried 50 miles away.

Edit's son's birthday was February 14. I agreed to take her to the grave. It was snowing, and snowing heavy. She had two dozen roses and 6 balloons. Her son would have been 49 then. We made it to the cemetery. "But wait," ... she told me. "There is no tombstone. It would only be a piece of cardboard on top of the grave. The tombstone will not be put up until after December."

"He is buried somewhere towards the inner part of the lot, fifth from the left, not far from a willow tree." The snow was knee-deep.

"Stay in the car," I said. "Let me look for his grave."

I went to the direction she pointed me to. But the snow was deep. I searched for the cardboard with his name on it. I could not find it.

"Edit!" I said. "I cannot find the cardboard with his name on it. The snow is too deep to find it."

She cried. "I will let the balloons go, and I will leave the flowers right here."

We said a little prayer. Then she signaled me to go.

"Edit, I think I lost the car key. Let me trace back my steps and see if I could find it." The snow was getting deeper. I did not find the key.

"It's okay. I have the duplicate in my purse. And who would steal my car when we are 50 miles away?" And so we drove back.

I speak to my father by phone every week. He, too, is a family physician. I told him about my trip to the cemetery with Edit.

"There is nothing wrong with doing it again," he said.

So I told Edit. We agreed to go in June, on Father's Day.

That day in June was beautiful. The sun was out. Again, she carried 2 dozen roses and 6 balloons. We found the grave where she directed me to. We were silent for some time.

A man was coming towards us.

"Is that your car?" he said.

"Yes," I said. "Am I blocking you?"

"I am the caretaker of the cemetery. Every time I see a Honda, I click the alarm. I finally found the car! The snow melted in April, and I found this key on the ground. I said to myself, the owner will come back to see the grave. Here is your key!"

I turned to Edit. "Sebastian is watching over my key!"

I thanked the caretaker, still in awe over my keys after we left the cemetery.

Again, on a Sunday, I told my father the miracle of what happened.

"There is nothing wrong with doing it again," he said.

And so, Edit and I would do it for another 4 trips, until she joined Sebastian and her husband.

Patricia Hermogenes, MD is a practicing family medicine doctor in Elmhurst, NY.

My Mentor

By Louis Verardo, MD, FAAFP

I was introduced to Dr. Louis Ingrisano midway through my medical school training in Italy. He was a former GP, now board-certified solo family physician in our community, a Georgetown graduate who served as a clinical teacher at both Downstate and the Nassau County Medical Center. My mother was friendly with his wife, and his younger son and I had gone to grammar school together at our local parochial school. I needed to obtain what was then called a "supervised clinical clerkship", the ECFMG's version of a US medical school's third year experience, and Dr. Ingrisano was willing to make the proper introductions to the dean at NCMC who would certify my training. In addition, he did something truly extraordinary: he personally took me under his tutelage for the next several years, serving as direct preceptor for a 5-month rotation in his ambulatory care clinic (located right off the emergency room at NCMC), followed by bringing me into every aspect of his daily practice, including office and hospital rounds, nursing home rounds, and his work at creating continuing medical education programs for his departmental colleagues.

A few things I recall from our time together. First, he was the consummate physician, confident but not arrogant, superb in his physical examination skills, and able to explain his diagnostic conclusions to the patient (and me) in ways we both understood. Second, his demeanor was very adaptable, and appropriately so. I witnessed incredible gentleness when he was telling bad news, combined with reassurances to patients that they would have his presence throughout their illness. I saw him gruff on occasion as well, but never demeaning or mean-spirited, and upon reflection, those may have been circumstances where he was trying to break through a patient's barriers, to help them deal with a particular illness or behavior affecting health. Third, he did something so generous in a way only a penniless medical student would appreciate: every day, for as long as we worked together, he bought me lunch wherever we went. Hospital cafeteria, coffee shop in-between house calls, delicatessen in the community, or his own home: he always paid, and the only thing he ever said to me was, you do the same when you have a student.

Dr. Ingrisano served as the physician for a group of retired and elderly nuns who had been members of a religious order for a local Catholic high school for girls. I watched him enter the ward and bring a courteous charm to each of those women as he dealt with the routines of a nursing home facility, with its collection of often difficult, sometimes terminal conditions. Never did I see his warmth or loving realism fail, and I believe the staff and the patients loved him for that; so much so that, years later, in failing health and widowed, I saw him taken into that same facility by those same women, and cared for by them until his death.

When I was completing my residency training, Dr. Ingrisano offered me a position in his practice. There were several personal and professional goals I was looking for post-training, including a possible fellowship in faculty development, plus getting out of what I perceived as an overly-crowded, overly-doctored environment here on Long Island, so I declined with what I hoped was sufficient gratitude for being asked. To his credit, my mentor remained gracious and kind, was supportive of my future plans, and never expressed any disappointment or anger with me for my career choices.

We kept in touch after I graduated. I took myself out of the running for the fellowship after my interview, decided that I needed to have more real-world experience before I took up a university position (a view which now seems quite old-fashioned in the contemporary academic medical center), and ended up in solo rural practice for several years before returning to the community hospital where I had trained, in the new capacity of faculty member in my former residency program. I had kept in touch with Lou through the years, and I had now taken on some of the same roles he had occupied in his own career: I saw patients, I taught medical students and residents, and I ran CME for my institution. My suspicion was that I never was able to make it seem effortless, a sensation I had clearly appreciated previously while watching him at work. I also lacked the grace under fire which I always admired in Lou, especially the in-fighting which occasionally comes up in our profession. I watched in awe as this excellent doctor received praise from his specialty colleagues for his knowledge, and sometimes jealous scorn from his fellow generalists for the same reason, yet he refused to be separated from his fellow family practitioners and remained loyal to a fault to all his colleagues. He was active in our county and state medical societies and academies, and his actions as well as his words showed me the importance of being part of a professional group. We compared notes on the challenges of navigating what appeared to be a very changeable medical environment and the explosion of medical information we needed to manage in the contemporary practice of medicine. On a night I will always remember, I hosted Dr. Ingrisano at one of our monthly medical education dinner programs, and I got the rare privilege of telling him, in front of my colleagues, how much I loved and respected him for all he had done for me, for our specialty, and for his patients.

It has been many years since my mentor passed away, and many years since my student days as well. I have had the privilege of learning from other physicians during my residency training, and also during my years of practice. I have also learned from my students and residents the last lesson my preceptor was teaching me almost 45 years ago: you remain young at heart, intellectually stimulated, and emotionally fulfilled when you teach our profession to younger colleagues.

Hippocrates says "...I will keep this Oath and this stipulation – to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him". I certainly hold Dr. Ingrisano in a special place of honor in my life, akin to my father; both men taught me much about being a man. And while I no longer have the privilege of hosting my mentor for a special meal or event, I have kept the faith and commitment he showed to me so long ago in a very special way: I do not let my students or residents pay for a meal when I am around, and I tell them why.

Thanks for everything, Lou; rest in peace, you have earned it.

Louis Verardo, MD, FAAFP is a 1978 graduate of the University of Bologna, Italy, and a 1981 graduate of the Family Practice Residency Program at Glen Cove Hospital. He has worked for many years, primarily on Long Island, in numerous facets of family medicine including clinical practice, research and teaching students and residents. He currently practices at Stony Brook Family Medicine and is an active member of the NYSAFP.

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