

IMS
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Bulletin



Indianapolis Medical Society
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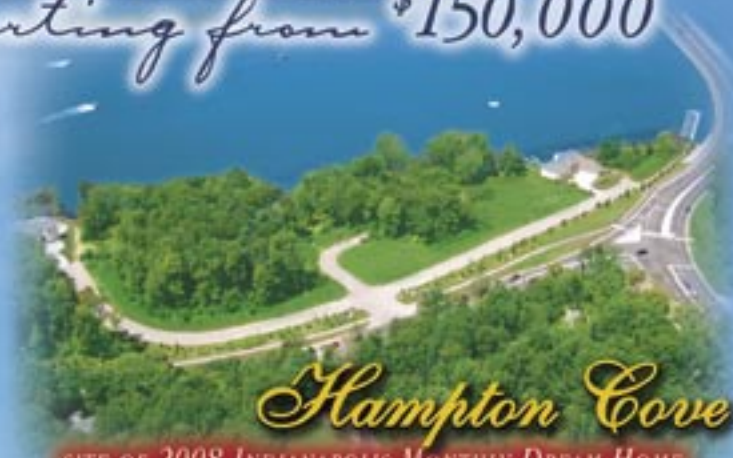




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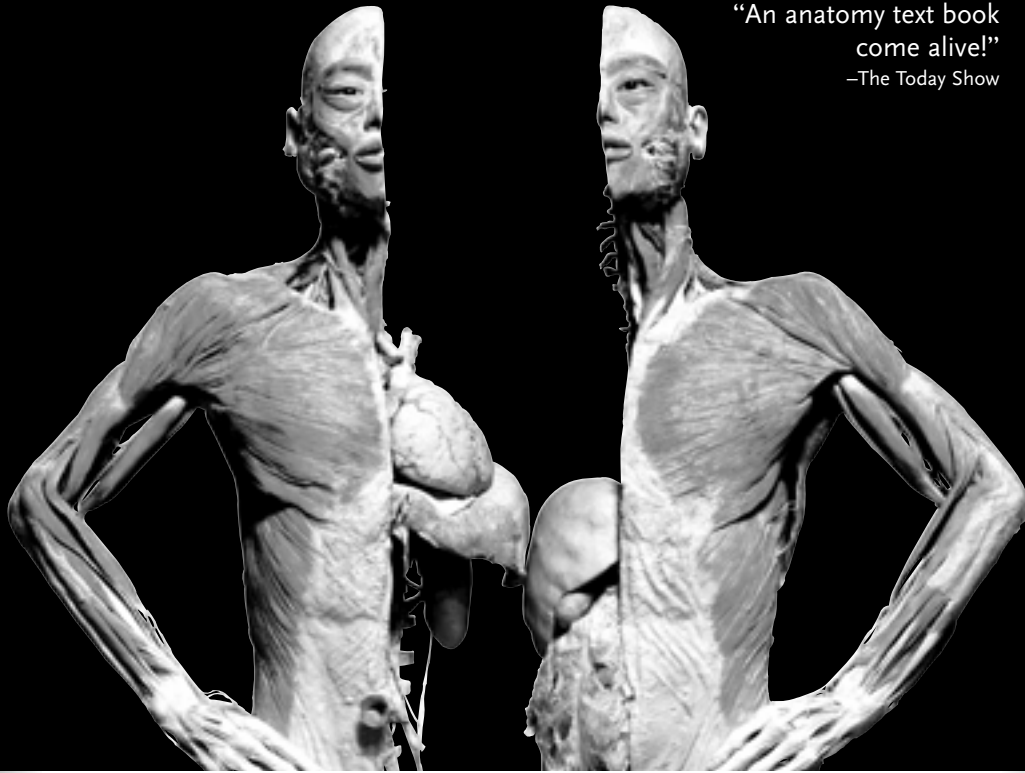
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ATTENTION SOCIETY MEMBERS

We like to feature photographs or other artwork shared by IMS members on the cover of *The Bulletin*. Submit photographs, artwork, etc., to Beverly Hurt at the Society Office.

The Bulletin is your magazine. Share your views by submitting reprints of your published articles; articles written expressly for *The Bulletin*; quips; short stories; brief comments; ideas; cartoons, etc.

Remember the *Indianapolis Medical Society Foundation* when planning your will. (Contribution form included in this issue.) Unless otherwise specified, your contribution will be directed toward medical scholarships.

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in this issue

Special Features

President's Page

Do You Make the Grade?

Heidi M. Dunniway, MD 7

Esteemed Leader Retires from MSE

Robert Winston Mouser Retires 8

Resident & Medical Student Abstracts

2007 ACP Competition..... 12

Indiana Professional Licensing Agency

Kristen Kelley, Director 14

Luke, Come Over to the Dark Side

Michael D. Brown, Health Care Economics, LLC 18

2008 7th District Annual Meeting 20

Project Health

Thank you, F. Thomas Kaplan, MD

Carrie Jackson Logsdon, Director 22

Project Health's Laura Gonzalez Honored

2008 Latina Woman of the Year 38

Departments

About Our Cover	5
Advertisers' Index	46
Bulletin Board.....	11
Classified Advertising.....	46
CME & Conferences	34
IMS Foundation	38
IMS Leadership	40
IMS Travel Group Insurance	28
New Members	16

about our cover



"Happy 4th of July"

Happy 4th of July!
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on her 232nd Birthday.

The photographer is unknown.



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President's Page *Heidi M. Dunniway, MD*

"The mission of the Indianapolis Medical Society is to promote professional growth, advocacy for all physicians, and quality health care for the community!"

Do You Make the Grade?

Feedback from patients can be helpful in improving our practices and the quality of care we provide, but a new forum available through an online rating service raises new concerns. In March 2008, Angie's List, an online service ranking list based in Indianapolis and available in several cities throughout the country, added a new category allowing patients to rate physicians. The site allows members to assign a letter grade to physicians in several categories, including price, quality, punctuality, professionalism, and an overall score. Also included are questions such as whether the physician recommended a generic or specific drug, was there adequate time to address concerns, what the member liked most and least about the physician, and whether or not the member would "hire again." The member is given the opportunity to include any other comments they wish. The patient's answers are posted on Angie's List anonymously; the physician receives notification that they have been rated and, after registering with the site, is allowed to view the entire rating and commentary including the patient's identity. The physician then has the opportunity to respond, either online or by speaking directly with the patient.

Here is where things get sticky. How do you respond publicly, especially to a negative report or specific complaints, without violating HIPPA? We all are very well aware that healthcare is a complex and often very emotionally charged subject. Our patients sometimes have very different ideas on what they want from a physician visit versus what we believe is appropriate, such as testing, medications or procedures. Sometimes, these differences of opinion are valid and can help us look outside the box. Other times, the patient had other motivations or has received confusing or faulty information from other sources. There is no way to discern this on Angie's List or any similar site. In a letter responding to concerns by one of our IMS members, Chris Austin, Senior Manager for Health Care at Angie's List, indicated that each report is screened before posting, and members are "held to the standards of fairness and accuracy..." He contends, "Our members are smart enough to evaluate whether they received satisfactory medical service and are articulate enough to express their assessment fairly. They're also smart enough to evaluate the reports they receive on any given service provider." He also makes note that Angie's List offers "suggestions for language that the provider may consider" to comply with HIPPA. The initial letter sent to physicians after they have been rated touts Angie's List as a great way to build a new client base, with 600,000 members nationwide.

The biggest challenge presented by physician ratings on a forum such as Angie's List is patient confidentiality and HIPPA compliance. After much discussion, including legal opinion, the IMS Executive Committee concluded that, as a physician, you really cannot respond publicly/online. Certainly, physicians have the option of speaking directly with the patient, but there is no clear way to publicly refute anything negative relayed in a physician review. This not only applies to physicians but also has the potential to affect any profession requiring confidentiality, such as law, counseling, and physical therapy. I, personally, am not trusting in or comforted by the suggested language provided by Angie's List. I doubt the company would stand behind me if it came down to a HIPPA violation.

Patients are definitely the best sources for feedback on several facets of our practices, such as office environment, our staff, ease of scheduling, and our own ability to communicate and interact with those in our care. I firmly believe patients should have an active role in their own healthcare. Our patients deserve understandable explanations of our recommendations, test results and proposed procedures. This also comes with responsibility on the patient's part to verbalize their questions and concerns, in addition to following an agreed treatment plan and providing us feedback on problems that occur prior to scheduled return visits. The Angie's List approach is also problematic in that the patient evaluation is mostly subjective, with little medical background in most cases. As pointed out by Greg Larkin, MD, IMS Immediate Past President, "a patient dissatisfied because a desired test wasn't performed, a new drug prescribed, a less than expected outcome or a delay to return to work ... doesn't interpret into bad care, just not an agreement with the physician's expertise."

Based on the relatively small number of subscribers (600,000 nationwide), it is doubtful that physician ratings on Angie's List will have a significant impact on our practices, and most patients will continue to rely on other physicians, their family and friends to find their doctors. I, for one, would hope that my patients would provide feedback directly to me so that I can try to address their concerns immediately rather than venting publicly in a forum where I am unable to respond. Communication is a two-way process; along with trust, isn't that fundamental to the patient-physician relationship? I wonder if Angie realizes how much she's doing to undermine that...

Esteemed Leader Retires from MSE



Robert Winston Mouser has retired from the leadership of the Indianapolis Medical Society Exchange. Dr. Mouser served on the MSE Board of Directors from 1977 – 2008. His wisdom, wit and service will be missed by the Exchange. He retired from active practice earlier this year.

Dr. Mouser, physician and surgeon, was born October 21, 1931 in Indianapolis. His ancestors settled in this country prior to the American Revolution and he is of English, Scottish-Irish, French and German decent. He studied at Wabash College, Butler University, Purdue University and the Universite Laval in Quebec, Canada and earned his degrees from Indiana University and Indiana University School of Medicine. He served his pre-residency Specialty Partial Internship at Veteran's Hospital in 1953-54, his rotating internship at Methodist Hospital in 1954 and his residency at Veteran's Hospital in Medical Neurology in 1955.

From 1955 to 1957, he served as a member of the United States Air Force, assigned as Commanding Officer of the 6029th United States Air Force Dispensary in Japan and holding the rank of Captain in the Medical Corps.

Dr. Mouser has had a vibrant and varied career with an extraordinary devotion to medicine and a passion for life. In Family Practice since 1957, he was staff surgeon at the Indianapolis Motor Speedway; Class I Medical Flight Examiner and Aircraft Accident Investigator

for the Central Indiana Area of Federal Aeronautics Administration; staff member of St. Vincent's, Methodist, Community and the Indiana University hospital systems; Indiana State Past President of the Indiana Diabetes Association; Medical Advisor for the Indianapolis Draft Board and Clinical Associate in the Department of Family Practice of the Indiana University School of Medicine. Fraternally and socially active, he was International Director and former Governor of Sertoma International Service Club; Past President of Nu Sigma Nu Medical Fraternity for the local and state chapters; Member of the Contemporary Club; Admissions Council for Wabash College; Life Member of National Rifle Association; member of the American and Indiana Orchid Societies; member of Sons of the American Revolution; member of the Indiana Historical Society; Past National Alumni President Wabash Chapter Phi Kappa Psi Fraternity; Member Mystic Tie Masonic Lodge, Scottish Rite, York Rite and Murat Shrine; Tabernacle Presbyterian Church; and the Highland Golf and Country Club. Dr. Mouser is a member of the Indiana and American Academies of Family Practice and board certified by the American Board of Family Practice.

Dr. Mouser was admitted to the Indianapolis Medical Society in November 1954 and has served the Society in many capacities over the years including Board of Directors Vice-Chair, IMSA Alternate Delegate and Delegate, County Executive Committee, County Secretary Treasurer, Articles and By-Laws Committee and, of course, his favorite the MSE.

According to friend and long-time colleague, Dr. Bernard J. Emkes stated, "There is no physician more revered and adored by his patients than Dr. Bob Mouser. He recently retired from the practice of medicine, but many of his patients continue to use St Vincent Hospital. At least once a week one of his long-term, loyal patients recognizes me in the hall and asks, "What am I ever going to do without Dr Bob?" Dr Mouser remains the consummate physician. Always there for his patients, hard working and never complaining. He should be recognized first for his faithfulness to his patients and his partners, but also for his loyalty to one of his heartfelt interests – The Medical Society Exchange. Congratulations on a wonderful and fulfilling medical career and thanks for the many years of service on the Board of the Medical Society Exchange." Dr. Emkes also noted Dr. Bob's wit highlighting, "His 'Brain Surgery While You Wait' sign was always present in one of his exam rooms and very visible to patients.

Bob carried a Butazolidin tablet in his white coat. However, this was literally a "horse pill" – actually made for horses. About two inches or more long and at least an inch an a half circumference. On more than one occasion, I heard him tell a somewhat reluctant child, that if he did not take the liquid medication his mother was asking him to take, he could prescribe a pill. You should have seen the eyes of a 4 year-old as this pill was produced!"

Thank you, Dr. Bob!

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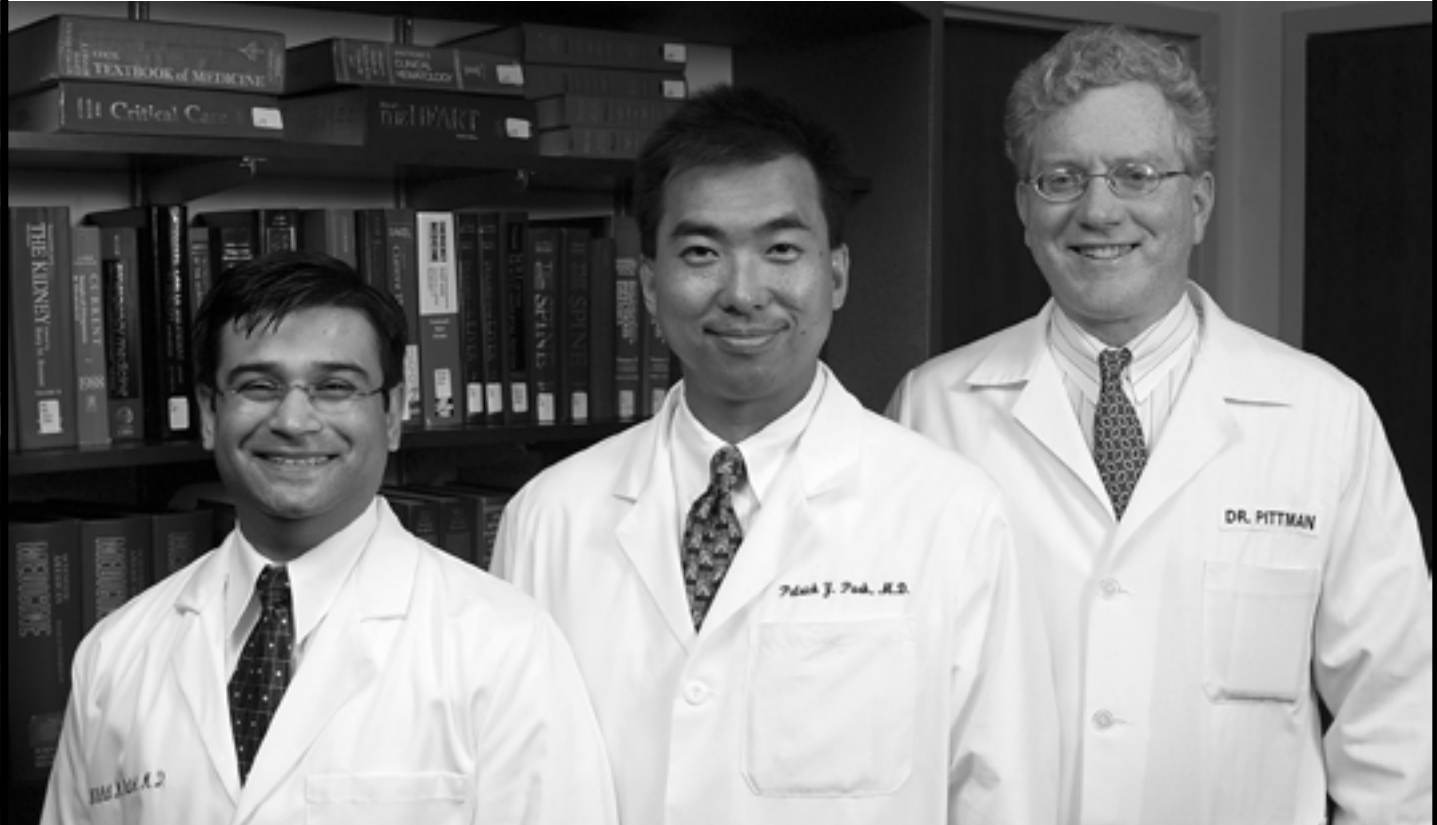
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Case #9

Patient: 40 yr old male w/ self diagnosis of "hemorrhoid problems" with 6 months of symptoms of itch, burning and seepage and slight blood tinge on toilet paper. No prolapse. No pain. No change in bowel movement. No family history of colon cancer.

Exam: Perianal, superficial excoriation @ verge w/thickening, pale appearance and radiating skin folds. No prolapse or bleeding. No fissure.

Diagnosis: Pruritus Ani.

Treatment Options:

- 1) Avoidance of soap to the area
- 2) Any reasonable topical agent such as calmoseptine
- 3) Time-months
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Bulletin Board

Shahid Athar, MD, received the “Distinguished Service Award” from the Internal Medicine Residency Program at St. Vincent Hospitals and Health Services in recognition of his outstanding service to the education of resident physicians. This is the second time Dr. Athar has received this award, the first time was in 2000.

Lee A. Fischer, MD, presented “Diseases without Borders – Conditions with Limited Objective Medical Evidence” in Kansas City, Missouri and to the Midwest Claims Conference in Lake Geneva, Wisconsin in May 2008.

Seth D. Cahn MD, Heartland Neurology, presented a talk, “Recent Advancement in Research and Treatment of Alzheimer’s Disease,” to an Alzheimer’s support group held at Riverwalk Commons in Indianapolis in May 2008.

Douglass S. Hale, MD, and **Patrick J. Woodman, MD**, Urogynecology Associates, presented original research on the Prolift Procedure for Pelvic Floor Disorders at the Society of Gynecologic Surgeons in April. Dr. Hale also was a discussant at the SGS Scientific Meeting.

Stephen W. Perkins, MD, Facial Plastic Surgeon, Meridian Plastic Surgeons, was a guest speaker and one of only four from the United States to speak at a program entitled, “Recent Advances In Rhinoplasty and Facial Plastic Surgery – II” at Ege University Atatürk Cultural Centre, Konak, İZMİR, Turkey. Dr. Perkins presented eight lectures and five video presentations to fellow Facial Plastic Surgeons at a special meeting to commemorate the 50th Anniversary of the Department of Otolaryngology at Ege University.

Richard L. Schreiner, MD, was honored with the Glen W. Irwin Jr., MD, Distinguished Faculty Award during the 2008 IU School of Medicine Spring Medical Weekend in May 2008. Dr. Schreiner, who joined the IU faculty in 1978, is the Edwin L. Gresham Professor of Pediatrics and chairman of the Department of Pediatrics at the IU School of Medicine, and has served as physician-in-chief at the James Whitcomb Riley Hospital for Children since 1987.

William J. Berg, MD, Indiana Heart Physicians, is the principal investigator for a catheter-based pump device being evaluated in a clinical trial under way at St. Francis Hospital & Health Center for the Impella 2.5. The trial, PROTECT II, is the second Food and Drug Administration approved trial for prophylactic preventive use of the device during non-emergent high-risk coronary intervention procedures.

Richard T. Miyamoto, MD, Arilla Spence DeVault Professor and chairman of the Department of Otolaryngology – Head and Neck Surgery at IU School of Medicine, was the senior study author of a study appearing in the May issue of *Otolaryngology – Head and Neck Surgery*. The study is the first research to show evidence that cochlear implants in both ears significantly improve the quality of life in patients with profound hearing loss and that the cost of the second implant is offset by its benefits.

Rick C. Sasso, MD, and **Kenneth L. Renkens, Jr., MD**, Indiana Spine Group, published an article in *The Spine Journal* entitled, “Randomized, Prospective and Controlled Clinical Trial of Pulsed Electromagnetic Field Stimulation for Cervical Fusion.”

Dr. Sasso served as an invited faculty member at the Symposium “Controversies in Contemporary Spine Surgery,” held in Washington, DC. Dr. Sasso spoke about minimally invasive spine surgery and the application of spinal intraoperative navigation technology to facility minimally invasive procedures. This image-guided, intraoperative navigation technology is very similar to a GPS system, which allows three-dimensional visualization of the spine on a heads-up computer monitoring system.



Shahid Athar, MD



Laurence H. Bates, MD



William J. Berg, MD



Seth D. Cahn, MD



Maureen A. “Penny” Cooper, MD



Lee A. Fischer, MD



David A. Fisher, MD



Douglass S. Hale, MD



Frank R. Kolisek, MD



Ronald S. Miller, MD



Richard T. Miyamoto, MD



Stephen W. Perkins, MD



Kenneth L. Renkens, Jr. MD



Rick C. Sasso, MD



Richard L. Schreiner, MD



Michael T. Slaughter, MD



David I. Steinberg, MD



Randall C. Trowbridge, MD



Patrick J. Woodman, MD

Dr. Sasso was co-author in 12 research studies presented at the Annual Meeting of the “Spine Arthroplasty Society, which was held in May in Miami Beach, Florida. He also co-authored an article on basic science biomechanical study evaluating stabilization techniques of the occipitocervical junction in the International Peer Review Journal, Spine.

Laurence H. Bates, MD, **Maureen A. “Penny” Cooper, MD**, **Michael T. Slaughter, MD**, and **Randall Trowbridge, MD**, Indiana Oncology Hematology Consultants (IOHC), has merged with the St. Francis Medical Groups to form a network of professionals practicing at St. Francis Hospitals in Indianapolis, Beech Grove and other locations throughout the state.

Enrolling patients in studies at OrthoIndy ...

Ronald S. Miller, MD, and **David I. Steinberg, MD**, study, “Transcutaneous Electrical Nerve Stimulator Outcomes Assessment Registry.”

David A. Fisher, MD, study, “A Comparison of Inorb Staples with Metal Staples in Total Hip Replacement.”

Frank R. Kolisek MD, studies, “A Multi-center Activity Survey Study Assessing the Patient’s Pre and Post-Op Activity Levels Following Total Knee Arthroplasty” and “A Multi-center Comparison of Pre- and Post-Op Activity Levels of Total Hip Arthroplasty Patients.”

IMS



Resident & Medical Student Abstracts

Your Indianapolis Medical Society is pleased to continue to present abstracts written by internal medicine residents and students for the 2007 Indiana ACP Abstract competition. The competition was judged by the separate categories with the top five in each category receiving awards. We want to thank the members of the ACP Associate Council for their help; in particular, Craig Wilson, MD, St. Vincent Internal Medicine Program Director; Lia Logio, MD, Indiana University Internal Medicine Program Director; Matthew Neal, MD, Ball State Internal Medicine Program Director; Robert Lubitz, MD, Governor, ACP Indiana Chapter and Brent M. Toney, DO, Chair, ACP Indiana Associates Council. *The Editor*

Second Place Clinical Vignette: Lakmali Ranathunga, MD, Jay Gaddy, MD

An Autoantibody against the RH-e Antigen, Primed by Allogeneic Red Blood Cell (RBC) Transfusion, Causing Severe Hemolysis

Introduction: The Rhesus (Rh) blood group system includes 5 important antigens D, C, c, E and e, encoded by two highly homologous genes on chromosome 1. Both pregnancy and transfusion are possible means of alloimmunization against Rh antigens. The D antigen is the most highly immunogenic Rh antigen with 50-70 % of D negative individuals transfused with D positive blood forming anti-D antibodies. Of those patients who are lacking C, E, c and e antigen and who are transfused with blood positive for one of the above antigens, less than 1 % form the corresponding alloantibody. Rarely autoantibodies against Rh antigens develop spontaneously, and even rarer still, autoantibodies against Rh antigens are elicited following allogeneic RBC transfusion. We describe a case in which a patient either spontaneously developed or had elicited by a remote RBC transfusion, an autoantibody against the Rh-e antigen causing a hemolytic anemia which was significantly worsened by subsequent allogeneic RBC transfusion.

History of Presenting Illness: An 83 year old white male with a history of coronary artery disease and prior coronary artery bypass graft (CABG) surgery, hypertension and hyperlipidemia presented to a regional hospital with increasing dyspnea and weakness. Initial work up revealed a hemoglobin (Hgb) of 6.4 with heme positive stool. Of note, the pt had a Hgb of approximately 13 one year prior at the time of his CABG. It is unknown whether the patient received RBC transfusion at the time of his CABG surgery as records were unavailable. Neither EGD nor colonoscopy was able to find a source of bleeding. One unit of packed RBCs was transfused prior to the endoscopies. During initial cross matching it was revealed that the patients' blood type was O negative and that his RBCs expressed the Rh-C and Rh-E antigens. Both IgG and IgM antibodies to the Rh-C antigen were present as well as a small amount of unclear reactivity. One week later, the patient received 2 units of RBCs and the crossmatch at that time again demonstrated the anti-C antibodies as well as a newly delineated anti-e activity. A repeat antibody screen 3 weeks after the second transfusion revealed markedly increased levels of anti-e compared to the previous screen. The pt was started on oral iron and was transferred to a tertiary referral center for further care. On admission, vital signs were within normal limits; he was jaundiced and displayed neither lymphadenopathy nor organomegaly. Laboratory work up revealed undetectable haptoglobin, very elevated LDH and indirect bilirubin, and an increased reticulocyte

production index, consistent with a hemolytic process. Despite a national search coordinated by the Indiana Blood Bank, a compatible donor could not be found. Therefore, the patient was started on oral prednisone and IV immunoglobulin and had a significant response with his Hgb rising to 8 without transfusions. Because the pt was relatively asymptomatic and hemodynamically stable, a decision was made in consultation with the Central Indiana Regional Blood Center to not transfuse, unless absolutely necessary, any e-positive or E-positive (e-negative) RBCs due to the risk of worsening autoantibody titers or alloimmunization. Unfortunately the patient died on day 6 of the hospital admission due to unknown causes. Labs demonstrated acute on chronic renal failure, elevated troponin and lactic acidosis which may have been provoked by his anemia. An autopsy was denied.

Discussion: Autoantibodies against Rh antigens occur rarely in spontaneous fashion and even more rarely following allogeneic RBC transfusions. Whether the patient described above spontaneously developed an autoantibody with anti-e specificity or if such an antibody was elicited by an allogeneic RBC transfusion that occurred at the time of his CABG or his first transfusion described above, it seems evident from the clinical and laboratory course that the anti-e activity became clearly apparent and increased significantly following further allogeneic RBC transfusions. In such a case it is prudent to avoid, if possible, further RBC transfusions so as to not cause an increase in autoantibody titer or new alloimmunization. However, RBC transfusions should be given if clinically indicated, with careful observation for worsening hemolysis or an acute hemolytic transfusion reaction.

Third Place Clinical Vignette: Andrew Martin, MD, Tom Slama, MD

Daptomycin Induced Pneumonitis

Introduction: Drug induced pulmonary disease is an adverse effect seen with many drug classes. Early identification of patients with drug induced pulmonary disease is important because stopping the drug usually reverses lung toxicity whereas those who go unrecognized can have fatal outcomes. As new drug classes emerge it is important to be vigilant to previously unreported adverse events.

Case: A 60-year-old diabetic male with charcot's foot was admitted to the hospital for treatment of an infected foot ulcer of his left first toe. He was empirically started on vancomycin and levofloxacin with local care and debridement of the lesion. His culture subsequently grew methicillin-resistant staphylococcus aureus and MRI of the affected limb suggested osteomyelitis affecting the first metatarsophalangeal joint. At this time his

Continued on page 36.

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Impressive estate home built by Pate tucked away in a private 1-ac setting! 5 flpcs, elaborate moldings, beautifully updated kit open to sunrm, sumptuous master w/ spa bath, spacious lwr lvl & so much more! (2821027)



4037 OAKLEAF DRIVE • \$669,900

Amazing custom home in a peaceful cul-de-sac setting in desirable Austin Oaks! Lovely den w/blt-ins, gourmet kit open to light & bright fam rm, main lvl master ste, fin daylight lwr lvl has media area, flpc & more! (2819458)



9446 PROMONTORY CIRCLE • \$1,749,900

Extraordinary Geist Waterfront home with pool, spa, multi-patios, 3 screened porches overlooking the water, wonderful views from almost every room, gourmet kit, main lvl master ste, dynamite walk-out lwr lvl & more! (2824141)



530 WILLOW SRPINGS ROAD • \$2,499,000

Wonderful newly constructed estate home in the heart of Williams Creek! Elaborate moldings, large gourmet kit, handsome den, luxurious master ste & bath, large bdrms up w/private baths, dynamite fin lwr lvl & more! (2818501)



1879 BLORE HEATH • \$969,900

Exquisite French architecture w/wrought-iron balconies & dramatic entry in a private lot in West Clay! Extensive moldings & trim detail, fabulous kit open to dynamite sunrm, palatial master retreat, w/o lwr lvl & more! (2832665)



10572 CHATHAM COURT • \$994,900

Gorgeous totally updated home in a cul-de-sac setting on nearly an acre w/backyard terraces! Elaborate moldings, soaring clngs, fabulous kitchen, luxurious master ste, impressive walk-out lwr lvl & more! (2823328)



445 PINE DRIVE • \$1,489,900

Magnificent Colonial-style home in a 1.07-Acre park-like setting! Beautifully re-modeled thru-out, fabulous kitchen open to family room, awesome sunroom, elegant master ste, finished lwr lvl /media center & more! (2802317)



9440 HOLLIDAY DRIVE • \$614,500

Stunning & immaculate home in a quiet cul-de-sac setting of a gated community! Sweeping balcony overlooking pool & pool house with sauna, beautifully updated kitchen, sumptuous master ste & much more! (2827843)



5850 WINDING WAY LANE • \$549,900

Gorgeous home nestled in the trees of a desirable Washington Twp. Location! Dramatic entry, spacious kitchen w/door to sunroom, main lvl master w/flpc, finished walk-out lwr lvl w/fam rm, ex rm, wet bar & more! (2825429)



755 WILLIAMS COVE DRIVE • \$1,199,900

Stunning brick home in a cul-de-sac setting w/sparkling pool! Gleaming hdwds, dramatic great rm, updated kitchen w/high-end appls, lovely den, main lvl master retreat, daylight lwr lvl has rec rm, ex rm & more! (2817615)

Indiana Professional Licensing Agency **PLA**

New Board Member

Governor Daniels appointed Robert L. Allen, MD, Columbus, Indiana, to the Medical Licensing Board on April 30, 2008. Dr. Allen practices at Urology Associates of Southern Indiana where he is the President and Founder. He is also an active staff member of Columbus Regional Hospital. He received his Doctor of Medicine from the University of Louisville. He is married to Karen Dorough, MD, and they have two children Robert and Michael. Dr. Allen's term expires on April 30, 2011.

Current Board Members

Board President - Stephen Huddleston, JD,

Consumer Member – Franklin, IN

Vice President - Navin Barot, MD, Munster, IN

Secretary - Thomas Akre, DO, Mishawaka, IN

Worthe Holt, Jr., MD, - Fishers, IN

Donald J. Vennekotter, MD, - Jasper, IN

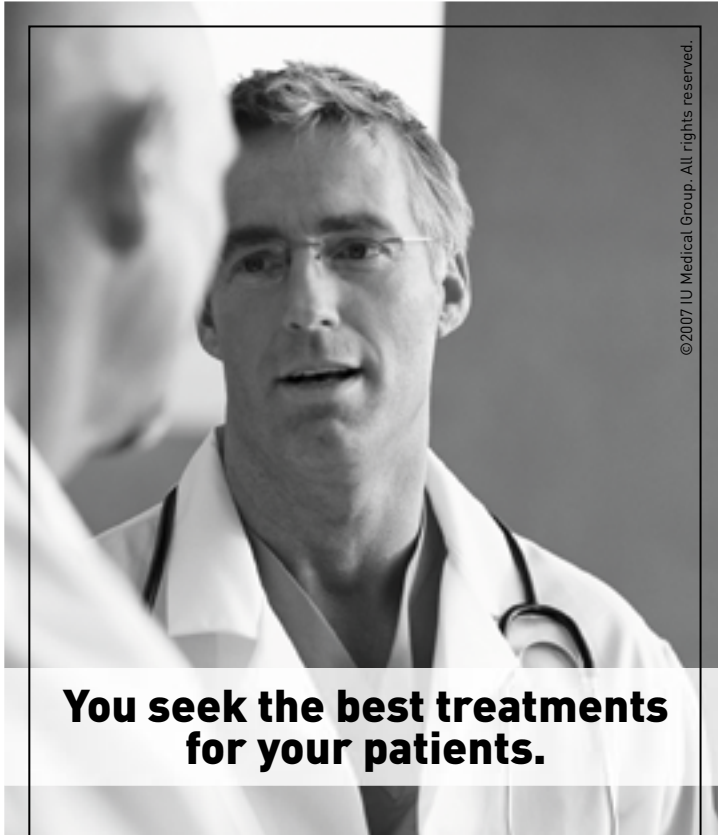
Bharat H. Barai, MD, - Merrillville, IN

Robert L. Allen, MD, - Columbus, IN

Board Director Resigned

The Board recognized Michael Rinebold at its meeting on May 22, 2008 for his three years of service and dedication to the Board. During his tenure the Board accomplished several important initiatives including:

- The "Provisional License" legislation to provide the Medical Board an additional tool when considering an application for licensure.
- Initiated paperless meetings for the Medical Board, eliminating the need for thousands of copies per year resulting in significant savings to Indiana taxpayers.
- Improved significantly the filing timelines of Medical Board's final orders to comply with Indiana Code.
- Increased staff's efficiency during peak renewal period by increasing online renewals by physicians through educational efforts from 53% in 2005 to 85% in 2007.
- Assisted with the Agency's License Litigation web database to provide web access to the public when searching for information concerning licensees that have had administrative action before their respective boards and committees.
- New rules regarding Office Based Procedures and changes to the requirements for passing the USMLE.
- Improved compliance with reporting requirements of adverse actions issued by the Board to the National Practitioner Databank.
- Updating the Board's Foreign Medical School list so that applicants, employers and the public are clear as to which schools are approved and not approved.
- Elected as the Administrators In Medicine Central Region Representative and to the Board of Directors.



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Continued on page 30.



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Glen A. Brunk, M.D.
Joseph C. Butterworth, M.D.
Scott B. Farnham, M.D.
Theodore F. Holland, M.D.
David W. Hollensbe, M.D.
Michael G. Hostetter, M.D.
W. Terry Jones, M.D.

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Neale A. Moosey, M.D.
Kenneth G. Ney, M.D.
Bradley G. Orris, M.D.
Scott C. Pike, M.D.
John C. Ramsey, M.D.
Daniel B. Salvas, M.D.
David M. Scheidler, M.D.

John K. Schlueter, M.D.
John W. Scott, M.D.
Philip A. Serbin, M.D.
William L. Shirrell, M.D.
Jason K. Sprunger, M.D.
David B. Stuhldreher, M.D.
Ronald S. Suh, M.D.
Samuel T. Thompson, M.D.
Jeffery D. Vaught, M.D.
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William Adair, MD
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Fax – 298-0011
Internal Medicine, 1989
Indiana University, 1984



Ciaccia, Dan, MD
(Reactivation)
Gastroenterology Associates
7950 N. Shadeland Ave., #350
46250-2041
Ofc – 578-2600*

Fax – 578-6474
Internal Medicine, 1992
Gastroenterology, 1997
Medical College of Wisconsin, 1989

Gerdisch, Marc W., MD
Cardiac Surgery Associates
5255 E. Stop 11 Rd., #200
46237-6341
Ofc – 851-2331
Fax – 851-2333
Email – mgerdisch@openheart.net
Web – www.openheart.net
Surgery, 1993
Thoracic Surgery, 1996, 2005
Loyola University, 1987



LeBlanc, Julia K., MD
550 University Blvd., #4100
46202-5250
Ofc – 278-8125
Fax – 278-8145
Email – juleblan@iupui.edu

Internal Medicine, 1996
Gastroenterology, 2000
Rush Medical College, 1993



Rampersad, Angeli G., MD
IN Hemophilia & Thrombosis Ctr.
8402 Harcourt Rd., #500
46260-2054
Ofc – 871-0000
Fax – 871-0010

Pediatrics, 2003
Pediatric Hematology-Oncology
University of the West Indies,
Trinidad, 1996

Sheridan, Carol B., MD
Fellowship – St. Vincent Hospital
Surgery, 2008
Case Western Reserve University, 2001

Walker, Katherine H., MD
IN Radiology Partners
714 N. Senate Ave., #205
46202-3299
Ofc – 472-4565
Fax – 472-4566
Diagnostic Radiology, 2005
Indiana University, 2000

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- IMS Foundation . . . operated exclusively for charitable and educational purposes.
- Project Health, a program developed and sponsored by the IMSF providing healthcare and medications for uninsured patients.
- Commissions & Committees . . . Commission on Professional Affairs, investigates charges made against individual members by patients or fellow members; efforts by this Commission generally result in resolution to the mutual satisfaction of everyone.
- Commission on Medical & Health Affairs, considers public health matters as well as legislative issues.
- Commission on Membership Services, implements programs and services beneficial to all members.
- Annual 7th District Meeting . . . provides physicians and their families in Hendricks, Johnson, Marion and Morgan Counties the opportunity to meet and elect representatives.
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Luke, Come Over to the Dark Side

Michael D. Brown, BSBA, CHBC
Health Care Economics, LLC, mikeb@forumcu.com

Of course, the words above are a metaphor for this consultant's view of the "Dark Side" clinical experience. For many years, I have been an editorial consultant for the business aspect of medical practices and have written those articles from a business perspective in *Medical Economics* magazine.

Due to my own major health procedure in February, I saw firsthand the clinical side of medicine and, I must say, I was vividly impressed. In addition to the obvious, "They saved my life," I gained firsthand knowledge of what works and what does not from a patient's perspective.

Perhaps using these observations and recommendations, you will examine your particular situation and consider, augment, reprioritize or pat yourself on the back.

- Help empower your patients to take charge of their OWN health care business. While your staff will make the precertification contacts, your patients must assume the responsibility of ensuring approval. It is their responsibility to check with their insurance companies, verify precertification and approval received prior to surgery. If you are willing to help, your patients become more involved, your business stressors will diminish greatly. Remember, patients ARE the **responsible** party!

- From the appointment scheduler to the receptionist, to the biller, to the nurse, everyone in your office must care about patients and your business. If your staff doesn't care, it shows. A sick patient has enough concerns and needs a caring staff. Caring cannot be faked. If you do not have caring personnel, find them, pay them accordingly and fire the rest! In my situation, everyone understood my condition and treated me with dignity and caring. I cannot emphasize this enough – personnel, personnel, personnel and the attitude of that staff are more important than you may realize in keeping patients and obtaining referrals. If you have staffs, who are always grouchy, ill informed or simply do not care – fire them now! I absolutely believe a caring attitude and providing an uplifting experience is as much a part of the healing process as the clinical aspect of medicine. No patient wants to struggle with your office staff.
- The team concept is also one of the most important aspects of good patient care. Coordination between physicians, professional staff, nurses, lab, ancillary testing, referrals and hospitals is critical, and with specialty driven health care, physicians MUST talk with each other. There must be a coordination of care. The primary care physician must coordinate with the cardiologist, the pulmonologist, the surgeon, the nurse

Continued on page 26.



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2008 7th District Annual Meeting

Dr. Mary D. Bush, 7th District Medical Society President, presided over the Annual Meeting on June 6th, 2008, at The Indianapolis Zoo's Dolphin Pavilion. More than 125 Seventh District Members, along with their families, guests, and special dignitaries enjoyed dinner in the Pavilion, followed by "shark petting" in the Shark Touch Tank of the newly-renovated Oceans Venue.



Dr. Bush recognized the evening's sponsors and their representatives:

- **Agency Associates**,
Ms. Becky Johnson and Mr. Andy May;
- **Pfizer**,
Ms. Polly Bailer;
- **MDWise**,
Dr. John Wernert; and
- **Staples®**,
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Doctors Kenny Stall and Michelle Murphy were winners of the District's version of a "stimulus" drawing. *Congratulations!*



Elections were then conducted with the results as follows:

President-Elect for 2009-10:

John Records, MD,
Johnson County

Trustee:

Heidi Duniway, MD,
Marion County

Alternate Trustee:

Vicki Roe, MD,
Marion County

Treasurer:

Carolyn Cunningham, MD, Marion County

Dr. Bush reminded attendees that **G. Joseph Herr, MD**, Hendricks County, will be the 2008/09 District President.

An impending storm and Tornado Watch (and the resulting record floods on Saturday) might have contributed to an early departure for some, but everyone who attended appeared to have a great time! **IMS**



Some photographs courtesy of Dr. Bernard J. Emkes



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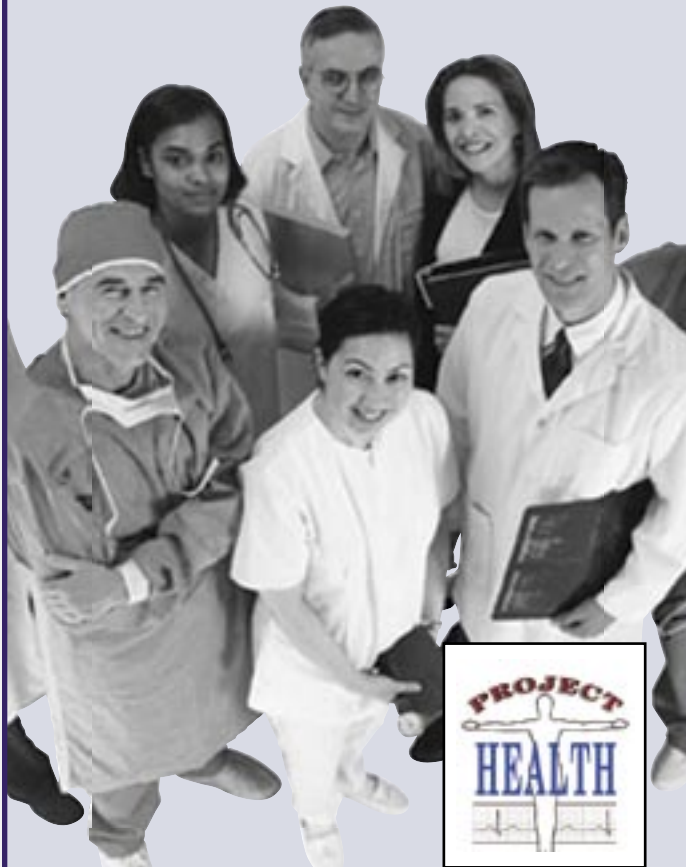
If you have interest in exploring this unique practice opportunity, please contact Dr. Matthew Priddy at mpriddy@pa-midwest.com. Questions and inquiries for more information are welcome and will be kept confidential.

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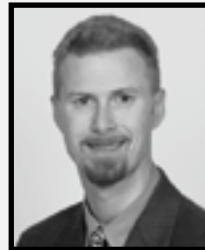
Please enroll today as a volunteer with your IMS Foundation's Project Health and let us help you ...help them.”
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Project Health

Carrie Jackson Logsdon, Director

Thank you,

F. Thomas Kaplan, MD



F. Thomas Kaplan, MD, The Indiana Hand Center is Project Health's volunteer doctor for the month of July. He was born in Baltimore and attended the University of Maryland School of Medicine. He completed his residency at the Hospital for Joint Diseases and Orthopaedics in New York. The

Indiana Hand Center's reputation convinced him to leave the East Coast to do his Fellowship in Indiana. Although he returned to the East Coast after his training, “in about five or six months I got the call to come back.”

“Back then, the Hand Center had microvascular surgery in addition to my special interests in arthroscopy, joint replacement and fracture care.” In fact, Dr. Kaplan just treated the severely broken hand of one of our 20-year old patients, who could not work, until now. “Project Health patients are so grateful – I guess you could say they are beyond grateful,” he said.

“The Hand Center offers a unique platform both academically and professionally that gives you the freedom to do more than just surgery all day, every day.” Currently he is one of 16 researchers worldwide working on Dupuytren's Disease that develops in people in their 40's and 50's where the cords in their hands just contract to the point where they can't do anything. Dr. Kaplan said he thinks it is inherited considering that only 2-3 percent of Hoosiers have it, but it is much more common in other parts of the world. “Surgery to release the cords used to be the only treatment, but now we are trying an injectable enzyme that would be a great advancement.”

Dr. Kaplan is the only person from his family to choose a career in medicine. He said he always liked nature and biology and even worked for a local veterinarian for a while. But, the fact that so many pets had to be put to sleep really bothered him so he went into human medicine. He is very interested in salt water fish, and just set up a 230 gallon tank in his home, which he takes care of himself.

He has wanted to go on a mission trip to India with one of his partners, but family matters right now preclude that. Thomas and wife, Linda, have a 5-year old, 4-year old, almost 3-year old and another one on the way in August. Playing with the kids is his main hobby.

Project Health patients have benefited from having Dr. Kaplan here in Indiana! From all of us – an enthusiastic round of applause!

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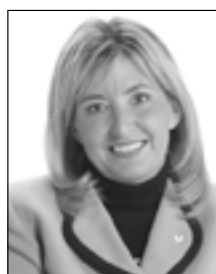
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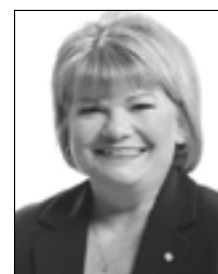
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Luke, Come Over to the Dark Side *(Continued from page 18.)*

on duty, the hospital staff, etc. While it might be best to have a meeting, that usually is not feasible. Patients can and should, at the very least, ask each one of them the same questions and make sure all the health care professionals are in agreement. This is the patient's responsibility with the help of a nurse or primary care physician. Health care team coordination is essential for all health care, but particularly with regard to pre- and post-operative care.

- After-care must also be coordinated. Does the patient need rehab or physical therapy? What drugs are needed? Should the patient enter a rehab facility or utilize home health care? Many of these items are handled by the hospital's discharge coordinator/nurse. You want to make sure that your patients are receiving the proper instructions and the coordination of after-care that they need. As patients approach discharge, it is important that the entire team of doctors involved coordinate their input and agree on the critical, after-care issues.
- Finally, patients must follow-up on their health care business. Many patients do not realize that it is their responsibility to follow-up and make sure providers are paid and paid correctly, their portion of the obligation is met and to contact the insurance company if needed. While this is easy to say, it is hard to implement, because patients have become accustomed to thinking that the doctor's office will do it all. Physicians and their staffs need to spend more time educating

patients. Physician's offices usually have patients fill out paperwork on their first visit. Then they copy the patient's health care cards and, usually, nothing more is said until the patient receives a bill or is asked for the co-pay. Many patients do not realize their role in health care insurance and the payment process. They need to better understand that they are not only responsible for the coordination of their health care, but their health care benefits as well. Patients need to better understand the business side of medicine. With this knowledge, they will respect you and your office staff even more.

I am hopeful that my thoughts will give you a better feel for how it is to visit the "Dark Side." I am very thankful and proud of the professionals who handled my care during and after my procedure. They were caring, motivated, and knowledgeable and they worked as a team to coordinate my care. I hope these points may be your "standard of care," but from my perspective, they are all valuable considerations for all health care providers.

I am now post-operative and doing well. The key to this is human relationships. Physicians and staff can never forget that they are dealing with people's lives. With the stress that patients are already trying to cope, they need the support, training, experience and understanding of all those handling their care. Keep in mind, even Darth Vader came over to the light in the end and so have I! Thanks to all my caring physicians, nurses and staff – God's speed!

IMS



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IPLA (Continued from page 14.)

In addition, Mike served as the Administrators in Medicine Central Region Representative and to the Board of Directors with the Federation of State Medical Boards. Mike accepted the position with the Indiana State Medical Association as their Director of Government Relations beginning June 1, 2008. Mike will be greatly missed and we wish him well!

New Board Director

Kristen Kelley has recently been selected as the new director to the Medical Licensing Board of Indiana. Kristen has worked at Professional Licensing Agency,

formally Health Professions Bureau, for almost 15 years. In the past she has served as Director of both the Indiana State Board of Nursing and the Indiana Board of Pharmacy. Due to her extensive experience in regulation and public administration, we anticipate a smooth transition.

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CME & Conferences

Continued next page.

Community Hospitals Indianapolis

Community Hospital East

2nd & 4th Chest Conference (Case Presentations)
Wednesdays Room 3436, 7:00 - 8:00 a.m.

Every Tumor Board (Case Presentations)
Tuesday Medical Staff Conf. Room, 12:00 - 1:00 p.m.

First Critical Care Conference
Wednesday Medical Staff Conf. Room, 12:00 - 1:00 p.m.

Second Medical Grand Rounds
Wednesday Medical Staff Conf. Room, 12:00 - 1:00 p.m.

Community Hospital South

Fourth Medical Grand Rounds
Thursday Conf. Rooms A & B, 7:30 - 8:30 a.m.

3rd Tumor Board (Case Presentations)
Wednesday Conference Room A, 7:00 - 8:00 a.m.

Community Hospital North

Second Tumor Board (Case Presentations)
Wednesday Board Room, 12:00 - 1:00 p.m.

First North Forum
Friday Board Room; 12:00 - 1:00 p.m.

North Cancer Pavilion

3rd Case Presentations
Wednesday Melanoma Conference, 7:00 - 8:00 a.m.

For more information, contact Valerie Brown, (317) 355-5381.

St. Vincent Hospital & Health Services

July 8 Intra-Operative Chemotherapy
Credit: 1.0 Contact: Donna Carl, 338-6711
Classrooms A&B
St. Vincent Women's Hospital

July 8 Thoracic Malignancy Conference
Credit: 1.0 Contact: Amy Vyverberg, 338-2460
Teleconference Room
Oncology Center

July 9 OB/GYN Grand Rounds
Credit: 1.0 Contact: Robin Nance, 415-7528
Classroom B
St. Vincent Women's Hospital

July 11 Holoprosencephaly
Credit: 2.0 Contact: Angela Koszyk, 338-3460
The Marten House
Indianapolis, Indiana

July 15 General Surgery CME Meeting
Credit: 1.0 Contact: Donna Carl, 338-6711
Schaefer Rooms C&D
St. Vincent Hospital, Indianapolis

July 17 Hematology Conference
Credit: 1.0 Contact: Kolleen Spencer, 338-3819
Schaefer Rooms C&D
St. Vincent Hospital, Indianapolis

July 22 Obstetrics Morbidity & Mortality
Credit: 1.0 Contact: Robin Nance, 415-7528
Classroom B
St. Vincent Women's Hospital

July 23 Perinatology Grand Rounds
Credit: 1.0 Contact: Dr. Vijay Menon, 338-3550
Classroom B
St. Vincent Women's Hospital

July 24&25 PALS Initial
Credit: 9.5 Contact: Kim Viehe, 338-6786
St. Vincent Children's Hospital

July 30 Cardiothoracic Surgery M&M
Credit: 1.0 Contact: Jennifer Irlbeck, 583-7800
Cine Room
St. Vincent Hospital, Indianapolis

Clarian Health Partners

IU – Methodist – Riley

July 11 Review and Interpretation of the 2008 ASCO Meeting
University Place Conference Center
Indianapolis, Indiana

July 14-23 93rd Annual Anatomy and Histopathology of the
Head, Neck and Temporal Bone
Medical Science Building
IUPUI Campus
Indianapolis, Indiana

July 16 The Ethics of Pandemic Influenza Planning in Indiana
Indiana Government Center South
Indianapolis, Indiana

Aug. 22-23 Pleuroscopy Workshop for Pulmonary Physicians
University Place Conference Center
Indianapolis, Indiana

Aug. 29-30 Fourth Annual Indy Urologic Laparoscopy
and Robotic Surgery Course
Ruth Lilly Learning Center
Indianapolis, Indiana

Sept. 18 5th Annual Cancer Update for the Non-Oncologist
Goshen General Hospital
Goshen, Indiana

Sept. 20 Pain Disorders: Why it is Really "All in Your Head"
Hyatt Regency Indianapolis
Indianapolis, Indiana

Course dates and locations are subject to change. For more information, please visit <http://cme.medicine.iu.edu> or call 317-274-8353.

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Friday, October 3, 2008
Arrhythmia and Heart Failure Symposium
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Friday, December 5, 2008
Update in Cardiology and Richter Lecture
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Saturday, August 16, 2008
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Indiana Medical History Museum

Wednesday, July 9, 2008 10:00-11:00
Wednesday, July 23, 2008 10:00-11:00 (repeat)
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Resident & Medical Student Abstracts *(Continued from page 12.)*

levofloxacin was discontinued. His response to the selected antibiotic, however, was slow and on day 5 of treatment he was switched to Daptomycin. Shortly afterward the patient's wound began to granulate, and the surrounding cellulitis improved. He was discharged on day 10 with home IV Daptomycin therapy for 4 weeks. Ten days later he returned to the emergency department with a 3-day complaint of increasing dyspnea, chills, and nonproductive cough. A chest X-ray revealed diffuse peripheral infiltrates. He was empirically started on levofloxacin for possible community acquired pneumonia but after 2 days of treatment his symptoms were not improving, with progressive hypoxia. At this time a CT scan of the chest revealed patchy peripheral nodular abnormalities within both lungs suggestive of pneumonitis.

Both antibiotics were then discontinued and his symptoms improved within 5 days. Repeat CT scan showed resolution of the peripheral infiltrates and he was discharged home. His Daptomycin was replaced with IV Vancomycin therapy until the completion of treatment under the suspicion that this may have been the causative agent. Five months later he presented to the hospital again with recurrence of the foot infection described above. He was rechallenged with Daptomycin but again developed findings suggestive of pneumonitis within 7 days. His antibiotic was again discontinued and his symptoms resolved. At least two other cases similar to this one have been reported in our hospital setting with the use of this drug.

Conclusion: Daptomycin is a novel drug being used with increased frequency for difficult to treat gram-positive infections. Although this type of adverse event is common, to the authors' knowledge there have been no previous reports of daptomycin-induced pneumonitis. Early recognition of this syndrome is important to prevent permanent sequelae and/or death.

Fourth Place Clinical Vignette: Hayley Lewis, DO, Shilpa Mallur, MD, Maryam Massoumi, MD

Acute Presentation of Pyoderma Gangrenosum in a young Healthy Female

Introduction: Pyoderma Gangrenosum is a rare rapidly progressing noninfectious skin lesion that presents most commonly on the pretibial area. Histology demonstrates a neutrophilic infiltration of the dermis with nonspecific inflammatory changes.

Case Description: A 39 year old healthy white female with no comorbid conditions presented to her primary care physician with a small red nodule on her right lower leg that appeared to be an insect bite. Over the next few days she was treated with several oral antibiotics and had local debridement to her wound. In spite of this, the patient had persistent low grade fevers with progression of the wound leading to an ER visit. Physical examination revealed a non-toxic febrile patient with a 6cm by 5cm cutaneous ulcer on her right lower extremity. The ulcer had a central area of healthy granulation tissue with a ring of mucopurulent discharge and a purplish ecchymotic halo with surrounding erythema. Laboratory data revealed a leukocytosis of 26,000, elevated liver function tests and negative wound and blood cultures. MRI demonstrated a soft tissue swelling but no subcutaneous emphysema or bone involvement. Empiric antibiotic therapy was started. Local wound debridement involving the ecchymotic ring was performed. Within a day the wound had doubled in size and the leukocytosis increased

to 38,000. Further laboratory investigations were negative for hepatitis panel, HIV, ANA screen, factor V Leiden mutation and protein electrophoresis. A skin biopsy was performed showing extensive central necrosis resembling a pyogenic ulcer. Despite broadened antibiotic coverage the wound continued to progress. High dose steroids were initiated with a strong suspicion for pyoderma gangrenosum. Biopsy results revealed extensive inflammation with predominantly neutrophilic infiltrates. The lesion responded quickly to steroids with resolution of the ecchymotic halo within days. The patient was discharged home with slow tapering steroids, gentle wound care and no future debridement.

Conclusion: Pyoderma Gangrenosum is a rare condition involving a noninfectious neutrophilic infiltration of the skin with the pathogenesis being unknown. Most common site is the lower leg region but it can appear almost anywhere. Many other conditions can mimic its appearance, which include sweet's syndrome, pyogenic ulcers, vasculitis, and drug reactions. It is important to distinguish bacterial lesions which require debridement and worsen with steroids. Pyoderma gangrenosum is often associated with underlying autoimmune pathology with the most common being inflammatory bowel disease. The diagnosis in this case was more difficult because no underlying pathology was found. It is essential to have a high index of suspicion for pyoderma gangrenosum when treating a rapidly progressing ulcer in a healthy nontoxic patient. Early initiation of steroids will likely prevent a prolonged disease course with extensive lesions requiring skin grafts and long term steroids or immunotherapy which is well illustrated in this case.

Fifth Place Clinical Vignette: William Graham Carlos, MD, Cassidy Menard, MD

Chronic Lymphocytic Leukemia diagnosed by Thoracentesis

Introduction: Chronic lymphocytic leukemia (CLL) occurs when a clone of dysfunctional lymphocytes progressively aggrandize. Characteristically it presents with lymphadenopathy, splenomegaly, and hematological abnormalities. We report a case of CLL that presented surprisingly with a unilateral pleural effusion.

Case Description: An 80 year-old man with a three year history of idiopathic pulmonary fibrosis on chronic prednisone therapy presented with three weeks of progressive dyspnea on exertion. He denied fever, night sweats, weight loss, and fatigue. He had a history of hypertension but did not have congestive heart failure or coronary artery disease. He had a 10-pack-year smoking history. Clinical exam was positive for a paucity of breath sounds in the right lower lung field along with dullness to percussion. No jugular venous distention or lymphadenopathy were appreciated. Chest x-ray demonstrated a large right-sided pleural effusion. Chest CT-scan confirmed this and was negative for pulmonary embolism. No pathologic axillary lymphadenopathy was seen but a right paratracheal lymph node was identified measuring 1.6 x 1.1 cm. The spleen and visualized portions of the liver, gallbladder, and adrenal glands were normal. Laboratory analysis was significant for anemia (hemoglobin 11.7 g/dl) with a white blood count of 6.1 K/CUMM. A chest tube was inserted for therapeutic and diagnostic purposes. The pleural fluid was cloudy orange in color. Analysis

Continued on page 38.

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La Ley 1590, El Sol de Indiana and Latino Action League honored Project Health's Laura Gonzalez as their 2008 Latina Woman of the Year at a ceremony, May 17, 2008. Laura was honored because she exemplifies strength, courage, commitment and leadership in the Hispanic Community.

Congratulations Laura!

Abstracts (Continued from page 36.)

of this fluid yielded 15,600 red blood cells per CUMM, 660 white blood cells per CUMM, 4% neutrophils, 81% lymphocytes, 13% monocytes, and glucose was 112 mg/dl. Fluid protein and lactate dehydrogenase were 3.5 gm/dl and 223 u/L respectively. This data was consistent with an exudate. Cytological analysis demonstrated an atypical lymphocytic infiltrate classified via flow cytometry as monoclonal B cell-type in origin with features of CLL or small lymphocytic lymphoma. Oncologic consultation was initiated and a CT-scan of the abdomen and pelvis was unremarkable. Peripheral blood immunophenotyping confirmed a low grade CD5(+) B-cell lymphoproliferative disorder. The patient was promptly started on a cycle of fludarabine. Unfortunately the effusion was refractory to chemotherapy and a pleurodesis with doxycycline was necessitated.

Discussion: This case first reminds us that in the absence of a contraindication the presence of a new unilateral pleural effusion requires a diagnostic workup. Typically symptomatic patients with CLL present with "B" symptoms of lymphoma: weight loss, fevers or night sweats, and extreme fatigue. Other patients are diagnosed by painless lymph node enlargement or when routine blood analysis reveals an absolute lymphocytosis. While there are rare but documented associations of malignant pleural effusions with CLL, we present a distinctly unusual presentation of CLL via an exudative pleural effusion. The possible mechanisms for the formation of this effusion include pleural infiltration by the paratracheal node with shedding or lymphatic obstruction secondary to lymphomatous infiltration.

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Alan R. Gillespie (2008)
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Bradford R. Hale (2010)
David C. Hall (2010)
Ronda A. Hamaker (2010)
James F. Leland (2010)
Frank P. Lloyd (2010)
Susan K. Maisel (2010)
John P. McGoff (2010)
Thomas E. McSoley (2010)
John J. Wernert (2010)

Alternate Delegates to the State Convention, September 19-20, 2008, Hyatt Regency Indianapolis

The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

Susan C. Dieterich (2008)
Christopher B. Doehring (2008)
Richard K. Freeman (2008)
Ann Marie Hake (2008)
Robert E. Holt (2008)
David J. Kenley (2008)
Alan P. Ladd (2008)
James G. Leatherman (2008)
Daniel E. Lehman (2008)
Jon D. Marhenke (2008)
Mary Ian McAteer (2008)
Mercy O. Obeime (2008)
George E. Waters, Jr. (2008)

John H. Ditslear, III (2009)
Stephen R. Dunlop (2009)
Leanne M. Fortner (2009)
Robert J. Goulet (2009)
Charlene E. Graves (2009)
Paul K. Haynes (2009)
Randy A. Hock (2009)
Terry L. Layman (2009)
Robert Michael Pearce (2009)
David M. Ratzman (2009)
Jeffrey M. Rothenberg (2009)
Bridget M. Sanders (2009)
David J. Scruby (2009)
Steven Richard Smith (2009)
H. Jeffery Whitaker (2009)

F. Keith Bean (2010)
Benjamin J. Copeland (2010)
Woodrow A. Corey (2010)
Sheila M. Gamache (2010)
Andrea Haller (2010)
Mark M. Hamilton (2010)
Timothy L. Hobbs (2010)
Andrew Johnstone (2010)
RoseMarie Jones (2010)
Martin Kaefer (2010)
Jeffrey J. Kellams (2010)
Anthony W. Mimms (2010)
Kimberly K. Short (2010)
Louis L. Winternheimer (2010)
Ronald L. Young (2010)

Indiana State Medical Association Past Presidents

Bernard J. Emkes, 2000-2001
Peter L. Winters, 1997-1998
William H. Beeson, 1992-1993
George H. Rawls, 1989-1990
John D. MacDougall, 1987-1988
George T. Lukemeyer, 1983-1984
Alvin J. Haley, 1980-1981

President

Jon D. Marhenke 2007-2008

American Medical Association Alternate Delegate


Peter L. Winters (2008)

Seventh District Medical Society Trustees

Carolyn A. Cunningham (2008)
A. Michael Sadove (2009)
Richard D. Feldman (2010)

Alternate Trustees

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John J. Wernert (2009)
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Advertisers' Index

Agency Associates, Inc.....	35
American Cancer Society	31
BODIES .. The Exhibition.....	4
Business Furniture LLC	27
Center for Pain Management.....	10
Central Indiana Cancer Centers.....	18
Circle City Evaluation Center.....	30
Community Health Network.....	41
CorVasc MD's.....	43
Diamond Capital Management.....	27
Hearing Center Inc.	47
Heartland Neurology	24
IMS Conference Center	32
Indiana Spine Group	25
IU Medical Group	14
Sonnie Laviolette, F. C. Tucker Co., Inc.....	6
The Marina Limited Partnership	3
Medical Doctor Associates	26
Medical Society Exchange	44
Midwest Colon & Rectal Surgery.....	9
Midwest Pain Institute.....	33
The National Bank of Indianapolis.....	23
National City Bank	19
Northwest Radiology Network	48
OrthoIndy	29
Otolaryngology Associates	37
Practice Billing, LLC.....	30
Premier Asset Solutions.....	45
Priority Access	21
St. Vincent Cyberknife.....	2
St. Vincent Heart Center of Indiana	17
Staples.....	42
Superior Linen Service.....	8
Urology of Indiana.....	15
Bif Ward, F. C. Tucker Co., Inc.	13
Joan Young, F. C. Tucker Co., Inc.....	39
Alex Zylberglait, Marcus & Millichap	35

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