Indianapolis Medical Society 1848

Volume XCXIV • Number 4
December 2017 • Indianapolis, Indiana

Bulletin

Indianapolis Medical Society
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Vol. XCXIV • Number 4
December 2017 • Indianapolis

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Official monthly publication of the
Indianapolis Medical Society
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Indianapolis, Indiana 46202-3706
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in this issue

Special Features

Departments

about our cover

The photograph, taken by Trevor Mahlmann, on the front cover is titled Circle of Lights, Indianapolis Monument from Above.

IMS Suggestion Box @ imsonline.org

Dr. McAteer welcomes suggestions from physicians, IMS Members and non-members. Simply click on the suggestion box icon and

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Special Feature

Proteinuria: Primary Care Workup before Referral to Nephrology

Executive Director, IU National Center of Excellence in Women's Health & S. Jawad Sher, MBBS Assistant Professor of Clinical Medicine, Division of Nephrology, IUSM

Proteinuria (protein in the urine) can be an ominous finding or can be a false positive result and an evaluation with a few simple diagnostic tests can be performed to help determine the cause and to help make the appointment with the specialist more productive.

There are many ways to detect proteinuria with the urine dipstick generally being the initial test used. For the PCP, documenting the validity of the results and performing a confirmatory, quantitative test is needed.

A routine urine dipstick grading of negative to 4+ is based on an increased intensity of color changes, is semi quantitative and influenced by the concentration of the urine. A result of 2+ or greater, is more likely to be predictive of significant proteinuria (urine protein-to-creatinine ratio (UPCR) greater than or equal to 500 mg/g).

However, a urine dipstick for proteinuria of trace or 1+ is only predictive of significant proteinuria if the specific gravity was 1.025 or less so understanding and using the specific gravity can be helpful.

False positive urine dipstick can occur for the following reasons:

- Within 24 hours after the use of iodinated radiocontrast agents
- With a highly alkaline urine (pH greater than 8)
- In the presence of hematuria as blood is a protein
- When specific antiseptics (eg, chlorhexidine, benzalkonium) are used for clean-catch urine samples

If the urine is positive for protein, especially > 2+, repeat the UA with microscopy within 2 weeks.

Persistent proteinuria should be evaluated with a quantitative measurement of total daily protein excretion. The gold standard being a 24-hour urine collection, with the normal value being less than 150 mg/day. This test however is cumbersome and is often collected incorrectly resulting in over or under collections.

You can substitute the urine protein-to-creatinine ratio in a spot first- or second-morning urine sample is best and is ordered as protein/creatinine ratio, urine. The patient should avoid exercise prior to giving the sample.

So, if you note proteinuria in your patient, and it is < 2+, repeat the test in 2-3 weeks with UA and microscopy (send the UA to the lab not POC this will automatically get the microscopy if the UA is positive) Then if +, order a UPCR (protein/creatinine ratio, urine) on a morning urine.

If the value is over 150 mg/gm Creatinine the patient is identified as having persistent proteinuria and a careful medical history and physical exam may reveal a cause, such as diabetes mellitus, malignancy, systemic autoimmune disease, or a prior history of kidney disease.

Once the patient is said to have persistent isolated proteinuria. The subsequent evaluation of patients with persistent isolated proteinuria usually involves referral to a nephrologist and, depending upon the degree of proteinuria and the results of other tests, a kidney biopsy.

Quantification of albuminuria is another way to assess proteinuria & is more sensitive predictor for glomerular pathology. Proteinuria can be comprised most of albuminuria (more common) or can be a combination of albumin & other proteins. It is simpler to use the spot Albumin-Creatinine measurement (ACR) and a value of 30 mg/gram or greater is considered abnormal.

Summary / Recommendations
Urine dipstick with + protein
> Repeat Full UA with microscopy in 2 weeks
>>If still positive, obtain a spot urine for protein-to-creatinine ratio (PCR) or albumin-to-creatinine ratio (ACR)

ACR < 30 mg/g or PCR < 150 mg/g: NORMAL results.
No further workup

ACR 30-299mg/g or PCR 150-499 mg/g: moderate albuminuria
> Blood pressure control
> maximize ACEi/ARB if diabetic
> refer to Nephrology if non-diabetic

ACR >= 300 mg/g or PCR >= 500 mg/g: severely increased albuminuria / proteinuria
> Non-urgent referral to Nephrology

PCR >= 3500 mg/g: Nephrotic range proteinuria
> Urgent referral to Nephrology

References: https://www.uptodate.com/contents/assessment-of-urinary-protein-excretion-and-evaluation-of-isolated-non-nephrotic-proteinuria-in-adults?source=machineLearning&search=proteinuria&selectedTitle=1~150&sectionRank=1&anchor=H11#H11

Snyder S, John JS Workup for proteinuria Prim Care. 2014 Dec;41(4):719-35.

President's Page

Mary Ian McAteer, MD

In preparation for this month's article, I read The Book of Joy by His Holiness the Dalai Lama, Archbishop Desmond Tutu with Douglas Abrams, along with books and articles about the shortcomings of the practice of medicine. I came away with a renewed sense of a need to continue prioritizing the very human, intimate patient/doctor relationship. Our medical profession's raison d'etre is to deliver medical care to our fellow human beings. When we approach the patient with compassion and kindness, it creates in us our true reward, joy. According to The Dalai Lama, "Joy resides within the human heart and will be increased when we strive to live more from the compassionate part of our nature, to have a sense of responsibility toward others and the world we live in." Practicing medicine calls us to share our humanity. Physicians are professional sources of compassion, kindness, and affection through the act of healing.

To dedicate our practice to our patient/doctor relationship, we must successfully deal with the many things that get in the way of our ability to concentrate on our patients. The daily tasks needed to simply get our job done compete with our attention. Unfortunately, these distractions and detractions are what are obvious to our patients, and may become the most important details to them of their entire experience. This holds them back from fully participating in the relationship, which affects their health.

Instead of spiraling into a strained relationship or quitting altogether, we can share strategies to take the rush and hassle out of the precious face to face time we have with our patient. Here are some things I do to try to remind myself how to be patient-centered:

- Be welcoming: Greet patients warmly, with a smile, they have come to the right place, the right person.
- Make yourself and your patient feel at home: Try to sit down at some point, close enough to each other to converse without raising voices.
- Show affection and respect through touch: Offer a handshake and explain the physical examination portion.
- Be honest: Sometimes briefly stating the existence of a distraction can shift the focus back to the patient.
- Change the dynamic: Think of the room or patient's space as an oasis away from the problems outside.
- Be perceptive: Observe the body language and facial expressions of patient and family members. If you sense misunderstanding or unease, take a break to seek clarification.
- Remain present: Use your own body language to actively listen, then reframe patients' statements to be sure you understand them.
- Apologize for running late: When I am late for an appointment I will rush in, collapse against the door and say, "Sorry to keep you waiting. I have been looking forward to seeing you all day and it seems that everything else was trying to keep me from you. How can I help you today?"

Patient centered actions are habits intended to create a togetherness in purpose. By integrating them into our practice of medicine our patients will see our efforts to treat them with kindness and compassion. We will intentionally share the gift of joy which leads to the ultimate source of satisfaction, fulfillment and happiness.

In Memoriam

Jack V. Gossett, MD

Dr. Jack Gossett was born November 20, 1945 in Anderson, IN and passed away at the age of 71 on October 22, 2017 in Traverse City, MI.

He earned his medical degree from IU School of Medicine after completing school at Xavier University. He also served in the US Army, first at the 121 Army Evacuation Hospital in Seoul, South Korea followed by Fort Bragg, North Carolina. Upon completion of his military service, he returned to Indianapolis to practice Otolaryngology with Northside ENT. He retired after 27 years of practice.

Dr. Gossett moved to Michigan after his retirement because he loved the outdoors and spending time with family. He also enjoyed cross country skiing, cycling and geology.

He had been a member of IMS since 1980.

Special Feature

Moral Choices for Today's Physician

A Piece of My Mind, December 5, 2017.
Author Affiliations Article Information: JAMA. 2017;318(21):2081-2082. doi:10.1001/jama.2017.16254

The current generation of physicians is the most challenged by moral choices in perhaps a century. Those choices come in three tiers: personal, organizational, and societal.

Carl Sandburg's poem,1 about fog rolling in "on little cat feet" comes to mind:

Some moral choices arrive with drama, but most do not. Most come unannounced, silent in arrival—on little cat feet—and are gone almost before we notice.

Forty-five years ago, I was a medical student interviewing for the match. The night before my Peter Bent Brigham Hospital interview, I was on overnight duty.

"I'm having my Brigham interview tomorrow and I'm nervous," I told my resident.

"You should be," he said. "They're brutal. I still remember the question they opened with. It was impossible."

"Tell me more," I said.

"Well, they told me a story from the very first days of hemodialysis, which the Brigham pioneered. They said that a patient on dialysis had become confused and then delirious. They called the medical resident to come and see him. The resident examined the man. He noticed nystagmus, immediately made the correct diagnosis, began the correct treatment, and, arguably, saved the man's life. They asked me, 'What was that diagnosis?'"

"I have no idea," I said.

"Neither did I," said the resident. "Later on someone told me the answer. The man had Wernicke's encephalopathy. He was acutely thiamine deficient. Dialysis was removing water-soluble vitamins from his body, and no one had, up to that time, realized that the dialysis could cause acute vitamin deficiency. The resident gave him thiamine, and rescued him."

"I'm cooked," I said.

The Brigham interview the next day was a marathon of three-person panels, each of which peppered the candidates with questions for 5 or 10 minutes. I was half way through when I entered the room with what I instantly knew was THE panel… the chief of medicine, the head of the residency program, and another world-famous physician. They paused and glared down at me. I gulped, and then the chief began.

"Mr Berwick, some years ago, during the first days of dialysis here, a patient suddenly became disoriented and dizzy. A resident was called, he noticed nystagmus, and he made the correct diagnosis…."

To this day, I recall the surge of feeling. The impulse to burst out laughing. The sweat breaking on my body. Unannounced. On little cat feet. The test was to be not of my knowledge or promise as a doctor. It was to be of my character.

I am not proud of this story. I failed that test. With cold-blooded precision, I furrowed my brow and faked it. I pretended I was reasoning my way to the right answer, even though, without forewarning, I could no more have done that on my own than I could perform an Olympic gymnastics floor routine.

I could see it in their eyes. They wanted me. The questions stopped, and they spent the rest of the interview telling me how fine a place the Brigham was for training.

A day or two later, I could not resist telling a close friend and mentor the funny story. His reaction woke me up. He did not laugh. Instead he said, "I am a bit disappointed in you, Don."

I realized, I was too. I dropped the Brigham from my match list. But that has never, not to this day, felt like absolution for me. A choice came, on little cat feet, and I did not see it at the time for what it was.

This is the moral choice in its simplest, purest, most elemental form. To tell the truth, or not, when "not" is perhaps in your short-term self-interest.

I say "perhaps" because when I recall that moment of choice, which I have done a thousand times, I can't help but wonder what would have been the consequence of honesty. "Sirs," I would have said to the panel, "this is an incredible coincidence, but last night I asked my resident about his interview here, and he told me that same story and the correct answer, which I assure you I would not by any stretch of the imagination, have arrived at." I wonder what would have happened then. I will never know.

A second form of choice comes in equal silence and has to do with one's self-image as a physician. It is the choice between being a hero and being a citizen.

The white coat, stethoscope, and prescription rights tempt some physicians into hero mode. Physicians have the power to look and act like we know what to do, even when we do not. We have the power to assert prerogatives denied to others: "my schedule," "my OR time," "my air time," "my excellence."

But health care is an exercise in interdependency, not personal heroism. Physicians simply cannot do the right job alone. This produces a clash between the time-honored, romantic image of the great physician and the greater need for teamwork, generosity, and deference. That greater need demands that the question, "What am I part of?" should supersede prerogative. It counsels a continual inquiry: Who depends on me? And how am I doing in their eyes?

In the past, an exploration of moral choices might have stopped with these two levels: personal honesty and proper organizational citizenship. But times have changed and the stakes are higher. As a newly minted physician, I held unquestioned the belief that the organizations I worked in and for were, at their core, ethical; that health care institutions usually, if not always, put the interests of those they served ahead of their own.

This may or may not have been true then, but it is not true now. At least, ethics cannot be taken for granted, not when the interests to be served are those of society as a whole. The symptoms of organizational gluttony are rampant, and the damage is severe.

For example, the drugs patients depend on are experiencing price increases that cannot withstand the scrutiny of public interest or moral compass. New biologics of undeniable value are being priced at levels that are not just like extortion—they are extortion, holding patients hostage. Old, invaluable preparations, like insulin, epinephrine, 17-hydroxyprogesterone, colchicine, and others, are being captured or patented under legal loopholes and then priced 10-fold, 30-fold, 100-fold more than their prior, customary levels.

Hospitals today play the games afforded by an opaque and fragmented payment system and by the concentration of market share to near-monopoly levels that allow them to elevate costs and prices nearly at will, confiscating resources from other badly needed enterprises, both inside health (like prevention) and outside (like schools, housing, and jobs).

And this unfairness—this self-interest—this defense of local stakes at the expense of fragile communities and disadvantaged populations goes far, far beyond health care itself. So does the physician's ethical duty. Two examples help make the point.

In my view, the biggest travesty in current US social policy is not the failure to fund health care properly or the pricing games of health care companies. It is the nation's criminal justice system, incarcerating and then stealing the spirit and hope of by far a larger proportion of our population than in any other developed nation on earth.2 If taking the life-years and self-respect of millions of youth (with black individuals being imprisoned at more than five times the rate of whites),3 leaving them without choice, freedom, or the hope of growth is not a health problem, then what is?

Second, the harm done to our planet by inattention to and denial of the facts of science is grievous too. If poisoning the air, drying up the rivers, and drowning the cities—our own, and those of the poorest people on earth, and creating a tsunami of displaced people greater than the world has ever known before, is not a health problem, then what is?

Healers cannot deny that leaving refugees at our gates unwanted, or children unfed, or families unhoused, or basic medical care uncovered, or relying on conflict, rather than compassion, are health problems. So is war. So is ignorance. So is hopelessness. So is blaming the blameless.

The work of a physician as healer cannot stop at the door of an office, the threshold of an operating room, or the front gate of a hospital. The rescue of a society and the restoration of a political ethos that remembers to heal have become the physician's jobs, too. Professional silence in the face of social injustice is wrong.

It is chilling to see the great institutions of health care, hospitals, physician groups, scientific bodies assume that the seat of bystander is available. That seat is gone. To try to avoid the political fray through silence is impossible, because silence is now political. Either engage, or assist the harm. There is no third choice.

Section Editor: Preeti Malani, MD, MSJ, Associate Editor.

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Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

Disclaimer: The views expressed herein are those of the author and do not necessarily reflect the views of the Institute for Healthcare Improvement.

Additional Information: This essay is adapted from a graduation address given at Dartmouth Medical School on June 3, 2017.

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Bulletin Board

News from Goodman Campbell Brain and Spine…

Goodman Campbell Brain and Spine and the Indiana University Department of Neurological Surgery hosted The Campbell Lecture on October 25 at IU Health's Neuroscience Center. M. Sean Grady, MD, chairman of the Department of Neurosurgery at the University of Pennsylvania, delivered an address on "A Unifying Hypothesis Behind the Short and Long Term Consequences of Concussion." Dr. Grady was the twenty-fourth guest lecturer of the annual event.

Nicholas Barbaro, MD, delivered the John Raaf, MD, Visiting Professor lecture at Oregon Health Sciences University. His lecture on "Advanced in Epilepsy Surgery" was held on October 21 in Portland.

Daniel Fulkerson, MD, participated in the international Sub-Saharan Africa Neuro-Oncology Collaborative Meeting regarding care of brain tumor patients in Kenya. The meeting took place October 18–20 in London.

Eric Potts, Jean-Pierre Mobasser, and fellow authors have published new work titled, "Comparison perioperative factors during minimally invasive pre-psoas lateral interbody fusion of the lumbar spine using either navigation or conventional fluoroscopy." It appears in the *Global Spine Journal* October 7 issue.

Several GCBS physicians participated in the Congress of Neurological Surgeons 2017 Annual Meeting that was held October 7–11 in Boston. **Mitesh Shah, MD,** served as faculty on the practical course, "Neurosurgeon-hospital relationships: options, negotiations, and achieving what you are worth." **Nicholas Barbaro, MD,** was faculty on the seminar, "Educating Neurosurgeons: the science and art of teaching surgery." **Andrew Jea, MD,** participated in a cased-based discussion session on "Management in pediatric athletes." **Aaron Cohen-Gadol, MD,** was a faculty member on the practical course, "3D Surgical Neuroanatomy (Supratentorial).

News from Franciscan Health Mooresville…

Franciscan Health Mooresville Recognized Nationally as Stroke Ready Center

Franciscan Health Mooresville has been designated as a Stroke Ready Center by Healthcare Facilities Accreditation Program (HFAP).

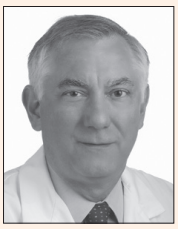
It is the only certified stroke center in Morgan County, and only the second facility nationally to receive this certification from HFAP. The certification means the Mooresville hospital – the only full-service hospital in Morgan County – provides rapid and evidence-based care to acute stroke patients, including the administration of t-PA (blood clot busting medication) in non-hemorrhagic stroke victims.

"This recognition is the result of the hard work by our entire Mooresville stroke team and recognizes our commitment to providing outstanding care to our patients and community," said Annette Seabrook, administrative director of neurosciences.

Franciscan Health Indianapolis is a certified Primary Stroke Center and Get With The Guidelines Gold Plus Quality award winner. Through their commitment to quality, the stroke programs at Franciscan Health Indianapolis and Mooresville have demonstrated improved treatment and better patient outcomes.

Francis W. Price, Jr., MD, Price Vision Group, was recently honored with the 2017 Thomas C. Hasbrook Award. Established in 1997 by Bosma Enterprises, this award recognizes outstanding individuals, organizations, or businesses that demonstrate an exceptional commitment to supporting people with disabilities. Dr. Price was honored at the Thomas C. Hasbrook Award Luncheon in Indianapolis and was sponsored by the Bosma Visionary Opportunities Foundation. The Foundation's mission is to support rehabilitation, education, training, and employment for people who are blind or visually impaired. Dr. Price is one of only two physicians to receive this prestigious award.

Indianapolis-based Community Health Network has selected **David Kiley, MD** as president of its south region. Kiley, who has been a part of the health system for 25 years, has served in the role on an interim basis since May.



Nicholas M. Barbaro, MD

Aaron A. Cohen-Gadol, MD

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Eric A. Potts, MD

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Theresa M. Rohr-Kirchgraber, MD

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In addition to practicing as an OB/GYN at Community Hospital North, Kiley worked as physician executive for the health system's north region, where he oversaw the Community Physician Network and independent physicians.

"We have high expectations for the South region as it continues to play an important role in the growth of Community Health Network as a trusted destination for exceptional healthcare," said Jason Fahrlander, chief operating officer of Community Health Network. "I am confident that the region will continue to be successful and perform at a high level under Dr. Kiley's leadership."

Kiley also assisted with managerial duties at Community Hospital North while the search for a new COO was ongoing.

Theresa Rohr-Kirchgraber

November: Interview with Debbie Knox CBS news re: prior authorizations for medicines (airing pending).

Presented at the Women's Leadership Symposium at UCSF on The Gender Pay Gap.

Presented at the Texas Immunization Conference, San Antonio on the HPV Vaccine How to Get Parental Buy In.

Presented at the AMWA UTSA Medical Students meeting: Assertiveness in Medicine: The Impact of Gender

Interview with RTV Channel 6 on Cyberbullying as self harm

http://app.criticalmention.com/app/#clip/view/31272539?token=ba003b16-9f48-4ed1-9547-2e6cbe664d76

CME & Conferences

Community Hospital East

First Wednesday	Critical Care Conference CHE Administrative Conference Room, 12:00 – 1:00 p.m.
Second Tuesday	Medical Grand Rounds CHE Theater, 1:00 – 2:00 p.m.

Community Hospital North

First Friday	North Forum Reilly Board Room, 7:00 – 8:00 a.m.
First & Third Wednesdays	Psychiatry Grand Rounds 7250 Clearvista Parkway Multi-Service Room, 12:30 – 1:30 p.m.

Community Heart & Vascular Hospital

First Wednesday of every month	Imaging Conference: rotates Cath & Echo Case Presentation CHVH 3rd Floor Boardroom w/telepresence to CHV Anderson, CHV East Conference Room (Ste. 420) CHV South Conference Room (Ste. 2400) CHV Kokomo, 7:00 – 8:00 a.m.
Second Wednesday of every month	M&M Conference: every other month rotates the Echo & Nuclear Q/A, CHVH 3rd Floor Boardroom w/telepresence to CHV Anderson, CHV East Conference Room (Ste. 420) CHV South Conference Room (Ste. 2400) CHV Kokomo, 7:00 – 8:00 a.m.
Third Wednesday of every month	Ken Stanley CV Conference: rotates Quarterly for CV Quality Data w/Gae Stoops, CHVH 3rd Floor Boardroom w/telepresence to CHV Anderson, CHV East Conference Room (Ste. 420) CHV South Conference Room (Ste. 2400) CHV Kokomo, 7:00 – 8:00 a.m.
Fourth Wednesday of every month	Disease Management Conference: rotates CHF & EP Case Presentations, CHVH 3rd Floor boardroom w/ telepresence to CHV Anderson, CHV East Conference Room (Ste. 420) CHV South Conference Room (Ste. 2400) CHV Kokomo, 7:00 – 8:00 a.m.

2017 Cancer Conferences
Community Hospital East

Fourth Tuesday	East Multidisciplinary Breast Cancer Conference - CHE Ste. 420, 7:00 to 8:00 a.m.

Community Hospital North

First & Third Tuesdays	North Multidisciplinary Breast Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550 7:00 to 8:00 a.m.
Second & Fourth Wednesdays	North Multidisciplinary GI/Colorectal Oncology Conference - CHN 8040 Clearvista parkway, Suite 550, 7:00 – 8:00 a.m.
Second Friday	North Multidisciplinary Gynecologic Surgical Oncology Conference - CHN 8040 Clearvista Parkway, Suite 550, 7:00 – 8:00 a.m.
First Wednesday	North Chest Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550, 7:00 – 8:00 a.m.
Third Wednesday	Melanoma Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550, 7:30 – 8:30 a.m.
Third Friday	North GU Conference - CHN 8040 Clearvista Parkway, Suite 550, 7:00 – 8:00 a.m.

Community Hospital South

Second Wednesdays	South Multidisciplinary Breast Cancer Conference - CHS Community Cancer Center South 1440 E. County Line Rd., Community Room, 8:00 – 9:00 a.m.
Second Tuesdays	South General - CHS Community Cancer Center South 1440 E. County Line Rd., Community Room, 12:00 – 1:00 p.m.
Fourth Wednesday	South Thoracic Community Cancer Center South, 1440 E. County Line Rd., Community Room, 8:00 – 9:00 a.m.
Third Tuesdays	South Molecular Community Cancer Center South, 1440 E. County Line Rd., Community Room, 5:00 – 6:00 p.m.
First & Third Fridays	South Case Presentations Hospitalist Office, Ste. 1190 1440 E. County Line Rd., Community Room, 12:00 – 1:00 p.m.

Indiana University School of Medicine/ Indiana University Health

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Online CME Activity	HPV Documentary: Someone You Love: The HPV Epidemic http://cme.medicine.iu.edu/hpvdocumentary
Dec. 8	Indiana Clinical and Translational Sciences Institute 9th Annual Meeting: Global to Local Health Hine Hall
Dec. 14	Public Health Insights and INnovations Webinar Series Webinar
2018 Jan.27	Breast Cancer Year in Review Drury Plaza Hotel Carmel, Indianapolis
March 1-2	RESPECT Conference Let's Talk Palliative Care: Caring for the Complex Patient Ritz Charles Banquet Facility, Carmel
March 21-24	AMWA 103rd Anniversary Annual Meeting Doubletree Center City, Philadelphia, PA
March 22-23	Transgender Healthcare Conference 2018 Goodman Hall
April 13	Annual Update in Pediatric Gastroenterology for the Primary Care Clinician Ritz Charles Banquet Facility, Carmel
May 4	21st Annual IU Gastroenterology/Hepatology Update Indiana History Center
May 15-16	53rd Annual Riley Children's Health Pediatric Conference NCAA Hall of Champions Conference Center
May 18-20	27th Annual Specialist Education in Extracorporeal Membrane Oxygenation (SEECMO) Conference

To submit articles, Bulletin Board items, CME & events, opinions or information,email ims@imsoline.org. Deadline is the first of the monthpreceding publication.

Course dates and locations are subject to change. For more information, please visit http://cme.medicine.iu.edu or call 317-274-0104.

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Special Feature

One in Five US Adults Still Using Tobacco Products in 2015

One in five US adults still using tobacco products in 2015

About 1 in 5 U.S. adults used some form of tobacco product in 2015, according to new data published by the Centers for Disease Control and Prevention and the U.S. Food and Drug Administration's (FDA) Center for Tobacco Products in the Morbidity and Mortality Weekly Report (MMWR).

This is the first time CDC, in coordination with FDA, has used the National Health Interview Survey (NHIS) to assess the range of different tobacco products used by U.S. adults. The survey has been used to assess current ("every day" or "some day") cigarette smoking among U.S. adults since 1965, but ongoing surveillance of other tobacco products began more recently.

About 42 million adults – more than 87 percent of the nation's nearly 49 million tobacco product users – reported using a combustible product such as cigarettes, cigars, or pipes (including hookahs and water pipes). The remaining adult tobacco users reported using e-cigarettes or smokeless tobacco products such as chewing tobacco, snuff, dip, snus, and dissolvable tobacco.

"Too many Americans are harmed by cigarette smoking, which is the nation's leading preventable cause of death and disease," said CDC Director Brenda Fitzgerald, M.D. "CDC will continue to use proven strategies to help smokers quit and to prevent children from using any tobacco products."

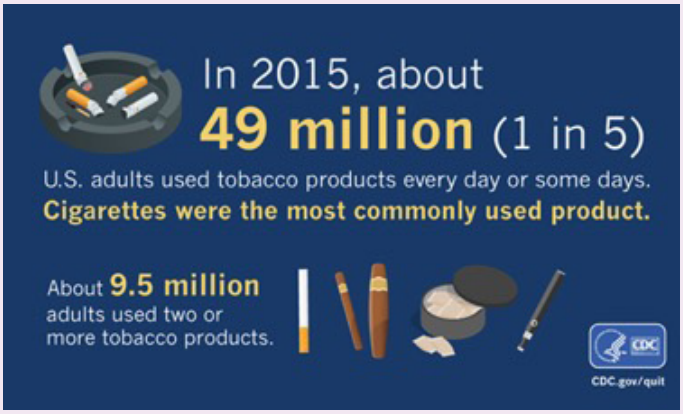
Key findings from analysis of tobacco use data

These data from the 2015 National Health Interview Survey also found that 9.5 million American adults reported "every day" or "some day" use of two or more tobacco products. Among all adults, cigarettes were the most commonly used product (15.1 percent); followed by e-cigarettes (3.5 percent); cigars, cigarillos, or filtered little cigars (3.4 percent); smokeless tobacco (2.3 percent); and pipes, water pipes, or hookahs (1.2 percent).

Use of any tobacco product varied by sex, age, race/ethnicity, U.S. region, education, marital status, annual household income, sexual orientation, health insurance coverage, disability status, and presence of serious psychological distress.

The data also show that:

- Use of any tobacco product use was more common among males (25.2 percent) than among females (15.4 percent) and more common among adults ages 25–44 years (23.3 percent) than among those ages 65 years and older (11.1 percent).
- By race/ethnicity, tobacco product use ranged from 9.0 percent among Asians to 26.6 percent among American Indians/Alaska Natives.
- Rates of use of any tobacco product were higher among adults living in the Midwest; people with a General Equivalency Diploma (GED); people with annual household incomes under $35,000; adults uninsured or insured through Medicaid; people with a disability; and those who are lesbian, gay, or bisexual.
- Among all groups, use of any tobacco product was most common among adults with serious psychological distress (47.2 percent), compared with use among those without serious psychological distress (19.2 percent).



"These results make clear that more action is needed to reduce the disease and death caused by cigarette use – and the FDA has announced a comprehensive approach to do just that," said FDA Commissioner Scott Gottlieb, M.D. "As part of this effort, the FDA is focusing on the role that nicotine plays in creating and sustaining addiction to combustible cigarettes, by seeking to regulate the nicotine content in cigarettes to render them minimally or non-addictive. This will be coupled with efforts to encourage innovation of potentially less harmful products, including electronic nicotine delivery systems."

What more can be done?

Full implementation of comprehensive state tobacco control programs, in conjunction with FDA regulation of tobacco products, are vital to accelerate progress toward reducing tobacco-related diseases and deaths in the United States. Targeted interventions are also needed to reach subpopulations with the greatest burden of use, which might vary by tobacco product type.

Cigarette smoking remains the leading preventable cause of death and disease in the United States. Smoking kills an estimated 480,000 Americans each year, and about 16 million Americans suffer from a smoking-related illness. For more information or for free help quitting, call 1-800-QUIT-NOW or go to www.smokefree.gov

Source: US Centers for Disease Control and Prevention

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