VOLUME CXXVII ISSUE 8 • INDIANAPOLIS, INDIANA AUGUST 2020

BULLETIN

EDITORIAL PG. 02

IMS STATEMENT ON RACISM

By IMS BOARD & EXECUTIVE COMMITTEE

INDIANAPOLIS MEDICAL SOCIETY

EST 1848

Indianapolis Medical Society
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Indianapolis, IN 46204

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IMS ON RACISM

STATEMENTS ON RACISM

The Indianapolis Medical Society (IMS) Board of Directors approved at their July Board meeting on July 14, 2020 to stand with American Medical Association (AMA) by stating their agreement with the AMA statement made on June 7, 2020 against racism. The statement reads as following:

- **The AMA recognizes that racism in its systemic, structural, institutional, and interpersonal forms is an urgent threat to public health, the advancement of health equity, and a barrier to excellence in the delivery of medical care.**
- **The AMA opposes all forms of racism.**
- **The AMA denounces police brutality and all forms of racially-motivated violence.**
- **The AMA will actively work to dismantle racist and discriminatory policies and practices across all of health care.**

Additionally, as an affiliate of the Indiana State Medical Association (ISMA), the Indianapolis Medical Society stands with the ISMA Board of Trustees and supports the following statement released by the ISMA on July 16, 2020:

ISMA opposes all forms of racism and denounces racially motivated violence, including police brutality. ISMA is committed to creating greater health equity by dismantling racist and discriminatory policies and practices across all of health care and amplifying diverse voices within the health care community through policy solutions, legislative advocacy and professional development.

We also know the health of Hoosiers depends on more than just the health care delivery system – it depends on other social determinants of health, such as employment, housing, education, public safety and access to healthy food. Racism is a contributing factor to social determinants of health and is a barrier to health equity. ISMA stands with people of color in the effort to improve public health outcomes, increase access to care, and reduce health disparities for our minority populations.

ACTIONS AGAINST RACISM COMMITTEE

The Indianapolis Medical Society is committed to working against covert and overt racism in our city. As public health servants, we believe that we must do our part to educate, take action and engage in conversations to end systemic racism.

That is why the Board of Directors and Executive Committee have created the Actions Against Racism Committee (AARC). It is our hope that the AARC will be a longstanding committee that will come together to find ways to educate physicians, take action and engage with the community to support racial equality. We hope to support and encourage our own membership throughout this process and encourage you to reach out to us with any suggestions or needed support.

We are proud to announce the Dr. Mary McAteer and Dr. Joseph Webster will be chairing the committee. We are currently looking for IMS members who would like to join this effort. If you are interested, please email Executive Vice President, Morgan Perrill at mperrill@iga.in.gov. Stay tuned for more information as this committee is organized.

VOLUME CXXVII • ISSUE 8
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OFFICIAL MONTHLY PUBLICATION OF THE

Indianapolis Medical Society
125 West Market Street, Suite 300
Indianapolis, IN 46204

Ph: 317-639-3406
www.indymedicalsociety.org

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TABLE OF CONTENTS

IN THIS ISSUE

SPECIAL FEATURES

ANNOUNCEMENTS

LETTER FROM THE EDITOR

Members,

As you can see, the IMS Board and Executive Committee have been hard at work advocating for physicians in central Indiana. They want to engage more of you who are looking to get involved. The AARC is what we hope to be the first of many opportunities.

Please reach out with any suggestions or comments.

Sincerely,

Morgan Perrill

Morgan Perrill
Executive Vice President

THE PRESIDENT'S PAGE

ERIC E. TIBESAR, MD

Welcome friends and fellow physician members of the IMS to the month of August. The main topic that I would like to talk about this month is something that I believe is on almost everyone's minds, regardless of what specialty you practice. Even though I am a pediatric sub-specialist, I still have a particular interest and passion for the health, safety and wellbeing of all children. In addition, like many of you reading this letter, I am also a parent of 2 school-aged children. Therefore, I want to focus this month on school and what we should be aware of when children start to go back.

As we have already seen for the majority of this year, we again find ourselves in unprecedented times. I feel like I have said that statement before several times in previous letters, but I find it completely apropos for this time of year. The summer break for many children is winding to a close (and for some of you out there, your children's summer is already over) and school is right around the corner. By now, almost every school district has had to come up with a very tough choice of allowing students to congregate together for in person learning in a classroom or offer virtual online education or a combination of the two. In addition, districts have had the painstaking task of coming up with guidelines to help benefit the health and safety of not only their pupils but the teachers, staff and faculty at their respective schools. As you are all likely aware, many schools have elected to hold off on offering in person classroom teaching. Washington Township schools was the first to announce on July 13 that all classes would be virtual. Shortly after that, Indianapolis Public Schools announced near the end of July that they would also start classes with remote learning until at least October. As of the writing of this letter, Avon high school was open for in person learning but shortly afterwards, 3 students and 2 staff members tested positive for COVID-19 so they switched to an all online learning format.

Parents right now are struggling with what type of guidance they should follow for their children. The American Academy of Pediatrics recently came up with recommendations that aim to benefit the social and mental health of the children in this country. They mention it would be best for children to meet together for in person learning in the classroom. They did have some guidelines including recommending face masks, social distancing of children in the classroom and lunchroom, frequent cleaning and disinfecting of the schools and equipment, frequent

hand washing and hand sanitizing by students and staff and of course avoiding school should any symptoms of infection occur. These guidelines seem to mirror the recommendations from the CDC but still leave a lot of question marks. Children get sick a lot more often than adults and get a lot of other viruses that do not have the same infectivity rate and morbidity that COVID-19 does. So, when should schools safely and effectively shut down if one child or more than one child gets sick? If the child does develop a fever but has a negative COVID-19 test, when can they safely come back to school? How can elementary schools effectively keep young, immature children socially distant from each other? How do you stop a kindergartner or a first grader from sharing their food or sharing their school supplies or sharing their masks? Is this a duty that the teacher needs to now take on, in addition to their education responsibilities? What about working families? How can we take care of them if there is no one at home to watch over their children should they need to be quarantined or need to switch to online learning? What if families do not have access to Wi-Fi or struggle to understand how to access e-learning resources?

THE PRESIDENT'S PAGE

ERIC E. TIBESAR, MD

On July 22, Governor Holcomb announced a state-wide mask mandate, also requiring that students from third grade on up wear masks at all times if they are at school. No requirement was made for those in kindergarten, first grade or second grade. Some school districts have required masks for all children when they are on buses or in the cafeteria. As my wife and I were going through all these mandates and school district recommendations, we went back and forth several times about whether we should send our children to school or do virtual learning. As of now, my second-grade daughter will attend school, but we will have her wear a mask, even though it is not completely required, and my middle school son will do a hybrid schedule where he will attend school every other day and then do e-learning every other day. This recommendation for his middle school just changed last week and seems to be a very fluid decision by the school district. The hybrid model seems to be popular with many other districts across Central Indiana and throughout the state.

As a pediatric sub-specialist, I also deal with lots of children who have significant diagnoses that put them at risk of getting infected. Patients with autoimmune disorders who are on immunocompromising medications, patients with other chronic diseases and those with malnutrition that put their immune system at risk of serious infection. I have received many calls and concerns from family members trying to decide if their child should be in school or not. Ultimately, based on a lack of significant research and evidence, the decision that parents must make is for them and them alone to decide. As a physician, I can render an opinion, but I cannot force them to stay home or go to school either way. What I can do, is make sure that schools are looking out for the best interests of their pupils and make sure that everyone stays healthy and safe as much as possible.

Again, as of the time of the writing this letter, the state of Indiana just reached a new 4-day record of new cases of COVID-19. As many more school districts go back into session, it should only be expected that this number will continue to rise. As physician members of the IMS, we will continue to do our best to care for our patients but also look out for the health and wellbeing of all Hoosiers, no matter their age. Children can certainly be vectors for disease and the worst thing we can do is allow them to transmit this virus to teachers, family members and those that are at high risk. I will always continue to advocate for the health of my pediatric patients but the health of their family and friends is also of utmost importance. If the situation continues to get worse, we, as a society, will advocate for the health of our patients and make sure we can stop the spread of this epidemic by any means. If that means shutting down school and keeping everyone at home, then so be it. We will continue to work hard for whatever keeps our patients safe and healthy. But make sure you keep yourself safe and healthy as well. Take care and see you again next month.

Eric Tibesar
President
Indianapolis Medical Society

IMS Foundation Scholarship Winner *McKenzie Greathouse*

The Scholarship: Medical Training Boot Camp

The Medical Academic Center (MAC) is a bio-skills lab/medical education conference center in Carmel, IN and where the Indianapolis Medical Society holds all of its board meetings. The MAC also hosts a special medical training boot camp in the summer for high school students who are interested in pursing a career as a physician. Students get to spend a week getting hands on experience outside a classroom.

The IMS Foundation teamed up with the MAC to provide a $1,000, full scholarship for Medical Training Boot Camp for the summer of 2020. The Foundation decided to support one Marion County student who met the following criteria:

- Participated in an anatomy and/or physiology course
- A cumulative GPA of 3.0 or higher (with transcript)
- A strong interest in pursuing a career in the health care field
- A paragraph (500 – 1000 words) describing why you should receive a scholar ship
- 3 letters of recommendation from past instructors/teachers
- A follow up essay 500 to 1000 words on your experience to be published in the Indianapolis Medical Society monthly bulletin and the Medical Academic Center newsletter

The Foundation was happy to award this year's scholarship to McKenzie Greathouse. McKenzie is a senior this year at Perry Meridian High School, met all the criteria and had excellent recommendation letters.

Below is a brief overview of some of what the students were able to do during the week.

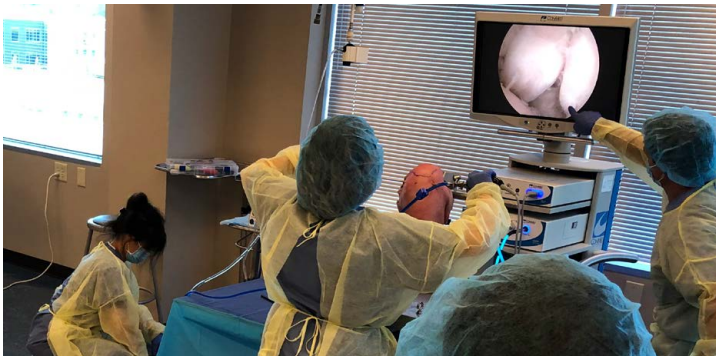
Monday:	Gross Anatomy Dissection of the Spine
	Gross Anatomy Dissection of the Respiratory and Cardiovascular Sys tems; including an additional dissection of the heart and lungs
	Gross Anatomy Dissection of the Upper and Lower Extremities
Tuesday:	Craniotomy and Gross Dissection of the Brain/Neuroanatomy
	Gross Anatomy Dissection of the Orbit, Neck & Hemisection
	Abdomen & Pelvis Dissection to include: Digestive, Gastro, Urogenital Systems & Organ Dissection
Wednesday:	Live Spinal Surgery (streamed)
	Spinal Navigation: Utilize the O-arm & Fluoroscopy
	Arthroplasty, hands-on experience repairing both a shoulder and knee
Thursday:	Arthroscopy, hands-on experience repairing shoulder &/or knees
	Cricothyrotomies, Chest Tubes, Laryngoscopes, Intubating
	Casting Techniques
	Suturing/Knot Tying Techniques & Wound Vacuum

McKenzie's Essay

By MCKENZIE GREATHOUSE
FUTURE PHYSICIAN AND IMS MEMBER

My experience at the Medical Academic Center was one I will never forget and will forever be grateful for. It gave me the chance to explore multiple career paths within the medical field. Before attending the medical academic center I had no idea what my plan after high school looked like but now my mind is pretty much made up. As for right now, I know I want to pursue a career in the field of medicine. I don't know specifically what I want to be but I know the direction I want to go. I also plan on looking into multiple shadow opportunities whether those are through Indiana Spine or somewhere else. One thing that we did that made me so sure was the multiple dissections. Being able to have that hands on experience let me know that I could handle the smells, the blood, etc. The dissections also give me a head start for the future since many medical students do not get the opportunity I did. Hearing from people from all different parts of the medical field helped to soften the intimidating idea of going to medical school as well. We were able to ask questions and really talk to them about what they love, what they dislike, and how they got there. Attending the MAC gave me the chance to meet other kids who were just as eager and open to new experiences as I was. They played a large part in making the experience what it was.

I'm immensely glad I pushed myself to go and was able to receive the scholarship from IMS in order to attend. I would highly recommend the camp to anyone who has the slightest interest in anatomy and physiology. Even the field trip my high school took to the MAC was very helpful. I can't wait to see what the future holds and where I will end up. Overall, it gave me the confidence I needed to create a structure for my future.



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Marilyn Bull, MD

By THERESA ROHR-KIRCHGRABER, MD AND EMILY FREEMAN

As women began to arrive into the medical field, Dr. Marilyn Bull saw this new wave as an opportunity to prove that women have just as much of a place in medicine as their male counterparts. Dr. Marilyn Bull's life has been filled with passion, achievement, and advocacy, all of which are noted in her extensive 40-page curriculum vitae. She owes much of her success and core values to her upbringing in rural Michigan. When asked what lessons she had learned, the self-proclaimed "farm girl" responded: "Working on a farm taught me lessons along the way that were very critical. It kept everything in perspective. On a farm, you are completely indebted to the weather. So, realizing that not everything in life is under your control and that you have to adapt accordingly is important" ... "Also, hard work. There's no question that I learned how to work hard from my life on the farm." From the age of 8, Marilyn could be found every summer selling cherries from her family's stand for 25 cents a quart. After her first semester at Michigan State University, the innovator in Marilyn asked, why not make cherry pies? Marilyn's cherry pies became a hit and allowed her to finance her medical school education at the University of Michigan. Today, these pies remain a signature item at the family-owned Cherry Point Farm and Market.

In 1964, Marilyn Bull was thrilled to be accepted into the University of Michigan Medical School along with 15 other women, comprising 10 percent of their class. Dr. Bull stated that there was apprehension amongst faculty at the time as to how they would "manage" such a large proportion of women. Despite the university's initial anxiety regarding the whopping 16 women, Dr. Bull described her experience and support at the University of Michigan as phenomenal. The university's women faculty even built a brand-new sorority building adjacent to campus for the female medical students. And while Dr. Bull never felt overtly discriminated against as a woman, she recalls that she and her female classmates always felt like they had to work harder and prove themselves: "we had to do more and we had to do better." These feelings pervaded into residency and her early academic years, always motivating her.

After medical school, Dr. Marilyn Bull matched into Northwestern University's Residency Program of 33 interns in 1968. The night before her first day of residency, Dr. Bull distinctly recalls that she dreamt the program would be comprised of 30 women and 3 men. Yet the following morning, she took a seat for orientation as one of three women surrounded by 30 men. She spent all morning talking with the man seated next to her. Little did she know that all these years later she would be celebrating her 49th wedding anniversary with him, Dr. Scott Bruins. While she met the love of her life in that program, her residency years were far from easy. Dr. Bull shared a story of when she got meningococcal meningitis during her pediatric residency. One of the nurses that she was working with noted her uncharacteristic absence and said something must be seriously wrong. That nurse grabbed some of Dr. Bull's fellow residents and they broke into her apartment to find her in the bathroom covered in a petechial rash. If it was not for her notorious work ethic, Dr. Bull may not have been saved that day. As a female resident in the 1960's, hard work was not always enough to receive equal respect from other healthcare providers. She recalls that men definitely got preferential treatment and help from the nurses: "the male interns IV's always stayed in and the female interns IV's didn't seem to be as important."

After surviving residency, Dr. Bull continued her education at Tuft's University in Boston where she completed a fellowship in birth defects and genetic counseling and then stayed for three additional years as junior faculty. It was at Tuft's where she observed more overt sexism. She witnessed as senior male faculty regularly moved prospective applicants with traditionally

"female names" to the bottom of the applicant lists. Dr. Bull helped fight this discrimination to allow women an equal chance.

Dr. Bull describes being a woman in medicine as a juggling act. Balance is not the ultimate goal, but instead juggling and adapting to your constantly changing priorities. In 1976, she moved across the country with her husband and newborn daughter to Indiana where she continued her career as a pediatrician. Marilyn Bull, MD is now the longest practicing pediatrician at Riley Hospital for Children. As a new mother and an emerging pediatrician, she recognized that as a woman, there were sacrifices and responsibilities she would have to make that would never befall a man. But nonetheless, Dr. Bull perfected the "juggling act" of a woman in medicine. Her fierce advocacy and passion have made advances in healthcare topics such as child passenger safety, genetics, firearm violence prevention, and Down Syndrome. Her tireless efforts towards establishing effective car seat standards for children, especially children with special needs, remains her legacy. The death rate of children due to motor vehicle accidents in the United States has been reduced by 46 percent since 1978. There is no doubt that this reduction was made in part by Dr. Bull's unwavering advocacy. She still receives about 5 weekly emails from around the world requesting her expertise on child passenger safety.

In her various leadership roles, Dr. Bull has always felt a responsibility to continue to create space for women. Her advocacy has no limits as she helped create the Women's Advisory Council at IU School of Medicine, which continues to promote the advancement of women in medicine today. As she reflects on her career and provides advice for young women, she emphasizes that "there's a place for women in medicine." Dr. Bull states that women serve an extraordinarily important role in medicine and provide a perspective that is essential for patient care. She quotes a friend who once said, "we do what can, so that they can do what they want." Dr. Bull hopes that her efforts, along with the efforts of countless female colleagues and physicians before her, have allowed future women physicians to encounter fewer unnecessary obstacles; the culture of medicine can always be enhanced and diversified.

In 2018, for the first time, women were the majority in both applicants and matriculants for medical schools in the United States. The current and future landscape of medicine for women would not be possible without women like Dr. Bull who helped break the glass ceiling. And for that, we thank you Dr. Bull.

Congratulations to our 50 Year Club Members!

Homer B. Beltz, MD

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Robert A. Colyer, MD

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Philip N. Eskew Jr., MD

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Elliott A. Yolles, MD

Thank you for 50 years of IMS membership!

Years of Frustrating Symptoms, Multiple Tests, Neurosarcoidosis is the Etiology

By JESSICA CARUSO, LUBABA HAQUE, HONGMEI YANG, MD & THERESA ROHR-KIRCHGRABER, MD

Abstract:

Neurosarcoidosis is a rare, chronic inflammatory disease that affects the nervous system. It is diagnosed in 5 to 10% of sarcoidosis patients, but has been found in 25% of autopsies. This suggests that a large percentage of patients are asymptomatic or misdiagnosed. Diagnosis is difficult due to variable expressivity and overlap of symptoms with other neurological disorders, such as multiple sclerosis. Moreover, diagnosis proves challenging because currently, the most specific test for neurosarcoidosis requires a histological biopsy confirmation of the affected neural tissue. This presents with its own complications. Due to the lack of fixed diagnostic methods and symptom overlap, a multidisciplinary approach is recommended in diagnosing a patient with possible neurosarcoidosis. This case describes the difficulty in making the diagnosis and the persistence of the patients' physicians.

Neurosarcoidosis, a neurological manifestation of systemic sarcoidosis, is a devastating disease. The vague and ambiguous symptoms of neurosarcoidosis require extensive effort and evaluation. With symptoms resembling multiple sclerosis (MS), a family history, and the increased incidence of MS in women, the initial diagnosis for our patient pointed to MS. A diagnosis of exclusion, sarcoidosis can be difficult to diagnose. Multiple tests, including but not limited to imaging, laboratory tests, and EMGs, must be done to rule out other more common diseases like Parkinson's, Alzheimer's, or other movement and sensory disorders. Lastly, the high risk neural biopsy, a confirmatory test for neurosarcoidosis, is rarely done. Luckily, for this patient, as the disease progressed, symptoms changed, astute physicians re-evaluated the initial diagnosis and concluded the problem was neurosarcoidosis and not MS.

Case Presentation:

In 2010, a sixty-year-old female presented with paresthesia of her face, arms, and legs associated with lethargy and weakness. Cardiac evaluation noted idiopathic total ventricle occlusion of unknown etiology, and a pacemaker was placed. She now noted paresthesia along the right temporal region of her scalp and legs, impacting her walking and worsening with any activity over fifteen minutes diagnosed as neurogenic claudication. About this time her sister was diagnosed with MS. She continued to live with these unexplained, recurrent episodes of numbness and tingling.

An evaluation for a sudden twenty-five-minute episode of right hemiparesthesia, involving her head, face, trunk, and limbs in 2014 led to an unremarkable head CT and a concern for a possible transient ischemic attack (TIA). Her evaluation included a CT angiogram, sedimentation rate (ESR), creatinine phosphokinase (CPK), and an EMG with nerve conduction studies. With normal results ruling out vascular stenosis, temporal arteritis, lumbosacral polyradiculopathy, polyneuropathy, myopathy, and mononeuritis multiplex.

Without remarkable findings, the neurologist discussed more possibilities with the patient regarding the etiology of her symptoms, including the remote chance of spinal stenosis, seizure events, or migraine aura without headache. The patient proceeded with a trial of antiseizure medication followed by a tricyclic antidepressant to determine if the symptoms were from migraine auras. Neither were helpful which led to a CT myelogram to look for spinal stenosis. Though the test did note severe degenerative changes involving the lumbar spine, there was no significant spinal canal compromise, negating the spinal stenosis theory.

Four months later, she presented with acute diplopia. The CT of the orbits noted abnormal, wispy attenuation of the intraorbital retrobulbar or intraconal fat suspicious for orbital pseudotumor, lymphoma or sarcoidosis. After four years of symptoms, this was the first suggestion of sarcoidosis.

Systemic sarcoidosis was diagnosed after a chest CT demonstrated granulomas and lumbar puncture demonstrated inflammatory spinal fluid, ruling out multiple sclerosis due to the lack of oligoclonal bands and an IgG index. With a presentation of transverse myelitis with a sensory level in the mid thorax later in her course, her diagnosis of neurosarcoidosis was confirmed, almost 5 years after her initial symptoms.

Discussion:

The clinical manifestation of neurosarcoidosis varies because multiple levels of the central nervous system may be afflicted. The symptoms may be monophasic disease presenting with only cranial nerve damage to a more widespread disease leading to peripheral neuropathy and myopathy (Ibitoye et al., 2017). Moreover, an accurate diagnosis proves challenging because the only current definitive test for neurosarcoidosis requires histological confirmation from a biopsy of the affected neural tissue. Due to their location, neural biopsies are not as easily performed and are typically considered in those who have an established diagnosis of systemic sarcoidosis (Maclean, Abdoli 2015). However, systemic sarcoidosis can also be a challenging disease to diagnose.

Neurosarcoidosis can be asymptomatic in up to 40% of patients (Maclean, Abdoli 2015). As in this patient, it is likely that if a patient with subclinical sarcoidosis that has not been diagnosed, presents with neurological symptoms, more common neurologic disorders will appropriately be considered. Blood tests and imaging are components of the diagnostic process, but may fail to distinguish neurosarcoidosis from other similar-presenting diseases. Imaging, such as chest CTs, PET scans, or abdominal ultrasounds, may be nonspecific for neurosarcoidosis, but can certainly help confirm systemic sarcoidosis. MRIs are useful, though findings may resemble those found in multiple sclerosis (MS) and thus may elicit some confusion and ambiguity. Although blood tests are of limited benefit for diagnosis, evaluation of cerebrospinal fluid (CSF) is useful (Tana et al., 2015). The ambiguity of imaging, the need for histopathological biopsy, and the possible utility of CSF evaluation demonstrates the necessity of a neurosarcoidosis diagnosis utilizing various diagnostic modalities.

Conclusion:

Though the process was time-consuming and frustrating, the patient eventually received closure with her diagnosis, allowing her to access accurate information, specialized physicians, and support groups. For years, the physical and emotional toll of her symptoms weighed on her without any offered rationale or community. However, once reaching a diagnosis, she was able to obtain support from others with sarcoidosis and physicians who could help her manage her symptoms as they present. Her experience highlights the importance of diagnosis both clinically and personally. Though physicians could have treated symptoms as they manifested, the patient's comfort and reassurance came from a named diagnosis for the neurological symptoms she experienced.

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EDITOR'S NOTE

All editorial articles reflect the viewpoint of the author, not the viewpoint of IMS. If you have an opposing viewpoint, we encourage you to share it by submitting a counterpoint article for print to mperrill@indymedicalsociety.org. All opinions of our members are welcome.

Caruso and Haque are medical students at Marion and Yang is an internist at IUHP. Theresa Rohr-Kirchgraber, MD is a Professor of Clinical Medicine and Pediatrics at IUSM. The opinions in this article are their own and do not represent IUSM.

EDITORIAL

The Federal Response to COVID

By RICHARD D. FELDMAN, MD
IMS Board Member, MHM Board member and Past President, Former Indiana State Health Commissioner

After months of minimizing the COVID-19 crisis, 150,000 lives lost, and rapidly escalating coronavirus disease activity, our President finally acknowledged in a July 21 press conference that our country is facing a disaster. Reading a script prepared for him, he was finally, finally ready to promote mask wearing, to resume coronavirus briefings, and to promise the development of a pandemic strategic plan. This was a result of a political calculus; somehow his advisors convinced him to change course. His "we are in a good place" handling of the crisis wasn't working politically. But he couldn't help himself and immediately declared the virus will disappear and touted some of his other favorite points of disinformation. His contradictory messaging continues. He can't stay on script.

Six months after COVID-19 surfaced in this country, we are still without a national coordinated response, adequate supplies of personal protective equipment, and sufficient levels of testing and contact tracing. The European Union closed its borders to U.S. travelers because COVID-19 is totally rampant here. We have a President who has minimized the pandemic almost to the point of denying it exists; a President who stopped attending COVID Task Force meetings long ago.

Coronavirus is deaf to the Administration's pervasive disinformation campaign and is delighted with some governors, who, like lemmings are jumping off a cliff in blind obedience to their leader and political ideology. We've had a total lack of federal leadership. Worse, we've had detrimental leadership. We will not gain control over this virus by minimizing, denying, or ignoring the situation. "Spinning" is what we have had plenty of and something we have long expected from politicians. But in this case, spinning will unconscionably cost tens of thousands of lives. It's astonishing to me that a third of Americans totally believe the spin.

Our President has discredited, undermined, dismissed, and marginalized the Administration's own Coronavirus Task Force medical experts. Evading science, he has actively crusaded at any cost in political self-interest against their recommendations for reopening the economy. He has especially discredited the expertise of Dr Anthony Fauci who has the courage to openly contradict the President to truthfully present the best public health advice in a rapidly-evolving scientific understanding of COVID-19.

The President exerted political pressure on Dr. Steven Hahn, Commissioner of the Federal Drug Administration and Dr. Robert Redfield, Director of the Centers for Disease Control and Prevention to promote his fervently advocated but unfounded positions or to modify their recommendations. The CDC's reopening recommendations for businesses and schools and Hahn's rush to declare emergency authorization of hydroxychloroquine for COVID-19 are just three examples. The CDC has been compromised. The Task Force medical experts' exposure to the public and Congress at times have been limited. Many other examples of interference could be offered. Complete chaos.

Mixing politics and public health is a dangerous proposition. Public health policy frequently becomes compromised when health officials report to politicians and serve at their pleasure - evidenced by the very carefully crafted and sometimes evasive statements of Coronavirus Task Force doctors. They want to keep their jobs.

This country is in critical condition. We can't look for leadership from our President and Vice-President. Shame on them. It will be up to governors, mayors, and the personal responsibility of everyday citizens to do the right things to protect the populace and each other.

The President's epiphany into COVID-19 reality was fleeting. If you think we are in a good place, then think again.

Note from the Editor

Editorials are opinions of the author and not the opinion of the Indianapolis Medical Society. Editorials are published with the intent to encourage discussion and opposing viewpoints are **welcomed**. Please submit articles for this publication to mperrill@indymedicalsociety.org.

WELCOME NEW MEMBERS

Mercy M. Hylton, MD
Indiana Physicians Management, LLC
7405 Windridge Way
Brownsburg, IN 46112-8800
317-507-3350
Emergency Medicine
University of Oklahoma, Col of Med, 2001

Rahul D. Abhyankar, MD
JWM Neurology PC Resident
Neurology
Indiana University School of Medicine, 2015

Katherine Anderson, MD
IUSM Pediatric Residency Program
Emergency Medicine, Pediatrics
Indiana University School of Medicine, 2019

Peter J. Davis, MD
Midwest Colon & Rectal Surgery Resident
Colon & Rectal Surgery
Indiana University School of Medicine, 2014

Jennifer M. Divine, MD
IUSM Emergency Medicine
Emergency Medicine
Indiana University School of Medicine, 2019

Julie F. Strum, MD
IUSOM Anesthesiology Residency
Anesthesiology
Indiana University School of Medicine, 2020

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THE BULLETIN BOARD

RICK C. SASSO, MD

Rick C. Sasso MD, Indiana Spine Group, served as guest Professor at the Thomas Jefferson University Spine Fellows Alumni Symposium held July11, 2020 in Newport, Rhode Island. The lecture Dr. Sasso was asked to give was: "The Future of Spine Surgery."

Dr. Sasso had a manuscript published in the Peer-reviewed-Spine Journal.

Kim DH, Hwang RW, Lee GH, Joshi R, Baker KC, Arnold P, Sasso R, Park D, Fischgrund J: Comparing rates of early pedicle screw loosening in posterolateral lumbar fusion with and without transforaminal lumbar interbody fusion. Spine J, 2020.

JOSEPH SMUCKER, MD AND RICK C. SASSO, MD

Journal article published by: Boody BS, Sasso RC, Smucker JD: Far lateral/Extraforaminal approaches for microdiscectomy and foraminal decompression in the lumbar spine. Clin Spine Surg, 2020.

Please submit Bulletin Board Information to ims@imsoline.org. Your photo in the IMS files will be used unless an updated picture is submitted with your material.

IN MEMORIAM

BRADLEY WEINBERG, M.D.

Bradley Adam Weinberg was diagnosed with glioblastoma multiforme, a fatal brain cancer. He was born December 20, 1957, in New Brunswick, New Jersey. Brad was a graduate of Livingston High School in Livingston, NJ, and attended Amherst College, where he studied philosophy and neuroscience. After Amherst, he attended New York University School of Medicine. After medical school, Brad completed his internship and residency at the University of Cincinnati. In 1987, he moved to a neighborhood near Eagle Creek Park in Indianapolis, Indiana. In Indiana Brad began a cardiology fellowship. Shortly after completing his fellowship, Brad joined Indiana Heart Associates, which eventually became part of the Community Health Network, where he would practice until his retirement in 2018.

Over the course of his over 30 year career in medicine, Brad cared for thousands of patients and performed thousands of life-saving procedures in the catheterization labs in the Community Health Network, including one memorable procedure to save the life of a pregnant young woman having a heart attack. In December 2019, the cath lab at Community Hospital South was renamed the Bradley A. Weinberg, MD, Cardiovascular Catheterization Lab in his honor. A dedicated teacher, Brad taught scores of medical students and residents, pharmacy students, and physician assistant students over the years and was to receive a teaching award from the Indiana Chapter of the American College of Physicians on Monday, June 29. IMS Member since 1991.

JAMES VANDIVIER, M.D.

James Vandivier was born January 10, 1935, in Indianapolis. Jim graduated from Shortridge High School in 1953. He received his Bachelor's Degree from DePauw University in 1957, and his Doctor of Medicine from Indiana University School of Medicine in 1961. Jim proudly served his country as a Captain in the U.S. Air Force. He then entered the private practice of internal medicine. His devotion to providing exceptional care spanned 48 years. He was a member of the Indiana State Medical Association, a past President of the Society of Internal Medicine and he also served on the faculty of the IU School of Medicine until retirement. IMS Member since 1967.

CME & CONFERENCES

MONTHLY EVENTS

	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1st Week of the Month	Community North: Breast Cancer Conf. 7-8 am	Community East: CHE Admin Conf. 12-1 pm Community North: Psychiatry GR 12:30-1:30 pm Community North: Chest Cancer Conf. 7-8 am Community Heart & Vascular: Imaging Conf. 7-8 am		Community North: Forum 7-8 am Community South: South Case Presentations 12-1 pm
2nd Week of the Month	Community East: Medical GR 1-2 pm Community South General CHS 12-1 pm	Community North: GI/Oncology Conf. 7-8 am Community Heart & Vascular: M&M Conf. 7-8 am Community South: Breast Cancer Conf. 8-9 am St. Vincent Simulation Center: Pediatric GR 12-1 pm St. Vincent Womens: Neonatology GR 12-1 pm	St. Vincent: Electrocardiograph Conf. 7-8 am	Community North: Gynecological/Oncology Conf. 7-8 am
3rd Week of the Month	Community North: Breast Cancer Conf. 7-8 am Community South: South Thoracic 8-9 am Community South: South Molecular 5-6 pm	Community North: Psychiatry GR 12:30-1:30 pm Community North: Melanoma 7:30-8:30 am Community Heart & Vascular: CV Conf. 7-8 am	St. Vincent Heart Center: Cardiac, Medical, Surgery 7-8 am	Community North: GU Conf. 7-8 am Community South: South Case Presentations 12-1 pm
4th Week of the Month	Community East: Breast Cancer Conf. 7-8 am	Community North: GI/Oncology Conf. 7-8 am Community Heart & Vascular: Disease Manage Conf. 7-8 am St. Vincent Womens: Perinatal Case 7-8 am		

Annual	St. Vincent Womens:	MFM Ultra Sound Series
	St. Vincent Simulation Center:	Sim Debriefing Essentials
	St. Vincent Simulation Center:	PMCH Crisis Management

Quarterly 1-4 pm
12x/Year
12x/Year

WEEKLY EVENTS

Day of the Week	Event
Monday	St. Vincent: General Cardiology 7-8 am
Tuesday	St. Vincent: Trauma Case 12-1 pm St. Vincent Womens: Neonatology Journal Club (every other month) 12-1 pm
Wednesday	St. Vincent: CCEP 7-8 am St. Vincent Heart Center: Intervention Cardiology 7-8 am St. Vincent: Advanced Heart Failure 7-8 am St. Vincent: Surgery Didactics 7:30-8:30 am St. Vincent: Surgery M&M 6:30-7:30 am
Thursday	St. Vincent PMCH: Pediatric Cardiothoracic Surgery & Cardiology Conf. 12-1 pm St. Vincent OrthoIndy: Fractures 8-9 am
Friday	

ONLINE EVENTS

Indiana School of Medicine

Indiana University School of Medicine is committed to providing valuable educational opportunities. Many of our educational activities usually offered as face-to-face meetings, have now transitioned to a virtual format in an effort to keep healthcare teams connected and engaged during the COVID-19 pandemic.

Current Virtual Series actives open to the public:

Grand Rounds: Dermatology, Gastroenterology, Medicine, Pathology, Pediatric, Psychiatry, Otolaryngology, OBGYN

Project ECHOs: Cancer Prevention & Survivorship Care, Integrated Pain Management

Education & Research: Child Neurology, Clinical Research Ed, Faculty Devel. Simulation, IU Health Pathology Digital Imaging, Neonatal & Prenatal Ed, Pulmonary Research

Schedule of activities, visit https://iu.cloud-cme.com

2020 Live Events

Oct 9 23rd Annual IU Gastroenterology Hepatology Update, IN History Center

For more detailed information, please visit the events page.

IMS is not responsible for the events listed. We recommend that before attending any CME/Conference events that you check with the provider to confirm the program is still available.

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

INDIANAPOLIS
MEDICAL SOCIETY

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Board of Directors 2020

Terms End with Year in Parentheses

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Rania Abbasi *(2021)*
Jeffrey L. Amodeo *(2022)*
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Julie A. Daftari *(2019)*
Richard D. Feldman *(2019)*
Ann Marie Hake *(2020)*
Mark M. Hamilton *(2021)*
David A. Josephson *(2020)*
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Jeffrey J. Kellams *(2021)*
John E. Krol *(2020)*
Ramana S. Moorthy *(2020)*
Thomas R. Mote *(2019)*
Mercy O. Obeime *(2021)*
Scott E. Phillips *(2020)*
Theresa Rohr-Kirchgraber
Taha Z. Shipchandler *(2020)*
Maureen Watson *(2022)*
Joseph Webster, Jr. *(2022)*
H. Jeffrey Whitaker *(2020)*

Past Presidents' Council 2020

** Indicates Voting Board Members, Term Ends with Year in Parentheses*

Carolyn A. Cunningham
David R. Diaz
Marc E. Duerden
John C. Ellis
Bernard J. Emkes
Bruce M. Goens
Paula A. Hall* *(2020)*
Susan K. Maisel* *(2021)*
Jon D. Marhenke
Mary Ian McAteer* *(2022)*
John P. McGoff
Stephen W. Perkins
Richard H. Rhodes

Delegates

Delegates to the Annual State Convention

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

Linda Feiwell Abels (2021)
Mary Pell Abernathy (2021)
Christopher D. Bojrab (2021)
Ann C. Collins (2020)
Carolyn Cunningham (2022)
Julie A. Daftari (2020)
Darrell D. Davidson (2021)
John H. Ditsler (2021)
Marc E. Duerden (2020)
Robert S. Flint (2021)
Bruce M. Goens (2022)
Ann Marie Hake (2022)
Ronda A. Hamaker (2022)
Mark M. Hamilton (2022)
C. William Hanke (2021)
Chad R. Kauffman (2020)
Susan K. Maisel (2022)
Mary Ian McAteer (2020)
Ramana S. Moorthy (2020)
Thomas R. Mote (2021)
Mercy O. Obeime (2020)
Robert M. Pascuzzi (2020)
J. Scott Pittman (2022)
David M. Ratzman (2021)
Taha Shipchandler (2021)
Jodi L. Smith (2022)
Eric E. Tibesar (2020)
John J. Wernert (2020)
H. Jeffrey Whitaker (2020)
Steven L. Wise (2021)

Alternate delegates

Delegates to the Annual State Convention

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

Ranai Abbasi (2021)
Laurie L. Ackerman (2022)
Jeffrey L. Amodeo (2021)
Nicholas M. Barbaro (2019)
Brian D. Clarke (2020)
Richard Feldman (2021)
Doris Hardacker (2021)
Brian S. Hart (2020)
Kyle Jamison (2021)
David A. Josephson (2020)
Penny W. Kallmyer (2020)
John E. Krol (2020)
Daniel E. Lehman (2020)
James Leland (2022)
Christopher Mernitz (2021)
Martina F. Mutone (2021)
Ingrida I. Ozols (2020)
Scott E. Phillips (2022)
Richard H. Rhodes (2020)
Theresa Rohr-Kirchgraber (2022)
Jason K. Sprunger (2020)
Richard M. Storm (2021)
Glenn A. Tuckman (2021)
Maureen Watson(2022)

**Several open positions, contact EVP if interested.*

Indiana state medical association

Past Presidents

John P. McGoff 2017-2018
Jon D. Marhenke 2007-2008
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

Executive Committee

At-Large Member
David R. Diaz

Seventh District

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