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HAMPTON ROADS
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A comprehensive publication for and about the local medical community

Vol I, Issue IV, Fall 2013

Recognizing the achievements of the local medical community

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Welcome to the Fall issue of Hampton Roads Physician

This issue is a prime example of the best laid plans going awry: when we were planning our edit calendar for 2013, it was our intention to treat obesity and diabetes as one topic. It made sense at the time, as the link between obesity and diabetes is well established. But as we began reviewing the nominations we received for cover physicians – and when we actually sat down with physicians and surgeons who treat patients with each of these two diseases – we found that there is simply so much truly extraordinary work being done here in Hampton Roads in each area, that combining them both in one issue wouldn't allow us to do justice to either.

Holly Barlow
Publisher

With the encouragement of the members of our Physician Advisory Board, we made the decision to focus this Fall issue on the topic of treating obesity, and to postpone the discussion of diabetes until our Winter issue.

Diabetes affects 8.3 percent of all Americans and 11.3 percent of adults age 20 and older. Some 27 percent of people with diabetes – 7 million Americans – don't even know they have the disease. The Centers for Disease Control and Prevention estimates that as many as one in three U.S. adults could have diabetes by 2050 if current trends continue.

In our next issue, we'll spotlight physicians who are caring for Diabetes, and how they're working to combat this alarming trend. These include endocrinologists, ophthalmologists, foot and ankle surgeons - virtually every specialty that deals with the effects of diabetes.

Deadline to submit nominations is December 10th.

The nomination form is on our website, and we look forward to hearing from all of you.

Bobbie Fisher
Editor

We continue to solicit your opinions about this publication, and how it might better serve the needs of the medical community throughout Hampton Roads. Our publisher and editor are eager to hear from you. You can contact us directly by phone or email, or through our website:

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2014 Editorial Calendar

We will feature the following topics and related physicians on our cover

Winter – Diabetes and related Physicians

Spring – Women's Health related Physicians

Summer – Trauma and Emergency Room Physicians

Fall – Geriatrics related Physicians

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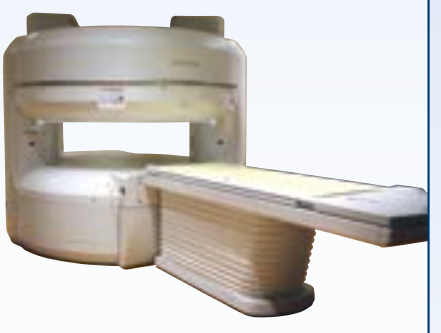

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Meet the Physician Advisory Board

Hampton Roads, Virginia is the home of world-class physicians who provide medical care of the highest quality to the 1.7 million citizens of the region, as well as to the many others who travel here for care and treatment.

Hampton Roads Physician would like to thank these physicians for their service on our inaugural Advisory Board.

JOSEPH A. ALOI, MD, FACP, FACE
Endocrinology, Diabetes, and Metabolism

Dr. Aloi is an Associate Professor of Medicine at Eastern Virginia Medical School, and Clinical Director of the Strelitz Diabetes Center for Endocrine and Metabolic Disorders. He is Board certified in Diabetes, Metabolism & Endocrinology, and in Internal Medicine.

DAVID R. MAIZEL, MD
Family Medicine

Dr. Maizel serves as Senior Physician Executive responsible for the overall operationsl operational performance of the Sentara Medical Group. He is Board certified in Family Medicine.

JEFFREY R. CARLSON, MD
Orthopaedics

Dr. Carlson joined Orthopaedic and Spine Center in 1999. He is Board certified in Orthopaedics, and is currently Chief of Surgery at Mary Immaculate Hospital.

JOHN M. SHUTACK, MD, FAANS
Neurosurgery

Dr. Shutack specializes in general surgery with an emphasis in Spine Surgery. He practices with Atlantic Neurosurgical Services, which is affiliated with the Chesapeake Regional Medical Center. He is Board certified in Neurosurgery.

ERIC C. DARBY, MD, FACS
Urology

Dr. Darby practices with Tidewater Physicians Multispecialty Group in Newport News. He is Board certified in Urology and is currently Chief of Staff at Mary Immaculate Hospital.

I. PHILLIP SNIDER, RD, DO
Family Medicine

Dr. Snider practices with Amelia Family Associates, and is Regional Medical Director of Bon Secours Medical Group at DePaul Hospital. He is Board certified in both Family Medicine and Bariatric Medicine.

KEVAGHN P. FAIR, DO
Pathology

Dr. Fair is a founding partner of Dominion Pathology Laboratories, an independent diagnostic and consultative practice serving all of Hampton Roads. He is Board certified in Anatomic, Clinical and Dermatopathology.

LAMBROS K. VIENNAS, MD, FACS
Plastic Surgery

Dr. Viennas is Chief of the Division of Plastic Surgery and Assistant Professor of Plastic Surgery at Eastern Virginia Medical School. He is Board certified in Plastic and Reconstructive Surgery.

Janice M. Newsome, MD
Interventional Radiology

Dr. Newsome joined Peninsula Radiology Associates in 2005. She is Board certified by the American Board of Radiology and also holds a Certificate of Advanced Qualification in Interventional Radiology.

CHRISTOPHER J. WALSHE, MD, FACOG, FACS
Urogynecology

Dr. Walshe practices with Atlantic Urogynecology in Suffolk. He is Board certified by the American Board of Obstetrics and Gynecology, and a member of the American Urogynecologic Society.

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Waging the War on Obesity

On June 18, 2013, the American Medical Association issued a press release that included the following item:

> Obesity as a Disease
>
> Today, the AMA adopted policy that recognizes obesity as a disease requiring a range of medical interventions to advance obesity treatment and prevention. "Recognizing obesity as a disease will help change the way the medical community tackles this complex issue that affects approximately one in three Americans," said AMA board member Patrice Harris, MD. "The AMA is committed to improving health outcomes and is working to reduce the incidence of cardiovascular disease and type 2 diabetes, which are often linked to obesity."

This statement was hailed by many in the medical community, and reviled by just as many. The controversy was hardly new: an August 2004 abstract published in the US National Library of Medicine, National Institutes of Health, stated:

> The epidemic rise in obesity has fuelled the current debate over its classification as a disease. Contrary to just being a medical condition or risk factor for other diseases, obesity is a complex disease of multifaceted etiology, with its own disabling capacities, pathophysiologies and comorbidities. It meets the medical definition of disease in that it is a physiological dysfunction of the human organism with environmental, genetic and endocrinological etiologies…

"Obesity is a critical public health problem in our country that causes millions of Americans to suffer unnecessary health problems and die prematurely," Health and Human Services Secretary Tommy G. Thompson said in 2004, announcing the decision. "With this new policy, Medicare will be able to review scientific evidence in order to determine which interventions improve health outcomes for seniors and disabled Americans who are obese."

Thompson's contention is no less true today, and no less true for the AMA's recent designation. The statistics are staggering: 60 percent of Americans are overweight, and five million of them

can be categorized as obese. "Looking back 20 years or so, there wasn't one state where more than 15 percent of its population were considered obese," says Dr. Stephen D. Wohlgemuth, Medical Director of Sentara Comprehensive Weight Loss Solutions. "Today, there's no state with less than 20 percent. Virginia stands at a little over 26 percent."

And it's not just America, Dr. Wohlgemuth notes. "It's global, in any industrialized country – Australia, England, Europe. There are a number of other reasons why, but genetically we haven't changed in the last 50 to 70 years, whereas obesity has become ever more prevalent."

Regarding the so-called 'fat gene,' Dr. Wohlgemuth says, "There are some genetic predispositions, a genetic component to obesity, but that doesn't mean you're going to be obese if you eat healthy and exercise. But if you look at society, serving sizes are astronomical compared to what they used to be. You can't go to the movie theatre and get less than a humongous serving of popcorn or candy."

Dr. Maggie Gaglione, an internist and bariatrician in private practice, agrees – and she has the numbers to prove it. In 1950, for example, French fries at a fast food restaurant came in one size, and had 210 calories. By 1970, what had been the only size was called a 'small' serving, and a larger size with 320 calories was introduced. In 1990, there were three sizes to choose from, with the small size remaining at 210 calories. The large size, however, was increased to 450 calories, and a super size was offered at 540 calories. And in the year 2000, the original 1950s 'regular' size – which had been considered an ample serving for a grown man – was dubbed the 'kids' portion. The 450 calorie large was renamed medium, the super 540 calorie was now the large serving, and the super weighed in at 610 calories.

It's easy to see where the excess pounds are coming from – and these numbers are just for a side serving!

"The scary thing," Dr. Gaglione says, "is that children growing up now don't know any difference. Today's adults may know that eating fast food seven times a week is a recent phenomenon, but most kids think it's an everyday occurrence." And today's kids don't know about the 'portion distortion' that's taken place over the last 50 years. Too many of them think those sizes are standard and appropriate.

"We have to teach people how to eat right and change their behavior," Dr. Gaglione says, "including changing their environment. They need to learn to control, and they need to be mindful."

She believes it will happen, but knows, "It has to be cognizant. We have to be mindful. We did it with smoking. We're already seeing the signs: there are apples at McDonald's and Greek yogurt at 7-Eleven."

In the pages of this issue of Hampton Roads Physician, you'll meet our cover physicians, each of whom knows that no matter how obesity is designated – whether as a disease or not – there are consequences to our nation's health and productivity if the epidemic of obesity isn't stemmed. These physicians have developed and perfected safe, effective and compassionate programs that are helping their patients return to full and satisfying lives. ■

Glen L. Moore, MD

Glen L. Moore, MD

Dr. Glen L. Moore is a Board-certified surgeon specializing in general and bariatric surgery with Chesapeake Surgical Specialists, and Director of the Bariatric Program at Chesapeake Regional Medical Center. He received his medical degree from the Eastern Virginia Medical School, and completed his general surgery internship and residency at Naval Medical Center Portsmouth, where he also served as staff surgeon. He has held academic posts as an instructor at Uniformed Services University of the Health Sciences in Bethesda.

Dr. Moore is a member of the American Society for Metabolic and Bariatric Surgery and a fellow of the American College of Surgeons.

Dr. Glen Moore developed an interest in bariatric surgery in the mid- to late '80s, while he was in the Navy, completing his internship and residency. At that time, he remembers, "Surgery for obesity was almost considered to be one of those fringe activities. It wasn't widely available, and certainly not widely accepted by the surgical community or by medical internists." Nor was it well understood by patients, carrying with it the stigma of being a last option that signaled failure on their part. Unfortunately, it also carried the stigma of a fairly high complication rate – a rate Dr. Moore found unacceptably high at the time.

But all that changed in the late '90s, Dr. Moore says, when surgeons learned how to perform the procedures laparoscopically, with markedly decreased complication rates and much better outcomes – leading to greater acceptance in the medical and lay communities.

During that same timeframe, Dr. Moore was reunited with a former Navy colleague, Dr. David D. Spencer, with whom he had trained during their residency in Portsmouth. "Dr. Spencer finished his residency in San Diego," Dr. Moore explains. "We stayed in touch until he returned to Portsmouth in the late '90s, when we rekindled our friendship and our interest in weight loss surgery."

The two surgeons established the weight loss surgery program at Portsmouth Naval, leading it until they each retired from the Navy in 2003. Today, with fellow bariatric surgeon Dr. Robert J. Chastenet, they work with the Bariatric Program at Chesapeake Regional Medical Center.

Dr. Moore finds the prevalence of obesity alarming, especially over the past 30 years. He's reluctant to make too many generalizations, but acknowledges that there are geographic areas – the southeast being one of them – where the prevalence of obesity is high. In fact, he says, "There have been some years where Tidewater has been in the top ten in the country."

"We're also seeing a high prevalence of obesity in cohorts of populations as they age," he notes. "The percentage of obese teenagers keeps increasing, and it's predicted that some of these current cohorts are going to have diabetes and severe obesity in the 40 percent range in their 50s."

Dr. Moore knows that many of these individuals will eventually seek the services of a bariatric surgeon to help them lose weight, but he contends that the surgical procedure by itself isn't the most important element of successful weight loss for the severe and morbidly obese. "I think we have to start with the premise that weight loss surgery by itself is not the solution to the epidemic of obesity in the United States," he says. "We are very selective with our patients, and apply the surgical option to those people who very much need it, who will benefit from it and who will be successful with it."

To accomplish that, Dr. Moore's emphasis is more on pre-operative education and preparation, and post-operative care and follow-up. Surgery can serve as a psychological line of demarcation, but it's patient selection, preparation, education, follow-up that make the surgery successful.

After surgery, he tells his patients clearly that they'll be followed for life. "At a minimum, they're seen by the surgeon once or twice the first month after surgery, again every three months for a year – that's the absolute minimum," he says. "They're seen by our nutritionist at one month, at six and again at twelve. And we encourage them to attend our monthly support groups."

He performs all three of the standard procedures – gastric bypass, sleeve gastroplasty and lap band – but for patients with complex problems like reflux, or those who need to lose a large amount of weight quickly, Dr. Moore prefers the gastric bypass. "Gastric bypass has proven to be the most successful, most durable, long term successful operation for most patients," he explains. "It has a very low and very favorable risk benefit ratio. Especially for obese patients with diabetes, there's a strong bias toward gastric bypass because of its dramatic results. It's not just the weight loss itself, but we're changing something on the inside, affecting some of the hormones that modulate diabetes. We see pronounced improvement, and in most cases, resolution of their diabetes."

"When patients are that obese, we have to do really good surgery. We have to get good results. We have to have low risk, low morbidity. It's a difficult operation, and it has to be done very well," he states. "While many surgeons don't want to operate on people who are very sick and have complex medical conditions, those of us in weight loss surgery feel just the opposite – this is our chance, and the patient's chance, to gain control of those conditions and get back their health and activity and quality of life. That's so rewarding. And I love seeing the success and the change in people's lives that comes about." ■

Anthony D. Terracina, MD

Anthony D. Terracina, MD

Dr. Anthony Terracina is a Board-certified surgeon specializing in laparoscopic bariatric surgery with the Bon Secours Surgical Weight Loss Center. He earned his medical doctorate degree at the University of Mississippi Medical Center in Jackson and completed his residency in general surgery at Parkland Hospital in Dallas, Texas.

He is a member of the American College of Surgeons and the American Society of Bariatric Surgeons. He is currently Chief of Surgery and the Director of Bariatric Surgery at Mary Immaculate Hospital.

Dr. Terracina remembers the first gastric bypass he performed in 1999. "The patient told me his name was Capt. Hornblower. He played the trumpet in local jazz clubs. He was a severely obese 65-year-old man who was suffering from both diabetes and hypertension." Dr. Terracina was honest: "I told him, 'look, this is the first time I've performed this surgery.' To which Hornblower replied, 'Doc, look what I've done with my body my whole life. I need help.'"

Months after the surgery, Capt. Hornblower's diabetes, hypertension and sleep apnea were resolved. "He said he wished he'd had the surgery 30 years ago," Dr. Terracina says.

Since that first surgery, he has performed more than 3,400 bariatric procedures, including the three standard operations in use today: gastric bypass, sleeve gastrectomy and gastric banding. He's still amazed at the number and variety of conditions that can be corrected by weight loss, including hypertension, reflux disease, polycystic ovarian syndrome, pseudotumor cerebrii, sleep apnea and several others. He also remembers one of his first patients reporting that six months after weight loss surgery, her glaucoma was gone. "I looked through the literature for any link between obesity and glaucoma, and found absolutely nothing," he recalls, "but 13 years later, sure enough an article was published reporting glaucoma being cured by weight loss surgery. Obesity affects virtually every organ system in the body."

In short, he says, "We know many conditions that are cured with weight loss, and there may be many more as well. There are things we don't yet completely understand – like curing diabetes. There are many theories about why diabetes is cured almost instantaneously in eight out of ten patients. No one understands that perfectly – yet."

The gastric bypass, Dr. Terracina explains, is one of the most studied operations in the world. "We really don't know everything about how and why it works," he says, "but there are four main mechanisms to help patients: portion control, hunger control, delayed digestion and aversion to sweets."

"We think the gastric bypass is a near-perfect operation," Dr. Terracina says. It's often the procedure he uses when doing one of the complicated revisions that make up a large percentage of his practice. These revision surgeries include improving an outdated prior surgical procedure, or converting a previous procedure to a different one. Recently, he operated on a patient who had a vertical banded gastroplasty twenty-eight years ago. "She had a staple line failure, a typical result with one of these archaic surgeries. Her stomach looked as normal as the day she had her first surgery. I did a gastric bypass on her," he says, "and she'll do well as long as she continues with the follow-up that's so important."

What he particularly likes about his practice with the Bon Secours Surgical Weight Loss Center, Dr. Terracina says, is the fact that everyone who walks through the front door is a weight loss patient. "Our waiting room becomes a sort of impromptu support group: everyone's either had or is having the surgery. There's a built in camaraderie. They develop alliances and friendships. Our patients know that when they come to our office, everybody's the same. There's no judgment, just support and understanding."

For patients in the super-obese category, finding a place where there is no judgment but plenty of understanding can be critical. "We see a tremendous population of the super obese," Dr. Terracina says, "people who are well over 500 pounds. These patients aren't always candidates for surgery due to the higher risk of their body size. But we can make them candidates in most situations." He cites the example of a patient who presented last year at 540 pounds: "He was 5'10". We first put him in our pre-op program, and he lost 80 pounds. We took him to the operating room and did a sleeve gastrectomy. He proceeded to lose more than 200 more pounds."

Dr. Terracina knows that even the most successful weight loss patients can relapse. "About 15 to 20 percent of people will need to get back on track at some time in their lives," he says. "And while we operate on people every day, the rest of the time, we're listening to them. Due to stress and busy lives, they can resort to bad eating behaviors. I assure them they can get through those situations. Sometimes, I counsel as much as I operate."

Dr. Terracina has a high percentage of patients who relocate from Hampton Roads after surgery, but they return every year to see him. They want that follow-up, he knows: "They want to come back in. If they did really well, they want that pat on the back. If it's the opposite scenario, they want that 'get back on track' help."

He insists, when his patients do well, that the credit ultimately belongs to them: "We perform the surgery and offer guidance. It's the individual patient who makes the lifestyle changes and commitment to a healthier existence." ■


Dominique R. Williams, MD

Dominique R. Williams, MD, MPH, FAAP

Dr. Dominique Williams is a Board-certified pediatrician who serves as Medical Director of the Healthy You for Life program at Children's Hospital of The King's Daughters. She earned a Bachelor of Science in Nutrition from Case Western Reserve University and her doctor of medicine degree from Wright State University School of Medicine in Dayton. She completed her internship and residency in pediatrics at Columbus Children's Hospital in 2004, and earned a Master of Public Health in Nutrition in 2013 from the University of Massachusetts Amherst. She is an assistant professor in the Department of Pediatrics at EVMS.

Dr. Williams is a Fellow of the American Academy of Pediatrics and its Virginia Chapter.

When Dominique Williams was 11 years old, she told her mother she was going to be a neurosurgeon. Her mother, an RN and director at a school of nursing, knew better than to question her daughter. "Education was always emphasized in my family," she says, "so it was assumed we'd finish college and go beyond. My mother didn't bat an eye: she found residents who would talk to me."

She took her bachelor's degree in nutrition, because, she says, "Even as an undergrad I had no interest in biology to study it for four years, no interest in chemistry. But I had a very big interest in nutrition, and I felt that would be relevant on my road to being a brain surgeon."

At no time did she ever consider a career as a pediatrician. "I didn't like kids," she says candidly. "I didn't like being around them; I didn't understand why they cried so much. I internalized it – I thought I wasn't supposed to take care of children." But that was before she had any clinical experience. It was in her third year that she took a pediatrics rotation. "I had enjoyed all the others," she remembers, "and I received positive feedback – but I always had a headache at the end of the day. But after my first day in pediatrics, no headache. Second day, no headache. I remember thinking, 'this is compelling.'"

As for their crying, the more she was exposed to sick kids, the more she understood what the crying was about. For some of them, that was the best they could do. "And that," she says, "was the beginning of my using my powers for good."

Dr. Williams describes herself as "fun-sized," referring to her not-quite-five-foot frame. "I'm kind of a dorky, goofy person, and for the first time, that worked to my advantage. For kids, suddenly a doctor in a white coat was accessible. I used my size and my personality to reach them. And I fell in love." She knew she had found her specialty.

Her first position was in primary care with Chesapeake Pediatrics. "They took a chance on an Ohio girl with a nutrition background," she says. Six months into practice, she was offered the opportunity to talk to parents about the complications of obesity for their children. It was then that she knew she had found her niche.

It took a leap of faith to leave private practice to focus entirely on the problems of overweight and obese kids, but, as Dr. Williams describes it, "It became increasingly evident that this is where I was supposed to be. I have a heart to serve these kids."

She has strong feelings about the epidemic of childhood obesity. "It's like a jigsaw puzzle with the tiniest pieces. Every piece needs to be connected to another piece in order to solve the puzzle. I can't say it's any one thing I'd attribute the epidemic to; it's been more of a shift over time. We've changed how foods are packaged and supplied, and we've created a salty, fat palate that has a preference for something with little nutritive value."

But that's only one of the pieces of the puzzle. Dr. Williams' Master's thesis was on the role of victimization in aspects of obesity. She researched the theory that witnessing domestic violence, being a victim of domestic violence, being a victim of bullying, operating in a constant state of fear and trepidation, wreaks havoc on a child's metabolism. It wreaks havoc on coping skills, and on willingness to go outside and play, whether for fear of getting beaten up or fear of being isolated. "These kids seek refuge in food that always makes them feel good, doesn't give them negative feedback," she says. "My thesis was that victimization was just as important to address as the food supply and environment and physical activity. Domestic violence, intimate partner violence, moms and children not feeling safe – these are the undercurrents that create obesity."

In the Healthy You for Life program, Dr. Williams says, "We have two social workers, a dietician, a physical therapist, an exercise specialist – there's a team of us to address the different aspects. But if that kid's heart is broken, it will undermine the attempts to address how they're going to eat or move their body. It will even undermine their willingness to consider that they're capable of change, if all they do is operate in this circle of negativity."

There is accountability but no judgment in the program, which is evidence-based and proven. Instead, the emphasis is on helping families gain the confidence that they had the potential to change all along. "We never ask for perfection, we ask for your best," Dr. Williams says. "We add personality to the science. I can still be nerdy and intellectual and use that drive to help these families." ■

Lateral Lumbar Interbody Fusion Speaks to the Future of Spine Care

By David Goss, MD

"Lateral Lumbar Interbody Fusion ("LLIF") is a newer and less invasive variation on a procedure that provides significant advantages to both patient and surgeon."

Most Americans will experience back trouble in their lifetimes. Behind skin problems and joint pain, back pain is the third most-cited reason for visiting one's healthcare provider (Mayo Clinic, 2013). For the patient who "throws their back out" after an episode of over-exertion, a treatment plan involving over-the-counter pain medication and rest generally gets them back on their feet and doing the things they enjoy within a week. As a spine specialist, the patients I see have tried rest and after several weeks are not getting better.

They may have symptoms other than back pain, like buttock or leg discomfort, or numbness and tingling in the legs that indicate a more serious problem. For these patients whose back pain is often secondary to herniations, degenerative disc disease, spondylolisthesis and other spine disorders, the treatment plan sometimes calls for surgical options -- including spinal fusion.

Anterior Lumbar Interbody Fusion ("ALIF") and Posterior Lumbar Interbody Fusion ("PLIF"), two traditional variations of spinal fusion, are invasive, lengthy surgeries that involve shifting organs and tissues in order to reach the affected vertebrae via a large incision. Lateral Lumbar Interbody Fusion ("LLIF") is a newer and less invasive variation on these procedures that provides significant advantages to both patient and surgeon.

In contrast to ALIF and PLIF, each of which require a sizable incision on either the anterior or posterior of the low back, LLIF requires only a small incision about an inch and a half under the rib cage through the flank. Avoiding the internal organs, nerves and major muscles, the surgeon gains a clear view of the spine using a tubular retractor. From there, the surgeon removes and replaces the problematic disc. Because of the smaller incision, shorter operation time and less muscle trauma, the patient has a lower risk of infection or nerve damage, and enjoys a shorter recovery time. With LLIF, they can get back to their daily activities much sooner.

The ideal candidate for LLIF is a patient who: 1) is reasonably fit, 2) has one or two discs affected versus issues with the entire low back, and 3) has tried all other recommended non-surgical treatments unsuccessfully. Spinal injuries and disorders of the spine can be catastrophic and life changing, but solutions like LLIF now offer patients the chance to get to a pain-free place more readily.

Surgeons also reap the benefits. Following extensive training and experience, LLIF allows surgeons repair degenerative spinal issues in less time. This makes the patient happier, as they return to their active life more quickly. A happy patient makes a happy surgeon. The growing use of minimally invasive approaches like LLIF speaks to a spine care future in which physicians are able to solve problems faster and patients enjoy shorter hospital stays. The continual development of surgical technologies will make it possible for treatments that allow for ongoing motion in the spine rather than traditional fusion methods. ■

Dr. David Goss is a Board Certified Orthopaedic Surgeon with The Spine Center at Chesapeake, part of Sports Medicine Orthopaedic Center (SMOC). Visit smoc-pt.com to learn more about Dr. Goss and the rest of the team at SMOC.

Key Choices for a Financially Successful Retirement

Provided by Danijel Velicki, Founder/Senior Partner with The Opus Group of Virginia, who represents MassMutual and other companies; courtesy of Massachusetts Mutual Life Insurance Company (MassMutual)

Establishing a retirement strategy and making decisions about income, liquidity, long term care and legacy may seem like a daunting task but it need not be. Consider the following key choices for less stress and more success.

Choose a knowledgeable financial professional to help you map out a course of action.

One of the most important choices to make is who may help you achieve retirement success. Consider someone with experience in helping others plan for retirement income and who can help you make informed decisions that help you achieve your goals.

Seek guidance from a local, knowledgeable financial professional who will never rush to fit you into a category or push products. One who believes that the best way to create a successful financial strategy is to build a strong relationship with his or her customers and will take the time to listen carefully to your needs, explain your options and customize solutions for you.

Choose a financially strong company to work with.

When it's time to choose the products to help you implement your plans, look for a company with the financial strength to be there when you need them.

No matter what solutions are right for you, work with a financial professional who can help you make the good decisions that retirement success requires. ■

Insurance products issued by MassMutual, Springfield, MA 01111-0001 and its subsidiaries, C.M. Life Insurance Company and MML Bay State Life Insurance Company, Enfield, CT 06082.

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Looking to get the most out of your vendor relationships?

Train vendors on your facility's needs and make them part of your team.

By Tony Acquaviva

Too often vendors are dismissed as just that, simply vendors. In the worst case scenario, it turns into "us versus them" with both sides focusing on finger-pointing instead of the business at hand. Successful organizations know that making vendors part of their team is crucial to maximizing the relationship.

Today's healthcare providers must derive the maximum value from their available resources (vendors, et al) in order to accommodate busy and growing practices. Nixon representatives recently sat down with a local surgery center's Clinical Director and Nurse Manager in an attempt to understand about what makes their practice so successful, and to learn more about their approach to making vendors part of their team. As a relatively large practice, this center receives laundry service twice per week. It has to be right, and it has to be timely.

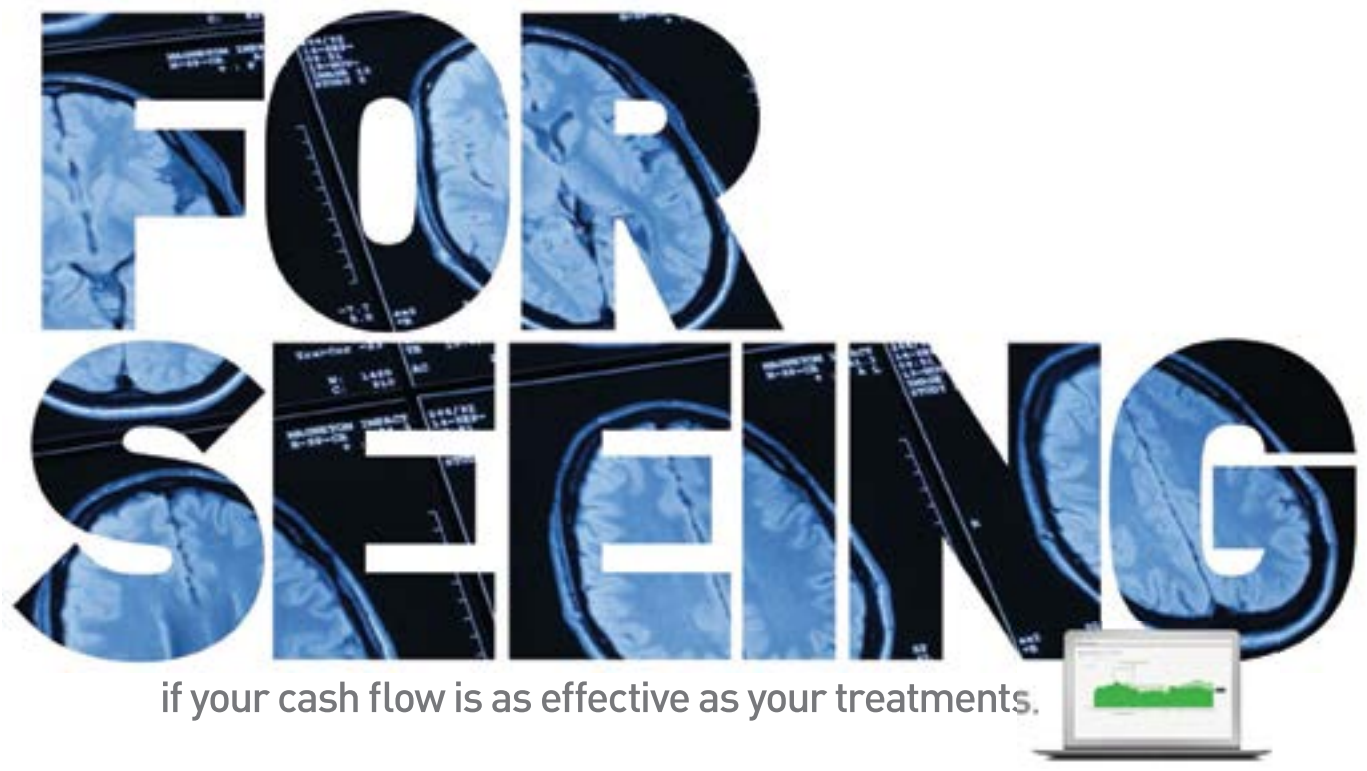
Making vendors part of the team, and executing the steps to make that a reality, is how successful companies continue to excel.

They told us that communication is the key. "Consistency in Route Service Representatives (RSRs) is important," the Director said. "We think it's incredibly important to have the same RSR for both deliveries." These healthcare professionals were able to train their RSR about their specific needs and expectations, essentially making him a part of their team. They noted, "Our RSR, Frank, is a key player in making sure things run smoothly. He's established a great rapport with our staff."

One area that this practice focuses on is maintaining a professional office environment. Once again, communication, training and teamwork proved to be a winning recipe. "A sloppy and disorganized workplace doesn't lend itself to professionalism," the Nurse Manager told us. "Frank knows it's important, so he'll even put away the linen. It's great that linen isn't just lying around. That's valuable for our presentation."

What's clear is that these professionals and their staff members have done a superb job in maximizing vendor value. By communicating and sharing information with their service representative about what needs to be done and how, these professionals have found the way to get the most out of their vendor resource. Making vendors part of the team, and executing the steps to make that a reality, is how successful companies continue to excel. ■

As Regional Sales Manager, **Tony Acquaviva** has over 10 years of experience in supporting cost reduction, compliance, eco-friendly and patient satisfaction initiatives via textile service. He can be reached via e-mail at acquavivaa@nixonmedical.com. For more information, please visit www.nixonmedical.com



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Moving to the Cloud

By G. Wythe Michael, Jr.

Over the past several years, many businesses have migrated essential software and business systems from company owned personal computers and servers to the "cloud." In general, cloud computing refers to a network of remote computer servers hosted on the internet that store, manage, and process data. Typically, third party vendors provide both the software and the data storage capabilities - thereby allowing the business customer to access the information through any internet enabled computer. The healthcare industry is no exception to this trend, with practice groups using cloud-based services for billing, scheduling, medical records, telemedicine and for other uses.

Cloud computing offers several advantages over the traditional hardware/software model. These advantages can include lower costs (no need to purchase and maintain expensive servers or software), flexibility (users can pay for just the right amount of service and quickly make changes) and ease of use (the services can be accessed wherever an internet connection is available).

With these advantages, however, come risks – especially for healthcare providers. Certainly the biggest risk for practice groups using cloud-based services involves data breaches and other violations of HIPAA and the HITECH Act regulations. This is especially important given the numerous changes and requirements addressed in the Omnibus Final Rule issued by the Department of Health and Human Services in January, 2013 (with enforcement beginning effective September 23, 2013).

To address these risks, practice groups desiring to utilize cloud-based services should, as an initial matter, determine whether each vendor is capable of providing the service levels required by the practice and complying with applicable data security standards. This should include, among other things, an assessment of the vendor's security infrastructure, the location(s) where the data will be stored, the vendor's disaster recovery plans, the vendor's service level capacity, the vendor's financial capabilities, and a review of the vendor's compliance history. These matters should be addressed during the initial negotiations with the vendor.

Second, practice groups should negotiate protective provisions into the agreement with the vendor. At a minimum, these protections should include the following:

- The agreement should require the vendor to adhere to specific service levels so that the practice group is assured that it will be able to access the services and data when needed.
- The agreement should require strict compliance with HIPAA and other applicable data and privacy security laws.
- The agreement should require the vendor to notify the practice of breaches of PHI and should describe the duties of the parties in the event of a breach.
- The agreement should require the vendor to return the practice's data in a usable format upon the termination of the agreement.
- The agreement should require the vendor to protect and indemnify the practice for data breaches caused by the vendor.

Given the importance of the services provided, the critical information being stored and the potential risks, practice groups should ensure that their cloud vendors are capable of performing the required services and that the agreement with the vendor contains adequate protections for the practice. Accordingly, a review of the vendor agreement by an experienced attorney will be extremely valuable. ■

G. Wythe Michael, Jr. is an attorney with the law firm of Goodman, Allen & Filetti. Wythe regularly works with medical, dental and other professional service firms and understands the unique issues impacting these firms and their owners. Call 804-565-6811or visit their website goodmanallen.com

Obesity in Joint Arthroplasty

By John D. Burrow, DO

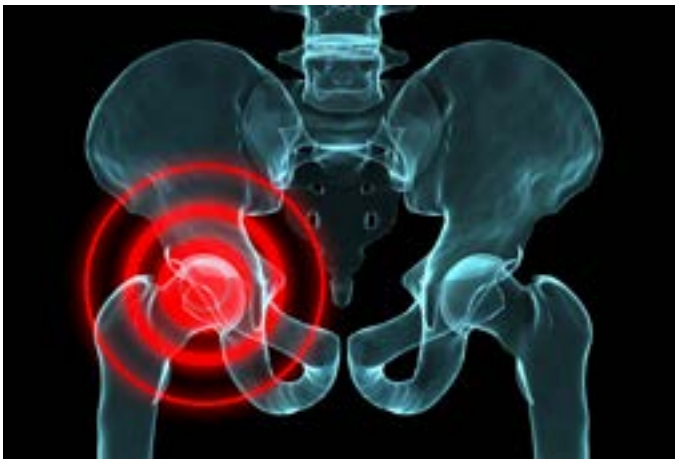
It is no secret that obesity has grown to epidemic proportions in the United States, with nearly 40 percent of adults over the age of 20 being obese and nearly 70 percent of adults over 20 being overweight. The impact to the medical community has also been noted, with increases in diabetes and coronary artery disease that continue to climb at an alarming rate. The impact not only affects the metabolic and cardiac system, but also affects the body's supporting architecture as well.

With increase in body weight, the stress that one displaces across the hip joint is greatly increased. The average person will exert 250 percent of their body weight across the joint in normal ambulation, which can increase to 550 percent of total body weight with activities such as jogging. These forces are at a much higher magnitude in people who are obese, simply as a function of multiplication. The stress endured by the joint is directly transmitted into compressive and shear stresses that are dissipated through the articular cartilage. With increased stress, the chondrocytes become damaged and die. Unfortunately, we do not have the capacity to regenerate these particular cells, so when they are damaged, they are lost for good.

This process signals the beginning of Osteoarthritis. As the disease progresses and the activities of daily living are significantly affected (walking, dressing and sleeping), joint arthroplasty may need to be considered. However, there is good evidence that the same forces that possibly increase the risk for developing osteoarthritis can present a significantly higher risk of complications in the setting of a joint replacement. Studies have shown an increase in premature hardware failure, component loosening, and most significantly, increased infection rates, with reported increased incidence of infection as much as 3 to 5 percent.

Many patients feel they are limited in their ability to lose weight, due to pain and difficulty with movement caused by osteoarthritis. This belief is reinforced when you consider the amount of physical activity needed to lose one pound of fat would be equivalent to running approximately 30 miles. For most osteoarthritis patients, the most effective way to significantly impact weight loss is through dietary restriction, with optimal caloric intake between 1800 to 2200 kcal daily.

With the list of complications due to obesity ever growing, the addition of joint pain and arthritis must also be considered. It not only affects the native joint and could possibly impact the need for surgery at an earlier time, but obesity can significantly influence the survivorship of the joint replacement. With this in mind, treating physicians should utilize a team approach to decrease these risks. With coordination by the physician, the patient should receive dietary counseling and possible bariatric surgery consultation to reduce surgical risk and optimize the patient's outcome after arthroplasty. ■



John D. Burrow, DO, holds an Adult Joint Reconstruction Fellowship and practices at Orthopaedic and Spine Center in Newport News, VA. For more information or for an appointment, contact OSC at 757-596-1900 or go to www.osc-ortho.com.

Honoring the Volunteer Service of

Dr. Roger H. Perry, Pediatrician

Dr. Roger Perry retired from the active practice of medicine in 1994, following a long and distinguished career. While a student at the University of Virginia (BA 1951; MD 1955), he was admitted into the prestigious Raven Society and a member of Alpha Omega Alpha Honor Medical Society. He completed both his internship and residency in Pediatrics at New York Hospital, Cornell University Medical Center in New York City.

During medical school, he signed up for the Berry Program. "You could sign up, and you were deferred until you finished your training," Dr. Perry explains, "and then you'd go into one of the services for two years. That's how I got into the Navy." His service took him to the Submarine Base Hospital in Groton, Connecticut, where he practiced from 1958 to 1960.

Completing his Navy career, he moved to Ithaca, New York, where he started his private practice in 1960. He was on staff at Tompkins County Hospital, and served as President of the medical staff from 1980 to 1984. After thirty-four years of caring for the children in and around the community of Ithaca, he retired in 1994; and with his wife, moved to Newport News, so, he says, "We could be closer to our daughter and her family."

After such a fulfilling career, many physicians are content to rest on well-deserved laurels, relaxing, enjoying leisure time with family and friends. Not so Dr. Perry: "I enjoyed my pediatric practice years," he says, "and I didn't want to give it up altogether. I figured volunteering would be a good way to keep active, but not be overwhelmed."

Immediately after arriving in Newport News, Dr. Perry began asking around for opportunities. A neighbor told him about the Olde Towne Medical Center (there was no dental service at that time), and he arranged a meeting. "We had started out in 1993 just doing primary care," says Dr. William J. Mann, Jr., the Center's Executive Medical Director. "It had become obvious to us that we needed to offer pediatric

care as well, just about the time Dr. Perry volunteered. It was heaven's timing."

It was also a match made in heaven, Dr. Mann continues. Williamsburg has a large community of un- and underserved families, headed by men and women who earn their living as seasonal employees at local hotels, restaurants, theme parks and historic attractions. From May to December, during the heaviest tourist season, these workers have hourly jobs that offer no benefits. From December to May, they're often without employment altogether, and thus without options for medical care. The Olde Towne Medical and Dental Center, which has expanded to include a full range of medical services (including geriatrics and prenatal care), that fills the void for these hard working individuals, who often lack basic English skills. In fact, Dr. Perry says, "We have a Spanish interpreter at the clinic, and all of our brochures are English and Spanish."

"When Dr. Perry is here, he lights up the hearts of staff, children and parents," a staff members says, while another describes Dr. Perry as a "fountain of knowledge and compassion. Working with him is a continuing learning opportunity."

For Dr. Perry, it's the opportunity to see children grow and develop. "I've always enjoyed well baby and well child work, and helping them along in their years of growing," he says. The Olde Towne Medical and Dental Center offers him plenty of opportunities to do just that.

So will this good deeds doctor retire? "I'll be here as long as the clinic will put up with me," he says. Adds Dr. Mann, "As long as he'll come, he's welcome." ■

If you know physicians who are performing good deeds – great or small – who you would like to see highlighted in this publication, please submit information on our website – www.hrphysician.com — or call our editor, Bobbie Fisher, at 757-773-7550.

Recognizing Outstanding Nurse Practitioners and Physician Assistants in Hampton Roads

Valerie LeGrone

MSN, ANP-BC, CNOR

Valerie LeGrone is very much a team player. As an adult nurse practitioner at Sentara Comprehensive Weight Loss Solutions, she's part of the multidisciplinary effort to help patients lose weight, and keep it off. "This is the perfect job for me," she says. "I'm able to incorporate my lifelong interest in nutrition and passion for exercise into my work with our patients." Indeed, her education, experience and passions have prepared her well for her demanding work schedule.

(L-R) Dr. Mark A. Fontana, Bariatric Clinical Director, Dr. Caren D. Beasley, Medical Bariatrician, Valerie LeGrone, Nurse Practitioner, Dr. Stephen D. Wohlgemuth, Bariatric Medical Director

LeGrone earned her BSN in 1991 at the University of Pennsylvania as part of a US Navy program. Upon graduation, she was commissioned as an Ensign, stationed at Bethesda Naval Hospital. She was co-assigned to the USNS COMFORT, and had the opportunity to experience deployment during Operation Uphold Democracy in Haiti. "We had 12 operating rooms with the ability to strap down tables in rough seas," she says. "It was wonderful training. Everything I did in my Navy career led to my role as a nurse practitioner and prepared me for what I'm doing now."

In 2003, she earned her MSN in the Adult Nurse Practitioner program at the University of Texas at Arlington. She began her career with Sentara in 2006, working with palliative care patients at Sentara Leigh Hospital; and in 2009, joined the team at the Comprehensive Weight Loss Center.

Her day begins at Sentara Norfolk General, where bariatric surgeries are performed. "I round on patients in the hospital," LeGrone says. "I watch their swallow studies to make sure there are no leaks, and I do all patient discharges." When that work is completed, she returns to the Center to see patients at all stages of pre- and post-surgery care.

When she's not actively working with patients, she assists with research projects between EVMS and the Center. "It's fascinating," she says, describing one current study that looks at the inflammatory markers in the blood of obese patients. "They're hoping that eventually they'll be able to draw blood samples that would indicate if someone had these inflammatory markers, which would identify them as being at higher risk for certain conditions, like diabetes or heart attack. We know that weight loss improves these inflammatory markers in patients and improves diseases like rheumatoid arthritis and gout."

One of the aspects of the work she loves is counseling. "Had I not been a nurse practitioner, I probably would have been a dietician," she says. "And I've always enjoyed exercise. So I really enjoy talking to these patients about diet, about nutrition and exercise. We know that a lot of them are eating for reasons other than hunger: stress, anxiety, monotony, or habit." She has a variety of strategies to help these patients, but she's also grateful that the Center has a psychologist on staff when patients need more structured counseling. She's also realistic about exercise: "A lot of our patients have never exercised at all," she says, "so we put together a program for them, focusing on what they can and will do. We have a small gym where they can start, with a certified exercise specialist."

Ultimately, LeGrone says, the Center's goal is for every patient to be successful with weight loss. "We have all the tools here to help them," she says. One of the more high-tech tools is an infrared scanner that produces a 3-D image of the body. "It gives a totally accurate scan," LeGrone says. Patients are scanned every three months, so they see exactly how many inches they've lost off their waists, hips, etc., giving them a better grasp of their progress.

"But our main tools are our world-class bariatrician and surgeons," she says, "and a dedicated professional team that supports them. I truly believe we can be successful with every patient." ■

If you work with or know a physician's assistant or nurse practitioner you'd like to nominate for a profile in Hampton Roads Physician, *please visit our website – www.hrphysician.com - or call our editor, Bobbie Fisher, at 757-773-7550.*

Weight Loss Experts for Better Health

BON SECOURS SURGICAL SPECIALISTS
Bon Secours Hampton Roads Health System

Bon Secours Surgical Specialists

Offering Hope For Individuals Suffering From the Health Effects of Morbid Obesity

It's currently estimated that greater than 60 percent of Americans are significantly overweight, and that more than 16 million are 100 pounds or more over their ideal weight. It is well established in both the medical and the lay community that even mild obesity is associated with a host of medical conditions, including high blood pressure, heart disease, high cholesterol, diabetes, respiratory problems, sleep apnea and reflux. But unchecked obesity can also lead to urinary stress incontinence, degenerative arthritis, venous stasis disease/ulcers, several different cancers (including breast, uterine, ovarian, esophageal, colon, prostate and pancreatic), skin infections and infertility. And for the morbidly obese, the sequelae are greater still.

The surgical weight loss division of Bon Secours Surgical Specialists, led by four innovative and world-class surgeons, treats the whole person with a comprehensive plan tailored to the individual. This includes psychological, nutritional, and physical evaluations, as well as counseling, support groups and long-term coordination of care – in addition to weight loss surgery.

Commonly known as bariatric surgery, these procedures alter portions of the stomach, and in some cases, the small intestine. As a result, less food is consumed and fewer calories are absorbed. Bariatric surgery is generally considered an option for persons who have a BMI above 40. It's also an option for people with a BMI of 35 to 40 who are experiencing potentially devastating health problems, such as Type 2 diabetes, high blood pressure or sleep apnea.

Melodye Myers, Administrative Director, Bariatric and Metabolic Services

The bariatric team with Bon Secours Surgical Specialists have the knowledge, training, experience, skill and compassion to help patients make significant weight loss a permanent reality, regardless of how much they may have struggled in the past.

Today's bariatric procedures are vastly different from the ineffectual and sometimes dangerous operations offered in the early days of weight loss surgery. Laparoscopic, less invasive techniques have rendered today's procedures safer, faster and more successful.

Bariatric surgeons with Bon Secours Surgical Specialists offer three different procedures.

Gastric Bypass

In a Roux-en-Y gastric bypass, the stomach is made smaller by creating a small pouch at the top, using surgical staples or a plastic band. The smaller stomach is connected directly to the middle portion of the small intestine, bypassing the rest of the stomach and the upper portion of the small intestine. The restrictive pouch along with the removal of the portion of the stomach that impacts the release of ghrelin (a hormone that stimulates hunger) makes patients feel less hungry. The rewiring of the small intestine helps with slight malabsorption. Loss of more than 100 pounds within the first three months is not uncommon.

Sleeve Gastrectomy

In this procedure, a thin vertical sleeve of stomach (about the size of a banana) is created using a stapling device. The rest of the stomach is removed. A sleeve gastrectomy limits the amount of food that can be eaten at one time, so patients feel full sooner and stay full longer. As they eat less food, their bodies stop storing excess calories and start using their fat supply for energy, resulting in weight loss.

Gastric Band

This surgery reduces the amount of food the stomach can hold at one time by placing a silicone band around the upper portion of the stomach. The band is then connected by thin tubing to an access port just beneath the surface of the skin, which allows the surgeon to adjust the fit of the gastric band by inflating or deflating its inner lining. Most patients experience an average weight loss of one to two pounds per week until their goal weight is met.

Gregory Adams, MD, FACS

These procedures in the hands of experienced and skilled surgeons are remarkably safe. Patients quickly learn that surgery is just a tool, and their surgeon is only one member of an impeccably trained and dedicated team that can help them lead a long, healthy and satisfying life. The team consists of professional and compassionate experts in nutrition, psychology and exercise physiology.

The members of this team know well the challenges that face people with extraordinary amounts of weight to lose. They understand the obstacles their patients must overcome on a daily basis. And they are keenly aware of the need for ongoing support. Serious weight loss is a lifetime commitment and as the surgeons note, they never really discharge a patient.

Meet our board-certified bariatric surgeons.

Gregory Adams, MD, FACS, began doing bariatric surgery more than a decade ago, in response to a community need. In the small Alabama town where he practiced, there were no surgeons performing weight loss procedures. "The nearest surgeon was a couple of towns over," Dr. Adams remembers. "He was a one-man practice, and he was probably doing 600 surgeries a year. His procedures were good, but bariatric surgery needs the long term care of the surgeon involved, and he wasn't offering that." Without long term surgical care and the ongoing support of nutritionists and counselors, these patients were failing badly, and began showing up in Dr. Adams' office seeking help. He and his partner obtained the training and expertise they needed, and established a program that met all of their weight loss patients' needs.

Dr. Adams describes caring for weight loss patients as one of the more satisfying parts of his career. "Physicians who go into surgery usually do so because they like to fix problems," he says. "I'm very much in that group. Patients come to me with a bad gallbladder or appendix, I take it out and they go on their way. And that's very satisfying."

But, like his partners, Dr. Adams enjoys his bariatric patients because of the long term relationships he establishes with them. "I get to really know people for a change, and that's great because I get to see them actually getting healthier. I enjoy the interaction."

The conversations can be challenging: Dr. Adams has to help patients face some hard truths. "It's not politically correct to call obesity a disease of addiction, and it isn't 100 percent addiction," he says, "but the behavioral issues related to obesity do have addictive tendencies. Within a few days of starting any diet, most people can quantify the foods they really want that they had forbidden themselves. That behavior is strong, those psychological desires are real and the only way you decide to conquer those behaviors is when you can't stand your life with them any longer. The patients who do the best are the ones who admit, 'I cannot live like this. I need help.'"

But he cautions them. "Patients can have the misconception that weight loss surgery is a magic trick, that they can continue to live the way they've always lived," he says. "I have to explain that in reality, that's not true; it's just a tool that makes it so they can live the way they need to. We're asking people to literally change the way they eat, exercise, drink – those are very personal things and can be difficult."

Changing those behaviors reaps tremendous health benefits for patients. Their diabetes is real, Dr. Adams assures them. Their sleep apnea is directly related to obesity, as is high blood pressure, high cholesterol and as many as nine different cancers. Their joint pain is real because the excess weight has compromised their joints.

Surgery changes patients' set points so they can lose weight and keep it off, Dr. Adams notes. "At the physiological level, there are all kind of interactions, everything from hormones to actual absorption of nutrients," he says. "In one way, it's a metabolic tool, and in another, it helps reinforce the behaviors we're asking patients to change. But it's still just a tool. To succeed, they need that follow-up care and support that we offer."

In her work with Bon Secours Surgical Specialists, **Elizabeth Salzberg, MD, FACS,** puts her undergraduate degree in psychology to good use. "I've always had a fascination with the human mind and behavior," she says, "and I love all aspects of surgery, so treating weight loss patients allows me to marry together all of my interests."

The team at Bon Secours Surgical Specialists knows that education and support are vitally important to current and potential patients.

Although she still performs and enjoys the whole spectrum of general surgery, she estimates bariatric surgery constitutes about 70 percent of her practice. She calls bariatric surgery her passion and explains how and why she came to feel so strongly: "After I'd spent about five years in general surgery, I did a fellowship in advanced laparoscopy. I was able to really delve into bariatric surgery, and I felt an immediate connection. I've always had a keen interest in women's health and nutrition, so it felt like a good fit. Today, 90 percent of my patients are women.

"Women in particular, every one of us, tend to have some struggle with weight," she says. "We're always seeking that work-life balance: finding time to exercise, eat properly, maintain a career and a home. I found a niche in caring for these women; not only is the surgery itself fascinating and technically challenging – and the biochemistry that goes into it – but I found I also really enjoyed the counseling."

Part of her counseling is aimed at determining the best procedure for each individual patient. "It has a lot to do with their diet history as well as their medical history," she explains. "There are certain operations that work better for some patients than others. It's a complex decision. And I counsel them so they understand that surgery isn't a magic wand. Their problems aren't solved when they wake up from anesthesia; their work is just beginning. That's when they need the invaluable support that our multidisciplinary program offers."

Herself the mother of two young boys, Dr. Salzberg is keenly aware of the rising number of obese American children in the 21st century. Some of the problems these obese children face started when they were in utero, she says. "We know that when one child gestates in an obese woman's body and another gestates in a body closer to normal weight, there's a greater risk of gestational diabetes, pregnancy induced high blood pressure and macrosomia in the obese mother."

But what was fascinating, Dr. Salzberg says, is the finding published in the journal *Proceedings of the National Academy of Sciences* (PNAS) that shows how different the children borne by obese women before and after bariatric surgery are. Compared with their peers born to obese women, children born to mothers following weight loss surgery are significantly less likely to be obese. They have healthier blood pressure, lipid profiles and metabolic function. The study makes clear that weight loss surgery does much more than change the example a mother sets for her child.

The PNAS findings suggest that, "a woman who goes into a pregnancy extremely obese is doing more than passing on genes that predispose her child to obesity and the health effects commonly associated with it; she may also be passing on the code that inclines those genes to behave in unhealthy ways. But maternal obesity does not set that code in stone; if reversed, as it was for these women by bariatric surgery, the chemicals that direct genetic expression may well become a force for good health."

"If there is one way you can motivate a parent, it's telling them something is better for their child," Dr. Salzberg says. "I can tell you that data was very powerful to me."

Revision Surgery

Bariatric surgeons are frequently consulted by patients whose previous weight loss surgery has failed. It might be the result of an ineffective procedure or perhaps a relapse into bad lifestyle habits. Two of the surgeons at the Bon Secours Surgical Weight Loss Center have the additional training and skill to perform revision procedures that set these patients back on the road to success.

Anthony Terracina, MD, FACS, decided on a career in surgery when he was in the ninth grade. A classmate's father, a general surgeon, invited him into the operating room, and he "fell in love

Elizabeth Salzberg, MD, FACS

at that moment. "I worked at the hospital as an orderly when I was in high school," he says, "and by the time I went to college, I knew exactly what I was going to do for a living."

Eager to work after completing his residency in general surgery in 1994, he joined a practice in Florida, where he performed a wide variety of procedures. A few years later, when a friend told him about laparoscopic bariatric surgery, he was intrigued. He returned to Parkland Hospital in Dallas to train in the procedure, and took it back to his practice in Florida.

Ultimately finding Florida too restrictive – many insurance companies were dropping coverage for weight loss surgery – Dr. Terracina looked for "a state where I could be guaranteed the profession that I loved." He chose Virginia, coming to Hampton Roads in 2004. "When I left Florida, about half of my practice was bariatric surgery," he says. "When I got to Virginia, I went to 100 percent."

He was performing the gastric bypass on a daily basis for years and was responsible for introducing the sleeve gastrectomy and gastric band procedure to the area. He is eager to also extend the lap band procedure to patients with a lower BMI of 30 with diabetes, whose disease can be cured by a weight loss of 40 or 50 pounds.

Anthony Terracina, MD, FACS

Matching the procedure to the patient is a painstaking process and done only after significant counseling. "We present the options to patients in a seminar format," Dr. Terracina says. "We listen to their health problems, their concerns, what's important to them, what they want to accomplish with the surgery. Then I tell them to go home, think about it and we'll talk again." He lets the patient decide ultimately, but he'll guide them if he thinks there's a better choice. "Once you've performed over 3,200 weight loss operations on patients, you know what surgery a person needs and what they'll respond to."

Several years ago, Dr. Terracina added another type of surgery to his arsenal: the technically challenging and complex revision procedure. These are for patients who have had other bariatric procedures in the past, who need to move on from the type of surgery they had to a more suitable one.

"These aren't situations that are cut and dried," he explains. "Often you're looking at old, failed procedures that are no longer performed. The surgeon has to figure out how to revise the older procedure and implement the newer one, without significant issues or putting the patient in jeopardy."

Unfortunately, revision isn't always possible. In fact, for every 10 people who seek revision surgery, there may be no more than two or three who are viable candidates. This is especially true in the case of the older procedures, the more unusual open procedures done before the advent of laparoscopy. "In the modern era of weight loss surgery, I always have an option," Dr. Terracina says, "but that's not true of the more archaic operations surgeons did years ago."

For example, if a gastric bypass patient regains weight, he can put a lap band over the pouch – or take a sleeve gastrectomy patient who isn't doing well and either put a lap band in place or convert to a gastric bypass, giving these patients a fresh start.

But even when revision isn't an option, Dr. Terracina emphasizes, they don't turn patients away. "Even if we can't help them surgically, we can help them from a medical standpoint. We enroll them in our program, we follow them and get them to lose weight naturally with our dietician."

The newest member of Bon Secours Surgical Specialists weight loss team, **Eric DeMaria, MD, FACS, FASMBS,** joined Bon Secours Weight Loss Center in September of 2013. A pioneer in bariatric surgery, Dr. DeMaria has 23 years of experience and is considered an expert in advanced laparoscopic surgery procedures. His surgical skills are often sought for high risk patients and those with complications, as well as patients in need of revisional procedures to correct complications or reverse weight regain.

Throughout his career, Dr. DeMaria has seen many of the milestones in the understanding of obesity and the treatment of obese patients. In 1991, he notes, the National Institutes of Health consensus conference set the stage for what has turned out to be a very slow adoption of the concept that obesity should be categorized, and treated, as a disease.

He acknowledges the strong evidence of a genetic predisposition to obesity – studies with identical twins raised apart who each become obese are compelling – but "You don't see extreme morbid obesity unless you have the prosperity to purchase food and a lifestyle that allows you to be sedentary. You need these factors to see the full expression of genetic type. I prefer to say it's a genetic predisposition that's aggravated by numerous social, behavioral and cultural factors," says Dr. DeMaria.

Unfortunately, he notes, there is still a great deal of ignorance about obesity. He has spent his career battling that ignorance, as well as caring for patients.

A year before the 1991 NIH conference, Dr. DeMaria had joined the faculty at the Medical College of Virginia and worked alongside the renowned bariatric surgeon Dr. Harvey Sugerman. "The work was fascinating and really helped people," he says. "It had a lot of positives. And later, when we started doing advanced laparoscopic procedures, it became my primary career focus."

In 1996, he and his colleagues worked on the FDA trials for the gastric band procedure, which gained initial approval in 2001 for severely obese adults and expanded approval in 2011 for adults with lower BMI and obesity-related comorbidities.

"In 1997, we started do the laparoscopic gastric bypass, which was really a technical challenge to do," he remembers. "We were one of the early adopter groups. It was energizing to be involved. It fit with my teaching and research interests." The procedure has stood the test of time, with good reason. The surgeons often see patients three weeks after a gastric bypass, who've already lost 20 to 30 pounds. And the effect on diabetes is phenomenal: it's not uncommon to send a diabetic patient home from the hospital off of insulin, before they've lost even one pound.

But it is revision surgery that has been his focus in recent years. "In all of bariatric surgery, that's what I do more than anything else," he says. "It's a hodge podge of things: it includes taking care of complications of previous surgeries. It includes fixing or converting surgeries that have failed for one reason or another. The risks of the operation are always increased when there's been a previous bariatric operation. It's challenging work that I love."

And it was the opportunity to do challenging work in a world-class facility, surrounded by exceptional surgeons and staff, that brought Dr. DeMaria to the Bon Secours Surgical Weight Loss Center. "I wanted to spend the next 10 to 15 years with a higher performing program around me, with people who understand how good bariatric surgery is for their patient population. Bon Secours Maryview has one of the top programs in Virginia, with a track record of excellent outcomes. I now have the opportunity to take this program to an even higher level, and they have the pieces in place to help me do that. It's very, very exciting."

Eric DeMaria, MD, FACS, FASMBS and Erin Burton, LPN

Ongoing Events and Seminars Offer Education and Support

The surgical team understands that education and support are vitally important to current and potential patients. Each month, a dozen or more weight loss seminars are offered to interested members of the public free of charge, on days and at times that fit within every schedule. These seminars cover the basic surgeries as well as options for revision procedures.

In addition, weight loss support groups meet each month, offering patients the opportunity for advanced education and guidance, as well as a place to share experiences.

The physicians and staff of Bon Secours Surgical Specialists have the knowledge, experience and compassion to help patients make significant weight loss a permanent reality, no matter how much they may have struggled in the past. ■

For more information or to sign up for an free educational seminar – and to read what some of our patients have to say about our program – visit us online at bonsecourssurgicalweightloss.com.
To schedule an appointment,
call us 757.673.5990.

Acknowledging and introducing medical professionals who have recently joined the community of Hampton Roads

BEACH EYE CARE

William Waschler, MD has joined Beach Eye Care. He earned his MD at the University of Miami, School of Medicine. Following an Internship at Mercy Hospital in Baltimore and his residency in Ophthalmology at the Medical College of Virginia in Richmond, he was Board-certified by American Board of Ophthalmology. He is a member of the Medical Society of Virginia, the American Academy of Ophthalmology, the American Society of Cataract and Refractive Surgery. He is also a Fellow of the American College of Surgeons.

BON SECOURS

Charles "Pete" Williams, MD, FACS has joined Tidewater Surgical Specialists in Suffolk. He earnd his MD at the University of North Carolina in Chapel Hill. He completed a general surgery internship at the University of North Carolina School of Medicine in Chapel Hill and a general surgery residency at Cooper Hospital/University. Board-certified in general surgery, he is a member of AMA and the American Society of Breast Surgeons.

Eric DeMaria, MD, FACS, FASMBS has joined Tidewater Surgical Specialists. He is an ad hoc reviewer for the New England Journal of Medicine, the Journal of the AMA, Annals of Surgery, the Journal of the American College of Surgeons, Surgery, the Journal of Gastrointestinal Surgery and the World Journal of Surgery.

Lenny Laureta-Bansil, DO is associated with Hampton Roads OB/GYN Center in Norfolk. She received her MD from Virginia College of Osteopathic Medicine in Blacksburg and completed her residency at State University of New York, Sisters of Charity Hospital. She is a member of the American Association of Gynecologic

Laparoscopists, the American College of Osteopathic Obstetricians and Gynecologists, the American Congress of Obstetricians and Gynecologists, the American Urogynecologic Society and the American Osteopathic Association.

Chhaya Patel, MD is associated with Tri-Cities Medical Associates in Portsmouth. She completed her internal medicine residency at EVMS, and also was awarded a research fellowship at the school's Strelitz Diabetes Center. She received her bachelor of medicine and bachelor of surgery from K.J. Somaiya Medical College and Research Centre in Mumbai, India. Dr. Patel is fluent in Hindi, Marathi and Gujarati.

Lauren James, MD is associated with Portsmouth Medical Associates. She earned her MD at Morehouse School of Medicine in Atlanta and completed an internship and residency at EVMS. She is a member of the American Academy of Family Physicians and AMA.

Emily Thomson, DO has joined Hampton Roads OB/GYN Center. She earned her MD at Western University of Health Sciences, College of Osteopathic Medicine of the Pacific in Pomona, and completed her residency in obstetrics and gynecology at Summa Akron City Hospital. Dr. Thomson is affiliated with The American Congress of Obstetrics and Gynecology, AMA and American Association of Gynecologic Laparoscopists.

Alexander M. Aboka, MD, MP is associated with Virginia Orthopaedic and Spine Specialists. He earned his MD at the University of Pittsburgh School of Medicine and a master's in public health degree from the University of Pittsburgh School of Public Health. He completed his orthopaedic surgery residency at the University of New Mexico in Albuquerque and an orthopaedic sports medicine fellowship at the Cincinnati Sports Medicine & Orthopaedic Center, with advanced training in sports medicine, modern arthroscopy, and shoulder and knee reconstructive surgery. He is a member of the American Academy of Orthopaedic

Surgeons, American Orthopaedic Society for Sports Medicine and Arthroscopy Association of North America.

Chong Suh Lee, MD, FACS, FASCRS is associated with Tidewater Surgical Specialists, Colon and Rectal Surgery Division. Board certified in general, colon and rectal surgery, Dr. Lee earned his MD at the University of Illinois College of Medicine. He completed an internship and residency in general surgery, as well as a colon and rectal surgery fellowship at the University of Minnesota Hospitals. A Fellow of the American College of Surgeons (FACS) and the American Society of Colon & Rectal Surgeons, he is a member of AMA, Michigan State Medical Society, Oakland County Medical Society and Michigan Society of Colon & Rectal Surgeons.

CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS

Dr. Cyrus C. Heydarian has begun a position in hospital medicine at CHKD. A graduate of Emory University, Dr. Heydarian attended medical school at Marshall University School of Medicine and did his residency at CHKD, where he was named Most Outstanding Resident in Pediatrics in 2009. Dr. Heydarian recently completed a fellowship in pediatric hospital medicine at Children's Hospital Los Angeles.

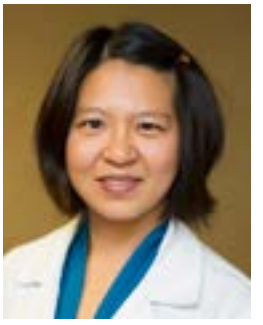
Dr. Wendy Brown, a pediatric neuro radiologist, has joined the staff at CHKD. She earned her MD at George Washington University Medical School, where she was a resident in diagnostic radiology. completed two fellowships in radiology, one in pediatric imaging and the most recent in pediatric neuroimaging, both at Children's National Medical Center in Washington, DC.

Dr. Allison M. Tenfelde has joined CHKD's Sports Medicine and Orthopedic Surgery Program. He earned his MD at Michigan State University College of Human Medicine and completed two fellowships, one in pediatric orthopedic surgery at University of Michigan C.S. Mott Children's Hospital and another in orthopedic sports medicine at Detroit Medical Center.

EVMS MEDICAL GROUP

Katherine Boyd, MD has joined EVMS Dermatology. She earned her MD at George Washington University and completed a Dermatology residency and Dermatopathology Fellowship at the University of Virginia School of Medicine. She is Board-certified in Dermatology and Board eligible in Dermatopathology.

Peter Takacs, MD, PhD has joined Urogynecology and serves as Division Chief. Dr. Takacs received his MD from the University Medical School of Debrecen, Hungary. He completed an Obstetrics & Gynecology residency at Virginia Commonwealth University School of Medicine and a fellowship in female pelvic medicine and reconstructive surgery at the University of Miami, Jackson Memorial Hospital. He is Board-certified in Obstetrics & Gynecology and Female Pelvic Medicine and Reconstructive Surgery.



Vivian Wu, MD has joined Otolaryngology. She received her MD from Howard University and completed an Otolaryngology residency at Oregon Health & Science University School of Medicine. She completed a head and neck surgical oncology fellowship at University of Michigan Medical Center in Ann Arbor. She is Board-certified in Ololaryngology and Board eligible in Head and Neck Surgical Oncology.

Joshua Sill, MD has joined Pulmonary & Critical Care Medicine and the Sleep Medicine Center. He earned his MD at the University of Texas Medical Branch and completed an internal medicine residency at the David Grant USAF Medical Center and a

pulmonary & critical care fellowship at San Antonio Uniformed Services Health Education Consortium. He is Board-certified in Internal Medicine, Pulmonary Medicine, Critical Care Medicine and Sleep Medicine.

Enrique Calvo-Ayala, MD has joined Pulmonary and Critical Care Medicine. He earned his MD at Universidad Nacional de Colombia and completed an internal medicine residency at the Henry Ford Health System. He completed a pulmonary and critical care fellowship at Indiana University School of Medicine. He is Board-certified in internal medicine and pulmonary diseases.

Liwei Huang, MD, PhD has joined Nephrology and Hypertension. She earned her MD at Sun Yat-Sen University Medical School and completed an internal medicine residency at the University of Tennessee at Memphis College of Medicine. She completed a nephrology fellowship at The Hospital of the University of Pennsylvania. She is Board-certified in Internal Medicine and Nephrology.

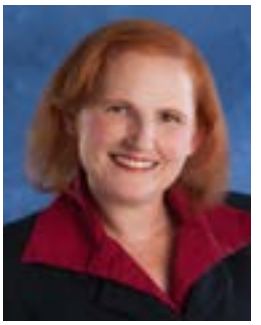
Patricia Kao, MD has joined Nephrology and Hypertension and is the Fellowship Program Director. She completed her medical degree, residency and fellowship at Case Western Reserve School of Medicine. She is Board-certified in Internal Medicine and Nephrology.

Ramin Tolouian, MD has joined Nephrology and Hypertension as Chief of the Division within Internal Medicine. He earned his MD at Behesti University of Medical Sciences in Iran and completed internal medicine residencies at Behesti University and the Yale School of Medicine. He completed a transplant fellowship at Western General Hospital in Scotland and a nephrology fellowship at Tehran University of Medical Sciences and at the University of Southern California School of Medicine. He is Board-certified in Internal Medicine and Nephrology.

Dr. Dan-Vinh Nguyen and Dr. Jennifer L. Knips joined Internal Medicine – Primary Care. Dr. Nguyen earned his medical degree at EVMS and Dr. Knips earned her medical degree at the University of Missouri School of Medicine. Both Drs. Nguyen and Knips completed internal medicine residencies at EVMS and both are Board-eligible in Internal Medicine. Dr. Knips served an additional year as Chief Resident in Internal Medicine.

Dr. Kenneth Surkin, Dr. Pallavi Reddy Kuppireddy and Dr. Stephen Greer have joined Hospital Medicine. Drs. Surkin and Greer are graduates of EVMS and also completed their internal medicine residency at EVMS. Dr. Greer served an additional year as Chief Resident in Internal Medicine. Both are board-eligible in Internal Medicine. Dr. Kuppireddy received his medical degree from Alrmadu Bello University and an internal medicine residency at Canton Medical Education Foundation. Dr. Kuppireddy is Board-eligible in internal medicine.

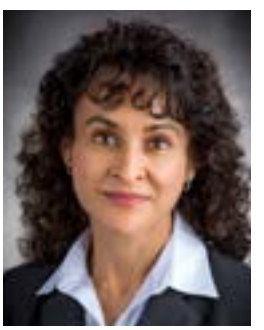
NEW HOPE CENTER FOR REPRODUCTIVE MEDICINE



Dr. Jessica Heller Zaret has joined New Hope Center for Reproductive Medicine in Virginia Beach. After having served for the past seven years as a leading physician in some of our military's finest medical centers, Dr. Zaret becomes the third fertility specialist physician on the New Hope team.

RIVERSIDE REGIONAL MEDICAL CENTER

Dr. Harry Lee Kraus, Jr., general surgeon, has joined Riverside Hampton Roads Surgical Specialists in Williamsburg. He earned his MD at the Medical College of Virginia School of Medicine. For the past several years, he has divided his practice between the U.S. and East Africa. He is Board-certified by the American Board of Surgery and will perform surgery at Riverside Doctors' Hospital Williamsburg.



Dr. Doris Quintana, general surgeon, has joined Riverside Hampton Roads Surgical Specialists in Williamsburg. She will perform surgery at Riverside Doctors' Hospital Williamsburg. She graduated from Michigan State University College of Human Medicine and completed her residency at University of Oklahoma Health Sciences Center. She is Board-certified by the American Board of Surgery.

Dr. Phillip Ding, a fellowship-trained, general surgeon, has joined Riverside Hampton Roads Surgical Specialists in Williamsburg. He received his MD from University of Alberta Faculty of Medicine and completed his fellowship at the Cleveland Clinic Hospital. He is Board-certified by the American Board of Surgery. He will perform surgery at Riverside Doctors' Hospital Williamsburg.

WELCOME MEDICAL PROFESSIONALS

The Breast Care Center is pleased to welcome **Renee Olexy,** a Women's Health Nurse Practitioner, Board-certified by the National Certification Corporation and licensed by the Commonwealth of Virginia. Olexy earned an advanced Master's of Nursing Degree for Nurse Practitioners at Drexel University in Pennsylvania.

SENTARA

Caren Beasley, MD, a Board-certified family practitioner and medical bariatrician, has joined Sentara Comprehensive Weight Loss Solutions. She earned her MD at the University of Missouri-Kansas City School of Medicine, and completed her residency in family medicine at Truman Medical Center. She is a member of American Academy of Family Practice, American Society of Bariatric Physicians and The Obesity Society.

VIRGINIA ONOCOLOGY ASSOCIATES

Ligeng Tian, MD, PhD has joined Virginia Oncology Associates. She earned her MD from Beijing Medical University, and her PhD in molecular biology and genetics from Cornell University. She completed her residency in internal medical at Long Island Jewish Medical Center and a fellowship in medical oncology and hematology at Yale University.

We want to extend a welcome to all of the physicians and medical professionals who join the Hampton Roads community. Please send announcements (with photos) to our editor at bobbie@hrphysician.com - or call 757.773.7550.

Spotlighting what's happening in the medical community, and who's making news

ATLANTIC UROGYNECOLOGY

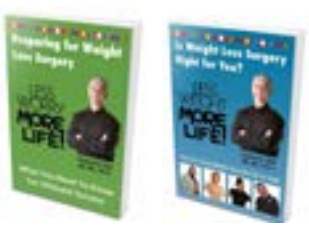
Dr. Christopher Walshe spent a week in Kinshasa, Congo in September, operating on obstetric fistula patients. Subequatorial Africa has the highest known concentration of these patients in the world – women of all ages, but particularly those who are forced to marry young and conceive right away. Their narrow immature pelvic structures are susceptible to birth trauma, but with no access to operative surgical delivery, they often become outcasts. Dr. Walshe plans to return in 2014 to spend more time performing the simple procedure that can restore these women to health.

BON SECOURS

Carla Gaton-Hall, RN, BSN, MBA, MHA, Nursing Supervisor, Care-A-Van Hampton Roads; Emily Lieb, MD, Care-A-Van Medical Director; and David Lieb, MD, EVMS Assistant Professor of Medicine, were among the health professionals participating in the Community Diabetes Screening in September at Suffolk's Town Square Shopping Center. Collaborating agencies were: Bon Secours Virginia, Southeast Virginia Health System Main Street Physicians, Sentara, Western Tidewater Free Clinic and Western Tidewater Health District. Participants received information on diabetes from the American Diabetes Association, the American Heart Association and the City of Suffolk Parks and Recreation.

CENTER FOR WEIGHT LOSS SUCCESS

Thomas W. Clark, MS, MD, FACS, Board-certified bariatric surgeon and medical director at the Center for Weight Loss Success in Newport News, released two books in his "More Life" series. The first, "Less Weight, More Life! Is Weight Loss Surgery Right for You: Top 21 Questions You Need to Ask" was in the top ten best-selling books for more than eight weeks on Amazon. The second, "Less Worry, More Life! Preparing for Weight Loss Surgery: What You Need to Know for Ultimate Success" ranked #1 for more than five consecutive weeks. Both include patient stories revealing their life changing experiences after weight loss surgery.



CHESAPEAKE REGIONAL MEDICAL CENTER

The Weight Loss Center at Chesapeake Regional Medical Center has been accredited as a Level 1 facility under the Bariatric Surgery Center Network Accreditation Program of the American College of Surgeons. The accreditation demonstrates commitment to delivering the highest quality care for bariatric surgery patients. Chesapeake Regional met the essential criteria that ensure its ability to support a bariatric surgical care program and the institutional performance requirements outlined by the BSCN accreditation standards. Accredited centers provide the hospital resources necessary for optimal care of morbidly obese patients and the support and resources necessary to address the entire spectrum of care and needs of bariatric patients.

Dr. Aswani K. Suthrave has been appointed chief medical officer and vice president of quality and medical affairs for Chesapeake Regional Medical Center. Suthrave most recently served as medical director of the University of Maryland Medical Center Midtown Campus in Baltimore, where he was responsible for utilization management, quality improvement, and physician assistant and hospitalist services. A board-certified internist and an experienced hospitalist, Suthrave earned his medical degree from Gandhi Medical College in Hyderabad, India, and completed his internal medicine internship and residency at New York Downtown Hospital in New York. He received a Master of Health Administration degree from Western Kentucky University and a Master of Business Administration degree from the University of South Dakota's Beacom School of Business.

CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS

Mr. John Harding has been named Senior Vice President of Physician Practice, Diagnostic and Therapy Services. Harding comes to CHKD from All Children's Hospital in St. Petersburg, FL., where he has worked for the past eight years with a wide variety of ambulatory, ancillary, rehab and home health programs.

Prior to his experience at All Children's Hospital, he managed and worked with over 100 pediatric specialty physicians during his tenure at Children's National Medical Center in Washington, DC.

Virginia Beach City Public Schools has awarded the contract for its middle school certified athletic training services to **CHKD's Sports Medicine Program.** CHKD certified athletic trainers provide for the safety of student-athletes throughout the city's 13 middle schools. All of the certified athletic trainers have current certification in sports medicine and work as an integral extension of CHKD's entire sports medicine team. CHKD has provided similar services to Chesapeake Public Schools for its middle and high school student-athletes since August 2010.

HAMPTON ROADS ORTHOPAEDIC & SPORTS MEDICINE

Dr. Anthony Carter is the first orthopedist in Hampton Roads to integrated into his practice the use of a long-acting anesthetic (Exparel) locally injected during knee replacement surgery. This technique eliminates the need for nerve block catheters and the use of knee braces post-operatively. Pain can be controlled for up to 72 hours after surgery allowing your body to recover quicker. A recent study showed that patients reported lower pain scores, greater improvement in knee flexion, and shorter hospital stay when utilizing this technique.

Dr. John Aldridge is performing a cutting-edge procedure, the iFuse Implant System. The iFuse system is a minimally invasive surgery, typically performed in under an hour, implanting titanium triangular implants across the joint to provide SI joint stabilization. Dr. Aldridge states "I have had patients with nagging low back pain for years and when I started looking at the SI joint as the pain generator, I was able to get these patients back to a high function quality of life, most of them pain free".

Dr. Adrian Baddar is one of the first orthopedist in the state of Virginia to use the new OrthoSensor during Total Knee Replacement Surgery. OrthoSensor is the first sensor-assisted orthopedic instrument to assist surgeons in verifying the position and balance of a knee implant properly during total knee replacement surgery. Dr. Baddar is able to visualize and quantify joint balance and load during knee replacement procedures which allows him to make informed adjustments to the soft tissues to optimize implant placement.

ORTHOPAEDIC & SPINE CENTER

Orthopaedic & Spine Center has opened its 1.2T (Tesla) Magnetic Resonance Imaging scanner to the public. With double the power of any Open MRI on the Peninsula, the Hitachi OASIS Open MR Scanner provides images with an astounding level of detail and clarity, providing physicians the accuracy needed to make a more accurate diagnosis. The scanner offers superb image quality, unparalleled patient comfort, with open views and interior lighting. It accommodates claustrophobic, large and anxious patients, and offers motion-compensated sequencing for patients with tremors or who cannot stay still for long periods of time. Studies include Orthopaedic, Vascular, Dental, Brain, Abdominal and Renal MRA.

Jeffrey R. Carlson, MD, Managing Partner and Spine Fellow at Orthopaedic and Spine Center in Newport News, VA, was recently featured in an article about innovative, Less-Exposure Spine Surgery, using instrumentation and hardware by SpineFrontier. The Daily Press story covered two of Dr. Carlson's patients who were surgically treated at Bon Secours Mary Immaculate Hospital, using the new hardware and LES (Less Exposure) techniques.

SENTARA

Dr. Stephen D. Wohlgemuth, Medical Director of Sentara Comprehensive Weight Loss Solutions, was recently published in the "Journal of Burn Care & Research" for his study: Does the *"Rule of Nines" Apply to Morbidly Obese Burn Victims?* The study assesses the applicability of the Rule of Nines to the obese patient population and presents the use of three-dimensional body scanning to evaluate

differences in body surface area of obese adults. Two hundred obese adults underwent 3D whole body scanning using a commercially available white light scanning device. 3D whole body scanning is now offered at Sentara Comprehensive Weight Loss Solutions.

Dr. Wohlgemuth, a Board-certified surgeon and past president of the Virginia Bariatric Society, has been invited to present at national and international professional meetings in November, including the first combined meeting of The Obesity Society and the American Society of Metabolic and Bariatric Surgery in Atlanta, and the 4th International Conference on 3D Body Scanning Technologies, Long Beach, CA.

Photo Courtesy of Hologic

Sentara is offering 3D mammography at eight breast imaging locations from Williamsburg to Virginia Beach. Conventional mammography creates a two dimensional image of the breast much like an x-ray, making it difficult to find small cancers hidden among layers of breast tissue. This advanced technology creates 3D breast reconstructions so radiologists can view the breast in paper thin layers. Early cancers are revealed that would not be visible using other mammography. A study published in the June 2013 American Journal of Roentgenology found 3D mammography increased cancer detection by 35% and increased invasive cancer detection by 53%.

AWARDS AND ACCOLADES

CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS

Neel Krishna, Ph.D. (a pediatric virologist with CHKD and an associate professor at EVMS) and Dr. Kenji Cunnion (infectious disease specialist with Children's Specialty Group at CHKD) were recipients of the i6Challenge grant from the Virginia Innovation Partnership at the recent Virginia Venture Forum in Alexandria and were selected to present their novel immune modulatory compound at the Forum.

The goal of VIP is to build value for the Commonwealth by creating Virginia-based start-up companies, attracting corporations to invest in Virginia and enhancing the licensing potential for technologies. They presented to a group of venture capitalists, university leaders, government officials and peers. Also speaking at the forum were Gov. Bob McDonnell, University of Virginia President Teresa Sullivan, and George Mason University President Angel Cabrera.

What is a Physiatrist?

By Rita Boslet, MBA, FACMPE

Physical Medicine and Rehabilitation physicians or "Physiatrists" work to improve the wellbeing of patients experiencing a decrease in quality of life because of a pain limiting condition or disabling disorder, often with amazing results. Physiatrists are experts at diagnosis and treatment of pain, as well as the evaluation of function. They focus on nerve, muscle and bone and their interrelationships that determine function or pain responses. Physiatrists often treat patients with acute work or vehicular injuries, sports injuries, adults suffering from low back pain, headache, neurological disorders and arthritis. The goal is to enable patients to return to full function through non-surgical methods.

Often, interventional procedures, such as epidural injections, can provide long-lasting pain relief. Relief of pain allows the patient to resume some normal activity and begin strengthening exercises which will lead to improved recovery. Treatment always includes specific explanation as to potential causes of the symptoms and a discussion of ways to prevent future injury.

A physical medicine-based practice will not use narcotic pain medication as a front line measure. Often, a patient with chronic pain currently treated with narcotics will be referred. This patient may be denied evaluation, due to obvious narcotic addiction or dependence after chart review. Accurate assessment of a patient's pain cannot be done while the patient is taking significant doses of narcotic pain medications and studies have shown that narcotic medications can worsen, rather than lessen pain in some cases. A Physical Medicine and Rehabilitation specialist is trained to diagnose and treat pain, not addiction. However, after a patient has been weaned from narcotics, the evaluation and treatment process may begin. When narcotics have been prescribed for a short term, the patient may be accepted for treatment. The patient must realize that the narcotics are temporary and the goal is the discontinuation of medication and the restoration of maximum function.

Pain management does not guarantee complete pain cessation, only progress toward a comfortable, active and optimal lifestyle. Hard work and persistence is required in combination with a team approach by patient, physician and therapist.

Specialized treatment modalities used by a Physiatrist can include: epidural blocks, selective nerve root blocks, prolo therapy and platelet rich plasma injections (PRP), radio frequency denervation, discography and intradiscal injection, spinal cord stimulator trials, diagnostic musculoskeletal ultrasounds, ultrasound guided injections, image guided intra-articular hip injections, electrodiagnostic testing, physical therapy, electrostatic therapy, therapeutic massage and more.

If a problem is in early stages, prompt treatment is essential to prevent the unintended slide into chronic pain. Appropriate diagnosis and treatment leads to correcting the harmful activity, breaking the pain cycle, and hopefully, restoration of normal function and a fulfilling lifestyle. ■

Rita Boslet, MBA, FACMPE is the Practice Administrator for APM Spine and Sports Physicians. APMSpineAndSports.com

Affordable Care Act

5 Tips Every Physician Should Know

By Alison Johnson

Much about the Affordable Care Act is still a big question mark, from the timing of its full implementation to the impact of its changes. How many new patients will come into medical practices as state health insurance exchanges enroll more people? Exactly how will payment reforms work? Will practices need a dramatic restructuring to stay profitable?

Even as answers grow clearer over time, they will vary by practice based on size, specialty, group and hospital affiliations, location and other factors.

There are a few common denominators, however. Here are five tips that experts on the ACA say apply to every physician at this point:

1) Be able to refer patients who ask about new insurance options. Physicians don't need to know how to answer every question about the Health Insurance Marketplace now open under the ACA. They should, however, know exactly where people can get help.

In Virginia, the first stop for many will be the federal Web site www.healthcare.gov, which lists all health plans available in the state. Open enrollment runs through March 31, although patients who want coverage to begin Jan. 1 need to sign up by Dec. 15. A single application on the site should tell patients if they or their family members are eligible for Medicaid, the Children's Health Insurance Program (CHIP) or financial help to pay for one of the private, third-party insurance plans.

People who want personal assistance can enter their zip code at https://localhelp.healthcare.gov. Virginia also has a Web site, www.enroll-virginia.com. For people who prefer the phone, a national call center is open at 1-800-318-2596; Virginia's statewide toll-free hotline is 888-392-5132.

One idea is to print a list of those resources on patient handouts, as well as on a practice's online site.

2) Know what services are covered under the ACA. According to a survey done in the summer of 2013 by the national physician staffing agency LocumTenens, more than six in 10 physicians were "not at all familiar" with what the new health exchange plans would cover (or what their payment rates would be).

All health plans in the marketplace offer a set of "essential health benefits." They are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including counseling and psychotherapy; prescription drugs; rehabilitative services; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

A good number of preventative care services must be covered with no co-payments. Just a few examples are blood pressure and depression screenings and obesity counseling for all adults, mammograms every one to two years for women over 40 and immunizations and vision checks for children. Other co-pay-free services are based on a patient's risk factors. For a full list, go to https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

For other services, the percentage of costs covered differs under four categories of plans: bronze, silver, gold or platinum. People also may be able to buy catastrophic coverage and stand-alone dental plans. No one can be turned away or charged more for a pre-existing condition, or on the basis of gender.

"My advice is be prepared to answer questions from your patients, know the most common buzzwords and be able to communicate the potential benefits," said Dr. Lisa Bielamowicz, executive director and chief medical officer at The Advisory Board Co., a global research, technology and consulting firm.

3) Plan for a possible influx of new patients. More than 8.5 million people visited the healthcare.gov site during its first week of operation, according to the Department of Health and Human Services, although many did not complete the process of applying for coverage.

Some options for practices if their patient rolls do jump: hire more nurse practitioners or physician assistants; pilot efficiency efforts, including more electronic communication with patients through email and possibly texting; increase office hours; and explore possible partnerships with hospitals or other medical providers.

Under the team model of care, doctors might see more – and more difficult – patients, but they'd have more support

from NPs, PAs and others who could handle jobs such as conversations about diet or exercise or make home visits to help, say, a diabetic monitor blood sugar levels. Practices that hire young doctors should look for residents trained in the team approach, Bielamowicz advised.

"Doctors will need to concentrate on how to use their time well, to make the tough decisions that they're trained for," agreed Dr. Karen Remley, former state health commissioner and founding director of the M. Foscue Brock Institute for Community and Global Health at Eastern Virginia Medical School, speaking at a recent lecture on health care reform. "It will be about maximizing what they're doing to add value but not burn out."

4) Be aware of two issues that have drawn concern from physician groups. One ACA regulation that may catch doctors by surprise says that patients who get subsidized health plan coverage through the exchanges but don't pay their premiums will have a three-month grace period before the policy is cancelled. However, health insurers only are responsible for paying doctors' claims for one month.

Insurers are supposed to warn doctors if they're about to stop paying a patient's claims, but the "loophole" could increase uncompensated care. HHS has promised to "monitor this issue moving forward and... work on the development of policies to prevent misuse of the grace period."

Another current worry is a rule that would reduce Medicare reimbursements for practices that fail to effectively use an Electronic Health Record by 2015. Under the measure, actually part of the 2009 Health Information Technology for Economic and Clinical Health Act, penalties would kick in if providers don't meet "meaningful use" objectives that include tracking patients' medications and allergies, sharing lab test results and summarizing a patient's office visit.

Both the American College of Physicians and the American Academy of Family Physicians have requested that federal legislators extend the 2015 deadline.

5) Prepare for – and stay educated on – possible changes in reimbursements. The traditional fee-for-service approach won't disappear in the near future. However, as most doctors know, federal officials are experimenting with other models, hoping to reward practitioners for providing better medical care rather than more of it.

Bundled payments would offer a fixed amount of money to cover all services for treating a sickness or injury. Value-based payments would be partially determined by outcomes, with penalties if patients need additional care. Or reimbursements might one day be set in advance, based on what Medicare officials decide treatment "ought" to cost.

Whatever happens, experts agree that few physicians will be able to survive in stand-alone mode. Specialists will need to be part of preferred referral networks, while Medicare fee-for-service providers might benefit from joining an accountable care organization (one resource: www.cms.gov/aco).

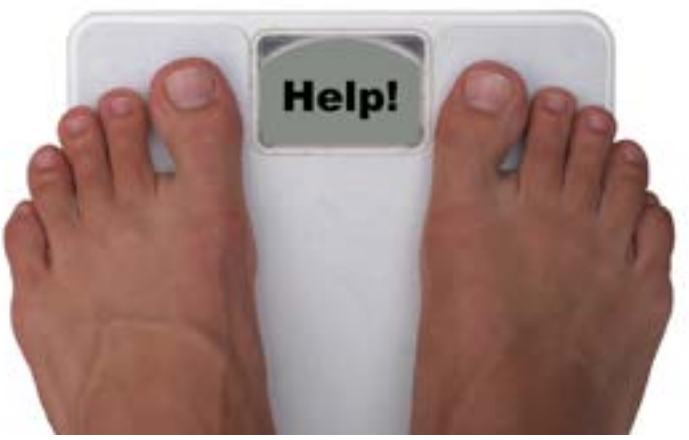
"Pay attention to the studies that come out," Dr. Remley said. "You will need to be informed to have control over what your life will look like in 20 years." ■

Do you have a specific question about how the ACA might affect your practice? If so, send an email to holly@hrphysician.com and Hampton Roads Physician will work to get an answer for you. Questions and answers will be published in future editions. Please include your name, specialty and practice name along with contact information (not for publication) should we need to get in touch with you for any reason.

Stress and Obesity

A Natural Connection with a Natural Cure

By Bobbie Fisher



"Stress-induced eating may be one factor contributing to the development of obesity."

In one form or another, this statement has appeared in studies published by the National Institutes of Health, the Harvard Health Publications and the World Health Organization, and countless others. It seems almost intuitive, but physicians know that the ability to cope with stress has a huge impact on people's behaviors, just as they know that people aren't on their best behavior when they're stressed.

"As doctors, we see it all the time in our offices," says, R. Phillip Snider, RD, DO, Regional Medical Director of Bon Secours Medical Group. "We know that patients sometimes say things, or behave in ways they wouldn't ordinarily, and aren't as flexible when they're under stress."

And that's when people are likely to fall back into habits like smoking, gambling – or overeating.

"Stress represents a challenge to the system," Dr. Snider says, "and while there are no physiological tests to measure stress, there are signs a careful physician can spot: elevated heart rate or blood pressure, enlarged pupils, muscle pain, etc. Stress makes the body vasoconstrict for the fight, flight or freeze reaction. Blood sugar goes up, and the blood clots more easily. I believe strongly that stress, and how we treat our bodies, dictates a lot of our choices."

He explains: the brain is very powerful; it can create chemicals in response to stress, it can enhance pathways and manipulate our decisions. It's what Dr. Snider calls 'basically a pharmacy inside our heads.' People learn to manipulate their brain chemistry: such as thrill seekers who try to get a rush of adrenalin to stimulate dopamine and serotonin receptors. One of the tools people learn to use to deal with stress is the ingestion of carbohydrates, which can create a similar effect. Once it becomes a daily habit to use food to create the desired chemical changes in the brain, weight gain results.

If the stress is great enough and prolonged enough, the prefrontal cortex – the portion of the brain where executive decisions are made – becomes sluggish. It sets up a vicious cycle, where excess weight causes even more stress, and that stress is relieved by eating the kinds of food that cause weight gain.

But humans also have the ability to reverse the pattern, Dr. Snider says. Meditation, getting enough sleep, having a good conversation – in short, anything that relaxes and calms the mind can turn the prefrontal cortex back on, allowing us to make our best decisions.

As powerful as the brain is, meditation can be just as powerful in the struggle with weight loss. Meditating for only five minutes, just three times a week, can widen the gap between action and reaction. "People have it within themselves to beat stress, and to start making better decisions," Dr. Snider says, "but they have to believe they do, and the first step is slowing down, paying attention and learning how to unplug a busy mind on a regular basis."

The important thing for people to remember is that they're not striving for perfection: it can be tremendously difficult to truly relax, to get into the moment, and be completely there. But it can work wonders. "It's really just about mindful thinking," Dr. Snider explains. "It means paying attention to being in the moment. We actually can rewire our brain and reinforce the more slow, well-reasoned and relaxed processing we're capable of."

Dr. Snider asks his weight loss patients to consider these questions when they reach for food: Is this my higher self wanting to eat, or my lower self? Do I need the calories? Am I choosing good food? Am I eating because I'm bored? Or lonely? Am I trying to avoid something? Am I responding to stress?

When patients develop the habit of mindful thinking, it's easier for them to ask themselves important questions about their hunger, and make appropriate decisions. ■

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