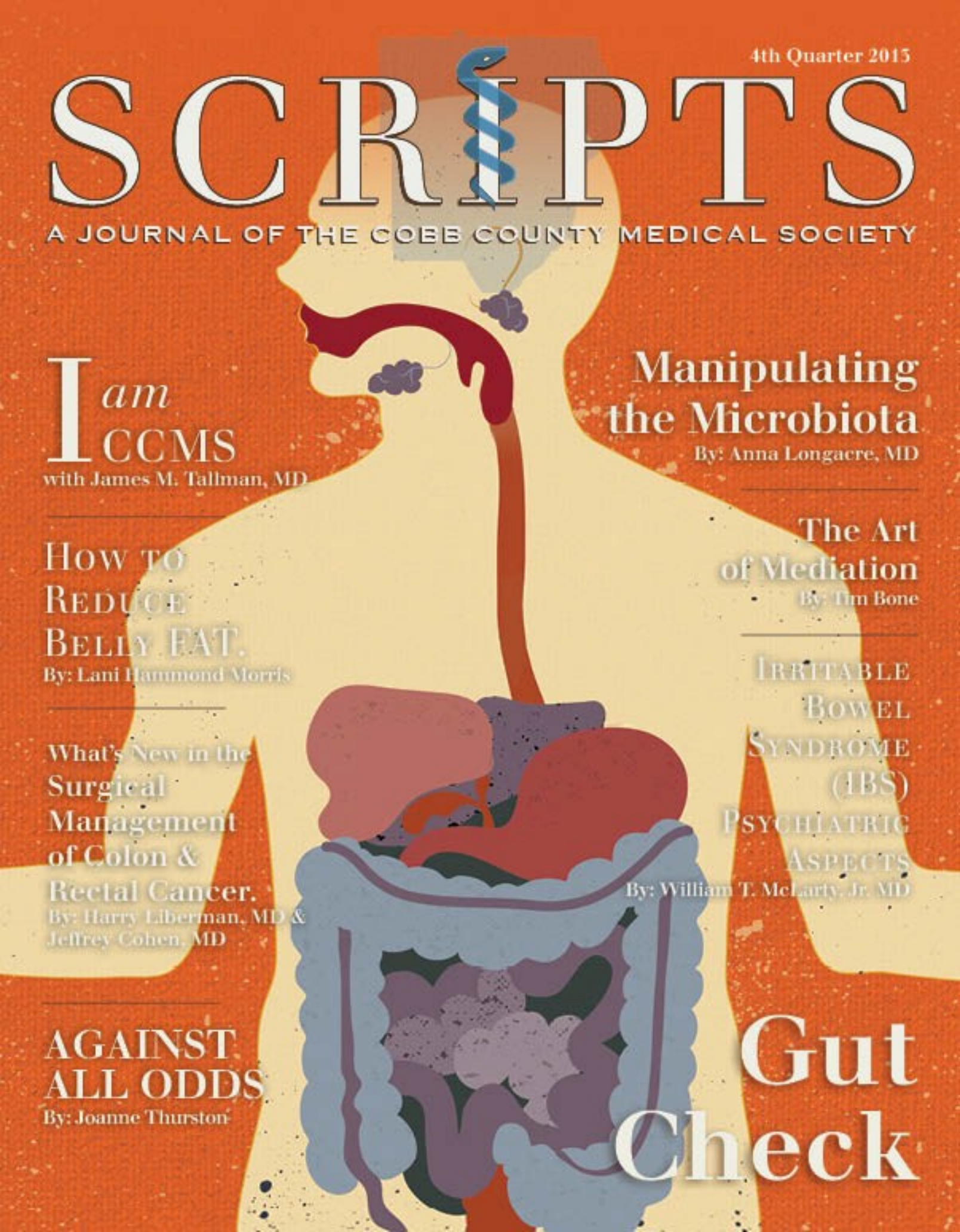
4th Quarter 2015

SCRIPTS

A JOURNAL OF THE COBB COUNTY MEDICAL SOCIETY



I *am* CCMS

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Gut Check

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4th Quarter 2013

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A Note from the Editor

STAN DYSART, MD | *Editor at Large*
member since '94

With the Season of Feasting upon us, this issue's focus on "The Gut" could not come at a better time.

Each year we gather with friends and family to celebrate the year's bounty and good fortune... and to fill our guts with delicious home cooking. But as we take this time to reflect on family, health and good fortune, we should note the significance of our Medical Society, and the bounty of knowledge and service it provides as a result of our collective efforts.

With the year drawing to a close, we near yet another opportunity to become more active in our society and in doing so help guide the course and propel CCMS through 2014.

Get Involved. Stay Connected. Enjoy the holidays and your time with your loved ones. And for those of you who overindulge, we have included a great list of bullet points in "How to Reduce Belly FAT," on page 16.

Enjoy,
Stan Dysart, MD MBA
Editor at Large

2014 Election of Officers

The nomination committee recommended and the Board of Trustees approved the following slate:

Election will take place Nov. 23, 2013 at our Annual Holiday Party

President
Despina (Debi) Dalton, MD

President Elect
Gerardo (Gerry) Prada, MD

Secretary/Treasurer
Nydia Bladuell, MD

CCMS Be a *Contributor*

Nominate yourself or a fellow CCMS peer for **article submission.** Send article inquiries and requests to **joanne.thurston@cobbdoctors.org**

Your medical society has worked all summer to create a memorial event for our members. It started in March when we contracted with Dr. Benjamin Carson to come speak at our annual summer meeting. The energy increased as the number of attendees increased. And with the assistance of WellStar in sponsoring the event, we had the largest gathering of physicians in the history of Georgia to hear Dr. Carson. The event drew over 478 physicians and their spouses from Cobb, Bartow, Paulding, Douglas, Cherokee, Pickens, DeKalb, and Fulton counties. Cobb County Medical Society membership composed 76% of those in attendance. Besides listening to Dr. Carson, another benefit of this assembly was the fellowship with peers: seeing physicians from medical school or training was fun both for the physicians and their spouses.

Speaking as one of us, Dr. Carson issued a challenge to not be bystanders in the current medical dialogue. We must be involved in our community and in government. He also challenged us to not let the government usurp our responsibility to care for our patients. Carson also thinks the free market approach to health care is the answer to the healthcare issue, rather than big government. He also likes EMRs but believes the medical record should be owned by the patient and not the healthcare agency or government. In allowing patients to own their records, Carson believes people will be more inclined to accept control and responsibility over their own healthcare.

While not everyone agreed with every point Dr. Carson made, he surely made us think about the problem. If you were unable to attend the meeting, mark your calendar for next year as we will have an even bigger audience as more people get involved and participate.

MARK HUFFMAN, MD | *CCMS President*
member since '11

The *Society*

CCMS has seasons just like the weather. Fall is the most fun season for me. September brings planning for our Holiday Party, being held this year on November 28th at the Gardens of Kennesaw Mountain. This event is created for a relaxed time to visit with old friends and make new ones. A good glass of wine and good food is always the center point to gather around. If you have not yet attended this social event please put it on your calendar – you'll have a good time. The only business at our last meeting of the year is the election of officers for the next year.

The enthusiasm of the incoming President is refreshing. He or she (2014 will be Dr. Debi Dalton) has goals, plans and dreams for their year as President. I look forward to being a part of their plan and helping make it a memorial year for them. When Dr. Dalton asks you to be a part of her team take a minute to let her excitement encourage you to say yes. CCMS has the committees of Review Committee, By Laws/Parliamentarian, Community Service, Legislative, Magazine/Public Relations, Disaster Resource Team, Programs, and CME/Conferences. If you have an idea of where you can participate please let us know. The Board meets for dinner no more than six times per year.

The next season is Winter when I send out invoices for your dues. Look for them in December.

See you on November 28th at the Gardens of Kennesaw Mountain.

JOANNE M. THURSTON | *CCMS Executive Director*
member since '01

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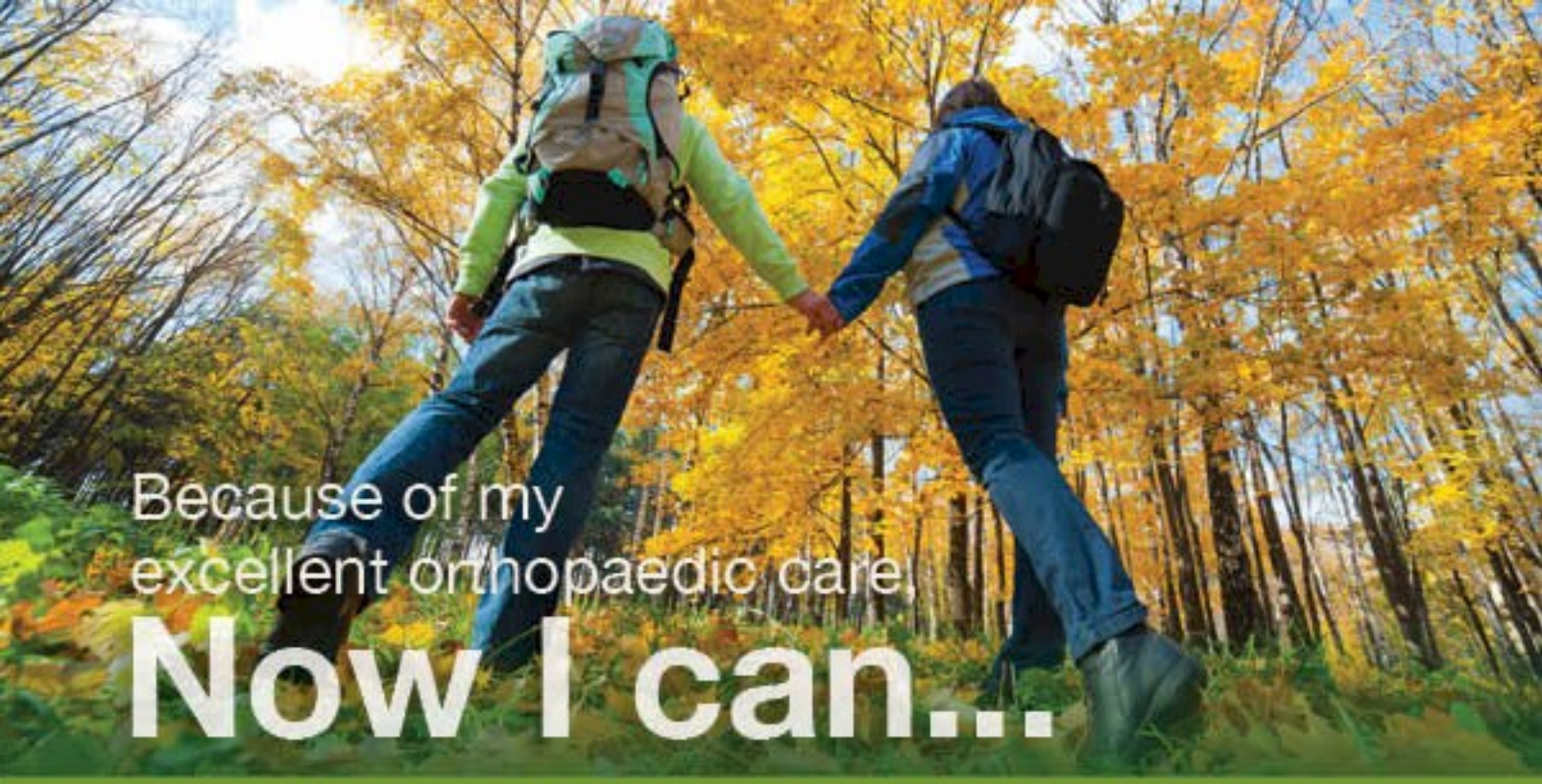

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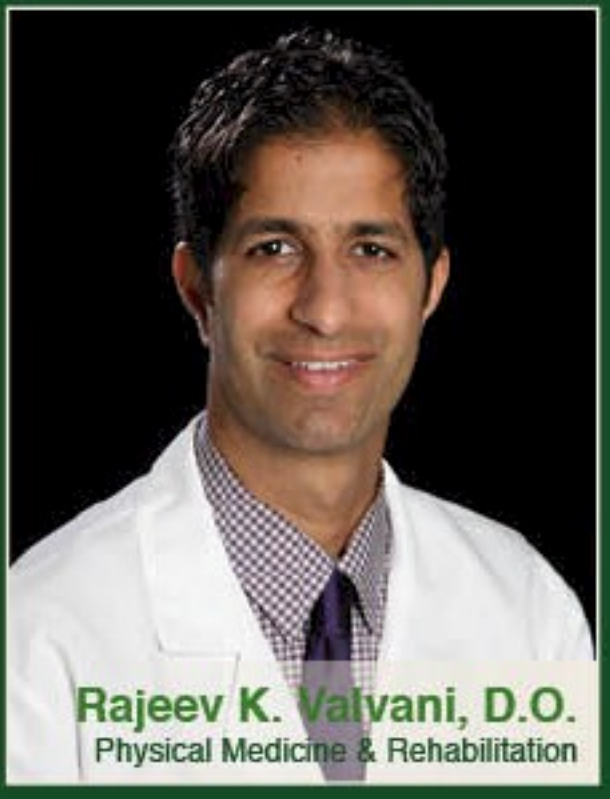

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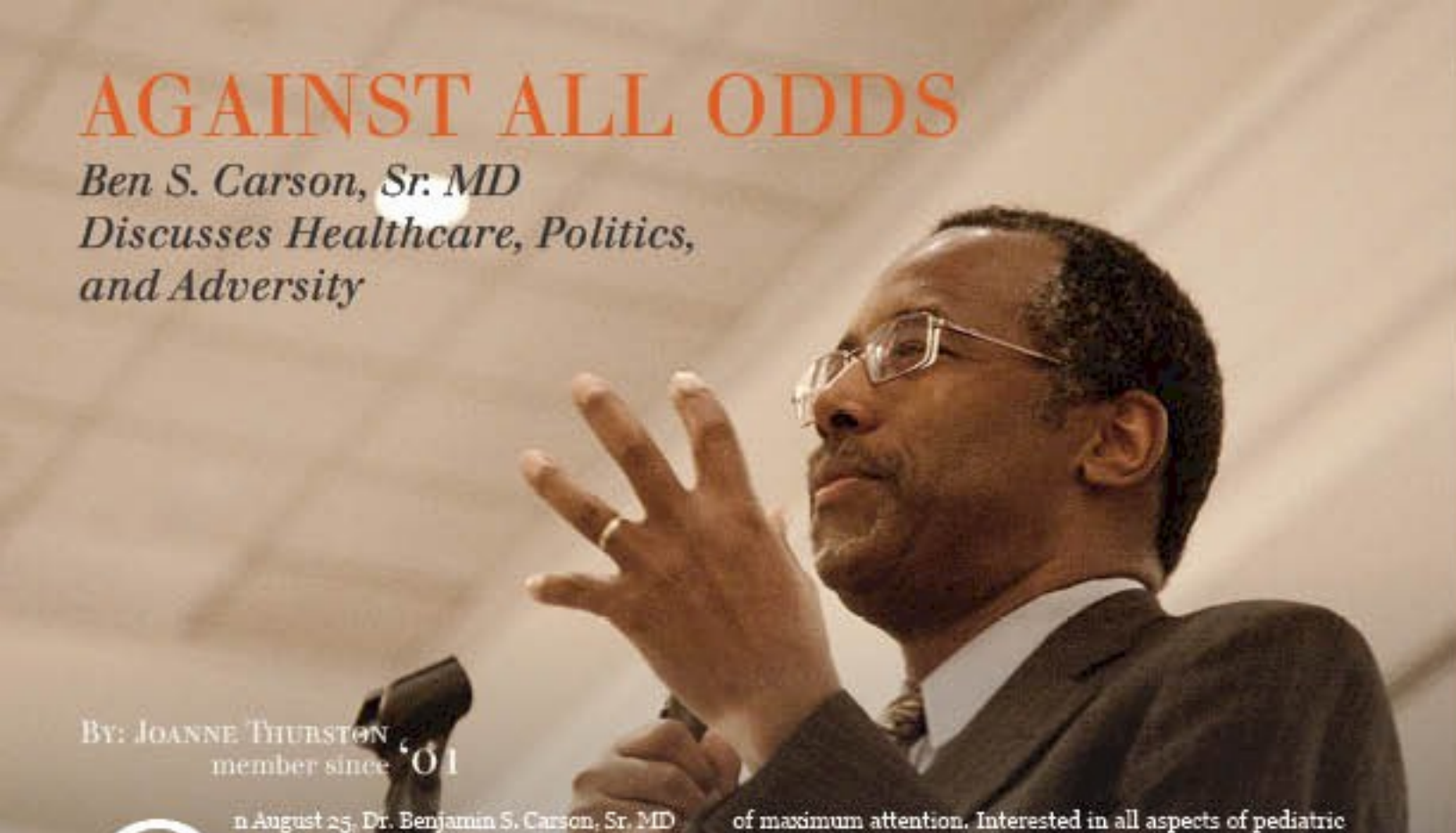
AGAINST ALL ODDS

Ben S. Carson, Sr. MD Discusses Healthcare, Politics, and Adversity



By: Joanne Thurston
member since '01

On August 25, Dr. Benjamin S. Carson, Sr. MD spoke before the largest group of physicians to ever assemble in Georgia – hosted by the Cobb County Medical Society (CCMS) at the Cobb Galleria Center. CCMS (composed of physicians from Bartow, Cherokee, Paulding and Douglas Counties), DeKalb Medical Society and the Medical Association of Atlanta came together to listen to this soft-spoken pediatric neurosurgeon, who challenges the concept of being politically correct and being a victim.

CCMS President, Dr. Mark Huffman, introduced Dr. Carson. Special guests were society members Congressmen Phil Gingrey, MD and Tom Price, MD. Several members of the Georgia General Assembly were also present, including Sharon Copper, Chairman of the Health and Human Services Committee in the Georgia House.

Carson had a childhood dream of becoming a physician. However, being raised by a single mom in dire poverty, his poor grades, horrible temper, and low self-esteem appeared to preclude the realization of his dream. But Carson's mother challenged him and his brother to strive for excellence. The young Carson persevered and today is a full professor of neurosurgery, oncology, plastic surgery, and pediatrics at the Johns Hopkins School of Medicine. Carson has also directed pediatric neurosurgery at the Johns Hopkins Children's Center for over a quarter of a century.

Some of Carson's career highlights include the first separation of craniopagus (Siamese) twins - joined at the back of the head - in 1987, the first completely successful separation of type-2 vertical craniopagus twins in 1997 in South Africa, and the first successful placement of an intrauterine shunt for a hydrocephalic twin. Although he has been involved in many newsworthy operations, Carson feels that every case is noteworthy – deserving of maximum attention. Interested in all aspects of pediatric neurosurgery, Carson also has a special interest in trigeminal neuralgia (severe facial pain) in adults.

Carson also went on to explain his view of healthcare in today's society: "Here's my solution: When a person is born, give him a birth certificate, an electronic medical record, and a health savings account to which money can be contributed—pretax—from the time you're born 'til [sic] the time you die. If you die, you can pass it on to your family members, and there's nobody talking about death panels. We can make contributions for people who are indigent. Instead of sending all this money to some bureaucracy, let's put it in their HSAs. Now they have some control over their own health care and very quickly they're going to learn how to be responsible."

When talking about today's elected officials and candidates for public office, Carson encouraged physicians to become involved. Five signers of the Declaration of Independence were physicians. For physicians there is no political correctness involved in their world. All men (and women) are created equal. They are born, they get sick, and they die.

Dr. Carson received numerous ovations during his talk.

Congressman Phil Gingrey asked Dr. Carson: "If you were a Congressman now and had to vote on the Continuing Resolution to fund the government how would you vote?" Dr. Carson told Congressman Gingrey that he would require the separation of Obamacare and the Continuing Resolution. He would not vote to approve funding the implementation of Obamacare.

When asked if he had plans to run for President, he answered "no," then added, "Certainly if there was no one on the scene and people [were] still clamouring, I would have to take that into consideration. I would never turn my back on my fellow citizens."

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Manipulating the Microbiota

Using Stool Transplant to Cure Recurrent C. Difficile

By: Anna V. Longacre, MD
member since '06

The problem of C. difficile

In recent years the problem of Clostridium difficile-induced colitis has increased dramatically in its frequency, severity and recurrence. We see this not only in our hospitals, but also in our outpatient clinics and in patients in the community previously considered to be at lower risk of infection. C. difficile is typically associated with exposure to antibiotics, resulting in disruption of the normal healthy gut microbiota, allowing spores of C. difficile to proliferate and produce toxin, which results in diarrhea due to a pseudomembranous colitis. The burden of disease has now increased such that an estimated 14,000 patients die per year of C. difficile colitis, with up to 3 million infections occurring yearly in the United States (1,2). In addition to the increasing prevalence of C. difficile is the problem of recurrence; in many cases antibiotics are unable to achieve a cure.

My first experience in practice

During one of my first years in practice, a previously healthy 50 year old woman presented to my office with her fifth episodes of C. difficile, 2 of which had required hospitalization. She was desperate to consider any treatment option, and when I told her about the possibility of stool transplant she enthusiastically embraced the idea. After discussion with my colleagues and completing comprehensive screening of stool and blood, her college age daughter returned home to provide a stool specimen that we processed and placed endoscopically far in her small bowel. The result was curative. When I saw her recently for her screening colonoscopy, 5 years since we performed the stool transfer, she was still grateful, healthy, and free of C. difficile. Since my initial experience, we have continued to seek and treat appropriate patients with this relatively simple, highly effective treatment of stool transplant.

Treatments for C. difficile

While the prevalence and severity of C. difficile have increased, standard treatment has remained limited to a select few antibiotics: metronidazole, vancomycin and fidoximicin (3). Initial infections are treated with metronidazole or oral vancomycin. These antibiotics are usually initially effective, but relapse occurs in up to 20% of patients after they complete a 10-14 day course of therapy. After initial recurrence the risk of further recurrence increases to greater than 40%. Second and third recurrences are treated with longer and tapering courses of oral vancomycin. Though fidoximicin has been shown to be effective in non-inferiority trials compared to vancomycin (4), its use in practice has been limited due to cost and lack of clarity as to where to best use it in the clinical algorithm. Additional treatment options have included the use of probiotics, xifaxan, and intravenously administered immunoglobulin, though there are little clinical data and variable efficacy.

How stool transplant works

The human gut is home to more than 1000 bacterial species that number in the trillions of cells. Many exist symbiotically in the gut and play a variety of beneficial roles in health including metabolism of carbohydrates, synthesis of vitamins, immune development and protection from pathogens. Alterations of the gut microbiome have also been described in multiple disease states ranging from Inflammatory Bowel Disease, Irritable Bowel Syndrome, obesity and the metabolic syndrome to atopic and autoimmune diseases as well as cancers. The understanding of the interactions of the microbiome with these conditions is in its infancy. The paradigm of C. difficile demonstrates how critical the gut microbiome is in maintaining health (5,6). Disruption of this biome, often with antibiotics, can result in imbalances that predispose an individual to C. difficile and result in a spectrum of disease ranging from asymptomatic carriage to watery diarrhea to severe complicated diarrheal illness including toxic megacolon. It appears that deficiencies of other bacteria, particularly Bacteroides and Firmicutes, anaerobes that dominate the gut microbiota, favor development of C. difficile infections. Stool transplant, otherwise known as fecal microbiota transplantation (FMT), involves using donor stool from a healthy individual and placing it into the gut of another individual in order to promote colonization of beneficial anaerobes and reconstitution of the colon's natural microbiota. FMT effectively and durably restores the balance of healthful bacteria to the colon and enables a cure for C. difficile infection.

The efficacy of FMT described in numerous case series has documented cure rates ranging from 87-93%, with colonoscopic administration appearing to have a slightly higher response rate. A recent systemic review of 11 series demonstrated cure of 89.5% with no significant adverse effects (7). In January 2013 the first open label randomized controlled study using FMT was published in The New England Journal of Medicine (8). Over 40 patients were randomized to one of 3 arms including donor stool administered by nasogastric tube, vancomycin, or vancomycin with bowel lavage. Though several study patients required a second treatment with donor stool, the overall cure rate with stool was 94% versus dramatically lower rates of 31% and 23% in the vancomycin groups. Due to the high response rate and discrepancy between the study and control arms, the study was terminated early by the data safety and monitoring board due to the ethical conflict that an effective therapy was being withheld from the control arms. Currently, a double blind placebo controlled trial is enrolling patients with recurrent C. difficile and randomizing them to receive colonoscopically administered donor stool versus a sham procedure with their own stool. In addition to efficacy and safety data, microbiome analysis will be performed on these patients before and after their procedures.

Several routes of administration for FMT are described. Endoscopically, stool may be placed into the duodenum, terminal ileum, or colon. Alternatively, stool may also be administered by nasogastric tube or retention enemas.

While variations in stool preparation exist in the literature, most are extremely simple. Our protocol uses a small (30-50 g) sample of freshly produced stool which we process with normal saline in a household blender, filter through gauze, and then draw up in 60cc syringe which can be easily inserted through the working channel of an endoscope.

Selecting patients and donors to ensure success

The recent American College of Gastroenterology guidelines for recurrent C. difficile published in April 2013 recommend considering FMT in patients with 3 or more episodes of recurrent C. difficile who have failed a 6-8 week taper of vancomycin (9). In my practice, we consider patients to be candidates for FMT if they have had 3 or more episodes of mild to moderate C. difficile colitis, or 2 episodes of severe C. difficile colitis. All patients are tested for coexisting stool pathogens, HIV, hepatitis, and syphilis to eliminate any concerns about potential transmission. Patients are maintained on vancomycin until the day before FMT to decrease the overall burden of C. difficile prior to FMT. Many patients with recurrent C. difficile colitis are elderly with multiple comorbidities, and thus the procedural risks of FMT need to be considered in addition to the potential risk of transmitting a pathogen not identified in the donor screening. In addition, the process of informed consent also involves discussing the potential risks of increasing the risk of a disease process such as obesity, autoimmune disease, or cancer, whose association and relationship with the gut microbiome is present but not understood. Thus far, no serious adverse events have been reported in the literature.

In my practice patients have identified their potential donors, often a spouse or family member. In some practices and parts of the country a "universal donor" has also been utilized. Donors are asked to be in good health, free of antibiotic use within the last 3 months, and willing and able to undergo the necessary testing to ensure the safety of FMT. In addition to testing the donor stool and blood for infections, HIV, hepatitis, and syphilis, we also ask them to complete a questionnaire similar to what is required at the blood bank assessing for potential risk of communicable or other diseases. While the cost of donor testing will sometimes be covered by insurance with use of appropriate screening codes, screening can be costly to potential donors.

Recent FDA developments

Following a public workshop in May 2013, the FDA announced that FMT required investigation new drug (IND) status in the treatment of C. difficile, such that an IND application and its subsequent monitoring and requirements were to be enforced. While intended to increase the safety, reduce risk, and ensure the process of informed consent, these requirements produced an unintended barrier to FMT, as many physicians stopped doing the procedure due to the administrative aspects and potential risk of noncompliance with FDA. The American Gastroenterological Association as well as numerous physicians and patient groups were swift to criticize, and in June the FDA rescinded its position, now emphasizing the need for informed consent of FMT including acknowledgement that it is an experimental practice. Use of FMT for any condition other than recurrent C. difficile continues to require FDA IND status.

In recent years there has been a significant increase in interest in FMT, in part due to increased prevalence and complexity of the disease driving the need for new treatment options. Clinical data continue to support the concept of FMT as a highly effective, extremely safe, low tech and logical treatment for a very difficult clinical problem. In my experience the enthusiasm and support for this procedure from patients is phenomenal, and they are extremely grateful to have a different solution than long term antibiotics and satisfied with successful outcomes. It is my hope that increased awareness of this elegant procedure, coupled with greater study of the human microbiome and the impact FMT has on individuals with C. difficile, will make this procedure more available and accessible to the patients who dearly need it.

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Dr. Longacre with her "awesome staff."

Anna Longacre, MD is a Board certified gastroenterologist. She is a partner with Atlanta Gatroenterology Associates and sees patients in their Marietta office.

What is new in the Surgical Management of Colon and Rectal Cancer.

Colorectal cancer remains the fourth most common non-cutaneous malignancy in the United States and the second most frequent cause of cancer-related deaths. According to the American Cancer Society, an estimated 142,820 new cases of colorectal cancer will be diagnosed in the United States in 2013, resulting in 50,830 estimated deaths. In Georgia 3,970 new cases are estimated to be diagnosed.

Survival in colorectal cancer is highly dependent on stage at diagnosis. Effective colorectal cancer screening programs allow for early detection as early stage colorectal cancers are seldom symptomatic.

Surgical therapy remains the mainstay in the treatment for non-metastatic colorectal cancer. A segmental resection, with high ligation of the vascular pedicle to ensure an adequate lymph node sampling, followed by a primary colonic anastomosis - either stapled or hand-sewn - is the standard surgical treatment in colon cancer. Often, chemotherapy is used in the adjuvant treatment for Stage 3 colon cancer.

Laparoscopic surgery is considered as effective as open surgery, often resulting in a smaller incision and faster recovery. In the United States only ten to thirty percent of all colorectal cancer surgery is currently performed using laparoscopic techniques. Barriers to adoption of laparoscopic surgery in colorectal cancer include education and training, a steep learning curve, personal experience, access to trained assistants, and length of surgery.

The introduction of robotic-assisted laparoscopic surgery includes all the advantages of minimally invasive surgery plus the benefits of three-dimensional high definition vision and visual magnification, up to fifteen times greater than normal vision, which is more than what is seen with standard laparoscopy and much more than the naked eye. Other advantages include better ergonomics - where the surgeon is seated comfortably at a console with hands positioned in a natural forward position, endowrist technology with the ability of robotic instrument tips that rotate and angulate in multiple different directions, and motion scaling, which allows to eliminate hand tremor entirely and target tissues with much greater ease. The combination of these various elements gives the surgeon a sense of total control over the operation and can translate into clinical advantages and better outcomes. Early outcome data suggests that robotic-assisted colectomy is safe, feasible and gaining wide acceptance as an alternative platform for minimally invasive surgery.

The management of rectal cancer is truly based on a multidisciplinary approach. Given the fact that neoadjuvant chemo-radiotherapy - that is, the use of chemotherapy and radiation therapy prior to surgery - has become the standard of care for patients with locally advanced rectal cancers (T3-T4 and or positive lymph nodes), preoperative staging is of paramount importance. Preoperative chemo radiation is associated with reduced local recurrence and increased treatment compliance when compared to post-operative chemo radiation. This approach may also improve sphincter preservation rates.

Multislice CT scan is the radiological investigation of choice in the evaluation of distant disease, with MRI reserved for detailed evaluation of non-diagnostic liver lesions. Transrectal ultrasound or MRI with phased array coils using higher performance gradient and higher field strength systems are used for local staging of rectal cancer.

The principle objective of surgical treatment is to obtain clear surgical margins, including a one- or two-centimeter distal rectal margin and a negative circumferential resection margin. Surgical principles include appropriate lymphadenectomy with proximal lymphovascular ligation at the origin of the superior rectal artery, total mesorectal excision (TME) for distal rectal cancers by sharp dissection between the fascia propia of the rectum and the presacral fascia and en block resection of adherent tumors. Studies suggest that high volume surgeons with specialty in colon and rectal surgery will yield improved outcomes for patients with rectal cancer.

I *am* CCMS

with James M. Tallman, MD
member since '79

GRADUATE OF: Medical College of Georgia, 1972
SPECIALTY: Diagnostic Radiology
PRACTICE: Quantum Radiology Northwest

photography by: Tim Song

Q What made you decide to practice medicine?

My maternal grandfather, Arthur Hunger, M.D. was a country doctor in Point Marion, Pennsylvania (southwestern Pennsylvania; 3 miles north of the WVa. border). He was my role model. He practiced from 1916 to 1964. He attended over 3000 births.
I was also a part time nursing aid/orderly for four years at the old University Hospital in Augusta, Ga. This job was instrumental in my decision to become a physician.

Q What do you think it takes to become successful in your field?

1. Post-graduate CME-reading, internet, and live meetings.
2. Group members are smarter than yourself.
3. Never assume.
4. Ask a lot of questions with patients and referring physicians.
5. Try to get in early and plan on staying late.

Q What does CCMS stand for and what does it provide for your community?

CCMS was founded to facilitate communication between physicians practicing in Cobb county, and enhance medical care.

Q What drew you to practice in this area?

Dr. Bill Mathis, a past president of CCMS. Dr. Mathis, Harvard trained, was the first full time radiologist in Cobb County. He grew up "across the river'" in North Augusta; I grew up in Augusta. Also Dr. Jim Cole, a college friend, and my future dentist, was in practice in Marietta. Two college friends (who died as young men - David Hagood, MHS 1965 and Dr. Steve Wing, MHS 1966) also influenced me.

Q What does this issue's theme: "Gut Check," mean to you?

Function/dysfunction of the alimentary tract (all 30+ feet of it).

Q What do you always carry in your lab coat or pockets while making your rounds/working?

Besides my wallet and keys - notebook, weekly schedule phone, ballpoint pen, ruler and professional cards.

Q While not practicing medicine, how do you like to spend your free time?

I enjoy reading history books, watching movies while on elliptical exercise machines and travel.

How to Reduce Belly FAT.

By: Lani Hammond Morris

I want to start by saying that belly fat is a mystery to many. Some people have heard it is all about hormones and others believe it is all about calories. So which is it? Well it's both, actually. First, we will begin by talking about the science behind belly fat; and along the way you will get 10 tips and strategies to reduce the gut and help your body burn fat more efficiently.

Here is the science on how to reduce fat in the "gut."

First, you need to understand that there are really two types of belly fat: visceral fat and subcutaneous belly fat. Visceral fat is underneath the abdominal musculature and in close proximity to the organs. You can't pinch it and those who have a lot of it can have abdominal muscles that feel tight and ridged despite the bulging protrusion. Subcutaneous belly fat is above the abdominal muscles and can be pinched (this is the stuff that hangs over the belt).

Visceral fat is more easily stored and more easily burned because being deeper in the body it has a greater blood supply and is more sensitive to fat burning catecholamine than is subcutaneous fat.

Belly fat is stored when the combination of excess calories meets the hormonal influence of cortisol and insulin. This is important to understand because those losing weight who take a purely caloric approach may find that the fat around their belly seems to burn off at a much slower rate, or lags behind all together. This is because belly fat is as much a hormonal phenomenon as it is a caloric one.

Let's talk about cortisol and insulin. The single biggest influence over the levels of insulin in your body comes from the amount of starchy and sweet foods you eat. The single biggest influence over cortisol has to do with stress levels which are probably most directly related to sleep quantity and quality.

10 tips and strategies to help reduce the gut and burn fat more efficiently:

1. Reduce the amount of sugars and starches that you intake on a daily basis.
FACT: carbohydrates and sugar are the body's first energy source. Therefore, we will use these calories first.

2. Reduce your stress, which in turn will help reduce your cortisol levels.
What people don't realize is that cortisol is a "schizophrenic" hormone when it comes to fat loss. It increases fat storage due to the actions it has on the major fat storing enzyme called lipoprotein lipase. But, ironically, it also speeds fat burning by stimulating the major fat releasing enzyme hormone-sensitive lipase. Notice the name of this enzyme is not "calorie sensitive lipase"? That should tell you something about the nature of fat loss. So, cortisol can be your best friend or worst enemy. By itself it does not have much of an impact on belly fat. Unless it's hanging out with its' friend: insulin.
Insulin activity shuts down any fat releasing activity of other hormones like cortisol and therefore accentuates the negative fat storing effects. Adding cortisol to insulin is sort of like pouring gasoline on a fire. The two together with excess calories are the real culprits in fat gain around the middle.
Belly Fat Formula—(SS + Ft X St = belly fat)—SS (starch and sugar)—Ft (fat)

3. Do not combine starches and sugars with fats. Starch and sugar combined with fat represent the WORST combination for fat gain.

4. Remember: P + V= Eat more protein and vegetables, both of which add a high-powered hunger-suppressing punch with little insulin production. This means less calories and better hormone balance.

5. Sleep magnifies the effect by lowering cortisol levels and increasing human growth hormone (HGH), a fat burning and muscle burning hormone.

6. Stick to Intense Exercise - exercise that favors weight training and interval training (more HGH and testosterone = more belly fat burning).

7. Long duration cardio burns more fat calories.

8. Replace sugar and starch with fiber and lean proteins. TIP: the foods with the highest ratio of fiber relative to starch are vegetables.

P + V= Eat more protein and vegetables

SS + Ft X St = belly fat (SS—Ft)

9 Walk 30 to 60 minutes, most days of the week. Walking is not exercise - it's a necessity... and it lowers cortisol.

10 Add metabolic training to your workout regiment - The short definition of metabolic training is completing structural and compound exercises with little rest in between exercises in an effort to maximize calorie burn and increase metabolic rate during and after the workout. FACT: your metabolism (aka metabolic rate) is how many calories your body burns at rest.

Lani Hammond Morris is a Clinical Exercise Specialist. She is a graduate of the American College of Sports Medicine. Hammond Morris has been an ACE Personal Trainer and a Clinical Weight Loss Director for over a decade. She now works with Wellstar Health Systems as Corporate Account Director and Metobolic

Irritable Bowel Syndrome (IBS)

Psychiatric Aspects

By: William T. McLarty, Jr.
member since '77

"I am coming to see you for depression and anxiety, but I have IBS, and it is affecting every area of my life: dating, work, traveling, simple errands. I have to be near a bathroom..." A young, healthy, intelligent lady recently entered my office with the above complaint. Her case may be on the intense side but may represent others who have IBS. Certainly, most patients with IBS have less significant life interference, but may still suffer much discomfort. The patient was functioning but with a great deal of distress. She is now improving with psychotherapy and continues to see and comply with her primary care physician and gastroenterologist.

The focus of this article will be on the psychiatric aspects of IBS, but a brief description of IBS is presented. Irritable bowel syndrome (IBS) is a functional gastrointestinal (GI) disorder with no clear biochemical or structural abnormalities. Predominant symptoms, in brief, include constipation (IBS-C), diarrhea (IBS-D), mixed symptoms (IBS-M) or less specific affects (IBS-U) - but IBS also commonly occurs with pain and cramping or discomfort. It is estimated that 3 to 20 percent of the population is affected and about 25 to 50 percent seek help. The diagnosis is based on essentially ruling out other GI disorders and on history, examination, negative laboratory findings and other diagnostic procedures. There is no specific genetic inference, but some articles have implied a tendency to respond with GI symptoms to environmental situations in some families. In a review of statistics for the United States the estimated prevalence for all GI diseases is 60-70 million with IBS comprising 15-3 million of these cases. So, although considered a syndrome and not classified as a disease, IBS seems among the more frequent disorders.

The causes of IBS are felt to be a combination of physical and mental health issues and are sometimes mentioned as the 'Brain-Gut' axis, with bidirectional communication or neural connections as an area of focus. GI motility is another area of focus with either slowing or hyperactivity. Other potential or contributing etiologies include mental health issues, bacterial gastroenteritis, small intestinal bacterial overgrowth, body chemicals (altered levels of neurotransmitters, especially hormones), potential genetics ('asymptomatic') and food sensitivity.

Treatment tends to focus on changes in living, or diet and nutrition, as well as medications, probiotics, and mental health issues. Medications in general include mental health agents or psychotropic agents, fiber supplements, laxatives, antidiarrheal agents, antispasmodics and lubiprostone, to mention some.

The psychiatric area of focus concerning treatment of IBS includes psychotherapies, e.g. cognitive behavioral therapy (broad area and most often mentioned and focusing on learning new ways of thinking and new behaviors), traditional psychotherapy, relaxation therapy, biofeedback, stress management, hypnotherapy, mindfulness training, yoga meditation, group therapy and others. Included in these approaches would be therapeutic relationship issues (exploring beliefs, concerns, fears, expectation, empathy, clarification, education, reassurance, and adaptation to illness).

Problems that have been seen include major depression, generalized anxiety disorder, panic disorder and a history of abuse. Some colleagues have mentioned obsessive-compulsive features, but these features are seen as falling under the anxiety-cluster umbrella. Some have suggested IBS could be seen as a "career (person) disease" in the sense that some patients may be compulsive, over conscientious, dependent and more susceptible to guilt and worry with a high need for social approval. This depiction is probably too simplistic but does communicate some features in a general sense. Historically, and before the biochemical era, psychoanalytic discussion focused on unconscious conflicts expressed somatically with GI symptoms. Psychoanalytic concepts, expressions or terms in the past may have included "frustrated oral-receptive demanding attitude, reaction formation, 'hungry for love', interjected fear, emergency discharge or retention, frustrated authority acceptance" and more. This discussion could be extensive and still holds merit, but, if held today, would need to mesh with biochemical theory on the same spectrum or approach a more united understanding.

Anxiety is considered to be the most frequent symptom (60%) followed by depression (20%). Stress and anxiety are also commonly associated, and IBS could be triggered by the immune system, which is affected by stress. Before mentioning medications, certainly regular exercise, adequate sleep patterns and "good" diet can and do reduce tension and stress, as well.

The medication, or psychopharmacology, tends to focus on reducing anxiety and depression - the areas of highest comorbidity in IBS. Essentially the leaning is towards more "target symptoms." The tricyclic antidepressants (TCA's) may help with pain, diarrhea and nausea as well as anxiety and depression. The selective serotonin reuptake inhibitors (SSRI's) may be more helpful with the constipation and bloating. The anxiolytic agents may be helpful in short term use, e.g. benzodiazepines, being mindful of risks for sedation, cognitive slowing and addiction or abuse potential. The serotonin-norepinephrine reuptake inhibitors (SNRI's) may be helpful for depression and anxiety and some have suggested a mild analgesic effect. All of the agents may help with the excessive cytokine release in stress reduction. The use of a typical antipsychotic agent has only been suggested if a comorbid indicated psychiatric disorder coexists.

Some future medications that have been mentioned and some in clinical study include opioidergic agents, gabapentin or related agents, kappa-opioid receptor agonists and others. Response rates reported variance (about 40 percent in some articles to some greater than 90 percent) depending on multiple factors, e.g. agent, method, modality, different settings, etc. But overall it is likely that more than 70 percent experience a positive response. Therefore, treatment certainly holds much merit and should be considered, since many will find relief. In summary, psychotropic agents and various psychotherapy modalities may be helpful in some selective cases of IBS, specifically when psychiatric symptoms are present. Hopefully this brief article will generate increased helpful attention to these cases.

I wish to express gratitude to those colleagues (psychiatrists, primary care physicians, family physicians and gastroenterologists) who offered feedback and thoughts regarding IBS.

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The Art of Mediation

Let the negotiations begin!

By: Tim Bone, President
MedMal Direct Insurance Company

Having been ordered by the court to attend mediation in your pending medical malpractice lawsuit, you've left your busy practice and entered into a foreign world filled with lawyers, mediators, risk managers and claims managers, otherwise known as the land of suits – with briefcases.

You know you did nothing wrong in treating this patient, yet you also have to acknowledge the reality: you didn't document the record as completely as possible. And the defense experts, though supportive of your care, have also admitted they would've ordered the additional test; which "more likely than not," would've resulted in an earlier diagnosis and possibly a better patient outcome.

The mediation begins. You sit with arms firmly crossed next to your attorney, while glaring at the plaintiff's attorney, and listen as each lawyer summarizes their client's case. You resist correcting their presentation of the medical facts and envision your day in court. Yet, as this lengthy discussion unfolds, you realize that rather than have a jury of six people – whose only clinical qualifications are that they possess a valid driver's license – decide your fate, you conclude in your own mind that this matter needs to be resolved. The allegations of negligence supported by the plaintiff's "expert" – an assistant professor from an academic institution on the other side of the continent – will get this case to a jury. And when you then consider your own time, stress, and financial exposure, you conclude it is best to compromise today.

Now is the time to make sure your defense team understands the medicine involved to counter the often absurd clinical allegations of the plaintiff's attorney.

Take a deep breath, exhale slowly, and survive. Let the negotiations begin!

Once the attorneys have completed their presentation, the mediator will keep the largest group of people – usually all defendants and their representatives – in the main conference room while the plaintiff's attorney and plaintiff disappear to a smaller conference area. When there's criticism among defendants they will also separate, but this isn't usually the case as open, public criticism of one defendant against another only inures to the advantage of one party: the plaintiff.

During the next half hour you'll discuss all possible ramifications of this mediation with your attorney in one room, while the mediator meets with the plaintiff and plaintiff's attorney in another space. This is where the mediator begins to display incredible skills of diplomacy by cajoling and badgering each side to expose their weaknesses, in an attempt to drive them to the center of the argument.

The plaintiff attorney's initial outrageous demand will then be brought to your defense team by the mediator, along with insightful comments concerning the mediator's take on the case. You'll be tempted to simply walk out of the mediation at this point, but the mediator will encourage you to "engage" - and you should.

Over the next few hours each party will parry and thrust with demands and offers, with each one attempting to drive the other toward their goal. Said plaintiff's attorney will want to receive as much money as possible for the plaintiff; your defense attorney will want to pay out as little as possible on your behalf.

Interwoven with a continuing discussion of the facts and the expert testimony, various methods of negotiation will be used, depending on what actually works with this particular group of people. Some behave like used car salesmen and simply jockey back and forth. Others give a hard and fast number and say: "That's it!" Some even use "brackets." For example, plaintiff's attorney may say something like, "I'll agree to decrease my demand to $250,000 if you agree to increase your offer to $150,000." In so doing, he's clearly signaling that he wants to settle the case for $200,000. So, the defense then offers another bracket, with a midpoint that's lower than $200,000. An infinite number of possibilities exist on how to best negotiate resolution of a medical malpractice claim; what's used on a given day is that which is best suited to the facts of the case and the people involved.

At the end of the process, the mediator will finally announce that all parties reluctantly agree to a final settlement number. The mediator then prepares a document formalizing this agreement, which will contain a clause stating you haven't admitted to any negligence.

The mediation has concluded. There's no fanfare, no shaking of hands between plaintiff and defendant. By the time you thank the mediator and move toward the lobby, the plaintiff and plaintiff's attorney will have already departed.

In the parking lot, you thank your attorney and your claims manager for applying their skills on your behalf today. And with your mind absolutely numb, you walk to your car. It's over. You survived. It's now time to remember to take that big breath of fresh air, exhale slowly and then drive carefully to spend the evening with your family and friends. Relax. Chill. You deserve it. And when you return the next day to the practice of the most honorable profession in the world, remember the words of Sir William Osler: "The best preparation for tomorrow is to do today's work superbly well."

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November 25rd
Holiday Social - Gardens of Kennesaw Mountain

December 6th
CCMS Board of Trustees Dinner -
at the Home of Dr. and Mrs. Mark Huffman

January 22nd, 2014
General Membership Meeting - Georgian Club

Our Officers & Our Mission

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