Connecting More than Flesh and Bone

State’s First Primary Care Sports Medicine Fellowship Promotes Athletics & Community
As a health care provider, you understand that no two patients are alike. That’s why the Centers for Disease Control and Prevention recommends specific flu vaccines based on a patient’s age and health status.

Everyone over the age of six months needs an annual flu vaccination, especially those who have a higher risk of medical complications due to influenza — including people under the age of 5 or over the age of 50, pregnant women, and people who have certain medical conditions like asthma, diabetes or chronic lung disease. By ensuring that your patients get the right type of vaccine, you can help all Arkansans stay healthy and well this winter. And remember, it’s vital that health care workers are also vaccinated.

**Influenza Vaccines Approved for Use in the U.S. for the 2015-16 Influenza Season**

<table>
<thead>
<tr>
<th>NAME</th>
<th>MANUFACTURER</th>
<th>AGES</th>
<th>TRIVALENT / QUADRIVALENT</th>
</tr>
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<tr>
<td>Afluria: Inactivated</td>
<td>bio/CSL</td>
<td>&gt; 9 years*</td>
<td>Trivalent: 0.5 mL single-dose • Prefilled syringe or multi-dose vial</td>
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<tr>
<td>FluLrix: Inactivated</td>
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<td>≥ 3 years</td>
<td>Trivalent and Quadrivalent: 0.5 mL single-dose • Prefilled syringe</td>
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<td>influenza vaccine</td>
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<tr>
<td>FluBlok: Recombinant</td>
<td>Protein Sciences</td>
<td>≥ 18 years</td>
<td>Trivalent: 0.5 mL single-dose • Single-dose vial</td>
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<td>influenza vaccine</td>
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<tr>
<td>FluSoCov: Inactivated</td>
<td>Novartis and</td>
<td>≥ 18 years</td>
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<td>Diagnostics</td>
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<td>FluLaval: Inactivated</td>
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<td>Quadrivalent: 0.2 mL single-dose • Prefilled intranasal spray</td>
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<td>≥ 6–35 months**</td>
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* Afluria is licensed for ages 5 and older, but ACIP recommends that it not be used in children 5 through 8 years because of increased reports of febrile reactions in this age group. If no other age-appropriate, inactivated influenza vaccine is available for a child 5 through 8 who has a medical condition that increases the risk for influenza complications, Afluria can be used. However, providers should first discuss the benefits and risks of vaccination with Afluria with the child’s parent or caregiver. Afluria may be used in persons 9 years of age and older. **For infants and toddlers 6 months through 35 months of age a second dose may be required 1 month later.
Different needs for influenza vaccination are different for different patients in the U.S. for the 2015-16 Influenza Season.

Influenza Vaccines Approved for Use

- **FluMist**: Inactivated influenza vaccine
- **Fluvirin**: Inactivated influenza vaccine
- **Fluzone High-Dose**: Inactivated influenza vaccine
- **Flucelvax**: Inactivated influenza vaccine
- **Flublok**: Inactivated influenza vaccine
- **Afluria**: Inactivated influenza vaccine
- **Novavax**: Inactivated influenza vaccine
- **Protein Sciences**: Inactivated influenza vaccine
- **MedImmune**: Live attenuated influenza vaccine
- **Fluceril**: Recombinant influenza vaccine

**Names, Manufacturers, Ages, and Numbers**

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<thead>
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<th>Name</th>
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<td>Trivalent</td>
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<td>≥ 6 months through 35 months</td>
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Special Article

**Dupuytren’s Disease**

John M. Stephenson, MD; Mark Tait, MD; John Bracey, MD; Theresa Wyrick, MD

**Fibrovascular Polyp: An Unusual Mass in the Esophagus Causing Dysphagia**

Jagpal Klair, MD; Mohit Girotra, MD; Neelima Velchala; Aneet Kaur1; Farshad Aduli

**Introduction to the Arkansas Center for Respiratory Technology Dependent Children**

Denise Willis, RRT, NPS and John Carroll, M.D.

Join us to stay updated on health care news in Arkansas.
As another year comes close to an end, the Arkansas Medical Society is focused on renewing and building the AMS membership base. We want to thank the vast majority of members who always renew with no questions asked. With their unwavering support, the AMS staff can continue to spend each day as your advocates for quality healthcare – not just for Arkansas physicians but also for the patients you care for.

During a recent gathering of AMS physician members, we asked some of them to articulate why they have chosen to be members and what they find most valuable. No matter if their practice setting was urban or rural, or if they own their own practice or are hospital employed, every doctor interviewed described intrinsic benefits found from their AMS membership. Comments included advocacy before state and national lawmakers, up-to-date news about proposed healthcare policy changes, continuing education, support with practice management and insurance negotiations, and the advantages found networking with colleagues. For every member the value has a different meaning. But ALL members mentioned one benefit they all found in common - preparing physicians to meet the needs of a continuously evolving system.

How can you help? If you have colleagues that are not members of AMS, sometimes the best invitation is a personal one from another physician. Share with them the benefits you find from your own association with the Society and why advocacy in government is more critical today than ever. We need their membership resources, we need their voice with lawmakers, and we need them to see the important role they play in the political process. Working together we can design and influence a better system that delivers high-quality health care with better patient outcomes.

Again, thank you for choosing to become and remain a member of the Arkansas Medical Society. You can trace back every single victory, major accomplishment, successful legislative sessions, etc., to those of you who know and understand that through the AMS, physicians have a STRONG VOICE in Arkansas. AMS
Switching Gears and the Golden Rule

It’s been over 40 years since I decided I wanted to be a physician. I was not a kid that grew up wanting to be a doctor. My father was the first in our family to go to college and went from a small high school to the University of Arkansas and became an engineer. I think he assumed I would want to do that. I had initially accepted an appointment to one of the service academies but changed my mind. Needless to say my father was not happy about this. Largely on the recommendations of my high school football coach, and my family doctor, I decided I would start out in pre-med, and ended up at the University of Arkansas by default. Dr. Joe Martinlade, told me that I needed to work at the hospital to “see if I liked being around sick people.” I worked the first of four summers as an orderly at the community hospital in my hometown, and I was hooked. I knew in my heart that I wanted to be a doctor and that I wanted to help others. Like all physicians I took the Hippocratic Oath upon graduation, but it has taken me years to fully understand the concept of “primum non nocere,” or first do no harm.

I waited until the new CEO was selected, and discussed the job with him. Despite he being an Aggie and I a Razorback, I thought we would make a good team. However, for the first time in my life I would have a “boss” to report to. (Now, what you have to understand is most surgeons feel that they only report to the good Lord himself, and sometimes that’s for a second opinion).

I think that three separate events helped formulate my present course.

In February of 2013, I was fortunate to get to go to the National Health Education Network meeting in Indianapolis, Ind. I was just beginning to navigate the maze of core measures, VBR, CAUTIS, CLABIS, HAC’s, RACS, MAC’s, and PSI 90’s. It was there that I learned that we had to acknowledge that in medicine and in the hospital that we “hurt” a lot of folks with medical errors. Within my practice of surgery, somehow I had insulated myself to my own world where, yes, there was risk and the occasional complication or death but most were not unexpected. It was my first introduction to the book To Err is Human and to the concept that every day, a jumbo jet load of patients die due to medical errors. I think it was at that time, that I first grasped just how important quality and safety efforts are. Despite many improvements, our culture and processes must continue to focus on optimal patient care and safety. After all, one is more likely to be the recipient of a medical error than to have a bag lost when traveling by air. We can and must do better.

The other defining moments were actually two-fold and involved an advanced formation session in St. Louis as well as my pilgrimage to Dublin, the home of the Sisters of Mercy. While in the chapel at St. Louis, at the headquarters of the Sisters, I felt the power and majesty of the stained glass as they pertained to the corporal and spiritual works of Mercy. I thought of how wonderful this could be if combined with the healing arts and skills of our physicians.

This experience was further crystallized with the trip to Dublin. It was there that I saw homeless people in the street on the way to the House of Mercy, simultaneously trying to imagine what it must have been like in Catherine McAuley’s time trying to deal with rampant poverty and illness. (Note: Catherine McAuley was the founder of the Sisters of Mercy)

Perhaps the most poignant thing I heard was Sister Jeanette’s comment that she made while we were in the Chapel at the Mercy Centre. It was her telling of the story of the poor young woman, taken initially to another convent in Dublin, where the driver was told that “they didn’t take on that kind of patient.” The story goes that he was told “take her to Catie McAuley’s, she’ll take anyone.” To me this is what we really are about; providing the best possible care to all who need assistance.

Cole, you were spot on about the opportunity to expand one’s influence on patient care and outcomes, without actually doing surgery one’s self. I thank you and the others who convinced me to take that leap of faith.

Let us remember what Jesus said in Matthew 25: 40

“Truly I tell you, whatever you did for the least of these brothers and sisters of mine
You did for me”

Ladies and gentlemen, let’s make sure that we physicians take ownership of quality and that we continue to do the right thing for our patients and each other.

David.hunton@mercy.net
Dear Editor:

Rapid change occurs daily in our health care system. It is important that Arkansas physicians remain at the forefront of health care delivery. An important part of health care delivery is the assurance that it is safe, of the highest quality and delivered in the most cost-efficient way. While we can rely on well-trained professionals to make sure we meet those standards, much of the responsibility for review ultimately lies in the hands of doctors.

AFMC was established in 1972 as a Professional Standards Review Organization to monitor the appropriateness, quality and outcome of services provided to Medicare, Medicaid, and Maternal and Child Health beneficiaries. AFMC has evolved from a peer review organization to a quality improvement organization. We know physicians are a vital resource and our most valued customers. Your membership in AFMC is important to the overall well-being of the organization as well as to Arkansas’ health care.

AFMC serves many diverse roles as we work to improve the state’s health care. One role is performing reviews for Medicaid and private insurance companies in these areas:

- Child health management services
- Emergency room utilization
- Extension of benefits
- Hyperalimentation
- Prosthetics and durable medical equipment
- Inpatient utilization management
- Solid organ and bone marrow transplant
- Medical necessity for surgical procedures and use of assistant surgeons
- Inpatient continued stay

Initial reviews are done by non-physician reviewers using approved screening criteria. Those that do not meet the criteria are referred to one of our physicians for review.

Physician reviewers are crucial to our work. We are always in need of more physician reviewers who have a medical degree (MD or DO), clinical experience in their specialty, a current medical license to practice medicine in Arkansas, and are a member of AFMC. Physician reviewers can work from home, on their own schedule and work only as much as their time allows. The physician’s time is valued and compensated accordingly.

We especially need physician reviewers in these areas: OB/GYN, orthopedics, psychiatry, general surgery, internal medicine, pediatrics, rehabilitation medicine, neurology and endocrinology. For more information about AFMC and the review process, visit our website, www.afmc.org. Contact me at crodgers@afmc.org if you are interested.

Sincerely yours,

Chad T. Rodgers, MD, FAAP

Vice President and Corporate Medical Director, AFMC
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Connecting More than Flesh and Bone
State’s First Primary Care Sports Medicine Fellowship Promotes Athletics & Community

There are more than 100 sports medicine fellowship programs throughout the United States. Last July, UAMS began operation of the first such program here in Arkansas – this one geared toward primary care physicians. A primary care sports medicine fellowship enables a physician already board certified in family medicine, pediatrics, internal medicine, or emergency medicine to obtain a certificate of added qualification in sports medicine.

Offered from UAMS Northwest Regional Center in Fayetteville and made possible with cooperation from the University of Arkansas Athletics and in partnership with Advanced Orthopaedic Specialists, the program is accredited by the Accreditation Council for Graduate Medical Education.

With its first fellow already in training, the fellowship provides specialized training in the treatment, management, and prevention of sports-related illness and injuries including concussions and other head injuries, chronic or infectious conditions (mononucleosis, asthma), nutrition, pre-participation and return-to-play decisions, training and conditioning safety, and more.

Kyle Arthur, MD, began the program after first completing his residency in family medicine. In addition to intense academic training, he sees and helps treat clinic patients in an office-based practice under the supervision of Robert Gullett, MD, an orthopaedic surgeon who was instrumental in developing the new program.

A Back Story of Community

Since 2006, Dr. Gullett has served as the assistant vice chancellor and director of the Northwest Regional Center. Prior to working with UAMS, Dr. Gullett practiced for 30 years in Pine Bluff; for 20 of those years, he served as team doctor for the local high school football team, the Pine Bluff Zebras.

As you might imagine, working those many years with a championship football team stirred in the doctor a passion for enhanced sports medicine training. “Being on the sidelines helped me to establish a relationship with so many people who watched the care I gave,” recalled Dr. Gullett, of treating and encouraging talented athletes such as Pro Football Hall of Famer Willie Roaf. Incidentally, after Dr. Gullett successfully treated Roaf’s knee injury, the offensive lineman went on to play for the New Orleans Saints and the Kansas City Chiefs. In 2013, when Roaf became a Hall of Fame inductee, he invited his friend and former team doc to the ceremony.

“Sports medicine is a relatively new subspecialty,” explained Dr. Gullett, “it’s a great way to give more knowledge to family physicians who already play a role in or who would like to play a role in their community’s teams.

“Being team doctor was a rewarding and wonderful experience for me and for the athletes. It connected me strongly to the community and allowed me to help many young athletes. I would love to see the same experience happening to physicians in communities around the state.

Putting an Idea in Play

Putting the new fellowship in place took some time – about nine years, according to Dr. Gullett, who worked with others at UAMS to get it done. “It has been worth the wait to do it right,” he explained. “We had to have important academic pieces in place.”

A major piece to the puzzle was finding the right physician to direct the program. For help with that, Dr. Gullett credited orthopaedic surgeon Chris Arnold, MD, who is part of the sports medicine team at Advanced Orthopaedic Specialists. The clinic provides care to the Arkansas Razorbacks and includes Dr. Arnold; fellow surgeons Terry Sites, MD, and Mark Powell, MD; and family physician Ramon Ylanan, MD.

“Chris provided the missing piece in Dr. Ylanan’s role. “As a sports medicine primary care doctor specializing in non-operative care musculoskeletal injuries, Dr. Ylanan has been a huge asset to our clinic. Through his part in training other fellows in this field, he will be an asset to the state as well.”

The fellowship director, Dr. Ylanan came to Arkansas after running a similar program at the University of South Carolina School of Medicine. Before he was recruited by Dr. Arnold, Dr. Ylanan was the assistant professor in family and preventative medicine and associate director of the USCSM Primary Care Sports Medicine Fellowship.

A sports medicine fellow himself (American Sports Medicine Institute, Birmingham), Dr. Ylanan has long held an interest in preventative care related to sports and fitness. “Sports have always been a large part of my life,” he said. “Growing up, I played baseball, volleyball, soccer and golf. My kids are active as well – my son in soccer, baseball, football, and basketball; and my daughter in gymnastics and dance. My priority is getting active...
people – from the recreational to the collegiate and from the weekend warrior to the elite athlete – back to their sport as soon as it is safe to do so.

Giving an example, Dr. Ylanan described being able to help an athlete who was experiencing chest pain and palpitations when engaged in his sport. When an EKG showed paroxysmal supraventricular tachycardia, Dr. Ylanan considered everything involved. “Based on timing of the season, we performed a stress test, which the athlete passed,” he recalled. “[The athlete] played that next weekend, subsequently had a cardiac ablation procedure for PSVT, and was back playing the following weekend. The athlete has since continued to play at a high level without return of symptoms, and based on the team effort of the sports medicine staff, the athlete safely returned to play without missing a single game once the diagnosis was made.”

In Progress

Dr. Gullett has watched Dr. Arthur flourishing under the program. “Dr. Arthur’s knowledge and professionalism have increased,” said Dr. Gullett. “That’s no easy task. The program includes hands-on work with patients as well as rigorous academic study.” The program will end with an examination that the fellow must pass in order to receive his certificate of qualification in this area.

Since starting, Dr. Arthur has worked with orthopaedic staff, trainers, athletic staff, therapists, coaches, and others in a hands-on setting. “The appeal [for me] is the quality of the faculty and their combined expertise as well as the understanding that I would have input into my experience here,” he said. “This fellowship is an excellent expansion of my primary care training. I utilize my education from UAMS and family medicine residency on a regular basis as well as daily expanding my knowledge into musculoskeletal pathology and treatment. Working with the University athletic department is invaluable and unique. Living in a great community such as Fayetteville is just icing on the cake.”

Upon finishing, Dr. Arthur’s plans are not set. He hopes to “continue to be a part of the medical community in Northwest Arkansas – ideally, this would involve finding a way to be a part of the fellowship moving forward.”

The fellow was chosen locally this first year, but moving forward, fellows will be chosen through a national study from applicants located nationwide. “Fellows that come here have the unique opportunity of being a part of the program in its early stages,” said Dr. Gullett, noting that with the program still in its first year, those running it will be looking for ways to make it better.

Spreading the News

Dr. Gullett and the team at UAMS Northwest want to share news of the fellowship with physicians around the state. Retired orthopaedic surgeon and former AMS board member Frank Griffin, MD, learned only recently about the program. Having spent 20 years himself treating athletes on sidelines at all levels, he praised the idea. “Orthopaedic surgeons cannot man every sideline or be at every game,” said Dr. Griffin. “Indeed, there are many more primary care physicians in our gyms and on our sidelines than orthopedists. Improving education among primary care providers as early physician responders to athletic injuries is an important service that I hope continues to expand in our state.”

Reiterating his praise, Dr. Griffin expressed excitement to see what will come out of the new program. “Sports medicine is vitally important to all of the young Arkansans who are out there on the fields, courts and tracks throughout our state on a weekly basis competing for their high schools and colleges,” he said. “Increasing primary care sports medicine training through fellowships like the one at UAMS Northwest is a vital step in providing quicker access to competent care for injured athletes.

For more information, contact Robert Gullett, MD, at rgullett@uams.edu or 479-713-8123 or call Advanced Orthopaedic Specialists at 479-966-4187. AMS
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To begin your search for a new lot, or home in Central Arkansas go to chenal.com, or redoakridge.com and see how life happens here.
This disorder is a commonly encountered in many types of medical practice. It is characterized as a benign, inherited, fibroproliferative disease involving the palmar fascia. It can manifest as discrete nodules or cords, often leading to progressive contractures of the joints of the hand. Although defined as a disease, there is no “cure.” The treatment is directed at local correction of the contractures. Although many treatments exist, recurrence is still quite common.

The goal of this article is to briefly describe the epidemiology and pathology of the disease. Treatments and their indications will also be addressed.

**HISTORY**

The disease claims its name from Baron Guillaume Dupuytren who became renowned for performing surgery for this contracture in Paris in the 1830’s. However, it was first described and treated by English surgeons Henry Cline and Astlee Cooper in the 1770s who Dupuytren visited prior to his interest in the subject.

**EPIDEMIOLOGY**

Dupuytren’s disease (DD) has been previously called “Viking’s Disease” due to the teaching that it is most common in people of Northern European descent. However, more recent data reflects that it is common through Southern Europe as well. The lowest incidence of DD has been found in those of Central African descent. African Americans have an incidence of one-fifth that of Caucasian Americans. It is much more common in men than women at a ratio of at least 2:1.

DD is strongly associated with a positive family history. It has been described as a dominant gene with a variable penetrance. One affected parent has been reported as having a 5-25% risk for each child. It has been hypothesized that DD is not one particular genetic pathway, but multiple pathways with a common clinical presentation. It has been found in association with epilepsy, alcoholism, diabetes, and HIV. There has been some association with local “triggers” such as surgery on the hand/wrist, manual labor, or hand-intensive sports. There is significant variability in families that have a history of DD.

DD is very closely associated with Ledehosen disease in the foot and Peyronie’s disease involving the genitals. It has a close relationship to adhesive capsulitis of the shoulder with these patients having an eight times higher risk of developing DD.

**PATHOLOGY**

The cords or nodules that form are normal palmar fascial structures that become abnormal. Molecular evaluation has shown an upregulation of TGF beta which results in increased collagen synthesis. There is also a noted decrease in matrix metalloproteinase activity and increased tissue inhibitor of matrix metalloproteinase activity. The predominant cell type involved is the myofibroblast.

**PATIENT EVALUATION**

Patients will present at various stages of the disease from isolated palmar nodules or skin dimpling to severe, disabling contractures. Dimpling of the skin in association with a palmar nodule is pathognomonic for DD (Figure 2). Patients can also present with “knuckle pads” on the dorsal aspect of the PIP joints. This is often associated with a more severe type known as Dupuytren’s diathesis. Dupuytren’s...
Disease is described as painless and progressive; however, neither of these is entirely true. The initial nodule formation can be associated with pain. These nodules are usually not treated but can be injected with a steroid if the pain is limiting. Many patients will not progress past these nodules to form cords or contractures. It has been estimated only 1/3 of those with nodules will progress.

For those that present with contractures, the “table top test” is a good clinical examination (Figure 3). The patient’s hand is placed flat on an examination table, and if the hand can be laid flat, then treatment is generally not necessary. The patients can be taught how to do this at home and monitor their progress.

Specific measurements that are an indication for treatment include an MP joint contracture greater than 30-40 degrees and/or any degree of PIP joint contracture. The ulnar digits of the hand tend to be more affected than the radial side. Radial sided involvement is usually in the form of a webspace contracture in the first webspace. Radial sided involvement is also an indication for treatment, and a more aggressive form of DD.

TREATMENT OPTIONS

Non-surgical modalities such as physical therapy, splinting, medications, or steroid injections have not been shown to have any benefit in correction of the disease or preventing its progression.

Many variations of surgical treatment have been described ranging from percutaneous needle release to wide-open radical palmar fascial excision with the wounds left open to heal by secondary intention.

Needle percutaneous fasciotomy can be an office procedure that involves anesthetizing the skin overlying the cord and repeatedly stabbing the cord with a hypodermic needle until the cord ruptures. The success rates in regards to contracture correction are good and recurrence rates low, but the treatment does place neurovascular structures at significant risk due to the close proximity in the palm. This procedure should only be done by a physician with experience in this technique.

A limited open fasciotomy can be done in the operating room, whereby the cord is cut or minimally resected. This has a similar good success and low recurrence rate when compared to the percutaneous procedure.

Open excision of abnormal fascial structures can be done to remove as much diseased tissue as possible. This can also be accompanied by skin grafting of other types of lengthening or advancement flap design procedures due to the risk of skin necrosis after the procedure. This open procedure is postulated to give a longer “disease-free interval” due to the fact that more tissue is resected (Figure 4).

A newer type of treatment has been extensively studied over the past decade that is an alternative to surgery and seems to be decreasing the number of open surgeries done. This treatment involves a collagenase (brand name Xiaflex) that is produced from clostridium histolyticum.

Collagenase injections can be done in the office and should only be attempted by someone who is familiar with the anatomy of the hand and trained in the use of the product. The medication is injected directly into the cord, and the patient is brought back to the office 24-72 hours later. The digit is then manipulated until the cord “pops” which represents a rupture of the fascial band. Care must be taken during the injection and subsequent manipulation so as to avoid tendon rupture. MRI studies after injection show disintegration of the cord both proximal and distal to the injection site indicating more than just a local rupture effect. Correction and recurrence rates have been similar to those reported for needle fasciotomy and limited open fasciotomy.

Unfortunately some contractures are so severe and longstanding that amputation might be the best choice for some patients.

No one treatment is superior to another. The best treatment is a collaborative discussion between the surgeon and the patient in regards to expectations, desires, recovery time, and risk profile. Surgeon experience, the location of the cord, and the cord characteristics certainly play a role in procedure selection.

Patients who have had treatment for Dupuytren’s are generally very happy with their increase in function and the cosmesis of their hands, but should be counseled that recurrence rates given enough time are 100%. Future treatments will certainly be directed at the molecular mechanisms so as to hopefully prevent the development of contractures and eliminate the need for surgery.
Dental School Could Fill a Cavity in Arkansas’ Health System

The state of oral health care in Arkansas is stagnant: we have more children with tooth decay than the national average and fewer practicing dentists than almost any other state. Drastic change is needed if the state is to escape this cycle that influences lives, educational opportunity and the state's economy.

A 2008 interim study report highlighted the need for more oral health care in Arkansas, particularly in school-aged children, elderly people and low-income populations. In a sample of 7,100 Arkansas third-graders, 61 percent had evidence of tooth decay. The Oral Health America National Grading Project in 2003 gave the state a grade of “F” for dental insurance status for elderly people and a “D” for access to providers for Medicaid beneficiaries. The state ranks 50th for the ratio of dentists to population.

The situation is not improving. A 2010 survey showed 64 percent of children 6- to 9-years-of-age had tooth decay; nationally the percentage was 54.4. Fifty-four percent of adults had at least one tooth extracted due to decay or gum disease compared to 44 percent nationally. Gum disease may also be related to damage elsewhere in the body, including an association between oral infections and diabetes, heart disease, stroke, and preterm, low-weight births.

The burden of poor oral health carries not only a medical cost for patients but also impacts society and our economy. Children who lack dental care miss more school days, use more expensive emergency room services for care and face worse job prospects. Adults with untreated oral health problems have reduced productivity and lost time at work. These problems are exacerbated in low-income and minority populations.

As Arkansas’ population nears 3 million, the average age is getting older — a time when health and dental problems typically increase. By 2030, 26 percent of Arkansas’ population will be over age 60.

There has been virtually no growth in the number of practicing dentists. There are 1,564 licensed dentists with 1,335 actively practicing in Arkansas. While this is a 13 percent increase (N=160) in the number of practicing dentists between 2008 and 2015, dentists' average age means many dentists are retiring or reducing their practice as they near retirement. In 2008, more than half of practicing dentists were age 50 or older (N=686); more than 20 percent (N=283) were age 60 or older. From 1998-2007, Arkansas only added 332 actively practicing dentists; more than twice that many were at or nearing retirement age. These trends are expected to remain consistent.

UAMS’ CENTER FOR DENTAL EDUCATION

The University of Arkansas for Medical Sciences (UAMS) established a Center for Dental Education within its College of Health Professions in 2012. The center includes an oral health clinic and a postgraduate residency program in general dentistry. The residency program increases the number of young dentists starting their careers in Arkansas — with the hope they will remain after residency completion.

The university already includes colleges of medicine, nursing, pharmacy, public health, allied health professions and a graduate school. UAMS has a well-established dental hygiene program that complements the Center for Dental Education.

In early 2014, the center began hosting groups of senior dental students from the University of Tennessee College of Dentistry for two-week rotations. By February 2016, the center expects to have...
hosted 115 students who work in the UAMS oral health clinic and the Arkansas Children’s Hospital (ACH) pediatric dental clinic. In addition to observing, they provide general dental care for patients under supervision of faculty dentists.

In July 2015, UAMS welcomed the first two dentists for a year-long postgraduate residency. Dental residents receive 12 months of advanced education from faculty dentists while providing dental care at UAMS, ACH, the student-led UAMS 12th Street Health and Wellness Center and the Harmony Health free clinic. The residency program will expand to six residents annually after the first year.

A residency helps new dentists transition from academics to real-world dentistry. Highlighting an interprofessional education at UAMS, dental residents attend orientation alongside medical residents, and complete two-week rotations in anesthesiology, emergency medicine, internal medicine and otolaryngology.

BUILD A DENTAL SCHOOL?

To build on UAMS’ successful oral health foundation at the Center for Dental Education, a consultant was hired to examine additional steps that UAMS could take to improve oral health, including the feasibility of establishing a dental school. Arkansas is the most populous state without a dental school.

The consultant will identify costs of start-up and operations, funding sources, and benefits and challenges of opening a school. Analysis will include how it would meet the needs of Arkansas’ dental community and potentially ease the debt incurred by Arkansas dental students going out-of-state. Recent examples of dental school startups place the cost at $50 to $60 million for new dental schools in Florida, Kansas, and South Carolina.

The state has long participated in an arrangement through the Southern Regional Educational Board and the Arkansas Health Education Grant Program that helps defray the cost of out-of-state tuition for students in programs not available here. In fiscal year 2015, the state provided $3.1 million in grants and loans through these programs for one year of dental training. This is a 13 percent increase from $2.7 million in 2011. Tuition and fees paid by Arkansas students, plus the state’s grant funds, totaled more than $8 million in 2011. These are public and private funds for dental education (not including living expenses) that leave Arkansas students. UAMS has historically kept a high number of physicians in the state after completing their residencies here. We feel confident that success could be replicated with graduates of residencies here. We feel confident that success could be replicated with graduates of residencies here.

Dr. Gardner is provost and chief academic officer, University of Arkansas for Medical Sciences (UAMS); Dr. Jines is director, Center for Dental Education at UAMS College of Health Professions and Dr. Rahn is UAMS Chancellor.

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STUDY CASE

FIBROVASCULAR POLYP: AN UNUSUAL MASS IN THE ESOPHAGUS CAUSING DYSPHAGIA

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KEYWORDS: esophagus, polyp, dysphagia, asphyxia, resection

ABSTRACT

We present a case of a 56-year-old Caucasian woman with long-standing gastroesophageal reflux disease complicated with non-dysplastic Barrett's esophagus and stricture presented with difficulty in swallowing. Her dysphagia was initially limited to solids but later to liquids as well, and was associated with 28 pounds weight loss in three months and occasional nausea. Esophagogastroduodenoscopy (EGD) was performed which showed a pedunculated fleshy ‘sausage-like’ endoluminal polypoid mass in the upper esophagus, which prolapsed into proximal esophagus potentially causing partial obstruction, characteristic of fibrovascular polyp (FVP) of the esophagus. Removal of these lesions is recommended because of the progressive symptoms and risk of complications (obstruction or asphyxiation from regurgitation of lesion into the pharynx or mouth), and options include surgery or endoscopic resection, based on lesion size and vessels that nourish it. Through this case we want to make gastroenterologists aware of this rather rare condition for prompt diagnosis and management.

CASE PRESENTATION

A 56 year-old Caucasian woman presented with chief complaint of difficulty in swallowing. Her dysphagia was initially limited to solids but later to liquids as well. Dysphagia was associated with occasional nausea and an unintentional weight loss of 28 pounds over a three month period. She has a past medical history significant for hypertension, long-standing gastroesophageal reflux disease that was complicated with non-dysplastic Barrett’s esophagus and stricture (requiring serial endoscopic dilatations in 2011 at an outside hospital). Her past surgical history includes gastric stapling in 1984 for obesity. Extensive work-up was performed during her last hospitalization. She had a barium study that showed no esophageal dysmotility, Bravo PH study with DeMeester score of 52 and 95 (average = 72). She also had an unremarkable gastric emptying study and CT scan with contrast of abdomen. She remained well for next two years and then started having difficulty in swallowing and was referred to us by her primary care physician. Her dysphagia was initially limited to solids but later to liquids as well, and was associated with 28 pounds weight loss in three months and occasional nausea. At time of presentation, she was surviving only on a jello diet. She

Figure 1a: Classic sausage-like endoluminal polypoid mobile mass in proximal esophagus.

Figure 1b: Histopathology of FVP - polypoid fibrovascular tissue with chronic inflammation lined by benign, reactive squamous epithelium.
denied any abdominal pain, diarrhea, melena or early satiety. She denied alcohol, tobacco or illicit drug use. Her home medications included omeprazole and alprazolam. Her vitals were stable and physical exam was unremarkable. She underwent an EGD that showed a pedunculated fleshy “sausage-like” endoluminal polypoid mass in upper esophagus, which prolapsed into the proximal esophagus potentially causing partial obstruction, characteristic of fibrovascular polyp (FVP) of esophagus. Surgical removal of this lesion was recommended because of the concern for potential obstruction. Endoscopic removal of FVP using snare was successfully performed and patient did well subsequently.

DISCUSSION

Benign esophageal tumors account for 20% of esophageal lesions and FVPs account for 1–2% of all esophageal tumors. The incidence of these tumors is highest in middle-aged and elderly men usually >50 years of age. Fibrovascular polyp usually arises from the cervical esophagus from one of these two areas of lower resistance in the pharyngeal musculature. One is between the superior and inferior cricopharyngeal muscle (Killian’s dehiscence), the other is between the inferior cricopharyngeus muscle and the proximal end of the esophagus (the Laimer’s triangle). Dysphagia, vomiting, weight loss, and respiratory symptoms are the most frequent symptoms, especially when it becomes large in size. However, the most feared symptom is obstruction or asphyxiation from regurgitation of lesion into the pharynx or mouth as it has the potential to cause sudden death. Thus FVP is a benign, but potentially life threatening condition. Other minor complications include necrosis of lesion, anemia, hematemeses, occult gastrointestinal bleeding which is thought to be secondary to the ulceration caused by peptic digestion when it protrudes into the stomach.

Diagnosis can be difficult for physicians who are not familiar with this type of tumor. FVPs can sometimes be identified during chest radiography by the presence of superior mediastinal mass, anterior tracheal bowing, or both. On CT scan, FVPs containing abundant fibro-adipose tissue appear as soft-tissue-attenuated lesions. Although most FVPs have an attachment site in the cervical esophagus, barium studies often fail to demonstrate a proximal pedicle. Accurate diagnosis is best established with endoscopy, with characteristic findings of a pedunculated fleshy ‘sausage-like’ endoluminal polypoid mass in upper esophagus characteristic of fibrovascular polyp (FVP) of esophagus. Histopathologically, the polyp consists of fibrovascular connective tissue with fatty cells and is covered with squamous epithelium. Malignant degeneration of FVP is thought to be extremely rare.

Removal of these lesions is recommended because of the progressive symptoms and risk of complications, and options include surgery or endoscopic resection, based on lesion size and vessels that nourish it. Usually small polyps less than 2 cm in diameter and with thin pedicles can be removed by endoscopic pedicle ligation and electrocautery. Larger polyps or those with a thick, richly vascularized pedicle should be removed by surgical excision, and usually through a cervical incision (cervical esphagotomy).

SUMMARY

1. Fibrovascular polyp usually arises from the cervical esophagus from one of these two areas of lower resistance in the pharyngeal musculature. One is between the superior and inferior cricopharyngeal muscle (Killian’s dehiscence), the other is between the inferior cricopharyngeus muscle and the proximal end of the esophagus (the Laimer’s triangle).

2. Fibrovascular polyp is a benign, but potentially life-threatening condition as it can lead to obstruction or asphyxiation from regurgitation of lesion into the pharynx or mouth.

3. The diagnosis is best established with endoscopy.

4. Removal of these lesions is recommended because of the risk of complications of obstruction or asphyxiation from regurgitation of lesion into the pharynx or mouth because they have the potential to cause sudden death.

REFERENCES:


Introduction to the Arkansas Center for Respiratory Technology Dependent Children

Denise Willis, RRT, NPS and John Carroll, M.D.

Children in Arkansas requiring long-term mechanical ventilation were first able to be discharged home [from ACH] in the 1980’s. These children were considered stable with the assistance of trained caregivers to provide for their medical needs. This milestone changed the mindset of the medical community that these children had to remain in the hospital for their lifetime or until they could wean from ventilator support.

The structure of teams and new roles were codified in inpatient and outpatient areas as the home ventilator program evolved; replacing the more informal structure which had existed for many years. In 2008, the Arkansas Center for Respiratory Technology Dependent Children (ACRTDC) was established. The mission of ACRTDC is to provide specialized care to respiratory technology dependent children and to enhance their quality of life through caregiver education, research and advocacy. There are approximately 300 children currently followed by ACRTDC with more than 20 different specific diagnoses and residing in almost every county in the state of Arkansas.

ACRTDC is a program led by the Pulmonary Medicine Section at Arkansas Children’s Hospital. Patient enrollment is dependent upon diagnosis and home respiratory equipment. Diagnoses include chronic lung disease of infancy (formerly known as bronchopulmonary dysplasia or BPD), cerebral palsy, spina bifida, traumatic brain injury, spinal cord injury, congenital central hypoventilation syndrome, interstitial lung disease, primary ciliary dyskinesia, bronchiectasis, neuromuscular disorders and other similar conditions causing chronic respiratory insufficiency. Cystic Fibrosis (CF) was specifically excluded; as there was already a program devoted to managing the care of this group of patients. In addition to diagnosis criteria, children followed in the ACRTDC program require at least one of the following: airway clearance device, tracheostomy, or chronic ventilator support.

Home ventilation can be provided invasively through a tracheostomy tube or with a non-invasive interface such as a nasal- or face-mask. Ventilator use may range from night time only up to 24 hours continuous depending on the child’s specific needs. Airway clearance devices commonly used by these children in the home setting include the cough assist device, also known as a mechanical insufflator-exsufflator; and high frequency chest wall compression device, usually referred to as a vest. One or both of these devices may be prescribed for an individual child, depending on their specific needs.

Children in the ACRTDC program can be divided into those who eventually wean from all of their equipment; and those who will require respiratory support for the duration of their life. Premature infants with chronic lung disease of infancy commonly fall into the former group. Patients with a spinal cord injury or a primary neuromuscular disease are more likely to require technology support for the duration of their lives. Patients with traumatic brain injury or those who have a progressive neurological disorder that is congenital in etiology are also likely to remain technology dependant.

Initially the ACRTDC program included only those patients who utilized a ventilator at home. It was later recognized that many children who did not require ventilator support, but had a tracheostomy or required airway clearance devices, often needed the same level of care as those who required mechanical ventilation. Depending upon the underlying diagnosis, many of these patients eventually require home ventilation or other devices. For example, due to the natural progression of respiratory failure in Duchene Muscular Dystrophy, these individuals ultimately will require ventilator support. However they may require only airway clearance devices for many years until mechanical ventilator support is indicated.

CRITERIA FOR ACRTDC

1. Diagnosis of chronic lung disease of infancy, cerebral palsy, spina bifida, traumatic brain injury, spinal cord injury, congenital central hypoventilation syndrome, all types of neuromuscular disorders and other similar conditions causing chronic respiratory insufficiency.

2. Require at least one of the following at home:
   a. Ventilator
   b. Airway clearance device
   c. Tracheostomy
The ACRTDC healthcare team is a multidisciplinary team of physicians, nurses, respiratory therapists, occupational, physical and speech therapists, discharge planners, dietitians, child life specialists, psychologists, pharmacists and a designated social worker. Patients are each assigned to a primary pulmonologist, who manages their outpatient care. A leadership group serves as the decision-making body for the program. Members of the inpatient and outpatient committees meet regularly to discuss issues in their respective areas of focus and to develop projects to improve patient care. There is also a research committee to provide oversight for all ACRTDC related research activities. Additionally, the ACRTDC team at Arkansas Children’s Hospital has partnered with the adult pulmonary affiliate at the University of Arkansas for Medical Sciences (UAMS) to plan for transition of these complex patients to adult care between the ages of 18-20 years.

ACRTDC was structured in a manner similar to our successful CF center model; however this program has the additional challenge that the ACRTDC program includes patients with many different chronic conditions, whereas the CF program manages just one primary chronic diagnosis. Despite this, the ACRTDC team has been able to adapt and implement several components used by the CF program including the annual review visit, caregiver education event and family advisory board.

The annual review is a comprehensive clinic visit that occurs on the appointment scheduled nearest to the child’s birthday. The purpose is to evaluate all aspects of pulmonary care by having the patient and family meet with the dietician, social worker, respiratory therapist and other disciplines as indicated. Additional testing such as a chest radiograph, blood gas, sputum culture or other laboratory data may be needed, depending on the primary diagnosis and degree of pulmonary dysfunction.

Resource Day and Camp is held at Camp Aldersgate in Little Rock annually for the caregivers and children followed by the program. Caregivers have the opportunity to network with one another and attend educational sessions while the children and their siblings attend a day camp. Children participate in activities including archery, fishing, nature and arts and crafts. ACRTDC team members, volunteers from ACH, and Camp Aldersgate staff work together to make this event possible along with financial support from local agencies.

In our current age focused on family-centered care, the caregiver(s) in the home play a vital role in collaborating with the hospital-based health care team. The ACRTDC Family Advisory Board (FAB) includes parents and caregivers who volunteer their time to offer input on practices that affect the care of their child. FAB members also serve as resources and advocates for other families.

While the ACRTDC program has made progress, there are still many challenges ahead to improve the care of respiratory technology dependent children. There is relatively little published literature to support evidence-based guidelines and practice in managing the care of these children. Additionally, the technology continues to advance but often the financial and community resources are not available to those who would most benefit. Although the outlook may seem bleak; there are many successes to celebrate, such as a child weaning from ventilator support, or returning to school for the first time after becoming ventilator dependent. The best place for a child is to be home with their family; any time that this goal can be achieved, the ACRTDC team feels a sense of accomplishment.

Another important aspect of the ACRTDC program is the primary care physician (PCP). The specialist is typically focused on specific facets while the PCP has the considerable task of coordination of care. Communication between specialists and the PCP is crucial to the success in caring for the child with technology dependence. While this can be challenging when multiple specialists are involved in treating these medically complex children, it is not impossible.

There are approximately 300 children currently followed by ACRTDC with more than 20 different specific diagnoses and residing in almost every county in the state of Arkansas.
The Journal welcomes articles and manuscripts for publication

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Contact Nicole Richards at (501) 224-8967 or journal@arkmed.org

AMS Annual Meeting

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ALL members are invited. Activities will include educational programs, exhibits, State Volunteer Risk Management Seminar, and the President’s Gala honoring Scott Cooper, MD, Rogers, Ark.

There is an opportunity to make your voice heard. AMS members can submit resolutions to be considered at the House of Delegates meeting. Resolutions may deal with socioeconomic, public health, science, medical education or AMS financial and organizational matters that are important to physicians and patients. The deadline to submit resolutions is April 1, 2016. Contact Kay Waldo at 501-224-8967 or kwaldo@arkmed.org for additional information.

THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY AND THE ARKANSAS MEDICAL SOCIETY WOULD LIKE TO THANK DR. LAURA SISTERHEN FOR HER YEARS OF SERVICE AS A JAMS EDITORIAL REVIEW BOARD MEMBER. YOUR CONTRIBUTIONS HAVE BEEN INVALUABLE.
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Arkansas Medical Society Seeks Candidates for Leadership Posts

Help Shape Your Profession — Qualified candidates are being sought for district trustee positions on the AMS Board of Trustees. The Board consists of the major officers (i.e. president, secretary, treasurer, etc.) and district trustees representing 10 geographic areas of the state. There are at least two district trustees from each district. Candidates for district trustee are elected by ballot mailed to all voting AMS members in the respective district. Deadline for submitting your name or nominating someone is February 1, 2016. Elections will take place from February 15-29. Eligibility criteria: must live and/or practice in the district you wish to represent; be an Active, Direct or Life member (most physicians fall into these categories); AMS dues must be paid for the current election year; and candidates cannot run simultaneously for two districts (live in one, practice in another).

Terms of office are two years with a four term maximum. Meetings are held four times per year and normally last 2-3 hours. Trustees are also voting members of the AMS House of Delegates which meets every April or May. Trustee terms begin with the first quarterly meeting following the House of Delegates. Interested candidates should contact the AMS office at 501-224-8967 or email Kay Waldo at kwaldo@arkmed.org.

Mountian Home – Mary Ruth Wren, MD, 60, passed away September 5, 2015. Dr. Wren lived an abundant and accomplished life, among these accolades were graduating Valedictorian at Cotter High School, BS in Medical Technology at UAMS, research on antibody detection of rare antibodies and antigens in Miami, published 20 peer-reviewed articles, received a Doctorate of Medicine from UAMS with honors, served on the Arkansas State Medical Board, Resident OB/GYN at University of Oklahoma, and Chief Administrative Resident in OB/GYN University of Oklahoma. In 1995 she moved back to Mountain Home and began practicing at The Center for Women and began graduate studies and clinical work for the American Board of OB/GYN. In 2005 Mary’s vision of a Women’s Health Education Center became a reality, The Schliemann Center for Women’s Health Education at BRMC. She also was a member of the Board of Admissions at UAMS and served on the BRMC Board of Directors. She is survived by her brother, Tom (Debbie) Wren of Mountain Home and her fiancé, Jim Myers of Mountain Home.

Little Rock – Fred J. Kittler, MD, 83, passed away October 18, 2015. After college, medical school and residency, he located his family to Little Rock, AR. At that time, he went into private practice at the then Arkansas Allergy Clinic located on Capitol Ave. He continued practicing for 40 years until his retirement in what became the Arkansas Allergy & Asthma Clinic. There he touched the lives of many individuals around the state with his calm, gentle manner, and always wearing a smile or telling jokes. He was a member of the Alan Cazort Allergy Society of Arkansas of which he also served as president. Fred also held membership in the American Academy of Allergy Asthma & Immunology, the American College of Allergy Asthma & Immunology, the Pulaski County Medical Society, the Arkansas Medical Society, and the American Medical Association, and was a professor on the staff at UAMS. He was a longtime member of Kiwanis and worked to help support the Pfeifer Kiwanis Camp.

Branch – Charles Henry Chalfant, Jr., MD, 81, passed away October 25, 2015. Dr. Chalfant began family practice in Rogers, Arkansas and later moved to Booneville, Arkansas. While in Booneville, he served as chief of staff at Booneville City Hospital for three years and was president of the Logan County Medical Society. In 1978, he moved to Fayetteville to practice medicine at the University of Arkansas Student Health Center, was on the board for the Women’s Shelter, and was a member of the Arkansas Medical Society. In 1983, he married Janine Lloyd and continued to practice medicine for another twenty-four years, the last seventeen with Cooper Clinic in Fort Smith where he was instrumental in building the first ProMed Clinic. He retired from Cooper Clinic in 2007 after serving as a physician for 50 years.

As a member of the American Academy of Family Physicians, he received the award of Fellow of the American Academy of Family Physicians in 2000. He is survived by his wife, Janine (Lloyd) Chalfant; four daughters, Julie Lacy (Ron), Sharla Chalfant (Rev. Thompson Murray), Jill Chalfant (Shawna Digby), and Christina Chalfant (William May, Jr.); three sons, Charles “Chuck” H. Chalfant, III (Debbie), Michael Chalfant (Amy Gonzales Chalfant), and Matthew Chalfant along with twelve grandchildren; five great-grandchildren with two more on the way.
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