

THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

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OCTOBER 2019



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Winner of the ASAE Excellence in Communications Award

THE Journal

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WHAT HAVE WE DONE FOR YOU LATELY?

New Law in Effect on ID Cards



DAVID WROTEN
EXECUTIVE VICE PRESIDENT

A lot of attention is focused on AMS successes during each legislative session, usually on big bills with big impact. What doesn't always get the attention they deserve are AMS bills that try to address some of the smaller hassles of practicing medicine and running a practice.

A good example is Act 706 of 2019, the Healthcare Payor Identification Card Act. The new law was originally filed as Senate Bill (SB) 527 and was sponsored by Rep. Deborah Ferguson (West Memphis) and Sen. Cecile Bledsoe (Rogers). The legislation addresses a common dilemma faced by clinic staff when trying to file complaints against payors.

Here's the scenario: AMS gets a call from a member clinic about a problem it's having with a particular insurance plan. Let's say that the clinic has a backlog of unpaid claims from this payor and has been trying unsuccessfully to get the issue resolved. Frustrated, the clinic staff calls AMS for assistance.

As part of our suggested course of action, we recommend that the clinic file a formal complaint with the Arkansas Insurance Department. First, we must determine if the health plan is regulated by the Department. We ask, "Is the plan an insured plan or a self-funded plan?" Frequently the answer is, "We don't know, but it says United Health Care on the card."

The reason the clinic doesn't know is that the ID cards, while containing lots of "stuff," usually don't make this clear. You'll see things like Trugreen PPO Network, BIC Insurance Company, UNG Prescription Plan, along with other information on deductibles, phone numbers for claims, etc. The problem is that having the names of these

companies on the card doesn't tell you if the plan is insured or self-funded. It is common for a company like Arkansas Blue Cross and Blue Shield to serve as a third-party administrator, or someone who provides customer service, claims administration, provider networks and other services for self-funded plans. Their name may be on the card, but that doesn't mean the plan is insured.

Does this matter? It matters a lot. Insured plans, or those whose customers pay premiums for insurance coverage, are regulated by the Arkansas Insurance Department. Self-funded plans, or those employer-sponsored plans where the employer is carrying the risk, are regulated by the U.S. Department of Labor.

Knowing who regulates the plan determines what your options are when filing complaints. Your options are many if the plan is regulated by the state of Arkansas. AMS and others have passed numerous laws designed to provide help for physicians, patients, and other providers such as any willing provider, prompt payment, prior authorization restrictions, timely credentialing, and now, Act 706. However, most self-funded plans are regulated by the Department of Labor and are exempt from our state insurance laws; thus, those protections are not available. Filing a complaint with the Department of Labor is usually an exercise in futility.

So, now comes Act 706. Simply stated, it requires health care payors to indicate on the card whether or not the plan is "insured" or "self-funded." The law went into effect on April 4, 2019, and applies upon renewal of the plan.

Is this the "be all that ends all" solution to all your problems? Of course not. It's really a small piece of a much larger puzzle. But you know how puzzles are solved ... one piece at a time. **AMS**

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Is Compulsory Vaccination Morally Justifiable by Medical Ethics?

In normative ethics, two theories for decision-making pertain: deontological and consequentialism. In deontological ethics, the morality of an action is based on whether the action itself is right or wrong under a defined set of rules rather than based on the consequences of the action. Thus, deontological ethics is basically duty/obligation grounded and prescriptive. Consequentialist ethical theory instructs that the consequences (outcome) of an act is the ultimate basis for judging the rightness or wrongness of that act, i.e., a morally right act (or omission from acting) is one that will produce a good outcome, or consequence. Utilitarianism is a version of consequentialism that holds that a practice is morally right when it leads to the greatest possible balance of good outcomes or the least possible balance of bad outcomes and thus minimizes harms and maximizes benefits for all concerned (fulfilling individual needs as well as social goals).

Medical ethics is the unique moral philosophy dealing with conflicts of duty/obligation and consequences of actions that regulate the conduct of the medical practitioner. In medical schools across the U.S., eager students are taught the medical ethical catechism of autonomy, justice, beneficence, and non-maleficence. In the context of normative ethics as described above, deontological medical decision-making is patient-centered and utilitarian medical decision-making is (often) society-centered. It is apparent that the basic principles of medical ethics just listed are largely deontological in nature. As physicians, we are taught (not inappropriately) from the very beginning of our professional training that the good of our patients should be our primary concern. However, we also owe a duty to society. Not unsurprisingly, the benefit of our patient and the benefit of society can sometimes be competing goods, and the physician struggles to find a balance. Since the primary focus of the

ethical training for most physicians has been deontological, this is typically the default framework for morally correct decision-making. But is this always the best practice? Perhaps no better example of this ethical conflict can be offered than that of current vaccination policy.

Measles was declared eradicated in 2000. In 2016, 86 measles cases were reported in the U.S. In 2017, that number jumped to 120. In 2018, the number of measles cases more than tripled to 372, according to figures from the Centers for Disease Control and Prevention. In 2019, from January 1 to July 18, there have been 1,148 individual cases of measles confirmed in 30 states. Arkansas law mandates that children receive vaccines for highly contagious diseases such as measles, mumps, and polio prior to beginning school. However, parents can file with the Arkansas Department of Health to opt their children out of mandated vaccinations for medical, philosophical, and religious reasons. According to data from the ADH, the number of children with such exemptions has increased by approximately 25%, from 6,397 exemptions in 2013 to 8,016 in 2018. For the 2018-19 school year, about 66% of the more than 8,000 exemptions in Arkansas were for philosophical objections, roughly 32% were for religious reasons, and 2% were for medical reasons, according to ADH data.

In the context of utilitarianism, the rationalization for a compulsory vaccination policy is that it will increase general public health (and consequently general public happiness). While this increase in public health may be accompanied by harmful effects (i.e., some individuals may have an adverse vaccination reaction), the beneficial effects will be far greater than any harmful effects that may occur (protection of the group from polio or measles outweighs the relatively rare adverse effects for some individuals). The effectiveness of vaccines in reducing morbidity and mortality (particularly among children) is well established; effectively then, it is demonstrable that a compulsory vaccination policy protects and saves more lives than are harmed or lost. Moreover, even accounting for exclusion of in-

dividuals that have a bona fide medical or religious exemption from receiving vaccination, society will be protected since vaccination of the remaining population will confer protection to the unvaccinated by increasing herd immunity. While the personal liberties of some individuals would be negatively affected under a compulsory vaccination program, the utilitarian ethical standpoint counters that this cost is acceptable since the welfare of the overall society is improved and consequently all individuals will be able to enjoy other personal liberties. All of this is contrary to deontological medical ethics theory. But is that the best practice considering the data cited above?

Will a state or national compulsory vaccination ever be adopted? Probably not voluntarily. Public health initiatives are typically reactive rather than preemptive. If Arkansas ever puts teeth into enforcing the already existing requirement for vaccination of children prior to attending public school or implements a focused vaccination campaign, it will likely be in response to an epidemic such as the 2014 Disneyland measles outbreak prompting California to propose mandatory vaccination. So far, this proposal has survived legal challenges, and recently (because of increasing rates of measles cases) California has toughened the proposed law to give state public health officials, instead of local doctors, the power to decide which children can skip vaccinations before attending school. This measure would also let state and county health officials revoke medical exemptions granted by doctors if they are found to be fraudulent or contradict federal immunization standards. Is this in the future for Arkansas? Time will tell.

Further Reading

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Becoming Social

A Discussion on Using Social Media in Medicine

Post. Share. Like. Follow. These are the simple commands of social media that dominate our world, and today's physician must make an informed decision about his or her professional and personal use of social media. Having an online presence as a doctor may afford you the power to disseminate medical news as an expert in health-related matters. Personally, social media may also help you stay up to date on public health trends and keep you connected to your peers.

But the question remains – how can you jump on the social media bandwagon to maximize your career and better serve your patients? To help you decide, we have pulled together expert advice. We'll share positive uses of social media as well as some of the diligence required to “social” safely.

“The benefits of using social media in a medical practice are becoming increasingly clear, which makes the pressure to get involved even greater. As medical practices become more sophisticated at using social media for knowledge sharing, marketing, and other forms of communication, those who fail to participate will fall behind,” the Norcal Group noted in their “Social Media Tips for Medical Practices: A How-to Guide,” (NorcalGroup.com, August 13, 2018).

Avoiding Legal Pitfalls Through Social Media Policies

As with anything done in a professional capacity, it's vital to know the rules. To begin with, your practice should not have social media accounts without a careful strategy. Emily Sneddon of Mitchell, Blackstock, Ivers & Sneddon, PLLC, acts as part of the general counsel team to the Arkansas Medical Society. “A meaningful social media presence can be a useful part of your overall marketing strategy,” she advised, “but there are some crucial no-no's when it comes to the uses of social media within your clinic and by your medical staff.”

Sneddon elaborated on the complex relationship between employers and employees in the

realm of social media. “You need a lawyer involved in writing your social media policy because the law evolves frequently,” she said. “Those you trust to advise you must be familiar with the current National Labor Relations Act and how that law impacts an employer's social media policy. In a nutshell, the NLRA gives employees the right to make certain kinds of public, negative posts about their employers on such matters as, for example, safety violations or working conditions affecting a number of employees. Those kinds of posts are considered ‘protected activity’ under the NLRA. Employers' social media policies must thread the needle to craft a policy that gives them some control over what employees say about them without illegally interfering with an employee's rights under the NLRA.”

When it comes to your social media policy, there are things you can and cannot control regarding your clinic employees, and it will be up to you to protect your practice reputation from negative impacts caused by inappropriate posts. “It's so important for your employees to understand what they can and cannot do on social media,” said Sneddon. “They cannot get on social media and talk about anything that happened in the clinic. They cannot speculate about a patient. Some people are under the mistaken belief that they can tell what happened as long as they don't use names. That is incorrect. If you give enough information that someone in the community can identify

the person, I believe it's a HIPAA violation. The hard and fast rule is this: you can't post anything or discuss anything that happens at work involving a patient.”

To guard Protected Health Information, or individually identifiable health information, that is held or transmitted, HIPAA (Health Insurance Portability and Accountability Act of 1996) set forth 18 identifiers that could be used to identify, contact, or locate a single person or can be used with other sources to identify a single individual. These include name, address, elements (except years) of individually specific dates, telephone numbers, Social Security Number, medical record numbers, account numbers, and more. Use of any of these identifiers on social media would be a HIPAA violation.

Some of this may feel like common sense, but it is not something to be taken for granted. The Society for Human Resource Management warned that “even the most cautious and well-meaning employees can give away information they should not.” They recommend that employers educate employees as to the risks of clicking without thinking. “Just because employees may have an online profile, it doesn't necessarily mean they have a high level of security awareness.”

“There's so much more to cover on this topic,” summed Sneddon. “Again, you really need a lawyer to help you write an adequate social media policy.”



Courtesy of Michelle Pugh.

Pay Careful Attention to Your Actions

Clinic employees aren't the only ones who need education on social media. As someone whose job it is to understand the ever-present potential for lawsuits, UAMS Managing Associate General Counsel Mark Hagemeyer understands that online is a place where evidence is being created, and physicians need to watch their own actions very closely. To help medical professionals



Mark Hagemeyer

avoid costly and embarrassing mistakes, Hagemeyer addresses common pitfalls of social media use through his popular training presentation, "Tweet Others as You Wish to Be Tweeted."

"Things they may never say face-to-face, people will post without even thinking about it," he said, reflecting on how life has changed for physicians over the years. "Twenty years ago, if you had a hard day at work, you might go home and talk to your spouse, but you didn't have a way to rant to the machine from your bed, in your footsie pajamas. Now you can do that, but there are going to be ramifications if you do."

"Most of us are not intentional in our usage," said Hagemeyer, who believes risks are not to be ignored in exchanged for quick satisfaction. "The hard part about technology is it's new, it's always changing, you can't keep up with it, and the law can't keep up with it. We see an app and we think, 'that's cool,' and we download it. We don't think, 'Wait, is that the NSA or the KGB or the Chinese secret security service?' We just think 'Oh, that's a cool app and we'll use it.'"

"I'm in the risk-management business, so my take on that for physicians is, you're a high-income earner, you walk around in a white lab coat with your name stenciled on it. I think you should be very intentional about how you're using any forms of social media."

Medical students, too, must understand the security and professional risks related to social media. Casey Pearce, associate director of External Relations & Marketing for NYITCOM at Arkansas State University, weighed in on the importance of teaching today's students how to behave professionally on social media. "Today's students have grown up in a world where they have the ability to share minute details of every aspect of their lives, and many are comfortable doing so,"



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Photo courtesy of Mark Hagemeyer.

said Pearce. “That’s not acceptable for a physician. We stress to students that we expect them to be servant leaders, and we’re clear to them that physicians are community figures and are viewed that way. Physicians are understandably held to a higher standard when it comes to personal conduct. Accordingly, we expect them to make wise choices when it comes to what they share on social media. We want them to represent themselves – both individually and as an aspiring physician at NYITCOM-Arkansas – in the most positive light.

“From day one, our medical students learn about different health care laws including HIPAA. We discuss the legal and ethical responsibility to respect the privacy of all patients. We’ve always included social media conduct throughout our discussions about professionalism, but we recently made the decision to hardwire it into our curriculum. Students will typically receive lectures on social media conduct during their spring term. We will continue to address the issue throughout the year as well.”

Hagemeyer trains medical students, too, sharing with them some terrifying mistakes made by students and new, young doctors. In one example, he tells the story of a woman, Naomi H., who made the statement on social media that she had been accepted to a NASA internship. Her post contained foul language and was noticed by Homer Hickman (subject of the movie “October Sky”) who commented with one word of caution: “Language.”

“Rather than tone down her comments,” said Hagemeyer, “Naomi doubled down in response, not knowing that Hickman was on the National Space Council that oversees NASA. Of course, she ended up losing her internship with NASA.”

In another surprising example, Hagemeyer shows trainees a video clip of a young woman attacking an Uber driver. “This woman was a doctor in the neuro-

logy residency program at Jackson Memorial Hospital. This event was all over the news in December 2014,” he explained. “She got fired, which caused her more loss even than it might sound. Since we have lots of medical trainees here – I tell them, ‘Okay, let’s do the math. She’d gone to four years of undergrad, four years of medical school, she was in her fourth year of her residency program, and a neurologist in this county makes about \$400,000 a year.’

“She threw all of that away after breaking up with her boyfriend and drinking too much when a record of the incident found its way online. So, it’s also not just what you accidentally put on social media you need to worry about, but also any public behavior that might be secretly recorded that could ruin your career for you.”

With warnings on one hand, and pressure to participate on the other, what is an unsure physician to do? Hagemeyer, who doesn’t use social media himself, realizes that avoidance isn’t the choice made by many people. For those ready to jump in, he recommends a book entitled “Tweets, Likes, and Liabilities: Online and Electronic Risk to the Healthcare Professional,” by Michael Sacopulos and Susan Gay. And like Sneddon, he advises you to keep perspective, do your homework, and understand what you’re getting into.

“Be intentional,” he reiterates. “Why? So that you can send your kids to school, buy a nice house, and survive professionally.”

Put Positive In to Get Positive Out Online

If you’ve made the decision to professionally use social media, there are some resources and best practices available to help you have a more positive experience.

“People love to hear from their clinic,” said Christi Baker of Healthcare Marketing Associates. Baker and her teamwork with medical clinics like

AMS group member Conway OB GYN to grow their practice. “We encourage our clinics to draw their audience in with posts about fun, non-patient-oriented activities – office birthday parties, Fun Friday, etc. – or use videos to share patient testimonials, introduce new doctors, or show modern technology. People are more likely to watch a short video segment than to even read a short post.”

Medical Economics.com shared, “Social media is more powerful than you think. It has become increasingly common for patients to find their physicians online. Creating a positive online presence can be one of the easiest ways to market your practice and make a lasting impression on patients.”

Conway OB GYN also takes advantage of social networks to promote good health. “For instance, in October and November, the clinic will share information about ‘Flu Shots for Two,’” said Baker. “This encourages mothers to get flu shot vaccinations even while they’re pregnant to protect themselves and their baby and informs patients that their OB-GYN clinic is a place they can go to have that done.”

Michelle Pugh of Munoz Pugh, a public relations and communications firm, also assists medical clients like Saline Memorial Hospital and National Park Medical Center reach out through Facebook Live segments or to advertise open positions. “We reached nearly 3,000 people organically with a live video in which patients were able to submit questions ahead of time or could ask them live,” said Pugh, using as an example an arthritis-related video featuring Scott Walsh, MD, of Arkansas Bone & Joint.

Because social media revolves around the recommendations and comments of its users, physicians want to keep a close eye on the conversations patients and potential patients are having online. Clinicians who wish to improve social media reviews and referrals and improve their employees’ customer-service skills may turn to an organization like HealthCARE Transformed for help. This Arkansas company provides online training to show employees how to interact in a way that promotes positive patient experiences. “The training focuses on soft skills such as phone etiquette as well as more complex topics like conflict resolution and explaining insurance to patients,” said Pugh, who routinely refers clients there. “By training employees on how to better interact with patients, hospitals and clinics can increase their patient satisfaction and retention.”

Conway OB GYN called on HealthCARE Transformed to train its employees, and in turn, its Facebook page reveals many positive comments

and five-star reviews from patients. “Health care today is not the health care it was 30 years ago,” said Robin Fagala, practice manager at Conway OB GYN. “The choices you make in your clinic, about making your patients feel valuable and comfortable, are extremely crucial.”

“It’s important to keep posts positive,” cautioned Baker. “We don’t want to be a chat room for negativity. We’re not asking questions, encouraging discussions, things to open us up for negativity.” In the event of a negative comment, she recommended moving the conversation to a private message to be resolved.

To avoid breaches of confidentiality, release forms are a routine requirement to complete before patients are featured in promotional videos. With that base covered, the response can be phenomenal, as was the case with one GastroArkansas patient story about the early detection of colon cancer that received more than 31,000 views.

Content is King

Once you’ve taken the necessary steps to create your online account and protect your business through social media policies and procedures, your next step will be to focus on the social platforms available and the content of your page. Each social media channel has its own strengths and you should keep that in mind when crafting your posts. Know your audience and determine how you want to reach them. Facebook is more casual and fun, and a great place to share information about latest research, events, and staff, while Twitter is a great way to share short and concise news-related messages in less than 100 characters. Instagram is a visual social media platform, so you’ll want to share engaging photos and videos showing off your staff,

events, and public health initiatives. Also consider the time of day and frequency of each of the channels when posting to maximize viewers.

Consider the words that you use. Those words portray your voice of your organization and your brand. Poorly written content reflects negatively on your group, so you’ll want to make sure you have editing procedures in place. Also consider the use of hashtags, which can help grow your audience and solidify your brand. Just don’t use too many or readers will get overwhelmed trying to determine your message. Ultimately, you will want to focus on content that’s useful to your patient and reflects what they want.

Join the Conversation

Anything worth doing well takes time and effort and becoming involved in social media is an endeavor that can bring many positive results in your career as a physician and in your practice. By taking the appropriate steps to mitigate risks and utilizing the right tools, you’ll be able to master the social networking environment quickly and successfully.

Emergency physician and medicine-and-social-media expert Tyese L. Gaines, DO, (drtyedia.com) recommends using social media platforms to build your brand, attract new patients, educate patients and the public, advance your passions, and publicize research. “I don’t think it’s mandatory to be on social media to take care of patients, but it’s an opportunity to broaden your reach as a physician,” urged Dr. Gaines, who was quoted by AMA News Editor Kevin O’Reilly (April 17, 2019, ama-assn.org). “That doesn’t necessarily mean posting 10 times a day to Twitter, Facebook, Instagram, and so on, but it does mean finding your niche and seeing what you have to add to the social conversation.”

» **“We’re not asking questions, encouraging discussions, things to open us up for negativity.”**

- Christi Baker

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AMA News Editor Kevin O’Reilly

<https://www.ama-assn.org/practice-management/career-development/5-reasons-why-physicians-should-use-social-media>

Modern Medicine Network

How social media can help promote your practice. Jan. 27 2016 Med Ec Blog

The Society for Human Resource Management

<https://www.shrm.org/resourcesandtools/tools-and-samples/toolkits/pages/managingsocialmedia.aspx>

American College of Obstetrics and Gynecologists

<https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Professional-Liability/Professional-Use-of-Digital-and-Social-Media?IsMobileSet=false>

Example Video Links:

Saline Memorial Hospital Arthritis Education Featuring Scott Walsh, MD
<https://www.facebook.com/SalineMemorialHospital/videos/655997211462907/>

GastroArkansas Patient Story

<https://www.facebook.com/GastroArkansas/videos/391399721409621/>

Uber Driver Incident

<https://www.youtube.com/watch?v=uQ0optOmTp8AMS>

Personal use

- Will you respond to patient texts?
- Will you let patients be your social media “friends”?
- What will you post about yourself on-line?
- Texts encrypted?

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Photo courtesy of Mark Hagemeier.

Confusion: Is it Dementia or Delirium?

KIMBERLY GARNER, MD, JD, MPH, and LYNDA BETH MILLIGAN, MD

In the middle of the night a nurse calls to report that your patient, who is scheduled for discharge tomorrow after hip fracture surgery, is now very confused, withdrawn and fearful. How you will manage this patient?

A common presentation of delirium in older patients is a relatively quiet, withdrawn state. You may not recognize it if you aren't looking for it, if you don't know the patient's baseline cognitive history, or attribute these symptoms to cognitive impairment or dementia. This is a common clinical misadventure that, if unrecognized, can result in increased patient morbidity and mortality. A finding of acute confusion indicates that the patient is quite ill, and these symptoms may be the earliest findings of a serious, possibly life-threatening illness.

In both dementia and delirium, cognition is disordered. You can distinguish them by the following:

- **Delirium** occurs acutely and is typically caused by an illness or medication; it is often reversible.
- **Dementia** occurs gradually over years and is typically caused by physical changes in the brain.

There is no test to distinguish between delirium and dementia. When you make the distinction, it is critical to obtain a baseline cognitive history from family or other trusted persons. A patient with dementia will have a history of progressive difficulty with one or more of the following:¹ retaining new information (e.g., trouble remembering recent events); handling complex tasks (e.g., balancing a checkbook); reasoning (e.g., unable to cope with unexpected events); spatial ability and orientation (e.g., getting lost in familiar places); and language (e.g., word finding).² You will hear family or others who know the patient well say things like, "My (dad, mom, husband, etc.) has never done/acted like this before!"

The American Psychiatric Association's Diagnostic and Statistical Manual, 5th edition (DSM-V), lists five key features that can distinguish delirium¹:

1. Sudden changes (usually hours to days) and fluctuating disturbance in attention and awareness
2. Represents a change from baseline
3. Cognition is impaired
4. Not explained by another neurocognitive disorder
5. Caused by a medical condition or medication side effect

Additional features that may accompany delirium include psychomotor findings of hypoactivity or hyperactivity; and emotional disturbances of fear, depression, euphoria or perplexity.

You or your nursing staff can use the Confusion Assessment Method (CAM) to identify when delirium is the likely diagnosis. It is a simple, evidence-based tool that, when used in a medical or surgical setting, has a sensitivity of 94 to 100 percent and a specificity of 90 to 95 percent.³ It can also be used in emergency department and long-term care settings.⁴ It takes about five minutes to administer and is particularly useful when incorporated into routine nursing assessments.

Virtually anything can precipitate delirium in an older patient. However, medication side effects or medication toxicity account for approximately 30 percent of all cases of delirium.⁵ The most important initial step is to initiate a thorough medication review, including all medications the patient was taking before admission to identify any sudden withdrawal as the likely etiology. If medications are not the cause, consider dehydration, another common cause. Start hydration while initiating

a work-up for delirium focused upon the most likely possibilities:

- Fluid and electrolyte disturbances (dehydration, hyponatremia, hypernatremia)
- Infections (urinary tract, respiratory tract, skin and soft tissue)
- Drug or alcohol toxicity
- Withdrawal from alcohol, barbiturates, benzodiazepines, selective serotonin reuptake inhibitors
- Metabolic disorders (hypoglycemia, hypercalcemia, uremia, liver failure, thyrotoxicosis)
- Low perfusion states (shock, heart failure)
- Postoperative states, especially in elderly persons

Less common causes to consider are hypoxemia, hypercarbia, adrenal failure, cerebral vascular accident, central nervous system infection, seizures and paraneoplastic syndromes.

Assessment of vital signs and targeted laboratory/radiological testing are essential. You should generally start with the following:¹

- Chest X-ray along with serum electrolytes, creatinine, glucose, calcium, complete blood count and urinalysis.
- Drug levels and urine drug screens should be ordered where appropriate; however, be aware that delirium can occur even with therapeutic levels of medications.
- Blood gas determination can be helpful. Respiratory alkalosis may indicate hepatic failure, salicylate intoxication or cardiopulmonary causes. A metabolic acidosis may indicate uremia, diabetic ketoacidosis or lactic acidosis.
- In addition to the acute change, a history of slowed cognition for several months increases the importance of evaluating thyroid function and vitamin B12 levels.

- Neuroimaging, such as a head CT, may be used selectively for most patients with delirium. However, neuroimaging should be performed if no other cause of delirium is apparent in your initial evaluation.¹

If you are called about a patient with delirium who is agitated or fearful, avoid using antipsychotic medications, such as haloperidol, unless needed to avoid serious harm to the patient. Recent research has found that these medications do not change the course of delirium and may cause harm in medical or surgical patients.⁶

Non-pharmacologic interventions that have little to no side-effects or risks and have been shown to decrease delirium include having familiar persons sit with the patient, gentle reorientation, getting the patient out of bed and engaging in physical activity. These should be your first-line approaches to treat delirium.

In summary, the most common presentation of delirium which occurs in about 30 percent of patients is a relatively quiet, withdrawn state that is frequently not recognized as a sign of serious illness. The incidence is higher in older patients and those with pre-existing neurological disorders. Obtaining the patient's baseline cognitive history along with the key features of acute onset, fluctuating course, altered consciousness and sudden cognitive decline should readily distinguish delirium from dementia. To manage delirium, rapidly address reversible causes including commonly found medication side-effects and dehydration. Some patients may be agitated but current evidence does not support antipsychotics for prevention or treatment of delirium.⁷ When in doubt, assume

it is delirium and identify/treat the underlying etiologies. ▲

Dr. Garner is a dual-boarded physician in geriatrics, hospice and palliative care. Dr. Milligan is a family physician. Both work at the Central Arkansas Veteran Affairs Health Care System, are American Academy of Family Physicians Fellows, and are board certified by the American Board of Quality Assurance and Utilization Review Physicians. Dr. Garner is an associate professor at UAMS.

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Unilateral Adrenal Hemorrhage in a Patient With a Known Adrenal Mass

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Keywords

Adrenal hemorrhage, anticoagulant, unilateral

Abstract

Introduction: Adrenal hemorrhage is an uncommon condition that is critical to diagnose early in the presentation due to its high mortality rate.

Summary: Here we present a 75-year-old female with atrial fibrillation on warfarin presenting with abdominal pain, hypotension, and syncope. Initial imaging showed a left adrenal hemorrhage. Hydrocortisone was started due to risk of adrenal crisis and interventional radiology performed a successful coil and glue embolization of the left phrenic artery. The patient was stabilized, and steroids were discontinued due to normal cortisol levels. She was continued on flecainide for atrial fibrillation, with discontinuation of warfarin, and followed with repeat imaging in endocrine clinic for resolution of the hematoma.

Conclusion: In patients presenting with abdominal pain, hypotension, and syncope, adrenal hemorrhage should be included in the differential. Though rare, adrenal hemorrhage and adrenal crisis are life-threatening diagnoses. High level of suspicion and prompt diagnosis are imperative so that life-saving treatment, including steroids and often embolization of the hemorrhage, can be performed.

Introduction

The occurrence of adrenal hemorrhage is very rare, with an incidence of only about 0.4-1.8%.

Although it is often difficult to diagnose due to a nonspecific presentation and the propensity for these patients to have multiple comorbidities, speedy identification is imperative due to the high mortality rate, which can reach 15%. Presentation often includes abdominal pain, vomiting, hypotension, weakness, confusion, and fever.

Case report

A 75-year-old female with atrial fibrillation on warfarin, diabetes mellitus, chronic kidney disease, coronary artery disease, hypertension, and cirrhosis secondary to primary sclerosing cholangitis presented with a chief complaint of abdominal pain, hypotension, and syncope. The two days prior, she suffered from poor appetite, left-sided abdominal pain, and back pain without radiation. The morning of admission, she began to feel light-headed and nauseous and subsequently had a syncopal episode. Emergency medical service was called by her family and, in route to the hospital, the patient was noted to be hypotensive with systolic blood pressure in the 70-90s. Upon arrival to the emergency department (ED), the patient had another syncopal episode with loss of consciousness lasting several minutes with witnessed brief gaze deviation.

In the ED, she had a second syncopal episode with temperature of 100.4 degrees F and tachycardia to 105. She was noted to be intermittently hypotensive, with systolic of 70-90. On physical exam, she was disoriented with left-upper-quadrant and left-flank tenderness without rebound or guarding. Her mucous membranes were relatively dry. Rest of physical exam was normal. Workup was significant for an international normalized ratio (INR) of 2.6, lactate of 5.6, and hemoglobin of 8.8, which dropped to 7.9 upon recheck. Basic metabolic panel notable for acute kidney injury with creatinine of 2 (baseline 1.3-1.6).

She was started on large, volume resuscitation with minimal improvement in blood pressure. Addition of a norepinephrine drip was initiated with subsequent stabilization of vital signs. She did have a known left heterogeneously enhancing adrenal mass measuring 2 cm from a previous MRI in 2011 but was lost to subsequent follow up. Due to concern of ruptured aortic aneurysm given her abdominal pain on presentation and history of smoking, a CT angiogram of the abdomen and pelvis was obtained and showed a large left retroperitoneal mixed density hematoma measuring 11.5 x 9.8 x 5.5 cm, with active left phrenic arterial extravasation. Due to her high INR, hypotension, adrenal hemorrhage, and concern for adrenal insufficiency, she was given hydrocortisone, prothrombin complex concentrate, and packed RBCs. Warfarin was held, INR was reversed with fresh-frozen plasma, and interventional radiology was emergently consulted. A successful coil embolization of the left phrenic artery was performed without complications. The patient tolerated the procedure well with stabilization of vitals. Endocrine was consulted and, due to a cortisol of 37.2 prior to steroids, recommended discontinuation of the hydrocortisone. Cardiology was consulted regarding future anticoagulation and recommended flecainide for heart rhythm control and complete cessation of warfarin. The patient remained hemodynamically stable for the remainder of the hospital stay and was discharged without complications.

Discussion

Adrenal hemorrhage is a rare and often life-threatening medical condition. It has an incidence of approximately 0.14-1.8% and is very difficult to diagnose due to the nonspecific findings.^{1,2,3} Therefore, high clinical suspicion is essential for early diagnosis and intervention. This is especially true since mortality rate can reach 15%.¹ Findings on initial presentation can include vomiting, weakness, abdominal pain, hypotension, and confusion.^{1,2,4} As seen in this patient, fever is one of the most common findings, occurring 70% of the time.¹ Adding to the difficult diagnoses is the fact that many of these patients are already suffering from multiple comorbid conditions.

Risk factors for adrenal hemorrhage include severe illness, comorbidities, use of anticoagulation, sepsis, burns, neoplasms, post-operative status, and thromboembolic disease. The most common cause of adrenal hemorrhage is trauma. Other causes include stress, bleeding due to anticoagulation, or bleeding due to underlying tumor.^{2,5,6,7,8,9} When the cause of adrenal hemorrhage is idiopathic, it is often thought to be related to increased vascularization of the adrenal glands in patients undergoing significant amounts of stress.¹ This is due to the release of adrenocorticotrophic hormones and catecholamines, which causes an increase in blood flow to the adrenal gland. Since the adrenal gland has a deficiency of adrenal veins for drainage, this leads to congestion, increasing the risk of hemorrhage.^{2,3} When there is unilateral adrenal hemorrhage, the cause can be due to trauma, with 77% of traumatic hemorrhage occurring in the right adrenal gland.⁵ Bilateral adrenal hemorrhage is more commonly due to non-traumatic causes including stress, sepsis, hypotension, or hemorrhagic diathesis. The case discussed above is perplexing since there was no history of trauma and the hemorrhage was unilateral. If the hemorrhage was due solely to anticoagulant use, you would predict bilateral rather than unilateral hemorrhage. In this patient, there is a prior known left adrenal mass that was obscured on recent imaging due to hemorrhage. The differential for this mass includes an adrenal gland tumor, either due to metastasis or primary adrenal tumor. Often in the setting of hemorrhage, visualization of an underlying tumor can be difficult. Therefore, as discussed later, follow-up imaging in these patients is crucial.

CT is the best tool to confirm the diagnosis, although MRI and ultrasound can also be utilized. In an impending adrenal hemorrhage, there will often be peri-adrenal fat stranding and thickening of the adrenal gland suggesting adrenal congestion.^{2,9} With a non-contrast CT, a bright hyperdense area is often notable on acute hemorrhage.^{5,9} The use of contrast CT can show acute hemorrhage with extravasation, confirming the need for emergent treatment. Once the presence of a hemorrhage is confirmed, it is imperative to treat immediately. Treatment with stress dose glucocorticoids should be started, given the common complication of acute adrenal insufficiency following hemorrhage. The current recommendation is 15-25 mg/day, although the patient must be continually monitored so that this dose can be adjusted based on clinical improvement or worsening.⁶ Infectious diseases can also be the cause of adrenal hemorrhage. Therefore, broad spectrum antibiotics should be initiated until a specific cause of infection is found or until infection is ruled out. Interventional radiology should be notified immediately, as they can play a crucial role in management as shown in this case.

Once hemodynamically stable, the next step is to ensure proper follow up. As discussed earlier, mimickers or causes of adrenal hemorrhage can include malignancies such as lymphoma or metastatic melanoma. In the case of a typical adrenal hemorrhage due to trauma or idiopathic causes, the imaging can show resolution of the hemorrhage, which requires no further action.⁸ Occasionally, the hematoma will not resolve on its own and surgical treatment can be considered due to the risk of re-bleeding.⁸ In the case of hemorrhage due to tumor, MRI or CT with contrast should be done to confirm the presence of a persistent mass, which can then be followed with further imaging, a guided biopsy, or possible surgical intervention.^{5,8} In this patient, it is highly likely that the hemorrhage was due to a left adrenal mass in the setting of recent anticoagulant use.

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A Culturally Centered Food Guide for Overweight Pediatric Latinos

Alyssa Bryant and Paola Carrasco, MD
UAMS, College of Medicine; Arkansas Children's Hospital

Abstract

Obesity is a common problem that affects American adults and children. Minorities experience higher rates of obesity when compared to their Caucasian peers. Our study found that providing families with a simple food guide can significantly decrease the Body Mass Index percentile of pediatric Latino patients at one-to-three and five-to-seven-month follow-up visits.

Introduction

Over the last several decades, obesity has been an increasing problem among the pediatric population in the U.S. Being overweight as a child can have lasting negative effects such as decreased growth and increased blood pressure, lipids, and glucose.¹ Childhood obesity may also have psychological impacts, contributing to anxiety and depression. Obese children are more likely to become obese adults than their healthy-weight peers.²

Obesity is especially prevalent among Hispanic and African American children.¹ This is in part due to socioeconomic status leading to food insecurity. Previous studies have shown that food insecurity is positively associated with obesity.³ These studies also showed that poverty-stricken communities have less access to fresh fruits and vegetables compared to higher-income neighborhoods. Living in lower socioeconomic status (SES) neighborhoods may also limit children's ability to play and exercise due to safety concerns and access to recreational facilities, further increasing obesity. Our study was aimed at testing one method for combating the obesity epidemic among Hispanic children.



Food Guide	
“Yes” Foods:	“No” Foods:
One Glass of Milk a Day	Soda: Coke, Dr. Pepper, Sprite
Water	Juice
Chicken, Fish, or Turkey	Gatorade, Sweet Tea, Starbucks
Beans	Junk food: Takis, Cheetos, Chips
Lentils	Ice Cream, Chocolates, Sweets
Garbanzos	Cheese
Eggs	Rice
Quinoa	Tortilla
Edamame	Bread
Soups	Pasta
Fruits	Cereal
Vegetables	Granola
Nuts	

Portion Sizes

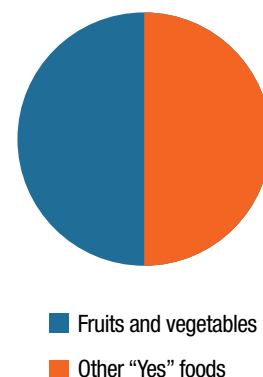


Figure 1. Food guide provided to patient families.

Methods

This study recruited Latino pediatric and adolescent patients with a BMI > 85% from an Arkansas Children's outpatient clinic. Families were provided with a food guide (Figure 1) designed to promote weight loss. BMI was remeasured at an average of two and six months after receiving the food guide. We also collected data from patients' families to assess the taste, affordability, and ease of preparation of the foods suggested in the guide. The assessment questionnaire was translated into Spanish to avoid the language barrier.

Results

Thirty-eight male and female patients from predominantly Spanish-speaking families, ages 6-17, participated in the study. The mean

baseline BMI percentile was 96.4%, ranging from 87.3%-99.6%. At the one-to-three-month follow-up, there was a significant decrease in the mean BMI percentile of -0.62% (95% CI -1.04%, -0.20%; P=0.006). At five-to-seven months, there was a mean change in BMI percentile of -0.74% (95% CI -1.38%, -0.09%; P=0.02). Nine out of 10 of the patients with a greater than 1% decrease in BMI percentile at one-to-three months continued to have a decrease in BMI percentile at five-to-seven months.

Post-intervention questionnaire data was available from 36 of the 38 patient families. Regarding taste, 72.23 % of responding families thought the diet was either “very tasty” (30.56%) or “medium in taste” (42.67%). Of the patient families, 41.67% thought the diet was “not expensive,” while 33.33% found it “somewhat expensive” and 25% thought it was “expensive.” The majority of the families found the meals easy to cook (55.56%).

Discussion

A study performed from 2009-2010 showed that 39.1% of Hispanic children between the ages of 2 and 10 are overweight or obese (BMI \geq 85th percentile).⁴ This finding is consistent with numerous other studies monitoring weight in Hispanic children. These studies have shown the percentage of Hispanic children that are overweight is higher than their non-Hispanic white peers.

Our study showed that simple food guides can significantly improve BMI percentiles in predominantly Spanish-speaking communities. The average BMI percentile was decreased at both the one-to-three month and five-to-seven-month follow-ups, indicating the weight loss can be maintained.

Part of the success of the food guide was likely that the families viewed it as tasty. Suggesting foods that children will enjoy makes it easier for the family to adhere to the proposed diet. Ease of cooking also aids in the sustainability of the food plan. Parents are more likely to cook meals that involve similar preparations

to what they have made in the past. Easy meal preparation also encourages parents to teach their children to prepare similar meals, so that they may carry on these practices as they grow older.

One drawback to this food guide was the cost. The majority of the families found the foods to be at least "somewhat expensive." Buying healthy foods can be more expensive than buying junk food. Discussing techniques to save money at the grocery store with the patient families, such as buying in season or directing them towards coupons, could help families who struggle financially to stick to the food guide. Studies have shown a correlation between low SES and obesity, so it is especially important to educate patient families on available resources.

One limitation of this study was that we were not able to monitor what the patients were eating and did not assess adherence to the food guide. The population was also limited to a single clinic in Little Rock, Ark. Future studies should aim to increase the population size and to include other communities and ethnicities.

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Ischemic Monomelic Neuropathy Following AVG With Full Resolution After Ligation

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Abstract

Ischemic monomelic neuropathy (IMN) is a rare complication following arteriovenous graft (AVG) placement. It is a sensory/motor impairment that can lead to irreversible limb dysfunction if not detected early. We present the case of a 56-year-old Caucasian female with end-stage renal disease. Immediately following placement of an AVG graft for hemodialysis, she developed decreased sensation, tingling, and pain. She was promptly diagnosed with IMN and her symptoms resolved after AVG ligation. This case is significant as there are few reports of IMN in the literature. This report further highlights the risk factors for IMN and the possibility for full recovery if the condition is diagnosed and treated promptly.

Background

Arteriovenous grafts (AVG) have long been a common type of vascular access for hemodialysis (HD) patients, along with arteriovenous fistulas and central venous catheters. These forms of vascular access allow patients to have more convenient and comfortable dialysis for several years. While these procedures are generally well-tolerated, rare complications like ischemic monomelic neuropathy (IMN) may occur. Here we present a unique case of an AVG resulting in IMN. IMN is a sensory/motor impairment without tissue necrosis, but with a transient reduction in blood flow. IMN is a form of steal phenomenon as the access surgery steals blood flow from distal nerve tissue,¹ causing multiple axonal-loss mononeuropathy distally in the limb. It is a very rare presentation with only a handful of cases reported in the literature so far.

Case Presentation

A 56-year-old Caucasian female with end-stage renal disease secondary to DM-II and a his-

tory of CAD, CHF, HTN, and morbid obesity, had a left brachial artery to axillary vein graft placed for HD access. She reported decreased sensation, tingling, and pain immediately after the procedure. The following day, she presented to the emergency department with complaints of shortness of breath that prevented her from going to dialysis that day. She also complained of decreased sensation and tingling, but capillary refill and pulse were adequate on examination. Two days later when receiving her first dialysis treatment since AVG placement, her hand numbness and pain had significantly worsened. Hemodialysis was discontinued after one hour and the patient was sent to the emergency department by ambulance. On arrival, she was dyspneic due to lack of HD for the past four days and also had complete loss of sensation in her left hand in a glove-like distribution. The patient stated her arm "felt like rubber" and she had loss of motor function in her wrist and fingers. On examination the capillary refill was delayed, and doppler revealed a radial pulse.

CV surgery was consulted to evaluate her for a ligation procedure of the AVG placed three days earlier. It was discussed with the patient that there was no assurance of neurologic restoration following the procedure due to the irreversibility of nerve ischemia. An urgent left brachial artery to axillary vein graft was ligated and tolerated well. Following the procedure, there was good triphasic doppler signal and brachial artery pulse was strongly palpable with increased warmth, good capillary refill, and mild residual numbness in her hand. She was able to tolerate hemodialysis later that day. She was discharged the next day, as she had no complaints and fully restored function, movement, and sensation in her left hand and fingers.

Discussion and Conclusions

IMN is a rare but critical complication of any AV fistula or AV graft placement that can lead to irreversible limb defects. There is limited literature on IMN due to its rarity. The incidence is less than 1% of vascular access creations.¹⁻³ The known major risk factors include brachial arterial inflow, diabetes, and usually female gender.⁴ IMN often goes unrecognized, as it can be mistaken for effects of anesthesia (such as axillary block), positioning, or surgical trauma.⁴ Early detection and treatment are crucial because if IMN is not discovered early, it can lead to disabling dysfunction of the extremity with severe pain.⁴ For our patient, early detection and ligation resulted in a full recovery.

This case provides insight into the importance of prompt diagnosis and treatment in a patient presenting with neuropathy and loss of function following AVG or fistula procedure and illustrates the importance of preoperative recognition of established risk factors for IMN. While infrequent, increased knowledge of this condition could lead to good prognostic management in the future.

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Kevin St. Clair, MD

Derm Dilemma: Pityriasis Rosea



Ashley Ederle, MD;
Kevin St. Clair, MD

A 24-year-old male presented with a four-week history of an erythematous, slightly pruritic rash that predominantly involved the trunk [fig. 1]. The eruption began with a single, oval shaped, slightly scaly salmon-colored plaque on the left upper chest which subsequently developed an area of central clearing [fig. 2]. A week later, he noted progressively more numerous morphologically similar but smaller papules and plaques that appeared on the trunk. Palms, soles, and mucosal surfaces were spared. The patient denied any antecedent or concomitant systemic symptoms. He reports having a mild sore throat of a few days duration about a month ago. Which of the following is the next most appropriate step in evaluation?

- Punch biopsy of one of the initially presenting plaques as the diagnosis is uncertain
- Serologic testing for anti-*B. burgdorferi* antibodies
- Reassurance that spontaneous resolution will occur and conservative topical measures for pruritus
- Potassium hydroxide preparation of scrapings of the active margin of one of the newer papules
- Rapid plasma reagin (RPR) test

Answer: C.

Pityriasis rosea (PR) is an acute, self-limited papulosquamous eruption of teenagers and young adults characterized by an initial “herald” or “mother” patch that originates on the chest, neck, or back followed by cephalocaudal spread of the lesions on the trunk. The herald patch is usually a 2 to 5 cm round or oval, well demarcated, pink or salmon-colored plaque that quickly evolves to become scaly with central clearing.

Days to weeks later, successive crops of smaller papules and plaques that resemble the herald patch typically develop on the trunk and proximal extremities. The angle of the oval lesions along the lines of skin cleavage leads to the classic pattern of lesions on the back referred to as a “Christmas tree” distribution. Although PR may mimic other papulosquamous conditions, the diagnosis of PR is usually made based upon characteristic clinical findings with a history of a herald patch. If palmoplantar or mucosal involvement is present, serologic testing to exclude secondary syphilis should be considered.

Generally, PR resolves spontaneously within one to two months. Reassurance and symptomatic therapy with topical counterirritants (lotions containing menthol, camphor or pramoxine) or low-to-medium potency topical corticosteroids are usually sufficient treatment of PR. Phototherapy may be utilized in patients with persistent or extensive eruptions. **AMS**



Figure 1.



Figure 2.



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AMS Student Membership Award-Hunter Cochran

Each year, AMS awards the Student Leadership Award to a medical student in good standing who is in the first, second, or third year of medical school. This student embodies the values of the medical profession through leadership, service, excellence, integrity, and ethical behavior, and also encourages other students to be community servants and/or political activists in addition to being dedicated students. This year's award recipient was UAMS student Hunter Cochran, who received the award from AMS President Dennis Yelvington, MD at the UAMS White Coat Ceremony on August 2, 2019.

During her time in medical school at UAMS, she has served as the chief of Harmony Health Coaching, Secretary of the American Medical Association group, vice president of the Internal Medicine Interest Group, and president of the Global Health Interest Group.



Hunter spends her time volunteering at free health clinics around Little Rock, providing medical services to politicians in session at the state capitol, creating science fairs for local elementary school students, and leading tours to incoming students and their families on campus. She traveled to Washington, D.C. in May of this year to advocate for the patients and doctors in Arkansas at the U.S. Capitol and continues to be a leader in advocacy in her medical school class. Finally, she recently received the prestigious Barton Foundation Scholarship for exceptional academic achievement during her medical school career.

Cochran completed her undergraduate degree at University of Wisconsin - Madison, where she graduated with honors in Biology and a minor in Global Health. Hunter also graduated with Honors in Research. Her Senior Honors Thesis research was published in *PLoS Genetics Journal* in 2016. During college, she volunteered at American Family Children's Hospital, the Coalition for the Elderly, and a local group that promotes young girls to pursue careers in science. She was also the public relations coordinator for the UW Fishing Team and is still passionate about fishing in her spare time.

Hunter is currently a fourth-year medical student and will be graduating in May of 2020. She is currently applying to residency programs in internal medicine and is interested in the field of hematology/oncology.

OBITUARY

LITTLE ROCK - **Edwin Nowell Barron, Jr., MD**, passed away August 12, 2019. He is survived by his wife, Bunny; his children, sons Edwin N. "Eddie" Barron III (Melanie) and Todd Barron; and daughter, Whitney Barron Perser. He also leaves behind 45 grandkids, 15 great-grandkids, and a host of friends and loved ones. Dr. Barron was a nationally recognized and respected physician who had a successful family practice for 53 years. He was inducted into the Arkansas Medical Society's 50 Year Club in 2014. For five years, Dr. Barron was the face of the weekly medical "HealthWatch" program on KTHV, Channel 11 in Little Rock and for other national CBS affiliates. Prior to his medical practice, he served three years in the U.S. Army as a cryptographer.



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