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THE Bulletin

JUNE 2009 Volume 85 Number 6

HOUSE OF DELEGATES REPORT

LEGAL ADVISOR – MARIHUANA

PRACTICE MANAGERS MEET

GENESEE COUNTY MEDICAL SOCIETY
Organized Medicine's Leading Edge

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THE Bulletin

Read by 96% of GCMS members.

FEATURE ARTICLES

REGULAR FEATURES

Our Vision

That the Genesee County Medical Society maintain its position as the premier medical society by advocating on behalf of its physician members and patients.

Our Mission

The mission of the Genesee County Medical Society is leadership, advocacy, education, and service on behalf of its members and their patients.

PLEASE NOTE

The GCMS Nominating Committee seeks input from members for nominations for the GCMS Presidential Citation for Lifetime Community Service. The Committee would like to be made aware of candidates for consideration.

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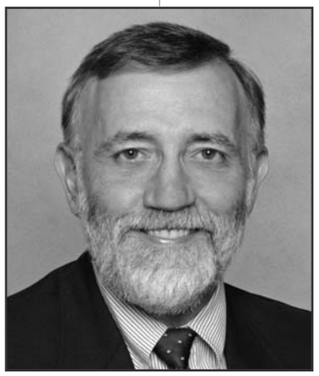
SINGLE-PAYER UNIVERSAL COVERAGE UTOPIA



John A. Waters, M.D.

The times in which we live are incredible. The problems in our Flint and Michigan economies are linked and enormous. Years of lack of foresight and mismanagement in our government, unions and the Big Three Auto Manufacturers combined with a world wide financial tsunami have taken us from the pinnacle of the industrialized world to where we are today. As Michigan enters its sixth year of recession, it is now in the dubious position of being the worst state (yes, 50th) in almost all economic categories. Not that long ago Flint was the urban region of the United States with the highest per capita income. Chrysler is in bankruptcy and GM may be, by the time this editorial is published. Governor Granholm is threatening a cut in Medicaid reimbursement in response to a $1.3 billion anticipated budget shortfall. Our nation has watched its economic and financial center move from New York to Washington, DC.

All these changes are disturbing. And we in Medicine will be challenged in many ways as insurance is changed, restricted or lost outright as layoffs and job losses mount. We must be vigilant and compassionate. “Compassion” needs no explanation in these circumstances. The need for “vigilance” may need some explanation. Healthcare is in the forefront as our national leaders move to use the current economic crises to press for more power and control over medical care.

The fight over nationalizing health care has gone on since the Great Society days of President Johnson and the establishment of Medicare. The ideas and discussion go further back to FDR and before that to the Progressives of the early 1900s. In these times, the use of government power to force universal insurance coverage, a single-payer system or frank nationalization may seem attractive. However, the potential benefits these alternatives may not be worth the problems and entanglements they cause.

Medicare was designed to achieve the best medical care for seniors. And our government promised not to interfere with the private practice of medicine, the independent judgment of physicians, the free market for medical services or the patient physician relationship. Well, things have changed over the years. Consider where we are today with pay-for-performance, price controls, medical record audits with threats and actual imprisonments for simple billing errors and most recently the establishment of an Institute for Comparative Effectiveness for medical treatment. Once physicians began to feed at the government's trough, it was easy for those in Congress to begin the changes. And promises made about the "reformed" health care will soon be changed to meet the government's desire for more control over medicine and the public's freedom. Eternal vigilance is the price of liberty.

THESE DAYS, EVERYONE IS A CRITIC

To avoid criticism, do nothing, say nothing, and be nothing.
– ELBERT HUBBARD (1856 - 1915)

Daniel Ryan, MD

No one will deny that patients are able to appreciate if a doctor's office runs on schedule, if the office is clean, if the parking is convenient, and if the staff is pleasant. But are these factors key in determining who is best suited to diagnose and treat one's disease? Not necessarily, but the proliferation of online sites that rate physicians would lead us to believe otherwise.

Like it or not, physicians are probably going to get an increasing earful from patients on these sites in the not-too-distant future. It's a rude awakening for a profession that has been relatively immune to retail standards that used to be the domain of restaurants, hotels, and trades such as plumbers, builders, roofers, and landscapers. After all, there is more than a modicum of difference between judging the tenderness of the beef at your local steakhouse and assessing the fitness of a particular doctor.

There are dozens of websites that include ratings for physicians. One of the most popular is RateMDs.com. The site boasts over 10,000 users each day and claims 350,000 ratings on 40,000 physicians in the United States. It considers three factors in its ratings; knowledge (????), helpfulness, and punctuality. The site is free and adds 500 new ratings per day. Others to check out include CareSeek.com, Vitals.com, DrScore.com, and Physician Reports.com. Some charge fees to view ratings, such as PhysicianReports.com, which charges $12.95 for the first rating and $9.95 for the second. A recent perusal of several sites revealed no or few, ratings on many physicians and so your search may not be very enlightening.

There are many inherent problems with these rating sites. The ratings are usually anonymous and there are legitimate concerns about the potential for inaccuracies, and irresponsible and defamatory allegations being published. There is no guarantee that the comments are actually from patients of the doctor being rated. On the flip side, glowing praises for a physician may be the online equivalent of stuffing the ballot box. Reliability of the rating source can have an effect on the validity of criticism. For example, a drug seeker may rate a doctor poorly based on a refusal to provide a prescription for narcotics. Human nature leads us to be more vocal about negative experiences than positive ones, and the opinions of a small sampling of disgruntled patients could lead to significant adverse emotional and financial consequences for the physician.

Medical Justice is a company which provides physicians with contracts that require a patient to ask for permission to grade the doctor online. The theory is that this will reduce the number of anonymous ratings. This smacks of paranoia and may actually be a detriment to a healthy physician-patient relationship. Others feel that rather than fearing and objecting to online ratings, doctors should be welcoming and encouraging them. Not only would site browsers come to appreciate the great job that the vast majority of doctors are doing, but negative feedback from patients can only aid us in achieving the goal of delivering the best possible care to our patients.

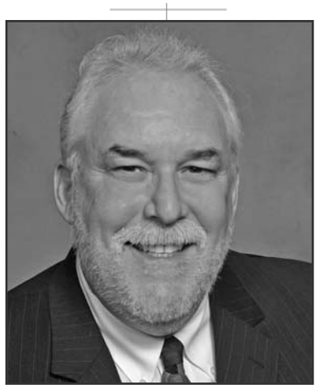
Physicians should be open to fair rating systems. A reliable rating system delivered transparently may be only a pipedream. Patients who choose their doctor based on anecdotal reports of a single, or very few, patient encounters, should be wary. In the meantime, an ancient rating system known as word of mouth from trusted friends and relatives may still be the safest way to choose a quality doctor.

- GCMS met with staff of MedAssurant, Blue Cross, Michigan State Medical Society, and Oakland County Medical Society to express concerns regarding the MedAssurant audit initiatives related to the Blue Cross' Medicare Advantage Program
- GCMS met with legislators regarding the Medicaid budget and proposed 4% physician pay cut, smoking in the workplace legislation, the health care stimulus package, and other issues
- GCMS participated in several political fundraisers
- GCMS interfaced with third-party payers regarding issues of concern to several members
- GCMS hosted several meetings of physicians working on various types of organizational issues
- GCMS met privately with several legislators to provide input on issues of mutual concern
- GCMS convened two Practice Managers meetings revolving around the Hurley PO, and MedAssurant
- GCMS planned Practice Managers meetings on HPM Imaging Management Program (IMP)
- GCMS began planning the 2009 Presidents' Ball
- GCMS hosted Dinner Business meeting/Town Hall on President Obama's health care plans
- GCMS met with consultants on MSMS membership initiatives
- GCMS held District Directors Briefing in preparation for the MSMS House of Delegates
- GCMS convened a full delegation at the MSMS House of Delegate in Grand Rapids
- GCMS presented 18 out of 107 resolutions to the MSMS House of Delegates
- GCMS actively worked with the Greater Flint Health Coalition on multiple issues relating to access, depression, regional health information exchange, diabetes, prompt payment and multiple other issues

GCMS MEETINGS - JUNE 2009

6/1, 8 a.m. - Legislative Liaison @ GCMS
6/3, 7:30 a.m. - Bulletin Committee @ GCMS
6/15, 12 Noon - Membership Committee @ Grill of India
6/23, 5:15 p.m. - Finance Committee @ GCMS
6/23, 6 p.m. - GCMS Board of Directors @ GCMS
6/24, 12:30 p.m. - Community & Environmental Health Committee @ Sagano Japanese Restaurant
6/25, 8 a.m. - Practice Managers @ GCMS

A MAGNIFICENT HOUSE OF DELEGATES, A MAGNIFICENT STATE ALLIANCE PRESIDENT, GEARING UP FOR ECONOMIC PROBLEMS



Peter Levine, MPH

This issue of *The Bulletin* contains a synopsis of the Genesee County Medical Society activities at the MSMS House of Delegates. I encourage each member to spend some time with it. You would be amazed at what your delegation does for you in this setting. This year was a particularly interesting year for a variety of reasons. First of all, nearly half of the delegates were at their first or second House of Delegates meeting. The reason for that is since the meeting was so early this year several of our delegates and alternates had made vacation plans that interfered with the meeting due to confusion about the date. As a result, it gave others an opportunity to attend. Many of them served on reference committees, and all performed beautifully. The Genesee County delegation is always the most organized, thanks to the leadership of Dr. Cathy Blight. This year, that organization was particularly evident in several of the debates in which GCMS members judicially spoke or didn't speak depending on the need of the House. It also featured a well managed campaign for victorious Vice Speaker candidate Pino Colone, MD. Drs. Cathy Blight, Bobby Mukkamala, and Nita Kulkarni and many others were heavily involved in that campaign.

Lakshmi Tummala has just finished her year as president of the Michigan State Medical Society Alliance. She did a great job. It was such a pleasure to see her relaxed and enjoying the banquet held in her honor by the Michigan State Medical Society Alliance. Our members need to know how strong this county's leadership role is in organized medicine and in the Alliance at all levels. We have people in large number involved at the nation, state, and local level. Great job Lakshmi! Thanks for doing what you do.

ASK AMA!

After attending the House of Delegates April 24 - 26, 2009, a light bulb went off in my head!

Although I was Board Advisor for Reference Committee E, I read our resolutions from the other Reference Committees. Time after time the "resolved" portion included the words "ask the AMA."

In fact, 20 out of 31 resolutions in Reference Committee A had the words "ask the AMA." In Reference Committee E, 17 out of 20 resolutions had the words "ask the AMA."

Edwin M. Gullekson, MD
District VI Director

Another fact, 57% of the resolutions had the words "ask the AMA."

With AMA membership in decline, does it seem strange that we depend on the AMA so much. As I have stated in the past, I can't be in E. Lansing every day, MSMS is there. And I can't be in Washington every day, AMA is there.

Every one of us should be a member of the AMA. I have been a member for over 40 years. We depend on the AMA. The AMA deserves our support!

2009 DISTRICT DIRECTORS BRIEFING

The 2009 District Directors Briefing, to prepare for MSMS House of Delegates, was held in late April. The meeting was attended by the Genesee County Medical Society Board of Directors as well as several GCMS members who functioned as delegates at the House of Delegates for their first time due to scheduling conflicts for GCMS Delegates and Alternates. The Briefing was chaired by Drs. Edwin Gullekson and Venkat Rao who serve on the MSMS Board, and Cathy Blight who chairs the GCMS Delegation.

GCMS DELEGATION
At House Of Delegates

For most of the House of Delegates, the Genesee County Medical Society had the second biggest delegation, after the Medical Students Section. GCMS Delegates in attendance on behalf of the GCMS membership included; Drs. Shafi Ahmed, Qazi Azher, Cathy Blight, Laura Carravallah, Edward Christy, Pino Colone, Gail Cookingham (the Michigan Allergy Society), Cyrus Farrehi, Mona

Hardas, John Hebert III, Rima Jibaly, Samasandrapalya Kiran, S. Bobby Mukkamala, Tarik Wasfie, John Waters, Sumathia Mukkamala, Sunita Tummala, and AppaRao Mukkamala. Also in attendance were MSMS Board Members; Drs. Edwin Gullekson, Venkat Rao, Venu Vadlamudi and Nita Kulkarni.

Of 107 resolutions, 18 were directly from GCMS or from GCMS via the Young Physicians and IMG Sections. In addition, three Board reports from past GCMS resolutions were dealt with. Thus GCMS was disproportionately represented at the House (only 200 people voted of which 10% were GCMS voters). Of the 107 resolutions, 12% were GCMS resolutions.

Of the four elections involving GCMS candidates, all were victorious. Pino Colone, MD, AppaRao Mukkamala, MD, and S. Bobby Mukkamala, MD were all reelected to the AMA Delegation. Pino Colone, MD was elected Vice Speaker of the MSMS House of Delegates. GCMS members serving on Reference Committees included; Sunita Tummala, MD, Samasandrapalya Kiran, MD, Mona Hardas, MD, Rima Jibaly, MD, Shafi Ahmed, MD, John Waters, MD, and Edward Christy.

Fifty-Year Awards were given to; Drs. Gerald Berner, MD, Peter Boyer, MD,

John Brody, MD, Donald Canada, MD, Cheng-Yang Chang, MD, Eugene Chardoul, MD, Minoo Chinoy, MD, Samuel Dismond, MD, Leon Friedman, MD,

Fikria Hassan, MD, Shawky Hassan, MD, Tai Kang, MD, Billie Lewis, MD, Kurt Mikat, MD, Sudarsan Misra, MD, Behrouz Moghtassed, MD, Carlo Petrozzi, MD,

Alex Solik, MD, Peter Thoms, MD, and Daniel Walter, MD. Drs. Moghtassed, Lewis, Dismond, Chinoy, and Canada were present to receive their awards.

Reports to the House of Delegates were made by; Nita Kulkarni, MD, Chair of the Young Physicians Section, Shafi Ahmed, MD, Chair of the International Medical Graduates Section, and Lakshmi Tummala, current President of the MSMS Alliance.

The 2010 House of Delegates will take place April 30-May 2, at the Ritz Carlton, Dearborn. In 2011 House of Delegates will take place April 29-May 1, at the Kalamazoo Radisson in Kalamazoo.

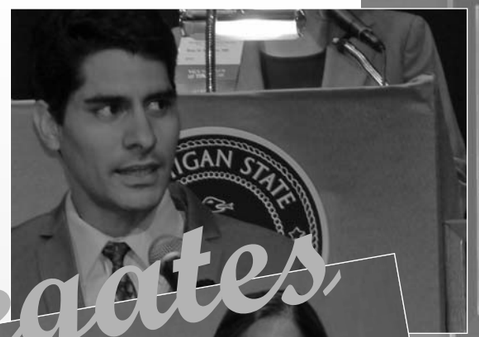
Presidential Citations were given to US Senator Debbie Stabenow, and Michigan Senators Tom George, MD and Roger Khan, MD by outgoing MSMS President Dr. Michael Sandler.

Of the 18 resolutions brought to the House, 14 passed for 77.77% rate. Three had no action taken for a 16.6% rate, and one was referred to the Board representing a rate of 5%.

Of the three Board reports, two were approved and one was rejected.

BOARD ACTION REPORT	RESOLUTION	APPROVED/NOT APPROVED
#8	Suspension of Physician by Board of Medicine and Board of Osteopathic Medicine	Not Approved
#9	Accredited Sleep Centers	Approved
#10	Encourage Creation of an Electronic Single Portal	Approved
#19-09A	Increase Breast Feeding Awareness	Approved
#20-09A	Reducing Medical Waste for Extended Care Facilities	Approved
#21-09A	Change Medicare Yearly Checkup Requirements	No Action
#22-09A	Timely Payments via Standardization of Medical Claims Submission and Processing	Approved
#23-09A	Develop a Payment Code for Prior Authorization of Procedures	Approved
#24-09A	Increase Public Awareness of Bisphenol A	No Action
#41-09A	Support Reduction in Paper Utilized at House of Delegates	Approved
#42-09A	Term of YPS Chair	Approved
#43-09A	Duplication of Certification of need Process	Referred to the Board
#44-09A	GME Collaboration for Resident & Fellow Education and Participation in Organized Medicine	Approved
#45-08A	Bill of Rights of J1 Visa Waiver Physician	Approved
#54-09A	Timely Issurance of Social Security Number	Approved
#55-09A	Awareness of Free Play Benefits to Children	Approved
#56-09A	Rationalize Visa & Licensure Procedures for IMG Residents	Approved
#57-09A	Prior Authorization Requirement of Insurance and Managed Care Entities for Medications	Approved
#58-09A	Prior Authorization Requirements of Insurance and Managed Care Entities for Radiological Procedures	Approved
#59-09A	Ensuring Diversity in USMLE Exams	Approved
#60-09A	Oppose Discrimination in Residency Selection Based on Medical Schools	No Action

House Of Delegates



APPLICATIONS

Edmund Louvar, MD
Diagnostic Radiologist
Diagnostic Radiology Associates of Flint
G3231 Beecher Rd., Ste F, Flint, MI 48532
Phone: 810-733-6184 Fax: 810-733-7667

Dr. Louvar received his medical degree from Wayne State University, Detroit, MI in 1993. He performed his residency at Wayne State/Detroit Medical Center. Dr. Louvar is Board Certified in Diagnostic Radiology. He is sponsored by Amitabha Banerjee, MD and S. Bobby Mukkamala, MD.

PRACTICE MANAGERS MEET TO HEAR ABOUT HURLEY PO

Forty Practice managers met in April to hear about the new Hurley Physician Organization. Tom Wolfe of the Medical Advantage Group spoke in detail about the program. Several ideas were provided to the PO staff regarding how to enhance service to physicians. Future meetings will revolve around Care Corp, human resources issues, and Medicare Advantage problems.

The Legislative Liaison Committee Discusses House of Delegates

In early May the GCMS Legislative Committee met with Senators Deb Cherry, John Gleason and Rep. Paul Scott and Jim Slezak to primarily discuss resolutions that passed the MSMS House of Delegate the previous week, which are likely to result in legislation.

Also discussed were the grave concerns about the State of Michigan budget and Medicaid cuts to physicians as a result of the budget cuts.

CERTIFYING "MEDICAL MARIHUANA" PATIENTS: WHAT ARE THE RISKS?

By Glenn M. Simmington, Esq. Cline, Cline & Griffin, P.C.

Introduction: In November, 2008, Michigan joined Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Vermont, and Washington as states that do not penalize the medical use and cultivation of marihuana. Among the provisions of the Michigan Medical Marihuana Act of 2008, (a ballot initiative which passed by a margin of 63%/37%), is one acknowledging that medical researchers, from the National Academy of Sciences' Institute of Medicine and elsewhere, have discovered beneficial uses for marihuana in treating or alleviating pain, nausea and other symptoms associated with a variety of debilitating medical conditions. Another of the provisions in this lengthy Act mandates, however, that in order for a patient with such a debilitating condition (or the patient's caregiver) to take advantage of the law's protection from state arrest, prosecution, or penalty of any kind (civil, administrative, or criminal), the patient must first obtain written certification from a licensed physician that he or she actually suffers from a diagnosed debilitating medical condition.

Michigan's Medical Marihuana Law, therefore, cannot function in the absence of physicians willing to provide their otherwise qualifying patients with the necessary written certification. That many physicians are willing to do so is evidenced by the fact that, on April 24, 2009, barely six months after passage of the Act, the Michigan Department of Community Health mailed "marihuana patient I.D. cards" to the first 150 patients who applied for listing on the State's registry.

Whether these physicians have subjected themselves to any legal risk is a legitimate subject for debate, and a question that deserves attention.

State Immunity: Michigan's Medical Marihuana Law recognizes that, in addition to providing legal protection for qualifying patients, "certifying physicians" also require protection, not only criminally, but also from civil and administrative perspectives. The law, in fact, actually attempts to do so in a comprehensive way.

Specifically, in Section 4, the Medical Marihuana Law provides:

A physician shall not be subject to arrest, prosecution or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by the Michigan board of medicine, the Michigan board of osteopathic medicine and surgery, or any other business or occupational or professional licensing board or bureau, solely for providing written certifications, in the course of a bona fide physician-patient relationship and after the physician has completed a full assessment of the qualifying patient's medical history or for otherwise stating that, in the physician's professional opinion, a patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the medical condition.…

Thus, so long as a Michigan physician strictly follows the requirements set forth in this section, (and otherwise refrains from violating the applicable standard of care), he or she has full immunity from any state sanction for issuing a written certification concerning the existence of a qualifying "debilitating condition" (as defined in Section 3 of the Act) from which a thoroughly examined and evaluated patient suffers.

What other risks, then, are there for physicians who issue such written certifications?

Federal law: State laws, even when passed by ballot initiative, do not pre-empt federal criminal statutes. Thus, the possession of marihuana, a Schedule 1 controlled substance, will continue to impose at least theoretical criminal liability in Michigan, (except, that is, in the relatively rare circumstance where the marihuana is possessed and/or used as part of a government-approved research project). Further, even though the act of certifying patients as eligible for medical marihuana use does not involve either the possession or delivery of the drug, "aiding and betting" theory, as well as "conspiracy" theory, could arguably subject a certifying physician to the risk of federal criminal charges.

For at least two reasons, however, the risk of such federal criminal liability, like the "risk" of state criminal or administrative liability, can almost certainly be considered non-existent. First, national statistics demonstrate that approximately 99% of all marihuana arrests and prosecutions occur in state courts, and so long as both the physician and the patient strictly comply with Michigan's Medical Marihuana Law, neither can be subjected to prosecution by Michigan authorities.

Additionally, even though the administrations of previous US Presidents, (including the Bush Administration), have taken the position that state laws authorizing the lawful use of "medical marihuana" provide absolutely no defense to federal prosecution, Justice Department officials in the Obama Administration have essentially reversed that position, stating that no federal money will be used in lawsuits in states that have allowed medical marihuana.

With no apparently meaningful risk of either state criminal or administrative penalties, and no apparent risk of Federal prosecution, for the act of certifying Michigan "medical marihuana "patients, what, if any, physician risk remains?

Civil Liability to "Third Persons." As noted previously, Michigan's Medical Marihuana Law does nothing to protect a physician from acts or omissions that amount to standard of care violations, or malpractice, whether in the context of certifying patients as eligible for medical marihuana use or otherwise. The absence of any medical malpractice immunity within the law is, of course, not surprising, since such immunity, if present, would encourage certifying physicians to issue certifications without conducting the thorough medical evaluations that the law requires. What concerns some commentators, however, (including Michigan State Medical Society Public Relations Director Dave Fox), is that the law also contains no specific language protecting physicians from other types of lawsuits, (e.g., by third parties injured or otherwise harmed as a result of marihuana use by medical marihuana patients).

As to "straight" medical malpractice lawsuits, again, any risk posed by Michigan's Medical Marihuana Law is obviously one of degree: physicians are daily called upon to prescribe potentially dangerous medicines, notwithstanding the possibility that their patients might suffer severe, and even fatal, reactions.

Regarding "third party liability" lawsuits, moreover, the weight of legal authority in Michigan is that psychiatrists and other licensed medical care providers owe no legal duty to third persons who may theoretically suffer injury or harm at the hands of their patients unless the specific identity of the person injured or harmed (as well as the likelihood that some such injury or harm will occur) is known ahead of time. Thus, the extent of risk in this context also seems "theoretical," at best.

Conclusion: Nevertheless, as suggested by MSMS's Dave Fox, Michigan's Medical Marihuana Law has given rise to a possibly difficult choice for physicians who are asked to provide written certification regarding patient eligibility for the use of "medical marihuana:" either physicians can provide such written certification where appropriate, allowing their patients access to the benefits of medical marihuana use, but risking possible inclusion in theoretical lawsuits, or they can refer such patients to other physicians who, presumably, are willing to hazard that risk.

Genesee County Medical Society
Board of Directors Meeting – March 24, 2009

MINUTES

Motion:
That the report on the Budget Report ending February 28, 2009 be approved as presented. The Motion Carried.

Motion:
That the Finance Committee consider a dues increase and to bring back a recommendation on that issue as well as on other support issues, as well as how to increase membership. The Motion Carried.

Motion:
That the GCMS revision of the Greater Flint Health Coalition Position Paper on Access be solely a response to the Greater Flint Health Coalition. The Motion Carried.

Motion:
That the membership changes be approved as presented.

Requesting change from Full-time to Part-time:
Leo Madarang, MD

The Motion Carried.

Motion:
That the Board of Directors meeting of April 28, 2009 be cancelled in consideration of the April 21, 2009 District Directors Briefing. The Motion Carried.

BISPHOSPHONATES
Their Effects on Dental Treatment

By Luis A. Perez DDS, MS
Diplomate, American Board of Periodontology
President Genesee District Dental Society

In April, the Genesee District Dental Society was presented with the latest information regarding bisphosphonates and their effect on the oral cavity, by distinguished medical faculty from the University of Michigan and the University of Detroit. We would like to share that information with our medical colleagues

Bisphosphonates in IV form are used to reduce bone pain, hypercalcemia and skeletal complications in patients with multiple myeloma, breast, lung and other cancers and Paget's disease of the bone (i.e. Zometa and Aredia). Oral bisphosphonates are used for the treatment of osteoporosis (i.e. Fosamax, Actonel and Boniva).

The most destructive and difficult to treat lesion associated with theses drugs is the Bisphosphonate-associated osteonecrosis of the jaw (BON). The typical clinical presentation of BON includes pain, soft-tissue swelling and infection, loosening of teeth, drainage and exposed bone. These symptoms may occur spontaneously, or more commonly, at the site of previous tooth extraction and/or post-trauma. Patients may also present with feelings of numbness, heaviness and dysesthesias of the jaw. However, BON may remain asymptomatic for weeks or months, and may only become evident after finding exposed bone in the jaw.

Although IV bisphosphonates been associated with osteonecrosis of the jaw (BON) since 2003, the incidence of BON with oral bisphosphonates have been increasing, probably due to the accumulative effect of these drugs over time.

"It is important to reiterate that, based on the current literature and on the cases reported so far, a patient's risk for developing BON is minute with oral bisphosphonate therapy as compared to intravenous bisphosphonate therapy in cancer patients. Although total U.S. prescriptions for oral bisphosphonates in 2006 exceeded 30 million, fewer than 10 percent of BON cases are associated with patients taking orally administered bisphosphonate drugs."

The prescribing information for these drugs recommends that cancer patients:

• Receive a dental examination prior to initiating therapy with intravenous bisphosphonates (Aredia and Zometa); and

• Avoid invasive dental procedures while receiving bisphosphonate treatment. For patients who develop osteonecrosis of the jaw while on bisphosphonate therapy, dental surgery may exacerbate the condition. Clinical judgment by the treating physician should guide the management plan of each patient based on an individual benefit/risk assessment.

Dentists should be aware that patients may not relay information about receiving IV bisphosphonates, because these drugs are administered in oncology wards. In addition, it may be important to know of any history of IV bisphosphonate administration, because these drugs have a long half-life (years).

An expert panel convened by Novartis Pharmaceuticals Corporation (the manufacturer of Zometa and Aredia) in 2004, made the following recommendations for prevention, diagnosis and treatment of osteonecrosis of the jaw in patients on IV bisphosphonate therapy:

• Patients should be educated on maintaining excellent oral hygiene to reduce the risk of infection.

• Dentists should check and adjust removable dentures to avoid soft-tissue injury.

• Routine dental cleanings should be performed with care not to inflict any soft-tissue injury.

• Dental infections should be managed aggressively and nonsurgically (when possible).

• Endodontic therapy is preferable to extractions; and, when necessary, coronal amputation with root canal therapy on retained roots to avoid the need for extraction.

Although the physiopathology of the disease is unknown, establishing a good communication between the physician and the dentist seems to be essential before any bisphosphonates treatment (oral or IV) to evaluate risk and/or identify BON in the early stages.

Given the increasing data that suggest correlations between not only BON but conditions like diabetes, preterm low birth weight babies, cardiovascular diseases among others and oral diseases (i.e. periodontal disease, oral cancer, caries, etc.), we believe that a strong physician-dentist relationship would deliver the best benefit treatment outcomes that our patients deserve.

Happy Birthday Doctor
MAY

Bala Aysola	1	Marigowda Nagaraju	14
James Graham	1	Ronald Smalley	14
Bruce Lawrence	1	Gary Keoleian	15
Anthony Miltich	1	Walid Abuhammour	16
Siva Sankaran	1	John Macksood	16
P.C. Shetty	1	Peter Mikelens	16
T Trevor Singh	3	Mattie Scott	16
Ernesto Duterte	4	Madhusudana Tummala	17
Sudarsan Misra	4	Lucille Saha	17
Vivekanand Palavali	4	Marc Silver	18
Mischa Pollard	4	Peter Boyer	19
Yazdi Sidhwa	5	Jose Lopez	19
Brian Bhagat	6	Ronald Sparschu	21
Edilberto Moreno	7	John Mackenzie	22
Athar Baig	8	E G Raj	22
Siddesh Besur	10	Michael Kia	25
C. Arch Brown	10	Alan Rice	26
June Murphy	10	Dale Wilson	27
Ravikumar Peddireddy	10	Julio Badin	28
Mark Dyball	11	Woodrow Pickering	28
Raouf Mikhail	11	Alice Platt	28
Tommy Stevens	11	Conrad Reinhard	28
Stephen Burton	12	Paul Lafia	29
Jitendra Katneni	12	Sasikala Vemuri	29
Sayed Osama	12		

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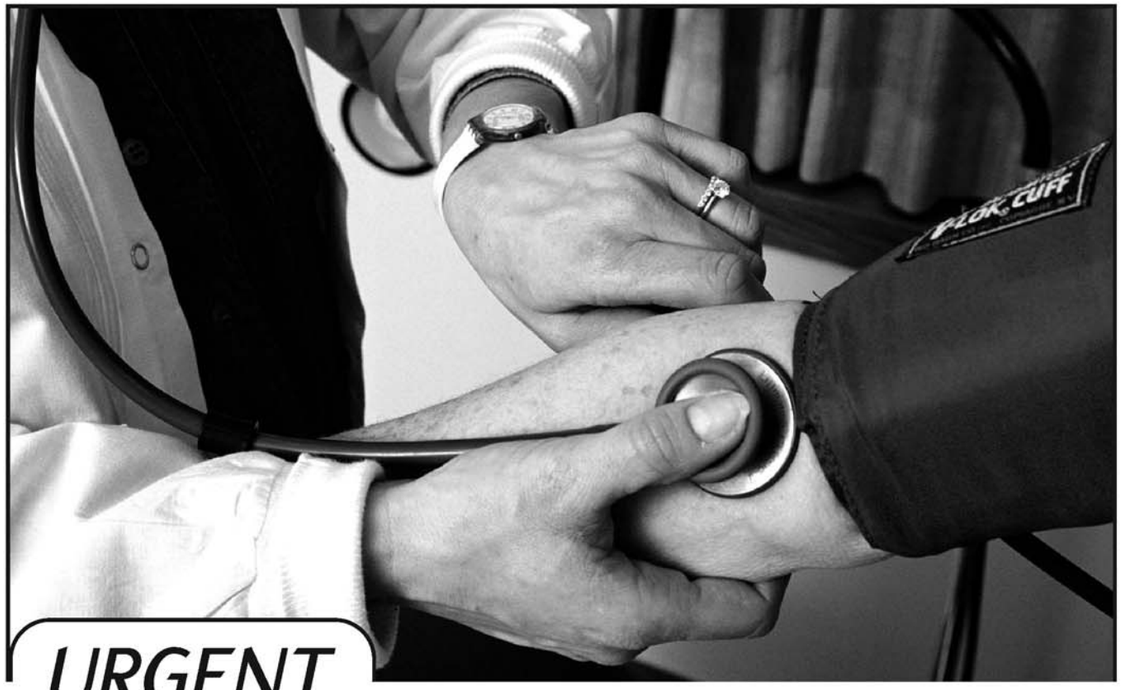

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