

M.D. NEWS

A BUSINESS AND LIFESTYLE MAGAZINE FOR PHYSICIANS

Features

What You Should Know About Women's Health

The Wide-Ranging World of Wound Care

Installing Electronic Health Records

It's Time to Explore

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Gynecologist*

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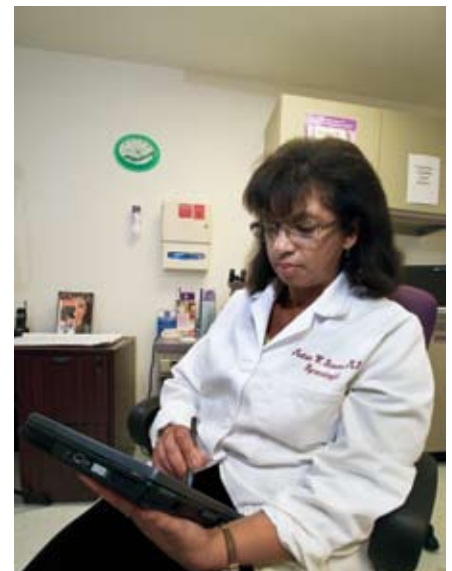


PHOTO BY LES HENIG

ON THE COVER

While in consult with her patient, Dr. Browne uses her computerized laptop/notepad combo to enter notes, instantly check lab results and determine when other tests, like mammograms, are needed.



from the publisher

We've covered a lot of ground in this issue: one of our more powerful "Good Deeds" profiles, updates in treatments of medical issues and diseases impacting women's health and the implementation of health care technology in a medical practice. And, this issue launches our digital editions — an online version of our print copies. As with every issue, my intention is to inspire you to explore new resources for treating your patients, running your practice and maybe even changing your life.



A massive overhaul of the U.S. health care system is underway. One of the first steps is the \$19.2 billion in stimulus spending, part of the American Recovery and Reinvestment Act of 2009 focused on the adoption of HIT within practices and hospitals. Not only is the staggering sum of money hard to comprehend; so are the who, the how and the when parts of the stimulus package. At this writing, "certification" and "meaningful EHR" have yet to be defined by government policy. However, the need for and the intention of the overhaul are clear with regard to health promotion, chronic disease management, electronic connectivity, interoperability and universal access. As part of our special report on installing EHR in a practice, we spoke to a few physicians who have already activated an EHR system in their practices. As one physician reports, "I couldn't live without it."

Digital editions have some obvious perks when it comes to being eco-friendly, easy to save and easy to search. One of the real advantages of this medium is the unique interactivity it provides. For those who appreciate the tactile "page-flip" aspect of a traditional print publication, the digital editions also include a clickable, animated page-flip experience. Once you're online with us, you'll see that the publication includes the ability to e-mail a link to the edition, full-screen viewing options and hyperlinks to our resources. We're not replacing our hard copies — just complementing them.

After you've found the digital edition of *M.D. News DC Metro* via www.mdnews.com, make one of your first virtual visits be to www.hospicechesapeake.org to register to play and/or sponsor the seventh annual Hospice of the Chesapeake Golf Tournament, scheduled for Monday, June 8, at Chartwell Golf & Country Club in Severna Park. This year is quite a special year for Hospice of the Chesapeake, which provides services in both Prince George's and Anne Arundel counties, it's the 30th anniversary. Hospice of the Chesapeake staff and volunteers work hard to provide an incredible tournament to support the Hospice of the Chesapeake's mission: to improve the quality of life for those in our communities experiencing advanced illness or bereavement through hospice and other palliative care, compassionate support and education regardless of one's ability to pay. I'm chairing this year's tournament, honoring the memories of my mother and sister, as well as lending support to one of our region's invaluable health care services.

To life!

Jacquie Roth
Publisher

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Fetal Demise Photography — Now I Lay Me Down to Sleep

By Les Henig

Since the dawn of time, humans have visually commemorated people and events. Such imagery has evolved from early cave drawings depicting hunts, to the statuary of the Romans and Greeks, to paintings of the grand masters and finally to contemporary photographic documentation of those same people and events. Those depictions have



often concentrated on the heroic or happy times, but have also marked the passing of individuals. We, as a people, have a strong desire to, in some way, hang on to those who have gone before us. The Now I Lay Me Down to Sleep (NILMDTS) program is an extension of that tradition.

NILMDTS is a 501(c)(3) organization run by a tiny staff and about 5,000 volunteers nationwide. All of the volunteer photographers are listed on the NILMDTS website (www.nowilaymedowntosleep.org) so that when the need arises, hospital personnel can locate someone close by. There is no cost to the hospital for this service and absolutely no cost to the families. The goal of an NILMDTS session is to commemorate the existence of an anticipated and loved child. Even though the child's time on Earth was extremely brief, no less love was poured into him or her. That which we can't see, we tend to forget. When we can no longer visualize a lost child, our grief is extended by the guilt of having forgotten the shape of a nose, the curl of an ear or the softness of a finger.

As a volunteer photographer with the organization, I have participated in 11 fetal demise photography sessions at area hospitals. Every session is gut wrenching, but I continue to participate because I feel that the end result is worth much more to the families than my temporary discomfort. What is real to parents needs to be validated, so they



can say, "My child was real, my child was here." By creating a series of photographs, participating photographers aid the grieving process by giving them a piece of their child to hang on to.

When we get a call from a hospital, we respond as quickly as we can. I will usually ask a nurse for some basic information before entering the room. I greet the parents and explain who I am and what I'll be doing. I approach the child as quickly as possible to prepare myself and to show the parents that I am not afraid or repulsed. I then do a portrait session with the parents. I usually capture somewhere between 40-60 images to be written to a disk that I will send to them.

Each of us commits to the concept of providing this service if at all possible. This is done with the knowledge that our regular business commitments may prevent responding in a timely manner. Just last week, I was arriving at a business meeting in Columbia, when I got a call from Montgomery General Hospital. I was unable to get my equipment in a reasonable time. Luckily, another photographer was available.

As portrait and wedding photographers, we are privileged to be able to document the joyous moments in the lives of our clients. Being paid to record the happiness of others is a significant job benefit. Why, then, do we want to be part of the saddest day of most people's lives? There's no one single answer, but I think most of us know that



what we're doing helps these families. The letters we get speak to this point. Here's an example:

"These are absolutely beautiful; I appreciate it so very much. Your doing this for us was honestly a gift of God. Your work is absolutely amazing and we appreciate it so much for you to help us capture such special moments with our son ..."

And from another letter: "They have provided immeasurable solace at this incredibly difficult time. We will cherish them forever."

I have a book stuffed with complimentary letters and cards from happy clients, but a letter like that is so much more meaningful than all of the ones I've gotten from paying clients.

Les Henig is a Certified Professional Photographer with over 37 years of wide-ranging experience in the field and is a past president of the Maryland Professional Photographers Association. Mr. Henig can be reached at (301) 933-5762 or les@LesHenig.com. For more information about Now I Lay Me Down to Sleep, contact Mr. Henig or visit www.nowilaymedowntosleep.org. ■

Installing Electronic Health Records

It's Time to Explore

By Wendy Meyeroff

When it comes to the number of practices that have electronic health records (EHR), estimates range from less than 9%¹ in one- to three-doctor offices to a more optimistic 39.24%² in larger practices. When members of the American Academy of Family Physicians (AAFP) were surveyed in 2005, their main objection to computerization was cost, but AAFP spokesperson David C. Kibbe, M.D., says he doesn't think dollar expenses are physicians' real concern.

"I think what they're really saying is, 'I'll have to change the way I practice medicine. I'll see fewer patients because I'll be doing more data entry and I'll have to change the workflow to accommodate that system,'" says Dr. Kibbe, senior advisor to AAFP's Committee on Healthcare Informatics (CHIT). "Doctors have looked at price point, cost of ownership, plus experiences of their colleagues, and often decided the value isn't there as an end user."

APPRECIATING THE ADVANTAGES

Armin Raoufinia, president of Digital Practice Solutions in Vienna, VA, has been establishing dentists on EHRs for six years, but only moved into medical offices about two years ago. "Dentists take digital X-rays every day and they want to be able to access them easily. But many physicians are often saying, 'I don't need anything like that, so why bother?'" he says.

Experts interviewed say those doctors obviously don't recognize all the equipment that can interface with the computer and the overall benefits. "I have a notebook that has a docking station,

so I can take it to the exam room," says Matrice Browne, M.D., a gynecologist in Olney who established her office in 2007. With that notebook, she can enter into her patient's records during the exam. "I can order labs right through the computer and see results without having to find a chart."

"All the tests I do, I do with the EHR or something attached to it. I can take an EKG and with two clicks, fax it straight to the surgery. It's more work to walk down the hall and ask [to] have someone fax it for me," says Helen Barold, M.D., a cardiologist in Washington, DC.

"It's a much more efficient way to run an office and practice medicine. We interface with major labs, like Quest and LabCorp. We can access records from anywhere — the hospital, home, other parts of the office. You're not taking paper messages, so they don't get lost. Everything — insurance cards, photo IDs — is scanned into EHR," says Jackie Goldberg, practice manager for a team of gastroenterologists, Digestive Disorders Associates, based in Annapolis with a satellite office in Chester.

EHRs allowed Drs. Barold and Browne to start practices with small administrative staffs. "I have a nurse who triples as a front desk/appointment maker/office manager. She has a desktop computer in a separate room and we can both be entering data simultaneously," says Dr. Browne. "When my office manager is out sick, I can manage much better than if I wasn't computerized. I can be at my desk and don't have to run someplace else to book an appointment," says Dr. Barold.

Electronic records lead to legibility. "That helps with audits and patient care, plus better collaboration among the entire staff. It eliminates redundancy; you don't have to retype the patient's name on charts, lab requisitions, etc. If the patient's phone number changes, it will be changed on all your forms," says Mark Hollis, president of MacPractice (providing Macintosh-based systems), based in Lincoln, NE.

"An EHR helps navigate the insurance system. The system includes the latest coding, giving us more billing accuracy. That will help reduce paper and the number of claim rejections," says Salliann Alborn, CEO of the Community Health Integrated Partnership (CHIP) in Glen Burnie, a network of eight health centers throughout Maryland.

ENHANCED PATIENT CARE

"I can tell when the patient didn't have something done, since the lab is entered automatically when it comes back. That reminds



Among the advantages practitioners cite in a truly computerized office: instant access to records and test results, easier invoicing, fewer insurance hassles and increased security.

me to call and say, 'Remember the tests we suggested you do? What happened?' It nudges us both," says Dr. Browne. It's easy to remember to remind someone about tests like mammograms, since most systems are loaded with formularies for evidence-based guidelines.

"If the primary care provider sends a patient to one of our specialists, like the mental health provider, the MHP will have a record of the primary care visit before the patient arrives," says Alborn.

Five years ago, when a doctor couldn't access a patient's records quickly, like on weekends, they might have no option except to send the patient to the ER. "Now, the provider can access the record right away and make an informed decision. Are their symptoms consistent with what they've complained of before, for example? We're hoping to cut down on ER visits," says Alborn.

DETERMINING YOUR PRACTICE'S NEEDS

"When you buy an EHR, you should evaluate it as a businessperson. Among the questions you should ask: Does it make you more efficient? Is it cost effective? Does it increase your productivity? Does it improve the quality of care you're providing to your patients? Will it still be functional if you get certified with the CMS reimbursement program?" Hollis says are some of the questions he advises physicians to ask. "How user friendly is it? Does it have a packet that's tailorably to a small practice?" Dr. Browne adds.

Time was key for Dr. Browne. "Greenway, the makers of PrimeSuite Practice Management Solution, agreed to my timeline of less than a month. Everyone else was talking six months for installation," she says. However, she admits that she didn't need the training many offices need.

Whatever is installed, remember that backup is critical. An extra server on site is recommended, and others do what Dr. Browne did: Greenway stores records remotely in Georgia. If a disaster like Katrina happens, the practice's records can be recalled from a distant location.

MAKING CHOICES

The recommendations everyone gave for choosing both hardware and software echoed the same themes: "I'd get a lot of advice and visit another doctor's site, maybe two, using the application," says Michael Epstein, M.D., who led Digestive Disorders' computerization effort. "A lot of times with EHRs, you can't bend the PCP package to a specialty," says Dr. Browne. "So I wanted to know how many specialists, particularly gynecologists, had already used the system."

"It's just like asking whose phone service you use; 90% of the people I knew used the program I settled on, eClinicalWorks," says Dr. Barold.



Washington gynecologist Matrice Browne, M.D., has found even a small practice can reap big benefits when it's computerized.

AAFP members can take advantage of a special online service. "CHIT has a listserv of doctors and what products and services they're using. Members can ask about a specific laptop, software program, speech-recognition program, printers, etc. Then they can contact the people using those to get feedback," says Dr. Kibbe.

Members can also ask about Macs versus Windows. It's something that's apparently coming up more, as physicians who are thinking of major computer outlays anyway are introduced to Apple equipment through devices like iPhones. "I started installing, training and supporting doctors on Macs 27 years ago, so clearly the idea that you can't run a practice on a Mac is mistaken," says Hollis, whose software include ones for doctors, chiropractors and eye experts. "You also can create a virtual PC on a Mac, making it possible for a practice to run PC-based software and equipment, interfacing with non-Mac systems, while taking advantage of other Apple products."

TRANSITIONING THE ESTABLISHED OFFICE

"You have to do a lot of legwork ahead of time to make sure everyone's comfortable," says Dr. Epstein. "You all have to agree on how you're going to implement the system: what's going to be copied from the chart, how much data is going to be stored, what's going to be used to install," he adds.

"At CHIP, we decided we'd develop one set of clinical content,"

says Alborn, so staffers wouldn't have to reacclimate when moving from one practice site to another. "We have people in gynecology, pediatrics, substance abuse and several other areas. All the providers and nurses and the operations people worked together to decide what would constitute content. Fortunately, the providers doing this have some history of collaboration."

Transferring files is a much bigger issue in an established practice than one just setting up. "It's expensive to scan them into the system. We've been in practice since 1990 and had so much paperwork the concrete floor wouldn't support it," says Dr. Epstein. It took two part-timers plus the internal team several years to complete the transition.

SOME COST BREAKDOWNS

"Some doctors think, 'I'll grab a couple of Dells for 400 bucks and you can set it up. That's not going to work for the average doctor,'" says Raoufinia. Instead, he says, "I'd estimate between \$35,000 and \$50,000 for a practice of about seven employees, two physicians. That's about \$25-40K for hardware, installation, wiring and network. Then you add in software: eClinicalWorks cost about \$10-15K depending on the number of licenses added."

Hollis has found costs less for the Mac-based office. "For a two- to three-doctor practice using seven to 10 stations, I'd figure \$11-16K for software, plus \$2,500 to \$3,000 for annual support. For everything — hardware, software, licenses, training, support — I'd say a total of \$25,000 to \$30,000. That's assuming you're setting up both the EHR and the billing system; it would be less for an office that's only installing EHR," he says.

If you're a larger group, ask for price breaks when making purchases. "We're able to use our size to decrease our costs for the purchase of hardware, software, licensing and consulting services," says Alborn. "We can also purchase the bandwidth on a marginal basis."

Don't forget the cost for the IT consultant; Dr. Epstein needed one on staff for two years. Also be sure to inquire about what, if any, ties your consultant has to the products he/she is recommending.

Dr. Epstein reminds physicians of other expenses. "Cabling, scanners, hiring someone to scan any current records, fax machines — the bottom line is the price is about triple what the vendors quote by the time you're done," he says.

Dr. Browne's costs weren't as intimidating. "I'd say I spent about \$55K to get set up, but remember you don't pay that money up front. I'm leasing to own, so I'll pay it over five years. It helps decrease my actual income for tax purposes," she says.

Experts agree that computerizing for the sake of government reimbursements is not worthwhile unless your practice is heavily supported by CMS payments. If not, the likelihood of seeing a decent return on your investment is minimal.

Getting recommendations, particularly from colleagues in the same specialty and practice setup, is key to choosing the right computer package.



PHOTO BY MOLESKY PHOTOGRAPHY

Gastroenterologist Michael Epstein, M.D., recommends getting a lot of advice and visiting practices using the EHR applications under consideration.

SECURITY: THE LAST OBSTACLE

"I've walked into a doctor's office and their records are not secured; the charts are sitting right there. If the receptionist walks away, anyone can grab one. To get my patients' info, they'd have to walk off with my whole computer and then they still need my password," says Dr. Browne.

Alborn agrees. "I can't tell you how many JCAHO accreditations I've been on where we've had to hunt for the charts. We're all extremely sensitive to security issues," she says, which means providing different security levels, additional backup and off-site record storage.

"We have a very secure system. The possibility of transporting a chart to a satellite office and leaving that chart is more likely when it's paper," says Goldberg.

"There are a lot of excuses not to computerize, but once you make the leap, I couldn't live without it. EHRs are fantastic; I can't recommend them strongly enough," says Dr. Barold. ■

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The Link Between Contraceptive Hormone Use and Cardiovascular Disease

By Mark Harrison

The use of contraceptive hormone treatments to prevent pregnancy — birth control pills, patches and vaginal rings — may heighten the risk of heart problems or stroke in certain women, particularly those who smoke, are older than 35 years of age or have existing cardiovascular risk factors. However, use of newer formulations of contraceptive hormones may lower risks.

More than 80% of women use hormonal contraception at some point in their lifetime. As with all medicines, contraceptive hormones must be selected and initiated upon evaluating the risks and benefits for each patient, according to a review article published in the January 2009 issue of the *Journal of the American College of Cardiology*.

The authors of the study conclude that as women use contraceptive hormone treatments more frequently and for longer periods of time, there is an urgent need to better understand and minimize associated cardiovascular risks.

According to the article, observational studies demonstrate that young women have a relatively lower age-adjusted risk of cardiovascular disease compared with men. However, cardiovascular risk increases after menopause, suggesting that endogenous reproductive hormones may play a protective role. The study notes that it has previously been demonstrated that disruption of ovulatory cycling, indicated by estrogen deficiency and hypothalamic dysfunction or irregular menstrual cycling in premenopausal women, is associated with an increased risk of coronary atherosclerosis and adverse cardiovascular events, respectively.

According to the study, women at high risk for cardiovascular problems, especially those who smoke, should consider alternate forms of contraception, while those with other cardiac risk factors such as hypertension or elevated cholesterol should consider

use while being monitored by a physician.

A COMPLEX DYNAMIC

The impact of reproductive hormones

on cardiovascular health is complex. Low estrogen levels and irregular menstrual cycles have been found to increase risk of coronary atherosclerosis as well as adverse

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cardiac events such as heart attacks, stroke or death due to heart disease. Conversely, supplemental estrogen can increase the risk of blood clots, which can also lead to heart attacks or stroke.

The authors found that older formulations of contraceptive hormones can slightly increase blood pressure, but newer formulations tend to use a progestagen, a hormone that produces effects similar to those of progesterone, which is expected not to raise, and may even lower, blood pressure.

Generally, the authors conclude that newer-generation contraceptive hormone formulations — which are just as safe and effective in preventing pregnancy — carry less cardiovascular risk. However, further study is needed.

between the ages of 35 and 44, while mortality rates across all other age groups have dropped. Possible contributing factors include increased rates of obesity and smoking and declines in physical activity in this age group.

As noted in the study, recently published data on mortality from cardiovascular disease also indicate an increase in the use of oral contraceptives in this same age group, from 4% to 17%. The authors note that there has been relatively little specific study devoted to evaluating links between contraceptive hormone use and cardiovascular disease, in part because oral contraceptives are effective and safe, and because premenopausal women are at relatively lower cardiovascular risk than the general public.

be evaluated for cholesterol levels, blood pressure, smoking, diabetes, kidney problems, obesity and other vascular diseases.

One recommendation of the study is measurement of a fasting lipid panel in women with dyslipidemia before use of oral contraceptives, and concludes that alternative nonhormonal contraceptives should be sought if LDL-C is not below 160 mg/dl. Measurement and monitoring of blood pressure are also important to ensure that blood pressure control is not compromised.

The research was supported by grants from the National Heart, Lung and Blood Institute, the National Center for Research Resources, the Gustavus and Louis Pfeiffer Research Foundation, the Women's Guild of Cedars-Sinai Medical Center, the Edythe L. Broad Women's Heart Research Fellowship and the Barbra Streisand Women's Cardiovascular Research and Education Program at Cedars-Sinai Medical Center. ■

MORTALITY RATES

Since 2000, the death rate from cardiovascular diseases has increased in women

EVALUATION RECOMMENDED

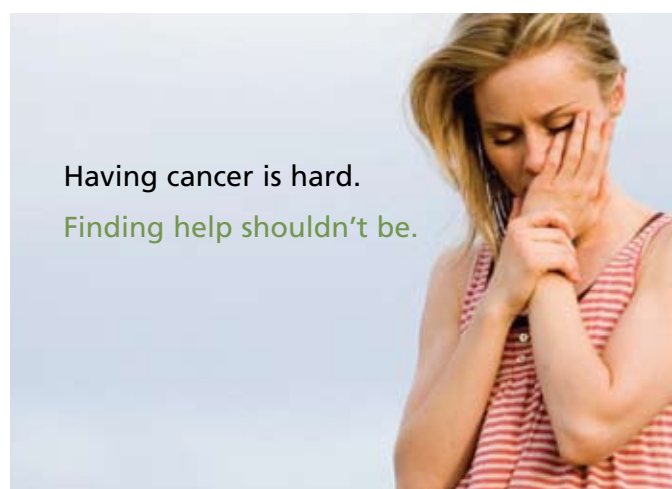
The authors contend that women who are considering the use of contraceptives should



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What You Should Know About Women's Health

By Jennifer Cathey

It's a simple truth, but one that bears repeating: Men and women are different. While the truth of this statement may seem easy to comprehend, the reality is that differences between the genders are far more complex than personal preferences or communication styles. They can — and do — impact overall health, especially in the diagnosis and treatment of the five most common health threats.

As a physician, it is vitally important for you to attend to the needs of all your patients, to educate them about common conditions they should understand and to generally look out for their health. In order to best serve your female patients, it is important to grasp the fact that you can't offer men and women the same treatments or the same medical advice and expect the same outcome.

1. HEART DISEASE: ROUTINE RISK ASSESSMENTS

Susan Bennett, M.D., FACC, Director of the Women's Heart Program at George Washington University Hospital in Washington, DC, is an advocate for educating women about the dangers of heart disease, a condition that kills approximately 50,000 more women than men annually.

"Studies have shown that many cardiologists do not realize that the numbers regarding heart disease are lopsided," Dr. Bennett

Go Red for Women (www.goredforwomen.org) was created to educate women of all ages about their increased risk for heart disease and stroke.



explains. "While more and more women are seeking cardiovascular care and speaking up when they have concerns about their heart health, the medical community still needs to meet them halfway and be prepared to answer their questions and offer solid advice."

In order to help raise women's awareness of signs, symptoms and prevention measures they should take against heart disease, Dr. Bennett played a key role in creating the influential red dress campaign, Go Red for Women.

"The important point to stress to women is that heart disease doesn't discriminate," Dr. Bennett explains. "To that end, I believe it would be beneficial to make a routine heart disease risk assessment an important part of the traditional yearly screenings, much like women now make it a point to undergo a yearly mammogram."

Making a heart disease risk assessment a vital part of primary care has many benefits, including allowing women to see exactly what their risk factors are and giving them the information they need to create strategies to control them. One recent study found that if Americans would get *all* of their risk factors under control, the incidence of heart disease would drop more than 80%.

Encouraging women to actively participate in ongoing medical research through signing up to participate in clinical trials for which they are eligible may also ultimately allow physicians to more effectively treat heart disease in women. In general, only about 25% to 30% of clinical trial participants are women, meaning it is difficult to collect accurate data about women's reactions to certain treatment modalities.

2. CANCER: BENEFITS OF SHORT-TERM RADIATION THERAPY

Originally published in the *Journal of the National Cancer Institute* in 2002, a study regarding the effectiveness of short-term radiation for low-risk, early-stage breast cancer patients following a traditional lumpectomy was updated and presented to the American Society for Therapeutic Radiation and Oncology in late 2008. Approximately five years after the original study, participants reported no increase in occurrences of breast cancer than patients who had undergone the traditional longer-term radiation therapy treatments. The cosmetic outcomes were also similar.

The new study followed the progress of participants in the original research. Participants were examined at regular intervals for cancer recurrences as well as cosmetic and tissue damage. The results of the group receiving the short-term radiation were almost identical to those of the group receiving long-term radiation therapy. Overall, approximately 97% of participants in each

group had no recurrences of breast cancer. After 10 years, the local recurrence risk hovered between 6% and 7% for both groups — almost statistically identical.

Of course, the short-term treatment course may not be as effective in higher-risk women, including those whose cancerous cells were not entirely removed during the original lumpectomy procedure.

3. STROKE: UNDERSTANDING GENDER DIFFERENCES IN STROKE TREATMENTS

A new stroke risk group has emerged in the population. Because this risk group has been overlooked in the past, much of the data needed to create effective treatments has not yet been researched.

“One of the newest topics in stroke is the increasing number of middle-aged women — those between the ages of 45 and 60 — who are having a stroke,” says Helmi L. Lutsep, M.D., associate professor of neurology at Oregon Health Sciences University. “The risk factors for this group can include increasing abdominal girth, uncontrolled high blood pressure and stressful life situations.”

Recent research has shown that men and women react differently to stroke treatments and can have vastly dissimilar outcomes after the event of a stroke. Although past stroke studies have not clearly evaluated this issue, current research is beginning to shed light on the ways men and women recover differently after a stroke.

“The bottom line is, women fare much worse than men when they do not receive proper treatment — especially thrombolytics,” Dr. Lutsep says. “This is becoming a bigger issue, especially since we are beginning to see more and more women presenting with stroke symptoms. One of the key actions physicians can take is to ensure strokes are recognized, and that the women with these symptoms are considered for treatment.”

Much like research for conditions such as heart disease, the lack of women participating in clinical trials and other research studies makes gathering accurate data about stroke in women more difficult. In order to fully assess the gender differences in reactions to treatment modalities, the number of women participating needs to increase enough to provide researchers with solid data.

Methods for preventing stroke in men and women differ, too. Dr. Lutsep points to a recent study on the effectiveness of aspirin in preventing stroke in women. While men showed no difference in incidences of stroke taking a low dose of aspirin, women over the age of 65 were found to lower their risk of stroke by taking 100 mg of aspirin every other day.

4. COPD: OUTCOMES IN WOMEN

Women surpassed men in the number of deaths from chronic obstructive pulmonary disease (COPD) in 2000 — 59,000 deaths in men as compared to 61,000 deaths in women. COPD is also linked with lung cancer, the leading cause of cancer deaths among women.

While research is still being performed to understand the full impact of COPD on women, several factors are being considered as part of the reason women tend to fare worse than men when faced with COPD. One of the most prominent is cigarette smoking, a trend that began to rise in women during the 1950s. Researchers



New studies are revealing a possible genetic link between Alzheimer's disease and X chromosomes.

believe that many of the cases of COPD presenting now are directly linked to that rise in female smokers.

As with many common health risks in women, COPD is likely to be overlooked or misdiagnosed in female patients. Common symptoms associated with female COPD patients include anxiety and depression, as well as chronic shortness of breath.

5. ALZHEIMER'S DISEASE: A GENETIC LINK

Research has shown that each year in America approximately 45,000 women die from the effects of Alzheimer's disease. Overall, nearly twice as many women as men die from the degenerative brain condition.

Published in the January 2009 issue of *Nature Genetics*, a study of the X chromosome revealed a possible variant on the PHDH11X gene. Previous studies have found a link between a mutation on the APOE 4 gene and the disease, as well as several genetic markers for the early onset of the illness.

Researchers profiled the genetic makeup of 844 people with Alzheimer's disease, as well as more than 1,200 individuals who did not present with the symptoms of Alzheimer's disease. A closer look at the genetic makeup of these individuals revealed an increased risk of Alzheimer's disease in those exhibiting a mutation on the PHDH11X gene.

In order to ensure the accuracy of the findings, additional screenings for the PHDH11X gene were performed on study participants whose autopsies had confirmed a diagnosis of Alzheimer's disease. While tests for the condition are generally considered accurate, the confirmation provided by autopsy findings increases the strength of the study's results.

Overall, male patients who carried a copy of the PHDH11X gene on their single X chromosome were at an 18% higher risk for developing the condition. Women who carried the discovered genetic variant on one of their X chromosomes were found to be at a 26% increased risk of developing Alzheimer's disease. Women who carried copies of the PHDH11X gene mutation on both X chromosomes were found to have a 75% higher risk of developing Alzheimer's disease.

While the findings associated with this study are preliminary and require more research, those involved are hoping the knowledge of this new genetic marker will aid in developing treatments and screenings for Alzheimer's disease. ■



Compliance With OSHA's Bloodborne Pathogen Standard 1910.1030

A Closer Look — Part One of Three

By Paul Capuano

PROVIDE, MANAGE AND MAINTAIN

THE EMPLOYER'S RESPONSIBILITIES REGARDING PERSONAL PROTECTIVE EQUIPMENT AND HOW TEXTILE SERVICE CAN HELP

This series of articles is designed to assist today's health care providers in better understanding the specifics of OSHA

standard 1910.1030. Part One focuses on the employer's responsibility to provide, manage and maintain all personal protective equipment (PPE).

1910.1030(d)(3)(i) provision: When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment.

The primary reason that employers struggle with this responsibility is that


if they decide to provide PPE themselves (and do it the right way), they will have to purchase a wide array of expensive products. Based on the varying levels of exposure, employer PPE purchases can include scrubs, clinical jackets or fluid-resistant gowns and lab coats, just to mention a few.

While the need to provide an extensive PPE product line is evident, many employers fall short on the provision responsibility because of the significant costs involved. This dynamic places their staff and their practices at risk.

There is good news. Employers can avoid the huge upfront costs associated with providing PPE by utilizing a textile service. A textile service will assume all of the upfront costs associated with PPE provision and can offer an appropriate and extensive product line to support different levels of exposure. In short, with a textile service, the employer can fulfill the provision responsibility in a cost-effective manner.

Beyond product availability, a textile service makes it easy to match health care professionals with the appropriate PPE. Working as an extension of the program administrator, the textile service provider's route service representative properly sizes new wearers, orders the appropriate attire and manages any customizations, like embroidered logos or names.

1910.1030(d)(3)(iii) accessibility: The employer shall ensure that appropriate PPE in the appropriate sizes are



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readily accessible at the work site or issued to employees.

1910.1030(d)(3)(v) repair and replacement: The employer shall repair or replace PPE as needed to maintain its effectiveness, at no cost to the employee.

While inventory management, sizing and repairs are not the typical responsibilities of today's health care employers, according to the 1910.1030 accessibility and repair and replacement clauses, they should be. Beyond providing PPE, it is also the employer's responsibility to make sure the appropriate inventory is available, sized accordingly and maintained appropriately. Employers struggle with accessibility and repair and replacement for the same reason they struggle with provision: cost. Carrying the right amount of inventory, accommodating sizing needs and replacing worn products are expensive and time consuming.



Textile service offers solutions to these and other inventory management issues. Textile service will manage inventory levels to accommodate business needs

and offer size or product adjustments as needed. The service will also maintain your products by repairing or replacing as necessary.

Accessibility is also supported with lockers and other garment distribution systems. Inventory management and product maintenance are the foundation of a textile service program.

SUMMARY

Understanding the compliance elements of OSHA standard 1910.1030 can be challenging for most employers. Once understood, employers that try to assume the requisite responsibilities themselves will often find this initiative expensive and time consuming.

The provision, management and maintenance of PPE alone can create significant costs. A cost-effective approach to

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Wound

The Wide-Ranging World of

Encompassing an array of treatment modalities that seek to help patients recover from both traumatic and chronic wounds, wound care is a wide-ranging specialty in every sense of the word. As wound care treatments and methodologies emerge, the medical community utilizes a variety of advanced treatments administered by a multidisciplinary wound care team.

Recent technological advances, from hydro-surgical debriding devices to biological skin repair therapies such as Apligraf, make this an exciting era in wound care for patients and physicians alike, but the most welcome development is the growing realization that it takes a team to heal a wound or save a limb.

THE TEAM'S THE THING

The Center for Wound Healing at Georgetown University Hospital in Washington, DC, provides an instructive case study on the importance of a team approach to wound care. Many of the patients seen by the center suffer from chronic diabetic foot ulcers and are at risk for amputation, but thanks to the collaboration of several specialists, the center boasts some of the best limb-salvage rates in the nation.

"We have vascular surgeons to restore blood flow to the leg, as well as excellent orthopaedists and podiatrists to address skeletal issues so it's biomechanically stable," says Christopher Attinger, M.D., plastic surgeon and Director of the Center for Wound Healing at Georgetown University Hospital. "Infectious disease specialists are available to treat infections, as well as endocrinologists to treat abnormal sugars and nephrologists to monitor patients on dialysis. As a plastic surgeon, I'm able to cover tissue or close the soft-tissue envelope over the skeleton. By utilizing the individual expertise of many physicians, we make sure the entire wound care spectrum is covered."

Thanks to the team approach, many successfully revascularized limbs that might have been lost due to infection or lack of adequate care are now saved.

METHODS OF DEBRIDEMENT AND TREATMENT

The first steps in caring for any wound are evaluating blood supply and debriding the wound to avoid or control infection. Once those areas have been addressed, physicians can turn their attention to determining why the wound persists in the first place and how the limb can be saved.

Methods of debridement and preventing infection range from the ancient to the ultramodern. Honey, used by the Egyptians to salve wounds millennia ago, has reappeared in the wound care world in the form of Medihoney, a dressing with manuka honey from Australia and New Zealand. When applied to diabetic foot ulcers or other wounds, Medihoney helps guard against some of the toughest infections, including methicillin-resistant *Staphylococcus aureus*.

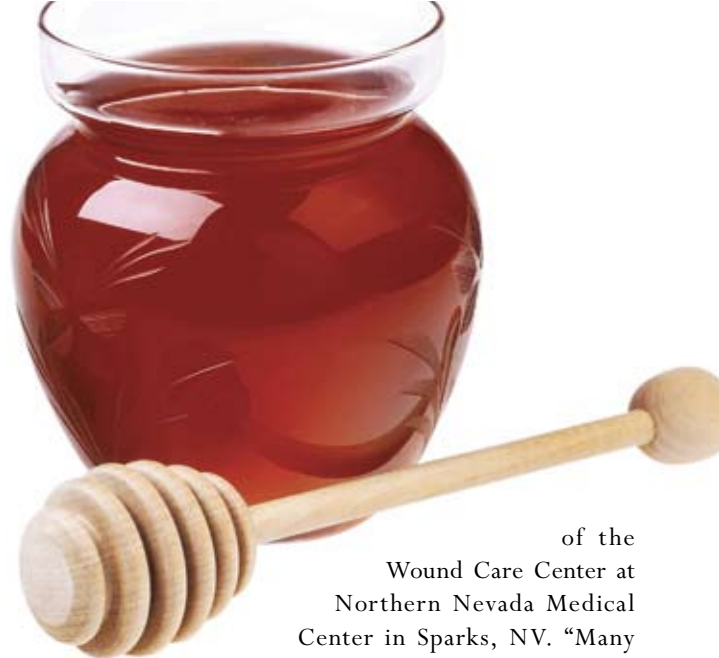
Maggot debridement therapy has also made a comeback. Maggots eliminate slough and necrotic tissue from a wound more quickly and with the aid of fewer antibiotics than conventional treatments, hastening the wound's transition from chronic to acute and opening the door for physicians to consider other treatment modalities.

Ultrasound helps physicians clean wounds once biofill is destroyed, while hydro-surgical debriding devices can also aid in ridding wounds of dead tissue. A typical



Care

By Thomas Crocker



device shoots water at 50,000 miles per hour, creating a vacuum and allowing dead tissue to be removed.

Sophisticated skin substitutes such as Apligraf can encourage wounds to heal by introducing essential substances that normally would be present in the skin.

"Apligraf has been one of the bigger developments in wound care since I began practicing," says John Steinberg, D.P.M., FACFAS, podiatrist and assistant professor in the department of plastic surgery at Georgetown University Hospital. "It allows us to transplant healthy fibroblasts onto a patient's wound site, thus delivering the building blocks of healing directly to the wound itself."

THE VASCULAR PERSPECTIVE

On the vascular end of the wound care spectrum, restoring circulation to limbs is critical to their salvation. Bypass techniques are the standard method for reintroducing blood flow to a limb, but more recent developments include types of endovascular therapy, such as angioplasty and cryoplasty.

"When you perform a bypass, the ideal situation is to use autogenous veins," says Richard Neville, M.D., Chief of Vascular Surgery at Georgetown University Hospital. "Many times, however, we're unable to use a patient's own veins for this purpose, so we employ prosthetic polytetrafluoroethylene grafts, which work well with small arteries in the lower legs."

Hyperbaric oxygen therapy — another key component of wound care and limb salvage — induces vascular endothelial growth factor to stimulate capillary regrowth.

"Complicated wounds, such as those due to diabetes, venous disease, bone infection or radiation, often are difficult to heal," says Sherwood Dixon, M.D., Medical Director

of the Wound Care Center at Northern Nevada Medical Center in Sparks, NV. "Many wounds, however, including those caused by radiation used for cancer treatment, now can be healed using a combination of wound care and hyperbaric oxygen therapy."

A patient receives hyperbaric oxygen therapy in a sealed chamber that contains one-and-a-half to three times normal atmospheric pressure. The pure oxygen inside the chamber stimulates the flow of oxygenated blood to limbs.

"One of the reasons wounds won't heal is that they don't have enough oxygen supplied by blood vessels," says Peter Allinson, M.D., board certified in anesthesiology, critical care and hyperbaric medicine and Director of Hyperbaric Medicine at Good Samaritan Hospital in Baltimore, MD. "Hyperbarics has many applications, from reducing the extent of burns to necrotizing soft wound infections."

A GLIMPSE OF THE FUTURE OF WOUND CARE

The future promises to hold a number of exciting advances in the realm of wound care, but perhaps the most highly anticipated advances are those that will allow physicians to more accurately determine when a wound is ready to close.

"If we could determine when a wound is ready to close with a greater degree of accuracy, we could reduce the number of operations," Dr. Attinger says. "A lot of diagnostic devices are coming down the pike that will allow us to look at proteins and bacteria in the wound fluid and determine if the wound is ready to close or not. We're still about five years away from putting these devices to use, but when we do, we'll be able to heal wounds much more quickly." ■



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While the need to provide an extensive PPE product line is evident, many employers fall short on the provision responsibility because of the significant costs involved. This dynamic places their staff and their practices at risk.

managing these important responsibilities is to utilize a textile rental service.

In Part One, we discussed how a textile service can cost-effectively assist in the administration of PPE provision, management and maintenance. In Parts Two and Three, we will look into other areas of 1910.1030 compliance and how it affects today's health care providers.

As Nixon's Corporate Sales Director, Paul Capuano has over 15 years of experience in supporting cost reduction, compliance, eco-friendly and patient satisfaction initiatives via textile service. He can be reached via e-mail at capuanop@nixonmedical.com. For more information, please visit www.nixonmedical.com. ■

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