TEXAS NEUROLOGICAL SOCIETY SUMMER 2007

Broca's Area

The Voice of Texas Neurology

President's Message

Preston E. Harrison, Jr., MD, FAAN

Five years ago, two old friends and TNS board members, Bill Riley and Gary Tunell, asked me to serve on the board as a member at large. I believe the intent was to expand the scope of the board into some of the more rural regions, such as East Texas. It had been years, if ever, that any neurologist from this area had served on the TNS board. (Incidentally, we now have three members from East Texas on the board.) I was a little self-conscious about taking on this responsibility because I had only recently begun regularly attending the Winter Conferences. I had only a superficial knowledge of what the board was about, and knew less about what my function was to be. Not wishing to decline civic responsibility, I accepted.

I was familiar with the Winter Conference, and aware that it was popular and well attended. Two years after joining the board, I served as Educational Chairman for the 2004 Conference. Even before I began planning curricula, I received a number of contacts from potential speakers who seemed to have extrasensory perception, offering to talk on various topics. I invited several speakers outside of Texas, all of whom were familiar with the TNS Conference and who accepted without hesitation. From this experience, I came to realize just how much the Winter Conference has become a nationally known and prestigious affair, and how much we TNS members have begun to take this aspect of the society for granted.

The TNS Board has a number of functions that are perhaps not visible to TNS members. These include implementing the winter and summer conferences and addressing the many practice issues that come up during the year. When I attended some of my first board meetings a few years ago as a neophyte member at large, I envisioned my role as a warm body holding down a chair in a figurehead organization debating and voting on various soporific matters. As I sat inconspicuously and anonymously in a back corner, I heard things about many issues, some of which were new to me, that sounded damned serious. It was during this phase that I really began to appreciate what and how the TNS and its board contribute to Texas neurology.

As a member of the board these past five years, I have been privileged to observe and personally participate in most of the decision making and achievements of the board:

- In the past two years the Summer Retreat was created and is now a reality. Early on, there was concern that one more conference would dilute and detract from the important Winter Conference. Despite apprehensions, the Summer Retreat has become a successful venture. This retreat has perhaps enhanced the Winter Conference attendance and contributed to a further increase in TNS membership. As of this past year, membership has exceeded 500 members, making us the largest state neurological society in the nation. In no small measure, this distinction is due to the cohesiveness created by the conferences.

(Continued on page 2)

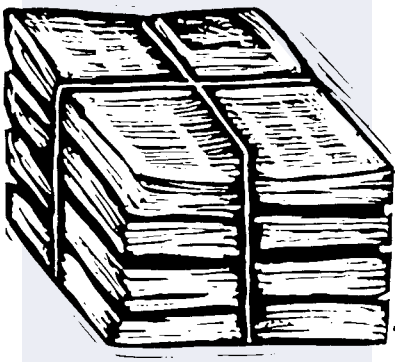
Mark Your Calendar

Mark your summer calendar for the **TNS 4th Annual Summer Retreat –** July 20-21 at the Westin Riverwalk Hotel in San Antonio. This will be a combined meeting with the National MS Society, Lone Star Chapter.

2008 Winter Conference:
February 28 – March 1
Austin Hyatt

2008 Summer Retreat:
July 25 – 26
Westin La Cantera Resort
San Antonio

2009 Winter Conference:
February 26 – 28
Austin Hyatt



Broca's Area Call for Newsletter Items

Who:
Texas Neurological Society members

What:
Submissions for Winter 2008 issue of *Broca's Area*. Tell us about your awards, recent appointments, etc.

Where:
Send to:
Gage Van Horn, MD, editor,
6431 Fannin St # 7.044
Houston, TX 77030-1501
phone: (713) 500-7119;
fax: (713) 500-7019
e-mail: gage.van.horn@uth.tmc.edu
(e-mail format is preferable)

When:
Send to Dr. Van Horn by December 1

Why:
To get involved with your society and communicate with your colleagues across the state.

- The conferences continue to attract an ever increasing number of pharmaceutical supporters, thanks in part to the resourcefulness of our executive director, Rachael Reed. For several years, the exhibit hall has sold out, and the booths have become quite competitive and sought after. Our pharmaceutical support is one important reason that the society can continue to produce quality conferences with respected regional and national speakers in the comfortable accommodations to which we have become accustomed. And it is the continued pharmaceutical support as well as a determined effort by the board that the dues have not been raised for years.

- In the past year, the TNS has joined the Patients First Coalition which works in close association with the TMA. This allies us with one of the most effective proactive and pro-medicine entities in the nation. The alliance allows the TNS to maintain vigilance over important concerns such as scope of practice issues, helping to assure that the patients of Texas will continue to benefit from high standards of health care while being protected from unscrupulous factions and profit motives.

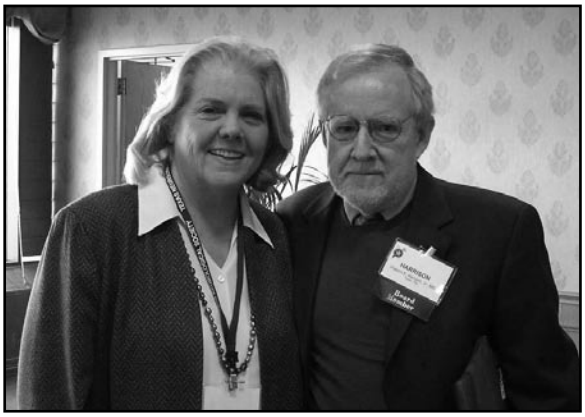
- In 2003, the TNS contributed $10,000 to the tort reform efforts of Texas Medicine's coalition. While at first considered a long shot by many, our determined effort resulted in the passage of Proposition 12. Now imbedded in Texas constitutional concrete, it is hopefully here to stay. Because of the passage of Proposition 12, Texas has become a magnet for neurologists seeking legal safe haven in which to practice and where malpractice insurance has become more affordable. This strategy has become a model emulated by other states engaged in their own efforts to achieve tort reform.

- The board in the past several years has created branches and sections representing the various subspecialty areas of neurology. Off to an uncertain start, this fledgling effort is gradually gaining ground particularly as Texas neurologists continue to subspecialize.

- The TNS continues to work closely with the AAN as well as the TMA. AAN representatives regularly attend TNS winter board meetings, providing a valuable and instant interchange about national trends. And the TNS, because of its success, has become a model for emerging societies in other states.

- The TNS now has its own website: www.texasneurologist.org.

In my years on the board, I have heard many unsettling accounts on matters of legal, political, and scopes issues. Rather than fret about them, I realize that it is far better to recognize and anticipate them, to take corrective steps if possible, or to avoid them if not. Besides overseeing the Winter Conference and Summer Retreat, recruiting pharmaceutical support, and being accountable for the revenue of the society, the TNS board has become a sentinel, a member of a large, informed network with its radar continuously scanning potential pitfalls that the Texas neurologist may encounter. The TNS informs its members through e-mail, *Broca's Area*, the conferences, business meetings, and word of mouth. Overseeing these many functions would be a tedious, time consuming and virtually impossible task for the busy practioner to do on his own. Among the several professional organizations to which one may belong, your TNS membership may well be the one from which you obtain the greatest benefit for the dues rendered. It may be the association you value the most.



Outgoing president Susan K. Blue, MD with Dr. Harrison.

2007 Winter Conference a Huge Success

The 10th Annual Winter Conference of the Texas Neurological Society took place at the Austin Hyatt Hotel from February 9-11, 2007. Attendance was an all-time high of 250 registrants. The program covered a wide variety of neurological topics and provided up to 18 hours of quality CME for a bargain registration fee. Thank you to the education committee and to Jerry Bettinger, MD, program director, for organizing this meeting. The new officers of the TNS were voted in by the membership.

Congratulations to the following:

President: Preston E. Harrison, Jr, MD
President-elect: William S. Gilmer, MD
Vice president: Alan Halliday, MD
Secretary-treasurer: Tommy Yee, MD
Member-at-large: Sara Austin, MD
2007 Summer Retreat program director: Brian Loftus, MD
Winter Conference 2008 program director: Tommy Yee, MD

The Texas Neurological Society's executive board places no higher priority than providing excellent, cost effective CME programs for the membership. Please plan on joining us for the 4th Annual Summer Conference in San Antonio, July 20-21 at the beautiful Westin Riverwalk Hotel.

Thank you to the Supporters of the 2007 Winter Conference!

DIAMOND SUPPORTERS
GlaxoSmithKline
Teva Neuroscience

GOLD SUPPORTERS
Ortho McNeil
Neurologics, Inc.
Serono
UCB Pharma

SILVER SUPPORTERS
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Allergan
Biogen
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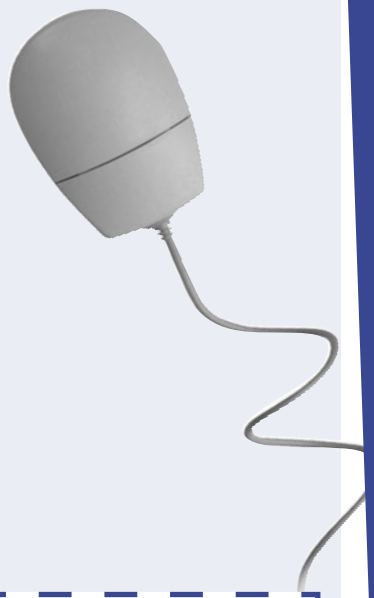
Visit TNS online at texasneurologist.org



Practice Opportunities

I am interested in selling my practice at a reasonable price. I am a neurologist in solo practice on the south side of Corpus Christi, a fast growing, upper middle class area. Located in a new hospital with abundant facilities, my office is supplied with top-of-the-line neurodiagnostic units including EMG-NCV, computers set up for VNS, and baclofen pump/DBS programming if needed. There is an extensive base of active patients. My office does independent medical evaluations, sees workman compensation cases and does impairment rating as well. If interested in knowing more details, please contact me or my office manager, Rachael at 361-994-8883, or email to neuron-guido@sbcglobal.net

Thank you so much,
Ernesto H. Guido, MD

Minutes

TNS Annual Business Meeting
Saturday, February 10, 2007
Hyatt Regency Austin Hotel

President Susan Blue, MD, called the meeting to order at 12:30 pm. She thanked Jerry Bettinger, MD, for his work as program director.

Approval of February 2006 Minutes
The minutes from the 2006 annual business meeting were approved as submitted.

10th Winter Conference – Dr. Blue acknowledged the members who had attended all ten of the Winter Conferences: Stanley H. Appel, MD; Jerry Joe Bettinger, MD; Peggy Brown, MD; Robert M. Cain, MD; Alan Wood Halliday, MD; J. Douglas Hudson, MD; Joe H. Juren, MD; Howard G. La Roche, MD; Stanton I. Moldovan, MD; Mark Edward Pretorius, MD; Kelvin Arthur Samaratunga, MD; Gage Van Horn, MD.

Secretary-Treasurer's Report
Alan Halliday, MD, presented the membership report and ballot. The membership approved the ballot as presented. The membership also approved the bylaws changes, which will shorten the term of the Education Committee Chair.

Advocacy
Dan Finch, TMA public affairs staff, updated the members on legislative issue that will impact medicine. Jeremy Carlson, AAN staff, updated the members on advocacy issues at the national level.

Lifetime Achievement Award
The Society honored Ernesto Infante, MD with the TNS Lifetime Achievement Award for his dedication to neurological care.

Election of New Officers
Dr. Blue presented the 2007-2008 slate of officers, which was approved unanimously. She also thanked Randy Evans, MD for his service on the TNS board of directors.

Change of Officers
Dr. Blue thanked the Society for a successful year, and presented Preston E. Harrison, Jr., MD with a gavel as incoming president. Dr. Preston thanked Dr. Blue for her hard work as president, and then gave his acceptance speech.

The meeting was adjourned at 1:45 pm.

What to Write?
Further Musings from the Editor

Gage Van Horn, MD

Periodically, I run out of ideas regarding editorial comments for *Broca's Area*. Editors may choose to comment on articles published in the current newsletter, or they may write an independent essay on any subject relevant to the society. Selecting something to say is easy when many articles have been submitted for publication, and the articles invite editorial comment. The problem often centers on not receiving enough submissions from members. Tom Hutton, the founding editor, once remarked that the biggest problem in publishing our society's newsletter was obtaining sufficient copy from the membership. This still holds, but we are getting better. If you have something to say to the membership – interesting anecdotes, unusual experiences in your practice, contrary views on controversial subjects, comments about Texas medical politics, or just about anything neurological – send them on to us. Also, I still haven't given up on publishing interesting short reviews, especially if I can find someone else to write a contrasting opinion. I know that we don't all agree on everything, do we?

This issue of BA contains a heartfelt message from our new president, Preston Harrison, who recounts his early experience with board membership and extols the virtues of belonging to the Texas Neurological Society. He outlines the board's recent accomplishments and points out that membership in TNS is quite a value. Not only does the board working through the program chairs support excellent scientific programs, the board monitors most of the political developments potentially affecting neurologists. In many cases, the board takes preemptive action, by joining with other interests in TMA or working through lobbyists in support of various issues coming before the legislature.

In a brief submission, Brian Loftus discusses the concept of therapeutic gain in comparing the various triptans used in the abortive therapy for migraine. Most of us subscribe to the notion that there is not much difference in efficacy from one triptan to another, a view supported by data illustrated in the two tables. Therapeutic gain, which I had not previously heard of, seems like an unnecessary addendum.

The American Heart Association/American Stroke Association Guidelines for acute stroke care is reprinted here for your review. In a separate submission, Walter Buell summarizes efforts in Texas for extending acute stroke management to hospitals throughout the state. Also in this issue, we reprint a truncated version of the American Heart Association recommendations focusing on women's lifetime heart (and stroke) risks.

Before my tenure as editor is up, I intend to compare the three electronic medical records that I have worked with. These include Care-4 at Memorial-Hermann Hospital, Allscripts at our university clinic, and Epic at LBJ Hospital. Each of these systems has helpful features but each also has annoying drawbacks. Those of you who have worked with EMRs may wish to remark on their virtues and liabilities. We certainly have room on these pages. Please drop me a line or send me an essay. Additionally, I want to comment on our almost universal lack of advanced directives in brain-damaged individuals populating our ICUs. What the legislature should have been talking about in this last session was some type of schema for making advanced directives with teeth a requirement for citizenship, for instance in obtaining a driver's license.

Welcome New Members

The following members were voted in during the TNS Winter Conference

Active Membership

Ahmad S. Ata - Greenville
Darryl S. Camp, MD - Austin
Erwin A. Cruz, MD – Dallas
Bhupesh Dihenia, MD - Lubbock
Roy Dana Elterman, MD – Dallas
John Marcus Kirk, MD - Frisco
Brian M. Faux, MD - Lackland AFB
Richard Neil Leidner, MD - San Antonio
Steven Leroy Linder, MD - Dallas
Steven Lovitt, MD - Houston
Kazi Imran Majeed, MD - Dallas
Mool Nigam, MD - Lubbock
David Owen, MD - Dallas
David Sperry, MD - Dallas
Olaf Stuve, MD, PhD - Dallas
Desiree B. Thomas, MD - Houston
Joseph K. Vaughan, Jr., MD - Tyler
Sara Westgate, MD, PhD - Austin

Associate Membership

Maria I. Aguilar, MD – Phoenix, AZ
Peggy Brown, MD – Searcy, AR
Carla J. Schad, MD, MS – Kaufman, TX
David L. Smith, MD - Oklahoma City, OK

Resident Membership

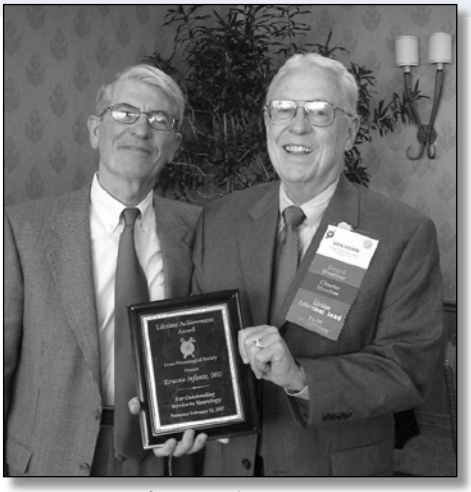
Krystin Calhoun, MD - Houston
Corey E. Goldsmith - Manvel
Alberto Maud, MD - San Antonio
Elias Ntsoane, MD - San Antonio
Irene Oh, MD - Houston
Santiago Palacio, MD - San Antonio
Melissa B. Ramocki, MD - Pearland
Noor Sachdev, MD - Houston
Pankaj Satija, MD - Houston
Prabhdeep Singh, MD - Galveston
Elena Anatolieuna Sokolova, MD - San Antonio
Toby C. Yaltho, MD - San Antonio
Martha Yanci-Torres, MD - Galveston

Congratulations to Dr. Infante

With distinct pleasure, this year TNS presented its Lifetime Achievement Award to Ernesto Infante, MD.

The TNS Lifetime Achievement Award is a peer-recognition award honoring members in the state for outstanding service to patients and to the profession. There are many neurologists in the state of Texas who have played enormous roles in the development of the practice of Neurology. This award will continue throughout the years to honor those physicians who have had great vision and have worked selflessly to advance our specialty on behalf of our patients and our colleagues.

TNS is now accepting nominations for its 2008 Lifetime Achievement Award.



Dr. Infante and Dr. Van Horn.

Ernesto Infante, MD, was born in Cordoba, Spain on January 12, 1940. He was raised in Spain but spent many of his summers visiting his maternal grandparents near Lillehammer, Norway and, later, attending schools in England and France. In addition to Spanish and English, he speaks Norwegian, French and German.

Dr. Infante graduated from the Instituto Gongora in Cordoba in 1956. Later that year, he traveled to the United States as a member of the American Field Service exchange program. In 1957, he graduated from Washington High School in Minneapolis, Minnesota. Dr. Infante then returned to Spain to begin his medical education at the University of Granada. He later transferred to the University of Madrid Medical School, graduating from that institution with honors in 1964. Following his military service as a medical officer in the Spanish Army, Dr. Infante completed his internship in medicine at the Fundacion Jimenez Diaz in Madrid.

Dr. Infante returned to the United States in 1965 as a Fulbright Scholar. He completed a rotating internship at Hennepin County General Hospital in Minneapolis and a residency in neurology at the University of Minnesota under Professor A. B. Baker. Following his residency, Dr. Infante worked for a year at the Mayo Clinic as a research assistant in Clinical Electromyography to Professor E. H. Lambert. He returned to the Fundacion Jimenez Diaz in Madrid in 1970. One year later, Dr. Infante joined Baylor College of Medicine as an instructor, and later as an assistant professor in the department of neurology, specializing in clinical neurology and electromyography. In 1973, he joined the department of neurology at Vanderbilt University School of Medicine as an assistant professor. During that time, he also served as a neurology consultant at the United States Army Hospital in Fort Campbell, Kentucky.

Dr. Infante entered private practice in 1974, joining the Diagnostic Clinic of Houston as a specialist in neurology and electromyography. Shortly thereafter, he again became active in teaching under Professor William S. Fields in the newly established neurology department of the University of Texas Medical School in Houston. Dr. Infante remains a Clinical Associate Professor in that department. In addition, he has served as an examiner for the American Board of Psychiatry and Neurology on five occasions and remains active in various professional organizations. He has served as President of the Houston Neurological Society and of the Texas Neurological Society, and as the Chairman of the Annual Session of the Texas Medical Association's neurology section. Dr. Infante has been selected as one of America's Top Doctors every year since 2001.

Despite his many professional accomplishments, Dr. Infante has remained a devoted husband, father and grandfather. He has been married for forty years to Christine, a native of Auckland, New Zealand, whom he met in the emergency room of Hennepin County General Hospital, where she worked as a registered nurse. They have three children and four grandchildren. Dr. Infante continues to enjoy practicing in the international atmosphere of the Texas Medical Center, and frequently takes time off to travel with Christine.

No Gain in "Therapeutic Gain" in Migraine

Brian D. Loftus, MD, Bellaire Neurology, PA,
Adjunct Associate Professor, Neurology Department, Baylor College of Medicine

Peter J. Goadsby, in an editorial, first used the concept of therapeutic gain to compare various triptans in the absence of head-to-head studies demonstrating one triptan superior to another. The concept of therapeutic gain is an attempt to correct the various studies for presumed differences in patient populations as indicated by placebo response rates. There has been no data presented demonstrating the validity of this concept. In fact, in a response to a letter to the editor critiquing the concept of therapeutic gain, Goadsby wrote "I agree entirely that calculations, such as therapeutic gain or number-needed-to-treat, are somewhat artificial constructs, but submit the view that they can serve a useful purpose of overall comparison". No attempt was made to show mathematically that the therapeutic gain is more useful than the active drug headache response.

How would one judge if this measurement of efficacy, i.e., therapeutic gain, would be more valid than simply looking at the absolute efficacy of response? If identical types of patients exist across multiple studies, then the most valid measurement should be the one which is most reproducible. In the case of migraine, would the migraine response be more reproducible or the therapeutic gain? Fortunately, for FDA registrations, it is very common practice for companies to run small initial pilot studies (phase II) and then run multiple phase III studies. These studies are usually identical in design, recruiting at the same time frame and therefore have similar populations.

Therefore, I have prepared a table to look at the following factors for these registration studies. These include absolute efficacy at 2 hours of migraine response, therapeutic gain (i.e. the migraine response minus the placebo rate), and adjusted therapeutic gain. The adjusted therapeutic gain has not been used in the literature but basically adjusts the number of responders to the number of potential responders (therapeutic gain divided by (100 – placebo response). Table I is the raw data and calculations for each of the 5 fast acting triptans. Table II is the summary table. For every triptan looked at, the standard deviation of the 2 hour migraine response is smaller than the standard deviation for either the therapeutic gain or the adjusted therapeutic gain. Therefore, I would conclude that in migraine studies looking at migraine response rates, therapeutic gain should not be used as a basis of comparison.

1. Goadsby PJ. A triptan too far? J Neurol Neurosurg Psychiat 1998;64:143-147.
2. Goadsby PJ. Response to "therapeutic gain": A critique" Headache 1999;39:518.

Table I: Registration studies of selected Triptans

Imitrex 100	Headache Response	Placebo	Therapeutic Gain	Adjusted Therapeutic Gain
1	62.0	27.0	35.0	47.9
2	56.0	26.0	30.0	40.5
3	57.0	17.0	40.0	48.2
Average	58.3	23.3	35.0	45.6
Std Dev	3.2	5.5	5.0	4.3
Zomig 50	Headache Response	Placebo	Therapeutic Gain	Adjusted Therapeutic Gain
1	60.0	16.0	44.0	52.4
2	66.0	19.0	47.0	58.0
3	67.0	34.0	33.0	50.0
4	59.0	44.0	15.0	26.8
Average	63.0	28.3	34.8	46.8
Std Dev	4.1	13.1	14.5	13.8
Maxalt 100	Headache Response	Placebo	Therapeutic Gain	Adjusted Therapeutic Gain
1	71.0	35.0	36.0	55.4
2	77.0	37.0	40.0	63.5
3	67.0	40.0	27.0	45.0
Average	71.7	37.3	34.3	54.6
Std Dev	5.0	2.5	6.7	9.3
Axert 12.50	Headache Response	Placebo	Therapeutic Gain	Adjusted Therapeutic Gain
1	58.5	33.8	24.7	37.3
2	57.1	40.0	17.1	28.5
3	55.6	33.0	22.6	33.7
Average	57.1	35.6	21.5	33.2
Std Dev	1.5	3.8	3.9	4.4
Relpax 40	Headache Response	Placebo	Therapeutic Gain	Adjusted Therapeutic Gain
1	65.0	23.8	41.2	54.1
2	61.6	19.0	42.6	52.6
3	61.9	21.7	40.2	51.3
4	62.3	39.5	22.8	37.7
5	53.9	20.6	33.3	41.9
6	63.9	31.3	32.6	47.5
7	57.5	29.5	28.0	39.7
Average	60.9	26.5	34.4	46.4
Std Dev	3.9	7.3	7.4	6.6

Table II Standard Deviation Summary

Product	Headache Response	Therapeutic Gain	Adjusted Therapeutic Gain
Imitrex 100	3.2	5.0	4.3
Zomig 5	4.1	14.5	13.8
Maxalt 10	5.0	6.7	9.3
Axert 12.5	1.5	3.9	4.4
Relpax 40	3.9	7.4	6.6

AMERICAN HEART ASSOCIATION FOCUS ISSUE SPECIAL REPORT

Updated Guidelines Advise Focusing on Women's Lifetime Heart Risk

Update gives definitive answers on HRT, aspirin, supplements

DALLAS, Feb. 20, 2007 – Health care professionals should focus on women's lifetime heart disease risk, not just short-term risk, according to updated American Heart Association guidelines.

The 2007 Guidelines for Preventing Cardiovascular Disease in Women – published today in a special women's health issue of Circulation: Journal of the American Heart Association – also include new directions for using aspirin, hormone therapy and vitamin and mineral supplements in heart disease and stroke prevention in women.

"The updated guidelines emphasize the lifetime risk of women, not just the more short-term focus of the 2004 guidelines," said Lori Mosca, M.D., Ph.D., director of preventive cardiology at New York-Presbyterian Hospital and chair of the American Heart Association expert panel that wrote the guidelines. "We took a long-term view of heart disease prevention because the lifetime risk of dying of cardiovascular disease (CVD) is nearly one in three for women. This underscores the importance of healthy lifestyles in women of all ages to reduce the long-term risk of heart and blood vessel diseases."

The guidelines include a new paradigm for risk assessment based on risk factors and family history, as well as the Framingham risk score. (First published in 1998, the Framingham risk score estimates the risk of developing coronary heart disease within 10 years.)

The new guidelines include expanded recommendations on lifestyle factors such as physical activity, nutrition and smoking cessation, as well as more in-depth recommendations on drug treatments for blood pressure and cholesterol control.

Furthermore, guidelines on hormone and aspirin therapy and antioxidant and folic acid supplements are revised based on recently published data.

"Since the last guidelines were developed, more definitive clinical trials became available to suggest that health care providers should consider aspirin in women to prevent stroke," Mosca said. "In addition, providers should not use menopausal therapies such as hormone replacement therapy (HRT) or selective estrogen receptor modulators (SERMs) such as raloxifene or tamoxifene to prevent heart disease because they have been shown to be ineffective in protecting the heart and may increase the risk of stroke."

A recent American Heart Association survey showed that women are confused about methods to prevent heart disease including the role of aspirin, hormones and dietary supplements.

"The new guidelines reinforce that unregulated dietary supplements are not a method proven to prevent heart disease. For example, recent studies have shown that folic acid is ineffective to protect the heart despite widespread use by patients and physicians hoping for a heart benefit," Mosca said. "These recent findings emphasize the importance of using well-conducted clinical trial data to develop national recommendations to help patients and their doctors use best practices to prevent heart disease – practices based on data rather than myth or wishful thinking."

CVD is the largest single cause of mortality among women, accounting for 38 percent of all female deaths. The public health impact of CVD in women is not solely related to mortality, as advances in science and medicine allow many women to survive heart disease. For example, in the United States 42.1 million (36.6 percent) women live with CVD and the population at risk is even larger.

In fact, "nearly all women are at risk for CVD, underscoring the importance of a heart-healthy lifestyle in everyone," the authors wrote. "Some women are at significant risk of future heart attack or stroke because they already have CVD and/or multiple risk factors. These women are

candidates for more aggressive preventive therapy and we define them as high risk."

Physicians can easily identify high-risk women, but tools to determine other levels of risk are limited, Mosca said. The authors have aligned their recommendations with treatments proven to work and give strong advice for what not to do, as well.

"Therefore, we have more aggressive recommendations for high-risk women, and strongly emphasize lifestyle strategies to reduce risk in all women," she said. "Medicine is still an art but these guidelines are meant to guide health care professionals on the best science available."
Highlights of the changes include:

- Recommended lifestyle changes to help manage blood pressure include weight control, increased physical activity, alcohol moderation, sodium restriction, and an emphasis on eating fresh fruits, vegetables and low-fat dairy products.
- Besides advising women to quit smoking, the 2007 guidelines recommend counseling, nicotine replacement or other forms of smoking cessation therapy.
- Physical activity recommendations for women who need to lose weight or sustain weight loss have been added – minimum of 60-90 minutes of moderate-intensity activity (e.g., brisk walking) on most, and preferably all, days of the week.
- The guidelines now encourage all women to reduce saturated fats intake to less than 7 percent of calories if possible.
- Specific guidance on omega-3 fatty acid intake and supplementation recommends eating oily fish at least twice a week, and consider taking a capsule supplement of 850-1000 mg of EPA (eicosapentaenoic acid) and DHA (docosahexaenoic acid) in women with heart disease, two to four grams for women with high triglycerides.
- Hormone replacement therapy and selective estrogen receptor modulators (SERMs) are not recommended to prevent heart disease in women.
- Antioxidant supplements (such as vitamin E, C and beta-carotene) should not be used for primary or secondary prevention of CVD.
- Folic acid should not be used to prevent CVD – a change from the 2004 guidelines that did recommend it be considered for use in certain high-risk women.
- Routine low dose aspirin therapy may be considered in women age 65 or older regardless of CVD risk status, if benefits are likely to outweigh other risks. (Previous guidelines did not recommend aspirin in lower risk or healthy women.)
- The upper dosage of aspirin for high-risk women increases to 325 mg per day rather than 162 mg. This brings the women's guidelines up to date with other recently published guidelines.
- Consider reducing LDL cholesterol to less than 70 mg/dL in very high-risk women with heart disease (which may require a combination of cholesterol-lowering drugs).

This 2007 update provides the most current clinical recommendations for preventing CVD in women 20 and older and are based on a systematic search of the highest quality science interpreted by experts in the fields of cardiology, epidemiology, family medicine, gynecology, internal medicine, neurology, nursing, public health, statistics and surgery.

The authors note that these guidelines cover the primary and secondary prevention of chronic atherosclerotic vascular diseases. Recommendations for managing vascular disease before or after cardiac procedures or post-hospital and valvular heart disease are covered in other American Heart Association guidelines.

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In addition, this report has been endorsed by: American Academy of Physician Assistants; American Association for Clinical Chemistry; American Association of Cardiovascular and Pulmonary Rehabilitation; American College of Emergency Physicians; American Diabetes Association; American Geriatrics Society; American Society for Preventive Cardiology; American Society of Echocardiography; American Society of Nuclear Cardiology; Association of Women's Health, Obstetric and Neonatal Nurses; Global Alliance for Women's Health; The Mended Hearts, Inc; National Black Nurses Association; National Black Women's Health Imperative; National Women's Health Resource Center; North American Menopause Society; The Partnership for Gender-Specific Medicine at Columbia University; Preventive Cardiovascular Nurses Association; Society for Vascular Medicine and Biology; Society for Women's Health Research; Society of Geriatric Cardiology; Women in Thoracic Surgery; and WomenHeart: the National Coalition for Women with Heart Disease.

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Editors Note: In 2004, the American Heart Association launched its multi-tiered cause marketing Go Red For Women movement to raise women's awareness of their risk for heart disease and to help them take action to reduce their risk. For more information on heart disease and stroke or the Go Red For Women movement, call 1-888-MY-HEART or visit goredforwomen.org. The American Heart Association urges Congress to make the No. 1 killer of women a national priority by passing the HEART for Women Act this year. The HEART for Women Act is bipartisan federal legislation that would improve the prevention, diagnosis and treatment of cardiovascular disease in women. For more information, please visit www.heartforwomen.org.

NR07 – 1118 (Circ/Women's Guidelines 2007/Mosca)
Contact information: Dr. Mosca can be reached via her assistant Lisa Rehm at (212) 305-4866 or lmr2@columbia.edu or by calling Bryan Dotson, NewYork-Presbyterian Hospital/Columbia, 212-305-5587, brd9005@nyp.org. (Please do not publish contact information.)

Come Join Us for 2007 Summer Retreat

Brian Loftus, MD

The Summer 2007 TNS meeting will be held at the Westin Riverwalk in San Antonio on Friday, July 20 and Saturday, July 21. The summer meeting is more laid back than the winter meeting and includes time for you to spend with your family on a mini-vacation. The Westin Riverwalk is a beautiful venue but the Riverwalk location will also allow those more financially conscious to choose a less expensive venue.

For those attending, I promise a great meeting combining education in multiple sclerosis with education for your practice. This meeting will feature a first in that it is being held in conjunction with the Lone Star Chapter of the MS Society. The Lone Star Chapter of the MS Society is currently serving more clients, raising more money, and has a larger land area than any other MS Chapter. The Lone Star Chapter has also won multiple national awards.

The first day of the meeting will be devoted to issues having to do with MS that will impact our practices in the coming years. Topics to be covered include Childhood MS, MS in Hispanics, Emerging Therapies in MS, and newer MRI techniques in MS.

The second day is devoted to improving your practice. Topics to be covered include issues regarding Electronic Health Records. Procedures to be taught tentatively include blood patch, occipital nerve block, trigger point injection, baclofen pump programming and refills, as well as botulinum toxin therapy. An ethics hour will be offered as well.

I hope we set a record attendance this year. For those who attend, I am sure it will prove to be a most enjoyable and educational meeting.

Update on Acute Stroke Management Plan

Walter Buell, MD

Neurologists have been working on a system of acute stroke management for Texas for over a year. The Governor's EMS and Trauma Advisory Council (GETAC) formed a Stroke Committee to provide for effective and timely stroke management to fulfill the new guidelines for acute stroke management, Chaired by Dr. Neal Rutledge of Austin (NeuroRadiologist and Endovascular Interventialist). The Committee included several neurologists and neurosurgeons, as well as EMS and other academic authorities for stroke management. Neurologists serving on the committee are Victoria Parada, MD, Harlingen; James Grotta, MD, Houston; Lester Collins, III, Tyler; Liana Dawson, MD, Longview; David Sherman, MD, San Antonio; Khalid Malik, MD, Texarkana; and myself.

A complete list of the members is available through the TNS office, spanning most all areas of the state.

After several meetings and much discussion, a plan was devised to include hospitals meeting criteria for acute stroke management in an EMS protocol to get the stroke patients to their best treatment within the TPA Rx time window. The end result has been good: Senate Bill 330 from the current legislature approves the plan and provides $1.5 M to get everything started. Details of the arrangements can be obtained from Steve Janda at the Department of State Health Services [Steve.Janda@dshs.state.tx.us].

I would be delighted to hear from any of the TNS group who have questions, ideas, or desire to participate in the project. My email is wbuell@austin.rr.com.

Thanks for your help.

American Heart Association/American Stroke Association Guidelines:

Intravenous Delivery of Clot-busting Drug Still Best Intervention for Ischemic Stroke

DALLAS, April 13 – Intravenous delivery of an approved clot-busting drug remains the most beneficial proven intervention for ischemic stroke, according to updated American Heart Association/American Stroke Association guidelines published in Stroke: Journal of the American Heart Association.

The Guidelines for the Early Management of Adults with Ischemic Stroke also indicate that new options – such as intra-arterial administration of clot-busting drugs and mechanical removal of blood clots – show promise.

The guidelines focus on the crucial first hours from the time an ischemic stroke occurs through emergency evaluation and treatment in a hospital. Ischemic strokes, the most common type of stroke, are caused by a clot that blocks blood flow in an artery to the brain.

The panel emphasized the importance of public education on the symptoms of stroke, which include:

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden, severe headache with no known cause

Patients or observers should call 9-1-1 when stroke symptoms first develop.

"We are pushing for the fastest possible treatment because 'time is brain.' For every minute that goes by, the likelihood of a poorer outcome increases," said Harold P. Adams, Jr., M.D., chairman of the writing group.

Intravenous delivery of the clot-busting drug tissue plasminogen activator (tPA) is only approved to be used within three hours of symptom onset.

The panel said other techniques – mechanical devices and intra-arterial administration (IA) of tPA – are becoming more widely available and should be considered for patients with moderate-to-severe strokes who arrive at the hospital too late to receive intravenous tPA. However, information on these techniques is limited and more research is needed.

The new guidelines suggest emergency medical personnel perform a quick stroke assessment, draw blood and alert the hospital that a patient with a suspected stroke is coming. Patients should also be transported to the nearest "appropriate" hospital for emergency stroke care even if that means bypassing the closest facility or calling for air evacuation.

"Appropriate" facilities are those with the expertise and resources to provide modern emergency stroke care. Regional plans for paramedics to bypass institutions that do not have emergency stroke care should be developed, according to the guidelines.

The updated guidelines are an extensive revision of those issued in 2003 and 2005. Among the new or revised recommendations:

- Hospitals should develop emergency stroke protocols so patients can be assessed and treated within 60 minutes of arrival in an emergency treatment center.
- More medical centers should seek certification as primary or comprehensive stroke centers from the Joint Commission on Accreditation of Healthcare Organizations.
- Patients should receive early and carefully chosen treatments for abnormal blood pressure, fever or abnormal blood sugar levels, which can negatively affect stroke outcome.
- Although clot-dissolving drugs other than tPA are being tested, none has been established as effective and they should only be given as part of a clinical trial.

For the first time, the association has included comments about palliative or comfort care of a patient with a devastating brain injury.

"We included this in the document so that physicians may recognize that they can take measures to not prolong suffering or dying in a patient whose extensive brain injury will result in a fatal outcome," Adams said.

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Editor's note: For more information on stroke, visit the American Stroke Association Web site: strokeassociation.org.

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Broca's Area *A periodic newsletter of the Texas Neurological Society*

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