TEXAS NEUROLOGICAL SOCIETY SUMMER 2009

Broca's Area

The Voice of Texas Neurology

President's Message

Alan W. Halliday, MD

It is certainly an honor to be able to lead this growing and dynamic society for the next year. I thank Bill Gilmer for his outstanding year as president. I also appreciate the work of outgoing board members Preston Harrison and Liana Dawson and continuing board members Tommy Yee, Jerry Bettinger, Mark Pretorius, Aziz Shaibani, Sara Austin, and Randy Evans.

We have just completed our 12th Annual Winter Conference and, as has been the continuing trend, it was the largest conference to date, necessitating a move to a larger meeting room. I attribute the success of the conference to its ability to provide low cost, first-rate CME for our membership. This success is due to the extremely hard work put forth by the education committee and its chair, Jerry Bettinger. The committee members meet multiple times throughout the year to review your critiques so as to craft a meeting that meets the expectations and needs of the membership. Sara Austin and the committee have put together a wonderful summer conference that is going to be held July 17-18 at the marvelous Hyatt Lost Pines resort in Bastrop. Do yourself a favor and take a couple of days to enjoy some neurology CME while your family members cavort amongst the many amenities this fine resort offers.

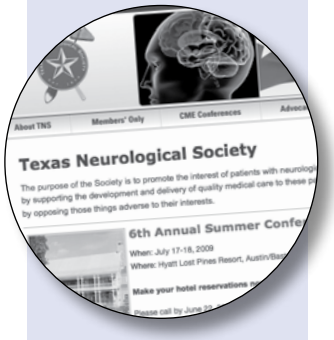
The Texas State Legislature is in session and that means many attempts by various groups to encroach upon medical scope of practice and related issues. The Texas Medical Association and The Texas Neurological Society review all bills submitted to assess their potential impact on patients. The TNS has many capable neurologists who volunteer their time to provide expert testimony on various aspects of pending legislation and their potential effect on the provision of medical services. Issues we are presently monitoring include ownership of diagnostic imaging facilities as well as scope of practice.

The Texas Neurological Society continues to grow and we strive to obtain 100% membership of our state's neurologists. If you have a colleague who is not a member, please encourage them to participate. It is by working together toward common goals that we can best ensure that Texas neurology continues to be a healthy, viable specialty for a long time to come. With the ageing of the baby-boom cohort, the need for the services provided by neurologists is greater than ever, and we have to make sure that we are able to deliver those services in a manner that best suits the needs of the patients while allowing the physician not to drown in administrative overhead.

(Continued on page 2)

NEW!
TNS Website

(Page 2)



About the President

Alan W. Halliday, M.D was born in West Point, New York. He moved around the country with his active duty military family until settling in Carlisle, Pennsylvania.

Dr. Halliday graduated from Indiana University of Pennsylvania in 1976 with a Bachelor of Science degree in Chemistry, summa cum laude. He earned his M.D. at the Pennsylvania State University College of Medicine and served his internship at the Brooke Army Medical Center in Fort Sam Houston, Texas, and his residency in neurology at Walter Reed Army Medical Center in Washington, D.C.

He served as the Chief of the Neurology Department at Brooke Army Medical Center for 21 years and served as chairman of the hospitals clinical personnel oversight committee. Dr. Halliday maintains academic appointments at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, and at the University of Texas Health Science Center in San Antonio, where he is clinical professor of neurology.

Over the course of his career in the Army, Colonel Halliday has been awarded numerous honors, including the Army Achievement Medal, Army Commendation Medal, Order of Military Medical Merit, and the Meritorious Service Medal. He holds the prestigious "A" prefix, the highest honor accorded an Army physician.

He has had articles published in medical journals, including *Military Medicine, Neurology, Epilepsia, and eMedicine Journal*. He is board certified in Neurology, Clinical Neurophysiology and Vascular Neurology. He is a Fellow of the AAN and is both a graduate and a mentor of the Palatucci Leadership Forum.

Dr. Halliday resides in San Antonio, Texas, with his wife, Ann. They have two sons, Stephen (a third year medical student) and Connor, who is about to start his freshman year in college.

Summer Conference Preview

By Sara G. Austin, MD, Program Director

Want to combine luxury, outdoors, water, golf and good science? Mark your calendars for the summer TNS meeting at the Hyatt Lost Pines this summer. The dates are Friday July 17 – Saturday, July 18. We are focusing on only two neurology topics and will cover them in depth.

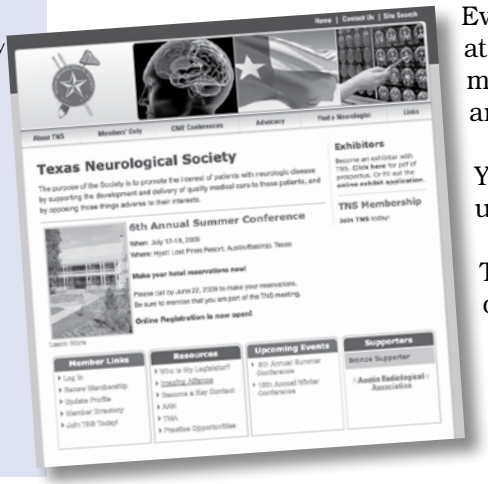
Friday afternoon will concentrate on epilepsy. As you all know, there are several new drugs coming on the market (for the first time in some years) plus information on traumatic brain injury and ICU monitoring and treatment of seizures. Dr. Susan Herman from Harvard, Robert Leroy, and Ramon Diaz-Arista will be speaking.

Saturday morning focuses on movement disorders with Dr. Christopher Goetz from Chicago talking about hyperkinetic movement disorders and the history of neurology and Dr. William Ondo and Richard Dewey will be rounding out the talks with update on Parkinson's disease and tremors. There should be plenty of time for questions and discussion.

Of course, on Saturday afternoon there will be hiking, or golf, or tubing, or spa-ing… and the list goes on.

We are hoping to see you there. It's a great way to learn what's new in neurology, get CME, and have a relaxing weekend at the same time.

NEW! TNS Website



Every member should check out our new TNS website at www.texasneurologist.org. You can now register for meetings, pay dues, update your contact information and more!

You can also enter your areas of professional interest, for use by other members and in the public search engine.

TNS hopes to do more for you on this website to cut down on mailings and reduce administrative costs.

Many thanks to the website committee for their hard work: William Gilmer, MD; Aziz Shaibani, MD and Brian Loftus, MD.

2009 Winter Conference a Huge Success

Marvin Fishman, MD is congratulated by his wife and TNS members.

Marvin Fishman, MD, accepts the Lifetime Achievement Award.

Dr. Gilmer, outgoing president, thanks Dr. Bettinger for his service as Winter Conference Program Director.

The 12th Annual Winter Conference of the Texas Neurological Society took place at the Austin Hyatt Hotel from February 27 – March 1, 2009. Attendance was an all-time high 270 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.

Many thanks to Preston Harrison, Jr., MD and Liana Dawson, MD, who completed their terms as board members.

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 6th Annual Summer Conference in Bastrop/ Austin at the Hyatt Lost Pines Resort, July 17 -18.

Thank you to the Supporters of the 2009 Winter Conference

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Congratulations to the following TNS officers:

(new positions)

President:
Alan W. Halliday, MD

President-elect:
Tommy Yee, MD

Vice president:
Jerry Bettinger, MD

Secretary-treasurer:
Sara G. Austin, MD

Members-at-large:
Aziz Shaibani, MD
Kimberly Monday, MD

My Year as a Public Policy Fellow

By Sara G. Austin, MD

Thanks to my profession and professional organization, I did something last year that very few people have the privilege to do. I spent a year working on Capitol Hill for a United States Senator.

The American Academy of Neurology, ANA and Child Neurology Society sponsor a public policy fellowship every year that is coordinated by the American Academy for the Advancement of Science (AAAS). AAAS has approximately 100,000 members and they work to advocate for science and scientists on the federal level.

The kids and I moved to D.C. (Northern Virginia actually) in August, and my fellowship started at the beginning of September with a 3 week orientation put together by AAAS. We began by meeting at their headquarters in downtown D.C., but after a week, they started moving the meeting places so that we would have the opportunity to see different federal buildings and get comfortable with the metro system. We met in the main conference room at the Department of the Interior, we met for several days in a beautiful room at the Library of Congress, and took a tour of the building. We had 2 days of conferences at the National Academy of Science, and could go visit with the statue of Einstein when we had a break. We had lunch on the roof of the Hotel Washington and were able to look over the Department of the Treasury to the White House.

They arranged for lots of speakers to come in. That is the first time that I noticed how different political speakers are from science types. First, they never, ever, used Power Point. They seemed to just talk at random, and in fact, it was pretty much at random. They had lots of opinions, but unlike scientific talks, did not have to provide any supporting data. Hum, that certainly makes things easier…. We were introduced to the Congressional Research Service which is a fairly large group of people, PhD's mostly, that are funded by Congress and provide information to Congress. A staff member or Congressman could call CRS at any time and get pretty much any information they ask for. CRS also published policy papers on all different topics, and would do research into a subject if asked. It is an incredibly valuable asset as you could imagine.

After the 3 week orientation, we started looking for a position in a congressional office. I interviewed with about 6 House offices, and an equal number of Senate offices. I learned that staff in House offices were much younger, the average age is probably 25. Senate staffers are older, averaging about 30 years. The average time spent working on the Hill is about 5-7 years, and then most people move on to a more permanent job in an Agency or on K street (lobbying). The jobs on the Hill are very competitive, and don't pay well. Every one has a college degree, and most have a graduate degree, either law or public policy. The hours are long, and the pay is very low. They really have little sympathy for doctors, who can make 3-10 times their salary.

The offices were very selective about who they allowed to work for them. I understand better now because what staff says is directly attributed to the member they work for. Once I started working in the office, I was included in all meetings. Information is gold and leaks can be a problem. I was happy to be asked to work for Senator Michael Enzi from Wyoming. He is the ranking (minority, Republican) member of the HELP committee (Health, Education, Labor and Pensions). Senator Kennedy is the chair.

Most of my days were spent reading. We read the newspaper every day and we read extensively about public health policy. When a bill was winding its way through the committee, we read the bill a zillion times. Every word is important, and small changes or seemingly insignificant sentences could translate into major policy shifts. We also met to negotiate a bill, we met with constituents, we attended hearings and many, many briefings. It was not nearly as busy as being a practicing physician, but it was incredibly interesting.

Some of the highlights of the year were sitting in the Senate gallery when the Medicare extension was passed. Or watching Senator Enzi, Kennedy, Dodd, Hatch, Burr, Coburn, Collins, Allard, Brown, and Sanders debate specific legislation during a mark up. I had free access to the Capital during the day and there is really nothing as awesome as standing in the Rotunda of the Capital, all by myself, watching it snow outside. I was able to attend Dr. Michael DeBakey's ceremony to receive the Congressional Medal of Honor, and to sit in on meetings when it was decided which Senators were allowed to sit in on negotiations about a bill.

I learned that 5,000 bills are proposed every year, and maybe 30 of any significance pass. I learned that policy is very important, but that procedure can just as easily derail a bill, and that politics is just as important as policy and procedure. I learned a lot about the background of how the federal government contributed to our current problems with health care, and how difficult it is to change a program after it's been written into law.

There are very few physicians working on the Hill in policy at any one time. As Neurologists we have an incredible opportunity to participate through the AAN's public policy fellowship. It was a lot of effort to get there, and I am glad to be back in Austin practicing medicine, but I would not have missed this for anything.

Commentary: Federal Advocacy

Sara G. Austin, MD

It's obvious that there is a lot going on up in Washington. It's harder to say if that is a good thing for us and our patients or not. As I'm sure you all are aware, heath care reform is at the top of the agenda, both for the Administration and Congress. I know that the Senate has been working on ideas for at least a year. The Academy of Neurology has been working to try to get ahead of the game, and to make sure that Congress hears our ideas and concerns. The Academy has 2 committees that are working on this, the Legislative Affairs committee, and a new ad hoc committee called HRTF (the Health Reform Task Force) which is chaired by Dr. Bruce Sigsbee. We are lucky to have Dr. Sigsbee, he's one of the last neurological members of the RUC committee (the AMA committee that sets Medicare fee schedule) and he'll be the AAN president in 2 years. I am fortunate enough to be on both committees, it's like a front row seat.

In March, the AAN sponsored Neurology on the Hill. We had 102 neurologists descend on Washington for 2 days to carry our message to Congress. All told, it was very successful. In addition, with the enormous help of our new Brain PAC, the AAN has been able to meet with the key players in health care reform, namely the Energy and Commerce Committee and the Ways and Means Committee in the House, and the Senate HELP and Finance committees. In fact, they were so successful that Dr. Sigsbee was asked to testify about fee schedule reform for the Energy and Commerce committee this Thursday. It is quite an honor, and the best chance for Neurology to really get our message out. I can't emphasize what a big deal this is.

The 'American Recovery and Reinvestment Act of 2009' had many sections that affected health care. Cobra subsidies are now available for those terminated between September 1, 2008 and December 31, 2009. Federal Medicaid assistance was increased. $19 Billion (with a B) was provided for Medicare and Medicaid health information technology (HIT) incentives over 5 years. Comparative Effectiveness research was also funded at a much higher level than in the past. The GAO has said in the past that funding research to look at best therapies would be a good way to potentially reduce the amount of money spent on health care. The $1.1 billion authorized would go to AHRQ (Agency for Healthcare Research and Quality) and also the NIH. The Institute of Medicine has started meeting already to try to figure out top priorities. The AAN has been invited to contribute ideas for issues most pressing for our patients. I think that over time, this will be a major shift in the involvement of the federal government in health care. I think that if it's done well, it will really enhance the ability of health care workers to care efficiently for patients.

In addition, $1 billion was set aside for prevention, and $1.5 billion extra was set up for community health centers, along with some extra funding for Title's 7 and 8, training for primary care providers and nurses. The NIH was a big winner with an extra $10 billion in funding.

The budget process is coming up next week which should be interesting. It was the only 24 hour stretch last year that I saw where all the Senators had to be in the gallery for votes that were occurring every 20 minutes. They ended at 3 a.m. last year, this year should be even crazier. There are rumors that the Democrats will use the budget process to circumvent the 60 vote closure rule in the Senate and essentially shut out the minority. It may be worth paying attention to.

In all, it looks like perhaps the Medicare fee schedule will get some type of overhaul. Hopefully, that will include Neurology and not just primary care. There is a lot of money floating around these days, and a lot of it is directed at medicine. I would strongly encourage you to donate to the Brain PAC if at all possible. $25-$50 would help tremendously and it has really made a difference. Give please if you can. Otherwise, pull up a chair, the games are about to begin.

Mark Your Calendar

2009 Summer Conference
July 17 - 18
Hyatt Lost Pines
Bastrop/Austin

2010 Winter Conference
February 5 – 7
Austin Hyatt

2010 Summer Conference
July 23 – 24
JW Marriott
San Antonio

2011 Winter Conference
February 25 – 27
Austin Hyatt

Congratulations to Dr. Fishman

With distinct pleasure, this year TNS presented its Lifetime Achievement Award to Marvin Fishman, 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 accepting nominations for its 2010 Lifetime Achievement Award – go to www.texasneurologist.org to make your nomination.

Marvin Fishman was born in Chicago on February 16, 1937. He grew up in Chicago where he attended the University of Illinois and graduated from the College of Medicine in 1961. After graduation, he did his pediatric training at Michael Reese Hospital and Medical Center in Chicago. He then enlisted in the Army for two years and was stationed at William Beaumont General hospital in El Paso, Texas.. Upon completing his military service, he began his Neurology training at the Massachusetts General Hospital and competed it at St. Louis Children's Hospital/Washington University.

Dr. Fishman was on the faculty of Washington University School of Medicine from 1967-1979. There he was a member of the division of child neurology, and Head of the Birth Defects Center at St. Louis Children's Hospital and Director of the Irene Walter Johnson Institute of Rehabilitation for the medial school. His early research focused on the development of myelin in the human brain and the effects of malnutrition in infancy on the development of myelin in the human brain. In 1978, he was promoted to Professor of Pediatric Neurology and Preventive medicine. In 1979, he joined the Baylor College of Medicine as Professor of Pediatrics and Neurology and Chief of the Neurology Service at Texas Children's Hospital. He held the latter position for twenty-five years until 2004. At that time he was awarded the George Peterkin Jr. Endowed Chair in Pediatrics. He retired from the faculty three years later and was given an emeritus position.

At Texas Children's Hospital in addition to clinical practice, his main focus was developing the child neurology training program and mentoring junior faculty. Throughout his career he has actively participated in the education of medical students, pediatric and adult neurology residents and child neurology fellows. For these efforts, in 2003 he was awarded the Arnold J. Rudolph Baylor Pediatric Award for Lifetime Excellence in Teaching.

Dr. Fishman participated in national activities. He was active in the Child Neurology Society and served as its president from 1987-89. The Society honored him in 1999 for his lifetime contribution to child neurology when he received the John B. Hower Award for Excellence in Pediatric Neurology. He was a member of the American Board of Psychiatry and Neurology serving as president in 1997-98 and member of the Residency Review Committee serving as chairman from 1995-96. He served the American Board of Pediatrics as a member of their Renewal of Certification Committee and as a consultant to the Board of Developmental-Behavioral Pediatrics. He has been on the editorial board of the *Journal of Pediatrics, Journal of Child Neurology, Developmental Neuropsychology, Pediatric Neurology, Annals of Neurology and Up to Date.*

Among his most rewarding professional accomplishments has been the development of trainees and observing them become competent, caring, empathetic clinicians and accomplished successful investigators while maintaining their intellectual curiosity throughout their careers.

He currently divides his time between Houston and Angel Fire, New Mexico. He has two children and four grandchildren who live in Houston, and he attributes everything to his wife of 49 years, Gloria.

TMA's Bicycle Helmet Giveaway Program a Great Fit for Neurologists

Texas Medical Association's Hard Hats for Little Heads bicycle helmet giveaway program offers a great way for you to give back to your community, while stressing good health and injury prevention to children. The matching program provides free helmets with a purchase, based on the number of helmets you buy.

Neurologist Wesley Dennis, MD, Arlington, partnered with his church to sponsor a helmet giveaway at a school health fair in August 2008. Dr. Dennis personally fitted the helmets on the kids and discussed proper use of them when riding bikes. "As a neurologist, we see many cases of epilepsy that could have been avoided if severe head injuries didn't take place. It is great to know the program could someday prevent someone from having a severe head injury, neurosurgery, and later post-traumatic epilepsy," says Dr. Dennis.

While events can occur at any time, Hard Hats for Little Heads will focus events during Bicycle Month in May and Brain Injury Awareness Month in October. By tying with these national observances, TMA can maximize statewide media exposure of the medical community's commitment to child safety and head injury prevention.

Along with helmets, TMA provides a host of educational materials, such as posters and flyers, and media relations support. All materials are available in English and Spanish. Head injury is the leading cause of serious disability or death in bicycle crashes, and helmets can help reduce the risk of head injury by 85 percent. Yet less than half of bikers wear a helmet when they ride.

Dr. Dennis says the Hard Hats program was easy to carry out. "I would encourage my colleagues around the state to sponsor or participate in the Hard Hats program — a great way to give to your community," he added.

Hard Hats for Little Heads was created by TMA in 1994 to help children more safely enjoy wheeled activities — such as biking, skateboarding, and inline skating. The program is funded by TMA Foundation, the philanthropic arm of the Association, through a grant from Blue Cross and Blue Shield of Texas and contributions from physicians and their families. Since the program began, more than 55,000 helmets have been given to Texas children.

To find out how you can get involved, visit www.texmed.org/hardhats or contact Tammy Wishard, TMA's outreach coordinator, at (800) 880-1300, ext. 1470, or tmaoutreachcoordinator@texmed.org.

Welcome New Members!

The following were voted in during the 2009 Winter Conference

Active Membership

Sabiha Ali, MD, Houston
Husam Alkhersam, MD, Bedford
Parveen Athar, MD, Houston
Hana Aubrechtova, MD, Austin
Viveca Bhat, MD, San Antonio
Pamela Young Blake, MD, Houston
Robert L. Boyne, MD, Tyler
Merrill K. Carolin, MD, San Antonio
Anwarul Haq, MD, Dallas
Joohi Jimenez, Shahed, MD, Round Rock
Rabia A. Khan, MD, Irving
Bruce Ian Lobar, MD, San Antonio
Ryan O. McDonald, MD, The Woodlands
Michelle M. Moon, DO, Seguin
Ali Moussaoui, MD, Sugar Land
Venkatesh Nagaraddi, MD, Richardson
Sreekumaran K. Nair, MD, Fort Worth
R. Braden Neiman, MD, Wichita Falls
Russell C. Packard, MD, Palestine
Michael Lee Palm, MD, Bryan
Erin L. Phillips, MD, Tyler
Payman Sadeghi, MD, Houston
Lawrence A. Schaeffer, MD, Amarillo
Kazim A. Sheikh, MD, Houston
Marcos J. Valdez, MD, McAllen
Matthew P. Wicklund, MD, Lackland AFB
Karin H. Woodman, MD, Houston

Associate Membership

Nordeli Estronza, MD, Austin
Norman D. Fry, MD, Odessa
John Marcus Kirk, MD, Las Vegas, NV

Resident Membership

Polo Alberto Banuelos, MD, San Antonio
Andrew Woodrow Bursaw, MD, San Antonio
Xiang Fang, MD, Galveston
Saumya N. Gill, MD, Houston
Melissa Jones, MD, Houston
Steve Thomas Kirk, MD, Houston
Qinghau Liang, MD, Galveston
Jung Gook Lim, MD, Galveston
Todd S. Masel, MD, Galveston
Gincy Koruthu Samuel, MD, Dallas
Snehi Sehgal-Kapur, MD, Houston
Prasuna L. Velur, MD, Austin
Guangbin Xia, MD, Galveston

Expert Opinion #1

Benjamin M. Greenberg, MD, MHS — *Director, Transverse Myelitis and Neuromyelitis Optica Program*
Deputy Director, Multiple Sclerosis Program

Cain Denius Scholar in Mobility Disorders — *Department of Neurology UT Southwestern*

Case

This 50 year old woman was seen in March, 2009 on referral by her PCP for recurring migraine without aura since the age of 18 years. A MRI scan of the brain 1 month previously was reported as showing multiple white matter abnormalities consistent with multiple sclerosis.

In 1991, she reported having an episode of right sided weakness with double vision and vertigo which resolved after some weeks. In 1998, she recalled having an episode of hypersensitivity of the left side of the face and double vision which resolved after a few weeks. A couple of months later, she had an episode of double vision which resolved after several weeks. She had previously seen 2 neurologists and had testing including normal blood studies and 3 MRI scans of the brains showing multiple white matter abnormalities consistent with multiple sclerosis. In 1998, the cerebrospinal fluid was positive for oligoclonal bands. Immunotherapy for multiple sclerosis was discussed but she declined and had no neurological follow-up or symptoms except for the migraines treated by her PCP.

Past medical history of hypertension on metoprolol. Neurological examination was normal.

Questions:

Would she benefit from immunotherapy for multiple sclerosis? Does she have benign multiple sclerosis? Is the prevalence of migraine greater in those with multiple sclerosis than in the general population?

Discussion

This case highlights an ongoing controversy within the field of multiple sclerosis, namely the questionable existence of "benign" MS cases. These patients were classically defined by the lack of disability they experienced 10 and even 20 years into the course of their disease. Their existence has been used to temper enthusiasm about treating all patients with immunomodulatory therapy, because they may not have the same needs as patients with 'aggressive' MS.

Based on currently accepted diagnostic criteria the patient in this vignette definitely has relapsing remitting multiple sclerosis. She has had clinical episodes separated in time and space, with MRI evidence of demyelination and CSF evidence of an active intrathecal immune response. She has experienced brainstem events, characterized by double vision and weakness in the past. At the time of her current evaluation, however, it has been over 10 years since her last exacerbation, raising the appropriate question, what value is there in starting therapy at this stage?

The definition of 'benign' MS has historically been based on patient assessments using the Kurtzke Expanded Disability Status Scale (EDSS). This scale is heavily weighted to reflect a patient's ambulation capabilities. It fails to capture significant information on cognitive capabilities, dexterity issues, fatigue or pain. Patients can have a low EDSS score (below 3) and be completely disabled by other symptoms. Thus, patients, such as this one might be labeled as having 'benign' MS, but in reality have quite disabling disease. Many patients are still ambulatory 20 and 30 years after the diagnosis of MS, come into clinic with significant complaints about difficulties with memory, language and multitasking.

Beyond the concern for disability, not represented by the EDSS scale, there is also concern about the transition of some patients from a 'benign' state to a more aggressive disease course. Some studies have noted that a large proportion of patients who have were benign in the early portion of their disease can have increased disease activity late in the course of their illness. For example, one study by Sayao and colleagues found that over 50% of patients with an EDSS of 2 to 3 at ten years, where above 3 by the 20 year mark. Even though they had prolonged periods of disease quiescence there was the possibility of disease activation later. There is a lack of data tracking these patients for 20-30 years, so predicting the rate of change from benign to aggressive MS after 20 years is not known. Furthermore, the studies documenting late activation still fail to adequately measure cognitive changes. Some data suggests than around 20% of patients with 'benign' MS (defined by EDSS criteria) have cognitive deficits.

(Continued on page 10)

Expert Opinion #2

James C. Grotta M.D. — *Professor and Chair, Department of Neurology*
Director, Vascular Neurology Program • University of Texas - Houston Medical School

Case

This 68 year old man is seen with a 2nd hemispheric TIA in the last year on aspirin 81 mg daily. There is a history of well controlled hypertension and hyperlipidemia on medication (blood pressure 110/70 and LDL of 60). There is no coronary disease and no cardiac embolic source with a normal EKG, cardiac stress test, and transthoracic echocardiogram.

Questions:

Could this patient have aspirin "resistance"? If he were switched to clopidrogrel, should he be tested for possible resistance? Should resistance for either drug be routinely tested? Can resistance be treated by using a higher dose of medication? Are there medications which interfere with clopidrogel?

Discussion

This case represents a common dilemma — the patient on antiplatelet therapy who continues to have ischemic events. What should be our response?

The first consideration is to ask whether this is a patient with "aspirin failure" or "diagnostic failure"?

First, we should re-evaluate the mechanism underlying the symptoms looking for a condition that would mandate alternative treatment. Is there an occult underlying cardiac source of embolization such as paroxysmal atrial fibrillation, carotid stenosis, or even a seizure disorder simulating a TIA.

Second, we should be sure that other risk factors have been addressed and optimally managed such as hyperlidemia and hypertension.

While these issues all seem to have been addressed in the current case, recent data from the SPARCL study indicate that all 4 risk factors, blood pressure, LDL, HDL and triglycerides have an effect on stroke risk, and that control of each of them has an additive effect on risk reduction. I, like most clinicians, tend to focus too much on the LDL without also controlling HDL and triglycerides.

In this case, then, the first steps I would take would be to obtain good arterial imaging with MRA or CTA to be sure there is no significant stenosis, do a Holter monitor and possibly a TEE to look for an occult cardiac source of emboli, take a good history of the event and consider an EEG to exclude a seizure, and be sure the HDL and triglycerides are as well controlled as the LDL.

The second consideration is to ask the patient if they are taking their medication. In several studies, the most common cause of variability in platelet function tests in patients taking aspirin or clopidogrel is poor patient compliance.

Patients tend to underestimate the importance of taking aspirin. It is not uncommon for them to even leave out mentioning they are on the drug when they are asked to list their medications. In this case, I would stress to the patient the importance of taking their aspirin daily.

The third consideration is drug interactions. Aspirin works by inhibiting cyclo-oxygenase-1. Non-steroidal anti-inflammatory drugs such as ibuprofen interfere with aspirin induced COX-1 acetylation. In the case of clopidogrel, proton pump inhibitors, especially omeprazole (Prilosec), and the H2-blocker cimetidine, reduce the enzymatic activity of the cytochrome P450 enzyme CYP2C19 which is needed to convert clopidogrel to its active metabolite in the liver. This seems to be less the case with pantoprazole (Protonix) and the H2-blockers such as ranitidine, famotidine, or nizatidine.

Patients on antiplatelet agents need to know about these potential drug interactions. In this case, I would ask the patient if he is taking an NSAID and warn him not to do so.

Having taken those steps, what about raising the aspirin dose or switching to clopidogrel? At present, the level 1, class A evidence-based response from randomized stroke prevention trials would be that the aspirin dose should not be raised and that clopidogrel has no advantage over aspirin. However, there are less certain data that might guide us in this particular case. This raises the issue of aspirin or clopidogrel "resistance".

There is ample evidence that patients may vary in their response to antiplatelet drugs as measured by various platelet function assays, even after compliance and drug interactions are taken into consideration. Diabetic patients in particular may have heightened platelet reactivity that is more resistant to platelet inhibition than non-diabetics. Genetic polymorphisms also play a role. Recent studies have shown that up to 30% of patients have a polymorphism in CYP2C19 that is associated with a higher rate of cardiovascular events. A recent meta-analysis shows that patients with laboratory-defined aspirin resistance are 3.78 times more likely to have a cardiovascular event than those without.

(Continued on page 10)

Expert Opinion #1

(Continued from page 8)

In the end treatment must be individualized to the patient, even when there is a lack of reliable prognostic variables that can be used to guide therapy. Even after a lack of relapses over a decade patients can present with severe debilitating relapses or steadily develop cognitive deficits. The medications that are used in MS are only partially effective, but their effect is 100% preventative. There are, as of yet, no restorative therapies. Hence, even in patients who have experienced stability for long periods of time, consideration should be given to using an immunomodulatory agent. When individualizing therapy, one should consider the nature of previous relapses and the potential significance of a future relapse. For example, if a patient has already suffered vision loss or partial weakness there is a greater chance that a subsequent relapse will leave them with more disability then in a person who has only had sensory attacks. Thus, in this patient I would strongly consider immunomodulatory therapy, even at this stage.

This case also raised the question about the association of migraines with multiple sclerosis. While headaches are a common complaint in patients with MS, they are not more frequent then the general population. In patients who are being evaluated for MS, however, the presence of concomitant migraines raises questions about the specificity of white matter lesions seen on MRI. Clinical judgment must be used when determining whether or not MRI changes are more consistent with demyelinating disease or some of the mild changes that can be seen in the presence of migraines.

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Expert Opinion #2

(Continued from page 9)

However, aspirin assays often give inconsistent results from one test to the next, especially those not specific for COX-1 signaling, or those not using arachidonic acid as the stimulant for aggregation. There is also a multiplicity of tests for clopidogrel responsiveness, and standardized criteria for non-responsiveness have not been determined. Clinically, one can always use the "bruising index". If a patient is noticing more bruising on their current dose of aspirin or clopidogrel, then you can conclude that platelet function is being inhibited, though the reverse may not be true—absence of bruising does not mean the drug is not working. No study has shown that adjusting therapy based on platelet function assays results in better clinical outcomes. Therefore, guiding antiplatelet therapy on the basis of platelet function assays is not recommended, and I would not send our patient for such tests.

If we can't rely on platelet function tests to guide us in managing our patient, then how can we decide about dosing or switching drugs? Increasing the dose of aspirin does not increase COX-1 inhibition, and doses above 81 mg do not show greater anti-ischemic effect and do increase the risk of bleeding in clinical studies. With clopidogrel, loading with 300-900 mg results in faster and more complete platelet inhibition, and fewer ischemic events in patients having coronary interventions. A recent study of diabetic patients randomized to the conventional recommended 75 mg dose vs 150 mg found reduced aggregation with the higher dose, but the safety and efficacy of the higher dose is still being studied. Finally, adjunctive treatment with cilostazol in addition to aspirin or clopidogrel is being tested, but is still of unproven efficacy.

Therefore, in this case, after taking the steps mentioned above, I would most likely switch the patient to clopidogrel 75 mg daily.

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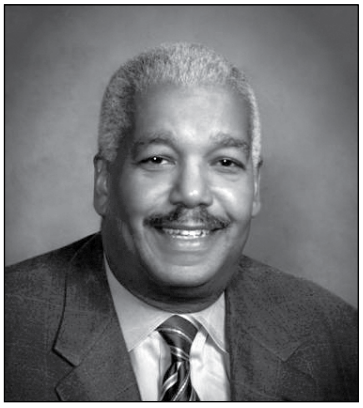
Neurologist Becomes TMA's 144th President



The Texas Medical Association (TMA) has elected TNS member and past president **William H. Fleming III, MD**, of Houston as its 144th president. Dr. Fleming was installed as president during TexMed 2009, the association's annual meeting, held this year in Austin.

"I am proud that the members of our society entrust me to lead the best state medical society in the land," Dr. Fleming said.

Dr. Fleming lists two big goals to improve the health of Texas patients during his one-year presidency. "No. 1 is health system reform — the system is broken and we need to fix it," he notes. "Second is access to care — we have to improve the access. When 30 percent of the population is either uninsured or underinsured, it's a problem. This 30 percent gets either no care, or delayed care, or poor care."

"I am proud that the members of our society entrust me to lead the best state medical society in the land."

Dr. Fleming just completed a one-year term as TMA's president-elect. Previously, the neurologist served as speaker of TMA's House of Delegates, vice speaker, and as a member of TMA's Board of Trustees. He also is a TMA alternate delegate to the American Medical Association's House of Delegates.

Dr. Fleming is TMA's first African-American president, which he believes is historic and long overdue. "It's a milestone in some ways and in other ways it's a non-issue," he says. "I stand on the shoulders of the African-American physicians who came before me, like Dr. Frank Bryant. I represent all the doctors. I'm the face of Texas medicine."

Dr. Fleming is a clinical assistant professor of neurology at The University of Texas Medical School at Houston. He also serves on the boards of Memorial Hermann Healthnet Providers, the Gulf Coast Regional Blood Center, and the American Heart Association. Dr. Fleming is board certified by the American Board of Neuromuscular and Electrodiagnostic Medicine. He also recently served on the Joint Quality Review Committee of Houston's Memorial Hermann Southwest Hospital, and on the Board of Regents of Texas Woman's University at Denton.

Dr. Fleming also has served in several leadership roles in other state and national medical societies. He was president of the Federation of State Medical Boards of the United States and chair of the State Affairs Committee of the American Academy of Neurology, and he has served as president of the Texas State Board of Medical Examiners, the Texas Neurological Society, and the Harris County Medical Society. He also has served on the board of directors, and in several other roles, of several medical organizations.

Born and raised in Memphis, Tenn., the Houston neurologist took a somewhat roundabout path to becoming a physician. "I had always wanted to become doctor since I was a child, but I strayed for a little while and didn't know what I wanted to do," he says. During that time he played several musical instruments, and even contemplated becoming a professional musician. However, second thoughts and medicine's draw influenced him. "The real factor was my desire to help people; plus, I was influenced by my family physician," he recalls.

Dr. Fleming earned his medical degree from the St. Louis University School of Medicine at St. Louis, Mo. He completed his neurological residency at the Mayo Clinic and Mayo Graduate School of Medicine at Rochester, Minn., and his medical residency at McGill University at Montreal, Quebec, Canada. Dr. Fleming completed his undergraduate studies at The University of Kansas, at Lawrence, Kan.

Dr. Fleming and his wife, Cheryl, have a daughter, Bria. TMA is the largest state medical society in the nation, representing nearly 44,000 physician and medical student members. It is located in Austin and has 120 component county medical societies around the state. TMA's key objective since 1853 is to improve the health of all Texans.

Minutes

TNS Annual Business Meeting
Saturday, February 28, 2009
Hyatt Regency Austin Hotel

President William S. Gilmer, MD, called the meeting to order at 12:30 pm. He thanked Jerry Bettinger, MD, for his work as program chair.

Approval of February 2008 Minutes
The minutes from the 2008 annual business meeting were approved as submitted.

Moment of Silence
The attendees observed a moment of silence to remember two deceased members:

- Jay Charles Duffield, MD, Joplin, MO, passed away on April 28, 2008.
- Rebecca S. Shank-Gill, MD, Granbury, TX, passed away on April 20, 2008.

Secretary-Treasurer's Report
Jerry Bettinger, MD, presented the membership report and ballot. The membership approved the ballot as presented.

Advocacy
Dr. Gilmer updated the membership on scope of practice battles that lie ahead in the 2009 Texas Legislature, as well as a challenge to physician ownership of imaging equipment. TNS is a founding member of ImagingAlliance.org, whose mission is to preserve physician ownership. Dr. Gilmer encouraged members to attend a TMA First Tuesday lobbying day.

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

Election of New Officers
Dr. Gilmer presented the 2009-2010 slate of officers, which was approved unanimously. He also thanked outgoing board members Preston Harrison, Jr., MD and Liana Dawson, MD for their service on the TNS board of directors.

Change of Officers
Dr. Gilmer thanked the Society for a successful year, and presented Alan W. Halliday, MD with a gavel as incoming president. Dr. Halliday thanked Dr. Gilmer for his hard work as president, and then gave his acceptance speech.

The meeting was adjourned at 1:30 pm.

2009-2010 Officers

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president@texasneurologist.org

President-Elect
Tommy Yee, MD

Vice President
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Education Committee Chair
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2009 Summer Retreat Program Director
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Program Director Summer Conference 2010
G. Mark Schwartze, MD, Waco

Delegate to TMA
William Gilmer, MD, Houston

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