



Broca's Area

The Voice of Texas Neurology

President's Message

Tommy Yee, M.D.



As your Society's president for the upcoming year, I know that these are challenging times for we neurologists on many fronts, and your Society will work for you on these issues. We will draw among the ranks of the members of the Society, as well as all other sources, to keep you informed to allow you to maintain and improve your practice.

Kudos to our past president Alan Halliday, MD for a job well done in leading us this last year. Also many thanks to Drs. Kim Monday, Marvin Fishman, and Gary Clark along with the board members of the Texas Neurological Society for all their work. Most of all, thanks to you, the members of this Society, who have given us the support

to allow us to grow into the largest state neurological society in the country as well as being generally recognized as the prototype for all other state societies.

The Society has continued to put on educational conferences featuring both national and state speakers who are recognized authorities in their field. The past Winter Conference was the largest ever for the Society with close to 300 attendees. Your continued support is instrumental in maintaining the high quality of our meetings, and we will strive to be responsive to your needs. The education committee reviews all the comments about each meeting making full effort try to place topics and speakers you list. Most of you will agree that the low cost of our conferences, the amenities, and reconnecting with friends make it a bargain!

With the new health care law and its ensuing changes, there will be challenges for all of us as we deal with the needs of our patients, along with our providing the highest level of care while trying to maintain a financially viable practice. I, being in private practice, like most of you, fully appreciate what each one of us are faced with. The Society will have practice management topics with our conferences which will address these issues. Also, we are in the early process of developing a coding website for our members where questions can be addressed to experts within our Society and when this task is completed, we will notify you. Maintenance of certification is another requirement for some of us which the Society recognizes and will strive to establish a program to help facilitate this for you

Advocacy on behalf of our patients and neurology has become of primary importance. We have two excellent advocates on our board, Dr. Sara Austin and Dr. Bill Gilmer, both of whom are well versed in the political process. Please read Sara's legislative update in this newsletter to help keep you informed, but most importantly talk to your local, state, and congressional representatives. Both Sara and Bill would welcome any help and comments in this very important endeavor.

The day of dwindling pharmaceutical financial support for continuing education is here and to maintain the high quality of our education conferences, the Board is faced with the responsibility of keeping the conferences financially sound. Even with gradual increases in meeting fees to be expected, The Texas Neurological Society's annual education conference still remains your best value in continuing medical education.

Finally, I want to acknowledge and thank all the members who signed up this past Winter Conference to become more involved in your Society. The Board is currently looking for ways to integrate you within our framework.

In closing, we have many challenges ahead but working collectively together we will be able to tackle each one. The Board and I welcome your comments and involvement as we continue to build an even stronger Texas Neurological Society.



**2010 SUMMER
MEETING**

July 23-24

**JW Marriott Resort
San Antonio**

More details inside



Thank you to the Supporters of the 2010 Winter Conference

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2010 Winter Conference a Huge Success

The 13th Annual Winter Conference of the Texas Neurological Society took place at the Austin Hyatt Hotel from February 5-7, 2010. Attendance was an all-time high 296 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 Kim Monday, MD, program director, for organizing this meeting. Special thanks also to Marvin Fishman, MD and Gary Clark, MD for directing the pediatric session.

Many thanks to Aziz Shaibani, MD, who completed his term as a board member.

The new officers of the TNS were voted in by the membership.



Congratulations to the following:

President:

Tommy Yee, MD

President-elect:

Jerry Bettinger, MD

Vice president:

Sara G. Austin, MD

Secretary-treasurer:

Mark Pretorius, MD

Members-at-large:

G. Mark Schwartz, MD and

Robert F. Leroy, MD





TNS 7th Annual Summer Conference Preview

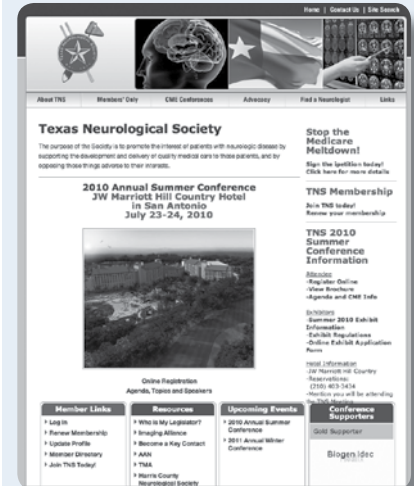
G. Mark Schwartze, MD, Program Director

This is an excellent opportunity to update the state of the art in headache including diagnostic testing, understanding and treating migraine through a woman's life cycle, and chronic migraine. We can all benefit from the E&M coding update. There are also reviews of pseudotumor cerebri and papilledema, acute evaluation and management of concussions in sports, deep brain stimulation for non-Parkinson's conditions, and multiple sclerosis. The conference concludes with a workshop including live demonstrations on the use of botulinum toxin for headache, dystonia, and hemifacial spasm.

The meeting will be at the new JW Marriott Hill Country Resort in San Antonio. The attendee can obtain up to 9.75 CME credits including one hour of ethics. The cost is only \$150 for TMA members who register by July 9 (go to www.texasneurologist.org).

Book your hotel room at the beautiful New JW Marriott Hill Country Resort and Spa by July 1st. The rate for TNS Attendees is an unbeatable \$168. Call (210) 403-3434 or book via www.texasneurologist.org.

Visit TNS
online at
texasneurologist.org



Editor's Notes

Randolph W. Evans, MD



I thank all of our contributors for their excellent contributions to the newsletter keeping you current on TNS and current political, coding, practice, and treatment issues. Mark Schwartz, MD and the education committee have done an excellent job planning the Summer Conference being held at the new JW Marriott Hill

Country Resort in San Antonio. Remember to register by July 9 for a fee of only \$150 for 9.75 CME credits including one hour of ethics.

Do You Still Love What You Do? Are you working longer hours and enjoying it less, being asked to complete more and more paperwork and finding insurance companies and government agencies an ever increasing presence and burden in your practice? You're not alone (Chen P. Doctor and patient: fueling the anger of doctors. *New York Times*. May 2, 2010. Available at <http://query.nytimes.com/gst/fullpage.html?res=9A01E2DF103AF937A35756C0A9669D8B63>). In addition to dropping compensation, an increasing loss of autonomy is fueling this anger. Neurologists also spend large amounts of uncompensated time daily as do PCP's (Baron RJ. What's keeping us so busy in primary care? A snapshot from one practice. *N Engl J Med*. 2010 Apr 29;362(17):1632-6) with patient phone calls, emails, reviewing test results and records, prescriptions, etc. Hopefully, the lobbying efforts of AAN will succeed in having neurologists recognized for reimbursement as primary care physicians especially since the unjustified demise of consult codes.

The EMR Era – I don't yet have an Electronic Medical Records System (EMR) but have been shopping around as have many of you. One year ago, I placed PC's in each exam room as an experiment and started typing all of my own new patient and follow-up notes. It's been a huge success. I've saved about \$15,000 on transcription costs and the reports have been immediately available to send to other physicians and insurance companies for pre-certs.

More importantly, and perhaps the real value of EMRs, is the connection to the internet. I've become immediately smarter when I see patients. Although I read and write extensively and attend CME courses, I still forget a lot and there's material I just don't know. When I was younger, there was perhaps a conceit that you should know everything. But neurology can be an

open book test except in an emergency situation. (Or as Einstein said, "Never memorize what you can look up in books.") The key is to access information quickly. I can do so in front of a patient with a PC. Previously, I would have to look material up later which I might not have done unless really critical.

Usually, I access MedLink Neurology (www.medlink.com) or UpToDate (www.uptodate.com) (disclosure: I'm on the editorial board of MedLink and a contributor to UpToDate), and I can obtain the answer within a minute or two. UpToDate has prescription and natural drug information and interactions as well. If I don't find the answer, I can quickly do a pubmed search. Sometimes, I'll copy and paste some information and include it in my report to send to the referring physician. In addition, both references provided patient summaries on many topics which I can print out or, if the topic is not available and the patient is sophisticated, I'll provide the patient a copy of the physician article.

For those adopting EMRs, the LCD screen and the keyboard are new barriers between the physician and the patient which we all need to get used to. However, quality of care can increase if all physicians take the time to access online medical references rather than use EMRs to upcode poor quality documentation. Some of the worst medical records I've seen are EMR notes which are long only for the purpose of upcoding, replete with copy and pasted segments and long review of systems but don't really tell me much about the patient. EMRs don't replace a good history and exam and a physician actually thinking about their patient's problem even though an auditor can't distinguish quality from documentation.

Unfortunately, many EMRs seem to have been designed to meet the demands of the fee-for-service system and now to qualify for government incentives rather than to meet the demands of patient care (see Chen P. An Unforeseen complication of electronic medical records. *New York Times*. April 22, 2010. Available at <http://www.nytimes.com/2010/04/22/health/22chen.html>). In addition, EMRs may interrupt physician workflows and interfere with patient communication where "some doctors liken the presence of EMR to having a 2-year-old in the exam room." (O'Malley A, et al. *Electronic Medical Records and Communication with Patients and Other Clinicians: Are We Talking Less?* Center for Studying Health System Change. April 2010. Available at <http://www.hschange.org/CONTENT/1125/>).

About the President — Tommy Yee, MD

Tommy Yee was born and reared in Tallulah, Louisiana, a small, rural town in northeast Louisiana. He attended and received his Doctor of Medicine degree from Louisiana State University School of Medicine in New Orleans in 1975. Subsequently he completed his flexible internship at the University of Tennessee in Memphis then finished his first year of neurology residency at Baylor College of Medicine followed by completion of his final two years of neurology residency at Louisiana State University School of Medicine in New Orleans. He is board certified in neurology.

Upon completion of his residency, Dr. Yee has been in solo private practice in general adult neurology in McAllen, Texas since 1979. He has been recognized as Best Clinical Teacher by the family practice residency program of the University of Texas Health Science in San Antonio's McAllen branch. In addition he has been recognized by Texas Monthly's Super Doctors of Texas in neurology. In addition to his practice, Dr. Yee has also been involved in many local civic activities and organizations.

He resides in McAllen with his wife Anita, and they are the parents of two daughters, one of whom is an attorney with the other a journalist.

Sign the Petition to End the Medicare Meltdown, Plus 10

Have you signed the Stop the Medicare Meltdown petition yet? Have you asked your friends, family, and neighbors to sign it? If not, please do so today. Rarely has there been an issue as important to medicine as the impending Medicare crisis.

You must act now and sign the petition go to www.ipetitions.com/petition/meltdown. You must let the members of Congress know that you and your patients are watching their every action and care deeply about this issue. Congressmen keep telling us that physicians don't care because they never hear from them. Let's prove to Congress that "PHYSICIANS AND PATIENTS DO CARE."

TMA is asking every physician to sign the petition. After you sign it, please ask your friends, family, and neighbors to sign it until you get 10 signatures or more. If you belong to civic groups, take the petition with you to meetings. We must get 1 million signatures. It's imperative to your profession!

If you want hard copies of the petition, call Pam Udall at TMA at (800) 880-1300, ext. 1382, or download one from the TMA website (www.texmed.org), click on Governmental Affairs on the left, then U.S. Congress.

Note: Due to HIPAA regulations, we recommend that you not collect signatures directly from your patients nor use patient lists to disseminate this information without first having a HIPAA-compliant patient authorization to do so. You can post a flyer in your waiting room (see website above).



Mark Your Calendar

2010 Summer Conference

July 23-24
JW Marriott
San Antonio

2011 Winter Conference

February 25-27
Hyatt Regency
Austin

2011 Summer Conference

July 15-16
Westin La Cantera
San Antonio

2012 Winter Conference

February 3-5
Hyatt Regency Austin



[www.ipetitions.com/
petition/meltdown](http://www.ipetitions.com/petition/meltdown)

Legislative Report

By Sara G. Austin, MD

To say that a lot has happened in healthcare in the past six months is like calling a cheetah a house cat - it hardly does it justice. I think the last time I wrote this article, I was comparing the House and Senate bills. Since then, the Senate bill passed the House, the reconciliation bill passed both houses, and, with no surprise, President Obama signed the whole thing into law.

Now we are scrambling to figure out what it all means and we are coming to terms with what was in the bill, and what has been left out. I could give you all tons of background, but to keep it readable I will just list some of the issues that the American Academy of Neurology (AAN) and/or the Texas Medical Association (TMA) are working on.

1. The Neurology amendment. There is a 10% bonus payment in the law for primary care docs to kick in starting in 2011. Primary care is defined as physicians who are board certified by internal medicine, family practice and general surgery AND who have more than 60% of their total Medicare billing made up with E&M codes (evaluation and management). Neurology, it turns out, is the only cognitive specialty that does not take the internal medicine or family practice boards. We think the exclusion of Neurology from the bonus was an oversight; however fixing it is difficult because of the legislative process. The AAN has been working very hard to get that remedied. The most recent hope is that some recent SGR legislation that has been proposed will take out the specialty board requirement, therefore any physicians who bill 60% E&M codes will be eligible. If you see a Vocus alert in your mailbox for this, please respond and contact your congressman. It will make a huge difference to Neurology.

2. The SGR formula remains in place and is flawed. As you all know, the 21% cut mandated by the SGR was allowed to go into effect on April 1st, but Congress kicked the can down the road by mid April and now the 21% cut is scheduled to happen June 1st (yes, next month). The most recent news is that the Senate Finance Committee along with some members in the House are working on a 5-year fix that will be exempt from pay-go rules (they won't have to come up with cuts elsewhere). There is no doubt about it - physicians are in a bad place in this whole mess.

Our own TMA has started a petition to get the SGR permanently repealed called "Stop the Medicare Meltdown." They are working on getting one million signatures to Congress asking for repeal of the SGR formula. So far, all 50 state medical associations (including TNS) and more than 20 specialty societies including the AAN have joined. You can see information on the signature drive on both the TMA and the AAN website (<http://www.texmed.org/Template.aspx?id=8421>). Please work on getting some signatures yourself.

Let us not forget that our seniors have paid into the Medicare program for years and Congress has an obligation to put together a program that is fiscally responsible and that provides care. We all know of those insurance plans that pay so poorly that doctors refuse to be providers. They are really not insurance plans at all.

3. The Texas budget and the expansion of Medicaid and CHIP. Per the new health care reform bill, Medicaid must now be expanded to include all adults who are below 133% of the federal poverty level. This is a huge expansion for Texas, which at this time, extends Medicaid eligibility only to adults in families with dependent children. The bill also expands the number of kids eligible for CHIP. Medicaid in Texas has had trouble attracting providers for years because of low pay rates, AND the state is looking at a huge budget deficit in the next 2 years. It's hard to imagine that Medicaid payments will improve under the current budget constraints. It looks like a perfect storm to me, increased enrollment and decreased budget. I'm not sure how this will turn out.

4. The IPAB - or the Medicare Payment Advisory Board. This panel will consist of 15 members, all appointed, who are charged with finding ways to save Medicare money. The system is set up much like the military base closing panel of several years ago. They are to make recommendations to Congress and Congress will have the opportunity to vote down the recommendations. However, if Congress chooses NOT to vote, the recommendations will go into effect. This type of panel enables Congressional members to avoid having to go on record with unpopular votes. Because of this, this panel will be incredibly powerful and stakeholders will have much less influence. The AMA and TMA were completely against this but it got thru anyway.

This new law changed an enormous number of programs including new rules for graduate medical education, medical student loans, Medicaid rules, and on and on. One thing that is clear is that the department of Health and Human Services (HHS) and the agencies under them, including CMS (Medicare and Medicaid), ARHQ (comparative effectiveness), NIH, and HRSA (rural health, community health centers and medical student loans) will be growing in the next several years. This is the regulatory branch of the government as opposed to the legislative.

I hope this helps you to understand more of what is happening. I feel confident that the AAN and TMA are doing all that they can to help the House of Medicine survive this, and hopefully keep us healthy as well. It will be important over the next several years to be involved in both the legislative process (your Texpac and Brain PAC contributions really matter). In addition, both the AAN and the TMA will become much more involved in the regulatory process as the regulations are written to put these laws into effect.

Congratulations to Walter F. Buell, MD



Walter Buell was born in Austin, Texas in 1940. He subsequently moved to Rusk, Grand Saline, Littlefield, and Brownwood before returning to Austin where he graduated from Austin High in 1957 and entered the University of Texas, and later UT Medical Branch in Galveston.

He received a BA from UT in 1961 (with honors) and MA and MD from UTMB in 1965. He also attended the National University of Mexico and the University of Washington, along the way. He completed a medical internship at

Hospital, and assisted with UTHSCSA Resident Board preparation and other med school activities. In 1997, Dr. Buell began working half-time with the Texas Rehabilitation Commission, Division of Disability Determination, in Austin. Over the next few years, he retired from his private practice and moved to his retirement home in Austin, built by his son, Jeff, now partner in award winning Sitterle Homes Inc. of San Antonio. Dr. Buell has two grandsons in San Antonio. His younger son, Robert, is a board-certified neurologist in Columbus, Indiana and the new father of a baby girl!

Dr. Buell trained under Dr. Juan Taveras in St. Louis, and in his early days of practice performed angiography, myelography and pneumoencephalograms on his own patients. Dr. Buell attended the 2nd World Conference on Computer Tomography in Bermuda, and in 1979 he spent the summer at the National Hospital at Queen's Square in London. He met Godfrey Hounsfield, the inventor of computed tomography, in London: Hounsfield was the English 'home guard' during WWII and had noted that

*With distinct pleasure, this year TNS presented its
Lifetime Achievement Award to Walter F. Buell, MD*

the University of Pittsburgh in 1966 and entered the USPHS as an Epidemic Intelligence Officer assigned to the state of Illinois. Inspired by Dr. Alan Leviton, another EIS Officer, he began residency in Neurology at Washington University (Barnes Hospital) in St. Louis in 1968, and on completion he began private practice of neurology in San Antonio in 1971. He was Board Certified in Neurology in 1973. Dr. Buell is Clinical Professor of Neurology at UT Health Science Center in San Antonio, and was on the Founding Organizational Committee of the Texas Neurological Society in 1974. He signed as a Charter Member of the TNS at its first meeting in 1975 and subsequently served as President in 1980. He was the founding Chairman of the TNS Stroke Section in 2003, and is now a Charter Life Fellow Member of TNS. Since arriving in San Antonio, Dr. Buell attended the medical school's Neurology Clinic on Friday afternoons at the Robert B. Green

in a moving car he could visualize an object "through" a fence, even with closely spaced pickets, at a certain speed. He did the math, and the CT was born! The Neurology Clinic of San Antonio, now with Dr. Buell, Dr. Michael Merren, and Dr. Richard Senelick as adult neurologists, and Dr. Joel Rutman seeing the children, owned one of the first CT scanners in downtown San Antonio, but soon gave way to ever-improving and more expensive technology such as MRI. These technological advances were a major change in the practice of Neurology.

Dr. Buell has always been a traveler, with summer school in Seattle, as well as Mexico City. He enjoyed visiting German relatives on many occasions, including a weekend in divided Berlin; he and

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Position Open – Dallas

Dallas Diagnostic Association in Plano, Texas currently has an opportunity available for a board certified/eligible adult general neurologist. The group practice is currently 90% outpatient work and 10% inpatient work. Call is 1:3 and they cover both Baylor Regional Medical Center in Plano and the Heart Hospital at Baylor Plano. This opportunity includes a strong salary and benefits packages and relocation assistance.

Baylor Health Care System is a network of hospitals, primary care centers and practices, rehabilitation clinics, senior health centers, affiliated ambulatory surgery centers and the Baylor Research Institute. One of the largest, not-for-profit health care systems in the Southwest, BHSC is devoted to improving people's lives.

The Dallas/Fort Worth Metroplex offers a great real estate market, strong school systems, passion for arts and culture, all major professional sports teams, and endless entertainment options. If you are interested in practicing in North Texas or would like more information about this opportunity, please contact Jennifer Beal at Jennifer.Beal@baylorhealth.edu or (972) 860-8505.

Walter F. Buell, MD (cont.)

Elizabeth skied the Swiss Alps and travelled the west coast of South Africa from Santiago to Machu Picchu. The Buell family toured Alaska by car, float plane, and boat with the help of Walter's old friend from internship in Pittsburgh, Dr. Dan Failoni.

Dr. Buell has spent elective time with Dr. Benjamin Castleman's Pathology Department at the Massachusetts General Hospital, has been President of the Medical Staff at Santa Rosa Hospital, served on the Texas Governor's Council on Cardiovascular Disease and Stroke and the Stroke Council of the American Heart Association. He was Chair of the TMA Stroke Project from 1996-2000, and participant in the Ad Hoc Committee on Epilepsy of the Texas Department of Health. For 33 years he attended the Medical Advisory Board of the Texas Department of Health, Division of Driver Licensing. He is a member of the Sealy Society of UTMB. Dr. Buell was Examiner for The American Board of Psychiatry and Neurology for Oral Exams in several cities, over the years. Dr. Buell is a Charter Life Fellow of the Texas Neurological Society.

Credits are due to Dr. Joel Yehudah Rutman for wise counsel, Dr. Micheal David Merren for technical savvy, Dr. Richard Charles Senelick for his great brain, Ms. Wendy McGrath for doing all the work, and Dr. Joe C. Rude for being a good role model. Appreciation is expressed to Drs. Allen F. Kingman, Jr., George B. Livesay, Robert A. Partain, and J. Fletcher Lee, The Neurosurgical Associates of San Antonio, for their considerable help and support in the early days.

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TEXAS MEDICAL ASSOCIATION

Hard Hats for Little Heads

Physicians Caring for Texans

A Case Report

A Familial Clustering of Neurologists localized in Texas

Robert F. Ulrich, D.O.

Photo and editing suggestions provided by Nancy Ulrich

How did we end up here, as neurologists? The question is not posed in a politico-economic sense but rather as a reflection upon the various factors and events that somehow led us all to careers studying and attempting to treat various disorders of the nervous system. Do we share a commonality, a desire to understand the pathological aberrations of brains gone awry (perhaps combined with an unhealthy dose of masochism) or are we hardwired for our profession?

Sixty percent of my immediate family are neurologists: my father, sister, and I. Whenever the not infrequent question "Why did you go into neurology?" arises, the interest is compounded when the above fact is mentioned. So how did this come about? Doctors often tend to cluster in families, but neurologists? Given the presumptions regarding our specialty (It's too hard! You can't treat anyone! The patients are nuts!) Why would anyone go into neurology? Perhaps there is a genetic component.

My father, Richard Ulrich, still practicing in Tyler at age 75, came to medicine in a somewhat roundabout fashion. Raised in Cleveland, he decided to major in Chemistry and then apply to dental school after being told he would never make it in his initial chosen field of commercial art. After two years of looking into mouths, he decided to go to medical school instead. He received his M.D. from Ohio State in 1964 and served two years in Internal Medicine at Barnes/Washington University in St. Louis, during which time he contracted hepatitis from a needle stick, met and married my mom Nancy, and had his training interrupted by the Vietnam War. He was drafted and shipped to Okinawa where he helped produce the crowning achievement of his life, his first son Robert in January 1967.



After returning stateside he began his neurology training at Case Western Reserve in Cleveland and had a second son, Gregory, who apparently did not get the neurology gene but did get the car enthusiast one (our father's hobby). Greg has always been considered the lucky one. A

momentary desire to consider a career in academics led to a fellowship in Neuro-Otology in Iowa City and then to a brief stint practicing in Lafayette, Louisiana. He then moved the family to Texas, where he started a solo practice in Tyler in 1974. Going solo was not a choice – there were no neurologists in East Texas at the time and for the first few years he shared call coverage with the two neurosurgeons in town. 1974, also, saw the completion of the Ulrich family when my sister Beth was born.

When I asked my dad how he chose neurology, the reasons given were essentially variations on the same thought processes I suspect most of us have gone through. "No one seemed to know anything about it" was his initial response, a fact that 40 years later remains undeniable. Having some understanding of the mysterious workings and diseases of the brain and nervous system automatically confers a sense of job security. Being the type of person who always enjoyed probing the fragile depths of the human psyche, he was intrigued by the psychiatric aspects that infiltrated many of the interesting cases, an interest that has no doubt served to fuel his continued avoidance of thoughts of retirement.

I ended up in neurology by what I generally thought of as a process of elimination during my clinical rotations at Texas College of Osteopathic Medicine, but perhaps the end result had been predetermined all along. I

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initially had no plans to follow my Dad's footsteps into neurology, possibly a reflection of my tendency towards iconoclasm, another trait inherited from him. The emphasis on primary care at TCOM led to a flirtation with the idea of going into internal medicine, but I found myself most interested in the neurology cases that were seen during the months of core rotations – those were the times that the routine was interrupted by what struck me as the most fascinating. (And probably by most everyone else as the cases they wanted to avoid). Finally I got to my neurology rotation. I was fortunate to be taught by two brilliant and fascinating neurologists, Bill McIntosh and Ed Kramer, who taught me the fundamentals of performing a proper neurologic exam and how to think like a neurologist. For the first time

by her genuine and calm exterior. She likely decided to become a doctor before she was toilet trained and I suspect has been following a master plan that was outlined years ago in tremendous, color coded detail. She went to TCOM, as well, where she met her husband Russell, and was able to juggle the complexities of a couples match, complicated by the fact that Russell had joined the Army during his first year and was restricted to military programs. It appears as though the decision to become a neurologist was inevitable. When my choice of specialty became known, she recalled thinking “well, there's no way I can go into neurology now”. But she found herself interested in neurological disease, just as I was. She and her husband did internships in San Antonio and

“Sixty percent of my immediate family are neurologists: my father, sister, and I.”

rotations were interesting and fun and I was confident I was on the right path.

My Dad's advice for choosing a residency was “go somewhere where you see a lot of sick patients”. UT Southwestern, with the majority of training at Parkland Memorial Hospital certainly met that requirement and I was soon thrown into the fire where, despite the Emergency Room's repeated attempts to destroy me, I managed to emerge with only minor permanent psychological damage and what seemed like much more than three years of experience and confidence under my belt. The neurology professors at UTSW were all top notch and space does not permit acknowledgement of everyone by whom I was positively influenced, but certainly Elliot Frohman and the late Hal Unwin would be at the top of the list. I stayed on as clinical faculty a few more years before life circumstances took me to South Carolina where I started a very busy solo practice and saw a lot of unusual cases that would probably not be possible in any other part of the world. If you have ever been to rural South Carolina, you understand. My beautiful daughter Emma was born there, which prompted the desire to get back home to Texas and family, and my sister was instrumental in helping me to find a position in Dallas.

Beth is the youngest and by far the most organized, determined, and obsessive of the three of us, traits belied

then moved to Washington, D.C. where he was at Walter Reed and she did her training in neurology at Georgetown with a fellowship in movement disorders at the NIH under Mark Hallett. When Russell decided to forgo internal medicine for a second residency in dermatology, they ended up in Dallas where she joined a practice headed by Stuart Black, now affiliated with Baylor University Medical Center, and has continued to balance the growing demands of her movement disorder practice with her growing family; Kate, about to turn four, and Jay who just reached age 2. Her third child is scheduled to arrive in midsummer, just as, I'm sure, she planned years ago.

So now Beth and I are in the same practice, although in different locations, and while neither of us have plans to relocate to Tyler, we are close enough to see our parents frequently and make sure they get to spend a lot of time with their grandchildren. We both enjoy what Dallas has to offer and plan to stay in the Metroplex for the foreseeable future. We have all ended up happily in Texas, as neurologists, by different paths, but I think for very similar reasons. Regarding the issue of genetics as a contributing factor towards becoming a neurologist, it will be interesting to see how the third generation of the ongoing experiment plays out. Perhaps in another 30 years or so, Emma or one of her cousins will be writing a similar article. Time will tell.

CAC UPDATE

Stuart B Black MD, FAAN

2010: The Year of Healthcare Changes and the Year of the RAC

It would be nice to say that as of 2010, physician compensation will increase, physician autonomy and the private practice of medicine will be preserved, the risk of audits will decrease, and because of Healthcare Reform, physicians can stay the course and have a bright future. Unfortunately, many healthcare providers, legislators and other learned individuals have indicated that those ideals are of the past. Most economists and experts agree that the current rate of spending on healthcare is fiscally unsustainable. According to a January 2008 report by the Office of Management and Budget (OMB), Medicare alone estimated a \$10.8 billion in improper payments in 2007. Now that Healthcare Reform is the law of the land, there is even greater debate regarding fiscal concerns with opponents indicating that it could accelerate the cost crisis rather than solve it. In addition the Congressional Budget Office (CBO) projected that Medicare costs will nearly double from \$528 billion this year to more than \$1 trillion in 2020. As our population ages, there are estimates that Medicare enrollment will grow 3% per year and that in 5 years, 45% of American patients may be Medicare. This means that even if physicians in the United States were to receive a 20% cut in Medicare costs could still double.

The year 2010 started off with the elimination of the CPT Consultation code; a change which is predicted to have a significant impact on reimbursements for Neurologists and other Evaluation/Management (E/M) providers. To better identify the impact of this CPT change, the AAN sent out a survey to identify the actual effects Neurologists experienced since the Medicare elimination of the Consultation Code. The survey was to be completed by the end of April 10, 2010. The AAN, AMA and 16 other specialty societies seek to modify the policy of elimination of the Consultation Codes.

Passage of the above mentioned \$938 billion Health Care Bill left the country polarized over the new legislation. As an example, those in favor of healthcare reform are of the belief that the current system cannot sustain itself under the existing guidelines and structure. There are concerns over the growing number of uninsured and the uncompensated care costs as well as the increase incidence and cost of treating chronic disease. There is criticism that the current payment systems are not tied to value or quality of care but instead increase reimbursements according to volume plus the number of tests ordered and procedures performed. Propo-

nents indicate that the new bill expands coverage to 32 million uninsured with a new "marketplace" through exchanges, subsidies for purchase of private insurance and insurance reforms. The legislation will make it possible for anyone who wants health insurance and can afford it to buy it and keep it

Examples of the opposition include concerns over the expense and funding of the legislation plus the potential long term economic consequences. New fees and taxes will be imposed and Medicare payments to physicians, hospitals and many other health care providers will be reduced. New taxes will include a 40% excise tax on "Cadillac" health plans. The tax rate will increase from 1.45% to 2.35% for individuals earning more than \$200,000 a year and families earning more than \$250,000 annually. In addition there will be a 3.8% tax on capital gains, dividends, interest and other "unearned income". Medicare economic policies, which include the decreases in reimbursements, are intended to result in an approximate \$500 billion savings out of the projected growth in Medicare over 10 years. The decreases in reimbursement to Medicare providers, however, coupled with the current and projected shortage of qualified physicians could mean that coverage will not be synonymous with access to care. In addition, 13 attorney generals sued the federal government claiming the health care overhaul bill is unconstitutional. There is also discussion as to what effect the new legislation will have on previously passed State tort reforms.

There is yet an additional piece of important legislation that became law January 2010. It is a statutory law neither frequently discussed in the news media nor given much press nationally, but it is a new program which is predicted to have a major impact on physician and hospital reimbursement. Under the program private contractors have been selected to identify "improper" Medicare overpayments and underpayment to health care providers. The contractors are paid on a contingency basis. Since the private auditors earn contingency fees that vary from 9% to 12%, it would be reasonable to assume they are quite motivated to find "errors" in billing and physician documentation. The program allows the federal government to step up its audit activities in Medicare which will result in greater scrutiny of physician and hospital billing practices. It is likely that private carriers will follow suit. The audi-

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tors will also be focusing on Evaluation and Management services. There are many who believe that it is not if a physician will be audited but when a physician will be audited. The new program is known as Medicare's Recovery Audit Contractor or RAC.

The RAC program had its origin in December 2003 when the Medicare Modernization Act (MMA) mandated that CMS establish a three year demonstration program to detect, correct and collect improper Medicare payments. The program began in March 2005 and involved California, Florida, and New York. South Carolina, Arizona and Massachusetts were added in the summer of 2007. The demonstration program proved to be extremely successful in returning dollars to the Medicare Trust Funds. CMS released an evaluation report and indicated that \$980 million in improper Medicare payments were collected from or repaid to health care physicians and suppliers during the demonstration program (March 2005-March 2008). Approximately 96% of improper payments identified by the RAC's in 2007 were overpayments to health care providers that had to be paid back to the government. The remaining 4% were underpayments that were paid to providers. During the three year pilot program, the RAC's focused mostly on hospitals because of the large dollar amounts involved in their claims. However, they also audited some Medicare Part B claims. About 15% of the \$980 million in overpayments collected came from physicians. The outcome resulted in Congress mandating, through the Tax Relief and Health Care Act of 2006, that the RAC program become permanent and nationwide as of January 1, 2010.

Now that the RAC program has become nationwide, there have been four private contractors, each assigned to different regions of the country, who will be using data mining, outlier analysis and proprietary software to determine normal limits and reasonable thresholds. If a physician falls outside of the norm, it may put the practice at risk for audit. The composition of the RAC contractors include certified coders, nurses, therapists and a medical director. The permanent RAC contractors were announced 10-6-08. The Connelly Consulting Associates, Inc of Wilton, CT will be doing the auditing for the Lower Western region which includes Texas. Their contingency fee will be 9% of collections. In addition to the use of proprietary software, audits will also be based upon claims history and identified patterns through other auditing entities such as Medicare Administrative Contractors (MACs). The MAC in Texas is TrailBlazer Health Enterprises, LLC. The data and records from

additional Medicare auditing contractors such as Fiscal Intermediaries (FIs), Quality Improvement Organization (QIOs) and Comprehensive Error Rate Testing (CERT) programs will also be used by RACs to help identify who might be audited. Physicians need to be aware of their own activities and compliance record as well as do their own outlier analysis so they can be ready to defend against a potential RAC audit.

At this point it is again important to emphasize the RACs will also be auditing Evaluation and Management services. During the demonstration project, E/M services only constituted a small percentage of the audits, but that is not the case now that the program is permanent. The importance of appropriate E/M documentation to support medical necessity and the CPT level of care cannot be overemphasized. In addition to audits on outpatient Medicare Part B services, RAC will also request physicians validate claims and explain why certain types of services are used in higher numbers when compared to other outpatient providers. RAC representatives will also identify and visit high-risk beneficiaries to make sure they appropriately receive the items and services for which Medicare is billed. In regards to hospital services, it is important that Part A and Part B physician claims are in sync with one another rather than in any type of coding, documentation, or billing conflict.

There are two review processes that will be used by RACs. They are Automated Reviews and Complex Case Reviews. The Automated Review is where the claims contained clearly-identifiable errors without review of the medical records. Software programs are utilized to identify potential payment errors such as duplicate payments and discharge coding errors. The RAC could perform Automated Review only when the improper payment was obvious or when a written Medicare policy, Medicare article, or Medicare-sanctioned coding guideline (e.g., CPT guidelines) existed and precisely described the coverage conditions. The Complex Case Review is the review of the medical record in which claims likely contained errors. Based on the medical record documentation, the RAC auditor determines whether the claim contains an overpayment, an underpayment or correct payment. The audits entail requesting medical records from the health care provider that submitted the claim.

The RAC request process is as follows. The RAC will send a medical record request letter to the provider containing the rationale for each request. The provider

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has 45 days to respond. No response will lead to an administrative denial. RAC has 60 days to make determinations after receiving the records. There is a specific appeals process for those cases in which the provider disagrees with the RAC determination. If a physician disagrees with a RAC determination, the provider must file the request for redetermination within 30 days to halt the recoupment of payment, rather than the 120 days allowed for most Medicare disputes. There are also limits on the number of medical records that may be requested based on type and size of the practice or facility. For a solo practitioner, the limit is 10 medical records per 45 days. For a partnership of 2-5 individuals, the limit is 20 medical records per 45 days. For groups of 6-15 individuals, the limit is 30 records per 45 days and for groups with 16+ individuals, it is 50 records per 45 days.

A much discussed area of concern with the RAC audit is the authority they have to extrapolate an error rate across a larger number of Medicare claims. This means that if a RAC finds a 10% error rate on 50 medical records, the extrapolation would permit the RAC contractor to apply that error rate across all of a physician's Medicare patients over multiple years. Obviously, with the RAC reviewers paid on a contingency, basis there is much potential for dramatically increasing the penalty. However, CMS has indicated that extrapolation can only be used in cases where there is a recurring payment error or a failure of the provider to take corrective measures. These check and balances, however, have not been tested and the contingency fees on extrapolated claims remain a point of contention for many providers.

Many leading medical societies have been very proactive in expressing concerns and opposition to the design of RAC including the financial incentives of RAC reviewers to identify overpayments. Despite ongoing communication with CMS, the program is the law of the land and is here to stay. In addition, experienced auditors know that many physician practices fail to recognize the importance of monitoring their E/M distribution and documentation to be certain they are compliant with the Documentation Guidelines. Physicians must recognize that even though there may be good reason why the practice is reporting level four and five services routinely, it will not stop RAC from taking a closer look with a practice audit. Keep in mind that if a RAC audit identifies a specific overpayment amount in the selected sample after reviewing the medical records, and then extrapolates that amount for all the claims submitted

for the time frame under review, the cost could be enormous.

2010 has truly been a year of monumental changes in healthcare. As a result of these changes, many experts believe that the traditional practice paradigm will also be altered. The new Healthcare Bill coupled with other forces focused on fiscal constraints, consumerism, and further government reform will clearly play an important role on the future delivery of health care. The changes such as elimination of the Consultation CPT code and initiation of RAC will influence reimbursements. For many physicians, these new regulations will also alter the infrastructure of their clinical practices. In today's medical environment, the key for physicians is to be involved in the billing aspects of the practice and to implement a compliance plan so that every employee will be aware of potential errors and recognize how to respond to those errors.

As government auditing and oversight of revenue is tightened, it is reasonable to assume that private carriers will follow suit. To be prepared for the consequences of incremental healthcare reforms, it will be important that practices operate more efficiently and that physicians become aware of the changes in the marketplace designed to meet the new demands. There are experts who believe that within the next five years the traditional payment models, which generally include Fee for Service and Capitation, will be forced to undergo significant change. A third practice model, Accountable Care Organizations, defined "... as a group of primary care physicians, specialist, hospitals and potentially other facilities who accept joint responsibility for the quality and cost of care of a defined population", is being looked at by various institutions as an alliance which would be designed to improve healthcare delivery by enhancing the strategic and financial performance of its providers. The healthcare changes of 2010 are felt by many to be "just the tip of the iceberg".

Rapid Eye Movement Behavior Disorder

*Robert W. Fayle, MD, Board certified, Sleep Medicine
TNS Education Committee Chair and Past President
Livingston, Texas*

This 65 year old man presented with complaints of dreams that he was back in the Korean Conflict, fighting an enemy soldier. He stereotypically dreamt that he was astride the enemy in hand to hand combat, strangling him. When the patient's wife could finally awaken him, the patient would find himself astride his wife, strangling her. In another dream, he would jump to block a shot while playing basketball in high school. When he did so, he would throw himself out of bed and headfirst into a bedside table, requiring repeated night-time trips to an ER for suturing of facial lacerations. Questions: What is the diagnosis and what are the minimal diagnostic criteria? What are the secondary causes and disease associations? What treatment would you recommend?

Discussion

Rapid Eye Movement Sleep Behavior Disorder (RBD) is a movement disorder of Rapid Eye Movement Sleep (REM) (Boeve BF. REM sleep behavior disorder: Updated review of the core features, the REM sleep behavior disorder-neurodegenerative disease association, evolving concepts, controversies, and future directions. *Ann N Y Acad Sci.* 2010;1184:15-54.) Like most movement disorders of sleep, RBD results from a breakdown of the normal mechanisms of sleep. This relatively frequent abnormality of REM is of interest to the clinical neurologist and will be discussed briefly.

Certain principles apply to understanding movement and arousal disorders of sleep. Sleep staging is normally under a complex neurochemical and neurophysiological control. There are three states of being in the sleep world: 1. Wakefulness, 2. Non-REM sleep (NREM) and 3. REM sleep. Sleep is an active state. The central nervous system (CNS) remains active across all three states, but there are changes in CNS activity as one state gives away to another. The frequent, often complex, physiological changes provide opportunities for errors. Movement disorders of sleep (parasomnias) and sleep state dissociations occur when the brain is in the process of shifting from one state to another. Given the frequency of these shifts through the night's sleep, especially considering the added burden of pharmacological effects and other brain disease, one could wonder why there are not more problems than we see?

Normal REM Sleep

During REM sleep, active motor generation is occurring, appropriate to the dream content which is one of the characteristics of REM sleep, but there is also active

segmental motor inhibition which prevents movement in REM sleep, normally (A complete description of REM physiology beyond the scope of this discussion, but for a good, concise review of sleep physiology see Swick T. *The neurology of sleep.* *Neurologic Clinics.* 2005; 4: 967-989). Cholinergic neurons in the pedunculo-pontine tegmental nucleus (PPT) stimulate firing in the medullary magnocellular complex, the source of the reticulospinal tract which inhibits the segmental lower motor neurons via glycine. The diaphragm and the extra ocular muscles are spared.
REM Sleep Disorders

Given the features of REM sleep, one can predict some of the REM sleep disorders, which include narcolepsy-cataplexy, Nightmare Sleep Disorder, RBD, REM-related sinus arrest, REM-related AV block and other less common disorders. Narcolepsy can be thought of as REM sleep state dissociation in which the normal, carefully orchestrated control of REM is lost and features of REM appear inappropriately in wake and wake-sleep transitions. Recently, inbred dogs and knockout mice with a loss of orexin-producing neurons in the perifornical lateral hypothalamus were found to have features consistent with narcolepsy-cataplexy. Patients with narcolepsy-cataplexy have low or absent measurable levels of orexin in their CSF. Low or absent levels of CSF orexin are becoming a standard for diagnosis as assays of CSF orexin become more widely available.

REM Behavior Disorder

In 1965 Jouvet and Delorme produced bilateral lesions in the area around the locus coeruleus in cats which resulted in oneiric behaviors (dream enactment). This behavior occurred only in REM sleep. These lesions interrupted the excitatory fibers that connect to the medullary magnocellular nucleus, which in turn is the source of reticulospinal tracts that inhibit spinal motoneurons. REM atonia is lost and descending pathways carrying the signals from motor pattern generators in the brainstem and subcortical motor nuclei can then generate dream-related motor activity. The human equivalent was first described by Schenck and Mahowald who described patients who exhibited dramatic, violent behavior, which arose from REM sleep. (See Schenck, C and Mahowald, M, *Neurologic Clinics*;2005(4),1107-1126.) The behavior was appropriate for dream content which was recalled- human dream enactment. Often the dream content and behavior is very stereotypic with patients describing dreams of in-

truders which are threatening and the dreams and behavior are defensive rather than aggressive. Bed partners can usually recognize the dream content by the patient's vigorous behaviors such as shouting punching and kicking, running. Close proximity of the bed mate incurs the risk of accidental injury. The patient's attempts to evade attack may cause them to be injured by running into walls or furniture. Fractures or lacerations during sleep are not uncommon to patients or spouses; clinical presentation is frequently for sleep-related injuries.

Schenck and Mahowald's minimum diagnostic criteria included:

1. Increased submental EMG activity or excessive phasic submental or limb EMG twitching
2. Abnormal REM sleep behaviors during PSG (prominent limb or truncal jerking, complex vigorous or violent behaviors) or a history of injurious or disruptive sleep behaviors.
3. Absence of epileptiform EEG patterns during REM sleep

The primary form of RBD is much more common in men (80-90% of cases) than women. RBD has a prevalence in the general population of about .5% with most developing symptoms from ages 40-70 years, but it has been reported in much younger patients as well especially in those with narcolepsy. Acute onset of RBD raises the probability of a medication effect related to tricyclic antidepressants, MAOI's, SSRI's, venlafaxine, bisoprolol, selegiline, or cholinesterase inhibitors for Alzheimer's (although Simmons reported 3 patients where donepezil was helpful in treating RBD and a follow-up study is in progress). Withdrawal from alcohol, barbiturate or meprobamate is also linked to RBD

Schenck and Mahowald also recognized a striking association between RBD and other synucleinopathies, especially Parkinson's Disease. RBD may precede Parkinson's by years and is now being identified as one of the Parkinsonian prodromal conditions. Many, if not most Parkinson's patients at some time in the course of their disease are found to have RBD.

Treatment with clonazepam in doses ranging from 0.25 mg to 4.0 mg at bedtime is effective in about 90% of cases (Frenette E. REM sleep behavior disorder. *Med Clin North Am.* 2010 May;94(3):593-614; Mahowald M. Rapid eye movement sleep behavior disorder. *MedLink Neurology.* Gilman S, editor. Available at www.medlink.com, 2010). The phasic EMG activity is suppressed with the clonazepam, but the REM atonia is not restored. The clonazepam is generally well tolerated over time, but there is immediate recurrence of the RBD if the medicine is stopped and daytime somnolence can be a problem, especially in older patients. Alternate medications include imipramine, carbamazepine, clonidine, carbidopa-L-dopa, gabapentin, pramipexole or melatonin (3-12 mg at HS variably reported as successful in 40-100% of cases). Due to the risk of injury to patient and bedmate, it is important diagnose and treat RBD.

RBD is a dramatic, violent and potentially threatening movement disorder of sleep which raises the description of a bump in the night to a different level. RBD should be considered a synucleinopathy and evaluated in patients with history of disruptive sleep problems and in patients with Parkinson's disease, multisystem atrophy and other synucleinopathies. RBD, like all sleep disorders including sleep apnea, is an example of normal sleep neurophysiology gone awry.

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Member News

Britt Talley Daniel MD, a neurologist from Dallas, published a textbook, *Migraine*, which may be purchased on line at Google, Barnes & Noble, and Amazon. Dr. Daniel also has a migraine blog (www.doctormigraine.com) which has 16 articles on migraine for patients.

Dr. Wesley Dennis has recently obtained subspecialty certification in Sleep Medicine. He is the medical director of The Arlington Sleep Disorder Center in Arlington, Texas.



TMA President Susan R. Bailey, MD has appointed **William S. Gilmer, MD** as chair of the Interspecialty Society Committee (ISC). The ISC meets three times per year. It provides a forum for specialty societies to bring its specific issues to the TMA for discussion and consideration. Dr. Gilmer's term will last two years.

Minutes

TNS Annual Business Meeting Saturday, February 6, 2010 Hyatt Regency Austin Hotel

President Alan W. Halliday, MD, called the meeting to order at 12:30 pm. He thanked Kim Monday, MD, for her work as program chair.

Approval of February 2009 Minutes

The minutes from the 2009 annual business meeting were approved as submitted.

Moment of Silence

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

- Morris H. Lampert, MD- Charter Life member
- C. Joseph Batson, MD
- Edward A. Gaer, MD
- George M. Ringholz, MD

Secretary-Treasurer's Report

The membership approved the ballot as presented with 50 pending members.

Advocacy

Dr. Gilmer updated the membership on legislative battles that lie ahead in the state and in the nation. He encouraged members to establish relationships with their senators and representatives.

Lifetime Achievement Award

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

Election of New Officers

Dr. Halliday presented the 2010-2011 slate of officers, which was approved unanimously. He also thanked outgoing board member Aziz Shaibani, MD for his service on the TNS board of directors.

Change of Officers

Dr. Halliday thanked the Society for a successful year, and presented Tommy Yee, MD with a gavel as incoming president. Dr. Yee thanked Dr. Halliday for his hard work as president, and then gave his acceptance speech.

The meeting was adjourned at 1:45 pm.

Expert Opinion

Chronic inflammatory demyelinating polyneuropathy: a question and answer mini-review

By Aziz Shaibani, MD, Nerve and Muscle Center of Texas, Houston, Texas

What are the diagnostic criteria of CIDP?

Published criteria vary in sensitivity and specificity and non-is universally acceptable.

The most practical approach is based on the presence of at least three of the following:

A-weakness that is (at least three):

- 1- Progressive (at least 2 months) or relapsing.
- 2- Predominantly motor
- 3- Proximal and or distal
- 4- Relatively Symmetrical

B- Diffuse areflexia or hyporeflexia.

C- Increased CSF protein with normal cells.

D- Demyelinating electrodiagnostic findings.

Can DTRs be normal or hyper?

Yes in about 10% of patients.

Is it required to have high CSF protein?

No, 10% of patients have normal CSF protein. However, a normal CSF protein and DTRs strongly argue against CIDP unless there are clear demyelinating electrodiagnostic findings.

What are the electrodiagnostic criteria of CIDP?

Markers for peripheral demyelination are:

- 1- Motor slowing.
- 2- Prolonged distal latencies.
- 3- Delayed F-responses
- 4- Temporal dispersion
- 5- Conduction block

The number of affected nerves and the magnitude of changes required for the diagnosis vary with the authors. The most rigid criteria are those of the AAN (1) which were mostly meant for research purposes.

Practically, at least 2 nerves must carry at least three of the above abnormalities with 25% deviation from normal is needed for the Electrodiagnosis.

Is nerve biopsy required to diagnose CIDP?

Although the AAN criteria require a nerve biopsy, most experts in the field do not mandate it in straightforward cases. Even in these cases, nerve biopsy shows inflammation in less than 15% of cases and the predictive value is low.

However, in atypical cases and when vasculitis is suspected, nerve biopsy can be useful (2).

What is the evidence that steroids are beneficial in CIDP?

There is only one (poorly conducted) randomized trial using prednisolone and several retrospective studies using intravenous steroids. Steroids seem to cause small but significant improvement in disability in previously untreated patients.

Does IVIG work in CIDP?

There are several controlled trials (3) to answer this question and all conclude that IVIG is effective in about 70% of cases. Frequent booster doses are usually needed to maintain remission. The initial dose is 2gm/kg/BWT given over 2.5 days. Booster doses are 1gm/kg/BWT every 2 weeks to three months.

What is the role of plasmaphoresis (TPE)?

TPE is as effective as IVIG according to a head to head (well conducted) comparison, single blinded trial (4). Several other trials of TPE in CIDP had shown at least 80% rate of improvement.

How does IVIG compare with steroids?

There is only one head to head randomized controlled trial with cross over design that was not adequately powered to detect a difference in efficacy between the two treatment.

What is the role of cytotoxic medications?

There are no large prospective studies on this. The standard of practice is that a cytotoxic drug such as Azothioprine, mycophenolate, or cyclosporine are at some point added to reduce the need for frequent (more than monthly) IVIG or TPE treatment.

How do you choose among these therapies ?

In otherwise healthy subject, it is reasonable to start IV soulmedrol, 1 gm/kg/BWT daily for 5 days. If there is no improvement within 3 weeks, it is recommended that IVIG is tried. Otherwise, IVSM booster is indicated. The frequency of the boosters depends on the duration of improvement. Diabetic with normal renal function maybe more appropriately treated with IVIG unless they can closely monitor their DM. If IVIG fails or if the patient has renal or cardiac decompensation or history of DVT or recent ischemic stroke or heart attack, TPE would be appropriate. These days with the advent of the new small TPE machine and the availability of outpatient TPE units, the threshold for TPE therapy is lowered.

Expert Opinion *(continued)*

Are diabetics more prone for CIDP?

That is controversial (4), but certainly diabetics are not immune against CIDP and when they get it, several diagnostic and therapeutic dilemmas arise.

What are these dilemmas?

1. Diagnostically, DM can cause demyelinating and axonal neuropathic changes and sometimes predominantly demyelinating neuropathy, thus making the electrodiagnostic criteria of CIDP less reliable. CSF protein is often elevated in DPN.

2. Therapeutically, steroids upset diabetes control and IVIG is more likely to cause renal impairment and even acute renal failure in diabetics.

How do you get around these dilemmas?

1. I put more emphasis on the clinical rather than electrodiagnostic features. DM rarely causes progressive painless symmetrical proximal weakness and areflexia. There is a controversial entity called proximal diabetic neuropathy but that is probably just CIDP. Diabetic amyotrophy although proximal, it is frankly asymmetrical, severely painful, and axonal.

2. I use more liberal upper limits for CSF protein values in favor of CIDP. CSF protein supports the diagnosis of CIDP only if it is more than 100.

3. Close monitoring of the blood glucose (several times a day) during IV steroids and coordination with the PCP.

4. Close monitoring of the renal function when IVIG is used. If the baseline serum Creatinine is more than 2, I avoid IVIG.

There are many clinical variants for CIDP. Is there a practical value for such classification?

Yes. They respond to different therapy and their prognosis is not the same.

The most important variants are:

- 1- Distal acquired demyelinating sensor motor neuropathy (DADSAM). This variant:
 - a. Mainly affect males after age 50 years.
 - b. Causes distal weakness and sensory loss
 - c. Causes ataxia and tremor
 - d. 2/3 of cases have IgM monoclonal
 - e. gammopathy, and MAG antibodies.
 - f. Do not respond well to IVGI or steroids but to TPE and Rituximab.

2- Multifocal motor neuropathy:

- a. Purely motor
- b. Mostly distal in the arms
- c. Asymmetrical
- d. Normal CSF protein
- e. High GM1 AB in 50% of cases
- f. Worsens with steroids and respond to IVIG and Cytosan

3- Multifocal acquired demyelinating sensory and motor neuropathy (Lewis-Sumner syndrome).(MADSAM). This syndrome share features from both DADSAM and CIDP and responds to IVIG and cyclophosphamide.

4- Questionable variants like sensory CIDP and Axonal CIDP.

What disorders occur in high frequency with CIDP and should be screened for:

- 1- HIV
- 2- Hep C
- 3- Sjogrene syndrome
- 4- IBD
- 5- Lymphoma
- 6- MGUS
- 7- MM

How do you deal with a patient with frank demyelinating EDX picture with minimal clinical findings?

I consider HSMN. Motor slowing is usually even in HSMN and there are no CB or TD.

What are some of the atypical presentations of CIDP?

Chronic progressive proximal or distal weakness that evolves over years with preserved reflexes and or normal CSF examination and mixed demyelinating and axonal EDX findings. Or the Reflexes are absent diffusely and there is proximal weakness but the EDX picture is that of predominant axonal injury.

1. Research criteria for the diagnosis of CIDP, AAN task force, Neurology 1991; 41; 617-618
2. Gabriel et al, Prospective study of the usefulness of sural nerve biopsy. JNNP, 2000; 69; 442.6
3. Hahn, et al: IVIG in untreated CIDP. A DBPC cross over study. Brain 1987; 110:1617-1630
4. Dyck et al, TPE Vs IVIG in CIDP. Anne , Course and recommendations for diagnostic criteria. Arch neurol 1989; 46,878-84
5. Haq et al, CIDP in diabetic patients. Muscle and Nerve 2003; 27; 465.70

Welcome New Members!

The following were voted in during the 2010 Winter Conference

Active Membership

Anitha T. Abraham, MD
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Mohamad S Al-Rifai, MD,
Sherman

Charisse Barta, MD
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Sadat Anwar Shamim, MD
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Robert Frank Ulrich, DO
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Matthew Steven Brock, MD
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Siresha Chaluvadi, MD
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Donna C. Graves, MD
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Bahram Hormozdi, MD
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Gina Mapes Jetter, MD
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Hongkui Jing, MD, PhD
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Karthikeyani Kathiresan, MD
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Ashkan Mowla, MD
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