Physiatrist's Voice

NEWSLETTER June 2019

Enhancing Health And Function Through Education And Research In The Field Of Physical Medicine And Rehabilitation

In this Issue

Inside this Issue, links for;

Meeting Agenda, Registration, & Hotel

Additionally, for

FSPMR Annual Business Meeting and Reception,

Saturday, July 21, 6:30 – 8:30 PM,

RSVP to FSPMR Executive Director, lorry4@earthlink.net.

PRESIDENT'S MESSAGE

Craig Lichtblau MD

Summertime! And with that comes our annual meeting. The Florida Society of Physical Medicine and Rehabilitation (FSPMR) is gearing up for an excellent conference in conjunction with the Florida Society of Interventional Pain Physicians (FSIPP), July 18 – 21, 2019, to be held at The Diplomat in Hollywood, Florida.

~continued next page

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PRESIDENT'S MESSAGE CONTINUED FROM PAGE ONE.

This is a beautiful, upscale facility, the full name being the Diplomat Resort & Spa Hollywood Curio Collection by Hilton. There is also a Diplomat Beach Resort on the Gulf Coast, unrelated.

Dr Jesse Lipnick who is on FSPMR's Board of Directors is also the current President of FSIPP, and he and his team have put together a terrific educational program.

FSPMR will have its own-day long breakout session on that Saturday, July 20, featuring Dr Randall Braddom ("The Recognition and Treatment of Chronic Pain Syndrome," and "Current Diagnosis and Treatment of Complex Regional Pain Syndrome"), and a tag-team of Richard Tucker, Former Assistant Special Agent-in-Charge of the DEA ("Identifying the Warning Signs of Non-Compliant and Abusive Patients") with Jennifer Bolen JD, Former Assistant US Attorney, Department of Justice ("Surveying the Ever-Changing Battleground in the Business of Pain Management: A Legal Perspective on Chronic Opioid Therapy and Risk Mitigation – Successes and Failure"). We've intentionally built in a lot of Q&A time because we know you will want to bring up specific situations for Rick Tucker's and Jennifer Bolen's responses.

And later that same day, 6:30 – 8:30 PM, FSPMR will hold its Annual Business Meeting and Reception. *RSVP to FSPMR Executive Director, lorry4@earthlink.net*. Hope to see you there!

You'll find the full day's program for the FSPMR breakout session inside as well as links for you to view the full FSIPP/FSPMR program, register to attend, and reserve a hotel room.

Inside this issue are the Florida Medical Association's 2019 Legislative Report, Florida PM&R Residency Updates, a Member Spotlight on Anthony Dorto MD, a Florida Sports Medicine History article on Boxing by Dr Rodolfo Eichberg, a PM&R Pioneers listing, and two articles by me, one on Osteopetrosis and the other on The Case for Physiatry.

With our Annual Meeting next month, the first half of my presidency is almost over. What has especially impacted me is finding Florida physiatrists who do not belong to FSPMR. I cannot stress strongly enough the importance of belonging to your specialty's state society, and maintaining that membership. When physiatrists are weak at the state level, we are weak at the national level and run the risk of becoming irrelevant, being absorbed into other specialties. I urge every one of you reading this to contact fellow physiatrists and engage them in a conversation about the importance of state society membership, and if they are not a member, encourage them to join. Thank you!

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Osteopetrosis
by Craig Lichtblau MD

Osteopetrosis also known as Strong Bone and/or Marble Bone Disease or Albers Schonberg Disease is an extremely rare inherited disorder whereby bones harden becoming dense in contrast in more prevalent conditions like osteoporosis in which the bones become less dense and more brittle or osteomalacia in which bones soften.

Osteopetrosis can cause bones to dissolve and break. The disease is caused by malfunctioning osteoclasts and its inability to reabsorb bone. The exact molecular defects or location of the mutations taking place are unknown.

Osteopetrosis was first described in 1903 by a German radiologist, Dr. Albers Schonberg. Despite the excess bone formation people with osteopetrosis tend to have bones that are more brittle than normal. Mild osteopetrosis may cause no symptoms and no problems. However, serious forms of osteopetrosis can result in:

1. Stunted growth deformity and increased likelihood of fractures.
2. Anemia, recurrent infections, hepatosplenomegaly and extramedullary hematopoiesis, minus facial paralysis and deafness due to increased pressure put on cranial nerves secondary to the extra bone formation surrounding the cranial nerves, abnormal cortical bone morphology, abnormal form of vertebral bodies, abnormality of temperature regulation, abnormality of ribs, abnormality of vertebral epiphysis morphology, bone pain, cranial nerve paralysis, craniosynostosis, hearing impairment and hypocalcemia.

Osteopetrosis may lead to elevated alkaline phosphatase. Malignant infantile osteopetrosis is autosomal recessive and is a rare type of skeletal dysplasia characterized by a distinct radiographic pattern of overall increased density of the bones with fundamental involvement of the medullary portion.

Infantile osteopetrosis typically manifests in infancy. Diagnosis is principally based on clinical and radiographic evaluation confirmed by gene analysis where applicable. As a result of medullary and canal obliteration and bony expansion, the patients suffer from pancytopenia, cranial nerve compression and pathological fractures. The prognosis is poor if untreated.

The classic radiographic features include:

Endobone or bone within bone appearance in the spine, pelvis and proximal femora, upper limbs and short tubular bones of the hand. Additionally, there is a Erlenmeyer class deformity type 2 which is characterized by absence of normal diaphyseal metaphyseal mottling of the distal femoral with abnormal radiographic appearance of trabecular bone and alternating radiolucent metaphyseal bands.

Hematopoietic stem cell transplantation offers a satisfactory treatment modality for a considerable percentage of infantile osteopetrosis. A melioration of radiographic bone lesions after HSCT in infantile osteopetrosis has been proposed as an important indicator of success of the therapy.

Adult Osteopetrosis

Osteopetrosis also known as Albers Schonberg Disease autosomal dominant. Most patients do not know that have this disorder because most of the individuals do not show an symptoms; however, patients that do show symptoms typically have scoliosis and multiple bone fractures.

There are two types of adult osteopetrosis based on the basis of radiographic biochemical and clinical features.

Type 1:

Marked sclerosis mainly of the skull vault. The spine does not show signs of sclerosis. The pelvis shows no signs of endobones; very low risk fracture. Serum acid phosphatase is normal. Many patients will have bone pain.

Type 2:

Skull bones show sclerosis mainly at the base. The spine shows the Rugger- jersey appearance. Pelvis shows endobones in the pelvis. High risk of fracture. Serum acid phosphatase is very high. Defects are very common and include neuropathies due to cranial nerve entrapment, osteoarthritis and carpal tunnel syndrome. About 40% of patients will experience recurrent fractures of their bones; 10% of the patients will have osteomyelitis of the mandible. Many patients will have bone pain.

Mechanisms:

Normal bone growth is achieved by a balance between bone formation by osteoblasts and bone resorption by osteoclasts. In osteopetrosis the number of osteoclasts may be reduced to normal or increase. Most importantly the osteoclasts dysfunction mediates the pathogenesis of this disease.

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Osteopetrosis

Osteopetrosis is caused by underlying mutations that interfere with the ossification of the osteoclasts resorption pit due to deficiency of carbonic anhydrase, an enzyme encoated by the CA2 gene. Carbonic anhydrase is required by osteoclasts for proton production. Without this enzyme hydrogen iron pumping is inhibited and bone resorption by osteoclasts is defective. As an acid environment is needed to disassociate calcium hydroxy appetite from the bone matrix.

As bone resorption fails while bone formation continues, excessive bone is formed. The genes associated with osteopetrosis are involved in the formation development and function of specialized cells called osteoclasts. These cells break down bone tissue during bone remottling.

A normal process in which old bone is removed and new bone is created to replace it. Bones are constantly being remottled and the process is carefully controlled to insure that bone stays strong and healthy.

Mutations in any of the genes associated with osteopetrosis lead to abnormal or missing osteoclasts. Without functional osteoclasts old bone is not broken down as new bone is formed. As a result, bones throughout the skeleton become unusually dense. The bones are also structurally abnormal making them prone to fracture. These problems with bone remottling underlie all of the major features of osteopetrosis.

Treatment of osteopetrosis has been attempted with hematopoietic stem cell transplantation (osteoclasts are derived from hematopoietic precursors). There is no cure although curative therapy with bone marrow transplantation is being investigated in clinical trials.

It is believed that healthy marrow will provide the sufferer with cells from which osteoclasts will develop. If complications occur in children the patients can be treated with vitamin D. Gamma interferon has also shown to be effective and it can be associated with vitamin D. Erythropoietin has been used to treat any associated anemia. Corticosteroids may alleviate both anemia and stimulate bone resorption.

Fractures in osteomyelitis are treated as usual. Treatment for osteopetrosis depends on specific symptoms present and the severity in each person. Therefore, treatment options must be evaluated on an individual basis. Nutritional support is important to improve growth and also enhances response to other treatment options. A calcium deficient diet has been beneficial for some affected people.

Osteopetrosis

Prognosis:

The long-term outlook for people with osteopetrosis depends on the subtype and the severity of the condition in each person. The severe infantile forms of osteopetrosis are associated with shortened life expectancy with the most untreated children not surviving past their first decade.

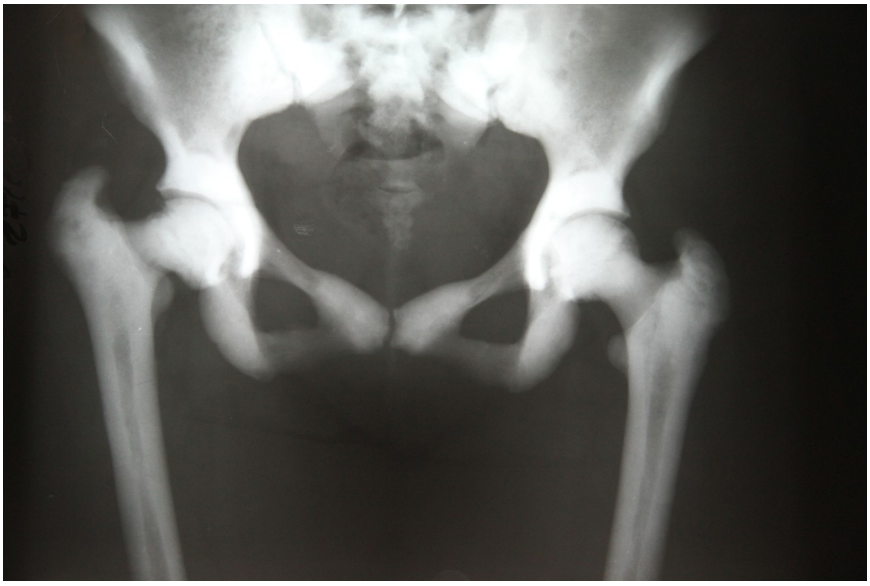
Bone marrow transplantation seems to have cured some infants with early onset disease; however, long-term prognosis after transplantation is unknown. For those with onset in childhood or adolescence, the effect of the condition depends on the specific symptoms (including how fragile the bones are and how much pain is present).

Life expectancy in an adult onset forms is normal.

Prevalence:

Approximately 8-40 children are born in the United States each year with a malignant infantile type of osteopetrosis. One in every 100 to 500,000 individuals is born with a form of osteopetrosis. High rates have been found in Denmark and Costa Rica. Males and females are affected in equal numbers.

The adult type of osteopetrosis affects about 1,250 individuals in the United States. One in every 200,000 individuals is affected by the adult type of osteopetrosis. Higher rates have been found in Brazil. Males and females are affected in equal numbers.



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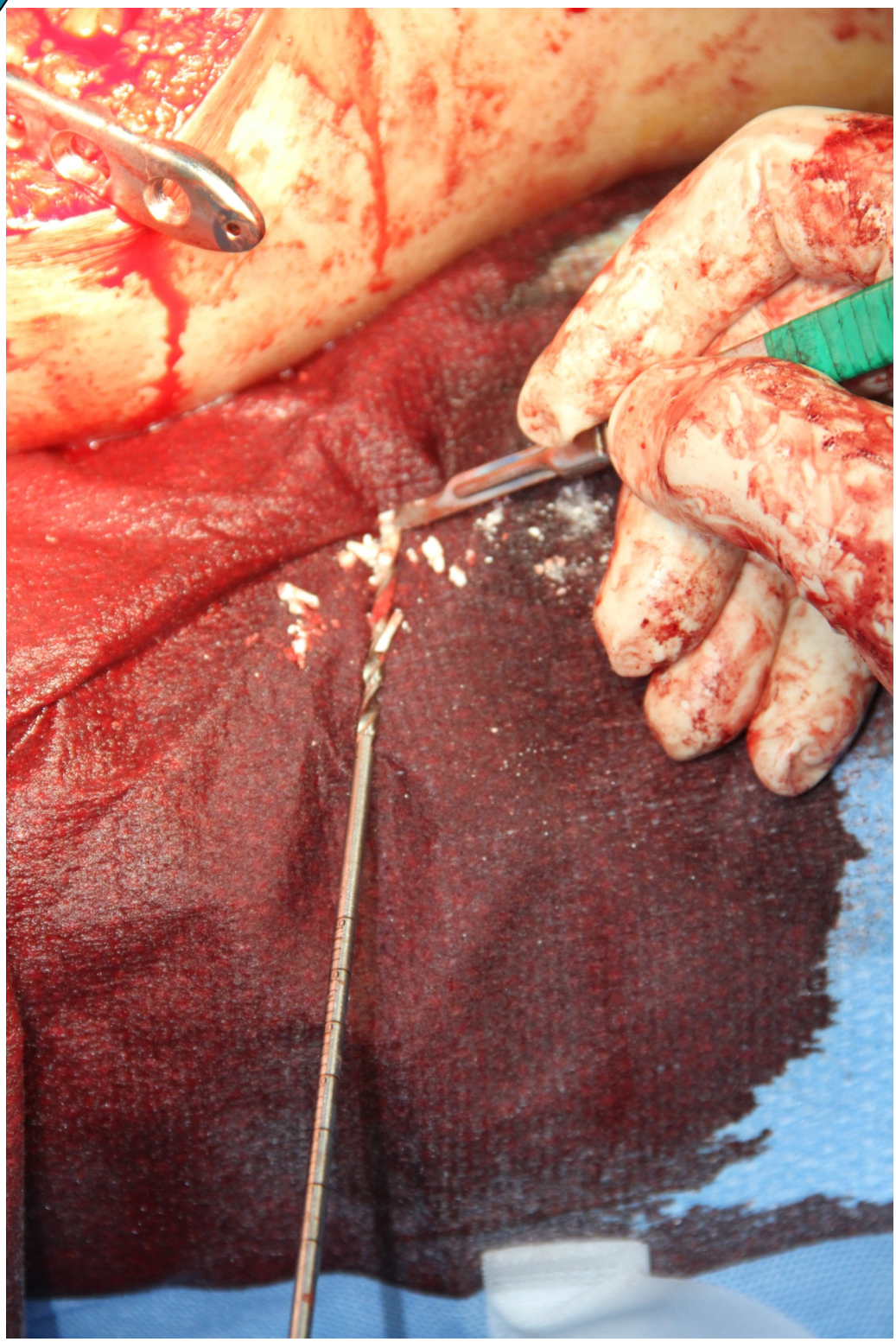

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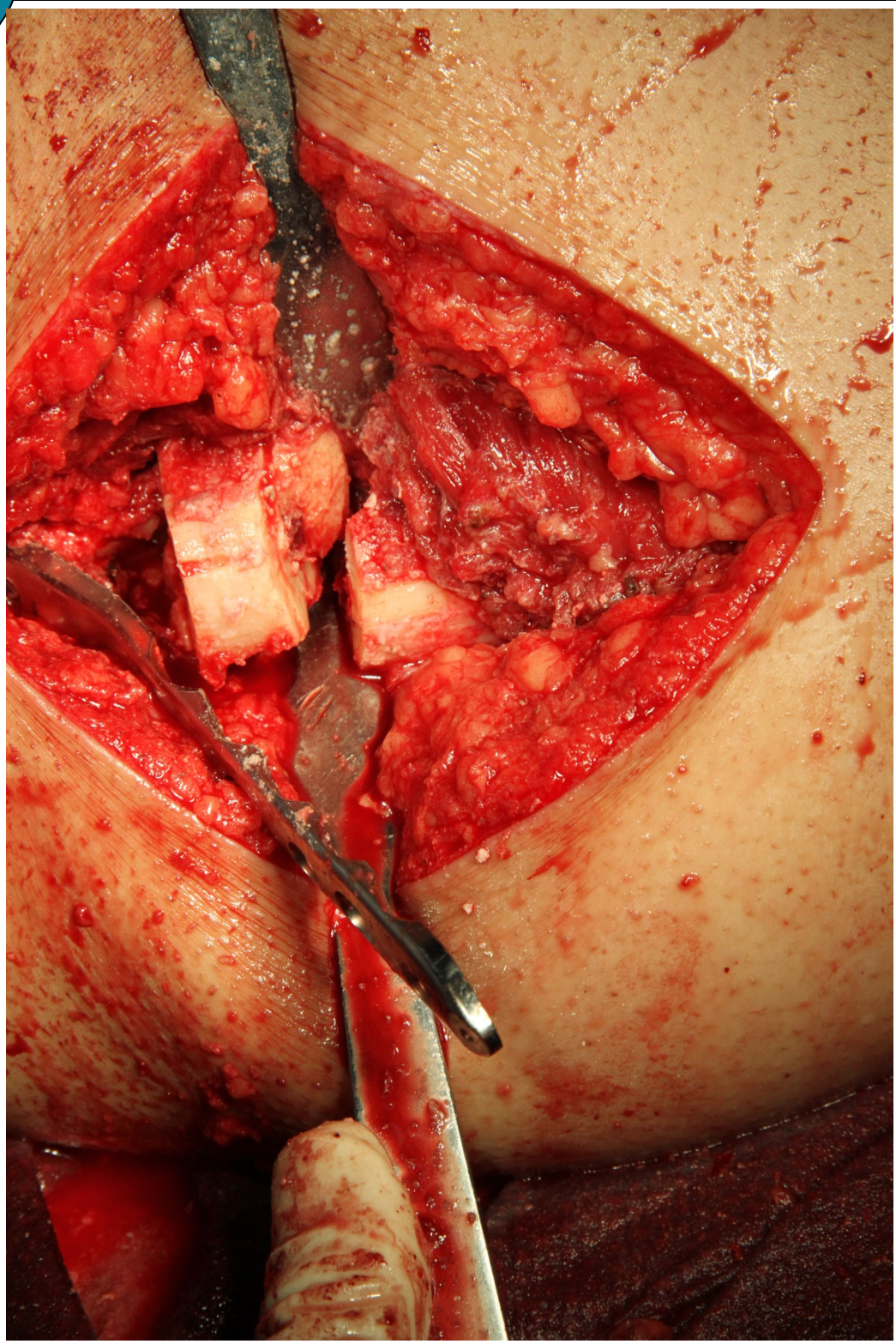

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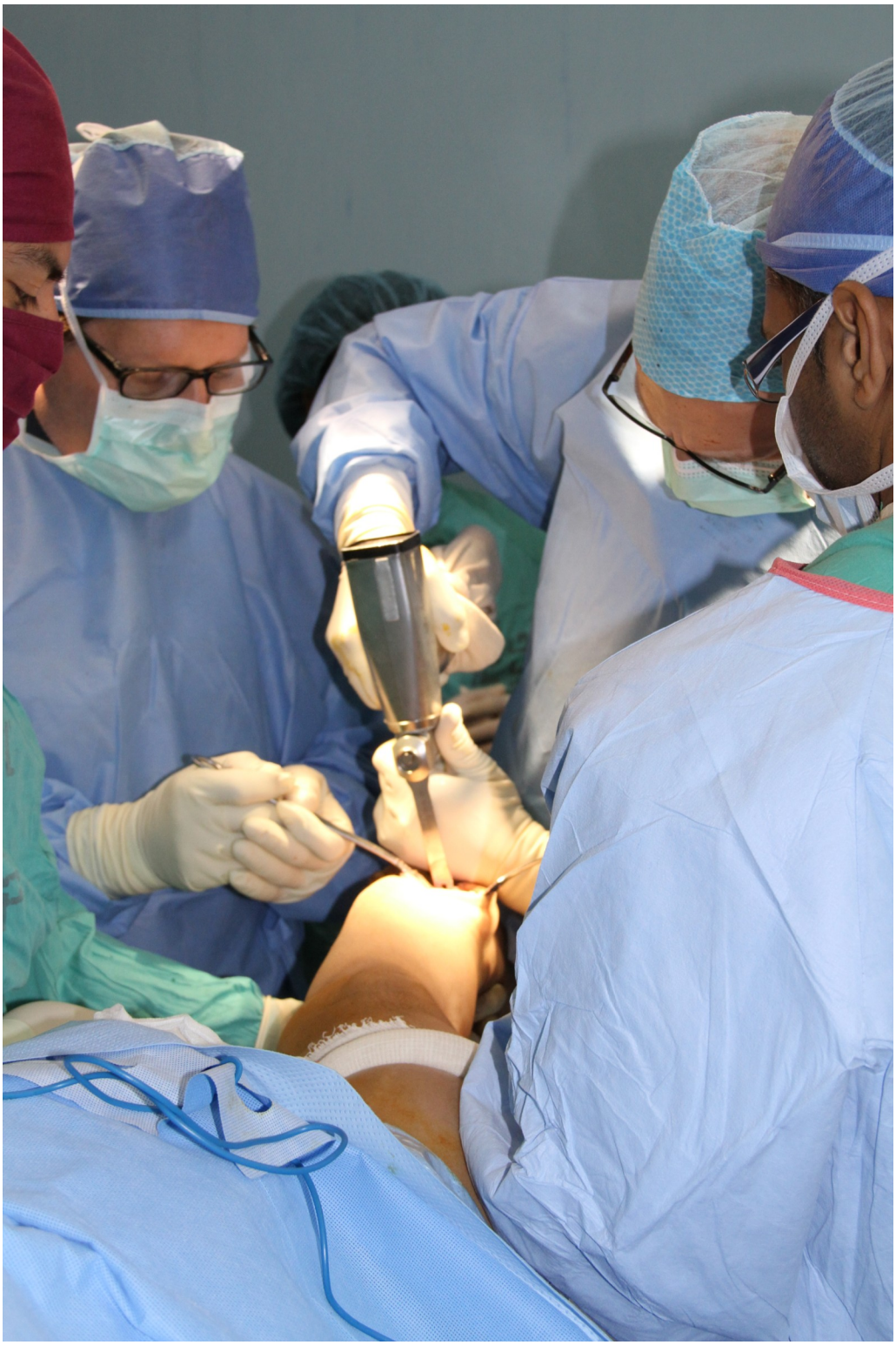

International Journal of Physical Medicine & Rehabilitation

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Commentary Open Access

Physical Medicine and Rehabilitation: The Case for Physiatrists

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Commentary

Physiatrists are either allopathic (MDs) or osteopathic (DOs) physicians (M.D., D.O.) who have completed four years of residency training to be board-eligible in physical medicine and rehabilitation (PMR). Specialists in PMR treat and manage patients with catastrophic and non-catastrophic injuries and conditions. Their responsibilities include the provision of follow-up medical care as well as ongoing medical and rehabilitation managements.

Physiatrists generally treat patients suffering from traumatic brain or spinal cord injury, stroke, amputation, burns, progressive neurologic diseases, musculoskeletal conditions and disabilities, as well as chronic pain. Thus, physiatrists must have clinical knowledge, training and experience to manage all such patients on a long-term basis which will include the medical complications associated with these conditions. The responsibilities of physiatrists include the definition of a patient's impairment, which is a number assigned to a loss of a body system; disability, which is how the impairment will affect that person's ability to reintegrate back into society; cost for future medical care, and life expectancy. All of these components are defined in a Comprehensive Rehabilitation Evaluation.

In this Commentary, we make the case that physiatrists are the most qualified physicians to render accurate and competent opinions contained in a CRE. This issue is of paramount importance in physical medicine and rehabilitation as the CRE is one of the most powerful tools in the armamentarium of healthcare providers to guide the recovery of patients with impairments and disabilities.

A CRE is a forensic medical report that uses knowledge, training, clinical practice experience, as well as peer reviewed literature to define impairment, disability, cost for future medical care, and life expectancy. A CRE should serve as a guide to the patient's recovery and gives them, their medical providers, insurance companies and parties to any potential litigation surrounding the patients injuries a clear and concise roadmap to the patient's medical history, condition, disability and need for future care and treatment. This report may also be utilized by non-physician decision makers, making its accuracy reliability of paramount importance. A CRE may be challenged by an adverse party, either in litigation or in the insurance context. As a result, it is imperative that the report be accurate, credible and defensible. The best way to ensure that the CRE meets these criteria is for all components of the report, including financial data, to be collected and authored by a qualified physical medicine and rehabilitation physician who should lend his or her credentials to the support and defense of the final product.

Impairment is defined as a significant deviation, loss or loss of use of any body structure or body function in an individual with a health condition, disorder or disease. Disability is defined as activity, limitations and/or participation restrictions in an individual with a health condition, disorder or disease [1].

Defining impairment requires the physiatrist to have a working knowledge of the appropriate guides to the evaluation of impairment. A permanent injury is the most critical factor in the prosecution of a personal injury lawsuit. The requirement of a defined impairment is needed in the federal, civil and worker's compensation arenas. The physiatrist needs to have an acceptable working knowledge in the use of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, Sixth Edition. The latest edition of the AMA Guides should always be utilized and physiatrists will have to be familiar enough to have an acceptable working knowledge of that text.

Disability is an impairment that may be cognitive, developmental, intellectual, mental, physical, sensory, or some combination of these. It substantially affects a person's life activities and may be present from birth or occurring during a person's lifetime. Disability is an umbrella term covering impairments, activity limitations, and participation restrictions. Disability is a complex phenomenon reflecting the interactive between the features of a person's body and features of the society in which he or she lives [2].

With extensive experience in clinical practice that involves caregiving to the aforementioned patient populations, a physical medicine and rehabilitation physician (M.D., D.O.) is able to define safe parameters for a patient to return to the work force if able to be accomplished safely. In a CRE, however, objective medical testing is utilized to formalize work restrictions and safe parameters based on objective functional testing so the patient can return to work. Physical functional testing equipment and protocols, such as the BTE and the Biodex, have a totality of peer reviewed evidence to support their normative data. In the medical and legal context, utilizing peer reviewed published normative data and validity testing will withstand legal challenges such as allegations of junk science. With functional testing utilizing normative data and validity testing, these patient's disabilities can be accurately defined using objective measures which can further substantiate the physiatrist's opinions.

The discipline of life care planning was born of necessity before the mid-1970s when a need arose to formulate and/or quantify future care. Physicians or other rehabilitation professionals were often solicited to address three basic questions: 1) What is the subject's condition? 2) What does the subject's condition require? 3) How much will the requirements cost over time? As one might imagine, there was significant variation in the quality, transparency, and legitimacy of

these assessments. At that time the industry was in material need of generally accepted standards [3]. Physiatry has played a central role in a life care plan (LCP), yet less than 1% of life care planners are qualified physicians [3-5]. Non-physician life care planners, as with all experts, are bound by limits of their professional licenses and in the case of non-physician life care planners, this limits their capabilities to perform medical examinations and to independently formulate diagnostic conclusions and opinions regarding impairment, disability, and recommendations for future care [3]. For these reasons, physiatrists have been heavily relied upon by non-physician life care planners. Section 1 of chapter 2 of the Life Care Planning and Case Management Handbook, A Central Text of Life Care Planning, is entitled, "The Role of the Physiatrist in Life Care Planning." It states: "For a life care plan to appropriately provide for all the needs of an individual, the plan must have a strong medical foundation." As physicians specializing in physical medicine and rehabilitation, physiatrists are uniquely qualified to provide a strong medical foundation for life care planning based on their training and experience in providing medical rehabilitation services to patients with disabilities. Physiatrists are uniquely qualified for this task by virtue of their training, experience, and expertise in dealing with patients who have catastrophic functional problems. Additionally, physiatrists are trained to anticipate the long-term needs of their patients [3,4].

A Continuation of Care Plan (CCP) which is a component of a CRE is constructed by a physiatrist (M.D., D.O.) and follows similar methodology that has been described as a LCP [3]. However, a CCP includes contacting as many treating physicians and vendors as possible to confirm procedures, protocols and pricing in the geographic location in which the patient resides or is going to reside.

The spirit and the intent of a CCP is to improve the quality of life of the patient by decreasing morbidity. These strategies include decreasing pain and suffering of patients during the aging process which combined with their impairment leads to a much greater disability over time. We believe that as a person ages they don't feel their pain less but they become more intolerant to pain.

Physiatrists are taught in residency training a comprehensive approach to the assessment of medical and rehabilitation needs and have received the best training to determine what medical conditions remain relevant to the patient's future care considerations [3]. Treating physicians can be of tremendous benefit to a qualified life can planner constructing a CRE, as their experience with the patient may lend valuable insights when crafting a plan unique to that individual [4].

The completion of a CRE should include the consideration of life expectancy. Life expectancy is not a guess as to when a particular person will perish. Life expectancy is a specific statistical concept [6]. The basis for estimating life expectancy is consultation of the literature regarding life expectancy for a particular diagnostic group. The published literature includes multiple peer reviewed articles regarding life expectancy for cerebral palsy, spinal cord injury, traumatic brain injury, coma, persistent vegetative state, and patients with specific cognitive and physical deficits [6].

Physicians who do not thoroughly review relevant medical and scientific data about life expectancy for the particular diagnosis in question should not offer an opinion, [7]. To do otherwise, is merely speculation and does not meet the necessary standard for expert testimony within a court of law, [8].

Life expectancy is defined as the average number of years of life remaining for persons who have attained a given age, [9]. Defining life expectancy requires having a comprehensive understanding of the literature which defines life expectancy within the patient population that is being defined. Life expectancy is different for different conditions such as coma, persistent vegetative state, minimally conscious state, cerebral palsy, and/or hypoxic/anoxic brain injury. When a patient is unable to ambulate and is fed by a G-tube, a spinal cord injury patient who may be a quadriplegic, paraplegic, incomplete or complete lesion, life expectancy should be defined by the strengths of peer reviewed literature regarding the specific patient populations. Without a thorough understanding of peer reviewed published accepted literature within the specific patient population, life expectancy cannot be accurately defined.

In order to produce a CRE, a physiatrist must accurately define the patient's impairment, disability, cost for future medical care, and life expectancy using a medical model. A medical model includes: observation and or performance of a physical exam on the patient, knowledge, training, clinical practice experience, combined with peer reviewed published literature.

When a CRE is produced using the appropriate methodology by the treating or disability evaluation physiatrist, it should then be presented to a medical economist who is familiar with medical inflation rates and discount rates who has the skills to translate those future medical care needs to present money value dollars to determine the ultimate cost needed by the patient. The physiatrist should have extensive working knowledge, clinical practice experience, knowledge of peer reviewed published literature, and utilize accepted methodology to accurately complete a CRE. Failure to follow this prescribed methodology can lead to misleading testimony resulting in disqualification.

An accurate CRE and COC section completed by a qualified physiatrist is paramount in decreasing the patient's pain and suffering thereby increasing their function which will help transform the patient's disability to ability, illness to health and hopelessness to hope.

Disclosures

Dr. Lichtblau and Foster and Ms. Meli reported no disclosures.

Professor Hennekens reported that he serves as an independent scientist in an advisory role to investigators and sponsors as Chair or Member of Data and Safety Monitoring Boards for Amgen, British Heart Foundation, Cadila, Canadian Institutes of Health Research, DalCor, Regeneron, and the Wellcome Foundation, as well as to the United States (U.S.) Food and Drug Administration, and UpToDate; and receives royalties for authorship or editorship of 3 textbooks and as co-inventor on patents for inflammatory markers and cardiovascular disease that are held by Brigham and Women's Hospital; and has an investment management relationship with the West-Bacon Group within

SunTrust Investment Services, which has discretionary investment authority and does not own any common or preferred stock in any pharmaceutical or medical device company.

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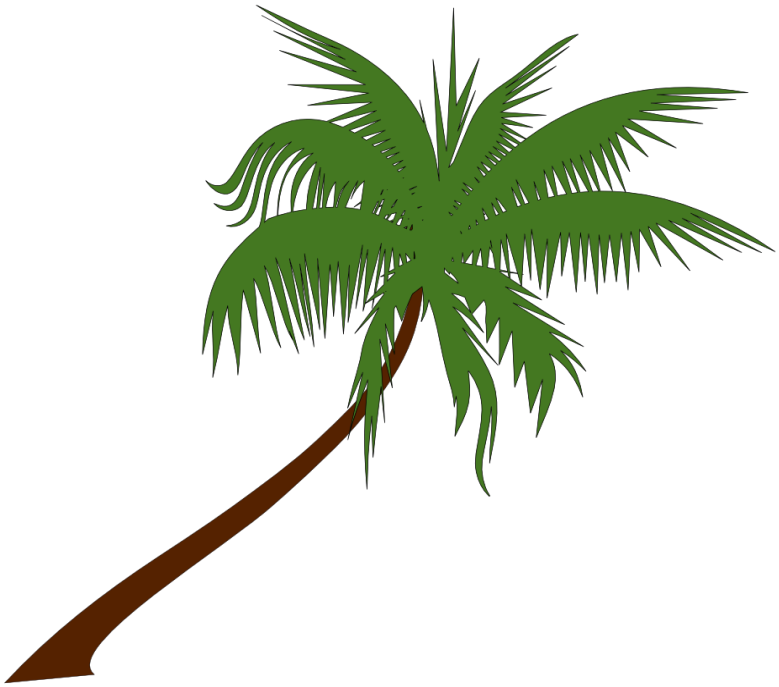

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2019 FSPMR/FSIPP Conference

Click here for Program Link

Just Added! Ultrasound Course-
July 21, 2019 11:30AM-2:00PM sign up here!

Click here for Hotel Room Block link

FSPMR Educational Breakout Session,

Saturday, July 20, 2019

8:30 – 9:30 AM: ***"Identifying the Warning Signs of Non-Compliant and Abusive Patients"***
Richard A Tucker
Former Assistant Special Agent-in-Charge of the DEA

9:30 – 10:00 AM Q&A/Attendee Participation and Input

10 – 10:30 Exhibitor Break

10:30 – 11:30 AM: ***"Surveying the Ever-Changing Battleground in the Business of Pain Management: A Legal Perspective on Chronic Opioid Therapy and Risk Mitigation-Successes and Failures"***
Jennifer Bolen JD
Former Assistant US Attorney, Department of Justice

11:30 AM – 12:00 PM Q&A/Attendee Participation and Input

12:00 – 1:00 PM Lunch Break

1:00 – 2:00 PM ***"Current Diagnosis and Treatment of Complex Regional Pain Syndrome"***
Randall Braddom MD
Former President of AAPM&R, Association of Academic Physiatrists

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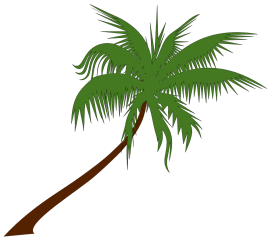


FSPMR Educational Breakout Session,

Saturday, July 20, 2019
continued

2:00 – 3:00 PM ***"Resident Case Presentations with Expert Panel"***
Expert Panel: **Craig Lichtblau MD**, FSPMR President
Matthew Imfeld MD, FSPMR Immediate Past President
Michael Creamer DO, FSPMR Past President
Attendees are also encouraged to ask questions/give input.

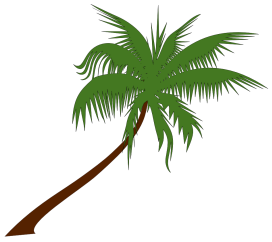
2:00 – 2:20 PM - USF ***"Chemodenervation of Eccrine Glands for the Treatment of Hyperhidrosis of the Residual Limb of an Amputee"***
Krystal Yankowski DO

2:20 – 2:40 PM - Nova/Larkin ***"A Facet Joint Injection: The Good, The Bad, & The Ugly"***
Vidur Ghantiwala DO and **Trevor Persaud DO**

2:40 – 3:00 PM - UMiami ***"Neuromodulation in Spinal Cord Injury"***
Jorge Caceres MD, Kazi Hassan MD, and Rosa Rodriguez MD

3:00 – 3:30 PM Exhibitor Break

3:30 – 4:30 PM ***"The Recognition and Treatment of Chronic Pain Syndrome"***
Randall Braddom MD



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FSPMR Annual Business Meeting & Reception Menu

Saturday, July 20, 2019, 6:30 – 8:30 PM, Atlantic Ballroom 1

SLIDER STATION
Mini Kobe beef sliders
Mini Maryland crab cake sliders ***(pescatarian offering)***
Mini blackened chicken sliders
Accompaniments:
Sliced tomatoes, lettuce, sliced pickles, tobacco fried onions, mayonnaise, mustard, ketchup, sweet relish, soft buns

PASTA STATION
Rigatoni, asparagus, crispy pancetta, roasted chicken, peas, roasted garlic cream sauce
Gemelli, roasted tomatoes, tri peppers, goat cheese, mushrooms, pine nuts, fresh basil, evoo ***(lacto-ovo vegetarian offering)***
Breadsticks, herb focaccia

CARVED VEGETABLE STATION
Grilled Balsamic Roasted Vegetables to Include Zucchini, Yellow Squash, Eggplant, Carrots, Yellow and Red Peppers, Tofu, Charred Vine-Ripened Tomatoes ***(vegan offering)***

DESSERT MINIATURE CREATIONS
Key lime bars, cake lollipops, assorted chocolate truffles, Snicker® tarts, chocolate covered strawberries

COFFEE

WINE AND BEER

Wine –Greystone Cabernet Sauvignon and Chardonnay
Sparkling Wine- La Marca Prosecco
Imported and Domestic Beer, Local Microbrew - Key West Sunrise Ale
Soft Drinks, Fruit Juices, Still and Sparkling Water

Medtronic

Thank you to Medtronic for Sponsoring FSPMR 2019 Annual Meeting and Reception

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Meeting Resources

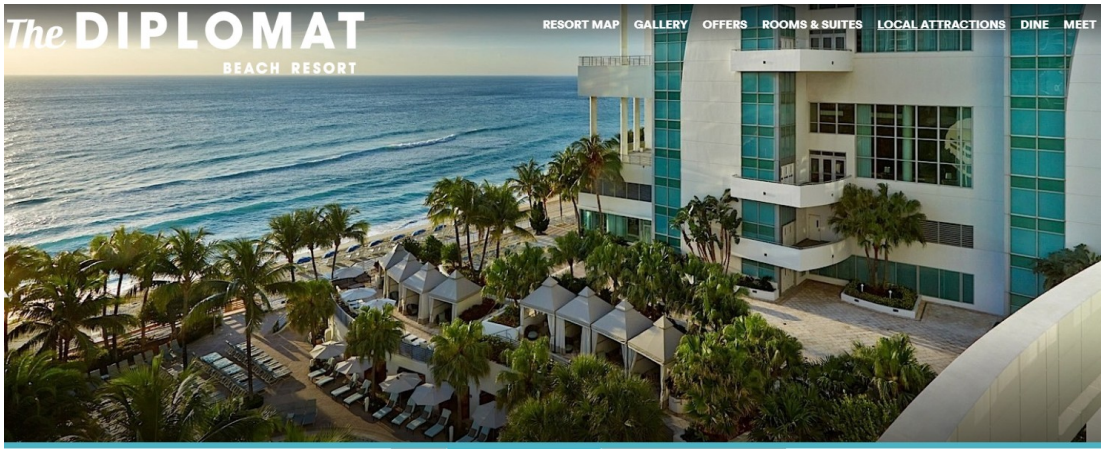
LINK TO FULL PROGRAM AGENDA:
https://www.fsipp-conference.com/2019/FSIPP%202019%20Meeting%20Agenda.pdf

LINK TO ATTENDEE REGISTRATION:
https://www.fsipp-conference.com/attendee-registration.html

LINK TO HOTEL REGISTRATION, ROOM BLOCK AT DIPLOMAT BEACH RESORT:

https://book.passkey.com/gt/217174175?gtid=4e33860f9f7c488c101175cd2e6181f1

Florida Society of Physical Medicine and Rehabilitation
2019 Annual Meeting, July 18 – 21, 2019,
with the Florida Society of Interventional Pain Physicians,
The Diplomat Beach Resort, Hollywood, Florida



FMA
FLORIDA MEDICAL ASSOCIATION

2019 SESSION SUMMARY

Without the FMA...

The number of bills hostile to the practice of medicine filed during the 2019 legislative session was the most in at least a quarter century. Through the efforts of the FMA PAC and the FMA lobbying team, the vast majority of these bills were defeated outright while the remainder were significantly amended from their original versions. Had the FMA not expended a tremendous amount of time and resources fighting this legislative onslaught, the practice of medicine could have been severely affected as follows:

- APRNs and physician assistants would be able to practice independently without any physician supervision.
- Pharmacists would be able to diagnose and treat "minor, nonchronic health conditions," such as the flu, streptococcus, lice, skin conditions, uncomplicated infections. They also would be able to "collaboratively manage" chronic conditions, such as arthritis, asthma, congestive heart failure, COPD, diabetes, emphysema, HIV, hypertension, obesity and renal disease.
- Consultant pharmacists would be able to initiate, modify or discontinue medications.
- Psychologists would be able to prescribe medications, including controlled substances.
- Physicians would have to refer patients to a chiropractor, acupuncturist, physical therapist or massage therapist prior to prescribing a controlled substance.
- Coverage for hearing aids for children would be mandatory, but only audiologists would get paid for providing the service.
- A "Health Innovation Commission" would exist and could grant exemptions that would allow allied health providers to practice beyond their statutory scope of practice, or even practice medicine without a Florida license at all.
- Any physician who performed any type of office surgery would have to get an ambulatory surgical center license.
- Physicians would have to provide a "non-opioid directive form" to patients every time they prescribed, ordered or administered an opioid. Physicians who failed to follow a patient's non-opioid directive would be subject to disciplinary action.
- Physician fees would be capped at 200 percent of Medicare for all services in all instances. Of course, insurance companies would be able to pay less than that amount.

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2019 SESSION SUMMARY

- Physicians would have to prescribe electronically in all situations, regardless of whether they had the capability to do so. Paper scripts would not be allowed.
- Personal injury protection benefits under Florida's no-fault insurance system would disappear. Physicians would have to wait years to get paid, and if the patient had no insurance and didn't win his or her lawsuit, would not get paid at all.
- Health insurance companies would receive $30 million in tax credits for providing telehealth services, but would not have to cover all telehealth services and could pay physicians less for providing telehealth than for providing in-person care.
- Physicians would face increased medical malpractice liability as more patients would be allowed to sue for pain and suffering. Medical liability insurance rates would increase.
- The maximum that physicians would receive for treating patients injured due to the fault of a third party would be the Medicare rate. If the patient was on Medicaid, the physician would be limited to the Medicaid rate, regardless of whether he or she participated in Medicaid.
- Physicians would be prohibited from providing any healthcare services to a minor without parental consent. Physicians who did so could be sent to prison for up to a year.
- Allied health professionals would be able to practice telemedicine in Florida without having to get a Florida license or having to comply with any of the statutes and regulations licensed providers have to meet, and without being subject to disciplinary action for violating any provision of their applicable practice act.
- Physicians who referred a patient to a healthcare provider who did not participate in the patient's insurance network would be required to inform the patient in writing and document in the medical records that the provider referred to is out-of-network, and that seeing this provider could result in additional cost-sharing responsibilities. Physicians, rather than patients, would be responsible for determining the network status of all healthcare providers referred to. Physicians who failed to satisfy this obligation would be subject to discipline.

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UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE /
JACKSON MEMORIAL HOSPITAL PM&R RESIDENCY PROGRAM UPDATES

Greetings from the University of Miami Miller School of Medicine / Jackson Memorial Hospital PM&R Residency Program!

This April, our residents volunteered at the Dolphin Cancer Challenge, providing medical coverage for the various events – from a 5K run to a 100-mile bike ride – in efforts to raise funds for cancer research.

Later that month, a few residents presented the following research at the American Medical Society for Sports Medicine Annual Meeting in Houston, TX.

Percutaneous Ultrasonic Tenotomy: A Meta-Analysis. **Martin Weaver, MD, PGY3**; **Jesse Charnoff, MD, PGY4**; Andrew Sherman, MD

Paratrooper Pelvic Pain: A Case Report. **Martin Weaver, MD, PGY3**; Xavier Aviles, MD

Ciguatera Poisoning Following a Fishing Tournament: A Case Report. **Myriam LaCerte, MD, PGY3**; R. Yaras; **Kazi Hassan, MD, PGY3**; Lauren Shapiro, MD.

Scuba Divers Knee. **Scott Klass, MD, PGY2**; Xavier Aviles, MD.

Our 13th Annual Research Day was held in May where our PGY4s and SCI Fellow presented their incredible research projects.

Injury Rate and Pattern Among Brazilian Jiu Jitsu Practitioners: A Survey Study. **Christopher Moriarty, DO, PGY4**; **Jesse Charnoff, MD, PGY4**; Elizabeth Felix, PhD

Efficacy of Spinal Cord Stimulator Implantation for the Treatment of Painful Diabetic Peripheral Neuropathy: A Systematic Review of Randomized Controlled Trials. **Christopher Alexander, MD, PGY4**; Andrew Sherman, MD; Chanë Price, MD

Resident Education of Ultrasound Guided Procedures: A Homemade Practice Model Pilot Study. **Jesse Charnoff, MD, PGY4**; Usker Naqvi, MD; Chanë Price, MD

Going Green: Chronic Pain Management. **Evan Dimmitt, MD, PGY4; Andrew Chang, MD, PGY4**; Lauren Lerner, MD

Systematic Review of the Clinical Effectiveness of Botulinum Toxin in Upper Back Myofascial Pain Syndrome. **Aaron Cross, DO, PGY4**; Andrew Sherman, MD

Characteristics of Patient Population in a PM&R Spasticity Clinic at a University Hospital. **Giancarlo Perez-Albea, MD**, **SCI Fellow**; Seema Khurana, DO; Kevin Dalal, MD

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UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE /
JACKSON MEMORIAL HOSPITAL PM&R RESIDENCY PROGRAM UPDATES
CONTINUED

We were glad to welcome our Keynote Speaker for Research Day, Dr. Jonathan Finnoff from Mayo Clinic Sports Center, who lectured on the new frontier of Ultrasound Guided Surgery.

13th Annual Research Day

(Left to Right):
Interim Chair - Robert W. Irwin, MD; Keynote Speaker - Jonathan T. Finnoff, DO; Program Director - Andrew L. Sherman, MD

We would also like to congratulate our new:
Resident of the Quarter – **Brittany Mays, MD, PGY-2** and
Chief Residents – **Myriam LaCerte, MD** and **Martin Weaver, MD**

We are looking forward to seeing everyone at the upcoming FSPMR annual meeting!

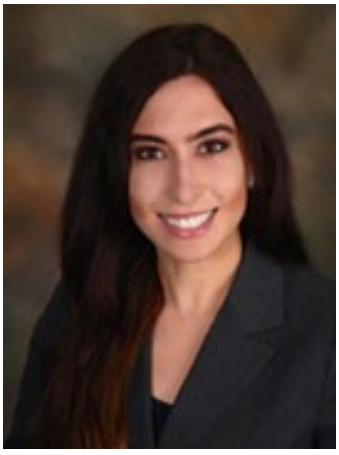
Rosa Rodriguez, MD, MS PGY-2 -Incoming FSPMR Resident Liaison

Martin Weaver, MD PGY-3—Outgoing FSPMR Resident Liaison

Andrew Sherman, MD,-MS -FSPMR Treasurer , Residency Program Director
University of Miami Miller School of Medicine

Rosa Rodriguez, MD, MS, Resident Liaison to FSPMR from UMiami

I was born and raised in Miami, FL. I majored in Chemistry at Florida International University and subsequently completed a post-baccalaureate research year at the NIH Academy focusing on health disparity medicine. I attended Medical School at the University of Colorado School of Medicine, there I learned to snowboard and road bike as well. I also completed a Master's in an Immunology lab while in Colorado. After graduating medical school, I did my intern year in General Surgery at a Community Hospital in Denver, CO, Saint Joseph Hospital General Surgery in Denver, CO. My Physiatry interests are many, but the highlights include Pain, MSK, Spine and research. One of the many things I enjoy about the University of Miami PM&R programs is the diversity we are exposed to. I enjoy salsa dancing, hiking and road cycling. I



Physiatrist's Voice
NEWSLETTER June 2019

LARKIN PM&R RESIDENCY UPDATES

We are coming to the end of the 2018-2019 academic year and PGY4's are gearing up for graduation in June. The Larkin PM&R Class of 2019 will be scattered across the country (and of course, Florida!) next year embarking on new adventures with fellowships and employment!

We would like to extend a big thank you to our outgoing chiefs Patricia Goodwin, DO and Thiago Queiroz, DO for an excellent year! The incoming chiefs Karen Rosen, DO and Ian Miller, DO have already been working hard to make the 2019-2020 year as successful as possible with new events and educational opportunities to enhance resident education.

We had a wonderful time at the AOCPMR annual assembly at the Drake Hotel in Chicago, IL in March and held a high-yield OMM workshop with the help of the FM/NMM residents in April!

LECOM/Larkin PM&R is seeking Florida physiatrists interested in clinical and didactic exposure. If you would like to learn more about opportunities to become an Assistant Clinical Faculty, Associate Professor, or present a lecture in your field of expertise, please contact the PM&R Program Director, Jose Diaz, DO (josediaz@larkinhospital.com) and Ernesto Alfonso (ealfonso@larkinhospital.com) the GME Program Coordinator.

LARKIN PM&R RESIDENCY UPDATES

CONTINUED

Shiel Jhaveri, DO PGY-4
Larkin Community Hospital
Department of PM&R
AOCPMR Resident Council
Social Media Chair

Dr. Jhaveri graduated from Philadelphia College of Osteopathic Medicine in Philadelphia, PA, and will be completing her Physical Medicine & Rehabilitation residency in June 2019 at Larkin Community Hospital. Going forward, she is looking forward to enjoying the year-round summers in Palm Beach County.

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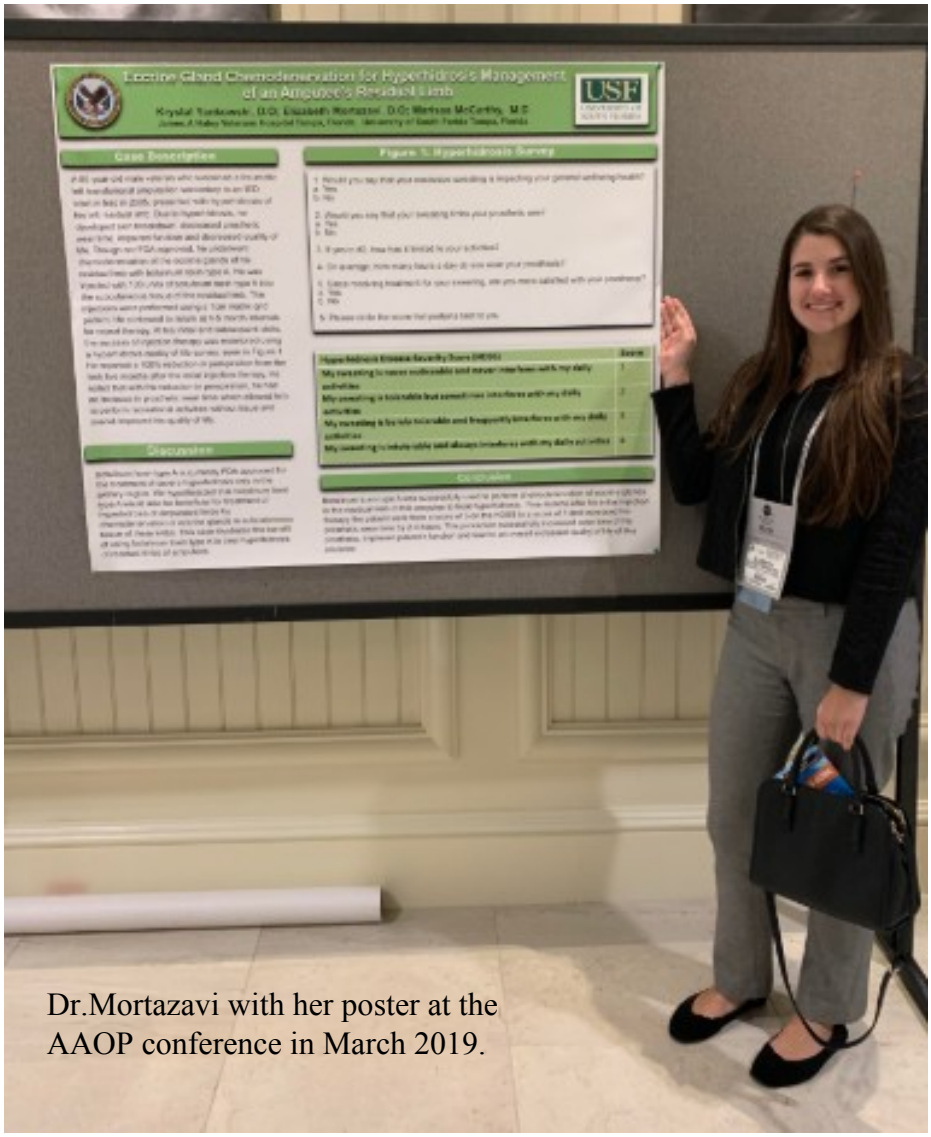
UNIVERSITY OF SOUTH FLORIDA UPDATES

It is nearing the end of the Academic year and the current PGY-4's are getting ready for graduation in June. We are excited to be keeping two of our residents close as they will be staying at the University of South Florida for fellowship. Morgan Pyne will be completing a fellowship in Spinal Cord Injury and Eric Catlin will be completing a fellowship in Pain Management. We also had a successful match day in March and look forward to the arrival of our newest residents this summer. Stefan Litzenberger, Matthew Weinstein and Margaret Zorc will all be joining our incoming intern class in July.

Residents Anabel Anon-Vila, Krystal Yankowski, Amanda Hanekom, Elizabeth Mortazavi and Morgan Pyne (pictured below from left to right), all attended the Association of Academic Physiatrists annual conference in San Juan, Puerto Rico in February. They all presented posters.

Research is ongoing at USF. PGY-2's Krystal Yankwoski and Elizabeth Mortazavi presented a poster at the annual Academy of Orthotists and Prosthetists in March, at the Caribe Royal in Orlando, Florida. Robert Rotman and Morgan Pyne had a paper published in the Interventional Pain Management Reports titled "Neurofibromatosis Type 2: A Review of Pain Management Options." Morgan Pyne is also presenting a poster at the VA research day titled "Patient Interest in Rehab Telemedicine Services."

UNIVERSITY OF SOUTH FLORIDA UPDATES
CONTINUED



Dr.Mortazavi with her poster at the AAOP conference in March 2019.

Elizabeth Mortazavi, DO, Resident Liaison to FSPMR from University of South Florida

Dr. Mortazavi was born and raised in Potomac, Maryland before moving to Tampa, Florida as a teenager. She completed an 8 year dual-admission medical school program at Nova Southeastern University. The program included 4 years of undergraduate studies, where she received a bachelors degree in Biology with a minor in Chemistry. The last 4 years were spent at NSU's College of Osteopathic Medicine where she received her Doctorate in Osteopathic Medicine. She is currently completing her residency in Physical Medicine and Reha-

Physiatrist's Voice
NEWSLETTER June 2019

Member Spotlight – Anthony Dorto MD

Interviewed by Robert Kent DO, MHA, MPH, FAAPMR

Anthony Dorto, M.D., is a definitive pioneer of physiatry in Florida. Dr Dorto graduated from the The Long Island College Hospital School of Radiologic Technology and then went on to attend Lincoln College in Indiana School of Chiropractic Medicine where he obtained a B.S. in Human Biology, as well as the New York City Community College and State University of New York and Downstate Medical Center where he graduated with a B.S. in Radiologic Technology. He worked as a chiropractor for five years and then went to medical school to further his education even more. After completing Medical School at C.E.U.X. Medical School and attending fifth pathway at SUNY, he completed an internship at Brookdale Hospital and Residency at Mount Sinai in Physical Medicine and Rehabilitation. His education provided areas of expertise in the musculoskeletal system few of us have the privilege of understanding or experiencing. He is a board certified physiatrist with additional training and experience in impairment and disability assessment, Functional Capacity Evaluation, Independent Medical Examinations, work capacity, work restrictions/ limitations, work / job assessment, future medical care needs, and occupational medicine. He has multiple publications and has literally 'written the book' on impairment and guidelines with his multiple text book chapters, papers, guideline development and articles dedicated to these subjects and many others in physiatry. Dr Dorto has also been an active teacher and trainer, helping current and future physiatrists from his time training at Jackson's PM&R program to SEAK training to his training in CARF accreditation. He has lectured at many conferences on the local, state, national and international level. In discussion with Dr. Dorto, who has been a part of the Florida community of Physiatrists for over three decades, you get a sense of his willingness to help other physiatrists. From his practice where he is an advocate for patients and medical standards, an investigator for medical integrity, to his role as an instructor, as well as knowing him as individual, you can see how he works to improve those around him. He is a pioneer in in his expertise, his knowledge, and his willingness to help other physiatrists. For anyone interested in medico-legal work, his number one recommendation is to train and know what you are going into, understand the ins and outs to make sure you can not only protect yourself, but to make sure you can do the best job for what is being asked. I have attended quite a few of his lectures, at Nova, FSPMR and SEAK and the intricacies of medico-legal work are vast. We are lucky to have Dr Dorto help us navigate these details.

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Boxing Medicine in Tampa and Around the World, My Point of View

By Rodolfo Eichberg MD

Executive Director Note: Following is an article from 12 years ago, published in the Hillsborough County Medical Association (HCMA) Bulletin, Vol. 53 No. 1 – May/June 2007. After reading it, I asked Dr Eichberg about the status of boxing today. Is it the same? Better? Eroded? His response, "It's the same. There is *less* boxing because mixed martial arts fighters perform for much less money. Promoters can put on an event for a lot less money. Safety regulations are the same." I shared with him my thought that this is historical Florida sports medicine. Dr Eichberg responded, "Indeed historical! So am I!" -Congratulations to Dr.Eichberg who will be inducted into the Florida Boxing Hall of Fame on June 23 of this year.

Writing about my experience in boxing just became much easier. Last night I returned from the II World Medical Congress of the World Boxing Council held in Cancun, Mexico (April 24 – 29, 2007). Talking to physicians from 88 countries dedicated to the safety and welfare of boxers proved to me that my 37 years as a ringside physician were not in vain.

I have been a boxing fan since adolescence. My career as a boxing physician started in 1970, when a ringside physician got sick on the day of a major card in Mar del Plata, Argentina. I was the physician for a professional soccer team and was asked to substitute.

When I arrived to Tampa in 1975, I met Mo Chardkoff MD who was then the Dean of ringside docs in Tampa. Mo was an "old school" family physician, housecall bag and all. I can still see his perennial smile and the chewed up, unlit cigar in his mouth. Hundreds of amateur boxers received free medical care and lots of hugs and love from Mo over the years. He was the only "access to care" they ever got.

A few years later under Governor Lawton Chiles, a serious effort was made to make the sport of boxing as safe as possible. Mr Mike Scionti was appointed Executive Director of the State Athletic Commission. Physicians around the state met in Tampa and started what proved to be a very successful mission. Several members of the HCMA assumed leadership roles. The names Victor Martinez, Jack Guggino, David Dillenbeck, and Don Mellman come to mind (my apologies to those who do not).

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Boxing Medicine in Tampa and Around the World, My Point of View

By Rodolfo Eichberg MD

continued

I am very proud of the accomplishments of all the physicians who have worked for the Florida State Boxing Commission over the past 30 years. They laid the groundwork for what we have today: safe boxing statewide. For the longest time we worked for free despite a very high medical-legal exposure. Today we are appointed by the state and legally protected. All boxing cards throughout the state are staffed by two certified ringside physicians, an ambulance, and at least two paramedics are on site.

The days of the doctor "friend of the promoter" sitting in a corner are gone. Boxers are examined pre and post-fight. They are covered by insurance in case they do get hurt. Boxers that are knocked out get a 60 day minimum suspension and are required to get follow up care and clearance to return to boxing. Physicians and referees work hand-in-hand and know each other well, so that a little gesture can transmit an important message.

Many safety measures are now the norm worldwide, both at the amateur and professional levels. The results are obvious to all who want to see them. The Athens Olympics had zero knockouts. Severe injuries are rare and death an infrequent occurrence worldwide.

A paper presented at the World Meeting, authored by Massimiliano Blanco MD (Italy), reported that the incidence of medical problems of any kind in European boxing was 1.8% overall. He also reported that 2.8% of female boxers suffered any kind of medical injury.

Data like these fly in the face of the AMA's position on boxing. Their verdict is "ban it." Boxing is a dangerous sport. So are polo, rugby, football, motorcycle or car racing, and many others. The "ban it" crowd argues that the object of boxing is to hurt your opponent. Does anybody believe that this is not so in football? Perhaps a little statistic might help. 6% of high school football players have at least one concussion per season. Pittsburg, Pennsylvania, does neuro-physiological testing on high school football players. Is the AMA going to advocate banning football?

I would go so far as to say that it is probable that inactivity and lack of exercise leading to morbid obesity is more dangerous than boxing, or any other sport.

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Boxing Medicine in Tampa and Around the World, My Point of View

By Rodolfo Eichberg MD

continued

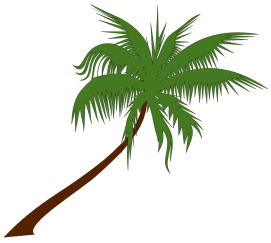
I submit to you that a position paper on boxing in a country with 50 million uninsured is more than hypocritical. I have been a member of the AMA for over 30 years and lament the fact that they have utterly failed to provide access to care for our citizens. All first world countries have it and so do some third world countries. Until they help resolve this problem they should refrain from opining on something like boxing, of which they know very little.

I can tell the illustrious leaders that in many cases my pre-fight physical, detailed eye exam, and hepatitis tests, required by our state are the only medical care these young people will get. The World Boxing Medical Meeting has convinced me that trying to ban boxing is, if nothing else, QUIXOTIC.

Amateur boxing is as safe as most sports. Professional boxing in the 21st century is heavily regulated all over the world. Safety measures such as limiting title bouts to 12 rounds, all other bouts to a maximum of 10 rounds, better gloves, mandatory ringside physicians, mandatory presence of an ambulance and paramedics, and many other measures have made it much safer; yet we still have biased reporting by the media.

A few weeks ago a millionaire died on the polo fields of West Palm Beach. The few sports pages that reported it gave it a "two liner." If it would have been a boxer it would probably have made front page headlines. Why? In 30 years I have admitted 3 boxers to a hospital. The most serious injury was a subcapsular hematoma of the spleen that did not require surgery.

I have come from Floyd Self's Gym in Ybor City to title fights in the St Pete Forum, from Florida Golden Gloves to major professional fights all over the state. I have made many friends along the way. Thanks to boxing, the day I die "the bell will toll for me" (Hemingway). In no other sport will anybody get that traditional "goodbye" and recognition.



Physiatrist's Voice
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Become a Florida PM&R Pioneer and Mentor a Young Physiatrist

We want to help our young physiatrists by providing mentors for them. Our mentors are PM&R Pioneers. These mentors are for both practice management and clinical issues. Your name and office phone number will be shared via our newsletter so that younger members can contact you. If you have a minimum of 20 years of experience and you want to share your knowledge, training and experience with new FSPMR members, please submit your name to Lorry Davis, FSPMR Executive Director, lorry4@earthlink.net. A special thanks to FSPMR's Board of Directors who have volunteered to be Florida PM&R Pioneers (with the exception of a couple of our younger Board members who do not yet have 20 years of experience). Thank you for your consideration and if you'd like to discuss it further with me before deciding, please contact me at C.Lichtblau@chlmd.com.

Craig Lichtblau MD

President, FSPMR

Young Physiatrists!

We are pleased to list ***FSPMR's PM&R Pioneers*** (alphabetical order), along with their office phone numbers, so that you can contact them for guidance:

Michael Creamer DO	(407) 649-8707
Rodolfo Eichberg MD	(813) 629-8407
Anthony Dorto MD	(305) 932-4797
Mitchell Freed MD	(407) 898-2924
Matthew Imfeld MD	(407) 352-6121
Craig Lichtblau MD	(561) 842-3694
Jesse Lipnick MD	(352) 224-1813
Bao Pham DO	(904) 527-3135
Mark Rubenstein MD	(561) 296-9991
Andrew Sherman MD	(305) 585-1332
Jonathan Tarrash MD	(561) 496-6622
Colleen Zittel MD	(407) 643-1329

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Job Opportunities

There is no cost to post Job Opportunities for Physiatrists. Posts remain for six months, or less if we are notified that a position has been filled.

Send your job ads to FSPMR Executive Director, lorry4@earthlink.net.

Thank you.

LOOKING FORWARD TO SEEING YOU THERE TOO!