

NEWSLETTER

March 2021

ENHANCING HEALTH AND FUNCTION THROUGH EDUCATION AND RESEARCH IN THE FIELD OF PHYSICAL MEDICINE AND REHABILITATION

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### PRESIDENT'S MESSAGE Mark Rubenstein, M.D.

reetings and Happy New Year! This newsletter message will be relatively brief. Our specialty has little to report since the last newsletter was published. We all have our struggles with the current pandemic and its inherent changes in our practices and our lives. The last few months have



been focused on our country's political climate with the headlines primarily centered upon the vaccination "race."

By now I hope that most of you have opted for and received the vaccination. Ethically I had wished that the most susceptible receive priority for the vaccine first. I concur with the elderly and immunocompromised and had initially planned to defer my own until it was readily available. It became quickly clear that we as physicians needed to understand the actions of the vaccines, the goals, and set examples for our patients with regard to the relative safety of the inoculations. Our day to day activities put us in contact with so many individuals that could risk mortality from Covid-19 exposure – it is imperative that we take all precautions and protect our patients and families to the best degree that science guides us.

The payroll protection programs that were rolled out last year have re-opened. Those of you that are qualified should re-visit whether a second round of "loans" are necessary, appropriate, or desired. Time is of the essence if you choose to do same.



One of my goals as your temporary leader is to increase the number of our members participating in organized medicine outside of FSPMR. Of course, our goal as an organization is to increase our own membership first, and that is a priority. If you know other physiatrists who are not currently engaged or members, please encourage them to join. There truly is strength in numbers for many reasons. Our executive staff stands ready to assist you in facilitating membership recruitment.

Participation in organized medicine can mean many things. Our own organization is granted a voice at the House of Delegates for the Florida Medical Association. We are voting members and therefore can help shape policies for years to come. If you were to read resolutions that are brought before the House of Delegates for the FMA, you would see that many are either requesting that the FMA "support", "seek", or "pursue" legislation. Effective pursuit of legislation means lobbying. Lobbying requires finances. Political Action Committees are imperative to achieve this.

Many physicians are upset that Florida Legislature passed expansion of scope of practice for nurse practitioners last year. Frankly, we were misled by a number of politicians, and the specific piece of legislation was the primary goal of the last House Speaker. It was an uphill battle. What people don't understand is that they may just be the tip of the iceberg. This year there is already legislation filed calling for more expansion of nurse practitioner privileges. The legislation that passed previously allows nurse practitioners to practice primary care WITHOUT physician supervision. The goal this year by several senators is to expand this to sub-specialties. Additionally, there is legislation that will allow optometrists to do eye surgery. This is an example of what needs to be closely followed each session.



Donations to Political Action Committees (PACS) should be considered an insurance policy. We as physicians need to contribute a bit each year so the medical profession as a whole does not lose standing. The end result could be that patient care suffers when physicians are not strong or powerful enough to impact the political process.

Changing directions completely, I'm proud to report that planning is underway for the annual meeting for FSPMR. This year it is planned for August in Tampa, and will again be in conjunction with the FSIPP Annual Meeting. Excellent educational opportunities will abound. Stay tuned and make plans to attend if able. In the meantime, stay safe, stay healthy, and stay productive.







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Florida Society of Interventional Pain Physicians Florida Society Physical Medicine & Rehabilitation August 12-15, 2021 The JW Marriott Tampa Water Street Hotel Tampa, Florida

### **CALL FOR ABSTRACTS**

### Submission Deadline: July 10, 2021

The Planning Committee for the Florida Society of Interventional Pain Physicians Annual Meeting invites you to submit abstracts for papers to be presented at the upcoming conference at The JW Marriot Tampa Water Street Hotel, Tampa, Florida. Abstracts should describe original research in the field of pain management. We welcome residents and fellows to submit abstracts as well.

### **General Information:**

The Florida Society of Interventional Pain Physicians together with the Florida Society Physical Medicine and Rehabilitation has reserved time on the program for scientific poster sessions. ePosters will be available for viewing throughout the entirety of the conference. You are welcome and encouraged to bring handouts.

Paper abstracts previously presented or published may not be submitted without modifications, Original work must be changed or expanded, resulting in a new abstract.

The Planning Committee will retain the copyright of the published abstracts. Awards will be presented to the top poster presenters.

For Submission Information, Policy on Commercial Support, Selection Criteria, Meeting Registration Guideline for Poster Winners, Abstract Submission Form, please go to <u>https://www.fspmr.org/2021conf/FSIPP.FSPMR.CallForAbstracts.2021.pdf</u>. Thank you!



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### ASTROCYTOMA

#### Craig Lichtblau, M.D.

A strocytoma is a type of brain tumor that originates in the glial cells, star-shaped brain cells in the cerebellum called astrocytes. This type of tumor does not usually spread outside of the brain or spinal cord and it does not usually affect other organs. Astrocytomas are the most common glioma and can occur in most parts of the brain



and occasionally in the spinal cord. Within the astrocytomas, two broad classes are recognized in the literature:

- Narrow zones of infiltration mostly noninvasive tumors, pilocytic astrocytoma, subependymal giant cell astrocytoma, pleomorphic xanthoastrocytoma, that often are clearly outlined on diagnostic images.
- Diffuse zones of infiltration, high-grade astrocytoma, anaplastic astrocytoma, and glioblastoma that share various features including the ability to arise at any location in the central nervous system, but with a preference for the cerebral hemispheres. They occur usually in adults and have an intrinsic tendency to progress to more advanced grades.

People can develop astrocytomas at any age. The low-grade type is more often is found in children and young adults while the high-grade type is more prevalent in adults. Astrocytomas in the base of the brain are more common in young people and account for 75% of neuroepitheleal tumors.

Astrocytoma causes regional affects by compression, invasion and destruction of brain parenchyma, arterial and venous hypoxia, competition for nutrients release of metabolic end products (free radicals alter the electrolytes neurotransmitters) and release and recruitment of cellular mediators (cytokines) that disrupt normal parenchymal function. Secondary clinical sequelae caused by elevated intracranial pressure attributable to direct mass effect, increased blood volume and increased cerebral spinal fluid volume.

#### **Diagnosis:**

An x-ray, computed tomography (CT), or magnetic resonance imaging (MRI) scan is necessary to characterize the extent of these tumors (size, location and consistency). A CT will usually show distortion of the third and lateral ventricles with displacement of the anterior middle cerebral arteries.

Histologic analysis is necessary for grading diagnosis. A physician would take a history of symptoms and perform a basic neurologic exam including an eye ex-



am and test the vision, balance, coordination and mental status.

A CT scan or MRI of the patient's brain is obtained. If the tumor is found, a neurosurgeon must perform a biopsy for the neuropathologist to examine and grade. The biopsy may take place with surgical removal of the tumor. Grading of the tumor sample is a method of classification that helps determine the severity of the astrocytoma and decide on the best treatment options. There are numerous grading systems.

#### Grading:

There are numerous grading systems in use for the classification of tumor of the central nervous system. The World Health Organization grading system is commonly used for astrocytoma. It was established in 1993 in an effort to eliminate confusion regarding diagnosis.

The World Health Organization system established a four tier histologic grading guideline for astrocytomas that assigns a grade from I to IV with I being the least aggressive and IV being the most aggressive.

The World Health Organization grading system is based on the appearance of certain characteristics:

Atypia Mytosis Epithelial proliferation Necrosis

These features reflect the malignant potential of the tumor in terms of invasion and growth rate. Various types of astrocytomas are given these World Health Organization grades.

#### Grade | Astrocytoma - Pilocytic:

A pilocytic astrocytoma, subependymal giant astrocytoma, and subependymoma consist of slow-growing astrocytoma with very slow-growing tumors where complete surgical removal by stereotactic surgery is possible and may experience total remission. Even if the surgeon is not able to remove the entire tumor, it may remain or be successfully treated with radiation.

#### Grade II Astrocytoma – Diffuse (Low-Grade)

A low-grade astrocytoma (fibrillary pleomorphic xanthoastrocytoma and mixed oligoastrocytoma), consists of relatively slow-growing astrocytomas usually considered benign that sometimes evolve into more malignant or as high-grade tumors. They are prevalent in younger people who often present with seizures. Median survival varies with the cell type of tumor.



Grade II astrocytomas are defined as being invasive gliomas meaning that the tumor cells penetrate into the surrounding normal brain making a surgical cure more difficult. Oligodendrogliomas (which might share common cells of origin) have a better prognosis than those with mixed oligoastrocytomas who in turn have better prognosis than in patients with (pure) low-grade astrocytomas. Other factors which influence survival include age (the younger the better) and performance status (ability to perform tasks of daily living).

Due to the infiltrative nature of these tumors, recurrences are relatively common. Depending on the patient, radiation or chemotherapy after surgery is an option. Individuals with Grade II astrocytomas have a five year survival rate of about 34% without treatment and about 70% with radiation therapy. The median survival time is four years.

#### Grade III Astrocytoma – Anaplastic

An anaplastic astrocytoma is often related to seizures, neurologic deficits, headaches or changes in mental status. The standard initial treatment is to remove as much of the tumor as possible without worsening neurologic deficits. Radiation therapy has been shown to prolong survival and is a standard component of treatment.

Individuals with Grade III astrocytoma have a median survival time of 18 months without treatment (radiation and chemotherapy). There is no proven benefit to adjuvant chemotherapy to supplement of other treatments for this kind of tumor. Although Temozolomide is affective for treating recurrent anaplastic astrocytoma as well as an adjuvant through radiation therapy, it has not been fully tested.

#### Grade IV Astrocytoma – Glioblastoma Multiforme (GBM)

A glioblastoma multiforme is the most common and most malignant primary brain tumor. Primary glioblastoma multiforme grow and spread to other parts of the brain quickly. They can become very large before producing symptoms which often begin abruptly with seizures. Less than 10% form more slowly following degeneration of low-grade astrocytoma or anaplastic astrocytoma. These are called secondary GBM and are more common in younger patients (mean 45 versus 62 years of age).

Surgical removal remains the main stay of treatment provided that unacceptable neurologic injury can be avoided. The extremely infiltrative nature of this



tumor makes complete surgical removal impossible, although radiotherapy rarely cures glioblastomas, studies show that it doubles the median survival of patients compared to supportive care alone. The prognosis is worse for these Grade IV glioblastomas. Few patients survive beyond three years. Individuals with Grade IV astrocytoma have a median survival time without treatment, 30 weeks with radiation and 37 weeks with surgical removal of most of the tumor and followed by radiation therapy. Long-term survival (at least five years) falls well under 3%.

According to the World Health Organization data, the lowest grade astrocytoma (Grade I) make up only 2% of recorded astrocytomas. Grade II – 8% from the higher grade anaplastic astorcytomas and Grade III – 20%. The highest grade astrocytoma (Grade IV GBM) is the most common primary nervous system cancer and second most frequent brain tumor after brain metastasis. Despite the low incidence of astrocytomas compared to other human cancers, mortality is significant as the high grades (III and IV) present high mortality rates mainly due to late detection of the neoplasm.

Treatment for low-grade astrocytoma is surgical removal of the tumor which generally allows functional survival for many years. In some reports a five year survival rate has been over 90% with well resected tumors. The broad intervention of low-grade conditions is a contested matter. In particular, pilocytic astrocytomas are commonly indolent bodies that may permit normal neurologic function. However, left unattended, these tumors may eventually undergo a neoplastic transformation. To date, complete resection of high-grade astrocytomas is impossible because of the diffuse infiltration of the tumor cells into the neural parenchyma. Thus, high-grade astrocytomas inevitably recur after initial surgery or therapy and are usually treated similarly as the initial tumor. Despite decades of therapeutic research and curative intervention, it is still nonexistent for high-grade astrocytomas. Patient care is ultimately focused on palliative management.





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### CASE STUDY

#### History of Present Illness:

his is a 17 year-old, right hand dominant, Caucasian male who just received a full scholarship to a 4-year college for Lacrosse who presented to Jupiter Medical Center due to 3-4 days of numbness and tingling down both of his forearms, hands, and left leg. MRI showed a spinal cord lesion at C7 2 cm x 1 cm with surrounding edema. The patient was transferred to St. Mary's Medical Center. Upon arrival he was started on dexamethasone, high dose. An MRI of his brain showed no parenchymal abnormalities. The patient was consulted by neurosurgery. He has paresthesias, motor strength 4-/5 bilaterally and very poor resistance. He was taken to the operating room the next day on 06/10/20 and underwent a cervical tumor resection. Blood loss was 200 mL. The patient was followed by neurosurgery, showed improvement in p.o. intake postoperative, and required morphine for pain. His left lower extremity weakness and lack of sensation was improving. Grasp strength weak but improving, right greater than left. Left lower sensation improving. The surgical specimen was sent to the University of California for pathological confirmation.

On 06/15/20, the patient demonstrated serosanguinous drainage in a very small area. It was not approximated. There was no site dehiscence and no concern for CSF leak. Preliminary pathological report was benign astrocytoma. The patient was seen by a Physiatrist secondary to bilateral shoulder pain, left greater than right, no sensation along his lower abdomen and down the entire left lower extremity. The patient was able to move his left lower extremity but had no idea that he was moving it.

An MRI of the cervical spine demonstrated C6 to T1 laminotomies, central cord lesion at C7 level significantly smaller than the prior study. The remnant measurement was 11 x 6 x 9.7 mm. On 06/16/20, the patient complained of left leg numbness, and there was no concern for CSF leak or signs of infection. The patient was on tapering doses of steroids and bilateral lower extremity compressions for DVT prophylaxis. The plan was to continue weaning the dexamethasone over several days. The patient was admitted to the inpatient rehabilitation unit at St. Mary's Medical Center on 06/23/20 and participated in an aggressive inpatient program under close medical supervision at the time of admission to the inpatient rehabilitation unit.



#### **Physical Examination:**

Upon admission to the inpatient rehabilitation unit at St. Mary's Medical Center on 06/19/20, the patient had significantly weak grip strength with intrinsic muscle strength of his left hand at a 1/5 with some mild weakness of grip strength of his right hand at 4/5. Left wrist flexors 3/5. The patient had left lower extremity weakness, left hip flexion 3/5, quadriceps strength 2-3/5, biceps femoris 2/5, left dorsiflexion and plantar weakness 2-3/5. The patient had profoundly impaired proprioception at his left lower extremity with significant generalized decreased sensation to light touch and pain on the front side of his torso from his nipple line to his lower abdomen, left side greater than right, and down his entire left lower extremity. The patient was unable to perform opposition touching his thumb to his ring finger and little finger of his left hand.

At the time of discharge from the inpatient rehabilitation unit at St. Mary's Medical Center on 07/03/20, the patient continued to have significantly weak grip strength and intrinsic muscle weakness in his left hand 2/5. Weak left wrist flexors 3-4/5. Weak left hip flexion 3/5. Weak left quadriceps strength weakness left side -3/5. Biceps femoris weakness on the left 3/5. Left dorsiflexion and plantar flexion weakness 3/5 with continued profound proprioception deficits along his left lower extremity with generalized decreased sensation to light touch and pain on the front side of his body from his nipple line to his lower abdomen and down his left lower extremity. The patient was able to perform opposition touching his thumb to his ring finger and little finger at that point.

The patient's initial physical therapy evaluation in my office on 07/08/20 demonstrated his strength was grossly 3/5 left upper extremity, including shoulder, elbow, wrist, and hand with 3+/5 weakness into his right upper extremity as well. Left lower extremity weakness was grossly 3+/5 compared to his right which was grossly 5/5. The patient also had some trunk musculature weakness -3/5. He continued to have impairment in sensation to light touch, sharp dull pain from his upper thoracic down to both lower extremities, left side more impaired than his right. The patient had fair standing dynamic balance with impaired heel-to-toe gait.

The most recent physical therapy evaluation on 12/03/20 demonstrated signifi-



cant improvement with left upper extremity and left lower extremity strength with improvement with gait and dynamic standing balance. The patient's motor strength at his left upper extremity was grossly 5/5 throughout shoulder, elbow, wrist with the exception of left grip strength. The patient's left lower extremity motor strength throughout his hip, knee, and ankle was grossly 4+/5, and trunk musculature -4/5. Grip strength hand dynamometer measurements were 20 pounds on the left and 100 pounds on the right on 09/15/20. The patient's reevaluation on 12/03/20 demonstrated grip strength hand dynamometer measurements were 40 pounds on the left and 120 on the right.

#### Assessment:

Reviewing this case, this patient was under my direct care, was admitted to the inpatient rehabilitation unit, and was there for 15 hospital days. Once stabilized, he participated in an aggressive outpatient Physical Medicine Program 77 times over a span of 20 weeks. The patient showed marked improvement in endurance, balance, strength, and coordination. Although he continued to have some deficits it did not preclude him from continuing to play Lacrosse, and he has not lost his four-year college scholarship.

An aggressive inpatient rehabilitation unit admission under close medical supervision followed by an aggressive outpatient Physical Medicine Program specifically tailored to his musculoskeletal deficits under close medical supervision maximized his functional potential, and he has, at this time, returned to playing Lacrosse.

Craig H. Lichtblau, M.D. American Board of Physical Medicine & Rehabilitation Board Certified Physical Medicine & Rehabilitation Board Certified Brain Injury Medicine CHL/sg/feb.21





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<u>University of South Florida PM&R Residency Update</u> Stefan Litzenberger DO, Resident Liaison Marissa McCarthy, MD, Residency Program Director

sincerely hope everyone has had a fantastic holiday season! Now that we have transitioned into the new year, there is much to look forward to. Here at the University of South Florida, we have been fortunate to receive the COVID-19 vaccine. Vaccination efforts amongst our patient population have been effective and we continue to encourage all who qualify to obtain it. We are proud to be doing our part to help our community move forward and hopefully escape this pandemic as soon as possible.

Our area is still celebrating an incredible Super Bowl victory and thanks to the NFL and their outreach program, several of our fully vaccinated residents were



Stefan Litzenberger DO

able to attend the biggest game of the year for free! It was definitely an experience that will not soon be forgotten. On top of the holidays, sporting events and cold fronts, we are also awaiting the results of the match. This application cycle has been full of unique circumstances that made the selection process more challenging than ever. Although we are not unique in this regard, we anxiously await the culmination of match season so we can properly welcome our budding physiatrists to the fold and wish the best to all those who unfortunately, may not experience their most desired outcome.

We are excited to also be a part of the team that will fill the brand-new rehab center being built in partnership with Tampa General Hospital. Recent ground-breaking signified the initiation of the construction process. Though we will not be able to enjoy the facilities for several more years, we look forward to increasing our services and helping satisfy an ever-growing need for rehabilitation in our community.

On a personal note, I am excited to report that we have welcomed a new member to our family! Riley joined us just a couple weeks ago and has been doing amazing. She loves to eat and sleep and gets along well with her older brother. I am grateful that USF is a place that allows and encourages us to maintain a healthy personal life while simultaneously enabling us to become excellent physiatrists as well. Program leadership has been





unwavering in their support throughout this experience and their dedication to us as residents, physicians, and individuals is very much appreciated.

May the following months be filled with as much excitement and progress as the last several. As we transition into the spring and summer, we will continue to do our best to lift our community, serve our patients and represent the field of physiatry with humility and diligence.





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<u>Memorial Healthcare System PM&R Residency Program</u> Dr Matthew Voelker, PM&R Resident Liaison to FSPMR Jeremy Jacobs DO, Residency Program Director



Following a successful interview season and AAP conference completed with 100% resident participation, we are poised to continue moving right along. This quarter we have a few fun new projects underway: A Case series, a Chapter and a resident led didactic series on an introduction to OMT. We hope this finds you and yours safe and continuing to grow.

MHS Residency Announcements:

AAPMR PHIT Board Ambassador for MHS will be Robert Mousselli (PGY-2).



Matthew Voelker, DO

- <u>A Case series</u> on COVID-19 Related Neuropathies is underway by PGY-2 Residents Uday Mathur and Andres Gutierrez and our Medical Director Dr. Salerno.
- <u>A Chapter</u> titled "Non Traumatic Myelopathies," that will be published in Spinal Cord Injury Medicine: Board Review (edited by Blessen Eapen and David Cifu) is being written by our PGY-2 resident Andres Gutierrez and Dr. Joanne Delgado, Associate PD and Principal Author.
- <u>OMT didactics</u> will be led by resident DO's Robert Mousselli, Matthew Voelker and Steven Tijmes, and are planned to begin this quarter for an introduction emphasizing high yield concepts and techniques such as myofascial release, soft and deep tissue, counter strain, and PINS, and more specifically occipital release and TART findings.

To excellent health and wellness!

Your MHS PM&R family in Hollywood



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LARKIN COMMUNITY HOSPITAL PM&R RESIDENCY UPDATE COLLEEN NEUBERT, DO PGY-3 Jose J. Diaz, DO, Residency Program Director

appy New Year from Larkin Physical Medicine and Rehabilitation Residency Program! We hope that you and your families have continued to stay safe and healthy during this time.

We have a couple of exciting updates to share with you all! Two of our residents, Grant Drake, DO PGY-4 and Eric Lam, DO PGY-3, along with LECOM medical student Benjamin W. Cooper, presented a case presentation *Phantom Tongue Pain* during the Association of Academic Physiatrists annual conference in February, 2021. Alan Nyugen, DO PGY-3 has been selected as an advisory board member for Nova Southeastern



Colleen Neubert DO

University Department of Health and Human Performance. Congratulations gentlemen!

We continue to adapt our educational activities based on current pandemic guidelines, making the most of virtual lectures and social distancing workshops!





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University of Miami Miller School of Medicine/Jackson Memorial Hospital PM&R Residency Update Natalia Miranda-Cantellops MD, RESIDENT LIAISON Andrew Sherman, MD, Residency Program Director

G reetings from Miami!

We are officially done with 2020 and into a new year 2021!

There are many exciting announcements from our residency. First off, on February 15<sup>th</sup>, our department officially opened the Pediatric Rehabilitation Unit at Holtz Children's Hospital. We can't wait for all the new opportunities this will bring.



Natalia Miranda-Cantellops MD



In late January, we elected our new chief residents for the academic year 2021 -2022, Cristina Brea and Minh Quan Le!! We are so excited to have them officially take over chief duties later in the year.

Sports Fellows here we go! This year, both programs' applying residents had great successful matches! Scott Klass PGY-4, now president of the Physiatrist in Training (PHiT) Board of AAPMR, matched at NY Presbyterian Columbia/ Cornell and Manoj Poudel PGY-4, matched at UC-Davis. Both are great academic residents and will further continue to become great fellows.



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Match day is soon approaching and we are eager to know who will join our residency in the upcoming year. With virtual interviews, it was a different and difficult year for all. Great candidates were interviewed and are sure to make their mark in the PM&R world.

In March, we will have our first annual wellness retreat. There is a full day of activities, starting with guest speaker, Dr. Monica Verduzco-Gutierrez from the University of Texas. We will be sure to share pictures in upcoming newsletters.

Be sure to listen to the UMiami *UrPM&R podcast* by our PGY-3 Armando Alvarez. In his latest episode he interviews Dr. Lauren Lerner over at Mount Sinai Hospital in Miami Beach. Be sure to listen to all the episodes who feature various attendings including our associate program directors, and department chair!

As a program, we had great poster and oral presentations by our residents and faculty members from our department. Some of the posters presented by our residents and faculty at the Annual AAP meeting 2021 are below:

*Terson's Syndrome.* Reed Yaras, DO, Minh Quan Le, MD, Lauren Shapiro, MD, Adriana Valbuena MD

*EMG-guided Botulinum Toxin Injections for Post-Stroke Upper Extremity Spasticity: Timing and Efficacy.* Michael Appeadu, MD, Natalia Miranda-Cantellops, MD, Angie Lastra, MD

Rehabilitation and Pharmacological Treatment for Posterior-variant Alien Hand Syndrome. Michael Appeadu, MD

*Lisdexamephetamine use associated with atrial tachyarrythmia and embolic cerebral vascular accidents: a case report*. Cristina Brea, MD, Gemayaret Alvarez, MD

*Pigmented Villonodular Synovitis, A Rare Cause of Knee Pain in a Young Female Veteran: A Case Report.* Natalia Miranda-Cantellops, MD, Angie Lastra, MD

A Stent (Thrombosis) in Rehab: A Case Report. Armando Alvarez, MD, Lauren Shapiro, MD



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University of Miami Miller School of Medicine/Jackson Memorial Hospital PM&R Residency Update Natalia Miranda-Cantellops MD, RESIDENT LIAISON Andrew Sherman, MD, Residency Program Director -continued

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A Unique Presentation of Avascular Necrosis of the Knee after Gastric Bypass: A Case Report. Armando Alvarez, MD, Manoj Poudel, MD, Alec Fernandes, Andrew Sherman, MD

*Prevalence and distribution of musculoskeletal disorders in Florida incumbent career firefighters.* Armando Alvarez, MD, Robert Irwin, MD, Laura Huang, MD, Thomas Best, MD, Alberto Caban, PhD, DO, MPH

Last but not least, we have to congratulate of our PGY-4 Rosa Rodriguez, who got married in December 2020. We wish them a lifetime of happiness.





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### ANTARCTICA

From the Hillsborough County Medical Association Bulletin, Vol 66, No2, Fall 2020

by Rodolfo Eichberg MD

(Editor's Note: Dr Eichberg is retired and a Past President of FSPMR)

The one-word title is intentional, suggesting that the Seventh Continent is very difficult to pair with adjectives. It was the last to be discovered, the driest, the least populous (0 permanent residents), and the coldest among other things.





My fascination with it began when I was ten years old, and read a book about the now defunct whaling stations in the South Orkney Islands. Seventy -two years later I was finally able to check it off my bucket list.



On February 2, 2020, I boarded the Celebrity Eclipse in Buenos Aires, with a group of friends and almost 3,000 other passengers. Our first port of call was Ushuaia, the southernmost city on earth, in Tierra del Fuego, Argentina, 3,000 kilometers and three days of navigation away. We got off the ship for the whole day to explore the area.



From there we traveled to Cape Horn (Chile), a barren, uninhabited Archipelago, and then crossed the dreaded Drake Passage, where the Atlantic and Pacific Oceans meet, or better said collide. A five-meter wave is normal, and ten-meter ones can be seen across the bow. The Passage is about 800 km (500 miles) long. The Antarctic Circumpolar Current, which constantly flows from West to East, plus the strong winds, contribute to the always rough seas. It took our ship about 36 hours to cross. Most other vessels take much longer.

On the morning of February 8<sup>th</sup>, we were at the Northern end of the Antarctic Peninsula, navigating through the Schollart Channel. There were ice-covered mountains, 1,000 to 2,000 meters high, on either side of the Eclipse; it took about two hours. The brochure calls this a Scenic Cruise, which indeed it is. However, this portion of it is more



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#### ANTARCTICA by Rodolfo Eichberg MD– continued



like a continuous, spectacular movie. Those of us that were outside were dressed with at least three layers of clothing, head and ear coverings, and gloves. It was sunny and a few degrees below freezing, but the wind chill factor made it feel much colder. Fog can block the view within 15 minutes, and lift a few minutes later. There was total silence. On board descriptions and announcements are limited to our stateroom TV sets and some indoor areas in order not to disturb the animals around us: whales, dolphins, giant and regular petrels, cormorants, sea lions and penguins. The whales, mostly humpbacks, were submerged most of the time, with only their humps visible. They were busy feeding on krill and small fish. Each one of them consumes about a ton a day. They do not have teeth. Killer whales eat larger prey, including dolphins, penguins, seals and sea lions. They, of course, have teeth.

About two hours later we were in Paradise Bay. Very beautiful, but not my idea of paradise. No trees or anything green. No flowers.



Our onboard lecturers explained that there are two very different types of ice. Continental ice is compressed so tightly by its own weight that it cannot be cut or broken by any instruments.

Since it never rains and rarely snows, it remains unchanged. There are many glaciers that flow in between the mountains and into the sea. The ice that breaks off and forms icebergs has a greenish color on the side which broke off, until the exposure to air turns it white, like all others.

Maritime ice is frozen sea water. It melts, forms icebergs, and constantly changes. How much of it melts in summer controls how far south a vessel can get. I saw an iceberg that looked like the Louisiana Superdome!!! To think that 80 percent is below the





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<u>ANTARCTICA</u> by Rodolfo Eichberg MD– continued

surface! We know that we have an Ice Captain on board. He is a retired Argentine Naval Officer, who commanded the only icebreaker owned by the Argentine Navy. In 2002, he was able to resupply a German research ship with Russian scientists on board. It was stranded and ice-locked in June (Southern Hemisphere beginning of winter). This had never been done before, or since.

We were in Paradise Bay for the rest of the day. In February, at 70 plus degrees south latitude, you have daylight until bout 10 pm. Nighttime is spectacular. Overhead the sky is black, with millions of twinkling stars. There was a yellow band just above the horizon, which is the sun on the other side of the globe, and then stripes that go from light to dark blue.

On February 9<sup>th</sup>, we reached Elephant Island, part of the South Shetland Archipelago, where Shackleton's expedition shipwrecked the Endurance.





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#### <u>ANTARCTICA</u> by Rodolfo Eichberg MD– continued

Ernest Shackleton was a member of several Antarctic expeditions. He reached 88 degrees south in 1909, 150 km from the South Pole, just before Roald Amundsen reached the South Pole in December of 1911. He later led three expeditions himself, and was knighted by the British Crown. He died at age 47 in South Georgia, in 1922. The area has historical significance because some members of the Endurance crew managed to survive in an encampment, Cape Wild, for four months. This was considered miraculous at the time.





After sailing past Cornwallis Island, only 8 km from Elephant Island, we headed northwest for the first time since we left Buenos Aires, towards our next stop: The Falklands/Malvinas. Soon after, we exited the Antarctic Circle. I had mixed feelings: happy because I finally got to fulfill my childhood fantasy, and sad because I know that I will never see this extraordinary part of our world again.







### Congratulations to Brian Higdon, MD

"After I finish my spinal cord injury fellowship in Pittsburgh, I'll be returning to Florida, working for Brooks Rehab in Jacksonville. I'll primarily be doing outpatient care for people with spinal cord injuries."

Dr Higdon is a past Resident of USF's PM&R Program. Welcome back to Florida, Dr Higdon!

### **Professional Opportunities**

are free and re-posted as a

service to FSPM&R members

Post YOUR Professional Opportunities here

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3 Month Other Ops Postings—\$150.00

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March 2021

NEWSLETTER

