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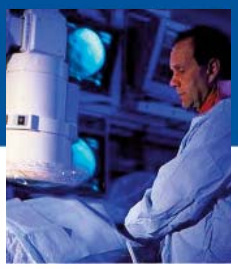
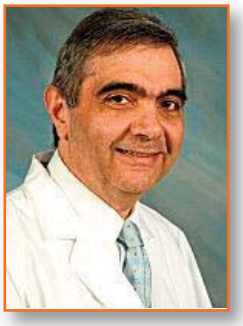


UF UNIVERSITY of FLORIDA
College of Medicine
Jacksonville

CHAIRMAN'S MESSAGE

Dear Colleagues:



I trust you had a happy holiday season with your families. Many people stay up to see new year come. They look forward to a chance to do better than the previous year. It's a time for forward thinking and optimism. It's a time for some to plan their New Year's resolutions. As an organization, we have our own resolution. We pledge to work harder to achieve new levels of excellence in patient care delivery, teaching and innovative research.

Our faculty and trainees have done exceptionally well in overcoming the typical daily challenges in patient care. Our training program had another year in which 100 percent of residents passed their boards. This repeated annual success of our trainees puts our program among the top of the leading teaching institutions in the country. The scholarly productivity of the faculty continues to be high despite increasing demand of their time to deliver clinical service.

We hope that our continued commitment to excellence will allow us to have a new year full of new achievements and successes.

We simply cannot rest on our past laurels. It's time again to energize with the arrival of the new year to push our mission "forward and upward."

Happy new year.

Arshag D. Mooradian, MD
Professor of Medicine
Chairman, Department of Medicine

By Khurram Tariq, MD; Fauzia Rana, MD.
Division of Hematology and Medical Oncology
Department of Medicine UF COM-Jacksonville

"Miracle" Therapies in the Age of Social Disparity and Rational Resourses

In the age of molecular medicine, there seems to be no better time to study and practice the art of medicine. In the field of Hematology and Medical Oncology, we are reaping the fruits of 25 years of research. This has led to the discovery of exceptional medications ranging from Gleevac, used in the treatment of CML that fits instead of the ATP kinase molecule and literally shuts the tumor off, to the discovery of Transuzumab, used in HER2/neu overexpressed breast cancers, which has led to a decrease in breast cancer recurrence in select patient population. Lymphoma patients are benefitting from the monoclonal antibody Rituximab, which specifically targets CD20 antigen on lymphoma cells. It is because of these outstanding advances in medical oncology that words such as "cured" have begun to be used more frequently in the oncologist offices.

In the face of these advances, a travesty will occur if we are not able to provide these "miracle" medical therapies for our patient population without prognostic considerations such as insurance status. One area that readily comes to mind is breast cancer in women. Published literature has long pointed to the social inequality as one of the sources of racial disparities in outcomes associated with breast cancer patients. It will be interesting to see how these differences pan out after the implementation of the Patient Protection and Affordable Care Act (PPACA), also known as Obamacare.

Keeping current trends in political and health care reforms in mind, we are taking the initiative to study the effects of universal health care in our patient population. The aim is to assess the effects of PPACA on breast cancer outcomes in our patient population. Two retrospective studies were designed for this purpose in mind. In the first of this series, BRCA-1 found that African American patients presented with a more advanced stage and aggressive subtype of breast cancer than Caucasian patients and were less likely to have health insurance. However, we have yet to determine if universal health care insurance can lead to improved health care access, better breast cancer awareness and an enhanced attitude toward breast cancer outcomes. Such factors could ultimately lead to an earlier diagnosis and better outcomes in both African American and Caucasian patients. We plan to investigate this critical issue in a follow-up study (BRCA-2; Breast Cancer and Racial Disparity Between Caucasian and African American Women, Part 2), which will begin a few years after the complete implementation of PPACA. BRCA-1 was recently published in the journal of Clinical Advances in Hematology and Oncology and these, along with the rest of our findings, will be presented at the ACP conference this year.

With decades of research behind us, we are now moving toward an era in which cancer will become a chronic disease rather than the death sentence it has traditionally been viewed. With the expected tectonic shifts over the next few decades in the field of medicine, our celebrations of these landmarks will only be fulfilling if we advance ourselves as a society in which all parts of our population are equally able to avail and enrich from these modern marvels.

Nilmarie Guzman, MD

Assistant Professor of Medicine
Division of Infectious Disease

Associate Program Director
Internal Medicine Residency

Teaching Interpersonal Communication Skills

As we strive to be consistently recognized as a program of high academic excellence, one of our primary goals is to teach trainees the importance of sustained professional and ethical relationships with patients. As educators, we teach and model "etiquette-based" communication. Effective information exchange and teaming with patients, families, and professional associates can be achieved by practicing compassionate medical care and by demonstrating strong interpersonal communication skills. It has been documented that a patient's attitude regarding their recovery is significantly influenced by physician involvement. Medicine residents are evaluated on interpersonal communication skills as one of six competencies in every resident evaluation. To help patients maintain a positive attitude, residents are expected to develop a professional relationship and to foster trust.

Residents have multiple responsibilities, including patient evaluation, reviewing laboratory results, rounding with the attending physician, writing notes and discharge summaries, and participating in didactic sessions. We are constantly involved in a hectic routine and sometimes take for granted the basics of patient-doctor relationships. Being a patient can be a daunting and confusing experience. Patients constantly meet new physicians and ancillary staff during their hospital stay. This experience can be made less traumatic by introducing ourselves and dedicating time to listen to our patients and explain their treatment plan. Most importantly, the patient will feel part of the decision-making process, stay informed and have a remarkably positive attitude toward their recovery.

An interesting article by Lauren Block, MD, MPH, published recently in the Journal of Hospital Medicine describes the results of a study performed at Johns Hopkins. Residents surveyed tended to overestimate their practice of etiquette based medicine. Findings reported that resident physicians introduced themselves to patients, explained their role, and sat down with patients infrequently. Questions raised by the study results are: How can we improve? How can we change the perception that doctors are at times impersonal, non-communicative, rude, or unprofessional?

First and foremost, trainees learn by observation and role modeling. We must teach and model appropriate etiquette-based communication in order for trainees to learn and practice the proper interpersonal communication skills instrumental in high-quality medical practice and in affecting the overall patient experience and outcome. When patients feel connected with their providers, they will better comply with medical care, therapy, follow-up appointments, and treatment plans.

As we all work together to provide the best training to our residents by teaching evidence-based medicine and providing excellent medical care, we must exemplify teaching the importance of proper communication skills. Learning excellent communication skills and putting them into practice benefits the patient-doctor relationship, improves patient and physician attitudes, and most importantly improves the overall patient experience and outcome.

Marwan Shaikh, MD, Internal Medicine Resident
Department of Medicine, UFCOM-Jacksonville

Castleman Disease

Case Presentation

A 43-year-old woman with a history of an umbilical hernia repair presents with peri-umbilical abdominal pain for two to three months. The pain was described to be constant, moderate, non-radiating, unrelated to food or position associated with mild nausea, and intermittent hematuria. She did not report fevers, chills, diarrhea or constipation. Medical history includes carpal tunnel syndrome, headaches, lumbago, hypertension, morbid obesity, total abdominal hysterectomy, breast reduction and foot surgery. She denied current or previous alcohol, smoking or drugs.

Physical examination was normal except for obesity and there were no visible hernia, abdominal tenderness, ascites or organomegaly. Laboratory tests including CBC, BMP, urinalysis and coagulation were all normal. CT abdomen showed 2.8 cm hyperdense heterogeneous cystic lesion of the right kidney for which she underwent a right nephrectomy. Gross specimen showed 5 x 3.5 x 2 cm mass weighing 28 grams.

Histology revealed lymphoplasmacytic infiltrate, numerous small regressed germinal centers with expanded mantle zones, occasional mantle zone areas with two to three associated germinal centers and sheets of interfollicular normal appearing plasma cells.

Immunohistology showed positive stains for CD3, CD20, bcl-2 and CD138. Light chain mRNA ISH staining revealed plasma cells that were monotypic for kappa light chain. Negative stains for CD56, HHV-8, and ALK-1. The pathologic diagnosis was extranodal Castleman disease, mixed hyaline vascular and plasma cell type.

Discussion

The true incidence and prevalence of Castleman disease are unknown due to its rarity. This is the first known reported case of renal disease. Histological variants include hyaline vascular disease (HVD), plasma cell disease (PCD) and a mix of both. It can present anywhere in the body. In general, there are two clinical presentations: nicentric disease (UCD) and multicentric disease (MCD). UCD presents as single enlarged lymph nodal mass. The majority can be asymptomatic and 90 percent of HVD presents as UCD. Median age of diagnosis is between 10 and 40 years, mostly in young women. MCD presents as dominant lymph node associated with fevers, chills, night sweats, fatigue, weight loss, anemia, thrombocytopenia, hypoalbuminemia, hepatosplenomegaly, pleural/pericardial effusions, ascites, CNS symptoms, arthralgias and rashes. It is more common in older male patients in their 50s to 60s associated with HHV-8 and HIV.

The treatment for UCD is curative surgical resection. There are rare incidences of recurrence because of incompletely resected lesions followed for progression that is treated with radiation. There is a report of rituximab with good response in unresectable UCD.

The MCD treatment includes tocilizumab and siltuximab to target IL-6; Rituximab is an anti-CD20 used to reduce IL-6 levels. These can be used alone or with other agents such as etoposide. One study reports up to 90 percent survival at five years. HHV-8 disease treatment should include antiviral agents. There is concern for reactivation of Kaposi sarcoma.

Prognosis

In UCD, incomplete resection is the only significant predictor of increased mortality. In MCD, there is potential for progression to malignancy. The disease carries a 26 percent mortality rate within one year after diagnosis, with median survival of about 29 months. Comparable outcomes between debulking surgery alone, immunochemotherapy alone or a combination of both. The HHV8 disease carries a worse prognosis.

UCD is rarely associated with other diseases such as lymphoma and paraneoplastic pemphigus (15 percent). MCD-associated diseases include POEMS syndrome (11-30 perecent) (polyneuropathy, organomegaly, endocrinopathy, monoclonal gam-

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mopathy, and skin changes). The most commonly HHV-8 associated diseases include autoimmune diseases such as paraneoplastic pemphigus, cold antibody hemolytic disease, lymphomas, Kaposi sarcoma and connective tissue disease. The HHV-8 can also be associated with HIV, non-Hodgkin lymphoma–large B cell, Kaposi sarcoma, hemophagocytic syndrome and herpes virus-associated germinotropic lymphoproliferative disorder. HAART therapy may increase risk of acute fulminant multicentric disease.

Conclusion

Castleman disease can occur anywhere in the body. It is a pathological diagnosis. It could be unicentric vs. multicentric. It should be on the differential diagnosis of lymphomas. A number of associated conditions include HIV, HHV-8, lymphoma, paraneoplastic pemphigus, Kaposi sarcoma and POEMS syndrome.

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RX UPDATES

Rachael Carloni, Pharm.D.

Colchicine (Colcrys®) - Risks, Benefits and Costs

Reprinted from Drug Update Volume 30, Number 2 April – July 2013

Colchicine (Colcrys®) is an anti-gout medication that has been used in the United States for years, but was only approved for this indication by the FDA in 2009. Colchicine use is associated with a multitude of adverse effects, most commonly nausea and diarrhea; however, more serious adverse effects include the potential for bone marrow suppression, myopathy, rhabdomyolysis, and nephrotoxicity. The risk for adverse effects is increased when patients are taking interacting medications, such as P-glycoprotein or CYP3A4 inhibitors (e.g., tacrolimus, cyclosporine, erythromycin, ketoconazole, grapefruit juice), or have renal or hepatic impairment. Colchicine has been associated with cases of accidental overdose, ultimately leading to multi-organ system failure and death. The toxic dose of colchicine has yet to be determined and it appears that toxic ingestions may occur with small doses. As a result, colchicine is contraindicated in patients taking strong inhibitors of CYP3A4 or p-glycoprotein who also have hepatic or renal impairment.

Traditionally, for treatment of acute gout, colchicine was dosed until patients experienced either symptom relief or intolerable gastrointestinal side effects. However, recent safety research indicates that lower doses of colchicine are equally efficacious as traditional dosing, with lower rates of adverse effects. As a result, the FDA-approved dosing recommendations for colchicine in patients with normal renal/hepatic function and no potential drug interactions are: one tablet (0.6 mg) once or twice daily for prophylaxis OR two tablets (1.2 mg) at the first sign of an acute flare, followed by a single dose of 0.6 mg taken one hour later (treatment dose not to be repeated any sooner than 72 hours later) for treatment of acute flares.

Due to the recent FDA approval of colchicine in 2009, the product is only available as a brand-name product, Colcrys. A 30-tablet supply of Colcrys costs $178.09 (average wholesale price) or just over $100 at the UF Health Jacksonville Ambulatory Pharmacy (special pricing). Alternative cost-effective medications may include NSAIDS and corticosteroids for acute treatment of gouty attacks. Probenecid and allopurinol may be cost-effective for treatment of hyperuricemia.

MEET YOUR COLLEAGUES

Amie Deutch, MD, Assistant Professor, Division of Gastroenterology

Dr. Deutch earned her medical degree from Loyola University Chicago in Maywood, IL. She completed her residency in Internal Medicine at St. Elizabeth's Medical Center in Boston, MA and her Gastroenterology fellowship at University of Massachusetts Medical School in Worcester, MA.

Rafik Jacob, MD, Assistant Professor, Division of General Internal Medicine

Dr. Jacob earned his medical degree from Ain Shams University in Cairo, Egypt. He completed his residency in Internal Medicine at Rhode Island Hospital/Brown University in Providence, RI.

Mariam Louis, MD, Assistant Professor, Division of Pulmonary, Critical Care & Sleep Medicine

Dr. Louis earned her medical degree from McGill University in Montreal, Canada. She also completed her residency in Internal Medicine and fellowship in Pulmonary Disease at McGill University. She completed her fellowship in Sleep Medicine at Johns Hopkins University in Baltimore, MD.

Tanya Reimschissel, DO, Assistant Professor, Division of General Internal Medicine

Dr. Reimschissel earned her medical degree from Lake Erie College of Osteopathic Medicine in Bradenton, FL. She completed her residency in Internal Medicine at the University of Florida College of Medicine - Jacksonville.

Reza Taba, MD, Assistant Professor, Division of Rheumatology & Clinical Immunology

Dr. Taba earned his medical degree from the University of Isfahan in Isfahan, Iran. He completed his Internal Medicine internship at Wayne State Univiersity in Detroit, MI, and residency at the Medical College of Ohio in Toledo. He completed his fellowship in Rheumatology & Clinical Immunology at the University of Louisville in Louisville, KY.

Lara Zuberi, MD, Assistant Professor, Division of Hematology & Medical Oncology

Dr. Zuberi earned her medical degree from Aga Khan University in Karachi, Pakistan. She completed her residency in Internal Medicine and fellowship in Medical Oncology at Henry Ford Hospital in Detroit, MI.

NEWS & NOTES

ANOTHER 100 percent Achievement in Board Pass Rate

We are pleased to announce that the 2013 graduating class of internal medicine residents have all passed their boards. This fantastic accomplishment is directly related to the hard work and preparation of the entire class. I'd like to recognize the faculty and fellows for imparting their wisdom and knowledge to our residents, for they also play a major role in this accomplishment. The program now has enjoyed three of the previous four classes with a 100 percent pass rate. The three-year rolling average is 95 percent, placing it among the highest in the country. This is a marvelous achievement for a group of very hardworking young physicians. Please congratulate these recent graduates on such a remarkable achievement.

Seven Faculty and Staff Named Health Care Heroes

The Jacksonville Business Journal honored the winners of its Health Care Heroes awards for 2013 in October. Among them were seven providers from UF Health. The weekly newspaper annually recognizes physicians, nurses and scientists who make extraordinary efforts to save lives and improve the quality of health care.

EDUCATION: **Kelly Gray-Eurom, MD**, associate professor and associate chair of emergency medicine
Gray-Eurom created a statewide program for senior emergency medicine resident physicians called Life After Residency, which prepares them for the business side of emergency medicine. During the past year, Gray-Eurom served as president of the Florida College of Emergency Physicians. She also works nationally with the American College of Emergency Physicians and locally with the citywide CaRE2 (Care and Coordination to Redefine and Reduce ED Encounters).

NURSING: **Cynthia Gerdik, RN**, director of critical care
Gerdik pioneered UF Health's Partners in Care program, which allows patients and family members to activate the Rapid Response Team. That team supports nursing when a patient's condition deteriorates. She created a color-coded armband system that easily identifies patients' special needs for clinical staff. She also oversees an initiative at the hospital called "Nursing CSI," in which nurses share best practices with each other.

NURSING: **Vicki Truman, RN,** UF CARES
Truman is a nurse case manager for the UF Center for HIV/AIDS Research, Education and Service (UF CARES). She works one on one with HIV-positive patients to help them understand their diagnosis and receive the proper medical care and support. Truman is also president of the North Florida Association of Nurses in AIDS CARE (ANAC). In that role, she assists in the development of other nurses who deliver care to people affected by HIV.

PEDIATRICS: **Daniel J. Indelicato, MD**, assistant professor of radiation oncology
Indelicato is the lead physician for the University of Florida Proton Therapy Institute's pediatric proton program, the largest program of its kind in the world. He works closely with physicians at Wolfson Children's Hospital and Nemours Children's Clinic to aid children who need combination cancer treatment such as chemotherapy or surgery. He contributes to medical journals and has helped establish protocols for the treatment of children with rare brain tumors.

PHYSICIANS: **Martha Wasserman, MD**, associate professor of radiology and chief of women's imaging
Wasserman helped introduce 3-D digital breast tomosynthesis for breast cancer diagnosis at the UF Health Breast Center – Jacksonville. The tomosynthesis equipment is the first of its kind in Northeast Florida. She assisted the hospital in getting the newest technology in bone-density screening. Last year, she created the first women's imaging fellowship program on campus. Also in 2012, she gained national recognition for her publication about women's imaging in "Applied Radiology."

PHYSICIANS: **Scott Silliman, MD**, associate professor of neurology
Silliman has played a major role in developing one of the largest multiple sclerosis programs in Florida and the busiest stroke center in Jacksonville. Silliman is now instituting a telemedicine stroke program for rural hospitals in southern Georgia and Northeast Florida, linking their stroke care to UF Health

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Jacksonville's program. He is the founding director of the neurology residency and vascular neurology fellowship programs at the UF College of Medicine – Jacksonville.

SURGEON: **Michael S. Nussbaum, MD**, professor of surgery
Nussbaum is director of UF College of Medicine – Jacksonville's general surgery residency program and the gastrointestinal/minimally invasive surgery fellowship program, which he established in 2010. During his five-year tenure as UF's chair of surgery in Jacksonville, he recruited several high-performing faculty surgeons and residents to the campus. Among his community involvement, he is president of the Jacksonville Chapter of the American College of Surgeons and serves on the executive committee of the Florida Chapter of the American College of Surgeons.