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# MEDICAL EXCEPTIONALISM: THE ETHICAL FOUNDATIONS



Exceptionalism describes the highly respected status of a group, culture or nation that stands distinctly above and beyond any historic or contemporary comparisons. For example, America's founding fathers envisioned that American exceptionalism would arise from constitutional, representative democracy. They laid the framework, and subsequent American generations progressively fulfilled this vision. Foreign admirers still seek replication of America's best governance principles for restructuring their own societies.

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*...our medical profession merits exceptionalist status, as it is infused with exceptionalism*

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I believe that our medical profession merits exceptionalist status, as it is infused with exceptionalism—it demands exceptional preparation, it asks exceptional individual responsibility, it commands exceptional respect, and it gives exceptional benefit to society. Some claiming exceptionalist status invoke pre-ordained entitlement (eg, "manifest destiny"). In contrast, I believe medical exceptionalism is an earned—one to be humbly accepted and to be diligently and continuously maintained, lest it erode. Some claiming exceptionalist status believe it elevates them above natural or human laws. In contrast, I believe medical

exceptionalism derives from embracing fundamental ethical principles and the laws derived from these principles.

I see medical exceptionalism as based on three core elements: 1) an unwavering adherence to medical ethics; 2) a legacy of professionalism; and 3) thoughtful stewardship—the watchful maintenance and careful reinvestment of resources to sustain exceptionalism and the causes we serve. These elements of exceptionalism can be represented as a temple of medicine, with exceptionalism as the overriding goal on the pediment, and ethics, professionalism, and stewardship as supporting columns (Figure 1). This month, I will discuss the ethical foundations of medical exceptionalism, and I will explore the



roles of professionalism and stewardship in subsequent essays.

### THE ETHICAL PRINCIPLES OF MEDICAL EXCEPTIONALISM

The Hippocratic Oath represents the ancient ethical basis of medical exceptionalism. Many ethical standards were added and refined over centuries, including the American Medical Association Code of Medical Ethics, an AMA priority since its 1847 founding. Among the many fine statements of medical ethics, I view the Belmont Report as the most elegant. It was formulated for protection of research subjects, and then extended to guidance of clinical practice. It proclaims three fundamental principles: First, *beneficence*—an extension of the Hippocratic principle that the purpose of medicine is to create good, and only good. Second, *justice*—the requirement that the medical good created be extended to all. Third, respect for persons (*autonomy*)—the commitment that each individual be respected at each encounter and throughout medical care. To these Belmont principles, I would add one element that I view as equally important, which I call *efficacy*. Efficacy requires that therapy be scientifically based and be objectively confirmed as effective and beneficial. Only effective therapies can truly bring good, and truly fulfill justice and autonomy.

The *beneficence* principle requires that our therapy not only bring good, but do so to the fullest extent possible. This drives us to relentlessly seek improvement in all arenas of medicine—patient care, health policy, and biomedical research.

The principle of *autonomy* asks respect for each individual, again, throughout health policy, research, and in each patient encounter. Our encounters with patients often occur at their most vulnerable moments of illness and injury. We respect that vulnerability and

its emotional impact on patients and their families. The compassionate individual care we provide during those periods of vulnerability is a sacred responsibility given to very few.

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*Among the many fine  
statements of medical ethics,  
I view the Belmont Report  
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The principle of medical *justice* underlies our advocacy for access, in which we aspire to leave none behind in our health care system. The KMA and AMA efforts to increase access to physician care in our medically underserved areas is a worthy and admirable application of the justice principle. The thoughtful scrutiny of health policy and proposals for health policy change is another responsibility in service of justice.

The principle of *efficacy* underlies our commitment to quality improvement, our advocacy of evidence-based therapies and our condemnation of cost-ineffective therapies, quackery, and inappropriate scope-of-practice expansion by marginally trained disciplines.

These fundamental principles are the foundations of medical exceptionalism, and they validate our individual practices and our policies of organized medicine. Our responsibility is to enhance and extend the principles of exceptionalism to future generations of physicians and patients. In doing this, we uphold the noble legacy of medical exceptionalism.

**Gordon R. Tobin, MD**  
*President*

# Broncholithiasis: Not Just a Middle Lobe Disorder

Abhijit A. Raval, MD; Jay B. Mehta, MD; Ryland P. Byrd Jr, MD; Thomas M. Roy, MD

*Broncholithiasis is the presence of calculi in the lumen of the tracheobronchial tree. Broncholiths typically arise from a granulomatous inflammatory response that causes lymph nodes to calcify and then erode into the airway. Most often calcified hilar and mediastinal lymph nodes cause no symptoms. However, calcified lymph nodes that impinge upon the lymphatic drainage of the middle lobe may cause symptoms associated with partial or complete obstruction of this lung segment. This involvement is one cause of the "right middle lobe syndrome," a diagnosis familiar to many health care practitioners. We present a patient with a symptomatic right lower lobe broncholith. This report serves as a reminder to health care providers that broncholiths are not always innocuous and can occur in areas of the lung other than the middle lobe.*

## INTRODUCTION

Historically the diagnosis of broncholithiasis was reserved for the patient in whom at least part of a calcified lymph node had eroded into the lumen of a bronchus and was then expectorated.<sup>1</sup> Lithoptysis or the "spitting of stones," however, is actually unusual and the definition of a broncholithiasis has recently been modified to include patients with peribronchial calcific nodal disease resulting in distortion of the bronchi as demonstrated by roentgenography or bronchoscopy.<sup>2</sup>

Broncholiths typically arise from long-standing foci of necrotizing granulomatous lymphadenitis that calcify. Broncholiths can subsequently erode through the bronchial wall. This egress is thought to be accelerated by respiration and cardiac movements.<sup>1,3</sup> Broncholiths are variable in size, irregular in

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shape, and often possess spur like projections or sharp edges that enhance their potential for bronchial wall penetration. The anatomy of the airways and the lymphatic system of the lungs favor broncholith development in the proximal right middle lobe bronchus.<sup>3</sup> We present a patient with a broncholith that compromised the right main stem bronchus, an unusual occurrence.

## CASE REPORT

A 30-year-old female complained of new onset cough and right-sided chest pain. The pain was exacerbated by deep inspiration and radiated to her right shoulder. She denied experiencing fevers, chills, hemoptysis, left-sided chest pain, or palpitations. She denied recent travel. She had a similar episode of "pleurisy" two year earlier. Her past history was significant for 19 pack-years of cigarette smoking and occasional ingestion of ethanol. Her only medication was an oral contraceptive. She had no significant environmental or occupational exposures.

Her oral temperature was 101°F. Her respirations were rapid and shallow due to the pleuritic chest pain that worsened with deep inspiration. She was tachycardic with a heart rate of 100 beats per minute. Her blood pressure was normal. She was not orthostatic. Her cardiac examination was normal except for the tachycardia. Auscultation of her chest revealed right basilar rales and rhonchi. The remainder of her physical examination was normal.

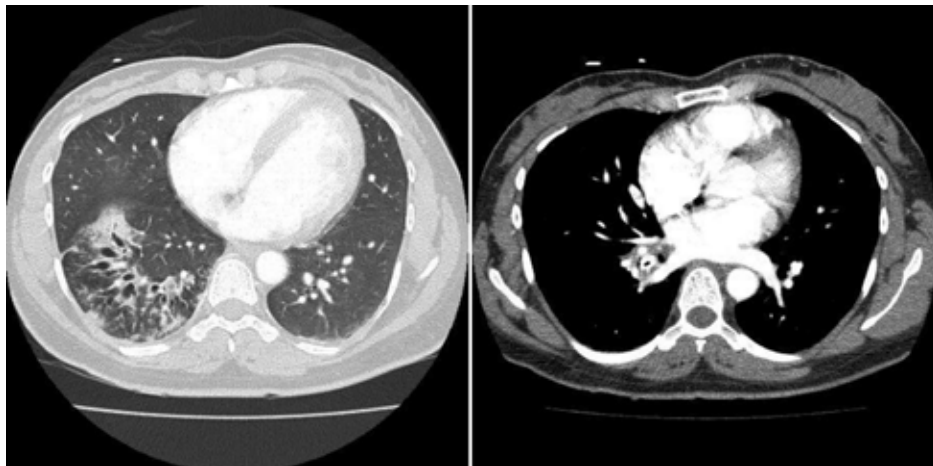
A complete blood count demonstrated an elevated white blood cell count of  $16.9 \times 10^3/\text{mcl}$ . Liver function tests, serum electrolytes, amylase, lipase, troponin levels, and a D-dimer assay were normal. An arterial blood gas analysis obtained on two liters of oxygen delivered by nasal cannula documented a pH of 7.48, a partial pressure of carbon dioxide of 32 mmHg, and a partial pressure of oxygen of 63 mmHg. Her electrocardiogram indicated a normal sinus rhythm without ST-T wave segment changes. Computerized tomographic angiogram of her chest failed to identify a pulmonary embolism, but did demonstrate a right lower lobe infiltrate and bronchiectasis (Figure 1A). A calcified hilar lymph node was also identified that appeared to be protruding into the right lower lobe bronchus (Figure 1B). Her tuberculosis skin test was nonreactive. Fungal serologies were negative.

Intravenous antibiotics, hydration, and analgesia were administered. Flexible fiberoptic bronchoscopy was performed, and an inflamed and swollen mucosa was visualized in the right lower lobe main stem bronchus. A yellowish calcified lesion protruding through the right lower lobe bronchial wall was also recognized. Gentle endoscopic manipulation of the concretion resulted in mild bleeding which resolved spontaneously. The patient improved and was subsequently discharged home on oral antibiotics. At follow up she declined further invasive therapeutic interventions, but has remained remarkably asymptomatic.

## DISCUSSION

### Epidemiology

Only a small number of patients with pulmonary lymph node calcifications develop broncholithiasis.<sup>2</sup> Broncholiths occur with equal frequency in men and women. They are diagnosed predominantly in patients in their fifth or sixth decade of life.<sup>1,3</sup> They most commonly involve the right bronchial tree, particularly the middle lobe.<sup>2,3</sup> The second most common site for broncholiths is the origin of the anterior segment of the upper lobe bronchi.<sup>3</sup> Occasionally broncholiths can cause symptoms bilaterally in the same patient.<sup>1</sup>



**Figure 1A.** CT of the chest demonstrating pneumonia and bronchiectasis.

**Figure 1B.** CT scan of the chest demonstrating a broncholith in right lower bronchus.



## BRONCHOLITHIASIS: NOT JUST A MIDDLE LOBE DISORDER

### Symptomatology

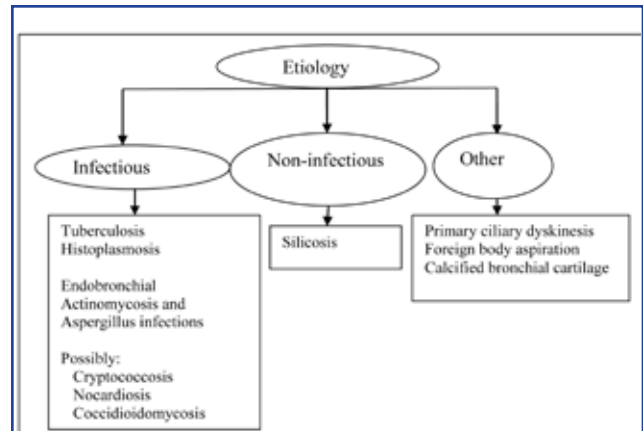
The commonly reported symptoms of broncholithiasis include persistent cough, recurrent hemoptysis, fever and chills, and purulent sputum (Table 1).<sup>2,4</sup> Some patients experience pleuritic chest pain. Lithoptysis is pathognomonic and has been reported to occur in 3% to 16% of documented broncholithiasis cases.<sup>4,5</sup> Fever with purulent sputum suggestive of respiratory infection is estimated to occur in 11% to 61% of cases.<sup>5</sup> Wheezing is a less common symptom, but may lead to a misdiagnosis of asthma.<sup>2</sup> An isolated wheeze or wheezing that does not respond to bronchodilator treatment should raise suspicion for symptomatic broncholithiasis, particularly if a calcified lymph node is present on plain radiographs.<sup>5</sup> Hemoptysis occurs in 37% to 85 % of cases and may be the sole presenting symptom. The typical duration of clinical manifestation from onset to diagnosis of broncholithiasis ranges from 8 months to 4.5 years.<sup>2</sup> Due to our patient's bronchiectasis, we suspect that the prior episode of "pleurisy" that our patient experienced two years earlier may have been a respiratory infection caused by her right main stem broncholith.

**Table 1.** Symptoms of Broncholithiasis

Cough	
Recurrent hemoptysis	37% to 85%
Fever and Chills	11% to 61%
Purulent sputum	11% to 61%
Lithoptysis	3% to 16%
Pleuritic chest pain	
Localized wheezing	

### Etiology

Broncholithiasis has a variety of potential causes. *Mycobacterium tuberculosis* is the most common cause of broncholithiasis worldwide, but histoplasmosis is thought to be the most common cause in the United States.<sup>6</sup> Other infections that may result in calcified hilar lymph nodes include cryptococcosis, nocardiosis, and coccidioidomycosis.<sup>1,6</sup> Broncholiths have also been described with



**Figure 2.** Etiology on Broncholithiasis.

endobronchial infections with *Actinomycoses* and *Aspergillus* species, silicosis, aspirated foreign bodies, calcified bronchial cartilage, and in patients with primary ciliary dyskinesia.<sup>1,6,7,8</sup>

### Unusual Complications

Mediastinal abscess formation is a rare complication of broncholithiasis. The abscess is thought to develop from retrograde migration of organisms into the mediastinum in association with broncholith movement.<sup>5</sup> Bronchoesophageal fistula formation has also been described as a rare but serious complication of broncholith erosion. A bronchoesophageal fistula can often be visualized by gastrografin study. However, the diagnosis can be missed due to obstruction of the fistula by the broncholith.<sup>9,10</sup> Acute respiratory failure from bilateral broncholithiasis has also been described.<sup>1</sup>

### Diagnosis

The diagnosis of broncholithiasis usually can be made from a combination of history, radiographic studies, and/or flexible fiberoptic bronchoscopy. The key radiologic finding is a calcified endobronchial lesion or a calcified peribronchial lymph node.<sup>2</sup> Other possible radiologic findings are due to bronchial obstruction and include atelectasis, consolidation, bronchiectasis, air trapping, and

fluid bronchograms.<sup>2,3,11</sup> Conventional computerized tomography is particularly useful in defining the location of the broncholith, its proximity to vessels, and any bronchial distortion.<sup>11</sup> Some investigators, however, encourage the use of high-resolution computerized tomography to assess these features.<sup>12</sup> Histological examinations of broncholith specimens demonstrate amorphous and sometimes laminated necrotic material with extensive dystrophic calcification. Histoplasma organisms can sometimes be identified within the calcified lymph node.<sup>3</sup>

## Treatment

Depending on the severity of the patient's symptoms, recommendations for intervention range from simple observation to removal of the broncholith by endoscopy or surgical resection. Removal of broncholiths by fiberoptic bronchoscopy is difficult and carries a high risk of bleeding. Rigid bronchoscopy, however, allows broncholith fragmentation by forceps and is the preferred endoscopic procedure.<sup>2</sup> Rigid bronchoscopy also allows efficient aspiration of the blood and tamponade of the bleeding site if hemorrhage is brisk.<sup>1</sup> The success of rigid bronchoscopic removal depends upon the stage of broncholithiasis. A success rate of 100% for bronchoscopic removal of broncholiths that are free in the airway lumen can be anticipated. However, attempts to remove broncholiths that are only partially eroded through the bronchial wall are only successful in 48% of procedures.<sup>2</sup> Unfortunately, there is 37.5% recurrence of symptoms in patients whose broncholiths are removed with rigid bronchoscopy.<sup>13</sup> This observation has led some authors to advocate that broncholithotomy be considered only in patients in whom pulmonary resection is not technically possible.<sup>14</sup>

Attempts at rigid bronchoscopic extraction of a broncholith should be conducted only after the relation of the broncholith to the adjacent vascular structures has been established. Rigid bronchoscopic broncholithotomy should only be undertaken in a medical center practiced in this intervention and with immediate thoracic surgical support.<sup>15</sup> Laser fragmentation of broncholiths is an experimental

treatment modality that may serve as an alternative to surgical removal.<sup>16</sup> Laser fragmentation has the advantage of reducing the morbidity from thoracotomy and decreasing the risk of hemorrhage.<sup>4</sup>

Surgical intervention is indicated for the patient with persistent or massive bleeding, recurrent pneumonia, and for the complications of mediastinal abscess and fistula formation. Surgical resection is an effective therapy and can be done with an acceptable morbidity and low mortality.<sup>13</sup> Some investigators argue that, given the risk of pulmonary artery erosion by a broncholith even when minimal hemoptysis is present, surgical intervention is the procedure of choice.<sup>4</sup> The surgical procedures range from thoracotomy with lobectomy to pneumonectomy. One series reported no recurrence of symptoms in patients that underwent thoracotomy.<sup>13</sup>

With the declining incidence of tuberculosis in the United States, the occurrence of broncholithiasis is unusual. However, we hope that our report will remind clinicians who practice in regions endemic for histoplasmosis and other systemic mycoses to consider the potential association of calcified lymph nodes with symptoms of bronchial obstruction and hemoptysis. Chest tomography and fiberoptic bronchoscopy are useful adjuncts to confirm the diagnosis and select treatment options.

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# Pulmonary Tuberculosis Associated With Abscess Invasion Through The Chest Wall

Praveen Seshabhattar, MD; Derek W Forster, MD; Rajeev K Bais, MD; Forest W. Arnold, MD

*Among the 1% to 3% of patients with Mycobacterium tuberculosis (TB) who have bone involvement, only 1% to 5% have chest wall involvement. We report a case of pulmonary tuberculosis complicated by a parapneumonic abscess that invaded through the chest wall to create a deformity easily appreciable upon visual inspection.*

## INTRODUCTION

**T**uberculosis remains a public health problem in the homeless, HIV, and immigrant populations of the United States. Skeletal tuberculosis is rare and is seen in 1% to 3% of patients with tuberculosis. Of those, 1% to 5% may present with chest wall tuberculosis.<sup>1</sup> This most commonly involves the margins of the sternum and along the rib shafts, but can also involve the costochondral junctions, the costovertebral joints and the vertebrae.<sup>2</sup> It is most commonly reported in the literature as a tuberculous abscess of the chest wall (TACW), but is also known as cold abscess of the chest wall, tuberculous osteomyelitis of the sternum and ribs, rib caries, TB sinuses of the chest wall, and rib tuberculosis. We present a case of TACW in a 59-year-old HIV-negative homeless male from Louisville.

## CASE REPORT

A homeless 59-year-old African-American male presented to his primary care physician for a swollen and painful left index finger that had begun to drain purulent material about a week earlier. He was unaware of a fluctuant anterior chest wall mass that was present. He reported symptoms of a productive cough of yellow sputum for about two months and a 30-pound weight loss. An abnormal CT

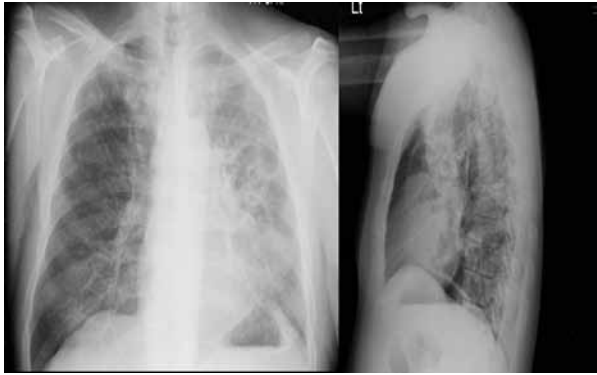
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scan of the chest prompted referral to the Emergency Department at the University of Louisville in Louisville, Kentucky, where he reported having a painless mass on his anterior chest wall for several months. He denied experiencing any discharge, warmth, or ulceration of the mass. He denied having any fever or hemoptysis.

On examination he was not cachectic, and his vital signs were stable. He was noted to have poor oral hygiene, with significant dental caries. On the anterior wall of the chest was a soft, nontender, fluctuant area across his manubrium measuring 8 x 6 cm<sup>2</sup>, which was without warmth or discharge. He had left-sided rhonchi. He had a swollen left index finger with ulceration and purulent drainage. His white blood count was 9,430 cells/cc<sup>3</sup>, erythrocyte sedimentation rate was 61mm/hr, and C-reactive protein was 5 mg/dl (normal 0.00 to 0.49mg/dl). His electrolytes and renal function were normal. His HIV serology and urine histoplasma antigen were negative; RPR





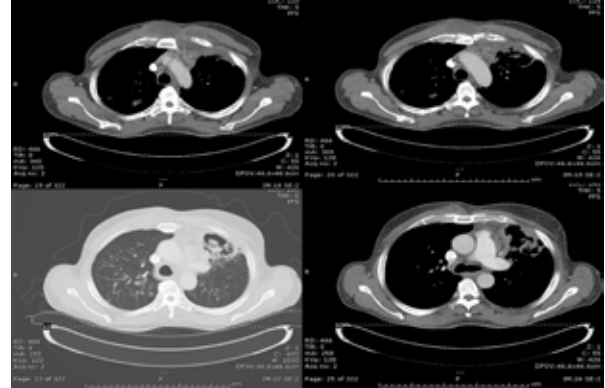
**Figure 1.** Chest X-ray - PA and lateral.

was non-reactive, and hepatitis C antibody was positive.

The CT scan of the chest showed a large anterior left upper lobe cavitory mass with a small component of a loculated pleural fluid collection anteriorly, which appeared contiguous with a multiloculated chest wall abscess of 14.8 x 4.2 x 8 cm<sup>3</sup>. There were areas of bony erosion. Multiple bilateral nodular opacities were present, some of which showed cavitations, and a surrounding tree-in-bud pattern (Figures 1 and 2). Sputum cultures yielded 4+ acid fast bacilli, and an *M tuberculosis* PCR test was positive. The patient was placed in respiratory isolation, and started on anti-tuberculous treatment (ATT) with isoniazid, rifampin, pyrazinamide and ethambutol. Needle aspiration of the chest wall mass yielded 4+ acid fast bacilli and a PCR positive test was positive for *M tuberculosis*. The abscess of his left index finger was incised and drained. It grew methicillin-sensitive *Staphylococcus aureus* (MSSA) for which he was treated with cephalexin. He was finally discharged and followed at Louisville Metro Department of Public Health and Wellness in their tuberculosis clinic for direct observed therapy. A repeat CT scan of the chest done after three months showed that the chest wall abscess and cavitory lesion had decreased.

## DISCUSSION

*M tuberculosis* involving a chest wall abscess commonly has a vague, indolent presentation.



**Figure 1.** Four sections of a CT scan of a 59-year-old male with active pulmonary tuberculosis showing extension from the lung (upper images), through the sternum and ribs to the exterior chest wall (lower images).

It may be with or without pain or underlying bony destruction. TACW has been associated with several presentations including a breast lump, a liver abscess, mediastinal lymphadenitis, and scrofuladerma of the neck. It was also associated as a complication of *Bacillus Calmette-Guérin* (BCG) vaccination and fine needle aspiration of a pulmonary tuberculoma.

Chest wall TB can occur by four different mechanisms: lymphatic spread, direct extension from TB empyema, hematogenous dissemination, and iatrogenic.<sup>3</sup> TACW has been classified into three types based on the extent of involvement of the chest wall.<sup>4</sup> A chest wall epiparietal lesion is confined to the chest wall. A periparietal and pleural space lesion is limited to the inner chest wall extending into the pleural space. A chest wall and pleural space lesion involves the chest wall and extends into the pleural space. Radiological features include periosteal reaction, bony sclerosis, severe bony destruction, sequestrum, and adjacent soft tissue abscess.<sup>2</sup>

Management of TACW is controversial. On one hand, are three case series. One series reported that pre- and post-operative ATT plus surgery yielded no recurrence.<sup>4</sup> Another case series of seven patients with a TB subcutaneous abscess concluded that TACW may

## TUBERCULOSIS ABSCESS OF CHEST WALL

**Table 1. Summary of the management of patients in six case series with tuberculous abscess of the chest wall.**

Study	n	Study Dates	Country	Mean Age (Yrs)	Management (No. patients)	Preoperative Antitubercular Therapy	Recurrence Rate
Faure et al <sup>7</sup>	18	1980-1995	France	45	Abscess drainage (2) Abscess drainage with rib resection (15)	9/18	1/18
Paik et al <sup>8</sup>	89	1970-2000	S. Korea	33	Abscess drainage (25) Abscess drainage and rib resection (64)	75/89	0/89
Sakuraba et al <sup>3</sup>	13	1994-2003	Japan	57.2	Abscess drainage (2) Abscess drainage and rib resection (10) Abscess drainage, rib and partial sternal resection (1)	13	0/13
Cho et al <sup>4</sup>	16	1996-2003	S. Korea	42	Abscess drainage (6) Abscess drainage and rib resection (9) Abscess drainage, rib and partial sternal resection (1)	16	2/16
Kim et al <sup>6</sup>	80	1981-2005	S. Korea	31	Abscess drainage (15) Excision of the Abscess without rib resection (9) Abscess drainage, rib, partial sternal and clavicular resection (56)	80	12/80
Gözübüyük et al <sup>9</sup>	10	1998-2006	Turkey	41	Abscess drainage (4) Abscess drainage and rib resection (4)	10	2

be managed with ATT alone.<sup>5</sup> The third series of 80 patients categorized treatment into three tiers based on surgical invasiveness.<sup>6</sup> Among 12 patients who had recurrence, 6 had the least invasive treatment (abscess debridement and drainage), and the other six had the most invasive complete excision of the abscess with possible rib and sternum resection. On the other hand, one case series reported managing 17 of 18 patients with surgery successfully.<sup>7</sup>

Some case series had mixed findings, but the authors made recommendations siding with surgical intervention with anti tuberculous treatment (ATT). The authors of a case series of 89 patients over 30 years performed abscess excision in 28% of patients, and abscess excision along with rib resection in the remaining 72%.<sup>8</sup> They noticed that the

recurrence rate was 16% in abscess excision versus 1.6% in rib resection. However, the complication rate was higher in the rib resection group. The authors ultimately recommended preoperative ATT, then extensive surgery including rib resection, followed by post-operative ATT. Another study recommended surgery in the presence of cavitory abscess formation, surgical wound TB, or sinus formation.<sup>9</sup> For smaller lesions they opined that ATT alone may be enough.

TACW is an uncommon complication of TB. It should be considered when evaluating a patient with a chest wall mass, and a high index of suspicion is needed in vulnerable populations, especially if they have had delayed treatment for TB. In contrast to recommendations based on case series of patients with TACW, the present patient had a

positive outcome with conservative aspiration and ATT rather than aggressive rib and sternum resection.

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# An Overview: Keys to Successful Local Smoke-Free Laws or Regulations Passage and Implementation Progress in Kentucky

Stephen W. Wyatt, DMD, MPH; W.R. Maynard, MBA; Katie Bathje, MA; Jennifer Redmond, DrPH

In 1993, an article by McGinnis and Foege, published in the *Journal of the American Medical Association (JAMA)*, identified and quantified the major external (nongenetic) factors that contribute to death in the United States.<sup>1</sup> This study shifted the focus from causes of death focusing upon diseases processes—cardiovascular disease, cancer, cerebrovascular disease, etc—to modifiable behavioral risk factors as the actual causes of death, a landmark paradigm shift in thinking about the leading causes of death. This study identified the major modifiable risk factors as:

- Tobacco
- Diet/activity patterns
- Alcohol
- Microbial agents
- Toxic agents
- Firearms
- Sexual behavior
- Motor vehicle
- Illicit drug use

The analysis by McGinnis and Foege suggested that an estimated 400,000 deaths in

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1990, or 19% of all deaths, were attributed to tobacco. A subsequent, similar analysis was conducted by Mokdad and Marks for deaths in the year 2000, and published in *JAMA* in 2004.<sup>2</sup> This analysis estimated that 18.1% (435,000 deaths) of all deaths in the year 2000 were attributable to tobacco. Table 1 presents data from these two analyses.

**Table 1.** Actual Causes of Death in the United States 1990 (McGinnis) and 2000 (Mokdad) Comparison

Actual Cause	Estimated # of Deaths		Percentage of Total Deaths	
	1990	2000	1990	2000
*Tobacco	400,000	435,000	18.9	18.1
*Poor Diet/Inactivity	300,000	365,000	14.2	15.2
*Alcohol Consumption	100,000	85,000	4.7	3.5
*Microbial Agents	90,000	75,000	4.2	3.1
*Toxic Agents	60,000	55,000	2.8	2.3
*Motor Vehicle	25,000	43,000	1.2	1.8
*Firearms	35,000	29,000	1.7	1.2
*Sexual Behavior	30,000	20,000	1.4	0.8
*Illicit Drug Use	20,000	17,000	0.9	0.7
<b>Total</b>	<b>1,060,000</b>	<b>1,159,000</b>	<b>50.0</b>	<b>46.7</b>

## SMOKE-FREE LAWS OR REGULATIONS IN KENTUCKY

The Mokdad and Marks analysis included projections on the number of deaths annually from secondhand smoke (35,000) and infant deaths due to maternal smoking (1000).<sup>3</sup>

Tobacco contributes to deaths from cancer (especially cancers of the lungs, esophagus, oral cavity, pancreas, kidney and bladder, plus possibly other organs), cardiovascular disease, lung disease, and low birth weight.<sup>4</sup> In general, estimates over the years have placed tobacco's contribution in the broad range of 11% to 30% of all cancer deaths, 17% to 30% of cardiovascular deaths, 24% of pneumonia and influenza deaths, and 20% to 30% of low-birth-weight infants.

Historically, Kentucky's pro-tobacco environment has been considered as presenting a significant challenge for impacting tobacco use by individuals and smoking ordinances/laws in communities. Tobacco has been not only an important economic issue in Kentucky; it also represents a "way of life" on many small farms.<sup>5</sup> For example, the 2005 article by Chaloupka and Hahn et al noted that in 2003, burley tobacco was being grown in 117 of Kentucky's 120 counties.<sup>6</sup>

However, the science beneath the impact of smoke-free ordinances/laws, their positive health impact, and lack of a negative impact on community businesses has matured and provided communities and advocates with the evidence/ammunition needed to expand smoke-free ordinances.

A summary of key findings from the published literature documenting the "lessons learned" as attempts have been made to pass smoke-free ordinances, and any subsequent impact, would be a valuable tool for use by community advocates and coalitions in Kentucky as they pursue local opportunities.

## METHODS AND RESULTS

A comprehensive literature search was conducted for recent published articles between the years 2004-2010. The comprehensive literature review focused on smoke-free laws or ordinances at the local or state levels, using appropriate search terms, including "health outcomes of smoking ordinances," "economic benefits of smoking ordinances," "smoking

ordinances process," and "passing smoking ordinances." The literature search yielded published articles in three general categories:

- Processes used to successfully pass laws/ordinances
- Health impact of smoke-free laws/ordinances
- Economic impact of smoke-free laws/ordinances

A summary of key findings from articles in each of these general categories follows.

### Processes to Successfully Pass Smoke-Free Laws/Ordinances

Greathouse et al<sup>6</sup> noted from their review of the process that resulted in the passage of a smoke-free ordinance in Lexington, Kentucky, four keys that provided a window of opportunity:

- Changing public behaviors and attitudes toward smoking and government involvement in protecting public health;
- An organized advocacy/dissemination plan to communicate the increasing scientific evidence of the harmful/effects of second-hand smoke exposure to hospitality workers and the general public;
- The increasing number of states and localities adopting smoke-free ordinances; and
- Organized, persistent grassroots and "grass top" pressure from health advocates and the Board of Health.

Ahrens et al reviewed the community and organizational characteristics of smoke-free ordinance campaigns in 15 Wisconsin cities and determined that the biggest difference between successful (n=9) and unsuccessful (n=6) campaigns was experienced leadership in the successful efforts.<sup>7</sup>

### Health Impact of Smoke-Free Laws/Ordinances

In the reviewed articles, notable health impact observations occurred for hospitalizations related to coronary heart disease and myocardial infarction. Khuder et al reported that hospitalizations for coronary heart disease decreased 39% after one year, and 47% after three years following the passage/implementation of the smoke-free policy in Bowling Green, Ohio.<sup>8</sup> Sargent et al reported a 40%

decrease in acute myocardial infarction during the 6 months (suspended pending legal action) smoking was restricted in bars during 2002.<sup>9</sup>

## Economic Impact of Smoke Free Laws/Ordinances

The reviewed articles note few (gaming only) negative economic impacts on businesses from the implementation of smoke-free ordinances/laws. In fact, one study in Ireland reported that pubs saw an increase in clients/visitors following the implementation of a country-wide smoking ban.<sup>10</sup>

## Progress in Kentucky

The prevalence of smoking among Kentucky adults and youth continues to be high, however there has been progress. According to the most recent data from the Behavioral Risk Factor Surveillance System (BRFSS), an estimated 25.6% of Kentucky adults (18 years and older) report routine smoking.<sup>11</sup> Recent results from the Youth Risk Behavior Survey (YRBS) indicate that approximately 26.1% of high school students reported they are current smokers.<sup>12</sup> The BRFSS and YRBS are collaborative efforts between the Kentucky Department of Public Health and the Centers for Disease Control and Prevention. The BRFSS survey is a random-digit dialed

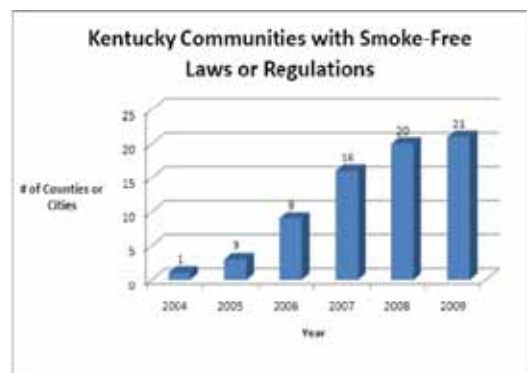
telephone survey of Kentucky's non-institutionalized population that is 18 years of age or older, and collects data on a variety of risk behavior and health issues, including smoking behaviors. The YRBS is a survey of youth through schools, and it also collects information/data on a variety of risk behaviors related to physical and mental health.

The progress against smoking in Kentucky, and in addressing exposure to second-hand smoke, can likely be attributed to multiple intervention efforts, including expanded smoking cessation education opportunities, including classes, Quitlines, provider education, and web applications; multi-pronged smoking prevention campaigns, including school curriculum development and implementation, online programs, and youth conferences; as well as policy interventions like an increased cigarette tax and increasing smoke-free laws/ordinances. Since this review specifically addresses policy intervention through smoke-free laws/ordinances, status in this critical area will be reviewed.

As shown in Figures 1a and 1b, in 2004 only one Kentucky County/City had a smoke-free law/ordinance in place. By the end of 2009, 21 Kentucky counties/cities had policies implemented.<sup>13</sup> An analysis of the strength of the smoke free laws and regulations by the University of Kentucky College of Nursing revealed some variation across counties/



**Figure 1A.** Kentucky Communities with Smoke-free Laws or Regulations.



**Figure 1B.** Increase in City/County Ordinances with Smoking Bans.

## SMOKE-FREE LAWS OR REGULATIONS IN KENTUCKY

cities with the most stringent (smoke-free workplaces and enclosed public places) level being, the most common. They estimated that as of July 2010, 31.5% of Kentuckians are protected by comprehensive smoke-free policies.<sup>14</sup>

### SUMMARY AND CONCLUSION

As noted, much policy progress has occurred since 2004 in Kentucky; however, there is still much work to be done to address second-hand smoke exposure to almost 70% of the population that remain unprotected. The Kentucky Cancer Consortium, a statewide coalition of organizations committed to cancer prevention and control, has the following policy agenda goal for 2010-2015 in this area:

- Kentucky will enact a comprehensive statewide smoke-free law according to the Fundamentals of Smoke-free Workplaces.

This goal is to be addressed through the achievement of the following short term objectives:

- **Key Collaborators:** Smoke-free Kentucky Coalition
- **5-year short-term objectives include:**
  - Increasing the number of cities and counties that enact comprehensive smoke-free work place ordinances or Board of Health regulations.
  - Implementing media campaigns/strategies to build support for a state-wide smoke-free law through education focused on the health risks of second-hand smoke.
  - Increasing the number of policy makers who are in support of state-wide smoke-free ordinances and law.
  - Building grassroots advocacy support through regional forums and partner networks.

In summary, community leaders across Kentucky can take great pride in the progress that has been made related to tobacco use. However, the high prevalence of smoking among Kentucky adults and youth, as reported by BRFSS and YRBS, indicates there is still much work to be done. The previously noted 70% of Kentuckians that are not currently

protected by smoke-free ordinances/laws is also a cause for concern. Expanding local smoke-free ordinances and laws is an important strategy, and one of the critical short-term objectives identified by the Kentucky Cancer Consortium. These local restrictions are critical components of comprehensive community-based strategies to reduce smoking prevalence and ultimately improve the health of their residents. Learning from communities that have been through ordinance development/passage attempts, including successes and failures, is extremely important. Having access to critical "lessons learned" and keys to success from the published literature can make other communities processes both more efficient and effective.

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Mark Newstadt, MD

# THE JOY OF PEDIATRICS

**T**he anticipation and thrill of match day has come and gone, and with my son Justin heading off to Washington University in St. Louis for his pediatric residency, I am inspired to reflect on my path towards pediatrics, and the joy and fulfillment I have obtained from my career.

My initial decision to specialize in pediatrics was not straightforward. Following high school graduation and a mandatory one-year stint in the South African army, I enrolled in medical school, where I completed six years of combined undergraduate and medical training under the British-style system. This was followed by one year of medical and surgical internships and a six-month senior internship in cardiology. My initial plan was to focus on pediatrics for six months before starting my internal medicine residency, but I fell in love with pediatrics and decided to change my course. Little did I know that I was about to embark on the first of two pediatric residencies.

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## *My initial decision to specialize in pediatrics was not straightforward*

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My first residency in Johannesburg was excellent. The training was superb, and the clinical exposure unsurpassable. The contrast was striking when my family and I immigrated to Louisville four years later, where I began my second pediatric residency to fulfill licensure and board requirements. Although the training and guidance were comparable, the clinical side was different in many ways. Patients presented earlier, often with more subtle clinical features, and in general, the

residency was much less hands on. As residents, we did not draw the labs nor start the IVs on most of the patients. It was a totally different side of pediatrics compared to my registrarship at Baragwanath Hospital in Soweto, South Africa, where malnutrition, measles, rheumatic heart disease, and tuberculosis were highly prevalent.

Nevertheless, I finally emerged from my training and went into practice. After six years of medical school and eight and a half years of residency, I was ready to see my first private patient.

From the beginning, I loved the way babies interacted with me, whether they were smiling, cooing, laughing, sitting, rolling, crawling, or walking. Older children also fascinated me with often very entertaining histories as their communication skills improved.

I found that working with children came with plentiful rewards. One time when performing a history examination of a 5-year-old child, I informed the child that I was 5 as well and, in turn, received a great big slobbery hug. His initial disbelief disappeared once I explained that my five had another number next to it.

I will never forget the time one of my patients, whose family was very religious, gazed into my eyes, stroked my beard as I was examining him, and asked earnestly, "Dad, is this Jesus?" Or the time another patient struggled with my last name and called me "Dr Newsnot."

Sometimes, of course, pediatrics can be very trying. Of all the specialties, it is definitely one of the least glamorous. It would be an unusual day if I was not sprinkled or showered with some kind of secretion, whether it be saliva, urine, vomit, poop, or pus. I just mop it up, wash my hands, and move on to the next screamer (a child who screams from



the time I open the door). There will sometimes be runs of successive screamers and I will think to myself, "Why, oh why, am I doing this?" And I usually get my answer in the next room when another cute little toddler talks my head off and makes me laugh.

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### *I found that working with children came with plentiful rewards*

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There are other times when I consider pediatrics the simple art of deciding whether or not to prescribe antibiotics. However, interspersed among the more routine patients I often see very intellectually stimulating cases like the 3-year-old presenting with jaundice, diarrhea, hematuria, and anemia who turned out to have hemolytic uremic syndrome, followed the next day by a 13-year-old with jaundice and right upper quadrant pain who had a common bile duct stone and gallstones.

Despite having to deal with a lack of history from screaming infants, the occasional clueless parent who arrives with a list from the spouse, insurance misdemeanors, and lastly, patients who have opted for urgent care centers and acute care clinics, I still love to go to work every day.

I am very fortunate to work with a group of excellent physicians who are always available to discuss mutual patients and provide plenty of intellectual stimulation to balance the monotony of mundane colds, ear infections, and routine health maintenance. We also have a great and loyal staff at our office, many of whom have been employed for more than 25 years.

Guiding and educating new parents as they struggle to deal with their newborn infants can be very fulfilling. Likewise, observing children as they grow and mature through the different stages from childhood to adolescence to young adulthood is also very rewarding. It is always a sad day when we have to inform our almost 22-year-old patients that they can no longer be seen in our office—yet we love it when they return later with their own children.

As my son prepares to embark on his career in pediatrics, I can quite honestly say that I have no regrets and would do it all over again. Just a few weeks ago, I realized I had reached the pinnacle of my career when, at the end of a 6-year-old well check appointment, which I had thought went really well, my patient proudly handed me a drawing of the two of us, clearly labeled at the top, "DR JAMES BELZA."

**Mark Newstadt, MD**

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Kimberly Moser

# A Focus on Childhood Obesity

**W**ell, now that the Royal Wedding has taken place, the Kentucky Derby is upon us, and the Annual KMA Alliance's Spring Meeting was a great success, we can finally move on with plans for graduations and other family celebrations! As the school year winds down and summer plans fill the calendar, the Alliance is staying busy with Annual Meeting plans and continuing our work on Health Promotion projects statewide.

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*One of our largest endeavors this year is to educate about...  
Childhood Obesity*

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One of our largest endeavors this year is to educate about the problem of and health risks associated with the epidemic of Childhood Obesity. In 2009, Kentucky had the unfortunate standing as one of nine states with a Childhood Obesity rate of greater than 20% of all kids aged 2-19 in the state. Obesity now affects 17% of all children and adolescents in the United States—triple the rate from just one generation ago. County obesity rates are variable within states, and low-income children have a higher rate of obesity. Even states with the lowest prevalence of obesity have counties where many low-income children are obese and at risk for chronic disease.

Obesity is defined as a Body Mass Index (BMI) of greater than 30 in adults and takes gender, age, and some other factors into consideration for children and teens when calculating BMI in kids. It is a useful tool and has been proposed as a good way to track our obesity rates in Kentucky. Legislation was

proposed during our short legislative session this year to add the BMI measurement to school physical forms. While it did not pass this year, it continues to be discussed for aggregate studies data, as well as other legislation looking at this dangerous trend. These issues are being discussed in a newly formed task force of several legislators.

It is imperative to look at ways to curb this epidemic by educating parents, health care providers and those who work with children. It is important to teach children about making healthy food choices and making physical activity a normal part of their daily lives.

There are known factors which contribute to the obesity problem in the US: lack of quality, daily physical activity in schools; greater availability of high-energy-dense foods and sugary drinks; limited access to healthy, affordable foods in rural areas and low-income neighborhoods; increasing portion sizes; and television and other media. A newly devised "5-2-1-0" campaign by the American Academy of Pediatrics is gaining popularity in outlining "5 servings of fruits and vegetables per day, 2 hours of 'screen time,' 1 hour of physical activity, and 0 calories consumed in the form of sugary drinks." The Alliance hopes to incorporate this into our Health Promotion Childhood Obesity theme.

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*The KMA Alliance is working...  
to provide and distribute  
educational materials*

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The KMA Alliance is working together with pediatricians, the Kentucky Department

of Public Health and other organizations to provide and distribute educational materials which help adolescents and teens make healthy food choices and understand the importance of staying active. We have beautifully illustrated brochures which are fun and

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*We are also advocating on behalf of healthy kids and lifestyles.*

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informative tools for kids and parents. We are also staying current on legislative efforts

and advocating on behalf of healthy kids and lifestyles. The September Annual Meeting will feature several speakers on this topic in a series on women and children. So, looking forward, we are really gearing up with some great ideas and collaborations to make a difference in the efforts of combating Childhood Obesity. Stay tuned for more information . . . and please share your ideas and get involved! Please contact Kim Moser, Betty Nolan. or Aroona Dave for more information on the Nutrition Brochures for your county.

**Kim Moser, President**  
*KMA Alliance*

*Dear Editor:*

*RE: Individual Factors Associated with the Exacerbation of Negative Perceptions of the Mental Health Care System*

[Mental Health Awareness Month is observed throughout May in the United States.] The perceptions patients have about mental health care services directly influence patient behavior and, ultimately, patient outcomes. One of the central factors that affect patients' perceptions of mental health care is whether their interactions with mental health care providers are positive or negative. It appears that there is a causal relationship between individual patient-related factors and satisfaction with healthcare providers. Some of these individual factors are age, ethnicity, and education levels.<sup>1</sup> The main reason for this is that patients who are not satisfied with their health care provider are going to change health care providers with greater frequency.<sup>1</sup> Some populations are more affected by this than others. Studies have shown that minority patients tend to experience a greater level of dissatisfaction with the process of seeking mental health care than non-minority patients,<sup>2</sup> making this population more likely to change health care providers frequently, and thus more likely to experience the negative effects associated with this process.

Frequent changes in health care providers, combined with patient dissatisfaction with health care providers, adversely affect treatment-seeking behavior. These factors create external barriers to patients seeking quality mental health care services. Adherence to treatment protocols can also be adversely affected by negative perceptions of mental health care. The lack of availability of general and specialized mental health care, as well as racial and ethnic disparities in mental health care, adversely affects adherence to patient treatment protocols.<sup>3</sup> In order to create mental health policies that are conducive to facilitating healthy relationships between patients and providers, it is imperative that policy makers have a fundamental understanding of perceptions. One of the major factors associated with changing providers frequently is the environment in which patients live.

Moreover, the environment plays a role in mental health status and outcomes. A positive environment is especially important in the adolescent mental health population. Research indicates that individuals in areas of lower socioeconomic status are predisposed to negative behaviors. For instance, individuals from more economically disadvantaged areas in which they feel unsafe are more susceptible to depression and aberrant socially negative behaviors.<sup>4</sup> These negative behaviors act as stressors that have a negative effect on adolescents with mental health-related problems.<sup>4</sup> On the other hand, individuals from areas of higher socioeconomic status are not exposed to these negative factors to the same degree.<sup>4</sup> Family and the surrounding community are factors that have been associated with positive mental health outcomes due to support, involvement, and available services.

It is demonstrated throughout literature that education levels are associated with positive or negative perceptions of mental health care. Educational outcomes and negative factors, such as sexual promiscuity, are linked to the socioeconomic status of the area in which adolescents reside.<sup>4</sup> These negative influences in the environment could ultimately contribute to negative outcomes in other areas of the patients' lives, perhaps leading to long-term negative patient perceptions of mental health care. Therefore, mental health policies should address problems in the environment in which adolescent patients reside.

In conclusion, the majority of factors associated with negative perceptions of mental health care appear to be associated with each patient as an individual. Facilitating healthy perceptions of mental health care should begin by emphasizing the importance of having a healthy, continuous relationship with a provider; taking greater care to ensure that patients understand the enrollment and treatment process; and educating patients about stigma and the negative effects of adverse treatment-seeking behaviors. The overall effect of these steps would be positive patient outcomes, lower overall mental health care costs, and increased community integration for the individual. The difficulty

with implementing policies and strategies that facilitate these steps is that many of these factors are unique to each individual, and it would be difficult to create legislation that caters to the entire mental health population.

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*Dear Editor:*

A recent study conducted to identify the medical patient profile of the University of Kentucky's Dental Urgent Care Clinic underscored the importance of obtaining an adequate health history, including vital signs, when treating urgent care patients.

We interviewed 100 nonconsecutive patients and recorded medical information from their health history forms, collecting

data on patients' insurance, demographics, tobacco usage, social history, medical conditions, and treatment.

We found that 59% of our patients were female, 47% had a high school education or less, and 71% had no insurance. The most common medical conditions were drug allergies (21%), seasonal allergies (16%), hypertension (14%), and depression (10%). The most common health problems by system were pulmonary, neurologic, and cardiovascular issues. Our results also showed that 67% of the subjects had smoked in their life and 47% were current smokers. The most common diagnosis was reversible pulpitis, and the most common treatments were extraction (38%) and pulpotomy (25%).

The medical profile of patients at our Dental Urgent Care Clinic shows a population with many conditions and a complicated history, and also suggests that our patients are often unreliable historians. It is important to understand the UDCC patient's profile to establish the need for training of student dentists to recognize and manage medically compromised patients.

More complete information on the method and results of our study, including a sample patient profile form, may be found at: [Dental Urgent Care Information](#). Other authors of the study are Adam Reynolds, BS, and John Lindroth, DDS.

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# Updated Child Day Care and School Immunization Requirements

*Alicia Tindall, Kentucky Immunization Program Manager*

**N**ew requirements for Kentucky children entering child day care, Head Start programs, public and private preschool programs and public and private elementary and secondary schools were approved in February 2011, and can be found online at <http://www.lrc.ky.gov/kar/902/002/060.htm>. The effective date for these regulatory changes is July 1, 2011. Any immunization certificate presented on or after July 1, 2011, for a child entering child day care, preschool, Head Start, kindergarten or sixth grade should comply with the new requirements.

Since the requirements had not been revised since 2002, several updates were made, in order to assure improved vaccine coverage for children in these settings. The following is a summary of the changes.

## Newly Required Vaccinations

- Pneumococcal conjugate vaccine (PCV)
  - Age appropriate immunization with PCV is required for children up to five years of age. Children aged five years or older are not required to receive PCV, as it is not licensed for healthy children in that age range.
- Meningococcal conjugate vaccine (MCV)
  - One dose of meningococcal vaccine for sixth grade entry, 11 or 12 years or older, is required.
  - The use of meningococcal conjugate vaccine is preferred, but meningococcal polysaccharide vaccine (MPSV) may be used if the conjugate vaccine is unavailable.

- Tetanus-diphtheria-acellular pertussis vaccine (Tdap)
  - One dose of Tdap regardless of interval since last dose of tetanus-containing vaccine is required for students at sixth grade entry, 11 or 12 years or older, with option for Td for individuals who cannot receive pertussis containing vaccines.

## Changes in Varicella Immunization and Documentation Requirements

- Additional dose of varicella vaccine
  - A second dose of varicella vaccine, or proof of disease, is required for children at least 48 months of age and less than 5 years of age *and* for children entering the 6<sup>th</sup> grade, 11-12 years of age or older, if these children have not already been vaccinated with two doses of varicella.
- More stringent documentation of varicella or herpes zoster disease
  - In lieu of immunization against varicella, the immunization certificate now requires that proof of disease be in the form of verification of a history of varicella or herpes zoster infection by a health care provider.

## Changes that Allow Greater Flexibility in Vaccine Administration

- Flexibility in use of different brands of *Haemophilus influenzae* type b (Hib) vaccine



- Children at least 5 months and less than 7 months of age are now required to have two doses of Hib vaccine instead of three. Some brands of Hib vaccine or combination Hib-containing vaccines permit doses at 2 months and 4 months, but do not require a dose at 6 months as described in the 2011 Advisory Committee on Immunization Practices (ACIP) recommended schedule. This amendment gives providers more flexibility in choosing Hib-containing vaccine brands for their practices.
- Flexibility in timing of Hepatitis B vaccination
  - The third dose of hepatitis B vaccine is now required for children at least 19 and less than 48 months of age. This amendment allows providers the flexibility to administer the third dose of hepatitis B vaccine as late as 18 months of age while maintaining compliance with requirements for child day care entry. This timing is in compliance with 2011 ACIP recommendations for hepatitis B vaccine administration.

## Other changes

- Polio (IPV) vaccine
  - The final dose of IPV vaccine should be administered at age four

years or older regardless of the number of previous doses and the minimum interval between this final dose and the previous dose should be at least six months.

- Measles-mumps-rubella (MMR) vaccine
  - Since MMR is the only measles-containing vaccine licensed in this country, the language for age appropriate vaccination against measles with a “measles-containing vaccine” was replaced with language requiring a second dose of MMR.

Providers should particularly focus immunization efforts through the fall of 2011 on immunizations for school age children, especially those children entering kindergarten and sixth grade, in order to meet the new school entry requirements. However, immunization records should be reviewed at every patient encounter, and age appropriate immunizations should be administered at any visit unless medically contraindicated.

Updated immunization certificates are available at the Kentucky Department for Education Website at: <http://www.education.ky.gov/KDE/Administrative+Resources/Coordinated+School+Health/Health+Services/School+Health+Forms.htm> or by contacting the Kentucky Immunization Program at 502-564-4478.

## Coding Tip

### Pediatric Vaccine Administration Codes

#### *Take the Sting Out of Immunization Coding—Use the Quick Reference Chart*

The pediatric vaccine administration codes 90460 and 90461 include counseling *and* the counseling *must* be performed by a physician or a qualified health care professional. The purpose of the counseling during an encounter for vaccine or toxoid administration is to address concerns or questions that may arise regarding the benefit of a vaccine, or to alleviate fears about the side effects of a particular agent.

Other important points to remember:

- Procedure codes 90460 and 90461 *must* be reported in addition to the vaccine and toxoid code(s) 90476 and 90749.
- The word “component” in the code description for 90460 and 90461 refers to all antigens in a vaccine that prevent diseases caused by one organism.
- Always check with each insurer to see what rules exist for covering these services.

CPT Code	Code Details
90460	First immunization administration (primary code)
Report	Per component
Age	18 years or younger
Counseling	Physician or other qualified health care professional
Routes of administration	All routes of administration
90461	Each additional vaccine/toxoid component – list separately in addition to the primary code (90460)
Report	Each additional vaccine/toxoid component
Age	18 years or younger
Counseling	Physician or other qualified health care professional
Routes of administration	All routes of administration

## Coding Tip

## Coding And Documentation Tips For Lesion Excisions

When President Ronald Reagan was shot in 1981 he was quoted as saying, "Since I came to the White House, I got two hearing aids, a colon operation, skin cancer, a prostate operation, and I was shot." President Reagan survived both his gunshot wound and treatment for his skin cancer while in the White House. His daughter Maureen Reagan was not as fortunate and in 2001 died of malignant melanoma at the age of 60.

Despite extensive prevention and awareness campaigns, skin cancer is still the most common cancer diagnosed in the US and physicians are treating more and more patients for both non-melanoma and melanoma skin cancers.

To ensure proper reimbursement, use these tips for correct coding and compliance of lesion excisions:

- To select an appropriate code for excision of a benign (11400-11471) or malignant (11600-11646) skin lesion, determine the lesion's diameter at its widest point, and add to that measurement double the width of the narrowest margin.
- Document the size of the lesion excision prior to removal for both clinical and coding accuracy. The lesion's size will decrease as soon as the first incision releases some of the tension on the skin, and the sample will likely shrink further when placed in formaldehyde.
- Be careful not to confuse the length of the incision with the width of the margins. Often, an incision will be made that is longer than the lesion to "flatten" the resulting scar, but this has no bearing on code selection. Base measurements on the actual size of the lesion before the excision is performed and prior to sending it to pathology, not according to the size of the surgical wound left behind.
- Because CPT classifies lesions as either "benign" or "malignant," wait for the pathology report before selecting CPT or ICD-9 codes to describe the excised lesion(s). There is a single exception to this rule: If a re-excision is performed to obtain clear margins at a subsequent operative session, report automatically the same malignant diagnosis which was linked to the initial excision. This is true even if the pathology report on the second excision returns benign, because the original reason for the re-excision was malignancy.

# CANCER COMMENTS

## May is National Skin Cancer Awareness Month

### Skin Cancer Screening Guidelines for Asymptomatic Adults

compiled by the [Kentucky Cancer Consortium](#)

	National Cancer Institute PDQ	American Cancer Society (ACS)	American Academy of Dermatology	US Preventive Services Task Force (USPSTF)	American Congress of Obstetrics and Gynecology (ACOG)
<b>Preferred screening method</b>	The only widely proposed screening procedure for skin cancer is visual examination of the skin, including both self-examination and clinical examination.	Visual examination of the skin by a physician and monthly self-examinations.	Full body exam by physician, for those at high risk (history of melanoma); monthly self-examinations.	N/A	Visual skin examination.
<b>Age to begin screening</b>	N/A	20	N/A	N/A	At first periodic health assessment visit, as early as age 13.
<b>Routine screening interval</b>	N/A	As part of periodic health examinations with physician; monthly self-exams.	Annually skin examinations by a dermatologist, for high risk patients. Self-exams should be performed monthly.	N/A	As part of periodic health examinations with physician.
<b>Considerations</b>	<ul style="list-style-type: none"> <li>In asymptomatic populations, the effect of visual skin examination on mortality from <i>nonmelanomatous</i> skin cancers is unknown.</li> <li>Evidence is inadequate to determine whether visual examination of the skin in asymptomatic individuals would lead to a reduction in mortality from <i>melanomatous</i> skin cancer.</li> </ul>	For people aged 20 or older having periodic health exams, a cancer-related check-up should include a visual examination for skin cancer.	<ul style="list-style-type: none"> <li>Dermatologists recommend a regular self-examination of the skin to detect changes in its appearance.</li> <li>Anyone with a changing, suspicious or unusual mole or blemish should be examined as soon as possible.</li> </ul>	<ul style="list-style-type: none"> <li>Current evidence is insufficient to assess the balance of benefits and harms of using a whole-body skin examination by a primary care clinician or patient skin self-examination for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer in the adult general population.</li> </ul>	<ul style="list-style-type: none"> <li>Perform skin examination</li> <li>Counsel re: health behavior - skin exposure to ultraviolet rays</li> <li>Physicians should be alert to high-risk factors. During evaluation, the patient should be made aware of high-risk conditions that require targeted screening or treatment, including: Increased recreational or occupational exposure to sunlight; family or personal history of skin cancer; clinical evidence of precursor lesions; fair skin, freckling; light hair; immune suppression; age; xeroderma pigmentosum</li> </ul>

# CANCER COMMENTS

	National Cancer Institute PDQ	American Cancer Society (ACS)	American Academy of Dermatology	US Preventive Services Task Force (USPSTF)	American Congress of Obstetrics and Gynecology (ACOG)
	<ul style="list-style-type: none"> <li>Based on fair though unquantified evidence, visual examination of the skin in asymptomatic individuals may lead to unavoidable increases in harmful consequences. These include complications of diagnostic or treatment interventions (including extensive surgery) and the psychological effects of being labeled with a potentially fatal disease.</li> <li>Another harmful consequence is overdiagnosis leading to the detection of biologically benign disease that would otherwise go undetected, and the possibility of misdiagnosis of a benign lesion as malignant.</li> </ul>			<ul style="list-style-type: none"> <li>Clinicians should remain alert for skin lesions with malignant features that are noted while performing physical examinations for other purposes. Features associated with increased risk for malignancy include: asymmetry, border irregularity, color variability, diameter &gt;6mm ("A," "B," "C," "D"), or rapidly changing lesions. Suspicious lesions should be biopsied.</li> </ul>	

## Sources:

[American Academy of Dermatology](#). Skin Cancer Fact Sheet. Accessed: April 2011.

[American College of Obstetricians and Gynecologists](#). Primary and preventive care: periodic assessments. Committee Opinion No. 483. *Obstet Gynecol* 2011;117:1008–15.

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Smith, RA, Cokkinides V, Brawley OW. Cancer screening in the United States, 2008: A review of current American Cancer Society guidelines and cancer screening issues. 2008. *CA Cancer J Clin*. 2008;58:161-179.

National Cancer Institute. [Skin Cancer Screening PDQ, Health Professionals Version](#). Accessed 4/2011.

US Preventive Services Task Force. Screening for [Skin Cancer: Clinical Summary of U.S. Preventive Services Task Force Recommendation](#). 2009.

## Life Members

*The Kentucky Medical Association would like to recognize physicians who have recently become Life Members of the Association.*

### FAYETTE

**Ben P. Bingcang, MD**

Nicholasville KY

**Jerold N. Friesen, MD**

Lexington KY

**Lawrence C. Maguire, MD**

Lexington KY

**Robert Steinberger, MD**

Lexington KY

### HARLAN

**Richard G. Stoltzfus, MD**

Ages-Brookside KY

### JEFFERSON

**Hirikati S. Nagaraj, MD**

Louisville KY

**Robert W. Powell, MD**

Louisville KY

### SIMPSON

**J. Michael Pulliam, MD**

Franklin KY

## New Members

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members of these organizations.*

### HENDERSON

**Arshad I. Husain, MD**

Newburgh

1992, Topiwala National Medical College/  
T.N. Medical College

**HC**

### JEFFERSON

**Saima B. Memon, MD**

Louisville

2001, Aga Khan Medical College

**PUD**

### KENTON

**Steven C. Bailey, MD**

Villa Hills

1967, Ohio State University

College of Medicine, Columbus

**NS**

### LESLIE

**Srinivasa R. Appakondur, MD**

Hazard

1994, University of Santo Tomas

**C**

## Obituaries

**Jeffrey A. Hilb, MD**

Louisville, KY

**1946-2011**

Jeffrey A. Hilb, MD, a retired internist, died March 16, 2011. Dr Hilb graduated from the University of Illinois College of Medicine, Chicago, in 1975, and he was a Life member of KMA.

**Laszlo Makk, MD**

Louisville, KY

**1932-2011**

Laszlo Makk, MD, a retired pathologist, died April 9, 2011. A 1960 graduate of Albany Medical College, Dr Makk was a Life member of KMA.

**Fred Pipkin, MD**

Louisville, KY

**1926-2011**

Fred Pipkin, MD, a retired pediatrician, died April 3, 2011. Dr Pipkin graduated from the Vanderbilt University of Louisville School of Medicine, Nashville, in 1952 and was a Life member of KMA.



**Edward Scofield, MD  
Louisville, KY  
1939-2011**

Edward Scofield, MD, a retired thoracic surgeon, died April 3, 2011. A 1964 graduate of the University of Louisville School of Medicine, Dr Scofield was past president of the Jefferson County (Greater Louisville) Medical Society and a Life member of KMA.

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### News-makers

**Kentucky Physician Named 2011 Emergency Department Director of the Year**

Blue Jay Consulting and the Emergency Medicine Foundation (EMF) recently announced that **Royce D. Coleman, MD, FACEP**, had been named the 2011 Emergency Department Director of the Year. Medical director at the University of Louisville Hospital and associate professor at the University of Louisville, department of emergency medicine, Dr Coleman was honored at the Emergency Department Directors Academy in Dallas, TX, on Monday, May 2.

The Blue Jay Consulting/Emergency Medicine Foundation Emergency Department

Director of the Year Award recognizes current emergency department physician leaders who made significant impacts on improving the operations of their departments, resulting in improvements in the quality of patient care.

**Morton Kasdan, MD, honored by U of L Medical Student Senate**

Each year the University of Louisville Medical Student Senate sponsors the Fitzbutler Humanitarian Award, a distinguished lecture series. On April 25, this year's award was presented to **Morton Kasdan, MD**, a Louisville plastic and hand surgeon. This humanitarian award honors a medical practitioner who has made a significant contribution to the art and practice of medicine. She or he must support

the spirit imparted by the Hippocratic Oath. Dr Kasdan is pictured here with KMA President Gordon Tobin, MD.



# AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the three highest awards the Association presents:

1. KMA Distinguished Service Award (Member Physician)

- Contributions to organized medicine
- Individual medical service
- Community health, education and civic betterment
- Medical research
- Distinguished voluntary military service

2. KMA Outstanding Layperson (Nonphysician)

- Outstanding accomplishment in the field of public health and/or medical care

3. KMA Physician Community Service Award (Member Physician)

- A physician who has served with great esteem in his or her local community or region

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award, the KMA Outstanding Layperson Award, and the KMA Physician Community Service Award. Any county society or individual member may suggest nominees to the committee. Nominations must be received no later than July 15 to be considered. The awards are presented at the President's Dinner during the KMA Annual Meeting.

## AWARD NOMINATION FORM

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Place: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Children: \_\_\_\_\_

☐ Distinguished Service Award  
(Member Physician)

☐ Outstanding Layperson Award  
(Layperson)

☐ Community Service Award  
(Member Physician)

Education: \_\_\_\_\_

Military: \_\_\_\_\_

Membership in Professional Organizations: \_\_\_\_\_

Membership in Civic Organizations: \_\_\_\_\_

Honors and Awards: \_\_\_\_\_

(Describe nominee's qualifications and other pertinent information that the Awards Committee may consider in making its decision)

Name of Person or Group Submitting Nomination: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_

(Office) \_\_\_\_\_

Please complete and mail to: KMA, Attn: Awards Committee, 4965 US Hwy 42, Ste 2000, Louisville, KY 40222-6301

Deadline for receiving nominations is July 15.

# EDUCATIONAL ACHIEVEMENT AWARD NOMINATIONS

The KMA Continuing Medical Education Committee is accepting nominations for the Educational Achievement Award.

- Nominee must be a resident of Kentucky who has made a significant contribution in medical or medically related education
- Nominee who has made contributions in all areas of teaching, research, clinical application in medical practice, patient education and ancillary involvement (civic, professional society, etc) will be considered.
- Nomination may be strengthened by including supporting letters from residents, students, or others who have benefited from his/her teaching.

## EDUCATIONAL ACHIEVEMENT AWARD NOMINATION FORM

**Nominee's Name:**

**Address:**

**City:**

**State:**

**Zip:**

**Office Phone:**

**Home Phone:**

Describe nominee's qualifications and other pertinent information which the CME Committee may consider in making its decision (attach additional page if needed):

***Attach nominee's curriculum vitae, together with three (3) supporting letters from peers indicating his/her qualifications for the award.***

**Person Submitting Nomination**

**Phone**

**Email**

Please fill in and mail to: KMA, Attn: CME Committee, 4965 US Hwy 42, Ste 2000, Louisville, KY 40222

**Deadline for receiving nominations is July 15.**

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