

THE MARYLAND
familydoctor **WINTER 2010**

The official journal of the Maryland Academy of Family Physicians

**SELECTED TOPICS
IN CHRONIC DISEASE
MANAGEMENT**

**Family Physicians Best Suited for
Chronic Disease Management**

**The Recognition and Treatment
of Depression in Family
Medicine, Part I**

**Screening for Depression in
Maryland Adolescents**

**Chronic Hepatitis B: Advances in
Diagnosis and Treatment**

**Fear of Insulin:
A Resident's Diabetes Education**

ALSO...

**AAFP Advocacy
Guidelines (Principles)
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Family Physicians Best Suited for Chronic Disease Management

by Trang M. Pham, M.D.



CHRONIC DISEASES—SUCH AS HEART disease, cancer and diabetes—are the leading causes of morbidity and mor-

tality in the United States. Each year they account for seven out of 10 deaths among Americans (more than 1.7 million people). They also cause major disabilities for one-

fourth of Americans. In addition, they are responsible for one-third of the years of potential life lost before the age of 65. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. Adopting healthy lifestyles such as eating nutritious foods, being physically active and avoiding tobacco use can prevent or control the destructive effects of these diseases.

Chronic diseases affect all countries, and the increase in their prevalence is largely attributable to changing demographics, increased life expectancy, changing lifestyles, better disease management and treatment and a better understanding of the factors that cause poor health and disease. In 2005, 133 million people, almost half of all Americans, lived with at least one chronic condition. The medical care costs of people with chronic diseases account for more than 75 percent of the nation's \$2 trillion medical care costs. According to the Centers for Disease Control and Prevention, "The United States cannot effectively address escalating health care costs without addressing the problem of chronic disease."

The CDC's National Center for Chronic Disease Prevention and Health Promotion

is leading the nation's efforts to prevent and control chronic diseases. The center conducts studies to improve understanding of the causes of these diseases, supports programs to promote healthy behaviors and monitors the health of the nation through surveys. These efforts are supported by partnerships with state health and education agencies, voluntary associations, private organizations and other federal agencies.

There are numerous flaws in our current health system that make it difficult to effectively and efficiently care for chronically ill patients. The following are some challenges presented by the system:

- The disjointed nature of the health system requires patients to have multiple care providers who lack adequate communication with each other and who are not individually or collectively responsible for the patients' entire care.
- Despite the fact that the overwhelming proportion of care needed by chronically ill patients is self-administered, health care is centered around care in doctors' offices or hospitals.
- High-cost medical interventions are rewarded over higher-value primary care, as well as volume of care over quality of care, by the current payment system.
- Increasing costs to patients (i.e., deductibles and co-pays) lead to decreasing patient use of chronic disease services that contribute to effective disease management and cost control.

With 75 percent of all U.S. health expenditures related to chronic disease treatment and two thirds of cost increases driven

by the rising prevalence of it, most would agree that growth in America's health care costs cannot be effectively managed without reforming the delivery of chronic disease care. One step toward such reform is to improve patient access to primary care and increase utilization of services. Family physicians are at the forefront of health reform because they possess the knowledge and skills to properly manage patients with chronic illnesses.

I am pleased to present this edition of *The Maryland Family Doctor* which focuses on chronic disease management of selected topics. We have some excellent feature articles, which we hope you will find enlightening and clinically relevant. Dr. Loc Le presents advances in diagnosis and treatment of chronic hepatitis B. Dr. Kevin Ferentz addresses depression (in adults), while Drs. Eileen Birmingham and Kenneth Lin review depression screening in Maryland adolescents. Our resident editor, Dr. Salah Al-Abbadi, discusses insulin and the current ADA consensus statement in type 2 diabetes. The AAFP Advocacy Guidelines for Health System Reform are also included in this edition, as well as the results of the October 2009 MAFP Membership Survey presented by MAFP Executive Director Esther Rae Barr. ■

Dr. Pham, who practices in Pasadena, is MAFP Southern District vice president and member of the MAFP Editorial Board (EB). She began her involvement on the MAFP EB while still a resident at the University of Maryland Family Medicine Residency, later joining the EB in her first year of practice. She edits this, her 2nd edition.

Note: References for this article are posted at [www.mdafp.org/publications and news tab](http://www.mdafp.org/publications_and_news_tab).



Membership Survey Results Are In!

by Esther Rae Barr, CAE



IF YOU ARE AN MAFP member who participated in the October, 2009, MAFP Membership Survey, I, on behalf of the leadership, thank you for contributing your thoughts and suggestions for the Maryland Academy as we move forward. We are grateful for the 112 responses received, comprising 12 percent of those sent to members via electronic means. In review of the survey responses, we conclude that the pulse is strong and that we are generally on the right track.

Many of you clearly voiced your concerns, and we appreciate any and all comments from members. This level of participation and interest is encouraging as we strive to fulfill our mission which is "Able, Responsive Family Physicians Serving Their Communities." Even members who didn't participate in the survey but continue to put their trust in MAFP by belonging, help the organization set goals which will address their professional needs.

MAFP leadership continues to review and analyze the data. The goal will be to consider the information obtained from members as the future course for the organization is charted. Complete survey results are posted at www.mdafp.org. Please take a look. In the meantime, here is a recap and a few additional thoughts.

Environmental Focus

We asked you to rank the areas with the greatest relevance to current practice, patients, MAFP service and your practice over the next three years. In order they were: tort reform and medical liability policy (61.9%); multiple disease management (57.4%); reimbursement, contract negotiations or managed care issues (56.8%); and managing practice more effectively to improve financial performance (55%).

Despite combined efforts by MAFP, along with the other primary care specialty societies in Maryland and MedChi's efforts, physician payment in our state continues to be about the lowest in the nation. Just prior to this writing, the national Congressional initiative to revise the Medicare payment schedule failed in Congress. Other current health care reform initiatives appear to address the disparity in primary care physician payment, but who knows what will have occurred by the time this edition is in print? MAFP will remain diligent and continue to work for ultimate improvement. At least there seems to be new awareness about what family practice/primary care is, along with the realization that the

practice environment must change if there is to be meaningful reform. The task is monumental.

On the item of effective practice management services, *e.g.*, contract review, electronic health records, many expressed need for assistance and information. We fully understand that this is an all-important area for most members and that perhaps MAFP should offer additional services. Available now is an excellent resource for information from AAFP's Delta Exchange, an interactive web-based practice management site (see ad on back cover). For a small monthly fee of \$30, enrollees are afforded an exclusive online practice learning network dedicated to physicians, clinical staff and office staff. Enrollees can access information, ask questions, share documents, collaborate on solutions, discuss issues and connect with like practices. We also encourage members to explore the TransforMED site (for practice assessment and transformation assistance) by clicking on the icon at www.mdafp.org. MAFP is a TransforMED partner, joining with them to serve our members in this area.

Internal Focus

We asked members to share their opinions about MAFP services such as publications, CME offerings, legislative advocacy, committee activities, etc. It is encouraging that members gave us positive feedback in each area. Suggestions will be taken to heart. For example, readership of this publication is high (82.6%), but 45 percent would like to see a change to an all-digital version. This transformation has been discussed, but for the time being, we will continue to print. Stay tuned. I believe a digital publication is

Complete survey results are posted at www.mdafp.org. Please take a look. In the meantime, here is a recap and a few additional thoughts.

in the offing, either exclusively or as an option. MAFP has embraced technology, making full use of our website in promotion of events and posting of CME materials and using the E-Bulletin and broadcast email capability for immediate information and alerts. "Everything is up-to-date" at MAFP!

The open-ended area of the survey gave members the opportunity to expound, opine, praise and complain. Twenty-seven members made comments. Eight expressed a desire for MAFP to eliminate the MAFP CME requirement (policy appears at www.mdafp.org). With the policy in effect since 2001, leadership appreciates members' compliance and has continued to reaffirm the policy when intermittent discussions have come up at MAFP Board meetings. For the most part, members are aware of and compliant with the requirement. Members do have

recourse, however, through a stipulation in the Bylaws (available at www.mdafp.org) to initiate Bylaws amendments which, if voted by a majority of members present at the Annual Business Meeting where such amendments are considered and voted, would change MAFP duly enacted policies. To date, two past such initiatives with regard to the MAFP CME requirement have not netted enough votes to change the policy.

The survey shows that, mostly, we are on the right track, with 67.6 percent indicating agreement with decisions and policies of MAFP leaders and 66.7 percent expressing approval of the general directional course of MAFP. We do know, however, that we must remain diligent, flexible and willing seek improvements to better serve members. This will be done. MAFP values its members. We are listening. ■



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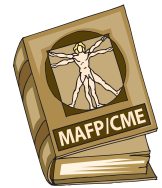
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The Recognition and Treatment of Depression in Family Medicine

Part 1

by Kevin Scott Ferentz, M.D.



This is the first part of a two-part article regarding the common problem of depression. Part I deals with the demographics, etiology, diagnostic criteria and differential diagnosis of depression. Part II will deal with treatment issues.

DEPRESSION IS ONE OF the most common diagnoses seen by family physicians. The frequency of mental disorders in general practice varies from 11 percent to 36 percent. Family physicians see patients with depression on almost a daily basis, and generally feel comfortable with their role in recognizing and treating depression. In one survey, 87.5 percent of family physicians indicated that it was their responsibility to treat depression, compared with 73 percent of general internists and 41 percent of obstetricians/gynecologists surveyed. Among family physicians, 35 percent were very confident and 48 percent were mostly confident about their overall ability to manage depression.

The majority of patients with depression are treated in the primary care setting. The training of family physicians allows for the vast majority of depressed patients to be cared for in their practices. Patients view their family physician as the preferred provider to care for mental health issues.

Relatively few patients with depression need to be referred, primarily those with severe depression that is not responsive to several trials of antidepressants, as well as patients that become psychotic or seriously suicidal. Should referral be needed, the family physician is in the ideal situation to recommend either psychotherapy or psychiatric care.

Demographics

The lifetime prevalence of depression is currently believed to be 16.2 percent, with a 12-month prevalence of 6.6 percent. The breakdown in terms of severity is 10 percent mild, 39 percent moderate, 38 percent severe and 13 percent very severe. An episode of depression lasts an average of 14 weeks. Depression is a disabling condition, with 59 percent of patients reporting severe or very severe role impairment. People with depressive symptoms have worse physical functioning than patients with back problems, arthritis, diabetes or hypertension.

In 2000, Unipolar Major Depression was the fourth leading cause of disability worldwide. By 2020, depression is predicted to be the second leading cause of disability, second only to ischemic heart disease. Unfortunately, only about half of patients with depression are treated, and treatment is adequate in only 41.9 percent. The end result is that only one in five patients with depression is being adequately treated.

While anyone of any age can experience an episode of depression, women are twice as likely to be affected as men. The peak age of onset is 20–40 years, so women in the childbearing years are the most common group seen. A family history of a primary relative (parent, sibling or child)

with depression more than doubles the risk to an individual. There are higher rates of depression in people that are separated, widowed or divorced. Married males have lower rates of depression than men who were never married, while married females have higher rates than women who were never married. The more chronic medical conditions a patient has, the more likely they will experience an episode of depression. Multiple medical problems can lead to attributing symptoms of depression to physical illness, i.e., fatigue. When faced with the possibility of depression, it is more likely that symptoms that overlap with medical concerns are actually due to depression. No matter what physical conditions a patient has, physical disease is never a “good reason” for depression.

A depressed parent can also have a profound effect on his or her children. Depression clearly impairs a parent’s ability to parent effectively. There is evidence that children who live with a depressed parent are less involved, more resentful, less affectionate, more distant and more irritable. They are also twice as likely to abuse their children. The children themselves are at increased risk for depression, substance abuse, psychopathology and learning disabilities. Treating a parent for depression can therefore have far-reaching benefits for all family members.

Etiology

Despite decades of research, medical science has not identified the biochemical underpinnings of depression. The prevailing theory is the monoamine-deficiency hypothesis, which links depression with decreased levels of the neurotransmitters norepinephrine and serotonin.

Many patients with depression do have decreased levels of these neurotransmitters in their blood and CSF, but this is by no means seen universally. The available antidepressants appear to work by blocking the uptake of these neurotransmitters, causing their persistence in the synapse. Other theories involve dysfunction of the hypothalamic-pituitary-adrenal axis. While genetics play a role in some patients with depression, no single "depression gene" has been identified. Psychological and social factors are commonly seen in many patients, but not in all. Stressful life events may precipitate an episode of depression within six months of the event.

Diagnostic Criteria

In order to meet criteria for a Major Depressive Episode, patients must have at least two weeks of symptoms. According to the Diagnostic and Statistical Manual (DSM) - IV criteria, at least five symptoms must be present. One of the two major criteria must be present: depressed mood most of the day, nearly every day; or diminished interest or pleasure in activities (anhedonia). The simplest way to ask about anhedonia is: "What do you do for fun?" Generally speaking, people with anhedonia no longer experience pleasure in the activities they used to enjoy, such as sex. Other symptoms that may be present include: a major change in appetite or weight; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feeling worthless, having excessive/inappropriate guilt; decreased ability to think, concentrate, indecisiveness; or recurrent thoughts of death, dying or suicide

A common mnemonic device for the diagnostic criteria is SIG.E.CAPS (which should also include a "D" for depressed mood):

- D** depressed mood
- S** sleep disturbance
- I** interest
- G** guilt

- E** energy
- C** concentration
- A** appetite
- P** psychomotor retardation/agitation
- S** suicidal thoughts

While depression is usually diagnosed using a structured interview which asks about these cardinal symptoms, clinicians would benefit greatly from the use of the Patient Health Questionnaire (PHQ) -9. There are many advantages to using a PHQ-9 to make the diagnosis. Most patients complete the questionnaire in several minutes. Patients can be given the questionnaire to fill out while another patient is being seen. Most importantly, the PHQ-9 not only helps make the diagnosis, but it also gives clinicians an idea of how depressed a patient is. Scoring of the PHQ-9 is as follows:

- 0-4 Non depressed
- 5-9 Mild
- 10-14 Moderate
- 15-19 Moderately severe
- > 20 Severe

Patients should also be given a PHQ-9 to complete at each follow-up visit so as to assess the effectiveness of treatment. The questionnaire is available at no charge on many web-sites and can be copied (see References).

Diagnostic Challenges

Patients with depression presenting to their family physician will often complain of a somatic concern. This is often due to the various physical complaints that accompany depression. For many patients, though, a somatic complaint is the "ticket in" to our offices. Many patients feel uncomfortable telling a scheduler or a nurse that they are seeing us for a psychiatric issue. Because of this, family physicians must often look past the presenting complaint to consider the diagnosis of depression. Complaints such as fatigue, vague symptoms, bowel dysfunction, palpitations, headache and dizziness may actually be due to depression, especially in young healthy patients.

The likelihood of depression increases with increasing numbers of physical symptoms. If the depressed patient does report a psychiatric complaint, it is often anxiety. Whenever depression is considered, simply ask about the two major diagnostic criteria ("Have you been feeling depressed?" and "What do you do for fun?"). If both are negative, the likelihood of depression is small. However, one can always administer a PHQ-9 if in doubt.

Differential Diagnosis

Various medical problems can present with symptoms similar to depression. One should certainly consider hypothyroidism in a patient with fatigue, weight gain and psychomotor retardation. There are, however, no specific laboratory tests that all patients with depression should undergo to "rule out" medical illness before making a diagnosis of depression. On the contrary - family physicians should "rule in" depression by taking an appropriate history and performing a limited physical exam. Laboratory evaluation should only be undertaken if indicated by findings on the history or physical.

Almost any medication can cause symptoms of depression, so a careful medication history should be taken, especially including over-the-counter medications and supplements. Patients presenting with "sadness" are not necessarily depressed, and may be experiencing a mood disturbance due to life circumstances. These patients are more likely suffering from an "adjustment disorder," which is treated with supportive psychotherapy. Patients who are depressed for several months after the death of a loved one are experiencing bereavement, which is usually not treated with antidepressants, but with small amounts of benzodiazepines, if necessary. Should the mood disturbance extend beyond several months, or sig-

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nificantly interferes with the patient's life, antidepressants may be indicated.

Some patients with depression actually have bipolar disorder. It is important to try to make the diagnosis before placing a patient on anti-depressant medication as antidepressants alone can "flip" the patient into a hypomanic or manic state. Some patients, however, have their first hypomanic or manic episode after being placed on antidepressants, so while a history of bipolar disorder should be asked about, family physicians should not hesitate to start antidepressants for fear of causing hypomania or mania. Should that happen, the diagnosis of bipolar disorder is then made. One can screen for bipolar disorder using the Mood Disorder Questionnaire (MDQ). The MDQ is available on-line at no charge (see References). Only a small percentage of depressed patients actually have bipolar disorder.

Approximately 75 percent of patients with depression have comorbid DSM-IV disorders, mostly anxiety disorders. While most antidepressants are also effective for these disorders, it is important for family physicians to make an accurate diagnosis of an anxiety disorder (panic attack/panic disorder, agoraphobia with or without panic, specific and social phobia, obsessive-compulsive disorder, posttraumatic stress disorder, acute stress disorder and generalized anxiety disorder). The diagnostic criteria for these disorders can be found in the DSM-IV Primary Care Version, which is a useful reference tool that all family physicians should consider owning.

Many patients with depression and other psychiatric disorders abuse substances as a way to self-medicate. It is critically important for all patients to be asked about their use of drugs and alcohol. An appropriate question to start the conversation is "How do you use alcohol?" Patients that become defensive often have a problem. It is then appropriate to administer the four-question CAGE questionnaire:

C - Have you ever felt the need to cut down on your use of drugs or alcohol?

A - Have you ever felt angry if someone said you drink or drug too much?

G - Have you ever felt guilty about something you did while drinking or drugging?

E - Have you ever felt the need to take a drink first thing in the morning? (eye opener)

One positive response indicates a problem with alcohol or drugs.

Natural History

The symptoms of depression typically develop over days to weeks. Left untreated, an episode of depression lasts 14 weeks on average and then symptoms remit in the majority of patients. However, 20-30 percent of patients will only have a partial remission, 5-10 percent will have chronic depression and more than 50 percent will have a recurrence at some point. The more prior episodes, the more likely the patient will have a subsequent episode.

Suicide

Suicide is the 11th leading cause of death in the U.S. Approximately 15 percent of severely depressed patients commit suicide, leading to 31,000 deaths per year. There are 18 attempts for every completed suicide. Women typically attempt suicide with less lethality (taking pills) while men succeed by shooting or hanging themselves. The rates of suicide are highest for men over the age of 65. Most patients who commit suicide have seen a physician within the month before. Risk factors for suicide include:

- Elderly
- Unmarried
- White
- Male
- Prior depression
- Current suicidal thoughts
- Living alone
- Prior attempts
- Family history of suicide

Current stressors - job loss, death in family

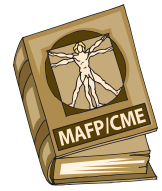
Substance abuse

All depressed patients must be asked about their suicidality. An appropriate question is: "Have you had thoughts about death or about killing yourself?" Many patients admit they have had suicidal thoughts, but quickly state they would never commit suicide. If the answer is "yes," additional questions should be asked such as what means would they use (gun, poison), whether they have rehearsed, how strong is their intent and whether they can resist the impulse.

If you believe the patient is an immediate risk, have someone stay with the patient while you call a psychiatrist with admitting privileges. If you are unable to find a psychiatrist, if the patient refuses to see one or the patient leaves the office, call the police. If the risk is not imminent, involve a family member or friends who can provide vigilance and remove the means to commit suicide. Increase your contact with the patient by calling them and seeing them more often. Appropriately treat their depression and any other disorder, such as alcohol abuse. Small amounts of a benzodiazepine may be helpful. Unfortunately, "contracting for safety" (having the patient promise they will not commit suicide before seeing their therapist, or before the next visit) is not an effective defense if faced with an angry family after a loved one commits suicide. Patients who are seriously suicidal must be evaluated by a competent mental health professional. ■

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Note: References for this article are posted at www.mdafp.org; publications and news tab.



Screening for Depression in Maryland Adolescents

by Eileen Birmingham, M.D., MPH, and Kenneth Lin, M.D.

MAJOR DEPRESSIVE DISORDER (MDD) is a common condition among adolescents. Data from national surveys indicate that in Maryland almost 9 percent of youths aged 12-17 suffer from MDD in any given year.¹ MDD is associated with decreased school performance and social functioning, early pregnancy and increased risk of substance abuse.² These impairments often continue into young adulthood and beyond. Depressed youths are five times more likely than non-depressed youths to attempt suicide, and as many as 8 percent of teens with MDD are estimated to successfully complete suicide by young adulthood.³ Despite the heavy burden of disease, most cases of MDD in adolescents remain undiagnosed. Improving screening, treatment and referral programs within the primary care setting can help to more quickly alleviate suffering.

In March 2009, the U.S. Preventive Services Task Force (USPSTF) recommended screening adolescents aged 12-18 years for MDD⁴. The recommendation includes an important caveat, however: "The USPSTF recommends screening adolescents for MDD when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal) and follow up." In settings where both time and mental health services are often limited,

how can you successfully incorporate this recommendation into your practice?

When deciding to adopt a screening program, you should carefully consider the needs of both your patient population and your particular practice. One way to initiate a program is to develop a systematic, logical protocol to identify adolescents at risk for depression. While the USPSTF does not recommend a specific screening tool, instruments that have been validated in this population include the Beck's Depression Inventory-Primary Care Version⁴ and the Patient Health Questionnaire for Adolescents.⁴ A toolkit specifically designed for use in the primary care setting is available (see box below). It is important to remember that screening instruments, often in the form of checklists, are not diagnostic tests. Both positive and negative results must be interpreted carefully, and providers should use their clinical judgment at all times. Positive results on initial screening tools should prompt further evaluation and care.

For a screening program to be worthwhile, your practice must ensure access to effective treatment when indicated. Research has shown that depression in adolescence is a treatable condition. Current evidence-based treatment options include

psychotherapy, pharmacotherapy and a combination of both. Currently, fluoxetine (Prozac) is the only SSRI approved by the FDA for use in children and adolescents. Decisions about treatment must be made in the context of what is available and acceptable to the patient and family. It is important to foster partnerships with local mental health providers to facilitate timely entry into care when it becomes necessary.

The USPSTF found no evidence on the harms of screening for depression in youths, nor did it find evidence of harms from psychotherapy. It did, however, find evidence about the risk of pharmacotherapy, specifically, selective serotonin reuptake inhibitors (SSRIs). Conservative estimates from analyses of trials demonstrated that treatment with antidepressants leads to a 1 to 2 percent increase in the absolute risk of suicidality.⁴ There were no actual suicides in these studies. In 2004, the FDA issued a public warning about the risk of increased suicidal thoughts and behavior in children and adolescents treated with SSRIs. In 2006, the agency amended the warning to include young adults under the age of 25. The USPSTF also found evidence that antidepressant use may increase the risk of conversion from unipolar depressive disorder to bipolar disorder. A comprehensive review of pediatric trials indicates that the benefits of pharmacotherapy for depressed adolescents are likely to outweigh the harms.⁵ Treatment with SSRIs requires a thorough diagnostic evaluation prior to the start of therapy and careful ongoing clinical monitoring throughout the treatment period.

All primary care practices must be prepared to deal with suicidal ideation when it is detected under any circumstances.

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Screening Adolescents for Depression: Selected Resources

- A full summary of the USPSTF recommendation, including supporting documents: <http://www.ahrq.gov/clinic/uspstf/uspstfdepr.htm>
- A Toolkit specifically designed for use in Primary Care Settings: <http://www.innovations.ahrq.gov/content.aspx?id=2545>
- Assistance with Maryland-based resources: <http://www.dhmd.state.md.us/mha/howtogethelp.html>
http://maryland.valueoptions.com/services/how_to_receive_svcs.htm
- **Maryland Youth Crisis Hotline: (Available 24 hours a day, 365 days a year): 1-800-422-0009.**



Chronic Hepatitis B: Advances in Diagnosis and Treatment

A Review

by Loc T. Le, M.D.



IN THE PAST FEW years, numerous advances in the diagnosis and treatment of chronic hepatitis B infection have been made. There is a much better understanding of the natural history of chronic hepatitis B infection, resulting in better methods of detecting and monitoring the viral DNA, genotyping and development of several highly potent antiviral agents.

Epidemiology

Due to rapid globalization, the worldwide distribution of hepatitis B is constantly changing. Globally, an estimated 350-400 million people are chronically infected with the hepatitis B virus (HBV) and up to 15-40 percent are at risk of developing cirrhosis and/or hepatocellular cancer (HCC). Approximately 45 percent of the world population is living in a highly endemic area with the prevalence of >8 percent among adults. The countries of intermediate HBV infection endemicity have a prevalence of 2-7 percent. Therefore, the recent 2008 CDC guidelines for hepatitis B screening include persons born in the region of >2 percent prevalence who have immigrated to the United States. In the U.S., the prevalence of the HBV infection is about

0.4 percent (~1.25 million individuals) of which more than 50 percent are Asians (South and Southeast Asians, Chinese and Koreans) and Pacific Islanders.



Transmission

Hepatitis B virus is extremely infectious. A viremic person can carry an extremely high viral concentration (>10¹² virions/ml) in the blood. It is also found in other body fluids such as semen, vaginal secretions and saliva. The virus may be transmitted horizontally or vertically. Horizontal transmission occurs in adults through several methods, including intravenous drug use, cocaine snorting and homosexual as well as heterosexual promiscuity. In endemic countries, the primary mode of transmission is vertical at birth from mother to child. However, in the hyperendemic areas, intra-familial horizontal transmission usually occurs in children under five years of age.



Natural History of Chronic Hepatitis B

A patient is considered to have chronic HBV infection only if he or she has hepatitis B surface antigen (HBsAg) longer than six months. The risk of chronic HBV infection after acute exposure is related to the patient's age at the time of exposure: 90 percent in the neonates of the HBV positive mothers, 25-30 percent in children under 5 and less than 5 percent in adults. Immunosuppressed individuals are also at higher risk for chronic infection after acute exposure. It is estimated that 15-40 percent of the chronically infected HBV patients will develop serious complications during their lifetime. During the course of illness, patients usually go through different phases.

In the initial phase of chronic HBV infection, the HBV viral load is high, but the serum ALT is low or normal, and there is minimal liver tissue injury (*Immune Tolerant Phase*). As the disease progresses, many of these patients will develop active inflammation, and the ALT becomes elevated while the HBV DNA level is lower (*Chronic Active Phase*). Among these patients, the rate of clearance of HBe antigen (HBeAg) and development of Anti-HBe antibody is about 8-12 percent per year. This is referred to as HBe seroconversion. As the HBe antigen clears, a brief exacerbation of hepatitis with elevation of ALT is frequently observed. After spontaneous HBe seroconversion, 67-80 percent of the patients will have very low or undetectable HBV DNA levels and normal ALT. The liver biopsy usually shows minimal inflammation (*Inactive Carrier Phase*). It is

observed that 4-20 percent of the inactive carriers will revert back to HBeAg(+) at least once. Approximately 10-20 percent of inactive carriers may have reactivation of the HBV replication and active hepatitis even after several years of inactive disease (*Reactivation Phase*). HBe seroconverted individuals have a reduced risk of progressive liver disease and better survival compared to those who do not achieve HBe seroconversion.

After many years of persistent viral replication and reactivation, many patients develop HBeAg(-) hepatitis, which is characterized by elevated ALT, elevated HBV DNA level and active hepatocellular inflammation. The majority of the HBeAg(-) patients have the variant HBV with mutations in the precore or core promoter region. These patients have lower HBV DNA levels compared to the HBeAg(+) patients and tend to have more advanced liver disease.

The rate of HBsAg spontaneous clearance is about 0.5 percent per year. These patients will develop hepatitis B surface antibody (HBsAb), but up to 50 percent of them will still have a low serum HBV DNA level. The patients who are able to clear the HBsAg and develop the HbsAb will have a much better prognosis. However, since cirrhosis may already occur prior to the HBsAg clearance, some may still develop hepatocellular carcinoma (HCC) and cirrhosis.

It is estimated that 15-40 percent of patients with chronic HBV infection will develop complications from the disease during their lifetime. Several factors are known to be associated with the progression of HBV-induced liver disease leading to cirrhosis: older age, high DNA level, alcohol, smoking and concurrent infection with Hepatitis C, Hepatitis D and HIV. Male gender, older age, family history of HCC, presence of cirrhosis, HBV genotype C, co-infection with Hepatitis C, core promoter mutation and a high DNA level are associated with higher risk of HCC. However,

it is observed that 30-50 percent of the HCC associated with HBV infection occur in patients without cirrhosis. Patients with HBV and HIV co-infection usually have high HBV DNA, lower rate of seroconversion and high liver related mortality.

Screening and Evaluation

Screening:

In September 2008, the Centers for Disease Control and Prevention (CDC) issued the expanded guidelines designed to increase HBV detection in the US. The main goals of the HBV serologic testing are to prevent disease transmission and to develop treatment strategies for patients with chronic HBV infection. The table below summarizes the CDC guidelines by grouping the patients at risk into *Country of Origin, Lifestyle* and *Clinical Presentation*. The new guidelines can be accessed online at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr7709a1.htm>.

Risk Category	Test	Frequency
Country of Origin (Africa, Asia, Europe, etc.)	HBsAg	Once
Family history of HCC	HBsAg	Once
Sexual partners (multiple, etc.)	HBsAg	Once
Occupational exposure (healthcare, etc.)	HBsAg	Once
Injection drug use	HBsAg	Once
End-stage liver disease	HBsAg	Once
Chronic kidney disease	HBsAg	Once
Chronic liver disease	HBsAg	Once
Chronic hepatitis C	HBsAg	Once
Chronic hepatitis D	HBsAg	Once
Chronic HIV	HBsAg	Once
Chronic hepatitis B	HBsAg	Once

Evaluation

Initial evaluation of patients with chronic HBV infection should include a comprehensive history and physical examination, behavioral history (drug, alcohol, smoking, number of sexual partners), personal and family history of liver disease and family history of hepatocellular carcinoma. Serologic tests should include HIV, HCV and HDV antibodies. Markers for HBV replication (HBe antigen, antibody and quantitative HBV DNA), serum ALT and Alpha-Fetoprotein (AFP), PT/INR and serum albumin are also important initial blood tests. Additionally, patients with advanced

liver disease should have an initial liver ultrasound, and a liver biopsy to establish the stage and grade of infection. All patients with chronic HBV infection should be checked for hepatitis A (HAV) immunity, and HAV vaccination is indicated if immunity has not been established. In the past year, the commercial laboratories LabCorp and Quest Diagnostics have provided HBV genotype testing. There are eight different HBV genotypes (A, B, C, D, E, F, G, H) distributed throughout different areas of the world. Genotyping is important because there are wide differences in virulence and viral response to different antiviral medications.

Since there is potential confusion when interpreting the HBV serologic tests, the CDC has also provided recommendations for HBV serologic interpretation as shown below.

HBsAg	HBeAg	Anti-HBe	Anti-HBc	Interpretation
+	+	-	+	Chronic HBV infection
+	-	+	+	Chronic HBV infection
+	-	-	+	Chronic HBV infection
+	-	+	-	Chronic HBV infection
-	-	-	+	Resolved HBV infection
-	-	+	-	Resolved HBV infection
-	-	-	-	Resolved HBV infection
-	-	-	+	Resolved HBV infection
-	-	+	+	Resolved HBV infection
-	-	-	-	Resolved HBV infection

Treatment

The goal of treatment for chronic HBV infection is to completely suppress the HBV replication to prevent the progression of liver disease to cirrhosis, liver failure and hepatocellular carcinoma (HCC). Currently, there are seven FDA-approved drugs for the treatment of chronic HBV infection. The oral antiviral medications include Lamivudine, Adefovir, Entecavir, Telbivudine and Tenofovir. The injectable forms include standard Interferon Alfa 2-a and Pegylated Interferon Alfa 2-a. Of the oral medications, Tenofovir and Adefovir are nucleotide analogues, while

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Lamivudine, Entecavir and Telbivudine are nucleoside analogues.

As of 2009, the approved first line anti-Hepatitis B medications are: Entecavir, Tenofovir and Pegylated Interferon Alfa2-a. This is due to the high viral resistance and lower efficacy associated with the other drugs. The resistance rate in the Lamivudine-treated patients is as high as 70 percent after five years while the Adefovir-treated patients have a resistant rate of only 29 percent after five years.

PegInterferon-alfa: (180mcg sq injection/week). The advantages of PegInterferon-alfa are: finite duration of treatment (48 weeks), absence of resistance and somewhat higher rate of HBe and HBs seroconversions compared to the oral nucleos(t)ide analogues. However, it is a weekly subcutaneous injection with significant side effects. In the HBeAg(+) patients, the rate of HBe seroconversion after 48 weeks of treatment is 27 percent compared to 20 percent in the Lamivudine treated group. Twenty-four weeks after treatment was stopped, the sustained response rate was 32 percent compared to 19 percent in the Lamivudine treated patients. In the HBeAg(-) patients, the response rate is much less: 15 percent in the PegInterferon-treated patients and 6 percent in the Lamivudine patients after 72 weeks. Therefore, the strongest predictors for response to PegInterferon-alfa are HBeAg positivity, high histologic activity index, high ALT level and low HBV DNA level. Additionally, HBV genotypes A and B are known to respond better than genotypes C and D.

Entecavir (Baraclude): (0.5mg QD, 1.0mg QD in Lamivudine resistant patients). Entecavir is a very potent nucleoside analogue. Compared to Lamivudine, it is more effective in histologic improvement (72% vs 62%), HBV DNA suppression (67% vs 36%) and ALT normalization (68% vs 60%) after 48 weeks of treatment in HBeAg(+) patients. The HBe seroconversion rate is 21 percent vs 18 percent.

Treatment results after the second year are even better with HBV DNA suppression (81% vs 39%) and ALT normalization (79% vs 68%). It is equally effective in the HBeAg(-) patients with histologic improvement (70% vs 61%), HBV DNA suppression (90% vs 72%) and ALT normalization (78% vs 71%) after 48 weeks. The rate of HBsAg loss is about 3 percent per year. Entecavir has a very low resistance rate of 1.2 percent after five years of treatment. In the Lamivudine resistant patients, the rate of Entecavir resistance is much higher.

Tenofovir (Viread): (300mg QD). A potent nucleotide analogue that has been a component of the HIV regimen for many years, Tenofovir was recently approved for treatment of chronic HBV infection. Compared to Adefovir, the response rate was superior after 48 weeks of treatment: Histologic response (70% vs 69%), HBV DNA suppression (93% vs 63%), ALT normalization (76% vs 77%) in the HBeAg(-) patient. In the HBeAg(+) patients, it is also quite effective compared to Adefovir: Histologic response (74% vs 68%), HBV DNA suppression (76% vs 13%) and ALT normalization (68% vs 54%). The rates of HBeAg loss and HBe seroconversion were 20 percent and 19 percent, respectively, compared to the 16 percent in the Adefovir treated patients. The yearly HBsAg loss is 3 percent and HBs seroconversion is 1 percent. The three-year data showed no evidence of resistance.

Below is the American Association for the Study of Liver Disease (AASLD) treatment guidelines for HBeAg(-) and HBeAg(+) patients.



Monitoring and Prevention of Hepatitis B Infection

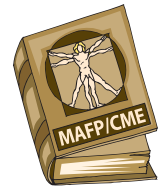
It is important to provide counseling for patients with chronic HBV infection. Lifestyle modifications such as reduction in alcohol and tobacco consumption are necessary to reduce the risk of cirrhosis and HCC. Hepatitis B carriers should have an AFP and liver sonogram done every 6-12 months for early HCC detection. Studies have shown a direct relationship between ongoing HBV replication and the development of HCC. African-Americans over 20 years of age and Asians (male >40 and female >50 years of age) with chronic HBV should be screened for HCC.

Additionally, all chronic HBV carriers should have their sexual partner vaccinated, practice barrier protection during sexual intercourse, cover open cuts and wounds and not share razors. There is no need for isolation from other children in school or daycare since carriers can share food, utensils, or kiss others without much risk of viral transmission.

Vaccination is extremely important for all newborns. It is also recommended that all healthcare workers, infants of HbsAg(+) mothers all sexual and household contacts and dialysis patients receive vaccination. Newborns of mothers with HBV should initially receive human immunoglobulin injection and HBV vaccine at delivery and then complete the standard vaccination series. Post vaccination testing should be done at 9-15 months of age in infants of HBV mothers and 1-2 months in all other persons who receive the vaccine. ■

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Note: References for this article are posted at www.mdafp.org: publications and news tab.



Fear Of Insulin: A Resident's Diabetes Education

by Salah Al-Abbadi, M.D.



AT 8 P.M. MY last patient for the evening finally arrived. Janet, an obese white female, presented for follow-up of her diabetes. Her glucose had been well controlled on metformin and glyburide for the past several years, with an HbA1c of 6.5 percent only two years ago.

The past year had not been good to Janet, however. She lost her job six months prior, and was planning to move in with her sister. Needless to say, she had been under a lot of stress, and her diet had not been very consistent. Her finger stick glucose levels had been elevated; instead of her usual 150s, they were in the 350s. She had symptoms of vaginal yeast infections and was making frequent trips to the bathroom.

At her last visit, I had checked her HbA1c and it was a whopping 12 percent. I tried "maxing out" her metformin and glyburide, but that was not enough. With discussion of other possible treatments, Janet was adamant about not starting insulin. She remembered her diabetic family members taking insulin

and associated their worsening outcomes with the medication. Not only did she not like the thought of frequent injections, but she knew that insulin would be expensive under her medication plan.

She had asked me about other oral alternatives, and I told her I would look into it. I remembered one in particular, Actos (pioglitazone). After a quick literature search, I found an article which showed that thiazolidinediones have a more durable effect on glycemic control than sulfonylureas.¹ Even though they sounded like good options, I really wasn't very familiar with diabetes drugs beyond the usual metformin and sulfonylureas, and I wanted some advice on the next best step.

After seeing the patient, I spoke to Dr. Richie, one of our Family Medicine attendings at Franklin Square. He asked me if I was familiar with the most recent guidelines by the American Diabetes Association² which were released in January 2009. It includes a consensus statement specifically addressing type 2 diabetes.

The recommendations are based on studies that compared the efficacies of all diabetes medications with levels of HbA1c as the marker for glycemic control. The drugs were divided into two tiers: Tier 1 for well-validated therapies that showed a decrease of HbA1c of about 1-3.5 percent; and Tier 2 for less well-validated therapies with average of about 0.5-1.5 percent decrease of HbA1c. All therapies include a continued effort toward lifestyle modifications.

The Tier 1 drugs include metformin (Glucophage), a sulfonylurea (Glucotrol, Micronase) and insulin. Metformin is the first drug that should be started, unless there are contraindications such as elevated creatinine. It can be initiated concurrently with lifestyle modifications. If the HbA1c is still too high after several weeks on metformin, the consensus article recommends starting basal insulin, although adding a sulfonylurea instead has shown a good response in newly diagnosed patients.^{2,7}

So what do you do after exhausting metformin and sulfonylureas? What would be your next oral hypoglycemic agent? Tier 2 medications include metglinide (Prandin), thiazolidinediones (Actos, Avandia), DPP4 inhibitors (Januvia), GLP-1 agonists (Byetta) and alpha glucosidase inhibitors (Acarbose). Despite the wide selection, the consensus article concluded that adding a third oral agent was not more effective in lowering HbA1c, and in some cases was more expensive than starting or intensifying insulin.⁴

Having said that, there are some scenarios where the Tier 2 drugs should be considered, particularly in a young or newly diagnosed patient with a HbA1c that is close to goal (<8%). Most of the medications are usually successful in lowering HbA1c by about 1 percent. In addition, if weight loss is a major consideration, then a drug such as exenatide (Byetta) would be a good option.^{4,6} However, Byetta is an injectable drug, so that may not be acceptable to patients like Janet who are wary of needles.

While reading the literature and going over the evidence based medicine, there was one thing that I had to confront

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While reading the literature and going over the evidence based medicine, there was one thing that I had to confront before moving forward: the fear of insulin.

before moving forward: the fear of insulin. Not just my patient's fear, but my own fear as a physician. My goals were to increase compliance, reduce HbA1c, avoid hypoglycemic episodes and prevent weight gain. The thought of forcing my patients to resign themselves to a lifetime of injections seemed a bit drastic, perhaps. It seems so much easier to just add another pill.

The evidence from the consensus article shows that adding that extra pill might not do much, especially if the HbA1c is quite high. With increasing insulin resistance and eventual depletion of pancreatic beta cells, oral hypoglycemic agents may eventually become ineffective. Several articles show that starting insulin early reduces complications.^{3,8,9} Therefore, insulin is not to be feared, but welcomed in some cases.

While discussing these different treatments, Dr. Richie also helped me to improve my diabetes monitoring. For

example, in patients who are not well controlled like Janet, HbA1c should be checked every three months.⁵ The same applies if a new medication is added. Once good control is achieved, monitoring can be spaced to every six months, but certainly more frequently than every two years (as in Janet's case). The HbA1C levels can help determine if the current treatment needs to be intensified, maintained or tapered down.

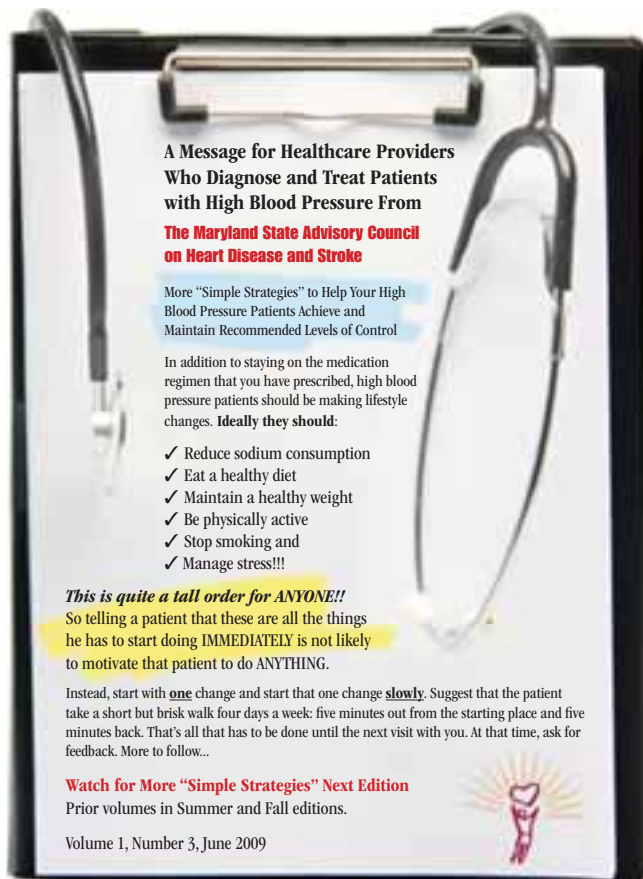
Dealing with Janet was only a small step in my diabetes education. "This is what you're going to go through with all of your diabetic patients," Dr. Richie told me. Choosing the right medications can have a big impact on a patient's glycemic control and, ultimately, can reduce their complications. The challenge varies according to the clinical setting, whether a patient is willing to start insulin, whether they need more persuasive information from their doctor and whether their doctor is ready

to coach them through starting insulin. Ultimately, I taught myself not to view insulin as a medication of last resort, but to understand it as giving the patient the tools to take control of their diabetes.

While I was still reviewing what I just learned about diabetes, Dr. Richie dropped a few more bombshells on me: "So what are you doing about her weight, cholesterol and blood pressure?" And how many calories are in one gram of carbs, protein or fat? One serving of carbs is defined as how many grams? How much insulin is needed per serving of carbs? And on and on...

Dr. Al-Abbadi writes this, his final in a series of articles as MAFP's resident editor. He is a PGYIII at the Franklin Square Hospital Center Family Medicine Residency.

Note: References for this article are posted at www.mdafp.org/publications_and_news_tab.



calendar



2010

- January 28-31 STFM Pre-doctoral Education Conference
Medical Education 2020: Developing a Vision for the Next Decade
Jacksonville, FL
- February 20 MAFP Winter Regional CME Conference
Issues in Treating Special Populations
Sheraton Hotel
Columbia (see p. 21)
- June 23-26 MAFP Annual CME Assembly & Trade Show
Solutions Through Interactive Learning
Westin Hotel
Annapolis (see p. 21)
- July 29-31 AAFP National Conference of Family Medicine Residents and Medical Students
Kansas City

2011

- June 23-26 MAFP Annual CME Assembly & Trade Show
Clarion Resort Fontainebleau Hotel & Conference Center
Ocean City

AAFP Scientific Assembly Schedule

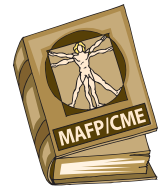
2010	September 29-October 3	Denver
2011	September 21-23	Orlando
2012	October 17-19	Philadelphia
2013	September 24-26	San Diego

Next Edition

- Focus on Cardiovascular Health



journal CME quiz



Articles:

1. Family Physicians Best Suited for Chronic Disease Management p. 5
2. The Recognition and Treatment of Depression in Family Medicine, Part 1 p. 8
3. Screening for Depression in Maryland Adolescents p. 11
4. Chronic Hepatitis B: Advances in Diagnosis and Treatment, a Review p. 12
5. Fear of Insulin: A Resident's Diabetes Education p. 15

The Maryland Family Doctor has been reviewed and is acceptable for up to 4 Prescribed credits by the American Academy of Family Physicians (AAFP). AAFP accreditation for the current cycle began on **October 1, 2009**. Term of approval is for two years from this date. This **Winter, 2010 edition (vol. 46, No. 3)** is approved for 2 Prescribed credits. Credit may be claimed for two years from the date of this edition. Note: total per-edition credit over the course of this term is subject to change based on topic selection and article length.

AAFP Prescribed credit is accepted by the American Medical Association (AMA) as equivalent to AMA PRA Category 1 credit toward the AMA Physicians Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed credit, not as Category I.

Credit Reporting Procedure: To obtain credit through the *Maryland Family Doctor* publication, complete and return the post-test (CME quiz) directly to the Maryland Academy of Family Physicians. MAFP staff will report credits for those members who return completed quizzes to the MAFP office. Each participant will receive a confirmation email (or postcard if no email) upon receipt of the quiz forms and be able to track credits granted on the AAFP website at www.aafp.org. Questions? Contact the MAFP office.

Answers p. 26

Instructions: Read the articles and answer all questions by circling the correct answers. Mail, fax or email the quiz form within two years (by January, 31, 2011) to:

Maryland Academy of Family Physicians

5710 Executive Drive, #104

Baltimore, MD 21228

410-747-1980, 410-744-6059 (fax), info@mdafp.org (e-mail)

Name: _____

AAFP Membership #: _____

Address: _____

City: _____

State: _____ Zip Code: _____

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Fax #: _____

E-Mail Address: _____

Questions Article #1:

1. Which of the following statements about chronic diseases is true?
 - A. They typically can be cured.
 - B. They are the leading causes of death and disability in the U.S.
 - C. They spontaneously resolve.
 - D. They have a short duration.
2. Which are the leading causes of deaths in the US.?
 - A. Heart disease
 - B. Stroke
 - C. Cancer
 - D. All of the above
3. Chronic diseases can be prevented by doing which of the following?
 - A. Start smoking
 - B. Drinking more than 4 alcoholic beverages daily
 - C. Exercising more
 - D. Eating more saturated fats

Questions Article #2:

4. Which of the following statements about depression is true?
 - A. Men are affected more often than women
 - B. Older women are more likely to get depressed than women in their childbearing years
 - C. Married people are less likely to be depressed than people who are divorced
 - D. A family history of depression does not increase risk
 - E. A large percentage of patients with depression actually have bipolar disorder
5. Which of the following symptoms must be present to make a diagnosis of major depressive episode?
 - A. Sleep disturbance
 - B. Depressed mood
 - C. Appetite disturbance
 - D. Loss of pleasure (anhedonia)
 - E. Either B or D
6. Which of the following statements about depression is false?
 - A. The lifetime prevalence is 16.2%
 - B. An average episode lasts about 12 months.

continued on page 18

- C. Most cases are moderate to severe in intensity
 - D. Almost $\frac{3}{4}$ of depressed patients have another DSM-IV disorder
 - E. A little more than half of depressed patients get any treatment.
7. Which of the following groups are at increased risk of suicide?
- A. The elderly
 - B. The unmarried
 - C. Caucasians
 - D. Males
 - E. All of the above

Questions Article #3:

8. Adolescents with Major Depressive Disorder are at increased risk for:
- A. Early pregnancy
 - B. Decreased school performance
 - C. Suicide
 - D. Substance abuse
 - E. All of the above
9. Most cases of Major Depressive Disorder in Adolescents remain undiagnosed.
- A. True
 - B. False
10. There are no screening tools for depression that have been validated in the adolescent population.
- A. True
 - B. False
11. The U.S. Preventive Services Task Force found evidence that use of SSRIs in adolescence may increase the risk of:
- A. Suicidal ideation
 - B. Liver failure
 - C. Development of bipolar disorder
 - D. Kidney disease
 - E. A and C
12. The U.S. Preventive Services Task Force does not currently recommend routine depression screening for children aged 7-11.
- A. True
 - B. False

Questions Article #4:

13. Screening for chronic hepatitis B infection is recommended for all children of the immigrants who come from a highly endemic area of world with >2% HBV prevalence, even if they were born in the US.
- A. True
 - B. False
14. Eighty to 90 percent of those infected at birth progress to chronic hepatitis.
- A. True
 - B. False
15. In patients with chronic HBV infection, the rate of spontaneous HBsAg clearance is:
- A. 15% per year
 - B. 10% per year
 - C. 5% per year
 - D. 0.5% per year
16. The approved first line agents for treatment of chronic HBV infections are:
- A. Lamuvidine, Adefovir and Entecavir
 - B. Tenofovir, Telbivudine and Pegylated Interferon
 - C. Entecavir, Tenofovir and Pegylated Interferon
 - D. Lamuvidine, Entecavir and Adefovir
17. Risk factors for hepatocellular carcinoma (HCC) include duration of infection, family history of HCC, male gender, HBV DNA viral load and presence of cirrhosis.
- A. True
 - B. False

Questions Article #5:

18. Which diabetes medication should you initiate in an obese patient with normal renal function and a glucose of 280?
- A. Glyburide
 - B. Metformin
 - C. Byetta
 - D. Actos
19. When should insulin be started in a type 2 diabetic?
- A. HbA1c <7%
 - B. When all oral hypoglycemic agents have been exhausted
 - C. With failure of metformin monotherapy
 - D. With failure of metformin and sulfonylurea
 - E. C and D
20. When is adding a 3rd oral hypoglycemic agent a reasonable alternative to starting insulin?
- A. Newly diagnosed diabetic
 - B. HbA1c <8%
 - C. If weight loss is a major goal
 - D. All of the above



AAFP Advocacy Principles for Health System Reform

THE FOLLOWING GUIDELINES HAVE been approved by the AAFP Board of Directors to guide our advocacy efforts during the final efforts to achieve meaningful health system reform. Such guidelines are subject to change and compromise in these negotiations with the administration and the Congress and are subject to approval as determined by the board chair. At printing, no definitive reform legislation had been enacted.

- 1) Any reform legislation should be consistent with current AAFP policy.
- 2) Expanded health care coverage should be accomplished by this legislation in a meaningful manner.
- 3) Reform of the private insurance market should be fundamental to such legislation including guaranteed issue of insurance and the elimination of pre-existing illness exclusions.
- 4) Such reform legislation must fundamentally begin to recognize and place value upon the role of family medicine and primary care as essential in a reformed health care system. The Academy will work to achieve the following goals in this regard:
 - a) GME reform favorable to family medicine and primary care training to assure an improved workforce.
 - b) A permanent fix to the current SGR formula should be included in the overall effort for health system reform – either inclusive of the reform legislation or other legislation achieving this goal for 2009.
 - c) A primary care bonus of at least 10% will be a strategic goal in lobbying for such reform legislation. The AAFP, however, believes that such a bonus should actually be 25 percent cumulative over the next five years.
 - d) Health reform legislation should expand the ability of Medicare and Medicaid to move forward rapidly with the implementation of the PCMH model of care, including a blended model of payment. This must include all Medicare beneficiaries and not just those with certain chronic disease conditions.
- 5) The AAFP supports a public plan that includes the following principles:
 - The administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace.
 - The public plan cannot be Medicare.
 - The new public plan must be actuarially sound.
 - The public plan cannot leverage Medicare (or any other public program) to force providers to participate.
 - The public plan should not be required to use Medicare payment rates.
 - The insurance market rules and regulations governing the public plan should be the same as those governing private plans.
 - The public plan cannot be granted an unfair advantage in enrolling the uninsured or low-income individuals who will presumably be eligible for subsidies in the new marketplace.
 - Public and private insurers should be required to adhere to the same rules regarding reserve funds.
 - The public plan would also need to contribute to value-based initiatives that benefit all payers.
- 6) The AAFP can support the creation of an independent commission to oversee the quality and cost of the Medicare and Medicaid programs. Legislation creating such a commission must assure the following:
 - a) The commission membership should be broadly based and inclusive of primary care physician representation as well as consumers, employers, and other major stakeholders. It must not be dominated by full time government employees.
 - b) Final commission recommendations should be subject to Congressional override by a defined mechanism.
 - c) The commission should follow the current procedure of a public comment period for any of its recommendations before final promulgation and approval of such recommendations.
 - d) The commission should have oversight of all providers in the Medicare program (physicians, hospitals, home health agencies, etc.) in exerting its authority to address quality and cost issues with Medicare and Medicaid. If this commission is only given jurisdiction over Medicare Part B in its work, there must be a clear, transparent, and enforceable alternative process to address and control the quality and cost of the other parts of Medicare and those provider sectors. And this process must assure coordination with the above noted commission in making its recommendations.
- 7) The AAFP does not believe that health reform legislation should include a penalty for certain physicians deemed by

continued on page 20

some mechanism to be 'cost outliers' as it is very uncertain as to the validity of such cost data within the Medicare program.

- 8) It would be preferable for the current PQRI program in Medicare to maintain or increase the 2 percent annual bonus and it should remain a voluntary program.
- 9) Reform of the medical liability system should be included in health reform

legislation and should include the following provisions:

- a) Impose a hard cap on non-economic damages;
- b) Limit attorneys' contingency fees;
- c) Inform juries of prior insurance payments to patients and reduce awards by the amount of compensation from collateral sources;
- d) Replace joint and several liability with proportionate liability, so each

party would pay a share of a malpractice award based on the proportion for which he is liable;

- e) Allow periodic payment of future damages at a defined award limit;
- f) Provide for Alternative Dispute Resolution Systems, and
- g) Require an expert witness who possesses knowledge and expertise and practices in the same medical specialty as the defendant. ■

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SCREENING FOR DEPRESSION from page 11

Suicidal thoughts, plans or attempts represent a medical emergency that requires immediate attention. Crisis services are available throughout Maryland, and the state runs a Youth Crisis Hotline. The hotline is available year-round and the number can be used by clinicians, concerned family members or youths themselves.

As family physicians, we are uniquely positioned to recognize the effects of depression, as well as possible concomitant depressive disorders within other members of a family. The Task Force did not find adequate evidence to recommend routine screening for children aged 7-11 and recently updated its recommendations on screening adults. Early identification of depressive disorders throughout the life cycle can potentially alleviate suffering and promote the long term health of families. ■

Dr. Birmingham, a pediatrician, is a 3rd year resident, general preventive medicine residency, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland.

Dr. Lin is medical officer, U.S. Preventive Services Task Force Program, Center for Primary Care, Prevention, and Clinical Partnerships, Agency for Healthcare Research and Quality, Rockville, Maryland.
Note: References for this article are posted at www.mdafp.org; publications and news tab.



2010 Maryland Academy of Family Physicians CME Conferences

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**Ramona G. Seidel,
M.D., Program Chair**

**Robert L. Phillips, Jr., M.D., MSPH,
Director, Robert Graham Center for
Health Policy**

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Health Care Reform**

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- Returning Servicemen
- Difficult Patients
- The Aging
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- Developmentally Disabled Children
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Special Program Elements

- Status of Health Care Reform:
Implications for FPs and Patients
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membership



News For and About MAFP Members

The 2009 Congress of Delegates: A Dichotomy of Views!

by William D. Hakkarinen, M.D., MAFP Senior Delegate

THE HEADLINE IN *AAFP News Now*, 10/16/09, said it all: “AAFP Delegates Split on How to support FPs Who Practice Emergency Medicine.” That would not be the only issue of contention. “What about pharmaceutical company financial support of CE? What is the role of FP hospitalists? (The new president announced she had become one.) Can the AAFP be home to a wide variety of types of family physicians?” An Academy that once consisted predominantly of office-based caucasian males in solo practices or small groups now reflects the spectrum of the changing world of medicine in gender, ethnicity and practice style.

On the ER issue, one group wanted a special “workforce plan” for FPs who practice emergency medicine. Others felt the workforce plan should focus only on physicians heading medical homes, with that being the “preferred future practice style.” (emphasis mine). The Academy had just recently released an overall policy on workforce reform and the delegates approved resolutions supporting federal legislation and programs that include the principle that medical care in patient centered medical homes be directed by a primary care physician. Left unanswered was what that meant for FPs with other than full-time office practice careers.

Discussion about pharmaceutical company support was vigorous. Some called for a total ban, particularly on AAFP materials intended for patients. The AAFP’s web site, www.familydoctor.org, was cited as an example, with drug advertisements on the home page. (Most of us went to the site to

see for ourselves. There was an antibiotic ad on the first page. It is not there as I write this on October 31.) Others expressed concern about how the Academy would fund programs without such support and what would be the effect of dues increases in the hundreds of dollars.

There was unanimity on the core financial issues, however: better pay for home visits, supporting primary care extension programs, closing the Medicare doughnut hole and a permanent fix of the Medicare fee schedule. All recognized that adequate primary care will not happen without adequate financial support.

That financial support must start with graduate medical education (GME) funding. The Congress supported initiatives

to enhance loan reimbursements and other financial aid policies to enhance the attractiveness of primary care. The need for student exposure was perhaps best illustrated by two of the most meaningful, to me anyway, observations.

First was the election of Robert Stenger, MD, MPH, of Portland, OR, to be resident board member. In his acceptance speech, Dr. Stenger related how he, a graduate of a Maryland medical school with no department of family medicine, became dedicated to the discipline. He received funding from the Maryland Academy to attend the National Conference of Residents and Students and also had an outstanding rotation at the Franklin Square Hospital Family Practice Residency. His personal



MAFP’s 2009 AAFP Congress of Delegates delegation: (l-r) Chapter Executive Director Esther Rae Barr, President Dr. Yvette Rooks, Delegates Drs. Bill Hakkarinen, Debo Prest, Bill Jones and Howard Wilson.

thanks to Dr. Sallie Rixey and staff were heartwarming.

The second, and I do request a point of personal privilege here, was seeing Dr. Wanda Filer as a new delegate from Pennsylvania. Dr. Filer has had a distinguished career as practitioner, residency faculty, state medical officer and educator. As a high school student in Millersburg, PA, circa 1976, then Wanda Price had a "career week" exposure to a practicing family physician. She has credited that exposure with "turning her on" to family practice. I speak from personal experience that not only was she an excellent student, but one of the best babysitters my then 4-year-old son ever had.

When we take a student, work with the med school or educate our kids with programs like Tar Wars, we are enhancing the future quality of medical care. It has been an honor and privilege to serve as your delegate to the Congress, and I thank you all for the opportunity.

P.S. from William P. Jones, M.D.: As the junior delegate from the Maryland Chapter, I feel privileged to have worked with "Dr. Hakk" at the Congress of Delegates. We approach many issues from philosophically different directions but were able to discuss and make our points and hopefully clarify some of the topics for each other. He has represented the Academy with verve and panache and I hope I can fill his very large shoes as delegate next year.



MAFP Receives Educational Grant for Excellence in CME programming

The Audio-Digest Foundation (ADF) has presented to MAFP a grant in support of the organization's ongoing continuing medical education activities. Quoting ADF, "In awarding this grant, the ADF recognizes MAFP's ongoing service to physicians.

Helping to maintain the highest quality medical education programs has been a long-standing goal of the ADF. We hope that MAFP will continue to provide CME activities for many years to come." The grant will assist MAFP in providing its 2010 CME programs (see p. 21).

continued on page 24

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Richard Colgan, M.D. of Annapolis has published "Advice to the Young Physician On the Art of Medicine." It is available through Amazon and Barnes & Noble websites.

Kisha N. Davis, M.D. of Columbia is featured in "Resident Spotlight," a AAFP publication sent to all U.S. 3rd year residents. She was tapped to offer advice to the soon-to-be graduates. The article can be viewed at www.aafp.org.

Timothy Feeney of Baltimore, UM MSII, was featured in "Primary care's hidden loss; To pay bills, medical students pick specialties, not family practice" in the September 29, 2009 edition of *The Baltimore Sun*.



Joan Lehmann, M.D. of Pasadena has published her first novel, "Heaven Below." It is set in 1930s Baltimore and Shady Side, Maryland, and is available through the Amazon website. www.JoanLehmannMD.com.

David McClure, M.D. of Bel Air was featured in "Do we have the infrastructure for universal health care?" in the September 3, 2009 edition of *The Baltimore Sun*.

Sarah F. Whiteford, M.D. of Cockeysville was featured in "Doctors coping with flood of calls about flu..." in the November 12, 2009 edition of *The Baltimore Sun*.

Joseph W. Zebley, III, M.D. of Baltimore, on October 31, 2009, appeared on a CNN on camera interview with Allen Chernoff on medical waste and overuse of resources.

AAFP/MAFP CME Requirements for Active/Supporting Members

Active and Supporting Family Physician Members must accrue at least 150 hours of AAFP Prescribed and Elective credit within each 3-year reporting period, of which:

- At least 75 must be AAFP Prescribed credit; of which at least 6 of those being obtained from MAFP sponsored programs every 3 years (eg. CME conferences and journal CME).

- At least 25 are from live learning activities
- Not more than 25 are from enrichment activities
- Not more than 30 are from presentation or publication of an original scientific or socioeconomic paper pertaining to medical care
- Not more than 45 are from publication in a state or national "refereed" journal
- Not more than 15 are from preparation and presentation

Welcome New MAFP Members September 1-October 31, 2009

Active

Khadijah L. Adejumo, M.D.
 Michele R. Arthurs, M.D.
 Gregory L. Beyer, M.D., FAAFP
 B. Toloria Braswell, M.D., FAAFP
 Judith Brutus, M.D.
 Andrea Cuniff, M.D.
 Allison A. Hearn-Sikirica, M.D.
 Danielle T. Gerry, M.D.
 Maia M. Patel, M.D.
 Yamuna K. Reddy, M.D.
 Vasantha Udugampola, M.D.
 Keith Wilson, M.D.

Lindsay Dancy
 Stacey Engster
 Patrick Fadden
 Darlene Forde
 Kathleen Gurman
 Danielle Harlan
 Brandon Haugh
 John Hornick
 Maggie Lin
 Allison Lindell
 Yahuda Mond
 Andy Newton
 Andrea Petes
 Laurie Podskalny
 Hannah Rosenblum
 R. Ian RossFry
 Anita Sahu
 Catherine Sharoky
 Elizabeth Siberholz
 Rebecca Switzer
 Elizabeth Suniega
 Sara Wozny
 Stephen Wreesman
 Amy Zhang

Resident

Oritsetsemaye G. Otubu, M.D.

Student

Kevin Affum
 Novlette Akinseue
 Selma Amrare
 Sanchita Bose
 Alexandra Charron
 Margaret Crehshaw

In Memory

The Maryland Academy of Family Physicians deeply regrets the passing of its member

Barry Rosenberg, M.D. (Chevy Chase)

and has made a memorial contribution to the MAFP Foundation.

Members are encouraged to review the document *AAFP Continuing Medical Education Requirements for Members* at http://www.aafp.org/PreBuilt/cmea_memberrequirements06.pdf or contact the MAFP office to request a copy; office@mdafp.org.

The AAFP will send Maryland Chapter members, at regular intervals, correspondence showing each member's reported number of hours and reminding members of what is required. All details about the AAFP/MAFP's CME records, reporting and information can be obtained through the AAFP web site at www.aafp.org/cme, toll free at 800-274-2237 (ask for the CME Records Department) or the MAFP at 410-747-1980; office@mdafp.org (e-mail).

Other Aspects of MAFP CME Policy

The MAFP Board of Directors has approved the following:

1. MAFP members who are faculty members at MAFP conferences may claim the credits for those sessions (even if they are not registrants) for the MAFP CME requirement.
2. MAFP members who are authors of CME articles published in *The Maryland Family Doctor* may claim those credits (according to AAFP policy; www.aafp.org) for the AAFP and MAFP CME requirements.
3. MAFP CME credits will be waived for those Active and Supporting members who relocate to the Maryland Chapter within six months of the end of their cycle of AAFP reelection.
4. Active and Supporting members who have not met the chapter requirement to report at least 6 chapter credits within their AAFP reelection cycle may receive a waiver for that cycle, to be made up in the subsequent AAFP Reelection cycle, by following the process:
 - 1) Member must contact the MAFP office submitting a request (written, email, phone call) for a one-time waiver for the chapter requirement indicating

a desire to continue membership, pledging to acquire the credits during the next AAFP reelection cycle. There is a waiver request administrative fee of \$50.

- 2) Member must make up waived credits in the subsequent AAFP reelection cycle (in addition to the required 6 credits).
- 3) If failing to acquire the required chapter hours in the subsequent

AAFP reelection cycle, MAFP will not accept another waiver request from member.

5. The MAFP Board of Directors will consider, on individual bases, each member failing to meet the chapter CME requirement. The Board will determine the course of action for each member in this category. ■

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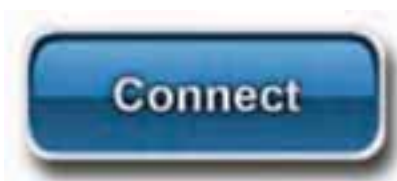
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