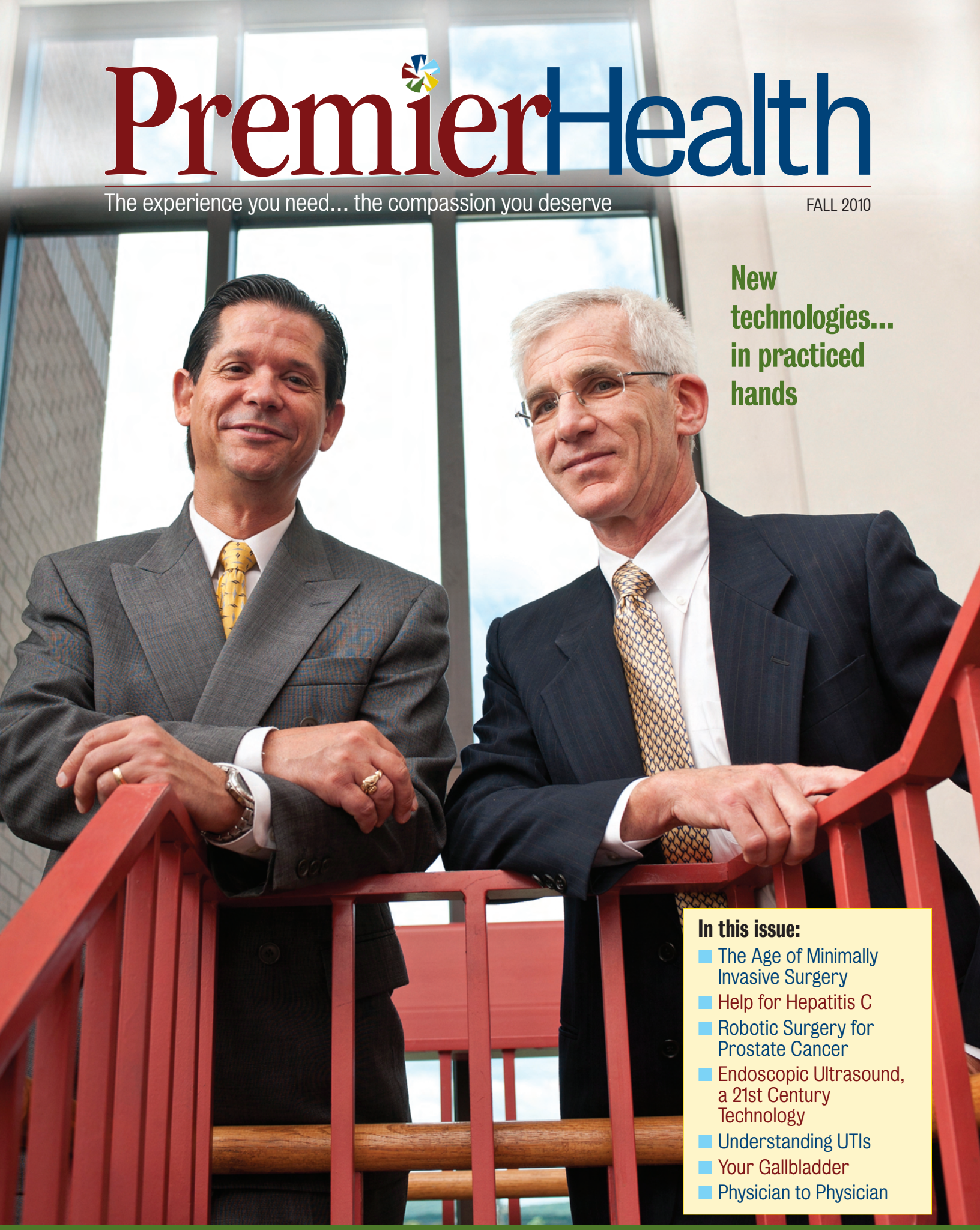
PremierHealth

The experience you need... the compassion you deserve

FALL 2010



New technologies... in practiced hands

In this issue:

The magazine of PREMIER *medical group of the Hudson Valley*

NEW TECHNOLOGIES... IN PRACTICED HANDS

Premier Medical Group

The old saying, "There's no substitute for experience," certainly applies to medical procedures and diagnostics. When experience is wisely combined with the newest technologies, you have medical care at its best. Senior physicians at the GI Associates and Hudson Valley Urology divisions of Premier Medical share observations on how their practices have developed...

"When I joined GI Associates 18 years ago, we were a three-physician group committed to empathetic care for our patients. Today, we're a ten-physician team with remarkable medical resources, state-of-the-art endoscopy equipment, and a continuing commitment to the highest level of empathetic patient care.

The size of our team and the range of subspecialties represented—such as liver disease, Crohn's disease and colitis, bile duct and pancreatic disease—enable our physicians to develop great expertise in their field of interest. We continue to recruit physicians to add additional levels of subspecialty care.

At GI Associates, we put a premium on staying at the cutting edge of medical knowledge. We enable our physicians to regularly attend medical conferences and take the time to stay abreast of the latest research in their areas.

We have weekly meetings to discuss cases, consult with each other, and share information from the medical literature. The physicians provide each other with expert opinions so, unbeknownst to them, our patients are regularly receiving a "second opinion" on their conditions. Our team method gives patients a high level of care approaching that of a university medical practice."

—Peter M. Varunok, MD

SENIOR PHYSICIANS: Dr. Peter M. Varunok of GI Associates (left) and Dr. Mark R. Libin of Hudson Valley Urology.

"The biggest thing that has happened over the course of my 22 years with this practice is the advent of laparoscopy and its use in urology. Now we can do everything from laparoscopic surgery for kidney tumors to robotic radical prostatectomy.

I've been fortunate in attracting great physicians with expertise in the new technologies. And because we have such breadth and depth in the subspecialties, our urologists are able to focus on a specific set of procedures and become extraordinarily proficient.

In-office diagnostics have also changed our practice considerably. For example, with our in-office CAT scan or ultrasound, patients can get their physician's preliminary interpretation of results within minutes of the test being ordered.

We have so many minimally invasive options, things that weren't even in the pipeline 20 years ago. And the complexity of procedures that can be done in our office has increased dramatically. Our patients appreciate how seamless—easier and hassle free— office-based surgery is compared to hospital-based procedures.

Doing the things we do, as well as we do, is exceptionally gratifying to me as a physician."

—Mark R. Libin, MD

Premier Medical Group's multiple offices reduces the travel time needed to get the specialty care you deserve.

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PREMIER *medical group*

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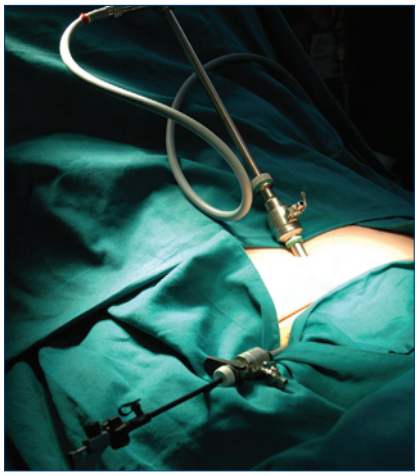
THE AGE OF Minimally Invasive Surgery

For hundreds of years, physicians have been seeking ways to spare their patients the trauma and risks of open surgery. Finally, the time has come.

Minimally invasive surgery is the long sought after alternative to traditional open surgery. Until very recently, surgery has always involved a sizeable incision through flesh and muscle (and sometimes bone) to reach the organ requiring repair or removal. Drawbacks to this method have led physicians to seek out other approaches.

The first minimally invasive surgeries were performed in the early 1800s for the urological problem of bladder stones, a very painful condition common to the era. The procedure called for breaking up or crushing a stone in the bladder and drawing out the pieces. Refinement of the tools and acceptance of the procedure took time, but by the end of the century, this technique had become the preferred method for removing bladder stones.



Today, a method of breaking up stones called shock wave lithotripsy is perhaps the most minimally invasive surgery possible, requiring no incision or entrance into the body at all.

Used predominantly for kidney stones, the technology (based on equipment originally designed to test supersonic aircraft parts) was introduced in the 1980s. The procedure uses x-rays or ultrasound to locate the stones. Then, precisely targeted, high-energy shock waves are generated outside the body and directed to fragment the stones into particles that are small enough to pass on their own. The entire procedure generally takes between 45 minutes and an hour and most people go home the same day.

A wide range of technologies

At Hudson Valley Urology, a division of Premier Medical, we utilize a wide range of technologies that allow us to provide minimally invasive procedures for almost all of our patients' needs. These techniques decrease the trauma of surgery, minimize blood loss and infection, and speed recovery time.

Endoscopic surgery, using small fiberoptic telescopes, allows access to the entire urinary tract—all the way up to the kidneys—by way of the urethra. Small ports in these *ureteroscopes* permit use of miniaturized instruments and laser fibers that can fragment kidney stones or destroy tumors.

Laparascopy is probably the best known type of minimally invasive surgery, replacing the large incisions of open surgery with "keyhole incisions", each about ¼ to ½ inch. A partial kidney removal, for example, uses 4 small incisions in the front of the abdomen while an open surgery would use a 10-inch incision on the patient's side or flank. One "keyhole" is used for a light source and video camera, while surgical instruments are manipulated through the other "keyholes."

Robotic surgery is the next generation of minimally invasive surgery that we use in some kidney procedures. This technology, in the capable hands of Dr. Rahman *(see page 8)*, is providing excellent results for those patients requiring prostate removal.

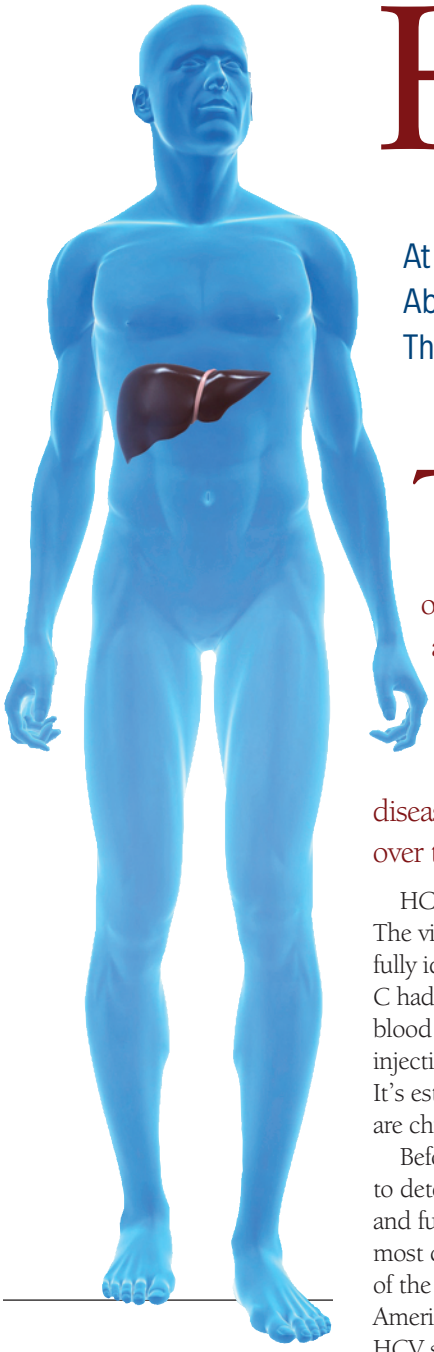
As Dr. Pietrow points out, minimally invasive surgery isn't just a minor procedure, it's still surgery, and requires a period of recovery. But, as patients attest, the healing happens more quickly.

Paul Pietrow, MD

"I remind my patients that minimally invasive surgery is still surgery — it's not magic, it's just better. It still requires recovery and healing time; there's a hill to climb, but it's a smaller hill. There's less of a wound, less external trauma, less bleeding, and patients get to go home sooner.

Urologists started using laparoscopic surgery in the 1990s. For some procedures, minimally invasive is now the first-line standard of care. Outcomes are just as good as in open surgery. Various conditions are cured just as efficiently and effectively, you just feel better. In kidney surgery, for example, the traditional approach required a flank incision to get to the kidney. Those were really painful and left longer scars and damaged muscles. Minimally invasive kidney surgery, when it's appropriate, provides a great benefit to patients.

I've done well over 600 laparascopic surgeries, and continue to be excited by the new refinements and techniques. In fact, I teach other physicians how to perform minimally invasive procedures at American Urologic Association seminars. I'm proud to be able to give Hudson Valley residents the opportunity to benefit from the latest techniques without their having to travel."



HELP FOR Hepatitis C

At least 3.2 million Americans are infected with the hepatitis C virus. About 2.5 million of them don't know it. They risk becoming the victims of a silent epidemic.

The hepatitis C virus (HCV) is a major cause of chronic liver disease, in the U.S. and around the world. Nationally, about half of all cases of cirrhosis are the result of chronic HCV infection, as are almost all the cases of primary liver cancer (hepatocellular carcinoma), and a large proportion of liver failure cases. Currently, 12,000 deaths a year in the U.S. are due to hepatitis C-related liver disease. Scientists expect that number to rise significantly over the next two decades.

HCV is transmitted by blood-to-blood contact. The virus was first discovered in 1975 but not fully identified until 1989. By then, hepatitis C had become a global epidemic, as a result of blood transfusions, hemodialysis, and the use of injections to deliver drugs— medicinal and illegal. It's estimated that 300 million people worldwide are chronically infected with HCV.

Before 1992, when a reliable screening method to detect HCV in blood products was developed and fully implemented, transfusions were the most common method of infection. At the height of the epidemic, two to three hundred thousand Americans were contracting HCV annually. After HCV screening was put in place, fewer than 1 in 2 million units of transfused blood contained the virus. Today, the primary avenue for getting HCV is through illegal drug injections.

The good news is that fewer than 18,000 people contracted the virus in 2009. The bad news is that the hepatitis C virus does its work very slowly and, for many years, very quietly. In most people, the infection has few or no symptoms as it progresses. As a result, they don't learn they have an HCV infection until they're screened before giving a blood donation, when elevated liver enzyme levels are detected during routine medical examinations or, eventually, when they experience the symptoms of liver disease.

For reasons scientists don't fully understand, about a quarter of the people who get infected with hepatitis C are able to clear the virus from their bodies without treatment, and don't develop a chronic infection. But for the rest, over a period of 10 to 40 years, the virus will cause chronic liver disease, ranging from mild to severe. About 5–20% of people with HCV will develop cirrhosis or liver cancer.

The hepatitis C "boom"

Currently, diagnosis with chronic hepatitis C is greatest among people born between 1945 and 1964, the "boomers." Most of them were infected during the 1970s and 80's. The effects of the virus have had 30–40 years to progress and they are now beginning to make themselves known. Scientists predict that HCV related liver problems will spike over the next 10-20 years, before falling off as dramatically as they rose.

BUT… a recent study in the journal *Gastroenterology* suggests that if everyone infected with hepatitis C were to seek treatment today, with the treatments currently available, the incidence of liver failure and liver-related deaths could be reduced by more than a third within 10 years. Improved treatment would bring an even greater reduction.

There are drug treatments currently in use that can eliminate hepatitis C in many people, and reduce the effects of the virus in many more. There are even more effective treatments on the near horizon, that are expected to successfully eliminate more variations of the virus in a wider range of sufferers.

The main public health challenge is to get people at high-risk to find out what their HCV status is. Knowing you have the virus not only puts

If everyone infected with hepatitis C were to seek treatment today, the incidence of liver failure and liver-related deaths could be reduced by more than a third within 10 years.

Are Tattoos Safe? Tattoos are all the rage, with about a third of Americans under age 30 sporting some skin art. Since tattoo instruments come in contact with blood, it's possible to transmit a hepatitis C infection if the instruments aren't sterilized between usages or if proper hygiene isn't followed. Research studies have not shown licensed, commercial tattoo studios to be a significant source of infection. Informal, unregulated tattoo artists and body piercers, however, aren't known for good infection-control practices, and should be avoided.

you in a position to seek treatment, it gives you the opportunity to adopt life style changes that may slow the progression of the disease.

For example, knowing you have HVC could give you a strong impetus to avoid alcohol use. The virus impairs the liver's ability to break down alcohol and remove its toxins. A heavy drinker with HCV has a 16 times higher risk of developing cirrhosis than a non-drinker with HCV.

Taking action, seeking help

If you are at high risk of having been infected with hepatitis C—because of a pre-1992 transfusion, long-ago or recent IV drug use, or any of the factors listed in the chart (at right)—you should speak to your physician about being tested for the virus. There is some evidence of a "low but present risk" of HCV infection from sharing the tools of intranasal inhalation of cocaine (snorting) and from high-risk sexual activity, especially with multiple partners. Talk to your doctor about whether your history with these activities merits HCV testing.

A series of blood tests is used to determine the existence of an HCV infection and, if there is one, the amount of virus in your system (viral load), and its genotype (genetic makeup). There are six known genotypes of the hepatitis C virus, and each responds differently to treatment.

If HCV is confirmed, the next step is getting evaluated for the presence of liver disease, a process which sometimes requires having a liver biopsy. Your specialist —a gastroenterologist or hepatologist—will determine the severity of the disease and what kind of treatment you may need.

Being diagnosed with hepatitis C doesn't always mean you need to get drug treatment right away. If tests show that you have only slight liver abnormalities or a low viral load, you and your physician might decide that it's wise to wait. Your age, overall physical and emotional condition and other health concerns will factor into the decision. In this case, what's called "watchful waiting," you'd have regular follow-up blood tests done to monitor your condition. You'll also be advised about lifestyle adjustments (such as nutrition, alcohol and drug consumption, and weight control) that will help protect your liver.

The current standard treatment for HCV is a combination therapy using two drugs, pegylated interferon and ribavirin. The duration of treatment ranges from 24 to 48 weeks, depending on the genotype of HCV the patient is infected with. About 50% of people with genotype 1 HCV—the most common type in the U.S.—are cured by this treatment, as are about 80% of people with genotype 2 or 3 HCV. New drugs and drug combinations have been upping the success rate every year.

Side effects, ranging from mild to severe, are common during hepatitis C therapy and some patients have trouble sticking with it. Yet successful treatment requires keeping to the appropriate dose for the prescribed length of time. Dr. Varunok and the GI physicians of Premier Medical Group have developed an approach that starts managing these side effects early, aggressively, and effectively. Their support helps patients stay with the treatment to get its full benefit.

Who Should Be Tested For Hepatitis C Virus Infection?

- Anyone who has ever injected illegal drugs, including those who injected only once, many years ago
- Recipients of clotting-factor concentrates (such as anti-hemophilic factor) made before 1987
- Recipients of blood transfusions before July 1992 when dependable screening for HCV was put in place
- Patients who have ever received long-term hemodialysis treatment for kidney failure
- People with known exposures to HCV, such as
  — Health-care workers after needlesticks involving HCV-positive blood
  — Recipients of blood or organs from donors who later tested HCV-positive
- Anyone who has HIV infection
- Patients who have signs or symptoms of liver disease (for example, abnormal liver-enzyme tests)
- Children born to HCV-positive mothers (these children should not be tested before the age of 18 months)

Source: Centers for Disease Control and Prevention

Peter M. Varunok, MD, AGAF, AASLD

"Though hepatitis C is a major risk factor for liver disease, it's both treatable and curable. When we identify people with the virus early enough, we can change the natural history of the disease. We can stop scarring of the liver and prevent cirrhosis; and if we prevent cirrhosis, we can prevent liver cancer.

There are exciting developments in the field. I've been involved in hepatitis C Clinical Trials for over 12 years—including active, ongoing and future trials—which include the small molecule medication (protease inhibitors) that is offering great hope.

The current medications used to combat hepatitis C have a reputation for being "difficult" to take. At GI Associates, we have great success with maintaining patients on a full course of the therapy that will give them the best opportunity for a cure. That's because we supply extensive support and comprehensive side effect management. The majority of patients we treat for hepatitis C can go to work and school and carry on with their lives.

The important thing is for people whose history puts them at high risk for hepatitis C to see their doctors to be fully evaluated and, when needed, treated appropriately."

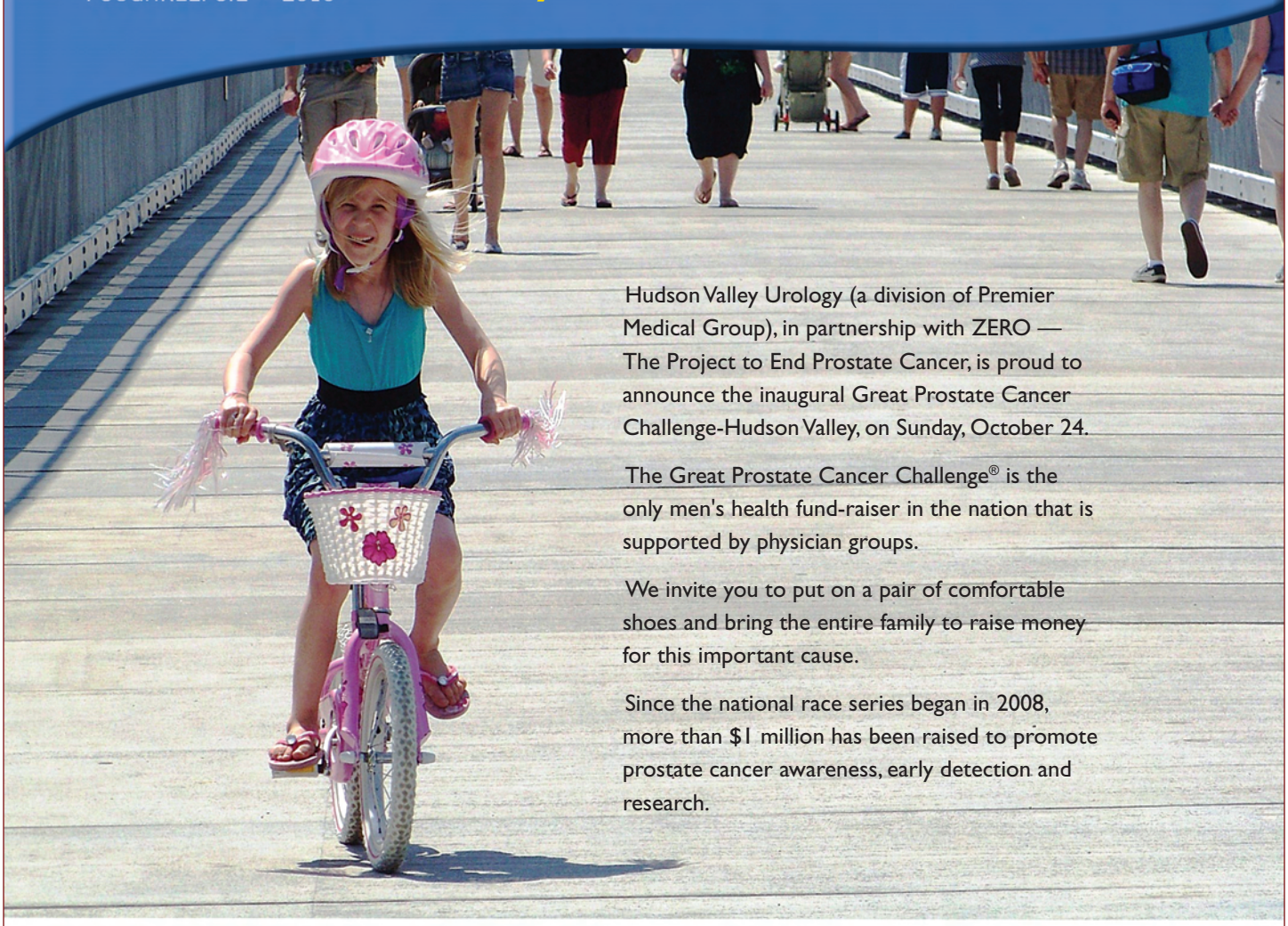
Dr. Varunok is the only member of the American Association for the Study of Liver Diseases (AASLD) practicing between Westchester and Albany.

GREAT PROSTATE CANCER Challenge® POUGHKEEPSIE • 2010

Join Us in Poughkeepsie's First Annual

Great Prostate Cancer Challenge® Fun Walk

Walkway Over The Hudson
Sunday, October 24 • 9am–noon (rain or shine)



Hudson Valley Urology (a division of Premier Medical Group), in partnership with ZERO — The Project to End Prostate Cancer, is proud to announce the inaugural Great Prostate Cancer Challenge-Hudson Valley, on Sunday, October 24.

The Great Prostate Cancer Challenge® is the only men's health fund-raiser in the nation that is supported by physician groups.

We invite you to put on a pair of comfortable shoes and bring the entire family to raise money for this important cause.

Since the national race series began in 2008, more than $1 million has been raised to promote prostate cancer awareness, early detection and research.

Date: Sunday, October 24, 2010

Location: Walkway Over the Hudson (Round trip: 2.5 miles). The Walk begins on the west side of the bridge—the Ulster County side—at 87 Haviland Rd. (West Entrance/Park Office) Highland, NY

Registration: 9:00 a.m. - 9:45 a.m.
$15 per person, kids under 12 free.

Walk: 10:00 a.m. - 11:00 a.m.

Awards & Refreshments: 11:00 a.m. - Noon

All children receive a Halloween "Goodie bag"!

Many walkers are raising additional funds through donation by friends, family and other supporters. Join the fun!

Community and business leaders who wish to sponsor this event or make a food or other in-kind donation should call Sinikka Sherwood at 845-437-3803.

Sixty percent of funds raised will go to the Dyson Center for Cancer Care at Vassar Brothers Medical Center and the Eileen Hickey Center at St. Francis Hospital and will be earmarked for prostate care such as free screenings and transportation. Forty percent of funds will go to ZERO for free prostate cancer testing and research to end the disease.

PREMIER medical group

HVU Hudson Valley Urology, P.C. Comprehensive Urology Centers

GI Associates

zero The Project to End Prostate Cancer

Register on-line at greatprostatecancerchallenge.com/Poughkeepsie.html

GETTING A CLEARER PICTURE OF GI Malignancy

Over the last decade, a new tool has revolutionized the way in which gastrointestinal diseases — particularly tumors — are diagnosed and managed. At Premier Medical Group, we have that tool, and the expert to use it.

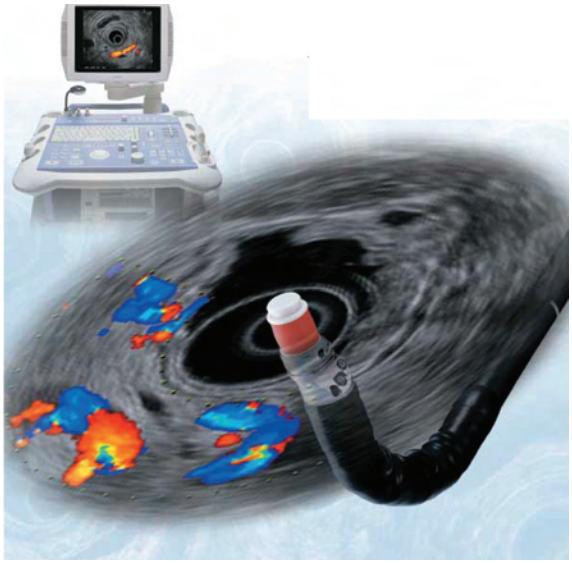


Illustration of EUS image and transducer courtesy of Olympus America Inc.

We're all familiar with ultrasound. That's the technology that uses high-frequency sound waves to image and examine internal organs and structures. It's ultrasound that gives expectant parents the first look at their child, as a fetus in the womb.

Endoscopy is the now-standard procedure your gastroenterologist uses to look inside the organs of the GI tract. The endoscope is a long, flexible tube tipped with a tiny camera that, on the equipment used by Premier Medical Group, provides high-definition video images. Colonoscopy, for example, employs an endoscope to examine the colon and, when appropriate, remove polyps that might lead to cancer.

21st-century technology

Combine these two late-twentieth century imaging methods—endoscopy and ultrasound—and you have endoscopic ultrasound, a true 21st century advance.

Standard endoscopy and ultrasound, as well as CT and MRI scans, provide physicians with a great deal of information about your body's workings. But each of these imaging tools has limitations that, in some situations, can prevent the capture of sufficiently detailed and revealing views.

In EUS, a sensitive ultrasound transponder introduced right into the digestive tract captures cross-sectional images of internal organs without the sound waves having to pass through gas, bone, and fat. The resulting high-resolution images can show even the tiniest of abnormalities.

EUS is currently used to evaluate lumps or lesions discovered through standard endoscopy or first seen on x-ray tests, such as a computed tomography (CT) scan. The procedure aids in diagnosing diseases of the pancreas, bile duct and gallbladder, and helps greatly in clarifying other inconclusive or conflicting tests.

But one of the most valuable usages of EUS is in the staging of GI cancer, determining how far advanced the cancer has become. EUS is unique in its ability to provide a highly detailed 5-layer view of the walls of the intestinal tract. This view allows your doctor to accurately determine the depth of the cancer in the organ wall and whether it's spread to nearby lymph glands and other vital structures. And, in a procedure called EUS-guided fine needle aspiration (FNA), your doctor can guide a needle directly into tumors and lymph nodes to perform a non-surgical biopsy.

Accurate staging of a cancer is critical to determining the best treatment approach, be it surgery or chemotherapy. EUS is also valuable in diagnosing inoperable cancers, sparing patients the stress of unnecessary surgery or treatments.

Though EUS is recognized as an essential technology, it is not yet available in all medical centers, largely because of a lack of skilled practitioners. Mastery of the procedure and of the image interpretation requires extensive advanced training. Premier Medical Group is proud to be able to afford our patients the benefits of EUS, right now.

Khurram I. Ashraf, D.O.

"We use the new technology of endoscopic ultrasound (EUS) for the purpose of staging and diagnosing GI malignancies, such as esophageal, gastric, and rectal sigmoid cancers. The procedure has proven invaluable in helping GI oncologists and surgeons decide on the best approach for managing their patient's cancer.

In the past, before EUS, there was more guesswork involved and patients often needed to undergo exploratory surgery. For pancreatic cancer, for example, we used CAT-scan aided biopsy. It was a painful procedure and not nearly as accurate as EUS.

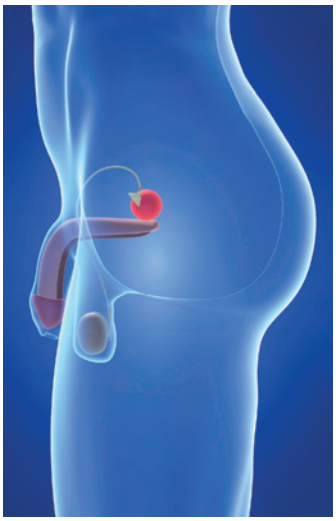
Now, we're able to see so much more. We can see how deep in the organ wall a tumor is and make important treatment decisions or even tell whether or not the tumor is operable.

Right now, in the case of pancreatic cancer, we use EUS to inject medicine into the celiac ganglion for pain control. In the future, we'll be using it to inject medicine directly into tumors.

I've been performing EUS for six years but, in many areas, the technique is still not widely available. I'm pleased that we have it right here in Poughkeepsie."

ROBOT-ASSISTED SURGERY FOR Prostate Cancer

More than 200,000 men will be diagnosed with prostate cancer in 2010. Those of them that need surgery will find a remarkable new tool in their surgeon's hands.



The PSA Test

The prostate-specific antigen (PSA) test is a prostate cancer screening method that measures the amount of PSA in a man's blood. A high PSA level has been linked to an increased chance of having prostate cancer, but does not mean that the person definitely has it.

The American Cancer Society recommends that men make an informed decision with their health care provider about whether to be screened for prostate cancer. They should get information about what is known and what is not known about the risks and possible benefits of prostate cancer screening.

The talk about screening should take place at age 50 for men who are at average risk of prostate cancer and are expected to live at least 10 more years, earlier for men at high risk of getting prostate cancer.

Men who choose to be tested who have a PSA of less than 2.5 ng/ml (see below), may only need to be retested every 2 years. Screening should be done yearly for men whose PSA level is 2.5 ng/ml or higher.

Health statistics tell us that about 1 of every 6 men will be diagnosed with prostate cancer during his lifetime. In the years since the prostate-specific antigen (PSA) test became widespread, most cases of prostate cancer are discovered in the early, localized stages. This is a good thing. It can also be a confusing thing for patients.

Not every case of prostate cancer will spread and become life threatening. Unfortunately, there is not yet a dependable way to determine which cancer will remain safely slow-growing, and which will dangerously pick up velocity. It's important to thoroughly discuss the benefits and risks with your physician before making a treatment decision.

"Usually, an elevated PSA is what brings a patient in to see us," says Premier Medical's Dr. Naeem Rahman. "We look at what sort of change has occurred in the patient's PSA history, consider any symptoms, and perform a digital rectal exam. Since there are a number of factors that can give a temporarily elevated PSA reading, we always double check and give a fresh test."

"If the PSA numbers suggest it," Dr. Rahman says, "we would advocate a prostate biopsy. If the biopsy is negative, we reassure the patient and advocate another PSA or exam in about six months. If the biopsy is positive, the response is open-ended. We consider the patient's age, comorbidities, and the aggressiveness of the cancer before making a treatment recommendation.

"In the PSA era there's a downward movement in the stage at which prostate cancer is first diagnosed," says Dr. Rahman. "It's considered a slow-growing cancer, and treatment decisions need to take that into account. But I would emphasize that we still see prostate cancers that are very aggressive and life threatening."

The promise of robot-assisted surgery

Radical prostatectomy, removal of the prostate, is used most often if the cancer is not thought to have spread outside the gland. An open surgery radical prostatectomy was first performed about 1901 and, with many refinements, was the reigning technique for a hundred years.

The first robot-assisted laparoscopic radical prostatectomy (RALRP), using the da Vinci® Surgical System—the system we use at Premier Medical— was performed in early 2000. Urologic surgeons have so enthusiastically adopted the procedure, and patients seem so satisfied with it, that RALRP is now the most common approach to removing the prostate. Just 10 years after its introduction, according to the National Cancer Institute, 70% of radical prostatectomies are performed with robotic assistance.

Surgeons have been impressed by robot-assisted surgery's ability to provide their patients with the reduced trauma of a minimally invasive procedure while overcoming the limitations of standard laparoscopy.

When compared to open surgery, a patient undergoing RALRP can expect to experience:

- Less pain following the operation
- Less risk of infection

The da Vinci Surgical System

- Less need for anesthesia
- Less blood loss
- A shorter hospital stay
- Faster and more complete recovery
- A quicker return to normal daily activities.

The goal of a radical prostatectomy is to remove the cancerous prostate and ensure that none of the cancer is left behind. Additionally, in most cases, the surgeon aims to spare the nerves necessary for achieving erections and to reattach the bladder to the urethra to maintain urinary continence. Numerous studies suggest that these goals are better met by RALRP than by standard laparoscopy and that results are at least as good as those obtained by open surgery.

The many surgeons who now recommend robot-assisted radical prostatectomy over other methods find that the technology gives them enhanced capabilities, including more surgical precision and dexterity.

How the da Vinci Surgery System works

The robotic system isn't "programmed" to perform operations and it doesn't make any decisions on its own. Your surgeon is the one making every surgical maneuver and decision. The robotic system just assists, translating the surgeon's hand, wrist and finger movements on the controls into the precise movements of miniaturized instruments.

In a da Vinci robot-assisted surgery, a series of small, dime-size incisions are used to introduce miniaturized instruments and a high-definition 3D camera into the patient's body. The camera delivers crystal-clear images enlarged as much as 12 times.

The surgeon sits at a console a few feet away from the patient, operating the surgical instruments with hand and foot controls. The surgeon can change the scale of motion: if the surgeon moves his hand two inches, for example, the robot can be set so that it will only move one inch. This provides exceptional control for procedures needing extremely fine movements. The surgical robot also removes surgical tremor, so that if the surgeon's hands shake slightly, those extremely small movements are not translated into the instruments and the maneuvers are rock-steady.

Since the da Vinci System's patient cart does the work of holding and re-positioning the instruments and camera — and because your surgeon operates while seated —surgeons can experience less fatigue when performing robot-assisted surgery. This translates into greater focus on the patient and the procedure.

The surgeon's experience, commitment, and skill remains of critical importance. At Premier Medical, Dr. Rahman's expertise ensures our patients get the most from the da Vinci system.

Naeem Rahman, MD

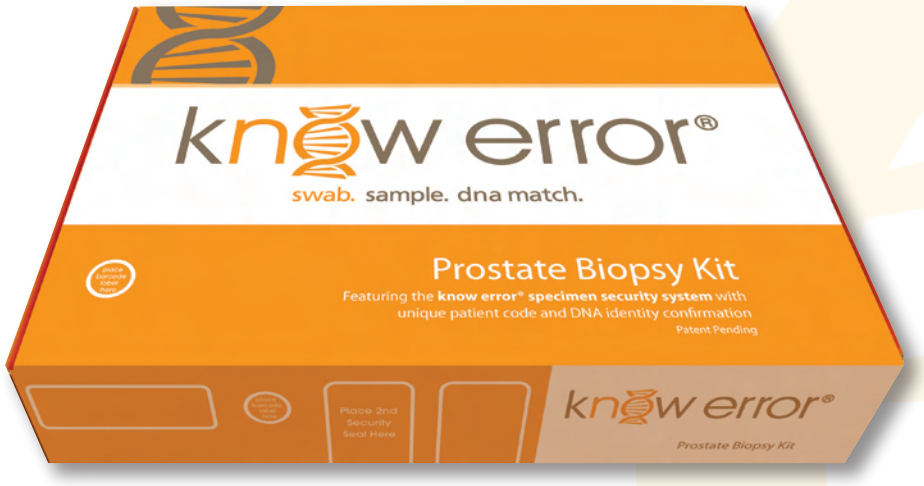
"My training bridges the old and new eras of prostate surgery. I began with open surgery, trained in laparascopic surgery, and now have expertise in robot-assisted surgery.

There is a pronounced difference going from regular laparascopic to robotic surgery. In the visual aspect, for example, we now see the organs in 3D rather than as a 2 dimensional image, and we see at a 12-times enlargement.

Robotic surgery gives the surgeon wrist articulation with the instruments that you don't get in regular laparascopic, and that makes a difference. Robotic surgery, across the board, reduces blood loss and improves recovery time.

When I counsel patients on their approach to treatment, I let them know that the experience and skill of the surgeon matters as much as the method. I know that in my hands, robotic laparoscopy is a very successful tool. In the end, for the patient, there are three things that matter most: How well is your cancer controlled and your urinary and sexual function maintained. In my experience with robotic surgery, we've had excellent results with all three."

A Partnership in Patient Safety



In an effort to provide the most accurate diagnosis possible, Hudson Valley Urology utilizes the **know error® system** for prostate biopsies. This system uses bar coding and DNA matching to ensure that, when your results arrive, the results belong to you.

Together we deliver an important measure of safety for prostate biopsy patients.

know error®

swab. sample. dna match.

For more information | **www.knowerror.com**

GREAT PROSTATE CANCER Challenge® 2010

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UNDERSTANDING Urinary Tract Infections

It's the second most common bacterial infection, affecting nearly 1 in 3 women by the age of 24. Treatment works wonderfully... if you seek it in time.

Mark R. Libin, MD

Anyone can experience a urinary tract infection (UTI)—men, women, or children. But it's women, far and away, who get the most UTIs and make the lion's share of the annual 8.3 million doctor's visits for the condition. The problem probably lies with the female anatomy.

Though it contains fluids, salts and waste products, urine is normally sterile and free of bacteria and viruses. Most UTI infections occur when bacteria from the digestive tract (E. coli) cling to the opening of the urethra— the tube that carries urine from the bladder to outside the body—and begin to multiply.

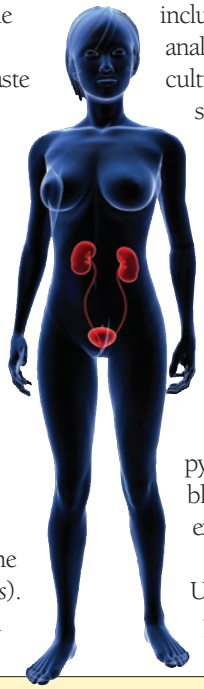
The ureters and bladder normally prevent urine from backing up toward the kidneys, and the flow of urine from the bladder helps wash bacteria out of the body. But still, infections occur.

An infection confined to the urethra is called *urethritis*. If the bacteria move up the urethra and establish themselves in the bladder, a bladder infection results (*cystitis*). If the infection isn't treated promptly and effectively, the bacteria may travel up the ureters and cause a kidney infection (*pyelonephritis*), a serious condition.

One reason that women get more UTIs than men may be that a woman's urethra is short, allowing bacteria quick access to the bladder. Also, a woman's urethral opening is near sources of bacteria from the anus and vagina. For many women, sexual intercourse seems to trigger an infection. Some studies also show that women who use a diaphragm are more likely to develop a UTI than women using other forms of birth control.

To determine whether you have a UTI, your doctor will test a sample of urine for pus and bacteria. This is most efficiently done with urinalysis, including diagnostic testing and microscopic analysis. The bacteria can then be grown in a culture and tested against different antibiotics to see which drug most effectively destroys it.

Often, a UTI can be cured with a few days of treatment if the infection is not complicated by an obstruction or other disorder.



Know the symptoms of UTI

- A frequent urge to urinate and a painful, burning feeling in the area of the bladder or urethra during urination.
- Malaise —feeling tired, shaky, washed out.
- Discomfort—women may feel an uncomfortable pressure above the pubic bone.
- Despite the urge to urinate, only a small amount of urine is passed. The urine itself may look milky or cloudy, even reddish if blood is present.
- If the kidneys are affected, there may be fever, pain in the back or side below the ribs, nausea, or vomiting.

Clearing up recurrences

If an infection doesn't clear up with treatment, or you experience frequent UTIs, your doctor may order some tests to determine if your system is normal. These might include a renal sonogram, CT scan, or intravenous pyelogram (IVP), which gives x-ray images of the bladder, kidneys, and ureters; and cystoscopy to examine the interior of the bladder.

Actually, many women suffer from frequent UTIs, and urologists have developed several approaches to stave them off or cut them short. If you have frequent recurrences (three or more a year) talk to your doctor about low-dose long term antibiotic treatments or prophylactic doses of antibiotics to take after sexual intercourse or immediately after symptoms appear.

Men take note...UTIs in men are often a result of an obstruction such as a urinary stone or enlarged prostate. In older men, they are frequently associated with acute bacterial prostatitis, which can have serious consequences if not treated urgently. If you think you have a UTI, consult your doctor.

"Not everything that looks like a urinary tract infection (UTI) is one. In fact, all the symptoms of UTI can actually be due to other disease entities, so appropriate evaluation is crucial for correct diagnosis and treatment.

There are simple UTIs and complicated ones that may be the result of kidney obstruction, stones, incomplete emptying, hormonal changes, and foreign bodies. Until the complicating factor is treated, you may not be able to do away with the UTI.

There is a wide range of factors that figure in UTIs. We see immunosupressed patients who can't fight off bacteria. We'll find sugar in the urine of poorly controlled diabetics, and sugar makes a wonderful culture medium for bacteria.

Sometimes it's the simple things that lead to a UTI, such as bathroom hygiene. Even your occupation can have an effect. Think of teachers, who can't go to the bathroom whenever they feel the need. Holding in urine gives bacteria a chance to get established.

In our office, we provide all the necessary tests to find the cause of a UTI, and all the treatments to cure it, including addressing complicating factors. Just don't wait for a urinary tract infection to develop into something more serious."

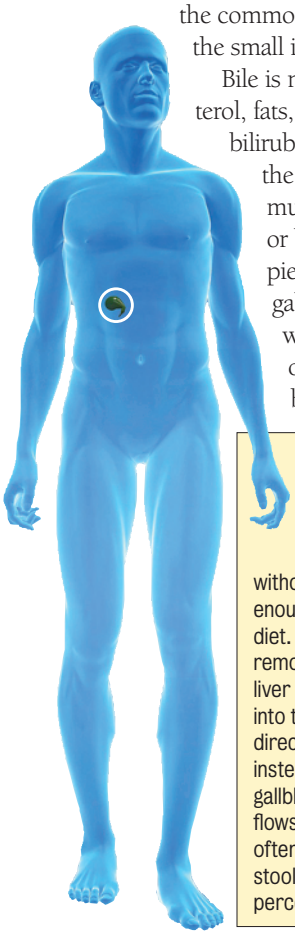
WHAT YOU NEED TO KNOW ABOUT

Your Gallbladder

Nearly 1 million new cases of gallbladder and gallstone disease are diagnosed every year in the U.S. Yet most of us don't even know why the little pear-shaped organ is there.

Most people don't give a thought to their gallbladder until it "attacks" them. A typical gallbladder attack might come shortly after a fatty meal, and often during the night. It usually announces itself with a steady pain in the upper right abdomen, a pain that increases rapidly and can last from 30 minutes to several hours.

The gallbladder is a small, pear-shaped sac located right below your liver in the right upper abdomen. It's the storage center for a liquid called bile, which is made in the liver, and helps the body digest fats. After a meal, the gallbladder contracts and pushes the bile into a tube—called the common bile duct—that carries it to the small intestine to do its work.



Bile is made up of water, cholesterol, fats, bile salts, proteins, and bilirubin—a waste product. If the liquid bile contains too much cholesterol, bile salts, or bilirubin, it can harden into pieces of stone-like material, gallstones. If a gallstone—which can be small as a grain of sand or as large as a golf ball—lodges in any of the ducts to and from the gallbladder, and blocks the normal flow of bile, you may experience an attack.

Aside from the initial pain, bile that's trapped in these ducts can cause inflammation in the gallbladder, the ducts and, more rarely, in the liver and pancreas. If the blockage remains for a significant time, infection and serious damage to the organs can occur.

Do you need your gallbladder?

Fortunately, the gallbladder is an organ people can live without. Your liver produces enough bile to digest a normal diet. Once the gallbladder is removed, bile flows out of the liver through the hepatic ducts into the common bile duct and directly into the small intestine, instead of being stored in the gallbladder. Because now the bile flows into the small intestine more often, softer and more frequent stools can occur in about 1 percent of people.

Responding to an attack

If you think you might have had a gallbladder attack—marked by abdominal pain, and sometimes pain in the back between the shoulder blades or under the right shoulder—you should make an appointment to see your physician. However, if the pain lasts more than 5 hours and you experience nausea and vomiting, fever or chills, or notice a yellowish color to your skin or the whites of your eyes—you should see a doctor *immediately*.

Gallstone symptoms may be similar to those of a heart attack, appendicitis, ulcers, irritable bowel syndrome, hiatal hernia, pancreatitis, and hepatitis, so an accurate diagnosis is important.

If, after discussing your symptoms and taking your medical history, gallstones are suspected, the specialists at Premier Medical's GI division will do an ultrasound exam. This is the most sensitive and specific test for gallstones. Other tests, like the CT scan and HIDA scan can be used to reveal possible complications or diagnose abnormal contraction of the gallbladder.

One of the most important procedures we do is called ERCP (endoscopic retrograde cholangiopancreatography). Using an endoscope, we can locate and remove stones that are lodged in the bile ducts. An EUS (endoscopic ultrasound) may also be used to better visualize the bile ducts and pancreas.

If you have frequent gallbladder attacks, you may be advised to have your gallbladder removed, one of the most common surgeries performed in the U.S. Luckily, the gallbladder is a non-essential organ, and you'll do fine without it and very fine without the pain of gallstones.

Salvatore M. Buffa, M.D.

"When gallbladder disease is suspected, the workup begins with a routine abdominal ultrasound to detect the presence of gallstones or dilation of the bile ducts. Although this exam is useful, it may miss stones in 15% of patients. Therefore, if no stones are seen on ultrasound the gallbladder is NOT necessarily ruled out as a cause for the symptoms. Another test called a HIDA scan, a nuclear imaging test, can be ordered to detect obstruction of the biliary tree or loss of gallbladder function.

An EUS (Endoscopic Ultrasound) can be used to better visualize the bile ducts and detect stones that are unable to be seen with conventional ultrasound.

If a stone is found in the bile ducts, an ERCP is necessary to remove the stone and "clear" the ducts prior to surgical removal of the gallbladder. By the way, even if stones are removed from the ducts, the gallbladder should still be removed by our surgical colleagues to prevent further attacks and symptoms.

Although patients may be apprehensive about the tests required for diagnosis of gallbladder problems, I can assure them that they are minimally invasive, well tolerated and essential for their diagnosis."

*IN THE TREATMENT OF SYMPTOMATIC BPH**

RAPID RELIEF

THAT KEEPS HIM GOING

*Benign prostatic hyperplasia

RAPAFLO® is indicated for the treatment of the signs and symptoms of benign prostatic hyperplasia (BPH). RAPAFLO® is not indicated for the treatment of hypertension.

Important Safety Information

RAPAFLO® is contraindicated in patients with severe renal impairment (CCr <30 mL/min), severe hepatic impairment (Child-Pugh score ≥10), and with use of strong CYP3A4 inhibitors.

Postural hypotension with or without symptoms (eg, dizziness) may develop when beginning treatment with RAPAFLO®. As with all alpha-blockers, there is a potential for syncope. Patients should be warned of the possible occurrences of such events and should avoid situations where injury could result. RAPAFLO® should be used with caution in patients with moderate renal impairment. Patients should be assessed to rule out the presence of prostate cancer prior to starting treatment with RAPAFLO®. Patients planning cataract surgery should inform their ophthalmologist that they are taking RAPAFLO®.

The most common side effects are retrograde ejaculation, dizziness, diarrhea, orthostatic hypotension, headache, nasopharyngitis, and nasal congestion.

Please see brief summary of Full Prescribing Information on adjacent page.

Models are for illustrative purposes only.

www.rapaflo.com

Watson

RAPAFLO® 8 mg (silodosin) capsules

READY. SET. GO.

06318 1/10

RAPAFLO®
(silodosin) capsules

BRIEF SUMMARY

For full Prescribing Information, see package insert.

INDICATIONS AND USAGE

RAPAFLO, a selective alpha-1 adrenergic receptor antagonist, is indicated for the treatment of the signs and symptoms of benign prostatic hyperplasia (BPH). RAPAFLO is not indicated for the treatment of hypertension.

CONTRAINDICATIONS

- Severe renal impairment (CCr < 30 mL/min)
- Severe hepatic impairment (Child-Pugh score ≥ 10)
- Concomitant administration with strong Cytochrome P450 3A4 (CYP3A4) inhibitors (e.g., ketoconazole, clarithromycin, itraconazole, ritonavir) [*see Drug Interactions*]

WARNINGS AND PRECAUTIONS

Orthostatic Effects

Postural hypotension, with or without symptoms (e.g., dizziness) may develop when beginning RAPAFLO treatment. As with other alpha-blockers, there is potential for syncope. Patients should be cautioned about driving, operating machinery, or performing hazardous tasks when initiating therapy [*see Adverse Reactions and Use in Specific Populations*].

Renal Impairment

In a clinical pharmacology study, plasma concentrations (AUC and C_{max}) of silodosin were approximately three times higher in subjects with moderate renal impairment compared with subjects with normal renal function, while half-lives of silodosin doubled in duration. The dose of RAPAFLO should be reduced to 4 mg in patients with moderate renal impairment. Exercise caution and monitor such patients for adverse events [*see Use in Specific Populations*].

RAPAFLO is contraindicated in patients with severe renal impairment [*see Contraindications*].

Hepatic Impairment

RAPAFLO has not been tested in patients with severe hepatic impairment, and therefore, should not be prescribed to such patients [*see Contraindications and Use in Specific Populations*].

Pharmacokinetic Drug-Drug Interactions

In a drug interaction study, co-administration of a single 8 mg dose of RAPAFLO with 400 mg ketoconazole, a strong CYP3A4 inhibitor, caused a 3.8-fold increase in maximum plasma silodosin concentrations and 3.2-fold increase in silodosin exposure (i.e., AUC). Concomitant use of ketoconazole or other strong CYP3A4 inhibitors (e.g., itraconazole, clarithromycin, ritonavir) is therefore contraindicated [*see Drug Interactions*].

Pharmacodynamic Drug-Drug Interactions

The pharmacodynamic interactions between silodosin and other alpha-blockers have not been determined. However, interactions may be expected, and RAPAFLO should not be used in combination with other alpha-blockers [*see Drug Interactions*].

A specific pharmacodynamic interaction study between silodosin and antihypertensive agents has not been performed. However, patients in the Phase 3 clinical studies taking concomitant antihypertensive medications with RAPAFLO did not experience a significant increase in the incidence of syncope, dizziness, or orthostasis. Nevertheless, exercise caution during concomitant use with antihypertensives and monitor patients for possible adverse events [*see Adverse Reactions and Drug Interactions*].

Caution is also advised when alpha-adrenergic blocking agents including RAPAFLO are co-administered with PDE5 inhibitors. Alpha-adrenergic blockers and PDE5 inhibitors are both vasodilators that can lower blood pressure. Concomitant use of these two drug classes can potentially cause symptomatic hypotension [*see Drug Interactions*].

Carcinoma of the Prostate

Carcinoma of the prostate and BPH cause many of the same symptoms. These two diseases frequently co-exist. Therefore, patients thought to have BPH should be examined prior to starting therapy with RAPAFLO to rule out the presence of carcinoma of the prostate.

Intraoperative Floppy Iris Syndrome

Intraoperative Floppy Iris Syndrome has been observed during cataract surgery in some patients on alpha-1 blockers or previously treated with alpha-1 blockers. This variant of small pupil syndrome is characterized by the combination of a flaccid iris that billows in response to intraoperative irrigation currents; progressive intraoperative miosis despite preoperative dilation with standard mydriatic drugs; and potential prolapse of the iris toward the phacoemulsification incisions. Patients planning cataract surgery should be told to inform their ophthalmologist that they are taking RAPAFLO [*see Adverse Reactions*].

Laboratory Test Interactions

No laboratory test interactions were observed during clinical evaluations. Treatment with RAPAFLO for up to 52 weeks had no significant effect on prostate-specific antigen (PSA).

ADVERSE REACTIONS

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

In U.S. clinical trials, 897 patients with BPH were exposed to 8 mg RAPAFLO daily. This includes 486 patients exposed for 6 months and 168 patients exposed for 1 year. The population was 44 to 87 years of age, and predominantly Caucasian. Of these patients, 42.8% were 65 years of age or older and 10.7% were 75 years of age or older.

In double-blind, placebo controlled, 12-week clinical trials, 466 patients were administered RAPAFLO and 457 patients were administered placebo. At least one treatment-emergent adverse reaction was reported by 55.2% of RAPAFLO treated patients (36.8% for placebo treated). The majority (72.1%) of adverse reactions for the RAPAFLO treated patients (59.8% for placebo treated) were qualified by the investigator as mild. A total of 6.4% of RAPAFLO treated patients (2.2% for placebo treated) discontinued therapy due to an adverse reaction (treatment-emergent), the most common reaction being retrograde ejaculation (2.8%) for RAPAFLO treated patients. Retrograde ejaculation is reversible upon discontinuation of treatment.

Adverse Reactions observed in at least 2% of patients:

The incidence of treatment-emergent adverse reactions listed in the following table were derived from two 12-week, multicenter, double-blind, placebo-controlled clinical studies of RAPAFLO 8 mg daily in BPH patients. Adverse reactions that occurred in at least 2% of patients treated with RAPAFLO and more frequently than with placebo are shown in Table 1.

Table 1 Adverse Reactions Occurring in ≥ 2% of Patients in 12-week, Placebo-Controlled Clinical Trials

Adverse Reactions	RAPAFLO N = 466 n (%)	Placebo N = 457 n (%)
Retrograde Ejaculation	131 (28.1)	4 (0.9)
Dizziness	15 (3.2)	5 (1.1)
Diarrhea	12 (2.6)	6 (1.3)
Orthostatic Hypotension	12 (2.6)	7 (1.5)
Headache	11 (2.4)	4 (0.9)
Nasopharyngitis	11 (2.4)	10 (2.2)
Nasal Congestion	10 (2.1)	1 (0.2)

In the two 12-week, placebo-controlled clinical trials, the following adverse events were reported by between 1% and 2% of patients receiving RAPAFLO and occurred more frequently than with placebo: insomnia, PSA increased, sinusitis, abdominal pain, asthenia, and rhinorrhea. One case of syncope in a patient taking prazosin concomitantly and one case of priapism were reported in the RAPAFLO treatment group.

In a 9-month open-label safety study of RAPAFLO, one case of Intraoperative Floppy Iris Syndrome (IFIS) was reported.

Postmarketing Experience

The following adverse reactions have been identified during post approval use of silodosin. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure:

Skin and subcutaneous tissue disorders: *toxic skin eruption, purpura*

Hepatobiliary disorders: *jaundice, impaired hepatic function associated with increased transaminase values*

DRUG INTERACTIONS

Moderate and Strong CYP3A4 Inhibitors

In a clinical metabolic inhibition study, a 3.8-fold increase in silodosin maximum plasma concentrations and 3.2-fold increase in silodosin exposure were observed with concurrent administration of a strong CYP3A4 inhibitor, 400 mg ketoconazole. Use of strong CYP3A4 inhibitors such as itraconazole or ritonavir may cause plasma concentrations of silodosin to increase. Concomitant administration of strong CYP3A4 inhibitors and RAPAFLO is contraindicated [*see Contraindications and Warnings and Precautions*].

The effect of moderate CYP3A4 inhibitors on the pharmacokinetics of silodosin has not been evaluated. Concomitant administration with moderate CYP3A4 inhibitors (e.g., diltiazem, erythromycin, verapamil) may increase concentration of RAPAFLO. Exercise caution and monitor patients for adverse events when co-administering RAPAFLO with moderate CYP3A4 inhibitors.

Strong P-glycoprotein (P-gp) Inhibitors

In vitro studies indicated that silodosin is a P-gp substrate. Ketoconazole, a CYP3A4 inhibitor that also inhibits P-gp, caused significant increase in exposure to silodosin. Inhibition of P-gp may lead to increased silodosin concentration. RAPAFLO is therefore not recommended in patients taking strong P-gp inhibitors such as cyclosporine.

Alpha-Blockers

The pharmacodynamic interactions between silodosin and other alpha-blockers have not been determined. However, interactions may be expected, and RAPAFLO should not be used in combination with other alpha-blockers [*see Warnings and Precautions*].

Digoxin

The effect of co-administration of RAPAFLO and digoxin 0.25 mg/day for 7 days was evaluated in a clinical trial in 16 healthy males, aged 18 to 45 years. Concomitant administration of RAPAFLO and digoxin did not significantly alter the steady state pharmacokinetics of digoxin. No dose adjustment is required.

PDE5 Inhibitors

Co-administration of RAPAFLO with a single dose of 100 mg sildenafil or 20 mg tadalafil was evaluated in a placebo-controlled clinical study that included 24 healthy male subjects, 45 to 78 years of age. Orthostatic vital signs were monitored in the 12-hour period following concomitant dosing. During this period, the total number of positive orthostatic test results was greater in the group receiving RAPAFLO plus a PDE5 inhibitor compared with RAPAFLO alone. No events of symptomatic orthostasis or dizziness were reported in subjects receiving RAPAFLO with a PDE5 inhibitor.

Other Concomitant Drug Therapy

Antihypertensives

The pharmacodynamic interactions between silodosin and antihypertensives have not been rigorously investigated in a clinical study. However, approximately one-third of the patients in clinical studies used concomitant antihypertensive medications with RAPAFLO. The incidence of dizziness and orthostatic hypotension in these patients was higher than in the general silodosin population (4.6% versus 3.8% and 3.4% versus 3.2%, respectively). Exercise caution during concomitant use with antihypertensives and monitor patients for possible adverse events [*see Warnings and Precautions*].

Metabolic Interactions

In vitro data indicate that silodosin does not have the potential to inhibit or induce cytochrome P450 enzyme systems.

Food Interactions

The effect of a moderate fat, moderate calorie meal on silodosin pharmacokinetics was variable and decreased silodosin maximum plasma concentration (C_{max}) by approximately 18 - 43% and exposure (AUC) by 4 - 49% across three different studies. Safety and efficacy clinical trials for RAPAFLO were always conducted in the presence of food intake. Patients should be instructed to take silodosin with a meal to reduce risk of adverse events.

USE IN SPECIFIC POPULATIONS

Pregnancy

Pregnancy Category B. RAPAFLO is not indicated for use in women.

An embryo/fetal study in rabbits showed decreased maternal body weight at 200 mg/kg/day (approximately 13-25 times the maximum recommended human exposure or MRHE of silodosin via AUC). No statistically significant teratogenicity was observed at this dose.

Silodosin was not teratogenic when administered to pregnant rats during organogenesis at 1000 mg/kg/day (estimated to be approximately 20 times the MRHE). No maternal or fetal effects were observed at this dose. Rats and rabbits do not produce glucuronidated silodosin, which is present in human serum at approximately 4 times the level of circulating silodosin and which has similar pharmacological activity to silodosin.

No effects on physical or behavioral development of offspring were observed when rats were treated during pregnancy and lactation at up to 300 mg/kg/day.

Pediatric Use

RAPAFLO is not indicated for use in pediatric patients. Safety and effectiveness in pediatric patients have not been established.

Geriatric Use

In double-blind, placebo-controlled, 12-week clinical studies of RAPAFLO, 259 (55.6%) were under 65 years of age, 207 (44.4%) patients were 65 years of age and over, while 60 (12.9%) patients were 75 years of age and over. Orthostatic hypotension was reported in 2.3% of RAPAFLO patients < 65 years of age (1.2% for placebo), 2.9% of RAPAFLO patients ≥ 65 years of age (1.9% for placebo), and 5.0% of patients ≥ 75 years of age (0% for placebo). There were otherwise no significant differences in safety or effectiveness between older and younger patients.

Renal Impairment

The effect of renal impairment on silodosin pharmacokinetics was evaluated in a single dose study of six male patients with moderate renal impairment and seven male subjects with normal renal function. Plasma concentrations of silodosin were approximately three times higher in subjects with moderate renal impairment compared with subjects with normal renal function.

RAPAFLO should be reduced to 4 mg per day in patients with moderate renal impairment. Exercise caution and monitor patients for adverse events.

RAPAFLO has not been studied in patients with severe renal impairment. RAPAFLO is contraindicated in patients with severe renal impairment [*see Contraindications and Warnings and Precautions*].

Hepatic Impairment

In a study comparing nine male patients with moderate hepatic impairment (Child-Pugh scores 7 to 9), to nine healthy male subjects, the single dose pharmacokinetics of silodosin were not significantly altered in patients with hepatic impairment. No dosing adjustment is required in patients with mild or moderate hepatic impairment.

RAPAFLO has not been studied in patients with severe hepatic impairment. RAPAFLO is contraindicated in patients with severe hepatic impairment [*see Contraindications and Warnings and Precautions*].

OVERDOSAGE

RAPAFLO was evaluated at doses of up to 48 mg/day in healthy male subjects. The dose-limiting adverse event was postural hypotension.

Should overdose of RAPAFLO lead to hypotension, support of the cardiovascular system is of first importance. Restoration of blood pressure and normalization of heart rate may be accomplished by maintaining the patient in the supine position. If this measure is inadequate, administration of intravenous fluid should be considered. If necessary, vasopressors could be used, and renal function should be monitored and supported as needed. Dialysis is unlikely to be of significant benefit since silodosin is highly (97%) protein bound.

Watson

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For additional information see:
www.rapaflo.com
or call 1-866-RAPAFLO (727-2356)

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Physician to Physician

Insight regarding Premier Medical Group's capabilities and concerns



Physicians in the new Kingston office, from left: Dr. Robert Dean, Dr. Farshad Elmi, Dr. Sven Hida

New GI Resources for Kingston

The specialist physicians at GI Associates (a division of Premier Medical) have provided the Hudson Valley with state-of-the-art care in gastroenterology for nearly three decades. Now, we are pleased to announce, they are expanding their practice with a new office, to better serve patients in the Kingston area.

Drs. Robert Dean, Farshad Elmi, and Sven Hida will extend the GI Associates commitment to providing the most effective and specialized medical services in all aspects of gastrointestinal disorders to the Kingston office. They can provide comprehensive treatment for IBS, Liver disease, Colon Cancer, Celiac disease and Gallbladder disease. Services will include ERCP, EUS, HALO ablation therapy, and a full range of endoscopic procedures.

Our Kingston office is located at 111 Mary's Avenue. Call 845-471-9410 for your appointment today. GI Associates, a division of Premier Medical Group, provides the experience you need, the compassion you deserve.

FAIL-SAFE Patient Safety

Matching a patient's DNA to the prostate biopsy sample eliminates Specimen Provenance Error.

To provide our patients with an added measure of safety and diagnostic accuracy, the Hudson Valley Urology division of Premier Medical has adopted the know error® system for prostate biopsies. Combined with the stringent practices of our in-house pathology lab, use of the system virtually eliminates the possibility that an error due to misidentification or sample contamination will result in an adverse patient outcome.

The know error® system provides DNA verification between the patient and his biopsy tissue samples. This system incorporates three steps:

The swab. Before a biopsy procedure, a reference sample of the patient's DNA is taken by swabbing the inside of the patient's cheek. The swab is sent to an independent forensic DNA lab.

The sample. The patient's biopsy tissue samples are placed in bar coded specimen containers from the biopsy kit and sent to the pathology lab for evaluation.

The DNA match. If the biopsy results come back positive, the forensics lab performs a DNA Specimen Provenance Assay (DSPA) using genetic microsatellite analysis. This test compares the Short Tandem Repeat (STR) profile of the patient's biopsy tissue to the patient's reference sample. A match of these STR profiles rules out Specimen Provenance Error.

Premier Medical believes this extra layer of safety is something our patients expect and deserve.

Clinical Trials CONNECTION

We are currently seeking patients to participate in studies in:

BPH/Nocturia
Alexa Markiewicz • 845-437-5051
amarkiewicz@premiermedicalhv.com

Chronic Pancreatitis
Alyson Cahill • 845-471-9410 ext. 41
acahill@premiermedicalhv.com

Erectile Dysfunction
Kimberly LaVigne-Secord • 845-437-5002
ksecord@premiermedicalhv.com

Female Sexual Dysfunction
Ann Scandariato • 845-437-5010
ascandariato@premiermedicalhv.com

Interstitial Cystitis
Kimberly LaVigne-Secord • 845-437-5002
ksecord@premiermedicalhv.com

Overactive Bladder
Kimberly LaVigne-Secord • 845-437-5002
ksecord@premiermedicalhv.com

Premature Ejaculation
Kimberly LaVigne-Secord • 845-437-5002
ksecord@premiermedicalhv.com

Prostate Cancer
Ann Scandariato • 845-437-5010
ascandariato@premiermedicalhv.com

Ulcerative Colitis
Alyson Cahill • 845-471-9410 ext. 41
acahill@premiermedicalhv.com

Patients with Diabetes

Do you suffer from nausea, vomiting, bloating, and abdominal discomfort after eating?

If the answer is YES, you may be eligible to participate in a study for an investigational medication to reduce the symptoms associated with delayed stomach emptying (gastroparesis) experienced by some patients with diabetes.

Alyson Cahill • 845-471-9410 ext. 41
acahill@premiermedicalhv.com

PREMIER *medical group*
1 Columbia Street
Poughkeepsie, New York 12601
www.premiermedicalhv.com

Faces of Premier

Good healthcare requires teamwork, and we're proud of the dedicated staff that makes up the Premier Medical Group team. Many of our nurses, technicians, and support staff have been with us for years, and their loyalty contributes significantly to the comfort and security of our patients.

Debbie Cantamessa (*left*)
Practice Administrator
GI Associates division of Premier Medical

Lorraine O'Donnell (*right*)
Director of Human Resources,
Clinical Research Manager
Hudson Valley Urology division of Premier Medical

We're the go-to types," says Lorraine, describing her and Debbie's roles at Premier Medical Group. For the last six months they've been collaborating on the nuts and bolts activities that go into merging two thriving specialty practices.

"Debbie and I have been going page by page through the clinical practice handbooks," says Lorraine, "unifying our approach to everything from patient confidentiality to staff vacations. Our goal is to organize the back office details that will allow the practice to run smoothly."

"One of the important things in merging a practice," says Debbie, "is to make sure everyone is on board. Here, the inspiration and leadership comes right from the top with Dr. Khurana and Dr. Goldfischer."

"I love working for a dynamic group of doctors who are devoted to the practice of medicine" Lorraine says. "One of the things I admire about our physicians," says Debbie, "is the respect they give to their patients and their staff."

"Both divisions, GI and Urology, are hard working," Debbie says, "and one reason the merger is coming along so well is that we have the same mindset — it's all about patient care."