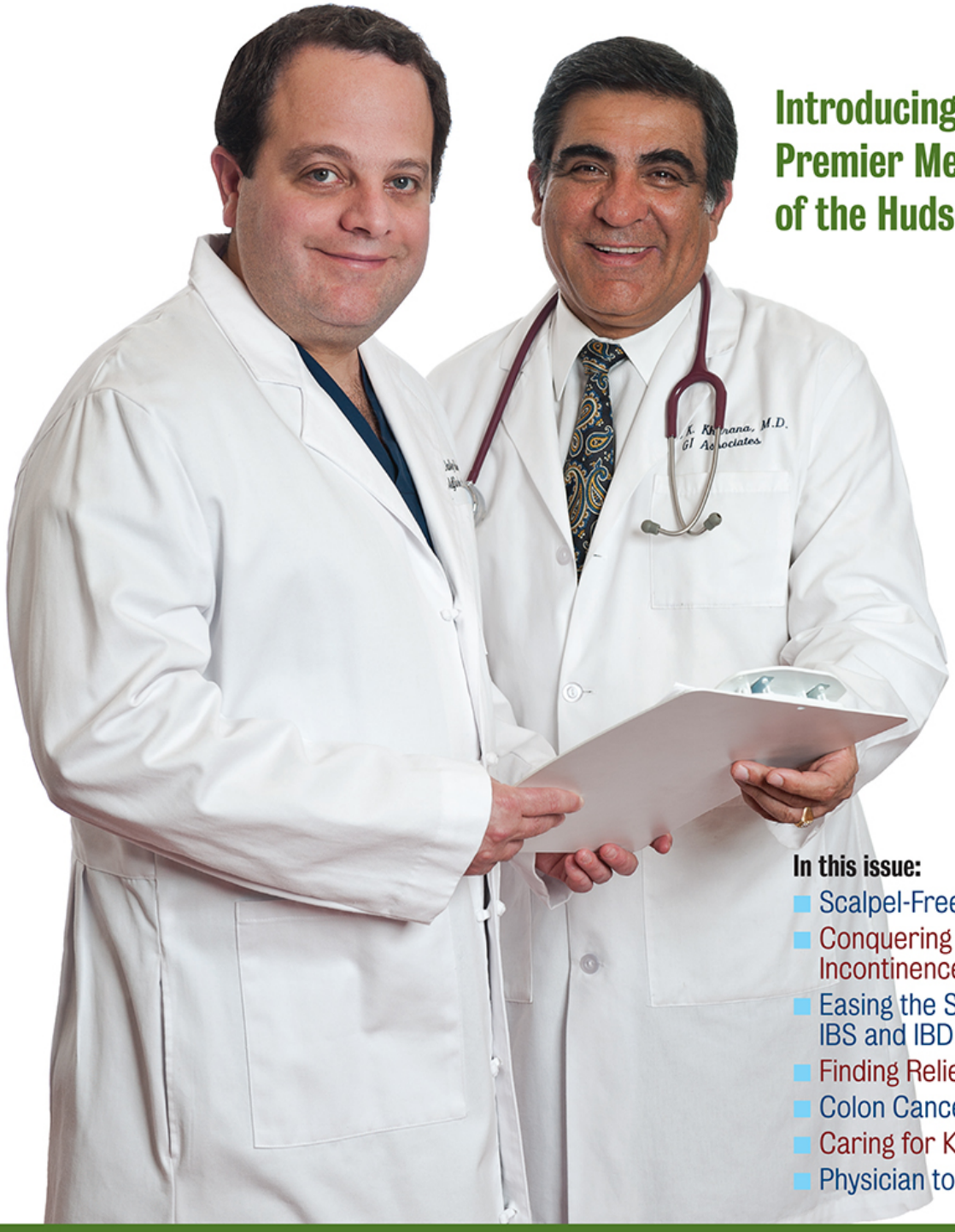
PremierHealth

The experience you need... the compassion you deserve

SUMMER 2010



Introducing Premier Medical Group of the Hudson Valley

In this issue:

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

INTRODUCING

Premier Medical Group

We are 18 experienced specialist physicians, 16 dedicated nurses, 2 physician assistants, 2 nurse practitioners, 2 pathologists, 7 lab technicians, 5 research coordinators, 6 medical assistants, 4 patient care representatives, and 41 support staff — all committed to providing you the specialty care you deserve.

Two of the region's top physician specialty groups — GI Associates and Hudson Valley Urology — have joined forces to establish Premier Medical Group. The union brings together 18 board certified doctors in both medical and surgical specialties.

Each of Premier's ten experienced urologists is highly trained in general urology and also in at least one of the various urologic subspecialties, such as neurourology/voiding disorders (female urology), urologic oncology (surgical and medical), and male reproductive medicine.

Urology patients are offered a full range of up-to-the-minute treatments for prostate conditions; urinary incontinence; overactive bladder; cancer of the prostate, bladder and kidney; stones; female and male sexual dysfunction and vasectomy. Our skilled surgeons have demonstrated expertise in reconstructive surgery and minimally invasive and laparoscopic surgical techniques. We are currently the only medical group in the area using the sophisticated DaVinci robotic surgical system for prostate surgery.

Premier's eight fellowship trained gastroenterologists offer specialized medical services in all aspects of gastrointestinal (stomach and intestines) and hepatologic (liver-related) disorders. These include treatment and screening for liver disease, celiac disease, heartburn, colitis, ulcers, hernia, Crohn's disease and colon cancer.

Office-based services include colonoscopy for colon cancer screening, upper GI tract endoscopy; capsule endoscopy for diagnosis of small bowel disorders; BRAVO monitoring to evaluate acid reflux disease and lactose tolerance testing. ERCP, used to diagnose and treat problems in the liver, gallbladder, bile ducts and pancreas and Barrx HALO ablation therapy for treatment of Barrett's esophagus are performed in the hospital setting. Premier is one of the few practices in our region to perform ablation therapy for Barrett's.

The depth and breadth of expertise on-hand in Premier's group practice means there's always a physician well-versed in your particular medical situation.

Premier maintains state-of-the-art, high-definition endoscopy suites at its gastroenterology centers in Poughkeepsie and New Windsor, making it convenient for patients to stay current with their exams.

Unique among area medical groups, Premier operates its own pathology lab and radiology department, concentrating exclusively on imaging and testing for urology and gastroenterology. All patients' slides are double-read by two in-house pathologists, yielding faster and extremely accurate results. The group also has distinguished itself by being one of the largest conductors of clinical research in the region. This offers patients the opportunity to benefit from the very latest treatments and therapies.

At Premier, patients are afforded more than just great medical care; they receive exceptional customer service and consideration, and can be assured that every effort is made to see them on time. Now when you need a specialist, you have the option of going to a "specialty" medical practice.

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

Gastroenterologists

With offices in...
Poughkeepsie: 845-471-9410
New Windsor: 845-562-0740
Fishkill: 845-897-9797

Sunil K. Khurana, MD
Peter M. Varunok, MD
Salvatore M. Buffa, MD
Robert S. Dean, MD
Khurram I. Ashraf, DO
Arif M. Muslim, MD
Rodney L. Camp, DO
Srinivasan Selvaraj, MD

Urologists

With offices in Poughkeepsie, Kingston, Fishkill and Rhinebeck
MAIN PHONE: 845-437-5000

Mark Libin, MD
Daniel Katz, MD
Evan R. Goldfischer, MD, FACS
Michael Solliday, MD
Jason Krumholtz, MD
Scott Kahn, MD, FACS
Jose Sotolongo, MD
Naeem Rahman, MD
Paul Pietrow, MD
Michael Young, MD

The physicians of Premier Medical Group are affiliated with:
Benedictine Hospital
Kingston Hospital
Northern Dutchess Hospital
St. Francis Hospital
St. Luke's Cornwall Hospital
Vassar Brothers Medical Center

PREMIER *medical group*

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[UROLOGY]

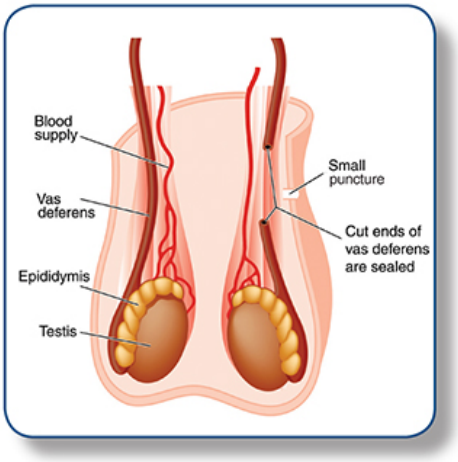
SCALPEL-FREE Vasectomy

A simple, painless, 10-minute procedure in the doctor's office can provide men with a lifetime of reliable contraception.

It's a simple surgery with a simple goal: Vasectomy provides permanent male birth control by severing and blocking the tubes through which sperm pass to mix with semen.

Sperm are produced in the male's testes (testicles) and stored in an adjacent structure called the epididymis. During sexual climax, the sperm migrate from the epididymis through a pair of tubes called the vas deferens and mix with other components of semen to form the ejaculate. All vasectomy techniques involve cutting and sealing both the left and right vas deferens, so the ejaculate will no longer contain sperm, and pregnancy will not occur.

In the traditional vasectomy, a technique going back a hundred years, the physician makes one or two small incisions, or cuts, in the skin of the scrotum; the vas is cut, and a small piece may be removed. Next, the doctor seals the cut ends and sews up the scrotal incision. The entire procedure is then repeated on the other side.



How we do it

At Premier, we use a method called scalpel-free vasectomy introduced in the U.S. in 1988. We use a special instrument to make a single tiny puncture in the skin and stretch the opening so that both tubes can be cut and sealed. No stitches are needed to close the punctures, which heal quickly by themselves.

Studies show that the no-scalpel method produces less pain and fewer complications than the conventional method. There's less bleeding, bruising, and risk of infection. In addition, no-scalpel vasectomy permits a faster return to sexual activity.

Protection against pregnancy doesn't occur immediately after vasectomy. Sperm count decreases gradually over two or three months and with each ejaculation. Some other form of contraception is needed until microscopic examination of a semen sample confirms that the semen is sperm-free. It's also important to remember that vasectomy provides no protection, for you or your partner, against sexually transmitted diseases.

The Benefits of Vasectomy

- The one-time, in-office procedure provides permanent contraception.
- The most reliable form of birth control.
- Safer and more dependable than tubal ligation, the equivalent operation for women, which requires hospitalization and general anesthesia.
- Spares the female partner from the possible side-effects of oral contraceptives or IUD.

The big question

In the United States, one in six men over the age of 35 has had a vasectomy. They can tell you that the procedure has absolutely no effect on sexuality. The body continues releasing the same amount of testosterone, the hormone related to sex drive, beard, deep voice and other masculine traits. There is no change in erection, sensation, or orgasm after vasectomy, and the amount of semen remains the same, though free of sperm.

In fact, according to the National Institutes of Health, "men who have undergone the procedure, and their partners, find that sex is more spontaneous and enjoyable once they are freed from concerns about contraception and accidental pregnancy."

Jason Krumholtz, MD

"During the procedure, there is very little discomfort. The procedure takes about 10 minutes and the patient is back to work in two days.

Vasectomy should be looked upon as permanent contraception. I advise people to think it through carefully and be certain they're committed to having no more children before they decide on the procedure. The vast majority of patients are very satisfied with their choice.

There are certain questions we get a lot from men and their wives. People want to make sure that sexual function isn't affected and we can assure them that there's no down side to vasectomy as far as sex is concerned. And as far as birth control is concerned, it's the most effective measure."

CONQUERING Incontinence

The first step to ending the discomfort and embarrassment is a visit to your doctor or urologist. We can help.

Sometimes it's a laugh or a sneeze that causes an accidental leakage. Sometimes, there's a sudden, overwhelming urge that can't be controlled. However it occurs, the involuntary loss of urine is called urinary incontinence (UI). It's a common problem, about 17 million men and women in the U.S. experience it, but that doesn't make it any easier to live with.

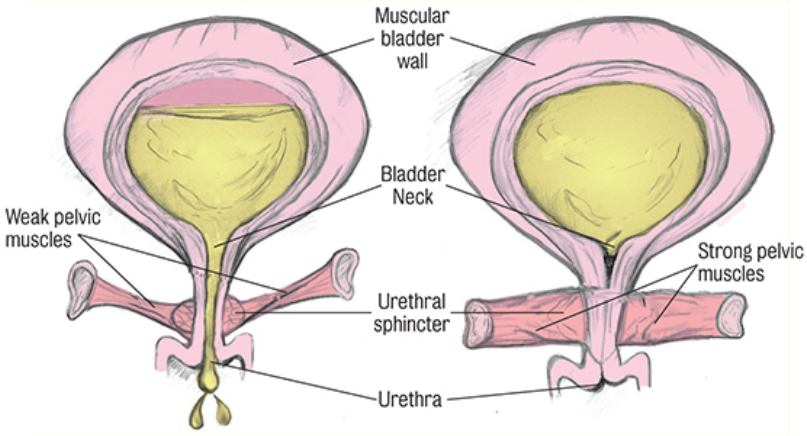
UI can be slightly bothersome or truly debilitating. The embarrassment of "wetting" in public can interfere with normal everyday activities and cause tremendous emotional distress. And, too often, embarrassment keeps people with urinary incontinence from confiding in the doctors who can help them.

UI is twice as prevalent in women as in men. The effects of pregnancy and childbirth, menopause, and the structure of the female urinary tract account for this difference. Older women experience UI more often than younger women, but incontinence is not an inevitable part of aging. UI is a medical problem and your doctor can help you find a solution.

Incontinence occurs because of problems with the muscles and nerves that help to hold or release urine. The body stores urine—water and wastes removed by the kidneys—in the bladder, a balloon-like organ. The bladder connects to the urethra, the tube through which urine leaves the body.

During urination, muscles in the wall of the bladder contract, forcing urine out of the bladder and into the urethra. At the same time, sphincter muscles surrounding the urethra relax, letting urine pass out of the body. Incontinence will occur if your bladder muscles suddenly contract or the sphincter muscles are not strong enough to hold back urine.

Front view of the female bladder. Weak pelvic muscles allow urine leakage (left). Strong pelvic muscles, which can be developed by practicing Kegel exercises, keep the urethra closed (right).



Finding Relief

There are several different types of UI, each with its own causes and each requiring a specific approach to treatment. The first step toward relief from UI is to see a doctor, like a urologist, who has experience treating incontinence. Your doctor's first steps will include diagnosing the type of UI you are experiencing.

The doctor will ask about your symptoms and medical history. Your pattern of voiding and urine leakage may suggest the type of incontinence you have, so you'll be asked to fill out a bladder diary over several days. This diary should note the times you urinate and the amounts of urine you produce, record your fluid intake, and note episodes of urine leakage and estimated amounts of leakage.

If your diary and medical history don't provide enough clues for diagnosis, they will at least suggest which tests you need. In addition to a physical examination for signs of medical conditions that may cause UI, urologists use an array of techniques to examine the anatomy and function of the urinary system. Ultrasound, cystoscopy (using a thin tube with a tiny camera to see inside the urethra and bladder) and urodynamics can now help provide a clear view of the causes of a patient's incontinence.

Cure or control

In the last decade, the number of options for curing or controlling UI have increased tremendously. The treatment plan you and your physician develop will depend on the type and severity of your problem, and generally starts with the simpler approaches. It's important to remember that there's no single approach that works for every patient.

• Behavioral Remedies. Many people with mild UI are able to regain urinary control by changing a few habits (such as smoking, weight control, or diet) and strengthening the pelvic muscles that hold urine in the bladder with Kegel exercises. For some, avoiding incontinence is as simple as limiting fluids at certain times of the day or planning regular trips to the bathroom—a therapy called timed voiding or bladder training.

• Biofeedback can supplement pelvic muscle exercises and help relieve stress and urge incontinence. In this approach, measuring devices help you become aware of when your bladder and urethral muscles contract, knowledge that can be used to gain control over these muscles.

• Medicines affect bladder control in different ways. Some prevent incontinence by blocking abnormal nerve signals that make the bladder contract at the wrong time, while others slow the production of urine. Still others relax the bladder or, in men, shrink the prostate. The urologists at Premier are actively involved in clinical trials, ensuring that our patients have access to the newest pharmaceutical developments.

• Electrical stimulation is an option for some patients with urge incontinence. A kind of pacemaker for the bladder sends electrical impulses to nerves that control the voiding function.

• Injections to increase the bulk of the sphincter muscle can be helpful for people with stress incontinence. The doctor injects the bulking agent around the bladder neck and urethra to make the tissues thicker and better able to close the bladder opening. The painless procedure, done with local anesthetic, takes less than half an hour.

• Surgery for UI has seen some of the most striking developments in recent years, particularly for the cure of stress incontinence in women.

MYTH

Urinary Incontinence is a natural part of aging.

In some women, the bladder can move out of its normal position, especially following childbirth. Surgeons have developed different techniques for supporting the bladder back to its normal position.

Among the newest procedures is a minimally invasive surgery called the Suburethral Sling. A synthetic mesh is placed under the urethra to support and compress it, effectively preventing the activity-related leaks of stress incontinence. The high success rate and fast recovery time make this surgery a boon to women who have been living with stress incontinence.

With new medicines and treatments being developed every day, there is no longer any good reason to resign yourself to living with UI.

Types of Urinary Incontinence

Stress — The involuntary loss of urine during actions—such as coughing, sneezing, and lifting—that put abdominal pressure on the bladder. Physical changes resulting from pregnancy, childbirth, and menopause often cause stress incontinence. These events can injure or weaken the scaffolding that helps support the bladder in women and prevent muscles that normally force the urethra shut from squeezing as tightly as they should.

Urge — The involuntary loss of urine following an overwhelming urge to urinate that cannot be halted. A common cause of urge incontinence is bladder spasms or contractions resulting from abnormal nerve signals. Urge incontinence can mean that your bladder empties during sleep, after drinking a small amount of water, or when you touch water or hear it running (as when washing dishes or hearing someone else taking a shower). Certain fluids and medications, such as diuretics, or emotional states such as anxiety, can worsen this condition.

Overactive Bladder — Bothersome urination eight or more times a day or two or more times at night; the sudden strong need to urinate immediately; and leakage or gushing of urine that follows a sudden, strong urge may be signs of an overactive bladder.

Functional — People with medical problems that interfere with thinking, moving, or communicating may have trouble reaching a toilet. Functional incontinence is the result of these physical and medical conditions. Conditions such as arthritis often develop with age and account for some of the incontinence of the elderly.

Overflow — When the bladder doesn't empty properly, it can result in "spill over," and a constant dribbling of urine. Overflow incontinence can result from nerve damage, weak bladder muscles or a blocked urethra. This type of UI is rare in women.

Mixed — Stress and urge incontinence often occur together in women. Combinations of stress and urge incontinence are sometimes referred to as mixed incontinence. Most women don't have pure stress or urge UI, and studies show that mixed incontinence is the most common type of urine loss in women.

Transient — Temporary incontinence can be triggered by medications, urinary tract infections, mental impairment, and restricted mobility. Severe constipation can cause transient incontinence when the impacted stool pushes against the urinary tract and obstructs outflow.

Daniel Katz, MD

"Urinary incontinence is prevalent and pervasive. It's also under-diagnosed and under-treated. Yet, well over 90% of the time, I can make my patients better. Sometimes all it takes is a simple treatment to get extraordinary benefits and literally turn someone's life around.

The main point I try to get across is that incontinence is not a normal part of aging. Just because grandma had a problem doesn't mean that you have to. But if you do have a problem, that doesn't mean you have to live with it.

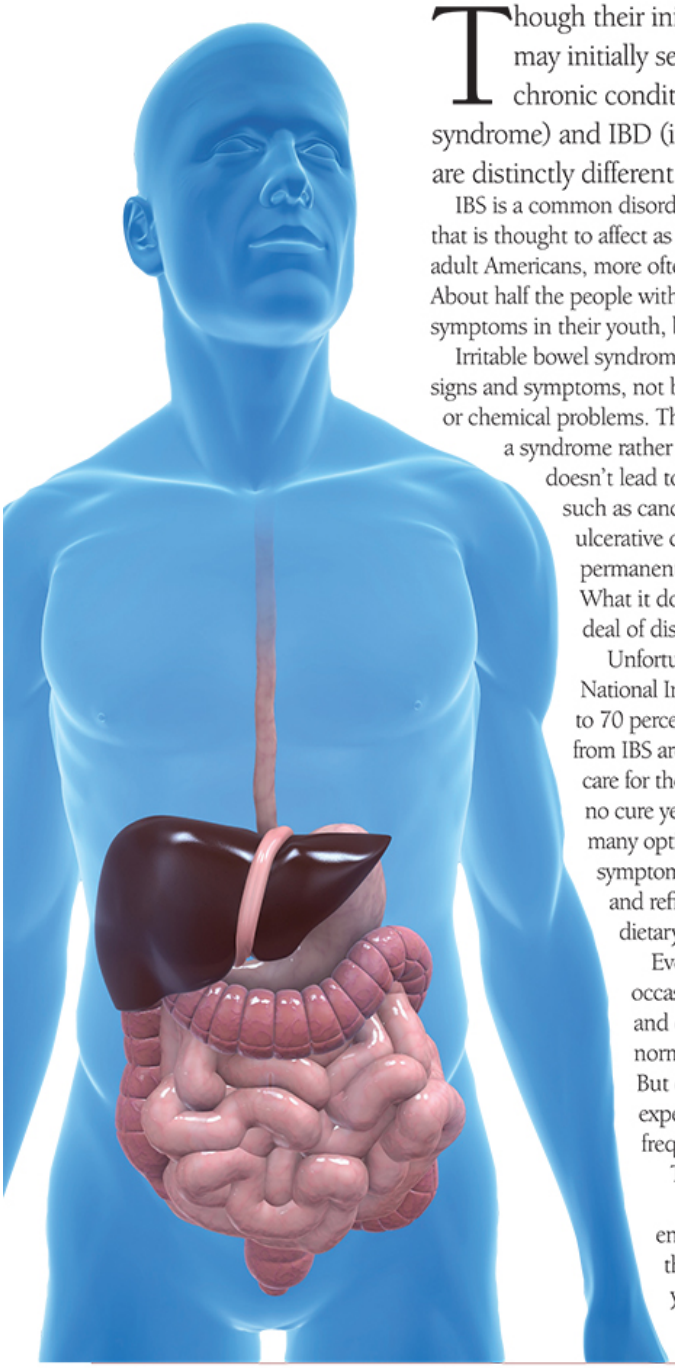
The field of urology has exploded in the last ten years. Medicines, procedures and technologies have improved, and so has patient satisfaction. Twenty years ago, diapers were the mainstay for treatment. Current treatments have advanced dramatically, so even minimally-invasive therapies can provide a cure. Surgery for people with stress incontinence, for example, is a 30-minute procedure that puts patients back on their feet in a single day.

If you're suffering from urinary incontinence, we can help you. Generally, when patients come to our office after a procedure, it's with big smiles and the rhetorical question, 'Why did I wait so long?'"

[gastroenterology]

EASING THE SYMPTOMS OF IBS and IBD

You'll need to work with your doctor to find the best combination of medicine, diet, counseling, and support to keep flare-ups down and quality of life way up.



Though their initials are close, their symptoms may initially seem similar, and they're both chronic conditions, IBS (irritable bowel syndrome) and IBD (inflammatory bowel disease) are distinctly different and separate ailments.

IBS is a common disorder of the intestinal tract that is thought to affect as many as one in five adult Americans, more often women than men. About half the people with IBS begin to experience symptoms in their youth, before the age of 35.

Irritable bowel syndrome is characterized by its signs and symptoms, not by anatomical, physical or chemical problems. That's why it's called a syndrome rather than a disease. IBS doesn't lead to more serious diseases, such as cancer, Crohn's disease or ulcerative colitis, and it doesn't permanently harm the intestines. What it does do is cause a great deal of discomfort and distress.

Unfortunately, according to the National Institutes of Health, up to 70 percent of people suffering from IBS are not receiving medical care for their symptoms. Though no cure yet exists for IBS, there are many options available to treat the symptoms, including new drugs and refined behavioral and dietary approaches.

Everyone experiences occasional stomach upsets and disruptions in their normal bowel movements. But everyone doesn't experience these episodes frequently or intensely. The American College of Gastro-enterology recommends this quick self-test: Do you have recurrent abdominal pain or discomfort? Do you often feel bloated? Are you frequently constipated? Do you have frequent diarrhea? If you answered yes to one or all of these symptoms, you may have IBS, a real and treatable medical condition, and seeing your doctor can put you on the path to relief.

Investigating your IBS

There is no specific test for IBS, but diagnostic tests may be performed— including stool sample testing, blood tests, and x rays—to rule out other problems. Typically, a doctor will perform a sigmoidoscopy or colonoscopy, which allows examination inside the colon

If your test results are negative, the doctor may diagnose IBS based on your symptoms, including how often you've had abdominal pain or discomfort during the past year, when the pain starts and stops in relation to bowel function, and how your bowel frequency and stool consistency have changed. One marker of IBS is having abdominal pain or discomfort for at least 12 weeks (not necessarily consecutive) out of the previous 12 months.

The specific cause for IBS isn't known, but researchers theorize that people with the condition have a colon, or large intestine, that is particularly sensitive and reactive to certain foods and stress. That may be why, for many people, a controlled diet reduces IBS symptoms.

Figuring out the right symptom-reducing diet for an individual often starts with keeping a journal that notes which foods seem to cause a flare-up or worsening of distress. Common culprits include gas-producing foods, the sugar substitute sorbitol, caffeine, alcohol, and large meals in general. Your doctor will help you devise a personalized plan that includes the right amount of fiber, fat, and carbohydrates to keep your symptoms controlled and your nutrition healthy.

Medications play an important role in symptom relief. Medications affect people differently, and no one drug or combination of drugs has been

shown to work for everyone with IBS. Options include fiber supplements or laxatives to deal with constipation and medicines to decrease diarrhea. Antispasmodic drugs can be effective in controlling colon muscle spasms and reducing abdominal pain. Newer medications have been successful in treating both IBS with constipation and IBS with diarrhea, but because of their side effects are not good choices for every patient.

IBD: Crohn's disease and ulcerative colitis

Inflammatory bowel disease (IBD) is the general name for diseases that cause inflammation in the small intestine and colon. IBD is both more rare than IBS (an estimated 1.4 million Americans suffer from it) and more serious. Though it's wise to seek doctor's help for irritable bowel syndrome, it is imperative to have a gastroenterologist's care for inflammatory bowel disease. Unlike IBS, which does not lead to other diseases, IBD frequently results in complications and increases the risk of colon cancer.

There are two main types of IBD: Crohn's disease and ulcerative colitis. It affects men and women equally and seems to run in families, with about 20 percent of people with Crohn's or ulcerative colitis having a blood relative with some form of IBD. It's most often diagnosed in young people under the age of 30.

Crohn's disease is a chronic disorder that causes inflammation of the digestive tract. It can affect any area of the digestive tract, from the mouth to the anus, but is most commonly present in the lower part of the small intestine, called the ileum.

The most common symptoms of Crohn's disease are abdominal pain, often in the lower right area, and diarrhea. Rectal bleeding, weight loss, arthritis, skin problems, and fever may also occur. Bleeding may be serious and persistent, leading to anemia. The range and severity of symptoms varies.

Ulcerative colitis causes inflammation and sores, called ulcers, in the lining of the rectum and colon. The most common symptoms of ulcerative colitis are abdominal pain and bloody diarrhea. Patients may also experience fatigue, weight loss, loss of appetite and other symptoms. About half of the people with ulcerative colitis have mild symptoms. Others suffer frequent fevers, nausea, and severe abdominal cramps.

Diagnosis of both major forms of IBD proceeds in a similar fashion. Blood tests are done to check for anemia, which could indicate bleeding in the intestines. Blood tests may also uncover a high white blood cell count, which is a sign of inflammation somewhere in the body. By testing a stool sample, the doctor can tell if there is bleeding or infection in the intestines. A colonoscopy allows for visual examination of the intestines and will reveal the inflammation, bleeding, or ulcers that characterize IBD. Sometimes x-rays or CT scans are also employed for diagnosis.

Control is the goal

Treatment of IBD strives to control inflammation, correct nutritional deficiencies, and relieve symptoms. A wide range of medications is utilized to reduce the number of times a person experiences a flare-up of symptoms, but at this time there is no cure for IBD. Some people have long periods of remission, sometimes years, when they are free of symptoms. However, the disease usually recurs at various times over a person's lifetime.

About 25% of patients with ulcerative colitis will eventually require surgery because of massive bleeding, severe illness, rupture of the colon, or risk of cancer. About two-thirds of patients with Crohn's disease will require surgery to relieve symptoms that don't respond to medical therapy or to correct complications such as blockage, perforation, abscess, or bleeding in the intestine.

People with inflammatory bowel disease may feel well and be free of symptoms for substantial spans of time when their disease is not active. The disease can be emotionally taxing, yet despite the need to take medication for long periods of time and occasional hospitalizations, most people with IBD are able to hold jobs, raise families, and function successfully at home and in society.

Why Stress Matters

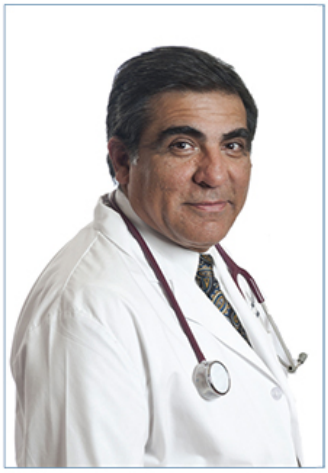
Stress does not cause IBS or IBD. Yet feeling mentally or emotionally tense, troubled, angry, or overwhelmed can stimulate colon spasms, bring on flare-ups and exacerbate symptoms in people with either condition.

The colon has many nerves that connect it to the brain. Like the heart and the lungs, the colon is partly controlled by the autonomic nervous system, which responds to stress.

These nerves control the normal contractions of the colon and cause abdominal discomfort at stressful times. People often experience cramps or "butterflies" when they are nervous or upset. In people with IBS or IBD, the colon can be overly responsive to even slight conflict or stress. Stress also makes the mind more aware of the sensations that arise in the colon, increasing the discomfort of symptoms.

Some evidence suggests that IBS, as well as IBD, is affected by the immune system, which fights infection in the body. The immune system is affected by stress. For these reasons, stress management is an important part of treatment. Stress management options include :

- stress reduction (relaxation) training and relaxation therapies such as meditation
- counseling and support
- regular exercise such as walking or yoga
- changes to the stressful situations in your life
- adequate sleep.



Sunil K. Khurana, MD

"It can be difficult to differentiate between IBS and IBD, but it's very important to do so. In IBS, even if diagnosis is delayed, the results aren't terrible, but with IBD the situation can be dire. IBS can often be handled by a primary care physician, but IBD really needs to be looked into by a specialist.

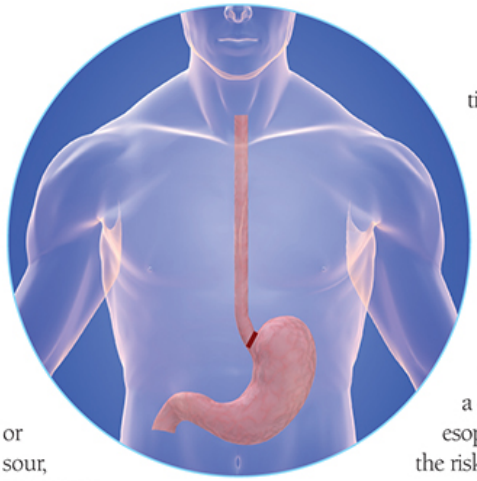
Over the last 5-6 years, some new treatments have been introduced that are getting good results. A new class of drugs, called biological agents is an exciting development in the treatment of Crohn's disease and ulcerative colitis. These medications can not only treat the symptoms, but also heal, which is a huge advance. These are strong medications and not for everyone, but they have really changed the natural course of the disease. And right now, we are one of two NY centers investigating a promising new drug for ulcerative colitis.

I'm pleased to say that, in my practice, there are fewer and fewer people needing surgery."

[gastroenterology]

FINDING RELIEF FROM Reflux

If you get heartburn — what physicians call gastroesophageal reflux— two or more times every week, it's probably time to seek relief. The pain and discomfort are bad enough, but chronic heartburn could cause serious complications.



For many people, heartburn — what physicians call gastroesophageal reflux—is considered just a fact of life. It's estimated that 60 million Americans have an episode of heartburn about once a month. To ease that burning sensation in the mid-chest, abdomen or throat, and to get rid of the sour, bitter taste in their mouths, some may take an over-the-counter medication for acid indigestion and some just tough it out.

But for those people, some 15 million of them, who get heartburn two or more times every week, toughing it out is not a good idea. Persistent reflux at this rate is considered to be a sign of GERD, gastroesophageal reflux disease, and the condition can lead to more serious health problems.

In the normal digestive process, food travels down the esophagus, a muscular tube connecting the mouth to the stomach. Strong acids in the stomach, the digestive juices, begin the process of turning the food into energy. It's meant to be a one-way path, and a ring of muscles at the bottom of the esophagus—the lower esophageal sphincter (LES)—acts as a valve to keep stomach contents in the stomach.

The cause of complications

If the LES doesn't close properly or opens spontaneously, stomach acid backs up (refluxes) and makes contact with the lining of the esophagus, causing the burning sensation we call "heartburn."

The discomfort, pain and other symptoms are bad enough, but if GERD is left inadequately treated over a long time, it can cause serious complications: refluxed stomach acid can damage the lining of the esophagus, leading to bleeding or ulcers; scars from tissue damage can narrow the esophagus and make swallowing difficult; and constant irritation of the lower esophagus lining may cause a condition called Barrett's esophagus that may increase the risk of developing cancer.

Getting a grip on GERD

If you've been having symptoms of GERD as often as twice a week or have been using antacids or other over-the-counter reflux medications for more than 2 weeks, it's advisable that you consult your health care provider. Treatment will depend on the severity of your symptoms and often begins with lifestyle and dietary changes. A range of medications are available that treat GERD by decreasing acid production or strengthening the LES and making the stomach empty faster. Some provide only short-term relief, while others actually help heal the esophageal lining.

In many cases, your physician can provide a treatment plan and prescribe a combination of medications that will bring your GERD under control. If your symptoms are severe or don't respond to treatment, you'll probably be referred to a gastroenterologist (GI)—a doctor specializing in diseases of the stomach and intestines—for further testing.

Procedures, such as barium swallow radiography and upper endoscopy, enable the gastroenterologist to spot anatomical problems, abnormalities, and areas of the esophagus that may have been damaged by acid reflux. These tests help the GI customize a treatment plan.

Robert S. Dean, M.D.

"From my perspective GERD is an under-diagnosed condition because people think it's part of their daily lives. They blame themselves for eating the wrong foods or smoking. But you shouldn't have frequent "heartburn." An accepted benchmark is, anyone experiencing "heartburn" two or more times a week would be wise to have a discussion with a specialist and perhaps an endoscopy.

Acid reflux is a problem because when the lining of the esophagus is frequently exposed to acid any number of things can happen. Chronic cough, frequent throat clearing, difficulty swallowing are just some of the symptoms. The incidence of the type of esophageal cancer, adenocarcinoma, associated with acid reflux has been increasing, and that's a concern.

The vast majority of my patients do very well with medications, living symptom-free. A smaller group, patients with Barrett's esophagus, may need periodic endoscopic surveillance of the esophageal lining."

[urology]

CARING FOR Kidney Stones

Shock waves, fiber optic telescopes, and lasers are among the high-tech tools we use in minimally-invasive surgery to break stones down to a size that can be easily passed.

Kidney stones have troubled mankind for about as long as we've had kidneys. Scientists have even found evidence of kidney stones in a 7,000-year-old Egyptian mummy. Today, kidney stones are one of the most common disorders of the urinary tract and, for reasons not yet known, the number of people in the United States with the condition has been increasing over the past 30 years. About 5 percent of the population forms kidney stones, and each year they send 3 million people to their doctors and another half a million to the emergency room.

The most common type of kidney stone in the U.S. is a calcium-based stone that develops from crystals that separate out from the urine within the urinary tract. Normally, urine contains chemicals that prevent crystals from forming, but these chemicals don't work adequately for everyone. Another type of stone is caused by infection in the urinary tract.

Kidney stones can be as small as a grain of sand or as large as a baseball. The tiniest ones will travel through the urinary tract and pass out of the body without any symptoms. Unfortunately, the first sign of a kidney stone that's too large to pass easily is the sudden onset of extreme pain. Typically, a person feels a sharp, cramping pain in the back and side in the area of the kidney or in the lower abdomen. Sometimes nausea and vomiting occur, pain may spread to the groin, and blood may appear in the urine.

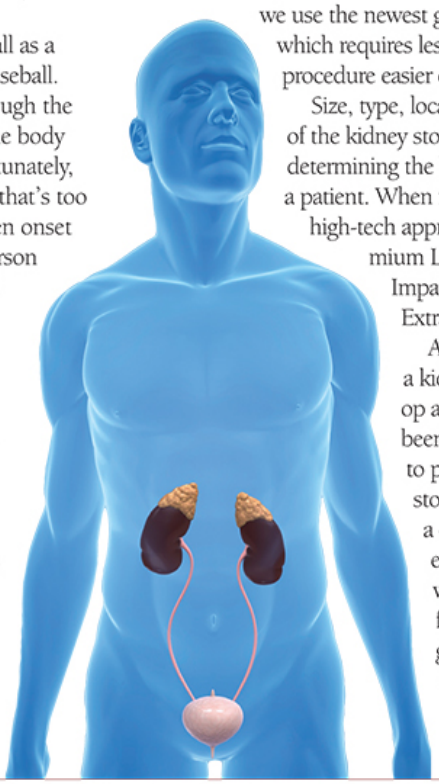
Getting past the pain

Small kidney stones can pass with the aid of medication and a tincture of time. The patient remains at home during the process, drinking fluids and taking pain medication as needed. But sometimes surgical intervention is required. Twenty-five years ago, open surgery (with a recovery time of 4 to 6 weeks) was necessary to remove a stone that was too large to pass on its own or was caught in a difficult place in the urinary tract.

Your current treatment options are much better. At The Hudson Valley Comprehensive Kidney Stone Center, a division of Premier Medical Group, we specialize in minimally-invasive surgery. We use the latest fiber optic telescopes and lasers for the removal of kidney stones. Most surgeries can be performed on an outpatient basis, or with a one-night hospital stay and a short recuperation.

High-tech treatments

The procedure most frequently employed is shock wave lithotripsy (SWL), in which shock waves from outside the body break stones down into small particles that are easily passed. At Premier, we use the newest generation of lithotripter, which requires less anesthesia and makes the procedure easier on the patient.



Size, type, location, and disposition of the kidney stone are considered when determining the best kind of treatment for a patient. When indicated, we use other high-tech approaches, including the Holmium Laser, Lithoclast Pneumatic Impactor and Percutaneous Stone Extraction.

A person who has developed a kidney stone is likely to develop another. Once the stone has been removed, the focus turns to prevention. We have the stone analyzed and give you a comprehensive metabolic evaluation to determine what's behind your stone formation. Treatment plans generally incorporate dietary changes and medications to control the acid, alkali, or calcium in the urine.

Evan R. Goldfischer, MD

"When someone calls and says they have pain, or blood in the urine, and think it's a kidney stone, our basic response is... 'come on over.' It isn't wise for patients to self-diagnose or self-medicate. The sooner we see them, the sooner the pain stops and they get better.

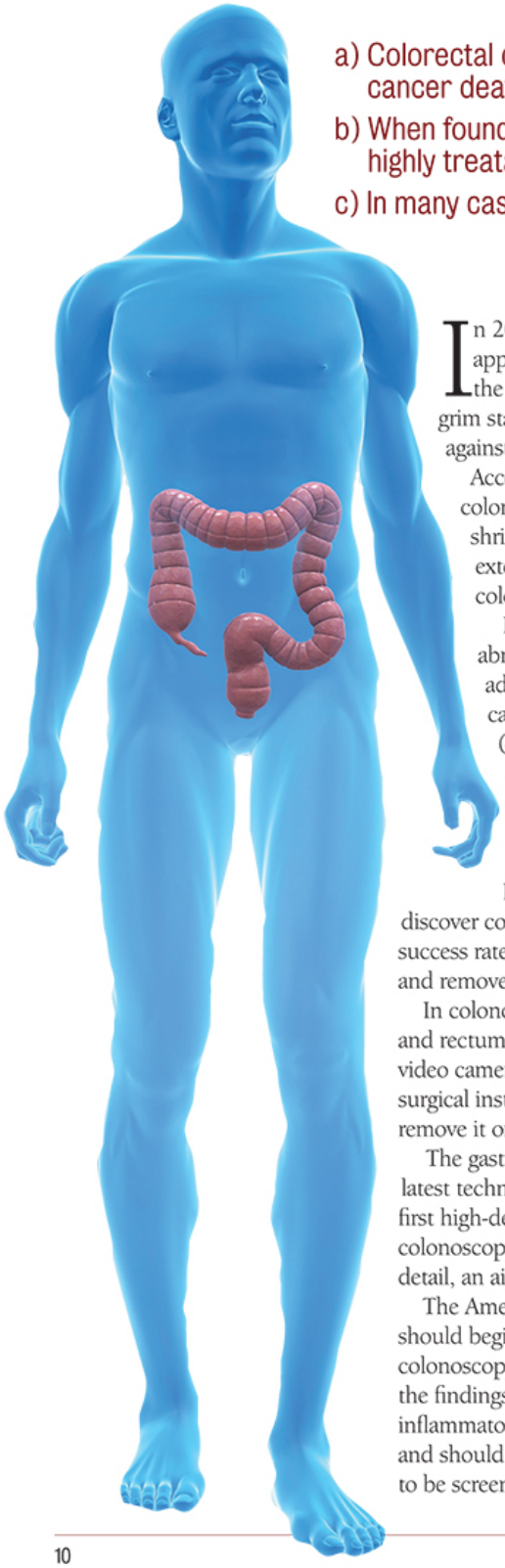
We take the patient's history, do a physical exam and get imaging studies. Then, based on the stone's size, location and other variables, we discuss the patient's options, the risks and benefits of each procedure.

We truly offer every single way there is to take out kidney stones. I have personally done more than 4,000 operations for stones and have never had to open up a patient. We've done it with minimally-invasive surgery every single time.

As part of our treatment we offer a metabolic study, measuring what's going in and what's coming out. The results help us advise on diet modification and to prescribe the right medication. The goal is to keep those stones from coming back."

WHAT YOU NEED TO KNOW ABOUT

Colorectal Cancer



a) Colorectal cancer is the second leading cause of cancer deaths in the U.S.

b) When found in its early stages, colorectal cancer is highly treatable.

c) In many cases, colorectal cancer can be prevented.

In 2009, colorectal cancer was newly diagnosed in approximately 150,000 men and women in the U.S., and the disease took nearly 50,000 lives. Yet, these seemingly grim statistics actually signal a significant success in the war against cancer.

According to the American Cancer Society, the rate of new colorectal cancer cases and deaths from the disease has been shrinking by about 2% a year over the last decade. To a large extent, this is because more people are receiving periodic colorectal cancer screenings.

Most colorectal cancers begin as tiny clumps of abnormal cells on the lining of the colon or rectum, called adenomatous polyps. These polyps are benign (non-cancerous), but have the potential to become malignant (cancerous). The transformation is slow—occurring over several years—and the polyps usually produce no recognizable symptoms to alert patient and doctor.

The need to screen

For this reason, regular screening is the primary way to discover colorectal cancer in its early, most treatable stages, when the success rate is as high as 90%. And screening is the only way to find and remove polyps before they become cancers.

In colonoscopy, the doctor examines the entire length of the colon and rectum with a colonoscope, a slender, flexible tube bearing a video camera and connected to a monitor. When a polyp is found, surgical instruments are deployed through the colonoscope to remove it or take a tissue sample for testing (biopsy).

The gastroenterologists at Premier Medical Group use the latest technology—including equipment providing the world's first high-definition television images of the colon—in performing colonoscopy. This provides a remarkably high level of clarity and detail, an aid to the most accurate diagnosis possible.

The American Cancer Society recommends that men and women should begin screening for colorectal cancer at age 50, and that colonoscopy should be repeated every 5–10 years, depending on the findings. People with a family history of the disease or who have inflammatory bowel disease are at increased risk of colorectal cancer and should talk with their physicians about how early and how often to be screened.

Arif M. Muslim, M.D.

"One in 18 Americans are at risk of getting colorectal cancer by the time they're 65. Most of these cancers develop from benign polyps that take from 10 to 15 years to become malignant. You don't have to be a rocket scientist to do the math and figure that screenings should begin at age 50 for most people, as the medical guidelines advise.

We've come a long way since I did my first colonoscopy in 1974. Now, some 30,000 procedures later, endoscopy technology has evolved tremendously. The prep is more stressful than the procedure, and even that has improved. These days, we use more gentle preparations and, with sedation in pleasant surroundings, the 15-30 minute procedure is painless and discomfort is minimal.

Some patients who resist colonoscopy say they don't want to know if they have cancer. I try to impress on them that colorectal is the only truly preventable cancer. If we remove a polyp, cancer will not develop at that site. And even if someone does have cancer, early detection can give them a normal lifespan. We're already seeing a decline in cancer deaths, and that tells us our screenings are working."

Physician to Physician

Insight regarding Premier Medical Group's capabilities and concerns

Premier Medical Group is committed to offering the most effective, cutting edge treatments available. One reason we conduct clinical trials is to provide patients who have need of them with access to the latest medications. And, as part of the broad international community of researchers, we contribute to the development of evidence-based medical treatments. Evidence-based medicine benefits our patients by providing objective data on the safety, efficacy, side effects and long-term results of various treatment options.

The Premier Research Department consists of a full-time clinical research manager and 5 full-time clinical research coordinators, all of whom are ACRP certified.

Clinical Research Trials in Urology

During the past 12 years, the Urology Research Department has conducted more than 170 clinical trials, including studies that have led to the approval of such drugs as Viagra, Levitra, Cialis, Detrol LA, Vesicare, Sanctura, Gelnique, Rapaflo, and Firmagon.

We are currently seeking patients for studies in:

Female Sexual Dysfunction —
Three FSD studies, including post-menopausal women and women who have undergone hysterectomy, and who are in a stable heterosexual relationship.

Interstitial Cystitis —
Two studies of new injectable treatments for the pain and discomfort caused by interstitial cystitis.

Benign Prostatic Hyperplasia —
Several BPH trials that include oral medications as well as injections directly into the prostate.

Premature Ejaculation & Erectile Dysfunction —
For patients who are on a stable PRN dose of ED medication, who also experience premature ejaculation.

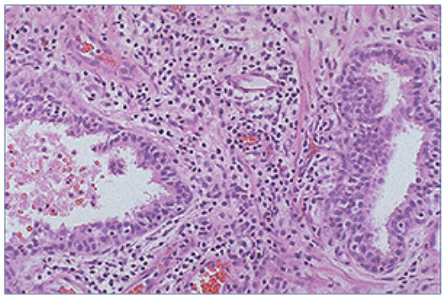
Clinical Research Trials in Gastroenterology

Hepatitis C —
Peginterferon Alfa-2A (PEGASYS®) and Ribavirin (COPEGUS®)
An open-label study providing Peginterferon Alfa-2A (PEGASYS®) and Ribavirin (COPEGUS®) for patients with Chronic Hepatitis C who have participated in a previous Roche or Roche-partner protocol.

Crohn's Disease —
Certolizumab Pegol (CIMZIA®)
A long-term registry study to evaluate patients treated with Cimzia® (Certolizumab Pegol) or other standard treatment for Crohn's Disease.

Diabetic Gastroparesis —
Metoclopramide Nasal Spray
A multicenter, randomized, double-blind, placebo-controlled clinical study to evaluate the safety and effectiveness of metoclopramide nasal spray solution in diabetic patients with gastroparesis.

Ulcerative Colitis —
Natura-Alpha (Natrogen®)
An efficacy and tolerability study of Natura-Alpha (Natrogen®) capsule administered to patients with active ulcerative colitis.



OUR IN-HOUSE Pathology Lab

Premier is the only medical group in the region to maintain its own pathology lab. Under the direction of pathologist Dr. Leon Isaac, all of our GI and urology tests are processed in a single facility.

From biopsies to urine cytology, all of a patient's labwork is handled by a dedicated team with the ability to cross reference test results and patient history within the practice. All slides are double-read by two pathologists for improved accuracy, yielding fewer false positives and fewer false negatives. This highest level of quality control can provide our physicians with dependable and timely results.

HIGH-DEFINITION Endoscopy

The gastroenterologists of Premier Medical Group are using the latest Olympus endoscope technology to help diagnose and treat disease in the upper and lower gastrointestinal (GI) tract. Compared to conventional systems, the high-definition images and Narrow Band Imaging™ of the Olympus system provide sharper images and better contrast, enhancing observation of subtle changes in the colon.

According to the manufacturer, the system is the world's first endoscope platform to deliver high-definition television (HDTV) and Narrow Band Imaging™ (NBI). The HDTV signal from the system's video processor produces 1080 lines of resolution, more than double the number of scan lines of conventional systems, and offers breathtaking images with a high level of detail and color.

NBI is a new image technology that takes advantage of the scattering and absorption properties of human tissue. This provides improved visual contrast of the surface structure and fine capillary patterns of the mucous membranes, which are normally difficult to distinguish.

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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. We'll be using this space to introduce you to some of the faces of Premier.

Jeanie Hefele, RN

Clinical Research Coordinator
With the practice for 7 years

It's exciting to work in a place that's on the cutting edge of urological medicine, with new procedures, medications, and treatments. In research, I use both my nursing skills and science background to work hands-on with patients, families and pharmaceutical sponsors.

I have a special relationship with my patients that allows me and the doctors to keep a close eye on their health, medication side-effects, and needs.

Making a difference in the forefront of medicine is rewarding in itself. Making a difference in someone's life is why I became a nurse!

Pam Faulds, RN

GI Clinical Nurse
With the practice for 12 years

As a GI clinical nurse, I'll take on just about anything, from triage and testing to patient education, which encompasses all aspects of managing quality patient care.

I think of myself as first and foremost a patient advocate, and anything I can do to make life easier for our patients is my main focus.

I've known some of these patients for more than 20 years, since my tenure at Vassar Brothers Medical Center. Since IBD is a chronic disease, our patients need a lot of emotional support and I'm grateful to be able to provide it.