

Patients want to know: frequently
asked questions in Internal Medicine

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hepatitis C

TESE: a revolutionary treatment
for male infertility

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Taking Part in a Medical Triumph

A clinical trial conducted by the Research Division of Premier Medical Group has contributed to the development of a new combination of drugs for the treatment of Hepatitis C that not only promises a cure for many patients but brings eradication of the disease into view.



Peter M. Varunok, MD, FACP

Premier's Research Division is invited to participate in many different studies, but we are very selective about what we take on. Yes, we're interested in the science and in advancing science, but we're most interested in treating our patients in Poughkeepsie and surrounding areas. These are patients we care for, so we're not going to expose them to something that we don't believe holds exceedingly high promise.

Our foremost goal in research is to offer our patients something above and beyond what the standard of care is, particularly when the standard of care is suboptimal, as it has been with hepatitis C. Taking a very cautious and thoughtful approach through our Research Division is something that has worked out well. We have been able to have access to an incredible amount of science well before it has become available to the general physician public and we have been able to share that with our patients.

This April, an article co-authored by Premier Medical Group's Dr. Peter M. Varunok was published in the prestigious New England Journal of Medicine. The article's title, "Retreatment of HCV with ABT-450/r-Ombitasvir and Dasabuvir with Ribavirin," provides a hint of how technical it is. PremierHealth magazine interviewed Dr. Varunok and asked him to help us understand the article's significance.

The clinical trial described in this paper is a game-changer. We don't have that many events in medicine that effect a sea change, where you see, in a very short time, an absolute, significant improvement in the quality of medicine and the quality of people's lives as a result.

When I graduated from medical school in 1988, the hepatitis C virus had not yet been identified. It was called "non-A, non-B hepatitis" and we knew it was IV-transfusion related. So I've witnessed the disease from when it was an unknown entity, to its identification in 1991, through initial treatments, and now to the point of potential eradication.

Initially, with the standard early treatment of Peginterferon and Ribavirin—anti-viral drugs that ramp up the immune system and immune response—studies showed a "cure rate" of about 40 to 50 percent. With the initiation of the first generation of protease inhibitors—drugs which attacked the virus directly, studies showed potential response rates of 60 to 70 percent. But in the real world, cures were significantly fewer because the side effects of these treatments were so brutal and so difficult to manage that many patients dropped out of treatment.

To this day, despite incremental improvements in the treatment of hepatitis C, there remains a vast number of patients who have been diagnosed and know they have hepatitis C, but are unable to be treated with standard care due to contraindications, or just the fear of the side



effects, which have been very profound... and word spreads like wildfire. Now, with this new combination of drugs used in the trial described in the NEJM article, we are achieving a response rate of about 96 percent, in just 12 weeks. On its own, that's a significant improvement, going from 70 to 96 percent. But that percentage difference doesn't tell the whole story.

The new medications are so well-tolerated that the total number of people who will take it for its full course and who will be cured is almost exponential compared to the number that we have treated so far.

We are finding more and more information about this virus and what it does. We know about its risk of progression to cirrhosis, liver cancer, ascites and bleeding and, eventually, to the need for transplantation. But there's also a significant increase in all-cause mortality, dying from anything, in people with hepatitis C. So we know there's something this virus does outside the liver. This effect on cardiovascular, renal and pulmonary disease will eventually figure into the number of lives saved by conquering hepatitis C.

To this day, despite incremental improvements in the treatment of hepatitis C, there remains a vast number of patients who have been diagnosed and know they have hepatitis C, but are unable to be treated with standard care.

Patients want to know...

The Mammogram Question

A large-scale study published earlier this year in the British Medical Journal (BMJ) cast doubt on the usefulness of mammograms for breast cancer screening. PremierHealth spoke to Dr. Lorraine Nardi of our Internal Medicine division to help clarify the matter.



Lorraine Nardi, MD

I believe the recent talk about changes in mammography guidelines over the last year has to be taken in the context of all the other research that's been done in previous years: new, interesting research does not necessarily negate old research.

I prefer staying with the standard guideline based on research done over many years: women between the ages of 40 and 75 should have a yearly

mammogram. There is enough data to show that early discovery of breast cancer really makes a difference for some women. The problem is, if you go strictly by mortality and morbidity statistics, it can be hard to prove that mammography saves enough lives to justify the cost.

Mammography is not a perfect test—it may not help every individual as much as we'd like—but it does do a lot; it's worth it in that sense.

The Over-75 Question

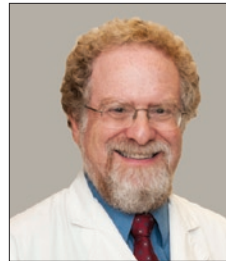
For women over 75 the question is a bit more complicated. As women get older, the risk for breast cancer does not go away, but breast cancers develop more slowly and grow more slowly. The statistics behind the guidelines look at mortality and morbidity, and the statistics say there is a chance that breast cancer in a 75-year-old woman will not affect her life expectancy.

I don't like that reasoning or playing the odds in that fashion. In our practice, we have active ladies who are going strong into their 90s and even one hundred-plus. I don't like the idea of stopping mammograms in a vigorous 75-year-old, it would be like we were not paying attention.

I tell my patients they should come from a place of information; what they do with that information is up to them. If breast cancer is found, for example, in an 82-year-old woman, I'll talk to her and her family. I'll make sure they know that these cancers in the elderly move more slowly and are easier to treat than in younger women, that they have options. If the woman is frail, can't abide the idea of surgery or chemotherapy and they're going to leave it alone, that's fine. Once the patient has all the relevant information, the choice is up to the patient. That's my feeling.

NOTE: Dr. Nardi's recommendation for annual mammography for women between the ages of 40 and 75 mirror those of The American Cancer Society the National Cancer Institute, the American College of Radiology and the American Congress of Obstetricians and Gynecologists.

What is COPD?



Alan H. Gross, M.D., FCCP

Chronic obstructive pulmonary disease, or COPD, is a progressive lung disease that, over time, makes it more and more difficult to breathe. The term COPD includes two main conditions, emphysema and chronic bronchitis. Emphysema involves damage to the air sacs in the lungs while bronchitis is marked by inflammation of the bronchial tubes, the airways to the lungs. Most

people diagnosed with COPD have both emphysema and chronic bronchitis.

The usual cause of COPD is long-term exposure to lung irritants, and the most common irritant—causing 80- to 90-percent of cases—is cigarette smoke.

“Early on in COPD, people may not have any symptoms, or just a little cough in the morning that they attribute to their smoking,” says Dr. Alan H. Gross, of Premier's Internal Medicine Division. “It's not until the disease is well advanced that people start noticing they're short of breath when performing regular activities. Even then, many people ignore the symptoms and instinctively just start to limit their activities—not walk as fast, not exercise as vigorously—and think ‘oh, it's just that I'm getting older.’ They don't realize they're having progressive limitations to their breathing.”

Typically, COPD doesn't develop in people until after the age of 50, but there are many exceptions to the norm. “For reasons we don't totally understand,” says Gross, “some people are more susceptible to the harmful effect of smoking than others; women tend to be more susceptible to COPD than men who engage in the same amount of smoking; an uncommon genetic condition—Alpha-1 antitrypsin deficiency—can lead to rapid development of COPD in people before age 40.

“The easiest way to diagnose the disease early,” says Gross, “is with spirometry, a simple breathing test done in a physicians office. It's just a matter of blowing into a computerized machine that measures how much air you're blowing out and how fast it's blowing out. The test gives a very good indication of early disease and a good picture of how much the disease has progressed.”

There are many medications that can be helpful in improving the quality of life of people with COPD, alleviating shortness of breath and improving symptoms such as chronic cough. But the best thing a smoker with COPD can do is to quit. “It's never too late to stop smoking,” says Gross. “In the advanced stages of COPD, very little can be done to reverse the disease, and people will require oxygen.”

Dr. Gross advises anyone who has smoked for more than 10-years to ask for a spirometry test. At the very least, knowing how much their breathing has been compromised may help them gather the will to quit.

Depression is a treatable condition

As primary care providers, we treat a lot more cases of depression than people may realize,” says Dr. Lorraine Nardi of Premier’s Internal Medicine Division. Over 16 percent of Americans will experience serious depression at some point in their lives, and statistics show that primary care physicians are the sole medical contact for more than half of them. “Some people find it easier to speak with their primary, they’re comfortable with that person,” Nardi says. “Also, depression can effect many other medical conditions and give rise to real physical symptoms. People should understand the mind is not disconnected from the body.

“Too many of my patients feel that they shouldn’t allow depression to happen. They feel like they should be able to talk themselves out of it; just pick themselves up out of it,” says Nardi. “They don’t think of depression the way one would think of, let’s say, diabetes. Yet, there is a large component of depression that is like diabetes: mainly, we now believe that a lot of depression—as well as

“Too many of my patients feel that they shouldn’t allow depression to happen. They feel like they should be able to talk themselves out of it.”

anxiety, schizophrenia, and bipolar disease—has to do with chemical imbalances in the brain. In depression, the chemical involved is serotonin, which may not be secreted at a high enough level for a given individual.”

There is a difference between feeling sad and being depressed. “When depression interferes with function—not sleeping, not getting along with coworkers, irritability, malaise—it colors a person’s whole life. That’s where we step in,” says Nardi.

“We always advise a patient to seek counseling, but that alone is not going to raise their brain serotonin level,” says Nardi. “Some people need medication to raise serotonin levels enough to help them deal with a period

of stress; some may need it forever. The optimal way to treat the condition is with medication in tandem with counseling.”

Some patients are resistant to seeking treatment. “Patients will say they don’t want to take medication for depression because it is habit forming,” Nardi says. “Tranquilizers are habit-forming, that’s a completely different issue. Medications for depression are not habit-forming.”



Cholesterol by the numbers



Daivde Michael DeBellis, MD

Every body has cholesterol; the waxy, fat-like substance is found in all of the body's cells and is a building block in the making of hormones and digestive substances. The problem with cholesterol is that there can be too much of it, circulating through the blood stream and building up plaque in arteries. This process leads to hardening and narrowing of the coronary arteries and an increased risk of coronary artery

disease and stroke.

To some extent, plaque build-up is a common consequence of the aging process. It need not be inevitable. With a balanced diet, a healthy lifestyle and medication, when indicated, most people can reduce their risk of arteriosclerosis, hardening of the arteries.

For the general population, guidelines recommend keeping LDL at the ideal level of under 100 mg/dl. Davide DeBellis, M.D., a practitioner in Premier's Internal Medicine Division, prefers to take a cautious approach to cholesterol management. "Unless a patient presents with extremely high test numbers or confirmed cardiovascular disease, I do not believe the disease should be treated with a drug right away," he says. "We know that plaque build-up takes decades to develop. I have found that a person who really wants to make the effort can, with some attention to diet and exercise, lower his LDL by 20 points."

People with a family history of heart disease, a personal history of heart attack, stroke or transient ischemic attacks or other risk factors, such as smoking, hypertension or diabetes, are advised to strive for an LDL of 70 mg/dl. For most of these patients, statins, a class of drugs that lowers cholesterol levels, will be prescribed along with a lifestyle prescription.

“We know that plaque build-up takes decades to develop. I have found that a person who really wants to make the effort can, with some attention to diet and exercise, lower his LDL by 20 points.”

Dr. DeBellis offers these recommendations for cholesterol control:

18-35: “If you have not had a baseline fasting lipid profile by age 25, you absolutely should,” Dr. DeBellis says.

36-50: “By this age, people have started to accumulate plaque in the arteries,” Dr. DeBellis says. An annual fasting lipid profile that can be compared to earlier tests helps determine the rate at which cholesterol is rising. “

51-75: “In addition to continued annual fasting lipid profiles, if you have not established a relationship with a primary care provider you should do so,” Dr. DeBellis says. I believe cholesterol management for women is as important as management in men; heart disease is also the #1 killer of women. Sometimes beginning drug based lipid therapy is more difficult in women of childbearing age. For them, diet and exercise is even more important than in men. Drug therapy should be reserved only for the most abnormal lipids with the most risk factors in women of childbearing age.

“Hardening of the arteries is extremely common throughout the American population,” Dr. DeBellis says. “But with regular screenings and careful management of their cholesterol we can help our patients reduce their risk of heart attack or stroke.”

Diabetes... the good news



Carol E. Miyake, MD

Diabetes is a chronic disease that currently affects more than one in ten Americans. There are two types of diabetes, type 1 and type 2. Type 2 diabetes is the most common, accounting for 80-90 percent of all cases. The disease is caused by a resistance to the effects of insulin as well as a deficiency of insulin. Type 2 diabetes can be effectively treated with exercise, diet, and medication, including insulin. Type 1 diabetes is an autoimmune disease: the body's own immune system destroys the insulin-producing cells of the pancreas. Persons with type 1 diabetes will require insulin injections to sustain life.

Diabetes can cause complications, including eye disease, nerve damage, kidney disease, stroke and heart disease. While the complications of diabetes can be severe, the good news is that these complications can be prevented. Over the past twenty-five years, research has shown that good control of diabetes, and treatment of high blood pressure and high cholesterol can greatly reduce the complications of both type 1 and type 2 diabetes by more than 30 percent.

Better treatment tools

Diabetes treatment is a very active area of medical research, leading to an ever increasing array of medications, new forms of insulin and methods for monitoring blood glucose. Fundamental to successful treatment of diabetes is the involvement of the patient in managing the disease. It is essential that they understand the role of diet, exercise, medication and self-monitoring of blood glucose to achieve successful treatment. Current guidelines for control of blood glucose recommend that the hemoglobin A1C—which reflects average glucose level over the previous 3 months—be maintained at 7 percent or less; LDL cholesterol (bad cholesterol) be maintained at less than 100 mg/dL; and blood pressure be kept under 130/80.

More recent research has also brought good news about prevention of type 2 diabetes. About 35 percent of the US population has prediabetes and about a quarter of those people will eventually develop diabetes. Yet research has shown that lifestyle changes, including weight loss and increased exercise, can prevent or delay the onset of diabetes. Bear in mind that the benefits of small changes can be significant: weight loss of as little as 7 percent of body weight and 150 minutes of exercise a week can reduce the risk of developing diabetes by 60 percent.



High Blood Pressure points



High blood pressure (HBP) is still sometimes referred to as a “silent killer” insofar as most people who have it experience no symptoms. Yet, over time, HBP can lead to coronary heart disease, heart failure, stroke, kidney failure and peripheral artery disease and other health conditions. The last decade has seen increased attention paid to controlling HBP, on the part of patients as well as physicians. “We think the focus on HBP has contributed greatly to the fact that cardiovascular mortality, which had been consistently on the rise, has actually come down a little bit, as have the statistics for stroke, over the past five years,” says Dr. Lorraine Nardi of Premier Medical’s Internal Medicine division. “In fact, paying attention to HBP has contributed greatly to longevity and quality of life as a whole.”

In Dr. Nardi’s view, “for the vast majority of people, the biggest step in controlling HBP is that people see a physician once a year and, among other things, get their blood pressure measured and followed up on if there is a problem.”

Frequently asked

Two related issues frequently arise when a patient learns that he or she has high blood pressure. Patients will say, “I don’t want to be on medicine, once you’re on medicine you’re always on medicine,” Nardi recounts, and they’ll ask about the non-pharmacological things they can do for HBP.

“It’s not the nature of the medicine that would require a patient to continue taking it, it’s the nature of the illness,” Nardi explains. If a patient is on medicine and changes in lifestyle lead to a reduction in blood pressure, dosage can be reduced or the medication can be stopped.

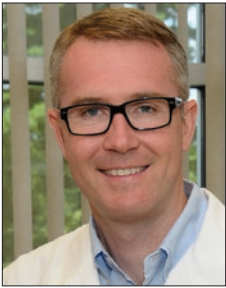
As for nonpharmacological approaches to controlling HBP, “there are many adjustments you can make to help take care of blood pressure,” says Nardi. “The three biggest things are reducing salt in your diet, increasing exercise and reducing your weight.” All of these approaches can contribute to a mild reduction in blood pressure. However, in cases of significantly high blood pressure, lifestyle changes alone can’t do the job.

“Even when you’ve done your very best to alter nonpharmacological factors, medication may still be necessary,” says Nardi. “Blood pressure is not just dependent on lifestyle, there is a large genetic component.”

WHAT YOU NEED TO KNOW ABOUT

Urethral Reconstruction

Urinary urgency, discomfort and slowing of the urine stream should never be dismissed as just a part of growing older. Such symptoms usually indicate treatable health conditions and, in some cases, they signal damage to the urethra, the tube that carries urine from the bladder out of the body.



Walter Parker, MD

Urinary dysfunction—including urinary urgency, discomfort and slowing of the urine stream—should never be dismissed as a normal progression of aging. Such symptoms may indicate real and treatable health conditions, such as a urinary tract infection or prostate disease or, in some cases, they may signal damage to the urethra, the tube that carries urine from the bladder out of the body. Men experiencing these symptoms are advised to visit their physician or urologist.

If infection or prostate enlargement is ruled out as the cause of the urinary dysfunction, your urologist will test for stricture, or narrowing, of the urethra. The male urethra is nearly eight inches long, making men far more prone to stricture than women, in whom the urethra is only about an inch-and-a-half long.

Though the condition can affect men at any age, it is most frequently found in men over age 65. Urethral stricture may be caused by inflammation or scar tissue resulting from traumatic injury to the pelvic area and from untreated infections, including sexually transmitted disease, yet in many cases the precise cause of the narrowing remains unknown. Left untreated, the condition can lead not only to increased discomfort, but also to an increased risk for infections that could ultimately result in bladder and kidney problems.

Strictures are typically found on cystoscopy. To confirm a urethral stricture and gauge the location and size of the narrowed area, Premier Medical Group Urologist Walter Parker, M.D. orders a retrograde urethrogram. This simple test involves taking an x-ray of the patient's urethra and bladder following injection with a contrast dye. Based on the results of the urethrogram, Dr. Parker can determine whether the patient may get relief from standard first options, such as catheter dilation to enlarge the narrowed area and endoscopic urethrotomy. If the stricture is too large or the tissue is permanently damaged, he may

recommend reconstructive surgery, known as urethroplasty, to open the blockage.

The urethroplasty procedure

The first surgical procedure for repair of a urethral stricture was described in a medical journal in 1914, one hundred years ago. In contemporary times, several surgical options are available. A patient with a simple stricture (generally 1 cm or less in length) may be a candidate for what is called a primary (or anastomotic) urethroplasty. During this procedure, Dr. Parker excises the diseased tissue that is constricted and reconnects the remaining segments of the urethra. The procedure typically requires overnight hospitalization and use of general anesthesia.

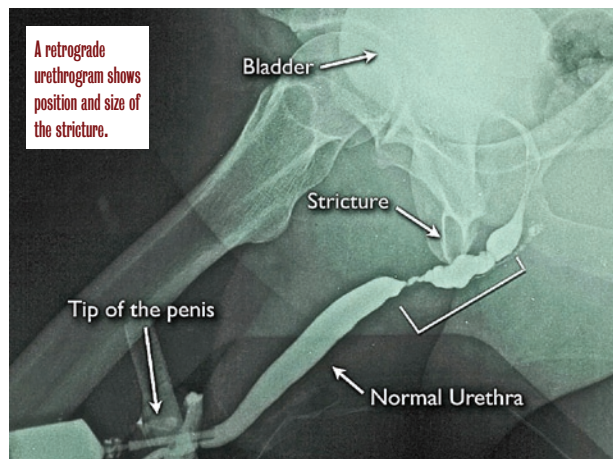
Patients with complex strictures may need a more extensive surgery, known as substitution (grafting) urethroplasty, in which Dr. Parker cuts the narrowed portion of the urethra lengthwise and grafts tissue from the lining of the patient's mouth to the excised area to enlarge it. Dr. Parker points out that this mucosa tissue is easily obtained, does not scar, is resistant to infection and usually heals quickly. In the case of a severe stricture, the grafting may have to occur in stages.

Substitution urethroplasty is, in most cases, performed in an operating room under general or spinal anesthesia. Recovery time is generally four weeks. Risks from the operation include those associated with any surgery, including bleeding and infection.

There is also a slight risk of sexual dysfunction following the procedure, although studies indicate urethral reconstruction appears no more likely to cause long-term postoperative

sexual dysfunction than does circumcision.

Some patients may have a repeated reoccurrence of the stricture when treated with non-surgical methods, but the odds of this are significantly lower following reconstructive surgery. "Urethroplasty is not a simple procedure and it requires the expertise of a skilled urologist," Dr. Parker says. "The recovery period is significant. But when successful, as it generally is, the procedure offers patients long-term relief."



Worried about cancer



Salvatore M. Buffa, MD

A 35-year-old white male complains of difficulty swallowing that he describes as a feeling of tightness in the chest after food ingestion as well as a sensation of the food “sticking” in his chest. He is afraid to eat and has lost 5 pounds; he is a smoker with a history of asthma and a moderate user of alcohol. He is concerned about the possibility of esophageal cancer.

PERTINENT HISTORY

Patient's symptoms are occasionally accompanied by nausea and vomiting of the ingested item. He states that his dysphagia (difficulty swallowing) can occur with both solid food and with liquids and occurs intermittently, without any warning.

THE EXAM

The patient is a well-developed male with no signs of cachexia, who appears to be in his usual state of health. He is not jaundiced, has normal breath sounds without wheezing and an unremarkable abdominal exam. He had a cardiac work up due to the chest tightness and any cardiac etiology was ruled out. A rectal exam showed no masses or tenderness and the stool was negative for gross or occult blood.

DIAGNOSTIC TESTING

Prior to consultation, the aforementioned cardiac workup was negative, as was a UGIS that revealed no masses, strictures or obstruction of the esophagus and a normal appearance of the stomach and duodenum. There appeared to be tertiary contractions of the esophagus that were nonspecific. His WBC was 8.4 with an eosinophil count of 2000 /ul (normal 0-500/ul). LFT's and testing for connective tissue disorders were normal as were his Hgb/Hct.

CONCLUSION

Our patient is doing well on Pantoprazole and Fluticasone and has gained weight. He was obviously relieved that he did not have cancer and this has provided the impetus for him to quit smoking and curb his alcohol ingestion.

Other patients should learn from this case and realize that their symptoms should always be evaluated, especially when they are persistent, and to remember that many of the possibilities for their symptoms can be diagnosed and treated in a timely manner.

TREATMENT

Patient was treated with Fluticasone (a topical steroid) and an antiseecretory medication (PPI), to help decrease the inflammation. The patient noticed improvement in his symptoms in about 6-days and has had no recurrent episodes in several months.

Lastly, I suggest the patient see an allergist due to the high incidence of food allergies in patients with EE, especially those with a history of asthma.

DIFFERENTIAL DIAGNOSIS AND DIRECTED TESTING

The differential diagnosis for dysphagia includes mechanical causes—such as stricture, esophageal web and neoplasm—as well as infectious esophagitis, eosinophilic esophagitis, radiation esophagitis and motility disorders such as diffuse esophageal spasm, achalasia, nutcracker esophagus and scleroderma.

In our patient, many of the obstructive disorders can be ruled out with the history and relatively normal UGIS. Typically, motility disorders and eosinophilic esophagitis (EE) present with dysphagia to both solids and liquids and occur intermittently. An upper endoscopy (EGD) was performed and verified the lack of tumor. Despite the patient's young age, cancer had been a concern because of his weight loss, smoking and alcohol use.

Biopsies of the stomach were normal without evidence of *Helicobacter Pylori*, but biopsies of the mid-esophagus showed mild inflammation with increased eosinophils of 40/HPF. The diagnosis of Eosinophilic Esophagitis (EE) was made from these findings. Although esophageal manometry was not performed, this test may show several motility abnormalities like diffuse esophageal spasm or nutcracker esophagus.

WHAT YOU NEED TO KNOW ABOUT

Female Sexual Dysfunction

Women do not have to resign themselves to sexual dysfunction. With the type of comprehensive treatment we provide—delivered in an environment of privacy, dignity and respect—90 percent of our patients experience improvement in their sexual health.



Megan M. Wright, FNP-BC

With the plethora of ads for erectile dysfunction treatments that dominate the media, it would seem that only men experience sexual dysfunction. Yet it's estimated that about 40 percent of American women cope with the condition at some point in their lives. Even though the subject is not yet getting the public attention it deserves, the development of a greater understanding of female sexual dysfunction

(FSD) and a multi-faceted treatment approach are providing significant improvements to the majority of women who seek the right care.

Many women initially turn to their general practitioners or gynecologists for treatment of FSD. Although these physicians can rule out some of the underlying health problems connected to FSD, they often do not have the time or the specialized training needed to address the complexities of the condition.

The treatment of female sexual dysfunction focuses on six domains: desire, arousal, lubrication, orgasm, satisfaction and pain. Typically, problems in these areas are intertwined. For example, a patient who experiences chronic vaginal pain will probably also suffer from lack of desire and have difficulty achieving orgasm and satisfaction.

"During the initial evaluation of the patient, a significant amount of time is spent reviewing the medical history and delving into the patient's description of her sexual frustrations, says Megan Wright, FNP-BC, Premier Women's Center for Continence and Sexual Health's specialist in female sexual dysfunction. "At this point, the patient typically feels like there will never be any relief for her symptoms; but throughout this initial visit we will explore the various individualized treatment options which may provide the patient the relief she has been in search of."

Wright then performs a physical exam of the patient's genital region under the magnification of a vulvoscope, looking for the signs of conditions that might contribute to FSD. "Part of the work-up includes a serum hormone panel, not only for a baseline reference but also to guide our treatment while maintaining safe patient management," says Wright. Blood tests will provide valuable information and help focus the treatment approach. "For example, with a vulvoscopy I will be able to assess for signs of irritation to either the patient's tissues or her genital glands and make

A key part of the physical exam, vulvoscopy of the genital area provides clues to the source of FSD.

recommendations regarding the use of vulvar soothing creams that can be applied."

Treatments that work

"Several topical creams, consisting of various combinations of estrogen and testosterone therapeutics are used locally on the genitals," says Wright. "Putting hormones back into the tissues helps to restore a healthy environment. For patient's who prefer a more homeopathic route, we have several options, such as vitamin supplements to help increase testosterone and herbal treatments which can bind to the patient's neurotransmitter dopamine, elevating the patient's excitatory stage."

A variety of other medications are available to address problems in various areas of FSD. "We may prescribe oxytocin, to be taken 30 minutes prior to intimate relations, to help women in their orgasmic phase," says Wright, "and physical therapy to strengthen the pelvic floor muscles and enhance sexual satisfaction."

"As research continues to be done in female sexual dysfunction, we are able to bring these therapies to our patients in the hope of improving not only their sexual health but also increasing their quality of life and well-being." This is a distressing topic for many women to discuss, so it is our utmost priority to maintain their privacy while we provide them with the highest level of evidence-based care."



Ten minutes that could save your life: Screening Colonoscopy



Salvatore M. Buffa, MD

“If you have the opportunity to prevent cancer or catch it early, why wouldn’t you?”

Death rates from colorectal cancer have been dropping, in both men and women, for more than 20 years, reports The American Cancer Society. As a result, there are now more than one million survivors of colorectal cancer in the United States. Yet the disease is still the third most common form of cancer diagnosed in the country today. An estimated 50,000 people will die from it this year.

Salvatore M. Buffa, M.D., a member of Premier Medical Group’s Gastroenterology Division, would like to see that number reduced to zero. “We know colonoscopies save lives because it gives us the ability to catch potential problems early,” he says. “With colonoscopy, we can remove adenomatous polyps before they become deadly. These are polyps that we know will become cancerous with time; we simply don’t know how long it might be before that happens.” Even when a cancer is found, Dr. Buffa adds, early detection and treatment is highly beneficial, yielding a five-year survival rate for 90 percent of patients with early stage cancers.

When should you be screened?

Guidelines recommend that patients with no family history of colon cancer or previous colorectal issues should begin regular screenings at age 50. Those with a negative initial screening should be screened again in seven to ten years.

For patients with a family history of colon cancer, however, the scenario is much different. “Those patients should have their first screening 10 to 15 years before the youngest age at which any family member was diagnosed with colon cancer,” Buffa explains. “That means if your parent (or other first degree relative) was diagnosed at 55, you should have your first colonoscopy at 40, no later than 45.” Patients with other risk factors, including Crohn’s disease or ulcerative colitis, are also advised to follow a more frequent screening schedule.

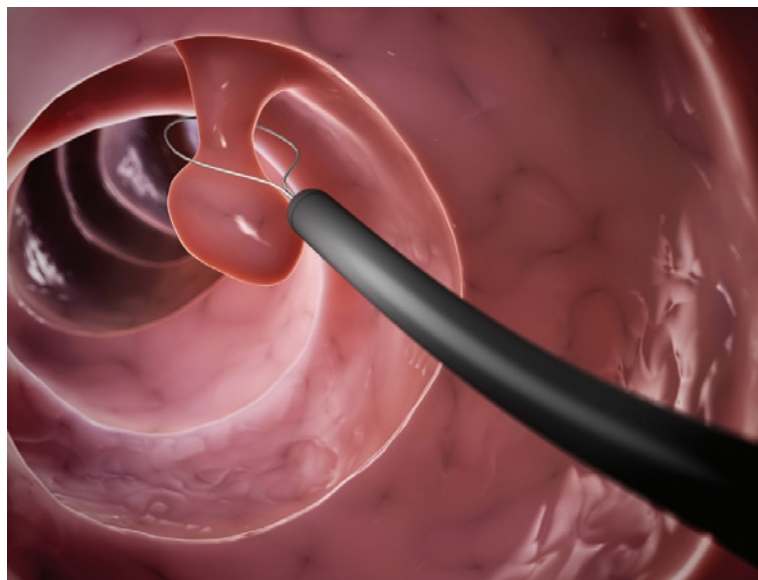
The risk of death from colon cancer, even in patients at higher than average risk, is reduced

by more than 50 percent for those who have adenomatous polyps removed during a colonoscopy. Yet, many Americans still put off regular screenings because of the somewhat unpleasant nature of the procedure. “I understand that preparing for a colonoscopy is not pleasant,” Dr. Buffa says. “But it is a whole lot better than it was even 15 or 20 years ago. The taste of the cleansing drink that is required has improved, as has the anesthesia we use during the procedure itself.”

Even newer forms of testing, such as virtual colonoscopy (a 3D CAT scan image of the colon) do not eliminate the need for thorough test preparation. “You still have to do the bowel cleansing and, if polyps are discovered, a traditional colonoscopy will still be needed to remove them—which means you have to do the bowel cleansing again,” he says.

In addition to having regular colonoscopies, patients can reduce their risk of colon cancer by consuming a low-fat diet rich in fruits, vegetables and whole grains. Smoking, obesity, a sedentary lifestyle and excessive alcohol consumption increase risk of the disease.

Thanks to increased awareness of the procedure’s life-saving benefits, discussing colonoscopy is not taboo in the way it once was. “We continue to work hard educating people so they are not afraid to talk about colonoscopies and colon cancer,” Dr. Buffa says. “Our annual Challenge Your Colon Chili Cook-Off (see related article on page 11) is just one of the ways that we encourage awareness and have fun at the same time.”



The risk of death from colon cancer is reduced by more than 50 percent for those people who have adenomatous polyps removed during a colonoscopy.

3d rendered illustration of a polyp removal.

Sebastian Kaulitzki /shutterstock

The Third Year

The Premier Cares Foundation has expanded its reach and contributions to include most areas of urology and gastroenterology, plus everything from aiding patients who need help paying for transportation to their chemotherapy or radiation therapy to assisting with end-of-life hospice care.

Premier Cares Foundation Care Fund Grants

In 2013, the Foundation began awarding Care Fund Grants to uninsured and underinsured individuals in the Hudson Valley undergoing treatment for urologic and digestive illnesses who are unable to cover the cost of their care. Care Fund Grants are also available for supportive services related to treatment, such as transportation to and from appointments, medication and other expenses patients may encounter as a result of their illnesses.

The Foundation works with local hospitals and community action agencies to distribute these grants. "The feedback we get from our partner hospitals and agencies has been very, very positive," says Elyse Brooks, Premier Cares Foundation Associate Director. "And we continue to be inspired by community members anxious to join our cause, such as Sean Gorwara, a junior at Arlington High School, who organized a charity tennis fundraiser and donated \$2,500 of the event's proceeds to the Foundation."

To learn more about Premier Cares Foundation Care Grants, including qualifying criteria, contact the Foundation's community action partner agencies.

Residents of Columbia, Dutchess or Putnam counties should call the Dutchess County Community Action Partnership at 845-877-9272, ext. 153; those residing in Ulster, Orange or Greene counties should contact Carroll Sisco at Family of Woodstock, 845-331-7080.

SIGNATURE FUNDRAISER 3rd Annual "Challenge Your Colon" Chili Festival March 30, 2014

This year's "Challenge Your Colon" Chili Festival, held in conjunction with Colon Cancer Awareness Month, was another huge success. More than 500 participants packed the Poughkeepsie Grand Hotel to sample the competition, which included 18 entries in the chili category and another six vying for the title of best cornbread.

The cold rain outside was a far cry from the heat being cooked up inside the hotel, where guests could sample chili that ranged from the safe to the volcanically hot. Joe Daily of Lite 92.1 FM emceed the event, which also featured entertainment by Bob Stump & the Blue Mountain Band.

In addition to food and entertainment, the Festival also gave participants the opportunity to meet Premier Medical Group's doctors, local nutritionists and pharmacists. "The Chili Festival allows us to talk about colon cancer in a way that isn't embarrassing," says Foundation Associate Director Elyse Brooks. "That's an important first step toward encouraging people to get tested."

The Festival's growing popularity is due in large part to the numerous restaurants, vendors, sponsors and individuals who eagerly sign up to participate every year.

Dr. Salvatore Buffa holding down the fort at the "Ask the Doctor" table



(Top) Keynote speaker Dena Delaney shared the story of her journey from colon cancer diagnosis to recovery; (top right) Tribute Cards in memory of a loved one; (left) Bob Stump and the Blue Mountain Band kept up the mood.

Chef Jason Kooperman accepting the People's Choice Award for Best Chili on behalf of Cosimo's



Arlington Firefighters won the 2014 "Premier" Award for Best Chili as judged by our team of food professionals

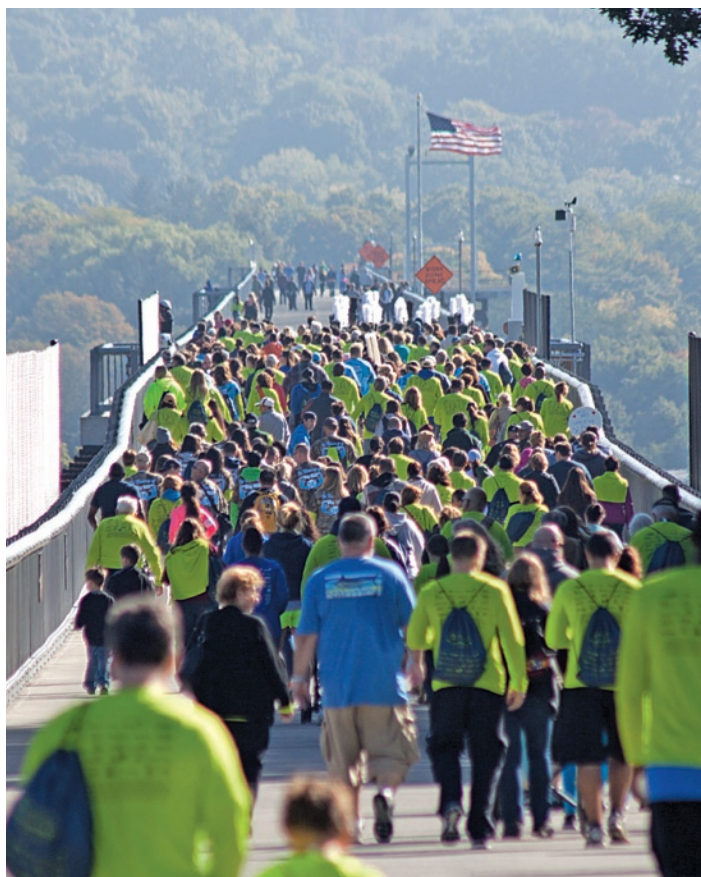


SIGNATURE FUNDRAISER
4th Annual
Prostate Cancer Walk
 September 28, 2013

The Premier Cares Foundation's fourth annual Prostate Cancer Walk was a buoyantly successful event. The sun was shining, the views from the Walkway Over the Hudson were breathtaking, and the award winning Arlington Marching Band leading the walkers across the bridge set the stage for a wonderful morning. More than 550 participants enjoyed morning refreshments while visiting the many informative stations, such as The Men2Men Prostate Cancer Survivor support group, Ask the Doctor table, and the DaVinci Robot, where individuals could try their hand with the latest surgical technology.

In addition to increasing the community's awareness of prostate cancer, the Foundation and its supporters raised over \$100,000 for financially challenged patients in our community who are in need of supportive services!

The funds raised will translate to tangible assistance for patients right away through grants from the Care Fund. Each and every walker and volunteer was an important link in the chain of aiding patients in getting the help they so deserve.



SAVE THE DATES
September 27, 2014
 5th Annual
Prostate Cancer Walk
December 6, 2014
Celebrity Chef Dinner
 featuring Chef Jacques Torres
March 15, 2015
"Challenge Your Colon"
Chili Festival

For information, please visit
www.premiercaresfoundation.org



Premier Cares Foundation's New Associate Director Elyse Brocks

Elyse Brocks (above, left) joined Premier Cares Foundation (PCF) in January as associate director. In her new role, Brocks works hand-in-hand with PCF Executive Director Julie Goldfischer (above, right) to raise funds to support the organization's mission and organizes special events designed to increase awareness of the Foundation in the community.

Brocks comes to Premier Cares Foundation from Vassar College, where she worked in institutional development. Although the constituencies of a college and a medical practice are different, Brocks says her work is essentially the same: "You need to get the word out and you need to be comfortable asking people for their support."

With scores of worthy organizations and causes throughout the Hudson Valley, Brocks says her challenge is to continue to promote Premier Cares Foundation and the work it is doing to make health care accessible to residents of the Hudson Valley. "My goal is to help the Foundation continue to grow. There is so much potential for us because we are still 'young,'" she says, noting that the Foundation was established only three years ago. "Despite our relatively new status, we've been able to find many corporate sponsors that are really supportive of the work we do. But there's a lot more we can do, and the best way to do that is to build our recognition in the community so that we can become a priority on people's agendas."



SIGNATURE FUNDRAISER

3rd Annual Celebrity Chef Fundraising Dinner

November 16, 2013

Generous sponsors, colleagues, and friends made the Celebrity Chef Fundraising Dinner—featuring Chef Sara Moulton—a rousing and tasteful success. Chef, author, and TV personality Moulton shared stories about her culinary adventures while guests enjoyed her delicious dishes—prepared with finesse by the Cosimo's team—all in the beautiful setting of the Poughkeepsie Tennis Club. This memorable, sold-out event featured a fabulous farm-to-table style dinner with wine pairings and the opportunity to contribute to the work of Premier Cares Foundation.



Attention to detail



Megan M. Wright, FNP-BC

The path to overcoming female sexual disorder (FSD) has grown much clearer over the last decade. At Premier Women's Center for Continence and Sexual Health we now have a wide array of diagnostic tools, medications and treatment protocols with which to help our patients. By taking into account the interconnected realms that effect female sexuality, we can often achieve success for women who had all but given up hope.

THE CASE

A 59-year-old post-menopausal woman presents with complaints of decreased libido and pain with intercourse over the last 10 years. She reports having sexual relations 4-5 times a year with her husband of 24 years, noting that her spouse is always the initiator. Patient reports no longer enjoying sexual relations with her spouse, a situation she fears will only continue to get worse.

THE EXAMINATION

The physical exam includes a vulvoscopy to assess the vagina and vulva through magnification. The vaginal tissue is noted to be pale pink and dry, with atrophy of the minor labial folds bilaterally and of the vaginal opening. The vestibule is erythematous, with decreased rugae noted within the vagina. Upon examination of the glands within the vestibule, the patient reports pain on a scale of 9/10.

A vaginal culture is obtained in order to rule out any infections as a cause of the patient's pain and erythema. Blood tests are ordered to assess patient's hormone levels, adrenal function, sex hormone binding globulins and thyroid function. A complete metabolic panel is obtained to help determine whether she is a candidate for use of certain hormonal treatments.

THE HISTORY

Patient reports a history of depression and is able to coincide her decreased libido with the onset of her depression and the initiation of anti-depressant therapy. She has had 3 C-sections with no vaginal births, a total hysterectomy, and spinal surgery. Currently, she is taking Tramadol for back pain and a selective serotonin reuptake inhibitor (SSRI) for depression. Tests for urinary tract infections, bacterial, and yeast infections done by previous providers have been negative. She has not had any sexually transmitted diseases or pelvic trauma caused by rape, infections, or vaginal births. The patient's partner is able to maintain relations through orgasm. She reports difficulty becoming aroused and notes that pain with intercourse limits the intimate time she spends with her spouse.

THE DIAGNOSIS

The physical exam reveals that the patient suffers from atrophic vaginitis-postmenopausal—the thinning and decreased lubrication of the tissues—caused by aging and a lack of hormones. Her pain with intercourse (dyspareunia) arises from the irritated glands and atrophied vaginal opening, leading to the diagnosis of vulvar vestibulitis. The patient also suffers from female orgasmic disorder and hypoactive sexual desire disorder, as deduced from her history.

THE TREATMENT

The patient's blood work shows her to be deficient in several hormones. After discussing treatment options with the patient, it is decided to begin a regimen of topical hormone replacement therapy (HRT), using various creams to provide for a healthy vaginal environment. The patient was advised to follow-up with the doctor who prescribes her SSRI therapy to discuss alternatives to her depression management, such as medications that bind with the excitatory neurochemical, which would help during the orgasmic phase. Using water-based lubricating solutions free from parabens and other irritants was recommended to decrease pain with penetration. The patient was also encouraged to bring her partner in to the next visit to discuss her therapy. Sensate activities were explored and the patient was educated regarding the pleasure receptors, which will help her and her spouse rekindle their bond and strengthen their relationship.

THE OUTCOME

Six weeks after initial evaluation, repeat blood work shows a slight increase in hormone levels. Patient reports being titrated off of her SSRIs with no increase in depression. She is happy with the effects of the topical creams and reports a 50 percent decrease in pain with intercourse. At the three month visit, the patient reports increased libido and that she has begun to initiate sexual relations with her spouse. She reports a 90 percent resolution of pain with intercourse and expresses satisfaction with her sexual relationship.

MAKING A DIFFERENCE:

Testicular Sperm Extraction

These procedures have effected a revolution in the treatment of male infertility for men with azoospermia, the condition characterized by an absence of sperm in the semen. Success rates are high and the results are gratifying.



Jason Krumholtz, MD

Continued advances in the treatment of male infertility have brought the joy of parenthood to couples that have struggled for years to have a baby. Premier Medical Group's Jason Krumholtz, M.D., is happy to be a part of this development.

Approximately 20 percent of all cases of male infertility are caused by azoospermia, a condition characterized by the absence of sperm in the semen. There are two main types of azoospermia, obstructive and non-obstructive. Men with obstructive azoospermia produce sperm, but they are not released into the semen because of a blockage in the reproductive system. In non-obstructive azoospermia, sperm are not being produced in the testes or are present in levels too low to effect reproduction.

In these cases, Dr. Krumholtz will identify the cause of the azoospermia and then proceed to treat the underlying problem. In many men, the problems can be corrected by targeting therapy at the anatomical, hormonal, and pathophysiologic causes of the condition. Nonetheless, there is a group of men whose azoospermia is uncorrectable and they, and their spouses, will need to pursue in vitro fertilization (IVF).

IVF requires a very small number of sperm to fertilize an egg through a process called intracytoplasmic sperm injection (ICSI). Testicular sperm extraction (TESE) and testicular sperm aspiration (TESA) are procedures that retrieve sperm from a patient's testes to make assisted reproduction possible and successful.

In the standard TESE procedure, a small incision is made in the testes to retrieve sperm that can be used—either fresh or cryopreserved (frozen)—for in vitro fertilization (IVF). Standard TESE generally takes 30 minutes and can be performed in the office with local anesthesia. The recovery time is typically two or three days.

A variation of the technique, micro-

(Micro-TESE), is appropriate for patients with non-obstructive azoospermia.

These men produce so little sperm that none of it is detected in the semen. The procedure is performed in the operating room, using a high-powered operative microscope. Dr. Krumholtz opens the outer cover of the testicle and examines the testicular tissue for tiny areas of healthy tissue that may produce sperm. He then examines the tissue in the operating room, using a standard light microscope. He will continue to search and, if necessary, move to the other testis until sperm is identified. The tissue is transported to a reproductive endocrinologist who processes the tissue the same day. Given the limited quantity and fragility of the extracted sperm, IVF must be performed within 24 to 48 hours of extraction.

A dream come true

"For many years it was thought that men who have zero sperm were candidates for nothing but adoption or would require sperm donors, but these techniques have really revolutionized infertility treatment—and have done so with high success rates," Dr. Krumholtz says. In fact, in patients with obstructive azoospermia, the ability to obtain sperm is nearly 100 percent.

He cautions, however, that infertile men should not expect to immediately opt for TESE or TESA. "We do not just jump to these procedures," Dr. Krumholtz stresses. "Very often we can determine through blood work, hormone testing and imaging that the cause is correctable."

For men with uncorrectable azoospermia, however, TESE and TESA can literally make dreams come true. "Unfortunately, it is fairly common for couples to have been trying for years to have a baby before they pursue this avenue," Dr. Krumholtz says. "Many couples don't know these procedures are available, which is why it is important to seek help from professionals who deal with infertility on a regular basis."

"Many couples don't know these procedures are available, which is why it is important to seek help from professionals who deal with infertility on a regular basis."



GIVING OUR DOCTORS AND PATIENTS THE ANSWERS THEY NEED

Premier's Pathology Lab

Entering the new era of molecular diagnostics, the lab is offering tests once available only at major academic medical centers. As a result, our physicians and patients are able to undertake treatment plans with a greater degree of certainty.

In 1990, the year before PSA screening came into use, about 45,000 men died of prostate cancer. Last year, fewer than 30,000 men died of prostate cancer. “Clearly, the PSA test and improved treatment have lowered the death rate by a third,” says Dr. Evan Goldfischer, co-CEO of Premier Medical Group. “However, we have probably over-treated some patients, removed prostates that didn’t need to be treated and diagnosed people that perhaps didn’t need to be diagnosed. A number of genetic markers that have only recently become available give us the opportunity to refine our techniques.”

There are four molecular tests being operationalized at Premier to enhance physicians’ decisions on who to treat. No single test provides enough information, in itself, to drive a patient’s care, but the additional data gives doctors and patients a better understanding of whether a negative biopsy is truly negative—roughly 25 percent of these are false-negatives—or, in the case of a positive biopsy, to have a better sense of whether a patient has the aggressive, life-threatening form of cancer that warrants immediate treatment. “Our goal is to decrease the number of biopsies performed and the number of patients who receive treatment when active surveillance might be more appropriate,” says Goldfischer.

Testing in the new era of molecular diagnostics

- The Prostate Cancer Antigen 3 Assay (PCA3), an automated molecular test, was approved by the FDA in 2012. The PCA3 gene is highly overexpressed in the urine of men with prostate cancer. “If you get a high PCA3 score,” Goldfischer says, “that tells you that there may be cancer that didn’t show up in the biopsy, while a low score suggests a repeat biopsy may not be indicated.”

- ConfirmMDx is a test performed on left-over tissue from a negative biopsy. “We know that cancer in the prostate leads to the biochemical process of DNA methylation, what we call a halo effect. “If the test finds DNA methylation, that suggests that some small cancer may be present, that it needs to be watched closely and maybe the patient needs a repeat biopsy,” says Goldfischer. “It gives you a much higher likelihood of that negative being a true negative, and you can take a big sigh of relief and maybe you don’t have to undergo repeat biopsy.”

- Oncotype DX® Prostate Cancer Assay is used for men who have been diagnosed with prostate cancer. It provides a more precise and accurate assessment of risk based on individual tumor



biology. “This test tells you, if you have prostate cancer, do you have the really aggressive, life-threatening prostate cancer or a lower-grade cancer for which an active surveillance approach might be reasonable,” Goldfischer says.

- The 4Kscore™ Test, a blood test soon to join the lab’s arsenal, measures four biomarkers for prostate cancer. The results are entered into an algorithm that yields a predictive score. “Let’s say you’re a patient who has undergone a biopsy that was negative,” Goldfischer explains. “Now your PSA has gone up and you’re worried and wondering whether to have another biopsy. This blood test will give you a percentage that is the chance of your having high-grade cancer, the aggressive kind that could kill you. If the test comes back at 25 percent, well, you’ll probably want to have the biopsy. Let’s say it comes back at 5 percent, which means there is a 95 percent chance you don’t have high-grade cancer: in that case you may want to watch and wait.”

The laboratory is entering a new era of molecular diagnostics. For some time the lab has been performing the Fluorescence in situ hybridization test (FISH), mapping the genetic material in cells to detect bladder cancer. It has been using the Know Error system, employing DNA tagging to ensure there’s no mix-up in biopsy samples. Now, Premier’s lab is engaging the newest, cutting edge techniques, the approach found at academic centers and some of the larger, more progressive urology groups. The Premier lab is among the leaders of the pack.

Motility and Manometry

We don't usually think about the contraction of muscles (motility) that moves the food we eat through our digestive systems. Yet, it is a complex progression and if these contractions function abnormally, anywhere in the process, it can result in unwelcome symptoms.



Zana Nikolla, MD

With each bite of food or sip of liquid, the body begins a carefully choreographed process of moving what we eat and drink through the entire digestive system. Sphincter muscles from the esophagus to the anus are responsible for this transportation process.

The medical field that studies this function of the gut is called motility. When the strength or coordination of these muscles fail, a person can develop problems such as dysphagia (difficulty swallowing), gastroparesis (abnormal emptying of the stomach) or constipation. Motility testing can help isolate the source of the problem and give doctors insights into the best course of treatment.

Unexplained difficulty swallowing, either for liquids or solid food, is known as dysphagia. If tests such as a barium swallow with x-ray and upper endoscopy do not reveal any blockages or narrowing of the esophagus (food pipe) that might be causing the condition, Dr. Nikolla can use a pressure-sensitive diagnostic tool called a manometer to discover the source of a potential motility problem.

Measuring the pressure

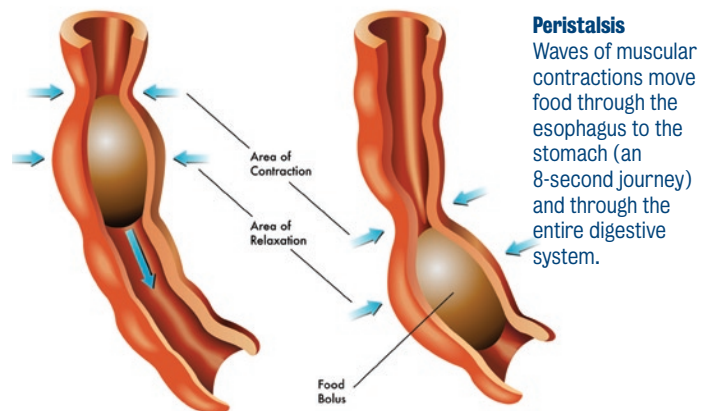
Esophageal manometry is a short, office-based and non-painful procedure during which a thin, flexible catheter is inserted through the patient's nose, down the esophagus and into the stomach. Patients are then asked to swallow, up to 10 times. Pressure sensors in the catheter measure the strength of the esophageal muscle contractions that occur during the swallowing process (peristalsis). The information received is transferred to a computer and analyzed by the doctors. Esophageal manometry can be performed for symptoms of dysphagia, in evaluation of patients with chest pain in whom heart problems have been ruled out and before surgeries for hiatal hernia repairs and esophageal reflux.

Dr. Nikolla says one of the conditions she is seeing more often through esophageal manometry is achalasia, which is caused by damage to nerve cells in the esophagus. This damage impedes the proper relaxation of the muscles at the end of the esophagus. As a result, food does not move through the esophagus into the stomach. Symptoms include dysphagia, regurgitation of food and chest pain.

Achalasia can be treated in several ways. Patients may be prescribed a course of medications, such as nitrates or calcium channel blockers, to help relax the esophageal sphincter. Botox injections to relax the

affected area of the esophagus are also an option, as is stretching of the sphincter muscles by pneumatic balloon dilation. In some cases, surgery to cut the taut muscles may be necessary to permanently correct the problem.

Patients suffering from chronic constipation or fecal incontinence (stool leakage) may benefit from anorectal manometry testing. Manometry lets the physician measure the strength of the anal



sphincter muscles; the sensation in the rectum and the neural reflexes that are all needed for normal bowel movements.

The test may reveal high muscle pressure in the anal canal—which can cause constipation—or low pressure, which may result in fecal incontinence. By analyzing muscle and nerve function at different points in the anal canal, doctors can diagnose conditions such as dyssynergia, which indicates the pelvic muscles do not relax and contract correctly.

When anorectal manometry indicates damage to the anal sphincter muscles, Dr. Nikolla may recommend bio-feedback exercises and other therapies to restore muscle strength (for fecal incontinence) or muscle relaxation techniques (to address constipation). Other treatment options include the implantation of a neurostimulator, a device that sends continuous, small electrical impulses to the nerves that control the anal and rectal sphincter muscles. At times, surgery might be needed to repair muscle defects.

“Motility issues can significantly impact a person's quality of life,” Dr. Nikolla says. “But given the testing and treatment options we have available today, they shouldn't. We can help patients regain control of their digestive symptoms.”

[premier in the community]

Premier Belongs

The physicians of Premier live here in the Hudson Valley, so their patients are also their neighbors and Valley culture and institutions are their culture and institutions. These are some of the worthy organizations they are part of. You can be a part of them too.



Vassar Haiti Project

Daniel Katz, MD — member, Medical Advisory Board

“Being involved in the Vassar Haiti Project Medical Advisory Board has been an inspiration to all of us. We have helped build a clinic to bring medical care to a place and people who lacked even the most fundamental services. This clinic will absolutely save lives and improve the welfare of many people who might otherwise suffer greatly. This is medicine in its purist form and it is very exciting to be a part of it.”

The Vassar Haiti Project has three main goals: Promoting the art of Haiti and supporting the welfare of Haitian artists; fostering education, health, and sustainable development in the village of Chermaitre, Haiti; mentoring student and community volunteers in the principles and practices of global citizenship.

As part of its mission, VHP has built, staffed, and supplied a brand new clinic to provide regular professional health care to residents of Chermaitre and surrounding villages. Funding supports the salaries of a full-time Haitian community health nurse and a Haitian doctor who runs the clinic every other week. A local medical committee oversees the administration of the clinic, while the Medical Advisory Board in the US, of which Dr. Katz is a member, helps to improve access to medicine and provides VHP with expert advice. thehaitiproject.org



Rhinebeck Crew, Inc.

Paul K. Pietrow, MD, FACS — Treasurer, Board Member

“My daughter has had a great experience with the team—she got into excellent physical shape, learned the importance of teamwork and developed new friendships. I also enjoyed a strong sense of teamwork and community that comes from the students and the parents. The students do the hard work of training and racing, but the organization requires involved and active parents to succeed.”

Rhinebeck Crew provides the students of Rhinebeck High School with a great recreational sports outlet that promotes physical fitness and camaraderie in a unique environment where there are no bench warmers or individual stars. Any RHS student that meets the school’s athletic participation requirements and is able to pass a swim test can join. In the sport of rowing everyone competes and the success of the team relies solely on being just that – a team.

The Rhinebeck Central School District endorses and supports the team, hiring and paying the coaching staff. Rhinebeck Crew, Inc. provides the remainder of the funding, which includes purchase, maintenance and storage of all boats and equipment, and transporting the boats to and from regattas. It also cover the costs of entry fees, insurance, training, and transporting our rowers to and from after school practices on the river. rhinebeckcrew.org



The Mid-Hudson Community Orchestra

Alan H. Gross, MD, FCCP — Cellist

The orchestra is composed of amateur, semi-professional and professional musicians, playing under the direction of a professional conductor. In partnership with Dutchess Community College, it creates beautiful music for the community to enjoy. Some sixty members—from all walks of life and from high school age to retirees—gather to rehearse on Wednesday evenings throughout the academic year. Their hard work and preparation culminates in a spring and a winter concert performed in the Dutchess Hall Theatre at DCC. Admission to the concerts is free to all. midhudsoncommunityorchestra.org



Miles of Hope

Peter M. Varunok, MD, FACG — Volunteer

"This is a fantastic grassroots, local organization that aids our neighbors in need with money that's raised here in the Hudson Valley and stays here."

The Miles of Hope Breast Cancer Foundation was established in 2004 to fund support services—including Medical Gap Care Fund, Peer to Peer Program, complimentary services, scholarship fund, and financial support for medical and daily living needs—for people fighting breast cancer in the Hudson Valley. It raises money to fund its programs and grants via five major fundraisers throughout the year: the Community Breast Cancer Walk (October), Hoops for Hope Basketball Tournament (March), Family Fun Run (April), Annual Spring Brunch (May), Dragon Boat Race and Festival (July), and Goals for Hope Soccer Tournament (August). milesofhope.org



Evan R. Goldfischer, MD, MBA, FACS

Bardavon 1869 Opera House — Board of Directors
Dutchess Day School — Board of Trustees

"I believe that the Arts are an essential part of the community and I am proud to be part of The Bardavon, a wonderful organization with an esteemed history of promoting art and culture in our community. I also believe in the importance of educating the next generation and Dutchess Day School has been producing well rounded, motivated, intelligent, and socially responsible graduates throughout its long history. The board of trustees is composed of very generous community leaders and I am honored to work with them."

Housed in a renovated 19th-century farmhouse in Millbrook, Dutchess Day School provides its students the perfect balance of academic rigor and coziness and warmth. The atmosphere of trust and mutual respect encourages students to take intellectual risks, use their imaginations, and develop independence and confidence. bardavon.org • dutchessday.org

Hindu Samaj Temple Blood Drive

Sunil K. Khurana, MD, FACG — Organizer

"Approximately 30 million blood components are transfused each year in the U.S., requiring more than 41,000 blood donations a day to keep abreast of the nation's transfusion needs."

Currently, about 9 million people a year donate blood, a quarter of all those who are eligible to do so. Members of the Hindu Samaj Temple in Wappingers Falls are making sure they do their part. I have organized blood drives in our temple for over ten years and have enrolled many people who had never donated blood in the past but have become regular donors to the American Red Cross." hindusamajtemple.org





PREMIER *medical group*

1 Columbia Street
Poughkeepsie, New York 12601

www.premiermedicalhv.com

RETURN SERVICE REQUESTED

Faces of Premier

Good healthcare requires teamwork. We are proud of the dedicated team that makes up Premier Medical Group. Their loyalty contributes to the comfort and security of our patients.

Marie Mazzucco

Human Resources Generalist

Patients often tell us how much they appreciate our employees. Not just the doctors and nurses, but also the people who greet them at the sign-in desk, make appointments over the phone and handle their billing questions. We realize that employees at all levels of the organization contribute to the total Premier Medical Group experience.

That is why we put effort into hiring the best people to join our team. Marie Mazzucco, our Human Resources Generalist, helps us find and train those people. Mazzucco works with Human Resources Manager Laine Belmonte to recruit new employees, conduct orientation, administer employee benefits, and lead training programs. She also assists with our employee recognition and employee wellness programs and special projects.

"We are very selective in the people we hire," Mazzucco says. "We want only the most qualified personnel, so we look for credentials and experience. But we also want to find people who will fit in with our practice and our patients."

It is a rigorous process, but it results in rave reviews from our patients. Another indication that we're choosing the right staff: "We continually hear from our employees that they love our patients and the people they work with," Mazzucco says.

Mazzucco makes an effort to get to know all the people who are part of Premier Medical Group. She admits, however, that with more than 220 employees in 12 locations, that can be challenging. But getting out and meeting co-workers in Fishkill, Rhinebeck or Newburgh is beneficial, Mazzucco says. "Putting a face with a name helps us all feel better connected, which is important because we are all on the same team. And I think our patients sense that."

