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SUMMER 2016



A Growing Practice for a Growing Hudson Valley

Colorectal cancer is now a concern for younger people.

How to stop prediabetes from progressing.

The prevention and treatment of kidney stones.

The magazine of PREMIER *Medical Group of the Hudson Valley*

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PremierHealth is published for Premier Medical Group of the Hudson Valley by Martinelli Custom Publishing.



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A Growing Practice for a Growing Hudson Valley
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 Audra R. Siegel, DPM;
 Christopher K. Bromley, DPM;
 Leonard S. Gerber, DPM;
 F. Gabrielle Summers, DPM;
 Dany Y. Jabbour, DPM.



Dear Reader,

As Premier Medical Group has grown, so has our ability to provide accessible, integrated, quality care to our patients. A case in point is Premier's online Patient Portal, which makes it easy for patients to view personal health information, schedule appointments, request prescription refills and securely communicate with the practice 24 hours a day, seven days a week.

Recently we have broadened our services in ways that save patients and physicians time, as well as significantly improving the quality of care we are able to deliver. With the opening of Premier's new clinical in-house lab, patients won't have to go elsewhere to get their blood or urine tests. Now, as part of a seamless process, we can keep close tabs on testing, receive results on the same day and make them instantly available on a patient's Electronic Medical Record.

Premier's new imaging department gives us the ability to offer ultrasound imaging across the entire practice. When a Premier physician decides that a patient needs an ultrasound, it can be ordered for that very day, with results available in a matter of hours, even more quickly if the situation is urgent. CAT scans are also done in-house, with similar efficiency.

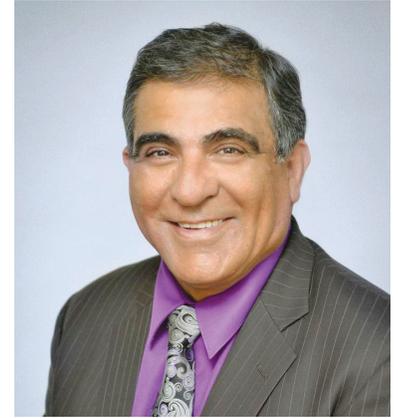
With this issue of PremierHealth, we are pleased to welcome a number of new physicians to PMG. Family physician Clement Landanno, M.D. has joined our Fishkill office. A seasoned practitioner, Dr. Landanno is well known and highly respected in our area. In addition to his private practice, he directed the family practice residency at St. Francis Hospital, helping to train a generation of physicians.

Dr. Leonard Gerber and Dr. Christopher Bromley, along with colleagues Dr. Florence Summers, Dr. Audra R. Siegel, and Dr. Dany Y. Jabbour have joined their Poughkeepsie podiatry practice with Premier. Drs. Gerber and Bromley have served our community for decades, not only in their offices but also with much-needed visits to seniors in nursing homes.

Premier's commitment to patient-centered care extends throughout the organization. Check in with PremierHealth magazine to find out about current developments—like the Urology Division's Same-Day Care Appointments (see page 5)—and for updates on exciting things to come, such as our Weight-Loss Clinic and our state-of-the-art Endoscopy Center..

Sincerely,

Sunil K. Khurana, MD, FACG
CEO, Premier Medical Group of the Hudson Valley



Zika Virus: What You Need to Know



Lorraine Nardi, MD

Over the past year, news reports have called attention to the growing global health concern caused by the Zika virus. In 2015, the virus appeared in Brazil and has rapidly spread through much of Central and South America. The mosquito-borne virus was first discovered in 1947, in the Zika Forest of Uganda. “For most people, Zika disease

is not a serious problem,” says Dr. Lorraine Nardi, of Premier’s Internal Medicine Division. You can have a fever, rash, joint pain and conjunctivitis (red eyes), which can last for up to a week, but there are no long term effects.

“For most people, Zika disease is not a serious problem... You can have a fever, rash, joint pain and conjunctivitis (red eyes), which can last for up to a week, but there are no long term effects.”



However, that’s not the case for women who are or may become pregnant. A pregnant woman infected with Zika is at risk of delivering a baby with microcephaly, a condition in which the baby’s head is much smaller than normal and its brain fails to develop properly. “Microcephaly is a terrible birth defect,” says Nardi, “leaving babies with a lifetime of medical problems.”

“The likelihood of Zika becoming a big problem in the Hudson Valley is small,” Nardi says. The virus is predominantly transmitted by a species of mosquito not found in northern climates. “It has been found in the U.S., but people were infected in other places, as far as we know,” she says. It has also been found that men infected with the Zika virus can transmit the virus through sexual intercourse. According to Dr. Nardi, if a man is diagnosed with the Zika virus, he should abstain from sex or use condoms for six months; if Zika is suspected but not confirmed, abstinence or condom use are recommended for six weeks. Currently, there are no vaccines available to prevent infection.

Nardi advises that it is important to stay vigilant. “If you are pregnant or planning pregnancy, don’t travel to countries where the virus is pandemic,” she says. “If you’re a man and have symptoms, see your doctor to be sure you don’t spread it to someone else.”

“Zika virus will be pretty newsworthy for the foreseeable future,” Nardi says. She recommends following the news, calling the health department and checking the CDC website, www.cdc.gov/zika, to stay abreast of the situation

Adult Vaccination’s Role in Protecting Your Health

Vaccinations aren’t just for children. There are several important vaccines recommended for adults, but too many adults fail to receive them. “Generally, people don’t like getting shots, let’s be honest,” says Dr. Anita V. Pavels, an Internal Medicine specialist with Premier Medical Group. “But adults need these vaccines because there are viruses and bacteria that can still make them very, very sick.

The most important vaccines are aimed at those types of germs.” These include protection against influenza, pneumococcal pneumonia, shingles and tetanus-diphtheria-pertussis.



Anita Pavels, MD

INFLUENZA—annual dose

The flu causes as many as 49,000 deaths and 100,000 hospitalizations each year, according to estimates by the U.S. Centers for Disease Control and Prevention. The flu vaccine, which is reformulated every year to match the ever-evolving viral strains, can be taken as a shot or a nasal spray by those under 50 with no respiratory problems. Fall is the best time to be vaccinated because it takes two to three weeks for the vaccine to kick-start the immune system.

PNEUMOCOCCAL PNEUMONIA — 1 dose PCV13 and 1-2 doses PPSV23 starting at least by age 65

There are two pneumococcal vaccines. The PCV13 vaccine, known by the brand name Prevnar-13, protects against 13 strains of the bacteria. The PPSV23 vaccine offers protection against 23 strains. Which one you get, and when, depends on your personal health history, but typically adults should receive the PCV13 vaccine by at least age 65, followed about a year later by the PPSV23 vaccine. The option of a second PPSV23 shot about five years after the first is discretionary, based on the patients’ health status.

SHINGLES — single dose at age 60 or over.

Shingles is caused by Varicella Zoster, the virus that causes chickenpox in children and then lies dormant in the body. The virus can reactivate and cause mild to severe pain and a blistering rash. The shingles vaccine is recommended for all adults age 60 and older who have a history of chickenpox. “If you have already had shingles, I still recommend the vaccine to prevent future flare-ups,” Dr. Pavels says.

TETANUS-DIPHTHERIA-PERTUSSIS — one booster.

Pertussis, better known as whooping cough, was nearly eradicated in this country, thanks to vaccinations. But it has re-emerged, because vaccination rates have dropped and the vaccine’s effectiveness wears off over time. Adults should receive the tetanus-diphtheria-pertussis (Tdap) booster vaccine at least once. Those who have children or grandchildren, or who work with children, should be especially vigilant, as pertussis can be fatal in infants. The Td vaccine would follow at 10 year intervals.

[internal medicine]

Dr. Landanno Joins Premier

Premier's Fishkill Internal Medicine office is pleased to welcome Dr. Clement Landanno to its team. A Fellow of the American Academy of Family Practice, Dr. Landanno specializes in comprehensive family care. "My special interest is everything from birth to death," he says. "I'm passionate about all of it."

A New York City native, Dr. Landanno graduated from SUNY Downstate College of Medicine in Brooklyn in 1975, and completed his residency there in 1979. He moved to the Hudson Valley that same year and began practicing in New Paltz. He lived until recently in Hopewell Junction, where he and his wife of 42



"When I fractured something, when something was wrong with me, when I needed to be stitched up, I went to one person and one person only—my family doctor... Becoming a family doctor appealed to me because you're not dealing with parts of the patient, but the whole patient. You basically learn to do most everything."

Dr. Landanno says he was drawn to Premier's Fishkill practice because he has "known most of the doctors in Premier for many years," and he shares their guiding principle of patient-centric care. "The patient is what's most important," he says. "I basically consider my patients to be part of my extended family."

The current trend in medicine, is "going back to the old family doctor who know his patients through their families and knew how to talk to them and approach them," he notes. "Family doctors have always been valuable, but there aren't a lot of us left."

Today, when training young family medicine residents, he says, "I teach that when you're going into family practice, you're going all in. Sometimes you need to be a little more than 9 to 5."

[urology]

Getting Care When You Need It

Introducing the Urology Division's Same-Day Care Appointments.

As part of its commitment to patient-centered care, the Poughkeepsie office of Premier Medical Group's Urology Division has instituted Same-Day Care Appointments (SDCA). Current or new patients can now call us in the morning and arrange an appointment with one of the practice's urology-trained Nurse Practitioners before end of day.



Marylu Williams,
FNP-C, CUNP

"It's always better to go where you know the practitioners and they know you and have access to your medical records."

Patients have been making use of SDCA for both urgent and non-urgent situations. When acute issues develop, such as kidney stones, painful urinary tract infections, or prostatitis, "patients really appreciate getting in and being taken care of quickly," says Marylu Williams (FNP-C). "It eases their minds and they like the convenience of being able to get in to see a specialist when they need one."

Though area urgent care centers and hospital emergency rooms can effectively deal with some problems, "It's always better to go where you know the practice and the practitioners, and they know you and have access to your medical records," Williams says. An additional benefit of SDCA, and a significant one, is that you won't have to spend hours in a waiting room hoping to see a doctor; appointment times are adhered to as closely as possible.

At the SDCA, a nurse practitioner will assess the patient's health concern, prescribe treatment as needed, schedule follow-up exams or procedures and consult with the patient's regular urologist. New patients receive streamlined access to medical care as Premier staff is expert at gathering all the necessary medical information quickly and efficiently.

Williams notes that some health crises do warrant an emergency room visit. "If you have a fever associated with pain; nausea or vomiting; or unmanageable pain immediate help could be necessary," she says. "However, if the pain that has been going on for a few days, and you are just waiting for an opportune time to see the doctor, calling us for a Same-Day Care Appointment is a good option."

For more information or to make a Same-Day Care Appointment, call 845-437-5000.



Weight loss of seven percent of body mass combined with exercise of 150 minutes per week (similar in intensity to brisk walking) has been shown to reduce the risk of progressing from prediabetes to diabetes by 58 percent, even more for people over the age of 60.

[internal medicine]

The Prediabetes Epidemic

Without intensive early intervention, up to 30 percent of those with prediabetes will progress to type 2 diabetes within five years of their diagnosis.

Diabetes is an all too common chronic disease. In 2012, 12.4 percent of the population over the age of 20 had diabetes. Incidence of the disease rises with age: by 2014, 21.5 percent of Americans aged 65-74 and 19.2 percent aged 75+ had diabetes. It continues to be a leading cause of cardiovascular disease, lower extremity amputations that are not due to injuries, end-stage renal disease and blindness.



Carol Miyake, MD

Diabetes is diagnosed based on test results revealing a blood glucose level of 126 mg/dl, a hemoglobin A1C of 6.5% or more (A1C is a measure of a patient's mean blood glucose level over the preceding three months), and a failing glucose tolerance test (one that shows a 2 hour, post-meal blood glucose level > 200 mg/dl). Up to half of the people with diabetes are not aware that they have it and many are diagnosed only when a complication develops.

Decisive clinical trials have shown that better treatment of diabetes—including controlling blood glucose, cholesterol and blood pressure—will decrease the risk of complications of the disease. This is heartening, of course, but it would be even more heartening if people at risk of the disease could mobilize to prevent it.

Prediabetes is a condition that may progress to diabetes. Fifteen to 30 percent of people with prediabetes will develop type 2 diabetes within five years of a prediabetes diagnosis, unless they participate in intensive, early intervention. There is a 50-70 percent risk of people with prediabetes developing diabetes in the course of their lifetime.

In 2012, studies found the incidence of prediabetes in adults over the age of 20 to be 36 percent, with 51 percent of Americans aged 65+ having the condition. A person has prediabetes when his or her blood glucose is abnormally high, yet still lower than the levels seen in a person with diabetes. The condition is diagnosed

when a patient's fasting blood glucose tests 100 mg./dl-125 mg./dl; when hemoglobin A1C tests 5.7% mg./dl-6.4% mg./dl; and when a 2-hour post-meal blood glucose level tests 140 mg./dl-199 mg./dl.

HALTING THE PROGRESSION

The good news for the 86 million Americans who currently have prediabetes is that weight loss and exercise together can have a dramatic impact on delaying or preventing the progression of prediabetes to diabetes. The results of a clinical trial conducted by the Diabetes Prevention Program (DPP), published in 2002, found that weight loss of seven percent of body mass combined with exercise of 150 minutes per week (similar in intensity to brisk walking) reduced the risk of progressing to diabetes by 58 percent for the entire study population. For those over the age of 60, the risk for diabetes was reduced by 71 percent.

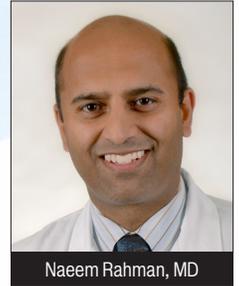
As a result of such research findings, many insurance companies now pay for nutrition education as well as for glucose testing supplies when an insured person has a diagnosis of prediabetes. In March of this year, the Centers for Medicare & Medicaid Services announced that Medicare will soon add coverage for participation in the National Diabetes Prevention Program (National DPP), a network of community-based, lifestyle intervention programs administered by hospitals, health care centers and community organizations. Delivered in a classroom setting by trained coaches, the National DPP provides a supportive, small group environment to promote healthier eating habits and increase physical activity. It consists of an intensive, 12-month, evidence-based intervention that includes 16 weekly core sessions followed by monthly maintenance sessions.

Visit the National DPP website at www.cdc.gov/diabetes/prevention to learn more or to locate a nearby program. You can even sign up for the Online Program, which follows a CDC-approved curriculum and includes a lifestyle coach, either in a group format or one-on-one.

[urology diagnosis]

The Premier Approach to Advanced Prostate Cancer

The Comprehensive Prostate Cancer Program ensures that our patients receive the most up-to-date specialized care available.



Naeem Rahman, MD

Advances in treating prostate cancer have been rapid and significant over the last five years. Keeping abreast of these changes and adhering to benchmarks of care can be challenging.

With Premier's Comprehensive Prostate Cancer Program, patients can continue to be seen by their regular Premier urologists while benefiting from specialized care and the most current treatment protocols and medications available. Under the direction of Dr. Naeem Rahman, the program's team-approach facilitates up-to-the-minute tracking of a patient's condition and disease status so that treatment can be adjusted to maximize outcomes.

Premier's Comprehensive Prostate Cancer Program focuses on a specific subset of patients, those with advanced stage 4 prostate cancer (PC). Even within stage 4 PC there is variation, and the program typically deals with two different populations: patients diagnosed as stage 4 for the first time and patients with castrate resistant PC.

CASE STUDY 1:

A 69-year-old gentleman with significant urinary symptoms — discomfort, urgency, frequency and nocturia — is referred to Dr. Rahman after initial analysis by his regular urologist. He has a PSA of 10 and, upon examination, his prostate is found to be very firm and irregular. We do a biopsy and the tissue samples are given a Gleason score of 9, which suggests high-grade cancer that is likely to be aggressive and to spread.

A CT scan shows that, while there aren't any lymph nodes involved, several areas along the patient's spine and pelvis show sclerosis, lesions that are consistent with metastatic prostate cancer.

Finally, a nuclear bone scan shows that these lesions are metabolically active, leading to a diagnosis of metastatic stage 4 prostate cancer.

As little as two years ago, the standard course of treatment would have been to put this patient on androgen deprivation therapy (hormonal therapy). We would then follow his condition via his scans and PSA, adjusting treatment as required.

The new paradigm for a man with multiple lesions, as are present in this patient, is to prescribe chemotherapy at the outset of treatment, in conjunction with hormonal therapy. This is a complete shift in approach insofar as chemotherapy, in the past, was reserved as a last resort in PC treatment. The data shows that this approach provides a significant survival advantage.

CASE STUDY 2

The other subset of patients the program focuses on is men for whom hormone therapy is no longer effective. Many advanced prostate cancers eventually adapt to hormone therapy and resume progression. In this case, the patient is said to have castrate-resistant prostate cancer.

A 75-year-old gentleman who had a prostatectomy and radiation treatment after being diagnosed with stage T3 PC eight years ago now has elevated PSA readings. Three years ago, after a dramatic spike in his PSA, he was started on hormone therapy and did well. With the rise in his PSA level, he is now considered to have castrate resistant prostate cancer.

There are a number of medications that may be indicated in this setting. Choosing the best treatment requires a holistic approach geared to the individual. A patient with seizures or central nervous system issues, for example, requires a different medication than one with diabetes or high blood pressure.

We would consider offering the patient Provenge, an immunotherapy that has minimal side effects and can yield dramatic improvement and survival.

For some patients we would consider the newer forms of anti-androgen therapies recently available, such as Zytiga or Xtandi. Patients who have disease predominantly in their bones may benefit from Xofigo (radium 223dichloride) a radio-pharmaceutical.

Our decision on which approach to use depends on a range of factors, including the patient's pain level and functionality. All of these approaches have been shown to improve survival.



With Premier's Comprehensive Prostate Cancer Program, patients can continue to be seen by their regular Premier urologists while benefiting from specialized care and the most current treatment protocols and medications available.

Tackling the Obesity Trend



Elizabeth Williams, DO

Since the 1960s, the US has seen a significant rise in the obese and extremely obese population. According to the CDC, approximately 50 percent of Americans will be obese by 2030.

Obesity is classified using the body mass index (BMI), a measure of body fat based on height and weight. Under this classification, a BMI of 18-25 is normal, 25-30 is overweight, 30-35 is class I obesity, 35-40 is class II obesity, and a BMI over 40 is class III obesity.

Obesity is expensive; it raises the annual cost of medical care in the US by approximately \$316 billion (2010 values). An obese individual will, on average, pay approximately \$1,470 more per year for health care than an average-weight person.

Obesity is also costly to one's health. All-cause mortality increases in individuals with higher BMI. Diseases associated with obesity are numerous and include, but are not limited to, hypertension, dyslipidemia, diabetes, coronary artery disease, gallbladder disease, gout, reproductive abnormalities, obstructive sleep apnea, nonalcoholic fatty liver disease (which can lead to cirrhosis), stroke and cancers of the breast, uterus, liver, colon, esophagus, pancreas, kidney and prostate.

It is for such reasons that the US Preventative Services Task Force recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.

The etiology of obesity is multifactorial but may be linked to both genetic and environmental factors. There are some indications that alterations in the gut microbiome may contribute to obesity. The intake of high calorie/high sugar beverages is a significant contributor, as is the US culture of eating on the run. Individuals tend to overeat when eating rapidly, as the stretch receptors in the stomach which are partially responsible for satiety have not had appropriate time to accommodate. Some studies have also shown that when patients are deprived of sleep, have been fasting, or are under stress, they have decreased activity in their prefrontal cortex, the area responsible for inhibition, and tend to crave high sugar, high calorie foods.

MULTIPLE WEIGHT LOSS OPTIONS

The optimum approach to weight loss is through behavioral modification, smarter food choices and better access to healthy, whole foods. In regard to a specific diet, many experts suggest the best diet is one that the individual can adhere to, be it Jenny Craig, Atkins or Weight Watchers. Smarter food choices—such as adding more fruits and vegetables to the diet and consuming fewer processed carbohydrates—will often help reduce caloric intake.

There are other options—such as pharmacotherapy and bariatric surgery—for patients who fail conventional weight loss. The FDA has approved several medications for weight loss, but they

can have significant side effects. Patients with a BMI higher than 40 or those with a BMI higher than 35 who have significant comorbidities are candidates for bariatric surgery. The International Diabetes Federation has recommended consideration of bariatric surgery for patients with a BMI of 30–35 if traditional medical management is unable to achieve adequate diabetic control.

Bariatric surgery rates in the US have increased over the past few years and 193,000 bariatric procedures were performed in 2014. The most common types of bariatric surgery include the Roux-en-Y gastric bypass, gastric banding and sleeve gastrectomy. These surgeries induce weight loss by different mechanisms, including restriction of food intake and malabsorption.



Obesity is expensive; it raises the annual cost of medical care in the US by approximately \$316 billion (2010 values). An obese individual will, on average, pay approximately \$1,470 more per year for health care than an average-weight person.

A NEW APPROACH

Two minimally invasive procedures approved by the FDA in 2015 utilize gastric balloons that are placed in the stomach via endoscope. ReShape Integrated Dual Balloon System and Orbera Intra-gastric Balloon System both take up space in the stomach to induce satiety and constrain calorie intake.

It is important to note that many studies have shown that bariatric surgery is more successful at inducing and maintaining weight loss, as well as bringing improvement to comorbid conditions such as diabetes, than lifestyle modifications alone.

[podiatry]

Podiatry Division Welcomes New Physicians

We are pleased to welcome the office of Dr. Leonard Gerber and Dr. Christopher Bromley, Podiatric Medicine and Foot Surgery, in Poughkeepsie, to Premier Medical Group. Along with Drs. Gerber and Bromley, the practice includes Dr. Florence Summers, Dr. Audra R. Siegel, and Dr. Dany Y. Jabbour.

After completing surgical training at the Podiatry Hospital of Pittsburgh in 1981, Dr. Leonard Gerber moved to Hopewell Junction and began practicing in Poughkeepsie. While growing up in New York City, in Queens, his family vacationed at Sylvan Lake, so he felt immediately at home upstate. "I live about a mile from the lake where I used to swim when I was a little boy," he says. "You never know where you're going to wind up."

Dr. Gerber, who specializes in sports medicine and foot dermatology, was drawn to podiatry by its uniqueness. "Most patients come to podiatrists with some type of pain. What's good is that they usually leave without the pain," he says. "One of my favorite things to be able to say to patients is, 'I've been through this before! This should be the worst thing you ever have.'"

Personal relations are an integral part of medicine for Dr. Gerber. "I like talking to people, dealing with seniors and hearing about their life experiences," he says.

"Most patients come to podiatrists with some type of pain. What's good is that they usually leave without the pain," says Dr. Gerber.

Joining Premier promises to be a big plus for Gerber's practice. "There's so much outside documentation, whether from insurance companies or the government, that needs to be done, it's too much. Premier has several departments to take care of that," he explains, which "frees us up to see more patients and provide more time for our patients."

"Older people have a wealth of knowledge that most people don't bother to listen to. I'm in a position where I can do that. That's what I enjoy."



Dr. Leonard Gerber (left) and Dr. Christopher Bromley join Premier Medical Group.

According to Dr. Gerber, the patient must come first. "We try to have entry for any patient that calls, and get them in as soon as possible," he says. "I don't look at the computer when I'm in the room with them; I look at the patient. I like the patient to ask me questions. We're hands on here."

Dr. Christopher Bromley has been practicing podiatry for almost 25 years. A native of Newburgh, he returned to the Hudson Valley after completing surgical training at the University of Maryland and Johns Hopkins teaching hospitals.

Dr. Bromley has special expertise in sports medicine, foot surgery, regenerative medicine and alternative therapies.

He has been the Chief of Podiatry Surgery and Podiatric Medicine at Vassar Brothers Medical Center for over ten years.

The breadth and variety of the field drew Dr. Bromley to podiatry. "Podiatry involves orthopedics, vascular, neurological and dermatological issues of the feet," he says.

Dr. Bromley has special expertise in sports medicine, foot surgery, regenerative medicine and alternative therapies. He takes a holistic approach in his treatment of feet. He is on the cutting edge when it comes to reducing pain and inflammation using Cold Laser Therapy, a modality that has also been shown to stimulate wounds and help the healing process.

One of the practice's guiding principles, says Dr. Bromley, "is to always treat the patients as we would want to be treated." This includes providing a careful explanation to educate each patient. "Our office is focused on conservative, non-surgical treatment, with surgical options when necessary," he says.

Lupus: The Great Imitator



Farah M. Ashraf, DO

Most people with the disease can lead normal, high-quality lives, despite their symptoms and the potential side effects of treatment.

Lupus is a disease that has been chronicled since the days of Hippocrates. Though modern science has identified it as a chronic autoimmune disease, there is still no cure. In lupus, as in other autoimmune diseases, the immune system malfunctions, producing autoantibodies that react with and damage the body's own healthy cells, tissues, and organs. This leads to inflammation that is the cause of numerous symptoms, the most common of which include extreme fatigue, painful or swollen joints, unexplained fever, skin rashes, and kidney problems.

Anyone can get lupus and, according to the FDA, about 25,000 new cases are diagnosed every year. However, 90 percent of new cases develop in women age 15-45, in their childbearing years. The disease is more common in women of African-American, Hispanic, Asian, and Native American descent than in Caucasian women. It is believed that hormones influence the probability of developing the disease, as well as genetic predisposition and environmental factors, but all the contributing factors have not yet been pinned down.

There are several types of lupus. The most common form, called systemic lupus erythematosus, can affect numerous bodily organs—such as the kidneys, lungs, heart and brain—as well as the joints and skin. Discoid lupus is a chronic skin disorder characterized by a red, raised rash on the face, scalp, or elsewhere that can last from days to years and may cause scarring. Subacute



cutaneous lupus causes skin lesions on parts of the body exposed to sun. Drug-induced lupus is caused by medications—such as antiseizure, high blood pressure and thyroid medications, and by antibiotics and antifungals—and typically goes away when the drug is stopped.

Diagnosing lupus is often a challenge. The symptoms of the disease mimic those of many other conditions and each patient has slightly different symptoms that may come and go over time. Diagnosis is based upon a complete medical history of signs and symptoms, physical exam and laboratory tests. There is no single test that determines whether a patient has lupus. But, considered in total, blood counts and tests for autoantibodies (such as the ANA, anti-DNA, anti-Smith, etc.) can help your rheumatologist confirm or rule out lupus.

Treatment plans, which are tailored to the individual patient, have several goals: prevention of disease flares; treatment of flares when they occur; minimizing organ damage and complications. Nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen and naproxen, are often used to reduce inflammation and resulting pain and swelling. Corticosteroids, such as prednisone, may be prescribed to rapidly suppress inflammation and reduce immune system activity.

For almost seventy years, the most commonly used medication for lupus has been Hydroxychloroquine (Plaquenil), an anti-malarial drug that can keep the disease in remission and may decrease the risk of lupus spreading to the internal organs. If this drug does not provide sufficient relief, or if there is internal organ involvement, newer potent immunosuppressants, such as methotrexate, azathioprine, or cyclophosphamide, may be prescribed.

The newest medications for lupus are biologic agents. The first drug specifically developed to treat lupus, Benlysta, was approved by the FDA in 2011. A human monoclonal antibody, Benlysta targets specific immune cells, blocking biological activity that contributes to the production of autoantibodies.

Anyone can get lupus and, according to the FDA, about 25,000 new cases are diagnosed every year. However, 90 percent of new cases develop in women age 15-45, in their childbearing years.

Most people with lupus can lead normal, high-quality lives, despite their symptoms and the potential side effects of treatment. Sitting down with your rheumatologist and discussing the different options and what best suits your disease process is the key to therapy and management.

It is crucial to learn how to recognize the warning signs of a flare and how to take steps to ward it off or reduce its intensity. It is also important for people with lupus to receive regular health care, rather than seeking help only when symptoms worsen. Staying healthy requires extra effort and care for people with lupus, so it becomes especially important to develop strategies for maintaining wellness.

Under the Microscope

Travel to Russia and antibiotic exposure puts a patient at high risk of infectious diarrhea.



Zana Nikola, MD

THE CASE:

A 60-year-old female presents in the office with diarrhea of four weeks duration. She describes it as watery, occurring up to ten times a day, without blood or mucus, but associated with some urgency and mild crampy abdominal pain. Patient denies any fever, chills, nausea or vomiting. She reports feeling generally unwell and having lost approximately ten pounds since the diarrhea started.

Patient had traveled to Russia three months ago, along with her husband, but did not get sick while there. Two months ago she was treated with antibiotics for a tooth infection.

She reports having been very depressed in relation to her daughter's marital issues and consulting her primary care physician, who started her on sertraline (Zoloft) for depression. Besides this medication, she also takes a baby aspirin to reduce cardiovascular risk as her mother had a heart attack at an early age. Patient is an active, life-long smoker but denies any consumption of alcohol. She has no other medical problems. Her last colonoscopy was performed ten years ago, for screening purposes, and it was normal. She denies any family history of major gastrointestinal diseases.

PHYSICAL EXAMINATION:

Patient is not in any distress. Her skin was normal and mucosa were not dry; no rashes were present. She had a normal head and neck exam. Her heart, lung and abdominal examination were normal. She had no swelling of the extremities.

DIAGNOSTIC WORK UP:

Patient has had some laboratory data performed by her primary care physician. Those included a complete blood count

that showed no anemia, normal white blood cell counts, normal kidney and liver function. Albumin and total protein levels were normal. Her thyroid function was within normal limits.

Upon presentation to the office, it was felt that she was at high risk for infectious diarrhea given her recent travel history and antibiotic exposure. Stool cultures for *Clostridium difficile* (*C. diff*) and for parasites were sent out. They all returned negative.

Blood work was performed to rule out celiac disease and patient was found to not be lactose intolerant.

NEXT STEP IN THE MANAGEMENT:

Patient continued to have diarrhea. A colonoscopy was performed to rule out inflammatory bowel disease. The lining of the large intestine appeared normal and was without the presence of inflammation.

Multiple biopsies were obtained which resulted in findings consistent with a diagnosis of lymphocytic colitis.

TREATMENT:

Patient was started on over-the-counter Imodium and advised to use Pepto Bismol as needed. The frequency of bowel movements decreased from ten times a day to five but stool was still loose. Sertraline—for which loose stools is a common side effect—was discontinued.

Patient received treatment with budesonide (a type of steroid medication with relatively few side effects) for two months, with excellent response. Medication was then tapered off over the course of three months. She was asymptomatic at a follow-up visit.

Microscopic Colitis: An Overview



Intestine image by Leocräfts

Microscopic colitis is a condition involving the large intestine that causes watery diarrhea. There are two types identified via biopsy—lymphocytic and collagenous—but they are treated the same way. This disease occurs when the colon gets inflamed. The precise cause is unclear but in some cases it can be caused by medicines such as nonsteroidal anti-inflammatory drugs (NSAIDs), antidepressants, or medications used to reduce gastric acid.

Symptoms include non-bloody diarrhea and belly pain, weight loss and fatigue.

Diagnosis is made by ruling out other causes of diarrhea (including infections), ordering blood work and performing a colonoscopy. During the colonoscopy, small samples of the large intestines are taken (biopsies) and looked at under the microscope. This is the only test that will yield the diagnosis.

Treatment involves stopping the culprit medications, using anti-diarrhea medications like Imodium, or steroid medication like budesonide, which helps reduce the inflammation in the large intestine.

Colorectal Cancer Rates Rising for Younger People

In an alarming new trend, more than 15 percent of CRC sufferers now receive their diagnosis before the age of 50.

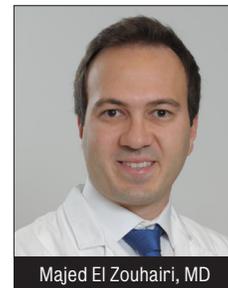
Colorectal cancer (CRC) is the fourth most common cancer in the United States and the second leading cause of death among cancers, affecting people of all racial and ethnic groups. It has traditionally been thought of as a disease of the elderly since it is most often found in people who are 50 years of age and older. However, there is a disturbing new trend that seems to challenge this conventional wisdom: more than 15 percent of CRC sufferers now receive their diagnosis before the age of 50.

While the overall CRC rates of incidence and mortality have gradually diminished—a trend that is largely attributed to the widespread screening of people who are 50 and older—younger people are increasingly among the sufferers of CRC. If these trends continue, researchers estimate that, by 2030, one in six colon cancers and one in four rectal cancers will be diagnosed in individuals younger than 50. By 2020 and 2030, the incidence rate of colon cancers will increase by 37.8 percent and 90 percent respectively for patients aged 20 to 34 years. Furthermore, the incidence for rectosigmoid and rectal cancers are expected to increase by 49.7 percent and 124.2 percent respectively for this same age group. Among people aged 35 to 49 years, the incidence rates are projected to increase at a slower pace: 27.7 percent for colon cancers and 46 percent for rectal cancers by 2030.

This increase in the prevalence of CRC among younger generations is an impending major public health problem for which the cause has not yet been discovered. Researchers know that some of the risk for CRC is inherited; behavioral factors, such as obesity and physical inactivity, may also play a major role. Obesity is a well-known contributor to CRC and its prevalence is on the rise in the US. Environmental aspects such as diet and gut microbiome are also big contributors. Since, as the saying goes, 'we are what we eat' and since gut microbiome is largely affected by the food that people eat and the medications they take, these factors heavily influence the prevalence of the disease. Western diets (high in red meat, junk food and processed meat and low in vegetables)

have also been associated with an increased risk for CRC.

Unfortunately, current screening guidelines recommend against routine screening for average risk individuals younger than 50 years. Accordingly, younger patients are often diagnosed only after they become very symptomatic, especially since younger adults are less likely than older adults to be concerned about symptoms and to seek medical care. Indeed, based on patient population data, the American College of Gastroenterology has already recommended that African Americans begin screening at the age of 45, although the US Preventive Services Task Force has yet to endorse that recommendation.



Majed El Zouhairi, MD



Younger people are increasingly among the sufferers of CRC. If this trend continues, researchers estimate that, by 2030, one in six colon cancers and one in four rectal cancers will be diagnosed in individuals younger than 50.

PRACTICAL GOALS

While these new studies and findings may not warrant the immediate revision of current guidelines, they add important considerations to the discussion about the appropriate age for screening. More studies are needed to prove that screening healthy people at earlier age can be cost effective and worth the risk as well. Colonoscopy has risks and other alternative screening modalities such as stool tests (fecal occult blood tests, fecal immunochemical tests, and stool DNA tests) and radiologic imagings (double contrast

barium enema, and CT colonography) are costly. It is imperative that these factors be considered.

Practically, doctors' and patients' biggest goal at this time should be to become more aware of the warning signs of CRC, including anemia, a significant change in bowel habits, and dark blood or blood mixed with the stools in bowel movements. Primary care physicians' index of suspicion should increase to include a greater range of at-risk patients and doctors should broaden their differential diagnosis to include malignancy in the appropriate clinical setting, even among younger people.

Removing Kidney Stones



Paul Pietrow, MD

Sometimes kidney stones can be avoided, but several minimally invasive procedures are highly effective if they occur.

“Anyone who has ever had a kidney stone knows how awful it is,” says Dr. Paul K. Pietrow, a urologist with Premier Medical Group. “Many women say they’d rather experience the pain of childbirth than pass a stone.”

Kidney stones are hard masses of material, usually calcium oxalate, that form in the urine. They may be as small as a grain of sand or as large as a marble. Most kidney stones pass out of the body naturally. Sometimes, however, a stone may get stuck in the urinary tract, blocking urine and causing tremendous pain.

The prevalence of kidney stones is rising in the U.S., Dr. Pietrow says. “That is probably because of the Western diet and weight gain; studies show that being overweight or obese raises stone risk.” Women are also experiencing kidney stones in increasing numbers. “The male-to-female ratio used to be 3:1, but now it is closer to 2:1 or even less,” he says.

For patients who experience repeat stone episodes or present unusual health histories, Premier’s urologists order a metabolic profile to discover the biochemistry that may be causing stone formation. “With a more precise diagnosis, we can get more precise prevention strategies,” he says. These may include medications that are directed at metabolic abnormalities. For example, the thiazide family of diuretic medications helps control calcium excretion; potassium citrates alkalinize the urine; allopurinol decreases uric acid production. “Medications can drop stone events by 90 percent,” Dr. Pietrow says. But less than 50 percent of patients are prescribed meds. “Most patients control stones through fluid intake and dietary changes. Weight management and other lifestyle modifications can have a significant impact; increasing fluids can drop the risk by 50 percent all by itself,” Pietrow says.

MINIMALLY INVASIVE STONE REMOVAL

There are three currently used techniques for removing stones. Open surgery, which was widely employed in past decades, “is now almost completely historical,” Dr. Pietrow says. “I have never done it or seen it done.”

The first approach, perhaps the most commonly known, is extracorporeal shock wave lithotripsy (ESWL). Sound waves are focused onto the stone to break it into smaller pieces that can more easily be passed. ESWL is effective up to about 70 percent of the time, working best on stones in certain areas of the kidney and urinary tract, and is not as effective on larger, denser stones. “When it was developed, 30 years ago, it was truly groundbreaking, but the field of urology is now considering, in light of other procedures available, how large a role it should play,” says Pietrow.



The top 3 ways to avoid kidney stones

- 1. INCREASE FLUIDS.** “We want people to make 2 quarts of urine a day, and to do that, drink about 2.5 to 3 quarts of fluid a day,” Dr. Pietrow says.
- 2. DECREASE SODIUM.** To help prevent stones, and for overall health, limit sodium consumption to less than two grams per day.
- 3. WATCH YOUR DIET.** Minimize animal proteins to one small portion per day, add citrates such as lemon juice or calcium citrate supplements to process calcium efficiently and avoid foods high in oxalates. Litholink.com is good source of information about oxalate content in food.

The second option, ureteroscopy, has become the workhorse of stone removal. Thanks to the development of thin, flexible, fiberoptic endoscopes, urologists are able to send a camera and laser through the ureter and, as Dr. Pietrow says, “check every nook and cranny of the plumbing.” The laser breaks down the stone and the surgeon can then extract it or allow the smaller pieces to pass naturally. “Because we can look at the stone, we can see whether we are done or not,” he says. “That’s why it has a much higher success rate than ESWL—above 90 percent.”

Percutaneous nephrolithotomy (PCNL), the third option, is usually reserved for large stones (over 2cm, the size of a marble) and cases in which the other options are not feasible. A small incision is made in the patient’s back through which a needle, a tube and several small instruments are positioned in the kidney. The stone is broken up with ultrasonic waves and the pieces removed through the tube. Though it is somewhat more invasive than the other methods, it is highly effective and, in some cases, the only option.

Your urologist will take all the particulars of your case into account and help you understand which is your preferred stone removal option.



Foundation Update

Premier Cares Foundation board members present the Premier Award for Best Chili to Texas Roadhouse.

This March, the Premier Cares Foundation raised over \$52,000 at its 5th Annual “Challenge Your Colon” Chili Festival. The funds will go toward providing supportive services to our financially challenged neighbors in the Hudson Valley who are battling gastrointestinal and urological diseases.

Equally important, the event raised community awareness about the crucial role of colonoscopy in preventing colon cancer and served as a reminder that we can do so much when we work together.

More than 500 people gathered at Villa Borghese in Wappingers Falls to sample delicious chili, cornbread and chocolate chip cookies whipped up by area restaurants. Q92 radio host Joe Daily was on hand to emcee the festivities, while Stringendo’s Raspberry Fiddlers provided rousing tunes. Kids enjoyed a wealth of activities, including woodworking crafts from Home Depot, science experiments with Poughkidsie and games from Partytime Rentals and Just4Fun Entertainment.

“It is heartwarming to know that so many people have made the Colon Cancer Awareness Chili Festival a staple in their spring schedule,” says Julie Goldfischer, Executive Director of Premier Cares Foundation. “When we designed the Festival, over five years ago, our hope was that people would come out for a delicious and fun, family-friendly afternoon, to raise awareness on a topic that many tend to shy away from.”

The event has expanded every year and more organizations—such as Healthquest Nutrition, Sparrow’s Nest, and Putnam Ridge Nursing Home—have stepped up to partner with the foundation in putting it on. A growing number of incredible restaurants and local businesses continue providing excitement and support. “The best part for me,” says Goldfischer, “is working with the more than 90 volunteers, many of whom are colon cancer survivors, who care about helping to prevent the dreaded, yet preventable disease.”

AND THE WINNERS ARE...

Chili, cornbread, and chocolate chip cookies were judged for Premier Awards by professional culinary judges in blind tastings and for People’s Choice awards by Festival attendees.

TEXAS ROADHOUSE - Premier Award Best Chili

MILL HOUSE BREWERY - People’s Choice Award for Best Chili

MOLE MOLE - Most “Creative” Chili

ADAM’S FAIRACRE FARMS - Premier Award for Best Veggie Chili

CROOKED ROOSTER - People’s Choice Award for Best Veggie Chili

YOLO - Premier Award for Best Cornbread

MILL HOUSE BREWERY - People’s Choice Award for Best Cornbread

ON-A-STICK BAKERY - Premier Award for Best Chocolate Chip Cookie

BREW SKY - People’s Choice Award for Best Chocolate Chip Cookie

DURANT’S PARTY RENTALS - Table with Best Country Flair

MOLE MOLE - Table with Best Country Attire

7th Annual Prostate Cancer Walk

Saturday, September 24, 2016
9:00 am – Noon at Walkway Over the Hudson
(Highland side of the bridge)



We hope you will join us for the magnificent views of the Hudson Valley as you walk 1.2 miles each way, 212 feet above the river on Walkway Over the Hudson. Spend an exhilarating morning with the entire family, friends and neighbors, enjoying refreshments, entertainment, and great prizes. At the same time, you'll be helping to provide support, awareness, education, and treatment to individuals in the community with urologic and digestive diseases. Money raised by the Walk supports local charities and prostate cancer programs in offering free screenings and other supportive services. Come walk in honor and in memory of a loved one. **To register in advance, visit www.PremierCaresFoundation.org.**

The 6th Annual Premier Food & Wine Experience

Saturday, October 29, 2016
6:00 pm – 10:00 pm at Poughkeepsie Tennis Club
UnWINEd with Kevin Zraly

A delicious evening to sip, savor and swirl is provided by Kevin Zraly, internationally acclaimed wine educator and author of "The Windows on the World Complete Wine Course." Be prepared for a fun and fast-paced tasting tour of Riesling, Sauvignon Blanc, Chardonnay, Pinot Noir, Merlot and Cabernet Sauvignon wines from around the world. Begin with hors d'oeuvres and cocktails, progress to Zraly's "One Hour Wine Expert" presentation, and finish with a turn at the food and wine pairing stations. This will be a night you do not want to miss! **To register in advance, visit www.PremierCaresFoundation.org.**



[giving back]

Dr. Muslim Goes on a Mission

This spring, Dr. Arif M. Muslim, a physician in Premier's gastroenterology division, spent his vacation in the Philippines. There were transportation snafus on the way to distant islands, stifling heat and humidity, but none of it phased him because he was on a mission.

"I've been involved for quite some time with the Rotary Clubs of America and its work with The Wheelchair Foundation. My first trip was to Chile," says Muslim. Rotarians in the recipient country identify people who are in need of a wheelchair they could not otherwise afford. "We travel as a group, with members paying their own way and donating wheelchairs in addition to those supplied by the foundation."



"Some of the folks came in with homemade wheelchairs made from wooden wheels and planks; it was unbelievable. We gave them a nice, shiny American wheelchair."

Once they're at the sites—four Philippine islands were visited on this trip—the volunteers assemble the chairs, fill the tires, clean them and hand them directly to the recipients. They're equipped with different sizes of wheelchair so they can help adults and children alike.

"It's a good feeling, says Muslim. "The first chair I gave out on this mission was to a kid with cerebral palsy who could not walk at all. He's getting bigger now and it has become difficult for the parents to carry him around. Some of the folks came in with homemade wheelchairs made from wooden wheels and planks; it was unbelievable. We gave them a nice, shiny American wheelchair."

Providing mobility to people who would otherwise be denied provides instant satisfaction. You hand the wheelchair to someone and see the gratitude; often they are in tears," says Muslim. "I'll keep doing this as long as I'm physically and mentally able."

Dr. Muslim's group is planning to make their next mission to Nepal. "There are a lot of people who, in the aftermath of the earthquake, are disabled and could use wheelchairs," he says.



PREMIER *medical group*

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www.premiermedicalhv.com

Faces of Premier

Good healthcare requires teamwork. We're proud of the dedicated staff that makes up the Premier Medical Group team.

BILL ABRAMS, RT, CT
PHILIP KROCHMAL, DMS, VT
ANTHONY TOZZI, ARDMS

Premier Medical Group has put together a team of seasoned professionals to provide its patients with convenient, quick and quality imaging. Each of them, along with being an experienced technician, is mindful that our patients' comfort and security is the top priority.

BILL ABRAMS started as an X-ray tech in 1979 and began doing CT scans in 1989. He's been with Premier for more than 10 years.

"The first machine I worked on needed 45 minutes to do a patient's abdomen and pelvis; now it takes about 20 minutes. Back then we saved images on magnetic reel-to-reel tape, now we save them on DVDs and the radiologist backs it up onto their system."

"I make it a point to make the patient feel comfortable; I explain, in detail, everything I'm going to do. I'm pretty good at easing the nervous people and treat them like I'm the one lying on the table."

PHILIP KROCHMAL started working with Premier six years ago and recently, after a distinguished career as a vascular sonographer, joined us full-time:

"Being able to correlate our studies to any other imaging the patient has had, as well as with their medical history, is something that differentiates us from other ultrasound providers. If you go to an imaging center or a hospital, there's



MEET THE TEAM: (from left) Philip Krochmal, Anthony Tozzi, Bill Abrams

a separation between the patients and their medical history. Having all that information makes for a far more diagnostic exam."

"Personally I have a lot of respect, for the way Premier maintains a very well-run office. It's put together to maximize the patient experience and, truthfully, the employee experience as well."

ANTHONY TOZZI has been a sonographer for 11 years, six of them with Premier.

"We do it all—from abdominal work to vascular work—and though each exam has its own particular challenge, we take pride in being consistent. We're able to easily talk directly with the patient's ordering physician so we can gather all the information we need to pinpoint the areas of concern. This helps us put all the pieces of the puzzle together so the patient gets a proper diagnosis."