CASE STUDY
Highly Recurrent Thoracic Sarcoma

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in Clinical Practice Today

How Does Your Practice Stack Up?
This 2-part feature explains how you can focus on benchmarking to check the pulse of your practice

Strengthening for Lung Transplant
Careful patient preparation before surgery is just as important as post-operative care

The ABCs of ICD-10
These basic tips will help you focus on the most important things as you make the transition to ICD-10

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Reducing Claims Denials
Submitting clean claims the first time around can reduce write-offs and keep your cash flow healthy

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More than 90% of physicians have at least one online performance rating, so it’s important to keep tabs on those ratings

Updated Guidelines for Reducing Atherosclerotic CV Risk
The 2013 ACC/AHA guidelines sparked debate with a new risk calculator and new therapeutic recommendations

LVAD: A Device for Life
The LVAD is becoming more than just a bridge to transplant

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Real Costs of Postponing Surgery

Decreased access to shoulder surgery may lead to high indirect costs to society, such as lost productivity and disability payments, researchers at Duke University Health System found and reported in the November 2013 issue of The Journal of Bone & Joint Surgery.

The researchers learned that, compared with nonoperative treatment, the estimated societal savings from rotator cuff surgery was $13,771 over a patient’s lifetime. When multiplied by the roughly 250,000 rotator cuff repairs performed in the United States (US) annually, the total estimated lifetime societal savings was $3.44 billion. The reduced indirect costs more than offset the costs of surgery in patients 61 years old and younger. Quality of life improved, too.

The team also found high indirect costs from an unstable knee after an ACL tear. “These patients were often unable to work because of their injuries,” says lead author Chad Mather III, MD, assistant professor of orthopaedics.

Drug Improves ALS Patient Strength

Amyotrophic lateral sclerosis (ALS) is a disease that creates worsening weakness as nerve cells die and pull away from muscle. Researchers at Duke have been studying a new drug from Cytokinetics called Tirasemtiv that activates troponin (the main structural protein in muscle) to bind more tightly to calcium so the muscle cells collectively generate more force.

“When ALS is a problem with nerve cells, I didn’t expect this drug to work,” says Richard Bedlack, MD, PhD, director of the Duke ALS Clinic. “This was the first drug, however, that has shown evidence of improved strength in the 14 years since our clinic opened. Now we need to replicate these findings.”

Autism & Induced Labor

Women whose labors are induced or augmented may have an increased risk of bearing children with autism, especially if the baby is male, according to data from Duke Medicine and the University of Michigan.

The findings do not prove causality, but suggest the need for more research into maternal and fetal health, the events at labor, and the titration of drugs during induction/augmentation to identify the elevated risk.

In this study published in JAMA Pediatrics, lead author Simon Gregory, PhD, associate professor of medicine and medical genetics at Duke, and team studied records of all births in North Carolina over an 8-year period and matched 625,042 births with corresponding public school records that included diagnoses of autism. The findings suggest that, among male children, labor that was both induced and augmented was associated with a 35% higher risk of autism.
In the pay-for-performance era, medical practices must deliver cost-effective care and meet quality targets. This dichotomous challenge requires that attention be paid to key performance indicators that can help track both aspects of a practice’s pulse; two such indicators are patient volume and satisfaction.

Patient Volume
Patient volume is critical to the financial health of your practice. The most basic measures track no-shows, cancellation rates, and the number of patients seen per day per clinician. Such data can be used to help meet productivity goals. For example, a large number of no-shows suggests that reminder calls would be well worth the investment of resources. Likewise, if volume is slipping or is lower than the national average, patient flow should be analyzed more carefully to identify bottlenecks that contribute to wait times.

The ratio of new patients to existing ones, meanwhile, is your primary leading indicator, explains Elizabeth Woodcock, a practice management consultant in Atlanta. If that number is trending lower, clinicians should implement a plan to network more effectively with referring physicians. If market forces are contributing to the decline—such as a competing practice opening up across town—management should step up marketing efforts.

In patient-volume analyses, new patient lag time—or the amount of time it takes between a new patient’s first phone call and when they are actually seen—is often overlooked. But it shouldn’t be. “This is absolutely business critical,” says Woodcock. “You’re not going to grow your revenue if you don’t have new patients, and you won’t have receivables if you don’t see those patients.”

Patient Satisfaction
Last but not least are measures of quality and service, which not only affect patient care, but also potentially your ability to collect incentive payments from health plans. Patient outcomes are an obvious starting point, but practices can also track the number of avoidable emergency room visits, including those that result in hospital admissions and readmissions for medical conditions like diabetes or asthma, which could have been managed on an outpatient basis.
If that figure is high, consider improving patient access by staffing a skeleton crew on Saturday mornings or being more proactive in educating your chronically ill patients. “Health plans are holding physicians accountable for quality improvement, so you need a baseline that tells you where you are,” says Mary Nix, health scientist administrator for the National Quality Measures Clearinghouse, an initiative of the Agency for Healthcare Research and Quality. She notes that the quality measures your practice tracks will largely be dictated by health-plan reporting requirements. For example, CMS (the Centers for Medicare & Medicaid Services, www.cms.gov) lists a number of measures that physicians who care for Medicare beneficiaries should report through their Physician Quality Reporting System.

The degree to which your patients leave your practice happy goes hand in hand with your performance. With compensation increasingly tied to patient satisfaction scores and patients being able to rate their experience with your office online, clinicians can no longer afford to neglect their customer base. Although sophisticated written surveys can be deployed by outside vendors, practices can also solicit feedback informally using short phone surveys, paper-based surveys, or Web-based questionnaires. Practices should ask patients whether they were happy with the quality of their medical care, whether practice access met their needs, and how satisfied they were with their interaction with your staff.

If you can only ask one question, though, get straight to the point: “Ask if they would recommend you to a friend or family member,” says Woodcock. “That’s the ultimate indicator of patient satisfaction.”

Benchmarking

Once you’ve gauged the financial health of your practice, you’ll need to compare the results with those of your peers. The Medical Group Management Association produces annual cost, compensation, and production surveys, with dashboards to compare your practice’s data with national norms. Many professional associations and specialty societies also produce statewide data or tips/tools that may be relevant to your practice.

Measurement alone, however, does not make an efficient practice. It’s merely a starting point. To truly improve your performance, you must use those findings to effect change. “Having a dashboard of various indicators only helps us determine what questions to ask next,” says Woodcock. “People think benchmarking data will solve their problem, but really it just identifies opportunities to improve your performance,” she says.

The best practices, she notes, circle back to the health plans with which they contract to find out how they measure success. Is it based on improvement or your ability to hit a specific target? Are incentive bonuses granted only if those targets are met in full, or is there a system to prorate the bonus if you come close?

As the health care industry evolves, practices must learn to adapt. Those that measure key performance indicators, compare the data with benchmarks, and use the results to improve processes will be better positioned to benefit from the shift to value-based reimbursement.
Strengthening for Lung Transplant

Very few centers that perform lung transplants require pre-transplant health indicators and an effective post-transplant exercise program, but Duke Transplant Center is having success with this approach.

“Managing patients going into the transplant is often just as important as after the operation,” says John Reynolds, a transplant pulmonologist at Duke. “The goal is to maintain their functional status, teach breathing techniques, and optimize their medical condition as much as possible.”

In general, any form of cardiovascular exercise would be ideal for pending lung-transplant patients. The lung program encourages patients who are exercising or rehabilitating to pursue a supervised program that includes, for example, walking on a track, riding an exercise bike, using steps, doing floor exercises, and lifting weights for strengthening.

Patients who receive new lungs at Duke must commit to moving to the area and working with the program. The Duke program initiated walking distance and other requirements for lung-transplant patients when they noticed that the outcomes for patients who exercised correlated with better survival. Length of stay became shorter, too.

Patients generally have the same requirements, with some modifications for younger patients, who are mainly cystic fibrosis patients.

Duke also performs transplants in older patients, some over age 70, and has not set a maximum age limit. With years of experience, however, the program has made some progress in learning how to predict patient outcomes. “We evaluate carefully and we agree to transplant the patients who we feel will have the best chance of doing well,” Reynolds says.

Another effective aspect of Duke’s lung transplant program is the short activation time for patients who have met their goals and are placed on the organ wait-list: about 2 to 3 weeks’ wait on average, which is well below the national average. The short wait-list time is advantageous because it allows for the optimization of patients before listing and then successfully proceeding to transplant while still in their “transplant window.” This approach minimizes deaths of patients on the wait-list and allows for the patients to undergo transplant while they have acceptable functional status.
Although the required switch to ICD-10 diagnosis codes is getting closer and may seem like a case of pile-on to practices already dealing with Meaningful Use and health care reform, there are many good reasons for the change. With 64,000 codes (versus 19,000 in ICD-9), ICD-10 provides more specificity and flexibility, which will help better track health outcomes and quality of care and possibly lead to reimbursement that more closely reflects the complexity of care. It also brings US-based providers in line with those from other developed countries, which have been using the code set for more than a decade.

The key to realizing more of the benefits and less of the pain is adequate preparation. Here are the ABCs of getting started with ICD-10:

A

**SSESS** To assess the extent to which this change will affect your practice, follow a fictional patient or transaction through a full cycle. Where are diagnostic codes used? Who are the people who use these codes? What are the most common codes you use? Use this information to streamline your transition, for example, by translating commonly used codes first. Pull a few charts and determine what additional information you need to document to support the specificity of ICD-10, then focus on filling the gaps.

B

**UDGET** The switch to ICD-10 will cost time and money. Expenses may include: staff training, renegotiation/adjustments of contracts, health information technology (IT) system upgrades, superbill revisions, and increased documentation time. Expect some loss in productivity; estimates range from about 10% to 15% for providers and 20% to 50% for coders. One report estimated that typical costs could range from $83,000 for a small practice to more than $2.5 million for large practices. Practices can prepare by securing loans and deferring discretionary spending.

C

**COMMUNICATE** Ask your payers, IT vendors, and clearinghouses about their plans for the transition. The amount of effort required may be enough to crush some smaller electronic health record (EHR) brands. Inquire about costs for system upgrades and training and timelines for getting through the implementation process. The sooner you know, the more time you have to prepare and adjust.

D

**DOUBLE CODE** Coding in both ICD-9 and ICD-10 might pay off for some practices, especially those that include complex specialties or those that handle workers’ compensation and auto insurance claims. (These companies are not required to make the transition to ICD-10.) Double-coding can also help during the training process. Some practice management and EHR vendors offer systems that code in both ICD-10 and ICD-9 to ensure that payers get the information that they need in the right format.

E

**EDUCATE** Targeted classroom and/or online training for providers, coders, and other staff will save your practice time and money in the long run. If possible, give staff time to experiment with the new code set and software before the training so that they come prepared with questions and background knowledge.
CASE STUDY

Highly Recurrent Thoracic Sarcoma

The patient, a 39-year-old physician in Greenville, NC, had marked shortness of breath while playing basketball in a charity game. He had been healthy and active, so he went to Duke Cancer Institute for imaging, tests, and consultation.

Physicians found a large tumor in the patient’s chest cavity that almost entirely compressed both his heart and his right lung. CT scans revealed a massive growth, consistent with liposarcoma, throughout most of the patient’s chest cavity.

The patient was diagnosed by biopsy of the lesion in his chest. Joseph O. Moore, MD, an experienced medical oncologist and medical director of the Duke Raleigh Cancer Center, recommended a course of chemotherapy known to have an effect on certain sarcomas that are difficult to treat medically.

“The tumor decreased in size and opened the possibility for surgical resection, even without a complete response,” says Dr. Moore. Initially and for several years thereafter, Moore oversaw the patient’s medical care with standard approaches to chemotherapy for sarcoma.

Surgical oncologist Thomas A. D’Amico, MD, vice chair of surgery at Duke, led the team in careful planning for the initial surgery, not certain that the tumor would be removable during the initial procedure because of its position around major organs and structures.

In May 2007, D’Amico performed a right thoracoscopic biopsy of the pleural mass to ascertain the histologic diagnosis of liposarcoma. Three months later, after chemotherapy had shrunk the tumor, a right thoracotomy and resection of the right thoracic mass was performed. In total, the resected tumor was 29.3 cm x 25.8 cm x 14.1 cm and weighed 4,070 g (approximately 9 pounds).
“Liposarcomas like the patient’s tumor have a propensity to recur and often do so in a different location,” D’Amico says. The initial tumor was as large as it was because it grew slowly over time.

The Duke surgical oncology team has closely monitored the patient, who continues to have regular CT scans. Since the initial tumor discovery and operations, the patient has had several recurrences and six more surgeries.

“As long as it is removable by our judgment, surgery is the most effective means to control the tumor, prolong life, and give the patient a chance for cure,” D’Amico says.

Liposarcomas are challenging because there is nothing specifically characteristic of the tumor when first seen on the surveillance CT scans.

The detailed monitoring resulted in the discovery of another tumor that was operated on in April 2009 with a right thoracotomy, including lysis of adhesions and resection of the posterior mediastinal mass.

Five more procedures have followed since then, four of which were performed minimally invasively. Tumors have been discovered, and each time the patient has made a healthy recovery:

- September 2010: right thoracoscopy with resection of diaphragmatic nodule and resection of pleural mass
- August 2011: left thoracoscopy with lysis of adhesions; left thoracotomy and resection of posterior mediastinal periaortic mass
- November 2012: right thoracoscopic resection of pleural and chest wall masses
- March 2013: left thoracoscopic resection of posterior mediastinal recurrent liposarcoma
- October 2013: left thoracoscopic resection of left and right recurrent liposarcoma.

The advantage of working with this type of liposarcoma is that, despite its recurrences, cancerous cells do not easily spread to the bloodstream. The earliest possible surgery to remove a recurrent tumor is the prudent path.

D’Amico observes that, so far, the patient’s tumors have not been locally invasive into the lungs, aorta, spine, or esophagus, so the surgeries have all had good outcomes.

Some lung conditions are never surgical, but some are indeed tumors that require surgical treatment. The Duke Thoracic Oncology Program can work up unknown masses, and, if needed, suggest and arrange for further care with the right team of specialists and support staff. The Duke Sarcoma Clinic is also available to care for patients with soft-tissue and bone sarcomas.

D’Amico says, “If it is a cancerous nodule, then we can help organize a plan for cancer treatments. Having a patient come here early could help streamline time and trips needed for imaging in advance of a diagnosis.”

To refer a patient, please call 800-MED-DUKE.
New Endocrine Surgery Options

Thyroid disease incidence is increasing. Statistics show that about one-half of women aged 55 years and older have at least one thyroid nodule; about 5% to 7% of these are cancerous. If your patient has a noticeably large neck mass, Duke’s endocrine surgeons can provide a workup and diagnose your patient’s exact condition.

Julie Ann Sosa, MD, and Sanziana Roman, MD, who recently arrived at Duke from their posts at Yale, offer world-class care for the treatment of thyroid cancer, thyroid disease, familial endocrine syndromes, parathyroid disease, adrenal tumors, and adrenal cancers for adults and children. They each perform more than 300 procedures per year and can consult on cases that may be ambiguous.

Sosa, Roman, and their partner, Randall Scheri, MD, can offer a variety of services, including:
- Minimally invasive parathyroidectomy and thyroid resections under local analgesia, with shorter recovery time and less time at the hospital
- Laparoscopic and posterior retroperitoneoscopic adrenal surgery; the most direct way to access the adrenal gland is through the back, which avoids entering the peritoneum, and thus avoids an ileus; patients tolerate the small incisions well with no abdominal pain
- Options for patients who have had many thyroid cancer recurrences
- Access to new clinical trials for patients with advanced thyroid cancer for whom surgery is no longer an option.

Save the date: The Masters of Endocrine Surgery Course will be held at Duke’s Trent Semans Center in Durham, NC, Sept. 5-6, 2014.

When Is Replantation the Right Solution?

Some of the most challenging surgeries are replantations and revascularizations of the upper extremities, hands, and fingers.

Duke Orthopaedics, known for its limb reattachment and microsurgery skills, actually performs fewer replantations than it could do. “We have studied our outcomes for functionality,” says hand surgeon Suhail Mithani, MD. “Very rarely is there a heroic save with mangled injuries. Typically, we have a frank discussion with the patient and discuss replantation or perhaps a better outcome with a revision amputation.” Clean cuts have better outcomes, he says.

Duke’s microsurgical expertise can help many different patients, including those with lupus and scleroderma, adult or congenital brachial plexus injury, congenital hand differences, and significant soft-tissue trauma injuries.

David Ruch, MD, chief of the Duke Orthopaedic Hand Service, says that the hand physicians’ broad anatomic expertise and research also makes them innovators who treat virtually every upper extremity condition.

If a patient does have an amputated part that needs replantation, remember not to place it on ice directly, which can damage tissue. It is best to wash off dirt and grime, place the part in moistened gauze, and place it in a zip-locked plastic bag, says Mithani. Place that bag in ice for transport to maximize the health of the tissue; replantation ideally should take place within 6 hours, but within 12 hours may be possible.
You love treating patients, but you can’t afford to work for free. Yet that’s exactly what happens each time a claim from your office gets denied. To reduce write-offs and keep your cash flow healthy, everyone on staff—from billing and reception to physicians—needs to be focused on filing clean claims the first time around. “Claims denials are a preventable cost to a practice,” says Donna Knapp, a health care consultant with MGMA Health Care Consulting Group.

According to MGMA, in better-performing practices, an average of 3.2% of claims get denied on first submission. If your percentage is higher, it’s time to put your revenue cycle management process under the microscope.

Eligibility, including outdated demographic and insurance information, is the leading cause of claims denials. Practices need to ensure that their front desk obtains authorizations and verifies eligibility for every patient, every time. To reduce manual errors, you can automate the process through the clearinghouse that you use to submit electronic claims.

Watch, too, for patterns of rejection, says Reed Tinsley, a Houston-based certified public accountant and practice management consultant. Billing staff should communicate registration errors with the front-office staff and review the explanation of benefits for all denied claims. “You have to stay on top of your revenue cycle process so you don’t repeat the same mistake,” says Tinsley. Most practice management software can be programmed to create monthly rejection reports.

Knapp adds that practices should create an editing process for batch and daily charge posting so that missing or invalid information is caught before the posting is complete. The process should screen to ensure that all required demographic information is included, ordering and rendering physician information is captured, revenue diagnostic codes are accurate for the CPT codes charged, and any modifiers applied are appropriate.

When denials do come back—and they will—it’s equally important to resubmit a corrected claim or appeal right away, which improves your odds of getting paid. To do that, says Tinsley, make a chart of each payer’s deadlines so you don’t miss the window and “leave money on the table.”

By following a checklist for processing claims and taking action when payers deny them, you can considerably minimize write-offs. “Most claims issues are tied to sloppiness or a lack of knowledge of what can be billed or how to bill for it,” says Tinsley. “If the process is smooth, you’re not going to have those problems.”
Managing Your Online Reputation

By Frank Celia

The days when physicians could dismiss the online world as terra incognita are long past. A recent study found at least one Internet performance rating for 91% of practitioners surveyed. Professionals ignore the Internet at their peril. Here are some tips for maintaining a positive image in cyberspace.

Stay current “Google search” yourself and your practice. Get to know Web sites that encourage patients to rate physicians. Health insurance plans often allow online rating of their physicians, but the sites to watch are those not associated with third party payers and that allow anonymous posting. Even the most proficient doctors can fall victim to undeservedly malicious online comments. That said, don’t discount all criticism. Weigh the value of comments being left. (Maybe your waiting room is too crowded.)

Be proactive The best defense is usually a good offense, so cultivate your own Internet presence. Include positive patient reviews on your Web site (if you have one). If you don’t have a Web site, use free services such as Google Places, which are easy to join and help bring your practice’s location to the forefront of Web searches.

To promote a Web site, employ search engine optimization (SEO) tactics. For example, include as many links to other Web sites as possible (referring practices, local businesses, etc) and many internal links. Because it will often be a search term, include your practice’s town somewhere in the text, not just in your address. According to Jessica Hill, a Philadelphia-based SEO manager, “You want people to be able to find your pages, so you want search engines to be able to find common search terms.”

Manage bad feedback Whenever possible, ignore unreasonable or bizarre criticism. Doing otherwise might be illegal. If the poster is identified, HIPAA legally prohibits even acknowledging the patient as yours. Never engage in mudslinging, cautions Jeffrey Segal, MD, CEO and founder of Medical Justice Services, Inc. of Greensboro, NC. Sites often have rules for taking down defamatory posts, so contacting the site itself might be a first step. Almost never file a lawsuit. “It will be expensive and capricious and will take a long time to get anything accomplished,” he says, and it may not accomplish anything. Better to take the high road with egregious anonymous posts. ☞
Updated Guidelines for Reducing Atherosclerotic CV Risk

In the fall of 2013, the American College of Cardiology and American Heart Association (ACC/AHA) jointly released a set of 4 new prevention guidelines.

A main focus of inquiry was the guidelines’ new risk calculator, which predicts the risk of an atherosclerotic cardiovascular disease (ASCVD) event (MI, stroke, or death) in the next 10 years.

If the input parameters result in a risk level greater than or equal to 7.5%, the guidelines recommend considering moderate- or high-intensity statin therapy. The guidelines also support the use of fixed-dose statin therapy in patients with known ASCVD, LDL cholesterol greater than 190 mg/dL, or diabetes mellitus.

Importantly, these new guidelines no longer recommend treating to specific LDL targets, as did the previous guidelines. The shift of emphasis from LDL targets to global risk assessment and fixed statin doses is a significant change from conventional practice patterns.

Previously, the cholesterol guidelines recommended the use of the Framingham Risk Score to determine risk in patients. The Framingham Risk Score was developed from a population that was largely white and male; on the other hand, the new risk calculator was developed from a much more diverse population, taken from a pooled cohort of 4 large and diverse population studies.

“While there are also limitations to the new risk calculator, it is an improvement from the Framingham Risk Score,” says Mahesh Patel, MD, a preventive cardiologist at Duke.

Some physicians have also expressed concern that the guidelines provide few insights on cholesterol-lowering drugs other than statins and significantly underestimated lifestyle factors.

The greater focus on risk assessment also means more work for doctors who are pressed for time, compared with the previous approach, which was a more straightforward “know your number” approach, says William Kraus, MD, professor of cardiology at Duke.

Kraus says that patient noncompliance is also a problem. Less than 20% of patients are compliant with their statin therapy, and they often don’t fully understand risk probabilities, he notes.

Statins as a drug class were the focus of the blood cholesterol guidelines because they have the strongest evidence base for ASCVD risk reduction, says Patel.

The ACC/AHA guidelines are scheduled to be updated in another 2 years.
Historically, left ventricular assist devices (LVADs) were only considered as a bridge to transplantation. The number of heart donors, however, is a limiting factor; approximately 2,200 transplants are performed each year, but it is estimated that 250,000 patients might benefit from transplants when medicines and defibrillation fail.

Duke, one of the most experienced centers for LVAD implantation in the US, implanted 154 LVADs last year; of those, 107 were durable LVADs, implanted in patients as a bridge until transplant or as a more permanent form of therapy.

**Who Needs an LVAD?**

“Heart failure patients demonstrating disease progression are best evaluated for advanced therapies before there is evidence of end-organ dysfunction or significant debilitation,” says Joseph Rogers, MD, medical director of the Duke Cardiac Transplant and Mechanical Circulatory Support Program.

The following are some signs that your patient should be evaluated for mechanically assisted circulation:

- Symptoms of heart failure at rest or with minimal exertion in a patient treated with optimal medical and electrical therapies
- Ejection fraction of less than 25%

- Need for IV inotropic agents
- Development of kidney dysfunction or pulmonary hypertension or the need to reduce heart failure medications secondary to hypotension or renal insufficiency.

Age is not a limitation. Level of frailty, however, may rule patients out for the surgery, which demands a minimum level of strength, Rogers says.

**Returning Home With an LVAD**

The typical post-operative length of hospitalization is 2 to 3 weeks. Much of this time is spent training patients and families or other caregivers, who need to learn to operate and troubleshoot the equipment and perform sterile dressing changes on the driveline exit site. With smart phones, patients can snap photos of their driveline and send them to their LVAD physician for assessment or monitoring.

Patients also need to learn how to plan for certain activities. For example, patients cannot submerge in water for bathing, swimming, or any other activities. They must learn to shower with special accessories that protect the electronics.

For the most part, patients can participate in submaximal exercise. Most are comfortable carrying on with activities of daily living, such as walking, fishing, bowling, golf, and dancing.

Physicians should exercise caution when prescribing immunosuppressants for... (continued on next page)
Prostate Screening Guidelines and Active Surveillance

In the past 2 years, there has been a national trend against screening for prostate cancer, which began with the US Preventive Services Task Force’s recommendations and was followed by other organizations setting similar guidelines.

Duke Cancer Institute devised its own screening guidelines because (1) existing clinical data didn’t include long-term follow-up that tracked how interventions were working and (2) some groups of high-risk patients, such as African Americans, might benefit from different guidelines.

Daniel George, MD, director of the Genitourinary Oncology program, participated in creating the guidelines and supports the idea of active surveillance for slow-growing prostate tumors so patients can delay prostate surgery and its effects.

“We consult for patients from around the region and state, while patients can get their follow-up, longitudinal care locally,” George says. “We may perform testing every 2 years,” because of the slow growth of these less aggressive tumors.

“We take PSA readings, but we may also use imaging to learn how a patient is changing,” George says.

At Duke, we use multiparametric MRI with a sensitive 3 Tesla magnet to evaluate the prostate, measure functional parameters like blood flow, and follow suspicious findings for changes that could represent disease progression, says Rajan T. Gupta, MD, of Duke Abdominal Imaging.

Monitoring with multiparametric MRI

1 Axial T2-weighted image reveals an area of abnormal low signal along the anterior aspect of the right peripheral zone of the prostate at the level of the apex (white arrow). There was no evidence of extracapsular extension on this study.

2 Apparent diffusion coefficient map reveals this same area to have mildly restricted diffusion, most compatible with a low-grade prostate cancer.

Prostate Screening Guidelines and Active Surveillance

Because of the post-operative challenges and considerable caregiver burden, Duke works closely with local physicians and also provides education to emergency rooms, EMS personnel, and office and medical staffs.

Meanwhile, manufacturers are responding to the need for more types of permanent devices, and new forms of LVADs are arriving or are in the pipeline. Innovations are making the pumps more convenient (no external wires) and durable (electromagnets instead of ball bearings).

To learn more about LVADs or to refer a patient, please call 800-MED-DUKE and ask for the Mechanical Circulatory Support Program.
Join Duke Medicine faculty members and other clinicians in a new online forum featuring updates from select specialty association meetings. Visit ClinicalPracticeToday.com

**Breast Cancer**  Highlights From the 2013 Breast Cancer Meeting in San Antonio

**Duke Faculty:** Kimberly L. Blackwell, MD, Rachel C. Blitzblau, MD, PhD, and Shelley Hwang, MD, MPH

“As chemotherapy is being tailored to individual patients based on tumor characteristics, it will be interesting to see post-mastectomy radiation after pCR.”

**Nephrology**  Highlights From the 2013 Nephrology Meeting in Atlanta

**Duke Faculty:** Thomas M. Coffman, MD, and John P. Middleton, MD

“Interesting...to see that there are prospects for identifying risk groups of CKD and acting proactively.”

**Ophthalmology**  Highlights From the 2013 Ophthalmology Meeting in New Orleans

**Duke Faculty:** Jill B. Koury, MD, and Prithvi Mruthyunjaya, MD

“Pressured infusion can be a real asset in promoting surgical consistency across the diverse eyes that we encounter in daily practice.”

**Rheumatology**  Highlights From the 2013 Rheumatology Meeting in San Diego

**Duke Faculty:** Megan E.B. Clowse, MD, MPH, and Lisa G. Criscione-Schreiber, MD

“I think the recent data suggesting similar efficacy [between triple therapy and biologics] is important and needs to be passed on to patients so they can have realistic expectations and start to be an active part of the effort needed to bring down health care costs.”

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