CASE STUDY
Years of Survival Possible After Glioblastoma Multiforme

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Concierge Medicine: Exploring Traditional and Newer Models

Nonmonetary Ways to Reward Your Staff

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Duke Medicine
Concierge Medicine: Exploring Traditional and Newer Models
This 2-part feature explores the pros and cons of the most common concierge models

Surgical and Supportive Care Help a Couple Cope
Duke’s commitment to teamwork and continuous support are key in the treatment of this patient’s chordoma

EHR Implementation: A Journey, Not a Destination
These simple tips can help ease the transition to EHRs and improve their functionality

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Years of Survival Possible After Glioblastoma Multiforme
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Nonmonetary Ways to Reward Your Staff
Think beyond financial incentives with these effective, low-cost ideas

Are Virtual Visits for You?
Seven things to consider before incorporating telehealth services into your practice

Excellent Results for Duke Liver Transplant Patients
This highly successful, life-saving program can be attributed to location, dedication, and shared decision making

Earlier Diagnosis of Peripheral Artery Disease Saves Limbs—and Lives
Symptoms of PAD are all too often brushed off as normal aches and pains associated with aging; learn what to watch out for and how to educate patients
News Briefs

Preventing Stroke in Women

The American Heart Association/American Stroke Association (AHA/ASA) has released guidelines to identify risk factors and prevent stroke in women.

Age and obesity are risk factors that contribute equally to stroke in men and women, says Monique V. Chireau, MD, an ob-gyn and epidemiologic expert at Duke and a co-author of the AHA/ASA guidelines published in the Feb. 6 issue of Stroke. “Migraine with aura, atrial fibrillation, diabetes/hypertension, and depression and psychosocial stress were found to be stronger stroke risk factors in women.”

Evidence suggests that pregnancy-related factors such as preeclampsia may increase long-term stroke risk. The guidelines recommend aspirin and calcium supplements for pregnant women with hypertension. The guidelines also recommend screening women with high blood pressure before prescribing birth control pills, screening women older than 75 years for atrial fibrillation, and encouraging women who have migraine headaches with aura to stop smoking.

Racial Differences in Diabetes

Reduced lung function and lower potassium levels correlate with a higher risk of diabetes in African Americans, in particular.

Researchers, led by Ranee Chatterjee, MD, MPH, a Duke assistant professor in general internal medicine, were surprised by the lung-function correlation. “This finding may be a proxy for higher BMI or obesity; however, we adjusted our findings for those factors, so there may be an independent association that we need to study further,” Chatterjee says. Likewise, low potassium levels are associated with hypertension, but after adjusting for that factor, “we were surprised by how greatly it influenced diabetes risk in African Americans.”

“The take-home point is that racial disparity in the risk of diabetes is huge,” adds Chatterjee, whose research appears in the Feb. issue of the Journal of General Internal Medicine.

Bacteria Linked to Early Fetal Sac Ruptures?

Researchers in the Duke Department of Obstetrics and Gynecology have discovered that in patients whose amniotic sac is broken early, the presence of bacteria is much higher.

“The more bacteria that are present, the more compromised the chorionic membranes appear to be, suggesting the presence of bacteria causes weakening,” says preterm labor researcher and maternal-fetal medicine expert Amy Murtha, MD, a Duke ob-gyn and senior author of the related study recently published in PLoS ONE.

Ruptures tend to occur lower, near the cervix and vaginal bacteria, but in women whose water has broken early, bacteria can be at sites distant from membrane rupture. Bacteria should be identified for treatment targets, Murtha says.
The term “concierge medicine” tends to evoke elitist overtones. One pictures practices in rich enclaves like Manhattan or Beverly Hills that spurn Medicare and third-party insurance, focus exclusively on the “wealthy, well, and worried,” and charge a minimum of $10,000 a year. Although such practices do exist, they are, by today’s definition of concierge-style practice, the exception rather than the rule.

Booming interest in what might be better termed “retainer-based medicine” is driving newer versions of this model into middle-income and even poverty-stricken areas. Patients see it as a way to retain access in an era of physician scarcity. Doctors see it as a means of avoiding ever-increasing regulatory hassles and reimbursement cuts, and, above all, returning to a style of personalized health care that has been elusive for the better part of 2 decades.

Endless variations exist, but most concierge-style models can be split into 2 broad categories: (1) traditional concierge practices with annual fees around $1,500 to $2,000 that provide enhanced, non-covered medical care but continue to accept Medicare and third-party insurance and (2) a newer variant called “direct primary care,” or DPC, that offers a wide range of more basic services, usually in a rural location, for about $600 a year and eschews Medicare and insurance.

This article, the first in our 2-part series, focuses on the traditional concierge style; the second article in this series will explore DPC.

Early Decisions When Moving to Traditional Concierge
Among the first big decisions any practice considering converting to a traditional concierge model must make is whether it intends to be a hybrid or full-scale concierge—a transition, it should be noted, that is estimated to require 2 years of careful preparation and at least $100,000. Full-concierge practices charge all patients a retainer fee. Hybrids offer a choice: pay for enhanced service or continue with existing care.

The hybrid model is considered to be financially safer, but it also requires more work. With this option, doctors essentially operate 2 very different types of practice under the same roof, with a relatively unchanged patient panel size (it can be reduced slowly only via attrition of non-retainer patients).

The full-concierge approach presents more risk but greater potential benefits. Success involves servicing perhaps as many as 75% fewer patients and delivering higher levels of care. Failure, however, can financially cripple a practice.
Some practices use the hybrid model as a stepping stone to transition to a full-concierge service. Making the jump directly to full concierge is difficult and is usually accomplished only by practices affiliated with large academic or medical centers willing to lend strong institutional support.

Another big, early stage decision is whether to go it alone or join forces with a franchise. Large marketing and service groups such as MDVIP, headquartered in Boca Raton, FL, and Concierge Choice Physicians, based out of New York, can offer invaluable research, advice, and support. However, such companies often charge a substantial percentage of revenue—as much as 30% over several years.

Practices that fly solo can hire a consultant, yet this, too, can present risk. Retainer-based medicine is still such a small, rapidly evolving cottage industry that little expertise currently exists, notes Wayne H. Lipton, CEO of Concierge Choice Physicians. “And in many instances, there’s nothing you can do if you mess [the transition] up.”

Challenges of Traditional Concierge

Geographic location and your panel’s economic demographics both play a considerable role in the feasibility of success. A traditional concierge model can work in middle-income areas but may be more challenging—if not impossible—to establish in lower-income areas (read Part 2, coming soon in the August issue of Clinical Practice Today, which highlights concierge models that are working in lower-income areas). The success of local retail establishments can be indicative. A thriving Starbucks or Whole Foods grocery nearby is usually a good sign, says Lipton. But be careful about applying socioeconomic assumptions to any community, he warns. “Incomes can be extremely difficult to judge.”

Another big challenge is breaking the news to your patients. Even in hybrid models, it’s impossible to make this transition without losing at least some patients, possibly many. The potential for negative feelings or comments should be anticipated. It is also worth noting that the American Medical Association’s ethical guidelines require physicians to help outgoing patients under these circumstances find new primary care doctors free of charge.

Rewards of Traditional Concierge Medicine

Satisfaction among patients who do stick with your practice through the transition tends to skyrocket, especially for patients with poorer health. For such patients, enhanced services such as 24/7 access to their personal physician, extended visits, electronic communications, home-based medical visits, and highly personalized specialty care consultations can generate enormously positive reactions.

And it’s not just patients expressing satisfaction. Physicians are also enjoying the transition to a more personal level of care. “My dad was in family medicine, retired at 80, and I remember him spending time with patients and doing house calls and that type of medicine, and that’s what I always thought I wanted to do,” says John J. Paat, MD, whose Durham, NC, practice successfully transitioned to full-concierge with Duke Signature Care over the past 2 years, losing only 20% of its panel. “It is so different to be able to sit with patients at the end of the day and really take time to talk about their care. I like it.”
Intraoperative CT imaging was used for surgical removal and for the reconstruction procedures. Surgeons had to remove bone from the pelvis and mobilize local tissue in the tumor-removal location to form a support composed of tissue, the spinal column, and titanium hardware. The entire operation took nearly 8 hours.

A second course of radiation was started 4 weeks later to clear up the edges of the surgical area and decrease the risk of tumor recurrence. Post-operative radiation dramatically reduces such a possibility, says neurosurgeon and spine specialist Carlos Bagley, MD, who removed the tumor. After surgery, the patient managed bladder function through self-catheterization and bowel function through the preemptive colostomy.

Bagley says that a predominant reason the patient and his wife decided on Duke was the support they received, including visits with geriatric experts on the team and detailed decision-making meetings with doctors. A behavioral psychologist in the Duke Spine Center also worked with the patient to help develop coping mechanisms, and the patient participated in tumor research by donating tumor tissue.

To make an appointment for your patient, call 800-MED-DUKE.
EHR Implementation: A Journey, Not a Destination

By Emily Paulsen

Setting up an electronic health record (EHR) can be a challenge—one that doesn’t necessarily end once the system goes live. Those who actively use EHRs report that it takes continuous learning and optimizing to ensure that the system pays off.

Chad Jansen oversees the EHR system for LaTouche Pediatrics, a 3-office, 18-provider practice in Anchorage, AK. He says his job is to keep asking the question: How can we improve EHR functionality in our practice?

Christopher Beale, MD, who practices internal medicine in St. John, MI, also advises practices to move to EHRs “wholeheartedly” by requiring providers to sign their notes before processing claims. But, he says, it’s important to be ready to “renovate once you’re in the building.” Give the system a try; see what works, then make changes as necessary.

One way to do this is to make EHR use a standing agenda item for staff meetings. This routine creates a forum for questions and comments and provides an opportunity for staff to agree on uniform ways to enter information into the record.

Although uniformity and guidelines are critical, it’s also important to give providers some latitude in how they use the system. For instance, would they prefer to dictate notes? Speech recognition programs can help. Some providers dictate in front of their patients, some type their notes as they talk to patients, and some record their notes after the visit. Any of these solutions can work, as long as they fit the provider’s work style.

Even simple things such as laptop battery life can make a difference in how the system gets used. In the exam room, the patient, computer, and physician should form a triangle so that the patient and physician can talk face to face and look at the screen together. A docking station with a monitor and full-size keyboard in a separate room can offer providers a quiet and comfortable area for correspondence and reviewing notes.

Ongoing training—integrated into the work flow—gives providers a chance to review problem areas and resolve challenges. A tech-savvy staff person (like Jansen) or physician champion (like Beale) may be more effective than an outside trainer because they are familiar with the practice and work styles of their colleagues.

Figuring out what works for each provider and practice can take some time; the transition to EHRs is a journey, not a destination.
A 59-year-old woman was referred to the Duke Preston Robert Tisch Brain Tumor Center in 2006. She had been experiencing some of the usual symptoms associated with primary brain tumors: loss of consciousness, seizures, headaches, and loss of balance.

Radiographic imaging, in addition to a physical exam, showed a primary brain tumor, glioblastoma multiforme (GBM). Typically, patients who undergo a combination of surgery, radiation, and chemotherapy survive 14 to 16 months after GBM treatment, but patients often experience a recurrence.

The bulk of the patient’s tumor, which was located in the right temporal region of the brain, was resected on April 27, 2006. Because of the broad infiltration pattern of GBM tissue, it was not possible to obtain clean surgical margins. The patient underwent a course of radiation and systemic temozolomide chemotherapy treatment for 12 cycles.

Because Duke has pioneered many research vaccines for GBM and other brain tumors, the patient was able to be matched to a clinical trial for an additional treatment for her type of tumor. She received a cytomegalovirus (CMV) pp65 RNA-loaded dendritic cell vaccine. The CMV antigen pp65 is a highly immunopotent viral protein used to load the patient’s own dendritic cells, which were retrieved through leukapheresis.

The patient received her first vaccine in August 2006 and has received 91 monthly vaccine doses to date. She continues to do well, pursuing work...
and activities of daily living without any clinical or radiographic signs of recurrence.

Her medical oncologist, Gordana Vlahovic, MD, of the Preston Robert Tisch Brain Tumor Center, says the timing of vaccine therapy is very important, and patients who will receive cancer vaccines for GBM must be examined and prepared before radiation and chemotherapy.

“We need to have patients agree to vaccine treatment as soon as possible if they want it, so we can complete the necessary preparatory steps,” Vlahovic says. “This program works well for patients, who can often return home for radiation and chemotherapy treatment.”

Vaccines are administered at Duke around the time that patients begin chemotherapy, she says.

John Sampson, MD, PhD, chief of neurosurgery, and Darell Bigner, MD, PhD, who directs the Preston Robert Tisch Brain Tumor Center, lead a team that has pioneered many different types of vaccine therapies for GBM and other kinds of brain tumors.

“Vaccine therapy is very tolerable, and the side effects are almost nonexistent,” says Vlahovic. “Our patients can often return to work and lead a full life. Many of our patients respond to the vaccine approach with a sustained response.”

She notes that patients can have a long-term response measured in years. “We have patients, for example, with 7, 8, and 12 years of survival after GBM with vaccine treatment,” Vlahovic says.

Duke is currently enrolling patients into a trial sponsored by Bristol-Myers Squibb on immune checkpoint inhibitors in GBM (PD-1 and CTLA-4). Sampson is the national principal investigator (PI) and Vlahovic is the Duke PI. The Duke Preston Robert Tisch Brain Tumor Center designed the trial for the first recurrence of GBM in patients who have never had a course of Avastin (approved for use in GBM and other types of cancer).

“We need to consider each patient individually and offer the best chance to beat this disease,” says Vlahovic. “I believe in doing everything we can for each patient, leaving no stone unturned. What began as incremental survival increases have now become noteworthy improvements, thanks to the vaccine trials.”

MRI Images of Brain Post-Resection, 2013

1 No tumor visualized, November 2013.
2 Resection cavity with no tumor visualized, November 2013.

To refer a patient for treatment or clinical trials, call 800-MED-DUKE
Medical practices succeed or fail on the strength of their staff. Each person on the payroll, from billers to physician assistants, plays a pivotal part in optimizing patient care.

Yet, their contribution to the cause too often goes unrewarded.

Eventually, that takes its toll, causing higher turnover and lower productivity, says Cindy Dunn, a consultant for the Medical Group Management Association.

“People want to be acknowledged when they go above and beyond, especially your best performers,” she says. “If no one notices, what’s the point of working hard?”

Pay raises and bonuses are a good start, but produce only a short-term bump in job satisfaction. A 2013 Gallop survey of 2,300 employees in the United States (US), for example, found that income did not significantly affect motivation levels.

Nonmonetary rewards can be more effective in reinforcing positive behavior and cultivating a healthy office culture, says Susan Murphy, a business consultant in Rancho Mirage, CA, and author of Building and Rewarding Your Team.

Consider starting with the suggestions presented to the right.

Gift Cards. Employees who suggest ideas for saving your practice money or improving performance can be recognized with gift cards to a movie theater or coffee shop.

Public Praise. Make positive reinforcement plentiful. Those who go the extra mile to meet your patients’ needs or help a colleague when deadlines loom should be thanked in front of their peers. A handwritten note can be even more powerful when mailed to their home, says Autumn Morris, partner relations coordinator for health care consulting firm Studer Group.

Confidence Building. Keep your best and brightest challenged by sending them to training seminars and asking them to teach their colleagues what they learn. Or, make them a point person on future projects. Vouching for confidence in their ability lets them know you want to invest in their growth.

Creative Goals and Rewards. Set measurable goals, explain why they matter, and reward your staff consistently when they hit the mark. Examples of goals include shorter patient wait times and fewer billing errors. Rewards should be compelling, like a catered lunch or half-day Fridays.

When it comes to recognizing your staff for a job well done, the rewards that cost the least often yield the best return.
Are Virtual Visits for You?

By Meredith Kleeman

Imagine a world where you no longer need to see patients in person to conduct an office visit. Impossible?

Guess again. Many doctors can now use computers, tablets, and mobile devices to treat patients across town or on the other side of the world. With the widespread adoption of EHRs, physicians can easily communicate with patients, and, in some cases, prescribe treatment without a physical office visit.

As part of a virtual visit, practitioners can chat with patients over the phone or on a face-to-face video call, share lab results through a secure patient portal, highlight abnormal results on the screen, and more. “The process of getting care can be much richer with some of these tools,” says Jon White, MD, director of the Health Information Technology Portfolio at the Agency for Healthcare Research and Quality.

Before determining whether to institute virtual visits in your practice, White urges clinicians to take the time to research the viability of this type of service. Here are a few things to consider:

1. Are other practices doing it? Seek out doctors in your community or approach members of your professional organization to see whether and how they’re using virtual visits, White advises.

2. Explore the technology. Contact your EHR vendor and ask how other practices are using their software to enable virtual visits. Find out what communication tools are available to you.

3. Research state regulations and talk to your licensing board. Some states might have laws about who can provide telehealth and under what conditions. Contact your state licensing board and ask about their policies.

4. Be aware of potential legal pitfalls. Make sure that your malpractice liability insurance policy covers virtual visits, especially across all states. If patients present with ambiguous symptoms, you may want to think twice about making virtual diagnoses. Additionally, it’s best to include a disclaimer about conditions that require immediate medical care, such as chest pain, head injuries, and fractures.

5. Determine your payment structure. Talk to the health plans you’re affiliated with about their payment policies. If you currently have a pay-per-visit model, find out whether you can get reimbursed for virtual visits.

6. Avoid making assumptions. “It would be a mistake to assume that older populations aren’t technologically savvy enough to participate in virtual visits,” White says. Many older patients like using computers and smartphones—and it may be easier for them to stay connected without having to worry about transportation issues associated with physical doctor visits, he explains.

7. Test it out. Start slowly, offer virtual visits to a select number of patients, and ask for their feedback. Most doctors find that their patients like having this kind of access.

June 2014
Excellent Results for Duke Liver Transplant Patients

In March 2014, the Scientific Registry of Transplant Recipients (SRTR) released outcomes data from transplant programs in the US, the first update in more than 2 years. Duke’s liver transplant program achieved a 96.96% 1-year adult survival rate and a 96.15% pediatric 1-year survival rate; the 1-year graft survival rate for adult and pediatric patients was 95.55% and 92.59%, respectively.

For both pediatric and adult recipients, Duke’s 1-year patient and graft survival rates exceeded the national average. Among US liver transplant programs approved by the Centers for Medicare & Medicaid Services, Duke’s outcomes rank in the top 5.

The Organ Procurement and Transplantation Network/SRTR evaluates each hospital according to a formula that takes multiple factors into account, including patient acuity levels. Because Duke’s liver transplant program includes many very sick patients at the time of transplant, achieving an excellent 1-year survival rate is noteworthy.

In addition, the program performed well in its transplant rate of patients placed on the wait-list. “If you get onto the wait-list at Duke, you are very likely to undergo a transplant, because we are at twice the expected rate of transplants.”

**Duke’s Liver Transplant Survival Rates**

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<th>1-Year Liver Transplant Survival Rate</th>
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says Carl Berg, MD, medical director of the Duke Abdominal Transplant Programs and incoming president of the United Network for Organ Sharing (UNOS). “Our surgical team aggressively considers all liver offers we receive. We travel to assess organs so that we know whether we can provide organs that will work well in patients.”

The Duke liver transplant program works well, in large part, because everyone works along the same hallway. “There are no barriers to interactions, which results in the best patient care,” Berg says. In addition, the Duke liver transplant team scrutinizes 100% of its liver transplant cases to improve every aspect of care.

Another aspect of the program is shared decision making, which allows patients and team members to discuss the best way forward. For example, the team optimizes candidates for surgery by making sure that patients reach certain exercise and strengthening benchmarks before surgery and that they commit to rigorous follow-up, including physical exercise, after surgery.

Duke performs many complex transplant procedures, including multiple-organ transplants. Duke is one of the few centers in the US that performs such complicated liver transplant combinations as lung-liver, heart-liver, and liver-small bowel. The program has achieved 100% survival of multiple-organ transplant recipients since late 2012.

“This is a demonstration that the hardest cases come here and are transplanted with excellent success,” Berg says. “Our goal is to practice transplantation on the forefront of all organ systems and at the same time, with the highest quality.”

(continued on next page)
Watching for Ureteral Kidney Stones

According to a recent study performed by Duke urologist Charles Scales, MD, the prevalence of kidney stones is on the rise nationally. It is important that a stone in the ureter is adequately managed, as obstruction could lead to permanent kidney damage. A ureteral stone is commonly diagnosed when a patient is in severe pain, but, later and if the stone is causing no symptoms, it may be forgotten. Over time, this can cause additional problems, and patients could have a false sense of security that the kidney is healthy, even as the kidney continues to be blocked and damaged.

Guidelines about using imaging to identify ureteral stones have been released by the American Urological Association (AUA). New guidelines on the medical and surgical management of kidney stones are also under review.

Glenn Preminger, MD, chief of urology at Duke, helped develop all 3 sets of guidelines, which can be found at https://www.auanet.org/education/imaging-for-ureteral-calculous-disease.cfm.

“Providers should engage with radiologists to make sure they use imaging that minimizes radiation exposure and costs, leveraging sonography or low-dose CT,” says Michael Lipkin, MD, a Duke urologist who reviewed the management guidelines.

Duke’s urology program is ranked in the top 10 nationally by U.S. News & World Report and treats complex and typical kidney stones.

Meet the Next Leader of UNOS

Carl Berg, MD, medical director of the Abdominal Transplant Programs at Duke, says his vantage point as incoming UNOS president gives him insights into best practices and quality improvements being undertaken at transplant programs throughout the country. “Being president at UNOS makes me an effective transplant leader at Duke because it permits me to understand best practices surrounding the entire transplant process while overseeing more than 500 transplant programs.”

Berg is excited about new projects under way at UNOS, where the mission is to perform more transplants— and perform them more safely. One new project is a coordinated effort to maximize the lifespan of all kidneys that are shared. “The effort will be to match the lifespan of the kidney, from a younger or an older donor, with the lifespan of the recipient,” Berg says. Done effectively, the total lifespan of transplanted kidneys in the US might amount to 8,000 additional life years during a typical year of transplants.
Peripheral artery disease (PAD) affects 8 million Americans and is associated with increased risks of cardiovascular death, myocardial infarction, and stroke.

“No patient—or physician—is likely to ignore severe chest pain without urgently seeking a cause,” says Duke cardiologist Manesh Patel, MD. “Yet patients and physicians alike may dismiss severe leg pain as part of the aches of aging—even though it can be an important symptom of potentially life-threatening PAD.”

Most people describe the pain associated with claudication as a cramp in their calf or related muscle when they walk. Because the pain goes away with rest, however, it can easily be dismissed as part of the aches of aging, and patients may not be aware that it can be a warning sign for PAD and part of the process of arterial occlusion, just like chest pain.

Although rates of lower-limb amputation due to PAD have declined significantly nationwide in recent years, Virginia, North Carolina, South Carolina, Georgia, and other southern states continue to have high rates of amputation; some parts of North Carolina, for example, have rates that are double national averages (see map).

The “amputation belt” is a swath of greater morbidity that bears much in common with the stroke belt, hypertension belt, and obesity belt. In fact, diabetes and tobacco use, which are common factors in these other conditions, are also the 2 most common causes of PAD.

Patel finds this situation frustrating because so many of these amputations are preventable with earlier diagnosis, and post-amputation mortality rates remain high. Following up on PAD symptoms is particularly important because they may be the first indications of more extensive disease. More than one-half of those with PAD also have severe coronary disease and a higher risk of stroke and related conditions.

Patel says that greater vigilance and earlier referral by physicians may help prevent significant tissue loss. About 1 in 5 patients older than 70 years have PAD, so this patient population should be watched carefully, as should people older than 50 years who have diabetes or who smoke. “Asking these patients a simple question about whether there is any wound or tissue loss or pain in their legs at rest or with walking can help,” Patel says.

Patel recommends that any patient with a lower-extremity problem that limits daily activities should be referred for further evaluation. The
preferred initial diagnostic tool remains the ankle brachial index, a straightforward test used to look for the warning sign of lower blood pressure in the ankle compared with the arm. The test is becoming easier to access. The next diagnostic step may be imaging studies to zero in on a problem.

If the condition is too far advanced to be improved by lifestyle changes, a variety of interventional therapies can be tailored to the patient’s condition. “We have both surgical and endovascular ways to get more blood flow to these patients,” Patel says. Many of the techniques that have improved heart outcomes have been adapted to the leg.

Even 5 years ago, procedures could revascularize only short areas of narrowing or occlusion. Today’s catheter-based procedures use balloons and stents and can revascularize the leg by opening the superficial femoral artery; both balloons and stents can be coated with drugs that prevent restenosis to extend their effectiveness.

Severe cases may require a bypass graft around an occluded artery. “Duke can even offer enrollment in a clinical trial that uses stem cells to try to generate growth of new vasculature,” Patel says.

He points out that another advantage of referring a patient to Duke Medicine is its holistic team approach. “Sometimes, at other institutions, when you are referred to a surgeon, you will most likely get a surgical procedure, or if you go to cardiology, you will get a catheter-based procedure. Here, we work together to figure out the best procedure for the patient, if a procedure is needed.” The Duke team ensures that patients receive every aspect of care, from wound healing to improved blood flow.

To refer a patient, call 800-MED-Duke.
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For more information, please call 866-858-7434 (toll-free) or email info@med-iq.com.

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