TEXAS NEUROLOGICAL SOCIETY SUMMER 2022

Broca's Area

The Voice of Texas Neurology

President's Message

Eddie Patton Jr., MD

The Texas Neurological Society has been an important part of my medical career since I joined during my residency at Baylor College of Medicine. I have seen this organization grow and establish itself as the premier state neurological society in the country. This society has embraced bold ideas and positive changes. Thinking back over my years of service on the board and with planning our bi-annual conferences, I am proud of the service that the organization provides for its members.

We must continue to educate our members on all facets of the practice of neurology. This includes continuing education on certain business aspects of practice. Through our video series "The Business of Neurology", we have led discussions on topics such as contract negotiation, increasing ancillary services, adding advanced practice providers, academic neurology careers, and advice on how to transition into different practice styles. I am excited about the direction of this project and the feedback we have received so far.

As president, I would like to increase the involvement of neurologists across the state. We have several committees' members can get involved in. We will continue to advocate for neurologists and the patients that we care for. Our legislative committee is active in Austin and making sure that neurology stays educated and involved with the issues that pertain to us. This includes scope of practice, prior authorizations, and surprise billing, among other important issues.

I am proud to serve as your president. Stay involved and stay active.

Connect with us on Facebook and Twitter!

Social media is a part of our communication strategy to help educate and promote the TNS' 2022 initiatives.

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A REFLECTION ON Dr. Stanley H. Appel's STELLAR CAREER

STANLEY H. APPEL, MD

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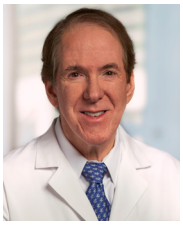

Editor's Notes

Randolph W. Evans, MD

I thank our officers and other contributors for their excellent submissions to this issue. We look forward to seeing you (hopefully in person but we'll have a hybrid meeting) at the TNS Summer Conference from July 22-23 2022, at the La Cantera Resorts, San Antonio. John DeToledo, program director, Erin Furr-Stimming, committee chair, and the education committee have planned an excellent program.

REFLECTIONS ON 40 YEARS OF PRACTICE

In 1977, when I was a 3rd year medical student, Stan Appel came to Baylor as chairman of neurology (see David Rosenfield's article in this issue). He joined us for a weekly game of doubles tennis. In talking after tennis, he convinced me as he had many before and after me that neurology was the most exciting field in medicine. (This was at a time when Dr. DeBakey was president of Baylor and many students considered CV surgery the most exciting field.) I stayed at Baylor for residency. Decades later, I am still grateful for Stan's mentorship and fully agree with his assessment.

When I started practice at the age of 29 in 1982, for several years, patients would tell me that I looked too young to be a doctor. Now I get frequent questions about when I'm going to retire. How can I possibly retire when many of my teachers from Baylor in the 1970s are still in practice and so productive including Stan Appel, Te Ashizawa, Yad Harati, Joe Jankovic, Jim Killian, and David Rosenfield?

A sports stadium. Because our histories and exams can take much longer than primary care and some other specialties, we may not see as many patients. But over years, they add up. I estimate that I have seen over 2000 new patients and over 2000 follow ups yearly in the office and hospital. Over 40 years, that's filling a large sports stadium with new patients.

In the clinic, we live by a regimented schedule broken up into news, olds, and procedures. Although I don't have highly superior autobiographic memory, I do have decades of appointment schedules and records. We can go through our outpatient schedules and see what we were doing for much of our professional lives. One of the best aspects of outpatient neurology is forming long-term relationships with patients some of whom I have been following since the 1980s.

Until 4 years ago, I was doing clinic and inpatient daily for 36 years. At one point, I was seeing patients at up to 6 hospitals (Have hammer, will travel. For fans of Paladin and "Have Gun-Will Travel"). Doing clinic only has been like a vacation without rounding before and again late after the office, going back to the hospital, middle of the night calls, and weekend and holiday call.

The end of private practice. I have been in solo practice which has become increasingly uncommon. In 1982, I received $140 ($419 adjusted for inflation) for what would now be a level 4 consult and $200 ($599 adjusted for inflation) for a level 5 consult. You know what we get now and it's not keeping up with inflation especially the last year. With ever increasing overhead, you will have no salary if you don't see more and more patients.

Our reimbursement rapidly dropped in the 1980s with the introduction of HMOs and PPOs and has been dropping ever since. With every drop, there's concern that the private practice of neurology would end which is happening by attrition. If you are a non-academic, what is autonomy worth to you? Is autonomy even possible?

For decades, running a practice wasn't too bad. There were occasional problems along the way such as some 20 years ago when the hard drive failed and the backup was corrupt and I had tens of thousands of dollars of lost AR. Or when I had an incompetent billing person (with good references) who fortunately left after only 4 months but hadn't filed tens of thousands of dollars of claims which I discovered too late when someone else took over.

The last 2 pandemic years have been the worse first with the drop off in volume early in the pandemic. Then high staff turnover which has been a national problem and affected many of you also (Avitzur O. The Great Resignation: The Workforce Exodus Hits Neurology Practice and Research. Neurology Today. American Academy of Neurology. December 2, 2021).

In April, 2021, I had 2 experienced MAs leave. Since then, I have hired 13 people for 2 positions with the expected chaos from the frequent turnover and retraining. I used to receive numerous MA applicants but in the last year none to a few. Despite posting a two-year experience requirement, candidates included a canine coach, bus driver, waitress, sales associate, babysitter, school volunteer, housekeeper, security officer, music school coordinator, and a preschool teacher. Five people worked in the office for less than 2 weeks and did not work out. Another left last year after one day due to my vaccine mandate which was also posted, one accepted and ghosted, and another left after 2 days for another job.

Fortunately, we have great new drugs in neurology including the gepants, lasmiditan, and MABs for migraine. Especially for headache specialists, we are prescribing lots of these new medications because we have so many patients who fail generics. We are overwhelmed with precertifications on top of the precerts for Botox (my billing person tells me it takes her an average of 1.5 hours to precert Botox). We've been trying to figure out how to best deal with the precerts including using specialty pharmacies but the precert burden is at an all-time high.

During the last year, I've spent countless hours doing the work that assistants would have done in the past. I'm sure many of you are having similar if not worse problems.

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Editor's Notes *(continued)*

Academic Private Practice. I went into private practice because I didn't have a subspecialty interest. Since I had enjoyed teaching as a resident, I volunteered. About 600 medical students and 120 family medicine residents have rotated with me for their required neurology. Medical students, neurology residents, and pain fellows have also done elective rotations.

Medical education should teach you to educate yourself as you must to fill in the inevitable lacunes and stay current. I became increasingly interested in two common but underemphasized areas in residency, headache and mild traumatic brain injury. I would expand the old adage to "See one, do one, teach one, write one." A great way of learning a topic is to lecture and write about it which generates additional research ideas.

I started one paper at a time. I have published as author, co-author, editor, or co-editor over 300 articles, 85 book chapters, and 18 books and have been on many journal editorial boards. Writing is hard work for most of us and, like Carnegie Hall, requires lots of practice. We welcome the "practice" of students, trainees, and members in "Broca's."

If you're in private practice and have an interest in teaching, publications, or research, go for it. See if there are voluntary teaching opportunities available in your area. There is a great demand for high quality manuscripts. There's also a great demand for well-done peer review which you can volunteer for. No one cares if you are in private practice or have a full-time academic position. There's no compensation for these activities but unlimited fulfilment and fun. If you're interested in clinical research and compensation, many neurologists add clinical trials to their practices.

TNS. The late Bill Riley, incomparable TNS founding member in 1974 and past president, got me involved in leadership as a program chair in 2000. TNS has been terrific for inexpensive and yet easily available and outstanding CME and advocacy. As important, we have all made many new friendships and maintained old ones. We have the best state neurological society which would not be possible without the support of the TMA, the best state medical society, and our amazing executive directors, Ky Camero, and her predecessor, Rachael Reed.

CLUSTER HEADACHES

As a medical student at Rice, I was fortunate to have done summer research in the cardiac pharmacology lab of Arnold Schwartz at Baylor College of Medicine (who later discovered the location of the cardiac voltage dependent calcium channel and developed diltiazem and amlodipine). My first publication in 1974 explored the mechanism of action of verapamil.

Verapamil MOA. Fifty years later, I frequently use verapamil for prevention of cluster headaches. Based upon studies in rats, blockage of voltage gated calcium channels (which are present in the trigeminal ganglion and spinal trigeminal nucleus) prevents presynaptic release of CGRP from trigeminal sensory nerve fibers (Wei DY, Goadsby PJ. Cluster headache pathophysiology - insights from current and emerging treatments. Nat Rev Neurol. 2021;17(5):308-324). Verapamil acts on L-type calcium channels and crosses the blood brain barrier but is actively transported out of the brain by the P-glycoprotein pump. This may be why high doses of verapamil are often needed for prevention of cluster headaches.

TNS member, Mark Burish, has recently co-authored an excellent review (Schindler EAD, Burish MJ. Recent advances in the diagnosis and management of cluster headache. BMJ. 2022;376:e059577). I'll summarize some salient points.

Epidemiology. The lifetime prevalence is 0.12% with a male to female ratio on 1.3-2.6. Sleep apnea is co-morbid. 80% of patients have the episodic type, 20% have the chronic type (remissions no longer than 3 months), and 15% may transition from one type to another. During bouts but not between bouts, there can be a variety of triggers most often alcohol in up to 80% but less often nitroglycerin, PDE5 inhibitors, strong smells, high altitude, change in weather, bright sun, sleep, circadian disruption, stress or relaxation, menses, menopause, postpartum, and low testosterone concentrations.

Clinical features. In those with multiple attacks daily, mild symptoms may persist between attacks requiring an indomethacin trial to exclude hemicrania continua. The associated symptoms (light and noise sensitivity, nausea/vomiting, aura, and cranial autonomic symptoms) may be the same as migraine. Cluster can be distinguished from migraine by a usual duration of less than 3 hours and restlessness during attacks.

Imaging. The European Headache Federation consensus statement recommends MRI of the brain in all patients with cluster (including detailed views of the cavernous sinus and pituitary area). In refractory patients, consider MRA of the head and neck, pituitary hormone testing, a sleep study to exclude sleep apnea, and imaging of the lung apex in those with Horner's syndrome (Mitsikostas DD, Ashina M, Craven A, et al, EHF committee. European Headache Federation consensus on technical investigation for primary headache disorders. J Headache Pain 2015;17:5).

Acute treatment. For acute treatment, consider subcutaneous or nasal sumatriptan or nasal or oral zolmitriptan. Oxygen at a flow rate of 6-12 L/minute with a non-rebreathing mask results in pain relief in 15" for 78%. Flow rates over 10 L/minute to 15 L/minute are generally preferred. Non-invasive vagus nerve stimulation (gamma core) produces pain relief in 15 minutes for 48% of episodic but not for chronic patients.

Transitional treatment. Occipital nerve blocks with steroid and local anesthetic may be effective with a relative risk ratio of 4.86 for freedom from pain at one month compared with controls and 50% freedom from pain at one month in

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Editor's Notes *(continued)*

a meta-analysis (Ornello R, Lambru G, Caponnetto V, et al. Efficacy and safety of greater occipital nerve block for the treatment of cluster headache: a systematic review and meta-analysis. Expert Rev Neurother 2020;20:1157-67). Gaul et al found significant efficacy with low dose steroid, 10 mg triamcinolone, and 1 ml of bupivacaine for episodic and chronic cluster (Gaul C, Roguski J, Dresler T, et al. Efficacy and safety of a single occipital nerve blockade in episodic and chronic cluster headache: A prospective observational study. Cephalalgia. 2017;37(9):873-880). Another study found benefit from injection of steroid alone without local anesthetic (Leroux E, Valade D, Taifas I, et al. Suboccipital steroid injections for transitional treatment of patients with more than two cluster headache attacks per day: A randomised, double-blind, placebo-controlled trial. Lancet Neurol 2011; 10: 891–897).

An oral steroid course of prednisone 100 mg daily for 5 days then titrating down by 20 mg every 3 days produced significant improvement (Obermann M, Nägel S, Ose C, et al. Safety and efficacy of prednisone versus placebo in short-term prevention of episodic cluster headache: a multicentre, double-blind, randomised controlled trial. Lancet Neurol 2021;20:29-37).

Prevention. For prevention, verapamil usually starting at 80 mg tid and increasing by 80 mg every 10-14 days as tolerated is the first line preventive (May A. Cluster headache: treatment and prognosis. UpToDate, 2022). 120 mg tid is effective for a 50% or greater reduction for both episodic (80% after 2 weeks) and chronic cluster (50% after 1 week). The immediate release is more effective than the sustained release formulation. Because verapamil can prolong the cardiac P-R interval, many experts recommend an EKG before initiation and 1-2 weeks after an increase in dose (Koppen H, Stolwijk J, Wilms EB, et al. Cardiac monitoring of high-dose verapamil in cluster headache: An international Delphi study. Cephalalgia. 2016;36(14):1385-1388).

Galcanezumab 300 mg monthly reduced headaches by 50% or more in 71% of those with episodic cluster. Topiramate at a dose range of 100-400 mg daily may be effective. Lithium may be effective but has a narrow therapeutic range and significant potential side effects. Open label trials showed benefit for melatonin 10 mg hs and baclofen 5-10 mg tid.

For refractory cluster headaches, occipital nerve stimulation may be effective. Implantation of a device for stimulation of the SPG ganglion when available may also be effective.

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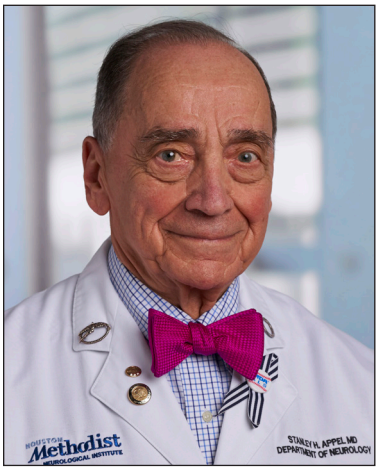
A REFLECTION ON Dr. Stanley H. Appel's STELLAR CAREER

By David B. Rosenfield, MD, Chair in Speech and Language in Neurology,
Director, Speech and Language Center Director, EMG and Motor Control Laboratory,
Stanley H. Appel Department of Neurology, Neurological Institute, Houston Methodist Hospital



I am privileged to write regarding Dr. Stanley H. Appel's retirement as Co-Director of the Houston Methodist Neurological Institute (2005 to 2022) and Chair, the Stanley H. Appel Department of Neurology at Houston Methodist Hospital (2005 to 2022). Dr. Appel is the Peggy and Gary Edwards Distinguished Endowed Chair for the Treatment and Research of ALS and Professor of Neurology, Weill Cornell Medical College. Dr. Appel will continue his research as Director of the Johnson Center for Cellular Therapeutics at the Houston Methodist Research Institute, focusing especially upon patients with ALS.

Most of us are familiar with Dr. Appel's career as a teacher, clinician and neuroscientist. Within this context, it is tempting and, frankly, somewhat easy to review his numerous accomplishments, awards and recognitions, especially given that I have known him for 50 years, having trained in his Neurology Residency Program when he was Chief of the Neurology Division and James B. Duke Professor of Medicine, Duke University Medical Center, North Carolina.

However, prior to reviewing Dr. Appel's numerous accomplishments, I discuss what it has been like to work with him for 50 years (e.g., minus my fellowship in behavioral neurology for three years) and, simply put, talk about the guy.

Minus those fellowship years in Boston, Dr. Appel has been my only boss for one-half century. One of my greatest achievements (not his) is that he never fired me during that time period. Despite my numerous personal and professional interactions with Stan (e.g., forgive the informality), many of which were signatures of my own imperfections, somehow, he kept me on board.

Fifty years is a long time: think about it. Interacting with someone for 50 years (e.g., 1972 to 2022) encompasses a lot, be it in the field of neurology, clinical care, medicine, academics, Medicare or, for that matter, the country and the world.

It is within this context that one must recognize that discussing anyone during a framework of five decades must include not only that person but also the changing environment in which that person functioned and the changing world around him.

Think about everything that transpired during the 50-year period prior to 1972. Indeed, from 1922 to 1972 (another 50-year segment), the world saw the aftermath and consequences of the First World War, the Great Depression, a Second World War, the Korean Conflict, the Civil Rights Movement, interstate highways, the discovery of DNA, the Cuban Missile Crisis, landing a person on the moon (and bringing him back), the establishment of new countries and dissolution of old, all intertwined with the changing world of neurology.

Then, we enter the Appel Era (1972 to 2022) and the subsequent eponymous chairmanship. And, try to imagine what the next 50 years will entail, encompassing legitimate inquiries regarding the human condition, Bitcoin, monetary policy, Ukraine, peace in the Middle East (e.g., a term invented during World War I, as was the term, totalitarianism), Global Warming, ecoterrorism, neuromodulation, neurogenetics, DRGs, electronic medical records, the world of documentation in clinical care, all admixed with the need to pursue neuroscience and neurological investigations.

The reason I note these issues is because the world is a dynamic, nothing is static, everything changes and whatever a person does or does not do with his or her life, their life is

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not some solipsistic lyrical interlude but, rather, an ongoing interaction between who they are, what they do, what they feel and how they impact others as their activities and the world about them constantly filter their efforts and, certainly, their persona.

So, to do a lot, as did Dr. Appel, recognizes the complexity of all about him and the tremendous accomplishments he achieved in the midst of the transmogrification of all about us.

Woody Allen once said that most of life is just showing up. A recent Nobel Laureate in literature states that most people are afraid of dying with broken teeth and no children, catalyzing their studying famous dogs of the Civil War so as to provide themselves some (vacuous) meaning. Me. I say that many people just take up space and consume oxygen. None of these percepts hold for Stanley Appel.

If there ever was a person on the planet who didn't just "show up," gather space and consume oxygen, it is Dr. Appel.

Stan has always had a passion, for knowledge, discovery and new ideas. How else would he allow a guy like me to pursue investigations into stuttering, a disturbance of the brain's equilibrium of speech motor control and achieve the findings (and funding) of ideas. Stan was always interested in new ideas, new concepts and long believed, contrary to many of the staid sober pillars of former neurological vestige, in the intercalation of science with our field, neurology.

When I was a resident at Duke, the Society for Neuroscience, then referred to as the Young Turks, was in an inchoate stage and Stan was definitely on board. Indeed, when I entered my fellowship at the Boston Aphasia Unit, I asked Appel on my last day in the program whether he believed that those people really understood language (whatever that means). He paused, had a twinkle in his eye and politely said, "Well, they speak the loudest."

As I later learned, Dr. Appel didn't care about who spoke the loudest or the most or who was more famous. He cared about the expanding platform of knowledge, especially the neuroscience of our field, recognizing its impact on patient care and expanding our armamentarium of therapies for neurological disease.

As hokey as this sounds, I well remember being with Stan at an American Academy of Neurology meeting when he briefly introduced me to a clinical practitioner who had studied the algorithm of the tapestry of colors that an individual sees following shining a bright light onto their closed eye, and impacting the retina.

Dr. Appel marveled (e.g., he may not remember, but I do) that someone would query this phenomenon, to which I politely nodded my head and he, again, complemented this person, being obviously interested in what transpired. He cared about knowledge, new ideas and innovative thinking.

This type of an interest, coupled with vast intellect, a good memory and a reactive force, separates Dr. Appel from many of us and, conjoined with his ability to endure and traverse the roads of academia and institutional bureaucracy, admixed with running a Department, teaching medical students. Residents, Fellows and colleagues, taking care of patients and pursuing his research interests, makes for a very unique individual, whom I am proud to know.

Dr. Appel never bought into simple models of any of this. I well remember when he told us residents at Duke that it made no sense to refer to patients as having Senile Dementia versus Pre-Senile Dementia (e.g., it was presumed sort of okay if you demented as an older person, currently deemed intellectual anathema). Now, we don't consider these delineations as we pursue Alzheimer's disease, and the other dementias.

We were on call every other day, dead tired all the time (e.g., sponsoring Stan to pantomime playing a violin juxtaposed to our moaning) and we somehow got through, learning continuity of care along the way and morphing into reasonably good physicians.

When we trained, there were no CAT scans, MRIs, fMRIs, DTIs, stents, DNA analyses, etc. Our biggest thing was serum protein electrophoresis (e.g., elevated alpha-2 and beta-1 signified active tissue damage), brain scans (What happened to them?) and even Dopplers of the skull to ascertain the presence or absence of a subdural hematoma.

When you think about it, when we saw patients (e.g., now referred to as Encounters), we had to know thoroughly how to obtain a history, perform a neurological examination and often had to decide whether to put a needle in the patient's carotid artery for an angiogram or in their lumbar spine for assessment of cerebrospinal fluid, none of which were trivial and, we had to discuss our thinking with Dr. Appel at Morning Report.

As the field of neurology grew and expanded, with bureaucratic systems certifying programs, providing residents nap time and curtailing long hours on call, all of us had to change and, people like Dr. Appel had to accommodate, grow and endure and…he did, all admixed with pursuing scientific investigations as well as running a Department.

Dr. Appel was intercalated in all these changes, encompassing patient care, training residents, pursuing research, obtaining funding, answering phone calls, all ensconced in an everchanging matrix of a world around us all, even including his attending a Bob Dylan concert and politely stating that he had to leave early to avoid parking/exiting congestion.

All of this makes Dr. Appel a very non-boring person.

The guy is truly one of the least boring people I know, is always doing and thinking about something and pushing ahead. Further, what makes him even more remarkable is

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that, busy as Dr., Appel is, he is always accessible, incredibly knowledgeable and available to provide advice that resonates with compassion, kindness and toughness as well.

Thus, it is not easy to be a person who has done and continues doing as much as Stan does. It is within this context (e.g., for the data- driven among the readers) that one notes that Dr. Appel, a native of Boston, Massachusetts, received his B.A. from Harvard University, his M.D. from Columbia College of Physicians and Surgeons, was a Medical Intern at Massachusetts General Hospital, a Neurology Resident at Mount Sinai Hospital, Research Associate in the Laboratory of Molecular Biology at the National Institutes of Health and had additional Neurology Residency training at the University of Pennsylvania School of Medicine, following which he went to Duke.

After leaving Duke, Dr. Appel became Professor and Chairman, Department of Neurology, Director, Jerry Lewis Neuromuscular Disease Research Center and Director, Vicki Appel MDA/ALS Center at the Baylor College of Medicine (1977-2004) and Director, Neurosciences Program at the Baylor College of Medicine (1977-1987).

Dr. Appel received the Gold Medal Award from Columbia College of Physicians and Surgeons (1997) for "Distinguished Achievements in Medicine," the Sheila Essey Award (2003) from the American Academy of Neurology for outstanding research in Amyotrophic Lateral Sclerosis, was elected Fellow of the American Association for the Advancement of Science (2003), Baylor College of Medicine Alumni Association Distinguished Faculty Award (2004), MDA's Wings Over Wall Street Diamond Award (2004), Texas Neurological Society Lifetime Achievement Award (2005) and the Forbes Norris Award for "compassion and love for humanity in research and treatment in patients with ALS" from the International Alliance of ALS/MND Associations in 2005. He also received the Museum District Business Alliance Award (2007) in recognition for his commitment to research, patient care and education. In 2008, Dr. Appel received the John P. McGovern Compleat Physician Award from the Houston Academy of Medicine.

Dr. Appel is a premier physician-scientist, clinically caring for patients and pursuing scientific endeavors. His research focuses upon developing new insights into neurodegenerative diseases, with primary emphasis on ALS. Dr. Appel's investigations on mutant SOD transgenic mice document that neuroinflammation and activated microglia are neuroprotective during early stages of disease and cytotoxic during the late stages of disease.

Dr. Appel is internationally recognized for his teaching, clinical skills and research as a neurologist, has spent more than 40 years diagnosing and treating patients with neurodegenerative diseases, especially ALS, and trained more than 200 neurologists, many becoming Chairs in their own Departments.

It is my honor and privilege to know and work with a person as outstanding as Dr. Appel. I thank the Texas Neurology Society for providing me this opportunity to share my thoughts.

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Business of Medicine

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TNS Legislative Update

Dr. Sara Austin, TNS Legislative Affairs Chair and Tom Holloway, TNS Lead Lobbyist

After three contentious special sessions spent redrawing the state's legislative and congressional districts and a lengthy primary season, the Texas Legislature is finally getting back to work on the business of the people.

Several weeks ago, Lt. Governor Dan Patrick and House Speaker Dade Phelan issued their long-awaited list of "interim charges" to their respective committee leaders – a list of policy issues that they feel merit further investigation before lawmakers return to Austin in January. These interim charges provide lawmakers with the opportunity to investigate complex issues more fully, receive expert testimony and policy recommendations, and develop potential legislation for the next session.

While the first round of interim committee hearings has yet to take place, the Texas Neurological Society's legislative affairs team has identified a wide range of interim charges which we intend to monitor closely in the months ahead, including: the impact of the COVID-19 pandemic on the state's healthcare workforce, exploring recommendations to improve telemedicine and telehealth services, standardizing documentation for healthcare providers to obtain for consent for treatment, and proposed public health measures to improve outcomes during any future infectious disease outbreak.

In other news, the Centers for Medicare & Medicaid Services (CMS) recently announced their decision to approve Texas' requested extension of its 1115 Medicaid waiver program through 2030. This program provides critical funding for Texas hospitals, particularly those that provide a large amount of uncompensated care to their communities. This waiver extension will allow the state to maintain an efficient and effective Medicaid managed care model while standing up new programs, including those to support the replacement of the Delivery System Reform Incentive Payment (DSRIP) program which ended September 30, 2021.

While expanded Medicaid coverage in Texas may provide a more long-term solution to uncompensated care, it continues to be viewed as a political non-starter to the state's Republican majority. Nonetheless, Speaker Phelan recently formed a new committee to investigate large-scale healthcare reform in the state of Texas. The House Select Committee on Health Care Reform, led by Chairman Sam Harless (R-Spring), brings together some of the legislature's foremost policy experts on health insurance, hospital funding, health care workforce, Medicaid, pharmacy benefits, and long-term care services to develop strategies to lower costs, increase transparency, and improve healthcare delivery in Texas. The committee plans to convene several times in the months ahead and make their final recommendations to the Speaker this January.

This past session, lawmakers took aim at one of the most frustrating and time-consuming aspects of operating a modern medical practice: the prior authorization process. HB 3459, also known as the "Gold Carding Bill," would allow physicians to earn a continuous exemption from prior authorization requirements on all state-regulated health plans by earning approvals on at least 90% of their preauthorizations for a given treatment or procedure over a six-month period.

Although this legislation was signed into law by Governor Abbott nearly a year ago, its implementation has been repeatedly delayed as the Texas Department of Insurance works to develop a practical set of rules to govern the program. The Texas Association of Health Plans (TAHP) appears to be working hard behind the scenes to weaken the provisions of HB 3459 through rulemaking and accomplish at TDI what they failed to do at the legislature. In response, the Texas Neurological Society co-authored a comment letter with the Texas Medical Association to push back against the health plans and aski TDI to implement HB 3459 in a manner that remains faithful to the bill's original legislative intent.

In a more concerning development, Texas Right to Life appears poised to make a renewed run at challenging end of life care in Texas hospitals by seeking to redefine the clinical definition of brain death. At this point, we have little more than rumors to operate on since legislation has yet to be filed, however the TNS legislative team will continue to monitor all new developments and make sure that neurology remains front and center in any legislative efforts to interfere in the independent medical diagnosis of brain death.

Finally, the new interstate medical licensure compact is now up and running. It will hopefully make it faster to receive a second state medical license in one of the 36 states that have agreed to join the compact. There is page on the Texas Medical Board website that provides additional details and cost on the program. https://www.tmb.state.tx.us/page/interstate-medical-licensure-compact.

The TNS Legislative Affairs team will continue to advocate for the best interests of our neurologist members as we approach the next legislative session. If you have a specific question or concern regarding the impact of state government on the practice of neurology, please feel free to contact our lead lobbyist, Tom Holloway (tom@crossoakgroup.com) or out Legislative Affairs Director, Dr. Sara Austin (saragaustin@gmail.com).

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TNS WINTER CONFERENCE 2022 POSTER WINNERS

1ST PLACE

Sarita Kambhampati, MD

Ultrasound obtained optic nerve sheath diameter in patients presenting with intracerebral hemorrhage

2ND PLACE

Kelly Block, DO

Seizure Alert: An Interdisciplinary Protocol for Timely Anti-Seizure Medication Administration in the Setting of Status Epilepticus

3RD PLACE

Spencer Gunnell, DO

Vaccine-Induced Immune Thrombotic Thrombocytopenia Following Administration of Janssen COVID-19 Vaccine: A Case Report

Congratulations!

SARA AUSTIN, MD

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TNS COMMITTEES

Women Neurologists Section Come network at conferences! This section gets together one evening at the close of a day's general session for the purpose of connection, support and mentoring. It is the best time to meet fellow TNS women neurologists. Get involved today!

Legislative Committee More of how we practice neurology is determined at the Texas Capital and in Washington D.C. This committee fosters relationships with legislators and policy makers to education them about the delivery of neurologic healthcare to all Texans.

Grants Committee TNS gives back to its membership through the grants committee. Annually, committee members review submitted applications to determine which one/ones achieve the goal of improving and supporting neurological practices, education, and disease awareness and prevention. Continuing to further neurology is what this committee is designed to do.

Communications Committee Outreach is important! Did you know TNS has various social media platforms? Distributes a biannual newsletter? This committee works to develop materials/projects as well as contribute to the TNS website as they relate to TNS; grab the attention of the current and future membership. Join this committee as well as contribute to the TNS website and let your creative side shine.

Medical Economics Committee This committee serves as a forum to discuss topics encountered in everyday practices. Join and bring your concerns and/or accomplishments to the group. Assist in the brainstorming of topics for the "Business of Neurology" video series. Help TNS help its membership.

Resident Committee Do you want to shape a young neurologist's mind? Answer their questions about their future as a neurologist? Then, this is the committee for you! Join resident representatives from all of the Texas programs and some board members, too, as they work to develop projects or materials geared toward neurology residents. This committee also is responsible for the continuing development of the "Business of Medicine" program.

For more information, visit the TNS Website.

Case Study of a 53 year-old Non-diabetic Female

Maryam Ahmed, MD, Husam Sultani, MD, Aziz Shaibani, MD
Nerve and Muscle center of Texas, Houston, Texas

A 53 year old non-diabetic lady presented as shown in the video. The most likely cause of the abdominal wall bulging is:

A) Systemic vasculitis
B) Isolated peripheral nervous systemic vasculitis
C) Non-diabetic radiculoplexus radicudlopathy (NDRPN)
D) Lymphomatous polyradiculopathy
E) Incidental abdominal hernia

Answer: C. NDRN is very similar to its diabetic counterpart, namely diabetic radiculoplexus neuropathy (DRPNP) or diabetic amyotrophy. Both are caused by microvasculitis of the LS plexus, nerve roots and peripheral nerves. Typically it starts with unilateral thigh pain followed by quadriceps weakness and wasting. It spreads to the other side in 30% of cases, to the distal musculature causing foot drop in 15% of cases, and to the arms in 15% of cases. Sometimes it is associated with thoracoabdominal polyradiculopathy, causing severe radicular pain and weakness of the abdominal wall. The later can present in isolation, leading to misdiagnosis as acute abdomen or myocardial infarction. This condition usually affects patients with well controlled diabetes. However, it can affect non-diabetics as well. DM may be just a risk factor. The course is typically that of progression for several months followed by stabilization, then recovery. Maximum recovery may take up to 2 years. Some residual deficit is common in severe cases. Although the pathology is microvasculitic, immunomodulation is not shown to be effective. Steroids early in the course may help compliance with PT by reducing pain but they do not change the natural course of the disease. IVIG does not either. Pain management and rehab are the mainstay of treatment.

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