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OF THE

AMERICAN ASSOCIATION

OF

SURGEONS' ASSISTANTS

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VOLUME I, ISSUE I

JUNE 1977

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VOLUME I, ISSUE I

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A.A.S.A. EXECUTIVE REPORTS

FROM THE EDITOR'S DESK

We've done it! A dream has become a reality, thanks to your support. I want to extend a special thanks to my associates Dave Bissonette and Becky Starkey for their contributions of time and ideas. Also, thanks to all of the contributors in this first issue. As Dr. Henry Laws, Director of the UAB SA Program would say, "I think we've got a winner!"

The big news of May 1977 is that the Cornell SA Program is funding their dues for all of their graduates and current students to join the A.A.S.A. We welcome the following new applicants from Cornell:

Joanne Ross ('78)
Lynn Mahaffey ('77)
Gene Faucella ('77)
John Graffeo ('78)
Andrea Portenoy ('78)
Roberta Rich ('78)
David Johnson (graduate)
Bettye Epstein (graduate)
Dorothy Davis (graduate)
Donna Hamilton (graduate)
Luis Barretto (graduate)

Two of the UAB graduates have relocated and can be reached at the following addresses:

James Boutselis
11 Burnett Circle
Rome, Ga. 30161

James Kraft
c/o Renal Transplant Service
VA Hospital
Birmingham, Ala

Our Fall Journal (September) will feature tips and research papers to help in reviewing for the National PA Certifying Exam.

Your comments and ideas for improvement of this journal are actively solicited.

COMMITTEE UPDATE

A modest response followed request for committee construction, Chairmen and committee members to carry out the respective charges.

The Membership Committee has already produced a significant document proposing a change in membership requirements. Charles Noyes and his committee members (Pepper, Drabek, Perry, Moran and D. Starke) deserve congratulations for a job well done. Yet to be dealt with are a new application form, formulation of a certificate of membership, and indididual review of new applications for membership.

The Election Committee chaired by Gregg Munson (Chang and Jacobs) has organized a ballot on membership requirement changes which should be in the mail to paid members by the time of this printing. New elections for 1978 AASA officers lay ahead for the committee's attention.

The Literature Review Committee chaired by Jim Boutselis (Lamprey, Pepper, Burger and Klein) begins work in June. The Newsletter will present their review in the December issue.

The Fees and Appropriations Committee and CME committee are hard at work on their respective projects. A Planning Committee has been organized with Dean Blietz as chairman. Already plans are underway for a Cardiovascular CME conference in Grand Rapids, Michigan in

October. In addition, a combined Medical/Surgical CME conference is tentatively planned for September in Pittsburgh with workshops designed to aid SA's/PA's planning for NBE October, 1977. The Planning Committee is also considering sites for the annual AASA business meeting which traditionally follows elections of new officers.

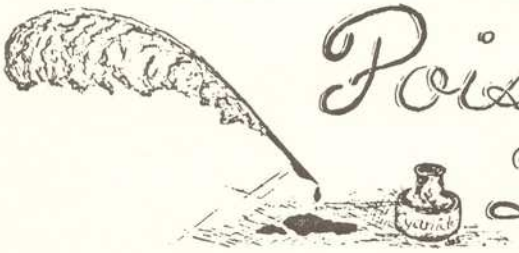
The greatest deficits in manpower involve the Legislative Research Committee. Regions 4, 6, 9, and 10 not only have no committee members, but likewise have no chairmen. Although suboptimal, SA's geographically removed from the regions concerned may have to pick up the responsibility of researching these states.

Your help can still be effectively utilized and is sorely needed. If you have hesitated in volunteering your services to date, please make a committment soon!

David J. Bissonette, S.A.
President, A.A.S.A.

All UAB graduates who are active AASA members and who do not have an AASA certificate and membership card, should notify Chris Spivey, Treasurer (Rt. 4, PO Box 138-5, Pell City, Ala, 35125) by July 1st so that she can get them printed. All other AASA members (students and Cornell grads) should get their certificates later this summer when their membership applications have been approved.

Membership applications from the Cornell S.A.'s mentioned in the front of the journal (as well as those of Michael Long and David Johnson) have been forwarded to Charles Noyes' Membership Committee for review.



Poison Pen Forum

WHERE'S YOUR HEAD AT?

This year marked the first time a House of Delegates has functioned within the AAPA. After a year of organizing state constituent chapters, smaller groups of PA's across the country had an opportunity to impact upon the AAPA by formulating, amending and forwarding to the AAPA Board of Directors a concerted opinion, a mandate of sorts from the body of PA's at large.

So what? Just another bunch of PA's doing their thing, right? What's all this bull got to do with an SA? Here comes another "get involved, we're all PA's" speech, right? RIGHT!

At the risk of being dubbed "quisling", "traitor", "turn-coat" or even "PA" (God forbid!), allow me to present a few issues for your consideration.

I spent the majority of my time in Houston observing the old and new AAPA Board of Directors meetings, the AAPA general business meeting and representing the Pennsylvania constituent chapter in the House of Delegates as a voting alternate member (absenteeism is relatively ubiquitous) of a six member delegation.

The Board of Directors represents a very small voting body responsible for decisions of far-reaching and profound consequence to PA's and, believe it or not, SA's if not by conscious design then unequivocally by oversight or tacit disregard.

The House of Delegates consists of AAPA state constituent chapter delegations whose members represent "grass roots" PA's from the states in which they are employed. Concerns of members may be formalized into resolutions and sent by the House to the Board of Directors where AAPA policy decisions are made.

The AAPA indicated that a professional P.R. man has been budgeted for, selected, and is preparing a high-powered national public relations campaign to inform the public about the P.A. (gasp!) and to make "'P.A.'a household word" (gasp, wheeze...!).

In view of the above observations one might be inclined to consider a number of options. With major policy decisions made at Board of Directors' meetings, a seat on the Board might well be advantageous in effecting policy statements consistent with one's special interests. Alternatively, one's presence as an observer complete with vigorous, unsolicited dialogue during the course of a Board meeting has an effect which does not go unnoticed.

Place yourself in the position of a member of the AAPA Board of Directors for a moment. Next, envision a body representative of your constituency at large (House of Delegates) delivering to you a set of resolutions suggesting a course of action or change in policy attitude. Astute politician that you are and, in all probability, sincerely concerned with the good of your profession and its representative organization, you would no doubt highly regard the suggestions forwarded to you. Subsequently, one might regard as valuable a position on a state delegation to the House of Delegates.

In publicizing the concept of the P.A. the a priore reasoning and justification was that of the myriad of titles; Medex, PA, SA, Physician Extender, Nurse Practitioner, ad nauseum, only one could surface and survive in the lay public's mind. That viable title of recognition was felt to be the one that would arise most rapidly and with the greatest hoopla. Accordingly, professional hoopla has been retained to make "Physician Assistant" a household term and the P.A. concept the hottest item since Adam and Eve discovered the solace of a fig leaf.

An astute, aggressive SA might conclude that he/she could effect significant favorable changes for other SA's with a Board of Directors seat or as a delegate to the AAPA House of Delegates. However, I see a major obstruction to the realization of the potential existent in the above cited opportunities. One can only take advantage of these opportunities as a member of the AAPA, as a PA (... oh NO!).

Perhaps more consideration should be given to the generic title of PA. Should a national PR campaign make "PA" a commonplace title, one would assume the image presented to the public would portray the PA as a dynamic, competent, qualified, well-educated pioneer in the medical community whose efforts would benefit the patient. Would anyone object to such an image despite specialty interests? If existing local or regional PA image presents a legal, ethical or political problem to assuming a title perhaps it should be dealt with locally, vigorously and with expediency.

Previously, to be regarded with some skepticism in view of my participation within the AAPA (guilt by association, a well-established dictum), I must engender overt distrust by the flavor of the above editorial comment which appears downright blasphemous. The above perceptions are offered for consideration, not as suggestions for the dilution of principles such as academic excellence and clinical competence. In addition, consider the prevailing political structure and thrust! Rather than resist this overwhelming trend, perhaps an Oriental philosophy would serve us better. Namely, do not resist the counterforce , rather modify that force to your own end. Utilize the PA initiative for your benefit without compromising basic principles. Does a title really make a profession?

David Bissonette, SA P.A.-C ?

5/10/77

SURGICAL COUNCIL MINUTES
(Houston)

The Surgery Council of the AAPA met in its second annual convocation. New elections were held resulting in the following change of officers:

David J. Bissonette, Chairman
Department of Neurosurgery
Presbyterian-University Hospital
Room 9402
230 Lothrop Street
Pittsburgh, Pennsylvania 15213

Charles Noyes, Vice-Chairman
8333 Eighth Avenue South
Birmingham, Alabama 35206

The issues of major concern which surfaced during the course of the Council Meeting include national certification for surgical physician's assistants, reimbursement for surgical physician's assistants, malpractice insurance, continuing medical education geared toward surgery subspecialties and the apparent poor communication in disseminating information through the National Office from Council officers to surgical physician's assistants and from surgical physician's assistants to their respective officers.

In reviewing the minutes of last year's Surgery Council Meeting, it is evident that many of the concerns are redundant ones indicating persistent difficulties yet requiring satisfactory resolution.

In terms of difficulties with communication, the Council's suggestion was that the Secretary of the Academy be apprised of the need for utilization of the AAPA Newsletter in disseminating information to surgical physician's assistants. In addition, the Council constituency requested that the addresses of Council officers be included in the initial report of Council minutes. In the past, information had apparently been funneled through the National Office and lost in transmission from constituency to officers of the Council.

Concerns over third party reimbursement were also raised during the course of the meeting. A point was made that special attention should be paid toward the wording and scope of official policy statements of the Academy such that subspecialty P.A.'s not be excluded in the development and implementation of the reimbursement process. It was emphasized that in terms of cost effectiveness, surgical P.A.'s are in a good position to effect an anti-inflationary impact on health care. The mechanism already exists for payment of first assistant fees. With a surgical physician's assistant in the position of first assistant, the surgeon would have experienced, qualified help with no more outlay for first assistant fees and perhaps lower first assistant fees when utilizing a surgical physician's assistant in lieu of another physician. It was also emphasized that surgical physician's assistants are not of a mind to displace all general practice physicians who may first assist surgeons. Rather, surgeons who wish to utilize physician's assistants in surgery should be able to count on appropriate reimbursement.

A special problem regarding surgical P.A.'s was raised. Specifically, surgical physician's assistants in Pennsylvania cannot be covered by the Lloyd's of London policy available to all other Academy members. Some clarification was provided by Mr. Neil Cohen at the general business session. However, the deficiency remains an enigma which will effect greater numbers of surgical physician's assistants and remains a concern of the surgery council.

The Council membership also encouraged reaffirmation of the Academy's position in encouraging the National Commission on Certification of Physician's Assistants to develop a mechanism of certification for subspecialty physician's assistants.

I urge surgical physician's assistants to utilize their Council as a sounding board for their concerns which in turn will be forwarded to the Academy. Concerns should be addressed to the Council officers directly at the addresses listed herein.

David Bissonette, [redacted] S.A.

Continuing Medical Education (June-Sept 1977)

	WHERE	WHO TO CONTACT
Colorado:	Denver-June 10-11, 1977 Stouffer's Denver Inn 14 CME Credits sponsored by Colorado PA Assoc.	Charles Cusumano, SA NE Colorado Surgical Assoc 1405 S. 8th Ave. Box 1191 Sterling, Colorado 80751
South Carolina:	Charleston June 23-24 Kiawah Island Inn Topics: Acute Hand Injury Folk Medicine in the South Burns Antibiotics--What's New Rheumatology Death and Dying	Vince Mosley, M.D., Director Division of Continuing Educ. Medical Univ. of South Carolina 80 Barre St. Charleston, S.C.
Kentucky:	Lexington-June 9 and 11 Univ. of Kentucky Medical Center Topics: Surgical Diseases of the Bowel Visceral Ischemia Intestional Atresia Hirschsprung's Disease Intestional Bypass Procedures Neoplastic and Inflammatory Diseases of the Bowel	Frank Lemon, M.D., Director Continuing Medical Education Univ of Kentucky Lexington, Ky 40506 606-2335161
	Lexington--Sept 16-18 Hospitality Inn 30 hours CME credits Topics: Breast Cancer Death and Dying ENT-When to refer Contraceptive Alternatives State Abortion Legislation Eval of Low Back Pain Eval of Closed Head Trauma and Headaches Pediatric Diseases Thyroid Diseases	Glenna Jones, PA Dept of Surgery Central Baptist Hospital 1740 S. Limestone St. Lexington, Ky 40503 Registration fee $40-$60
Nebraksa:	Omaha-Sept 12-23 or Oct. 3-14 Univ. of Nebraska Medical Center Eppley Science Hall 42nd and Dewey Ave. Topic: A Comprehensive Review Course for Physicians' Assistants (to provide a thorough update for PA's prior to certification 100 hours CME credit	James Van Arsdall Program Associate Continuing Medical Education University of Nebraska Medical Center 42nd and Dewey Ave. Omaha, Nebraska 68105 402-5414452 Registration fee $575 (a limited number of tuition scholarships are avaliable for $200

Pennsylvania:	Pittsburg (Monroeville) Sept 24-25 Co-Sponsored by Penn Assoc of SA's and Penn Assoc of PA's Topics: Dual Medical and Surgical Tracts will be offered	Dave Bissonnette, SA 608 Kelly Ave apt A Wilkinsburg, Pa 15221

Note: All topics listed above are tentative and subject to change prior to conferences.
Remember that SA's and PA's can often get reduced registration fees if they mention their status when they apply. Some conferences you may attend with your employing physician for a modest fee.
Interested in taking the National Physicians Assistants Certifying Exam this fall? Register now with
National Commission on Certification of the Physicians' Assistant
3384 Peachtree Rd. N.E. Suite 560
Atlanta, Ga., 30326

RESEARCH PAPERS

The Asymptomatic or "Silent" Gallbladder: Should One Operate or Not

Paul M. Lamprey S.A.
The Harbin Clinic, Rome, Ga.

Mrs. H. is a 40 year old white female who, on her routine yearly physical was noted to have several radiolucencies in the right upper quadrant on her chest x-ray. Further detailed questioning elicited no symptoms of gallbladder disease. An oral cholecystogram demonstrated cholelithiasis. Mrs. H. is in good health, is asymptomatic, works, has three children, and as would be expected, is somewhat reluctant to undergo an operation she is not sure she needs. What do you tell her?

This is an example of something more and more physicians and surgeons are being faced with: the asymptomatic gallbladder. Should Mrs. H. be advised to undergo surgery or not? Some would argue that since she is symptomless she should not be subjected to a surgical procedure with a moratality rate of 0.5 to 1.0%. Others would argue that she should undergo cholecystectomy now while she is young, healthy, and symptom free, rather than wait until she develops a possible acute attack of cholecystitis or has other concomitant diseases when she is older, which both increase the mortality.

This paper will attempt to review some of the literature concerning this "debate" and attempt to show the reasoning behind elective cholecystectomy for asymptomatic gallbladder disease.

Method, Mehn and Frable[1] at Passavant Memorial Hospital, Chicago, reviewed the records of 623 patients undergoing cholecystectomy for acute cholecystitis and came up with 17 patients who were asymptomatic prior to their attack. All 17 presented acutely ill with temperatures of 100-105° F., severe abdominal pain, vomiting, nausea, tenderness and guarding in the right upper quadrant. Two our of the 17 knew previously that they had gallstones and 11 out of the 17 (65%) were over 60. Ten of the 17 had coexisting diseases, with four of these having two or more coexisting diseases. All 17 had operative findings of cholelithiasis, with the following breakdown:

I) Six had gangrenous gallbladder with perforation and a pericholecystic abscess in two; perforation and peritonitis in one; and a cholecystoduodenal fistula in one.
II) Five had associated common duct obstruction with jaundice. Four of these had stone and one as obstructing adenocarcinoma.
III) Three cases were complicated by severe cholangiohepatitis.

There were three deaths in this group (17.6%); one, age 60, due to a cardiac arrest immediately post-op; one, age 61, at post-op day six due to a disecting aneurysm with thrombosis of the right renal artery; and the one with adenocarcinoma, age 47, of the hepatic ducts. This mortality is high but of all those presenting with acute cholecystitis (58) the mortality drops to 5.17% and to 0.8% in the entire series of 623 undergoing cholecystectomy.

This mortality of 17.6% is high, with two out of the three deaths being over age 60, but this compares with other reports in the literature. Ochsner[2] reports a 7.5% operative mortality in 462 cases of acute cholecystitis with a 21.1% mortality in patients over 65. Glenn and Hays[3] report a mortality of 4.2% in reviewing 375 cases but report in 92 cases over 65 years of age the mortality rises to 10.86%.

In this series 17 out of the 58 presenting with acute cholecystitis, or 29.3% were asymptomatic, which also compares with the literature. Again, Ochsner[2] found in his 462 cases that 21% had no previous symptoms, and Becker[4] in a study of 1060 patients found that 25% were symptom free.

In a study by Wenchert and Robertson[5] done at the Malmo General Hospital in Sweden, where 60% of the people die in a hospital and 99% of these deaths are autopsied, 55% of the adult females and 25% of the adult males had gallstones and many of these were asymptomatic. The authors reviewed 781 cases over an eleven year period of patients, who after having the diagnosis of cholelithiasis being made, underwent no operation and had no complaints within the first year. Of these 781 or 35% developed complications (severe cholecystitis, icterus, ileus or cancer) or other such severe symptoms requiring cholecystectomy. This compares with a study by Lund[6] who reports on 526 patients with surgically untreated gallstones, where 33 to 50% developed serious symptoms within 20 years. One hundred and five out of the 781 (13.5%) were over 60 and had severe symptoms or complications. By these same authors, of 4916 patients undergoing operation, the overall mortality was 1.1% but in patients over 60 this figure rises to 4.2%.

Colcock, Killen and Leach[7] reviewed the cases of 134 asymptomatic patients with cholelithiasis who were operated on at the Lahey Clinic between 1950-1968, and of 2978 who were symptomatic and were also operated on. In the symptomatic group x-rays showed evidence of gallstones in 114 cases and in the other 20 the diagnosis was made during celiotomy for some other condition. In 87 visualizing oral cholecystograms, 71 patients had multiple stones and 16 had a single stone. Thirteen gallbladders failed to visualize. In 15 of the 134 asymptomatic patients the common duct was explored but no stones found (11%), whereas, in the 1978 symptomatic patients, the common duct was explored in 28.6% and stones were found in 9%. This might suggest early surgery in asymptomatic patients with cholelithiasis may reduce common duct disease. There were no postoperative early or late complications directly related to the biliary tract. All complications were in people who had concomitant diseases or who underwent multiple surgical procedures at the time of cholecyctectomy. There was one postoperative death (0.7%) due to an undiagnosed preoperative diffuse metastatic cancer who experienced a coronary thrombosis on postoperative day one. There were three late deaths from biliary tract disease, but unrelated to the cholecystectomy, two from cirrhosis of the liver and one due to cancer of the common bile duct. Wenchert and Robertson[5] also reported in their study five patients out of 1402 (0.4%) who developed cancer of the gallbladder at one, one, three, six and nine years after initial study, all of whom had gallstones, and all of whom died. Early cholecystectomy may have helped these patients but these figures themselves are not significant to indicate performing elective cholecystectomy to prevent cancer alone. A follow-up study of these 134 patients from 1958-1966 showed 115 alive without symptoms related to the biliary tract; 18 were deceased, 14 without symptoms, one of an unknown cause and the three already mentioned; and one patient lost to

follow-up. The authors thus believe that unless there is a strong contra-indication to surgery, the presence of cholelithiasis, with or without symptoms, is an indication for surgery.

Comfort, Gray and Wilson[8] at the Mayo Clinic reported on 112 patients, from 1925-1934, where gallstones were found during some other abdominal procedure. They were concerned with two questions; how often was a stone silent and when to operate electively or after one or more attacks? Robertson[9] reviewed 1027 autopsies where gallstones were or had been present and showed that in 61% neither the patient nor the physician had any suspicion that stones were present. As the course of these patients progressed thirty developed indigestion and 21 reported colic (five out of the 21 had colic and jaundice). Fifty one out of 112 (45.5%) developed symptoms and 24 underwent cholecystectomy, with three postoperative deaths (12.5%). In 61 (54.5%) of the 112 cases no abdominal symptoms developed up to death or since the initial discovery. Twenty eight out of 112 have died, 21 asymptomatic and seven with symptoms. Six out of the 28 died of cancer but in none was the cancer related to the gallbladder. The authors conclude that a patient with silent gallstones has a 50-50 chance of developing symptoms, a 20% chance of developing painful seizures (colic) and a small chance of developing jaundice within ten to twenty years. The risk of operation electively before complications develop is about 1%. After complications develop or old age and disabilitites appear the risk increases to 3%, although, the patient may never develop symptoms.

Lund[6] has performed a five to twenty year follow up of 526 non-operated patients with gallstones diagnosed between 1936-1950. Thirty per-cent of the men and 50% of the women developed severe symptoms and/or complications at a later date. In this series 38.2% of the men and 44.1% of the women are over 60. Fourteen out of 526 (2.7%) died of their disease, with a mortality of 7.2% over age 65. In this study, cancer of the gallbladder accounted for deaths of three patients (.6% of the entire series). Only 34 patients (6.3%) in this study were asymptomatic. The author concludes that irrespective of symptoms one-third of the people with cholelithiasis will develop severe symptoms and 20% will develop complications. Cholelithiasis with biliary colic and complications is an accepted indication for cholecystectomy. The risk of developing cancer of the gall-bladder is at best 1%. Prophylactic removal of the gallbladder was found to be indicated in all gallstone patients who are reasonably good surgical risks. This will prevent much future morbidity and a primary, elective operation carries a lower mortality than non-operative treatment (1% vs 2.7%). The mortality over the age of 65 is 7.2%. The author also feels the prognosis of asymptomatic stones is approximately the same as that of patients with symptoms.

Glenn[10] showed in a series of 2021 patients over 42 years of age, between 1932-1974, that in patients over 65 the proportion operated on for acute cholecystitis increased from 3.3 to 37.6%. The older the patient and longer the duration of symptoms of biliary tract disease the more common are the complications of acute cholecystitis if not treated surgically. Five hundred and three of the 2021 were 65 or older and 47 (9.3%) died of their disease or its complications, whereas 1518 were under 65 and only 21 (1.4%) died. The total death rate was 3.4%. Thirty and five tenths percent of those over 65 undergoing cholecystectomy also had common duct exploration, while only 12.7% under 65 needed a common duct

exploration. Oddly enough in this study, 43% of those dying under 65 died due to disease related to their biliary tract, while only 30% of those deaths over 65 were related to the biliary tract. Fifty five per cent of those over 65 died as a result of cardiovascular system disease.

Thus what conclusions can reasonably be drawn from this review and how can they help the Surgeon or Physician's Assistant? The most reasonable conclusion is that in asymptomatic gallstone disease 50% of the patients will develop symptoms, with anywhere from 33 to 50% of these developing severe sumptoms or complications of their disease. The operative mortality of an elective cholecystectomy is about 1% in a good surgical risk patient and increases to approximately 3 to 5% in patients over 65. With concomitant diseases and an acute attack of cholecystitis over age 60, the operative risk can rise to between 10 to 20%. The per cent of common duct explorations is also significantly greated in the older age group, 30% versus 10% in those under 65. Gallstones can lead to cancer of the gallbladder but the occurence of this is not significicant enough to advise elective cholecystectomy for this reason alone. Prophylactic removal of the gallbladder demonstrating cholelithiasis does reduce future morbidity and the risk of elective operation (1%) is less than that of non-surgical treatment (2-3%).

To the Surgeon or Physician's Assistant it is wise to be aware of these facts because you will frequently be the one doing the patient's hospital work-up. The patient has already been told by her physician she has gallstones and needs an operation. If she is symptomatic she will most likely understand the need of an operation, but if she is asymptomatic she is most likely wondering why she has been advised to undergo an operation with all its associated risks for a disease she doesn't suffer from. You can reassure her of everything the surgeon has already told her (or should have told her) and stress the risks of not operating or operating at a less elective time (when she is admitted to the ER at 1 AM suffering severe right upper quadrant pain, nausea and vomiting, etc.)

So then, how would you advise Mrs. H. ?

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B-PROTEIN ASSAY IN EARLY DETECTION OF CANCER

Dr. E.T. Bucovaz at the University of Tennessee has developed a blood test useful in the detection of cancer which utilizes a protein extracted from Baker's Yeast. This binding protein binds to a specific protein in a patient's blood, designated B-protein (Bucovaz protein), indicating that cancer is present in that patient. This specific human protein has been found to interact with a low molecular weight component released from the coenzyme A-synthesizing protein complex of Baker's yeast. The protein is modified, or a similar protein is produced and released into the blood of patients with cancer, which then also interacts with the low molecular weight protein of yeast. B-protein may either be produced by cancer cells, or the presence of cancer may set off an immune system which manufactures this protein component. The exact source of B-protein is uncertain. Although the B-protein in cancer patients is similar to a protein present in patients who do not have cancer, as both interact with radioactively labelled binding protein, the differences are sufficient for separation and identification of the B-protein.

As part of my job as a Surgeon's Assistant for the group I am working for, which includes two thoracic and cardiovascular surgeons and two pulmonary medicine/pulmonary oncology doctors, I have now begun conducting a B-protein assay on our patients. This involves drawing blood samples from as many of our patients as possible, and keeping a record of the patients' names, ages, diagnoses, and results of the B-protein assay. The 10cc blood samples are simply collected with vacutainer in a red-stoppered tube, without anticoagulant. Samples are transported to Dr. Bucovaz, who then conducts the assay and reports the results back to me in two to five days. A significant number of our patients have bronchogenic carcinoma, and as Table 1 shows, B-protein assays were positive in 96% of patients with respiratory cancer. Upon completion of our study, we will publish our results in a paper.

The following tables illustrate results of a previously conducted B-protein assay which was positive in 287 of 322 cases in which the patients had cancer, or 89% accurate. Only 11% of patients diagnosed as having cancer did not show detectable levels of B-protein in their serum. This discrepancy may be due to destruction of B-protein during collection or storage of the sample. In surveying patients without cancer, 597 or 678 showed negative B-protein assays, for an 88% accuracy. Some of the unknown group could possible have cancer, and 5 of the miscellaneous patients who were severly burned showed positive B-protein assays. Overall results were in accordance with 884 or 1000 cases, for an 88.4% accuracy.

TABLE 1: B-PROTEIN ASSAY RESULTS OF PATIENTS WITH CANCER:

Cancer Location or System	Number in Category	Test Results Positive	Negative	Positive %
Head & Neck	27	25	2	92.59
Gastro-intestional	37	33	4	89.19
Genito-urinary	107	96	11	89.72
Respiratory	26	25	1	96.15
Reticulo-endothelium	29	26	3	89.66
Integument	9	7	2	77.78
Breast	45	35	10	77.78
Other	8	7	1	87.50
Unknown	34	33	1	97.06
Total	322	287	35	89.13

TABLE 2: B-PROTEIN ASSAY RESULTS OF PATIENTS IN CONTROL GROUP.

Patient Type *	Number in Category	Test Results * Positive	Negative	Negative %
Cardiovascular	28	1	27	96.43
Orthopedic	81	6	75	92.59
Gynecological	19	1	18	94.74
Obstetrical	246	32	214	86.99
Surgical	50	3	47	94.00
Medical	42	2	40	95.24
Neurological	32	4	28	87.75
Miscellaneous	31	9	22	70.97
Unknown	149	23	126	84.56
Total	678	81	597	88.05

*Information was provided by the physician or obtained from medical records.
*A positive test result indicates the presence of cancer, a negative test result indicates the absence of cancer.

Still to be clarified is the stage of cancer during which B-protein is produced, and exactly what B-protein is. In most patients included in Dr. Bucovaz's study, cancer had already been diagnosed or was highly suspected before the B-protein assay was performed. It is not necessary for a cancer to be widespread before the assay is positive; consequently, metastasis may occur much earlier than believed. Hopefully the B-protein assay will detect the presence of cancer much earlier than present diagnostic methods.

Susi Chandler, S.A.
UAB Graduate 1975
Memphis, Tenn.

Ref:

Bucovaz, E.T., Morrison, J.C., Morrison, W. C., and Whybrew (Jan. 1977). Assay for the Detection of a Protein Component in the Serum of Individuals with Cancer. Journal of the Tennessee Academy of Science, Volume 52, Number 1.

POLITICAL UPDATE

AND

GRADUATES AT WORK

Developments from VA Hospital, Birmingham

The last newsletter included information concerning Preston Scarber, and his fight for employment under the Physician's Assistant code in the Veterans Administration. Preston sent us some information concerning recent developments of this situation that we would like to share with you.

The most interesting and frustating is a letter to Preston's lawyer from Dr. John Chase, Chief Medical Director of the VA Administration. He states "VA Circular 00-75-40, which implemented the provisions of Public Law 94-123 relating to employment of PA's, provides that a candidate must have graduated from an AMA-approved PA training program. Paragraph 13 of this circular further provides that pending issuance of further instructions, PA's will be utilized in accordance with the guidelines authorized in VA Department of Medicine and Surgery Circular 10-72-252 This circular, under Guidelines, paragraph I.B., specifies that these guidelines for utilization of PA's are applicable only to PA's who have been trained to assist physicians providing primary care to patients, and that guidelines applicable to other areas, e.g., surgery, will be determined and issued seperately by VA Central Office. Such other guidelines have not been issued." He also said that successful completion of the National Certification Examination for Assistants to the Primary Care Physician may not be substituted for the training program requirement. Further more he states "Should we find that employment of PA's with specialized training, such as surgeon's assistants, would enhance the quality of medical care, we would provide for their utilization under Title 38 personnel system."

Preston feels that the only way to fight this problem if thru letters to key people. He urges all of us to write out Congressman, in our own handwriting. Key points to mention are:

1) The UAB Program is a type A program and is accredited by ACS and AMA. It is also a BS degree program.
2) The didactics of this program and the PA program were taught together with more emphasis on surgical aspects for graduates of our program.
3) The Veteran Hospital funds this program, or did until recently, and has done studies to validate the need for SA's in the VA system.
4) The Veteran's Hospital allows PA's to work in a surgical environment but will not hire people it actively takes a role in educating

We should all do our part in making this matter known to our Congressman . . . for the sake of our profession. We will keep you informed on further developments.

Becky Starkey

Possible Cancellation of Presription Writing Privileges for PA's in New York State.

In Feb. 1977, Assemblyman H. Miller introduced an act to the New York State Assembly to revoke the privileges currently extended to PA's and Specialist's Assistants to write medical orders and prescriptions. Current N.Y. law states that prescriptions and medical orders can only be written by a PA when assigned by the supervising physician. Ed Brown, PA, Chairman of the N.Y. State Council of PA Program Directors

spoke at a hearing on this bill on May 13, 1977. Here are some of the excerts from his testimony:

"Some studies have revealed increases in the efficiency level of the physician ranging from 33% to 50% by incorporating a PA in the practice setting. Studies reported a lower cost to the patient although the quality and amount of service is expanded."

"I submit that with the rigorous on-going training combined with the stringent certification procedures which PA's undergo, their competence to prescribe non-controlled substances, to write medical orders, or to carry out any medical tasks delegated to them by their supervising physicians, cannot be seriously questioned."

We shall all look forward with continued interest to the outcome of this situation

Information provided by Howard Rose, SA
Cornell Graduate

POLITICAL UPDATE: Current Legislation in Georgia and Michigan Regarding Physician's Assistants

Georgia

Prior to assuming any duties in the hospital other than assisting in surgery, the P.A./S.A. must be certified by the State Board of Medical Examiners. The following items are required as part of the application for certification:

Verification of his or her creditials by the director of the PA/SA program the applicant attended
Two personal references
Job description completed by the physician employer
Fee of $100

The Board meets once to approve or disapprove of the application. At the next meeting the PA/SA and his employing surgeon are interviewed in detail about job responsibilities, duties and restrictions. At this time the N.C.C.P.A. exam is not required for certification, so the Board passes judgement on the application after the second meeting.

Next the PA/SA can apply for full hospital priveleges with the submission of the following data:

Curriculum Vitae
Two personal references
A copy of the application for State Certification
A copy of the job description as approved by the State Board
A copy of Certification from State Board
List of all doctors the PA/SA will assist

The hospital's Medical Staff Board and Executive Committee then convenes to decide on whether or not to grant full or partial privileges to the PA/ SA.

Two UAB graduates, Paul Lamprey and James Boutselis, are now employed by general surgeons in Rome, Georgia. They have the same list of duties as those given out by the UAB entitled "Scope of Duties". The only functions that they cannot perform are inserting chest tubes, irrigating and removing endotracheal tubes, inserting CVP lines and reducing fractures.

Information provided by Paul Lamprey S.A.
Rome, Ga.

MICHIGAN

A committee of eight people governs the registration liscenture of each PA working in the state of Michigan. Four committee members are PA's, two members are physicians, one member is a person who is not a medical care provider and one member is the director. The applicant registers with this committee with his sponsoring physician. Currently, PA's cannot practice without direct supervision by their doctor or being within reach by telephone. The PA's may write prescriptions for any medicines except those listed as controlled drug items. Current state licensure for PA's is granted to those people who have either completed a formal training program accredited by the A.M.A. or passed the N.C.C.P.A. exam. Renewal of approval of the PA's license is required every six years with demonstration of continuing competence. Current legislation restricts the PA from performing refractive eye exams or prescribe spectacles for correction of visual anomolies. Except in emergency situations, the PA shall only provide medical care services in the scope of the supervising physician. A notable aspect of the Michigan legislation is that it states any person who practices as a PA without approval is guilty of a felony

punishable by a fine of $1,000 to $5,000 or 1 year imprisonment.

Information provided by Dean Blietz, S.A.
Grand Rapids, Michigan

General Surgery in Rome, Georgia

Rome, Georgia is a town of about thirty-five to forty thousand. The income here is generated chiefly by textiles. There are two main hospitals, Floyd County Medical Center which has 360 beds and Redmond Park Hospital which is Hospital Corporation of America affiliated and has 150 beds.

I work for Dr. Boyce Brice, a general surgeon, who works out of The Harbin Clinic, a thirty-five physician multi-specialty clinic. I first assist on all his cases; and we do approximately twelve to fifteen cases per week ranging from all types of GI surgery, mastectomies, thyroidectomies, neck dissections, thoracotomies, and hysterectomies.

There are two other surgeons in the clinic I occasionally help. One is a general surgeon with whom, SA Paul Lamprey recently signed; and the other is a peripheral vascular surgeon.

Paul and I share night and weekend call one week at a time. We carry beepers, thus eliminating in-house call; and as the nurses gradually get to know us, we are beginning to get called more frequently at night, mostly for minor problems concerning post-op care. We take no emergency room call and are required to leave for the hospital in the middle of the night only if something comes through the E.R. that need surgery when out doctor happens to be on call.

Typically, my day starts at 6:00 or 6:30 a.m. making pre-op rounds alone. Surgery begins at 8:00 and usually lasts until noon or 1:00 p.m., after which rounds are made jointly. Office hours start at 2:00 p.m. The only time I help Dr. Brice in his office is to assist on some minor surgery on Friday afternoons. If he does not need me for anything, I am usually free on most afternoons by 3:00 p.m. or so.

Privileges granted me by the hospitals include: rounding alone, writing any order, dictating, performing histories and physicials, drawing blood, removing chest tubes, and wound care. I can write prescriptions by they must be countersigned by Dr. Brice. Although I am allowed by law to do H&P's, Dr. Brice prefers to dictate the charts himself. Things that the state will not let me do include: inserting chest tubes, establishing a subclavian line, or doing lumbar punctures.

Working for The Harbin Clinic entitles one to several benefits, some of which include discounts for medical services for my dependents and myself, a free annual physical exam, free malpractice insurance, free BCBS, two weeks vacation after one year of employment, and a pension plan. I have no arrangement for CME requirements in my contract. My salary is fifteen thousand per year.

There are seven P.A.'s in Rome. Surgeon Assistants in the state of Georgia are classified as Physician Assistants, and as such are required to be state certified which is a time consuming but not difficult process. My arrival in September was met with a generally favorable attitude. I have had very good acceptance and cooperation with the nursing staff here. In my opinion, the doctors here are split fifty-fifty on the issue of P.A.'s.

In general, I am pleased with the way things are going at present and am confident that slowly the situation will become even better for P.A.'s in Georgia.

James Boutselis, S.A.
Graduate of U.A.B. S.A. Program 1976

JACKSONVILLE CARDIOVASCULAR SURGEONS ARE ASSISTED BY GORDON MALONE

Gordon Malone, a 1974 graduate of the U.A.B. Surgeon's Assistant Program and a certified Physician's Assistant is now working with three Cardiovascular surgeons in two hospitals in Jacksonville, Florida. Gordon, also a Certified Operating Room Technician and Registered Cardio-Pulmonary Bypass Pump Technician, has a strong clinical and academic background for his current position. His duties and responsibilities are as varied as his training.

In-hospital work includes taking medical histories and performing physical exams for both General and Cardiovascular surgery patients. He is currently responsible for the discharge summaries of all the heart patients. While making hospital rounds (often independently) he takes care of dressing changes, suture removal, removal of chest tubes, etc. As the First Assistant in surgery, Gordon is responsible for removing the saphenous vein and closing the chest as well as assisting throughout the case.

Outside the operating room Gordon assists with pacemaker implantations done under fluroscopy in the Radiology Department. Here he also assists with arteriograms. At this time Gordon is responsible for ordering all the supplies for heart surgery. Occasionally, he gives in-service cardiology lectures and attends cardiology conferences held in Jacksonville.

Gordon also has another set of duties as the Heart-Lung Perfusionist who operates the cardio-plumonary bypass pump for all cardiovascular cases at St. Lukes Hospital. At this hospital he sets up and maintains all the monitoring equipment and assists with heart catheterizations. The "Heart Team" expects Gordon to order all of the by-pass and monitoring equipment as well as to make sure that they are kept abreast of current innovations in the field of cardiovascular surgery.

Like all Surgeon's Assistants Gordon has a few restrictions on his duties. He cannot write a prescription; and his orders must be countersigned or orally authenticated by a M.D. The physician must be present within the hospital during surgery unless there is a "life threatening emergency." In that instance, the surgeon must be "notified and on the way." Gordon cannot admit a patient to the hospital unless he has been authorized to do so by a M.D.

Current legal restrictions on the activities of Physician's Assistants in the state of Florida require the Physician's Assistants to be licensed by the Board of Medical Examiners. Various types of licensure are granted according to whether or not the applicant has graduated from a two year American Medical Association approved program and is eligible for certification (by National P.A. exam). All other restrictions are imposed by individual hospitals.

Gordon who has been with his current employers for two and a half years, says that his rapport with and acceptance by the local medical community is good. Occasionally his surgical talents are actively sought by other general and neurosurgeons in the hospital. Other Physicians Assistants in Jacksonville report that their career is well respected and accepted by all parties involved.

Jean Cary


PA
HUMOR
FIX

PATIENT PERCEPTIONS

A lady who had previously had aspiration of a breast mass told the admitting nurse that she had been diagnosed as having "Asphixation of the breast".

An elderly patient who complained of low back pain said he's been seeing a "chiropractical" for several years who broke "all his verticles".

The attending physician walked into Farmer Jasper's room just as he was sweetening his morning coffee with Lubafax. "This melted new-fangled sugar shore is a great idea, Doc, but it takes three packs to sweeten one cup of coffee!"

Gynecologists in charity hospitals say that one of the more frequent statements their female patients make is, "My other doctor said that I need a complete hyster-rectum because I've got uterine fireballs."

Have you ever heard of bowel obstruction secondary to "adhesives"?

When asked if she had any breast lumps or masses, the dignified 85 year old woman flopped her two pendulous breasts out from under the sheet and announced, "No, but I've got these two big titties!"

One of my patients spent twenty minutes trying to convince me that she'd had a pacemaker implanted in her ear. "You can't see it anymore because it fell down inside my ear when I fell several months ago."

The post-vasectomy patient was told that he would still be fertile for about 2-3 months. He was instructed to bring the doctor a fresh sperm specimen after he'd had sexual intercourse with his wife 20 times. "Does it have to be with my wife?" querried the patient. About four o'clock the same day, the same patient called the doctor at his office. "Doc how many times do I have to have intercourse before I bring you that sample," he asked panting.

A MATTER OF DYING

A referring physician called and requested that a patient be sent over immediately because of emphysema and cyanosis. Upon arrival to the floor the nurse called me to "please come see this patient immediately he's very cyanotic". I went to the patient's room, quickly assessed him, and noticed that his hands were very blue, but streaked blue. The patient also had on a new blue plaid robe. Putting my SA mind into action, I looked beneath his collar to find that some of the blue dye had also rubbed off on his neck.

Becky Starkey

SUTURE SELF

Months of anticipation came to a climax as we prepared to embark on a journey which would take us to the fifth annual convention for Allied Health Practitioners, or was that Physicians Assistants--or was that assistants to the physicians? Anyway, we were ready for Houston come hell or high water and it turned out that we got a little of each.

Some of us came seeking the ever-elusive CME credits, some to cavort with a few friends. Some of us even came to learn something new about our professions and to commiserate with out colleagues about the lack of national understanding toward ourselves. But mostly it was nice to get away from the "primary care" or "surgical setting" and have a little fun--very little.

The airline trip was interesting. Who would have thought that for the meager air fare from Spokane, Washington, to Houston, Texas, we would be able to get a tour of four fifths of the continental United States. We almost had an opportunity to visit Havana but we encouraged the fellow with the beard, cigar, and army fatigues to deplane over Memphis. The flight crew was congenial--They say the pilot's new glasses should be in any day now, and reports are that Miss Watts' (the stewardess) reconstructive surgery was a success.

The convention was housed at the famous Houston ASTRO DOME. Acutally the event found itself situated in the Astro World Hotel complex which is somewhat less renown. The hotel, however, was not without it's benefits. Where else but in the ASTRO WORLD HOTEL can you find restaurants that provide less than 32 flavors of ice cream (i.e. none!!), no milk, a shortage of toothpicks, and one apple pie for 1500 people (judged by the sizes of the slices)? Why, nowhere, by George!! This was gourmet dining at it's finest and at only 45% more cost than any similar institution in the U.S.A. or territories (I hope). The cafe' staff was quick and courteous - (I expect to get my dessert next Thursday)-and there were rumors that the cashiers were all going to be sent to Abilene for a course in advanced remedial arithmetic.

The hotel facilities were unique--for only $32.00 per day, you had an option for a spacious room.--With luck there was a sofa provided to sleep on and authentic Texas drapes to wrap oneself in. Or, you could opt for the jewelry service where they remove up to $700.00 worth of jewelry at no expense to the owner.

Once situated in our respective units, we were eager for the meetings to start. The programs proceeded as follows:

Monday-six and one half hours of various hello's consisting of the (1) mayoral hello (mayor unable to attend), (2) Texas hello (which dispelled all myths about the size of Texas welcomes), and finally (3) the general hello which we said to each other as we prepared to depart for the cocktail lounge.

Monday Night- Reception which consisted of one complimentary coke. There-after all drinks were $8.00 each.

Tuesday- Teaching machines--where, in the time span of thirty minutes, practitioners demonstrated their amazing ability to accrue thirty hours of Class I CME credits. It was also interesting to see the comradery which developed as fifty per cent of the conventioneers simultaneously pressed in to learn at the 24 teaching

machines situated within a 12' x 20' room--never have so many come to learn so little from so few.

Tues. night- Tex Mex reception--a real highlight. There was an open bar reception lasting from 7:00 p.m. to 7:30 p.m. with entertainment provided by one of the conventioneers, who elected to swim in the guacamole dip.

Wednesday- Spouses Tour. Sights of interest included K-Mart, Pay 'n Pak, and White's Discount Basement.

Thursday - Convention called on account of rain.

The fifth annual P.A. conference was enjoyed by some! We left with definite opinions about our profession and our collegues. Tantamount in our goals for the future are:

1) Promote more females into the field so that the odds at the future conventions will be better than 60:1.
2) Design the certification exam so that any nurse or O.R. tech who attempts to take it will immediately self destruct.
3) Abolish supervising physicians who try to take credit for our cures.
4) Pass legislation allowing people only to be sick between 8 a.m. and 5 p.m., Monday through Friday, except holidays.

In summary, we hope everyone will start making plans for next year's convention in Las Vegas--it's bound to be fun. After all, it's not Houston.

Respectfully submitted,
Michael T. Moormann, SA

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