

Academic Physician Quarterly

A DEPARTMENT OF MEDICINE BULLETIN



UF UNIVERSITY of FLORIDA
College of Medicine
Jacksonville

FOCUS

Page 2

GME CORNER

Page 3

CLINICAL CASE

Page 4

RX UPDATES

Page 5

MEET YOUR COLLEAGUES

Page 6

NEWS AND NOTES

Page 7

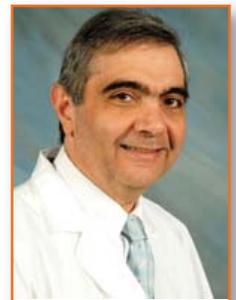
UF HEALTH JACKSONVILLE

Page 7

CHAIRMAN'S MESSAGE

Dear colleagues:

July is the month when the new academic year kicks off. The achievements of the faculty and trainees over the last academic year were remarkable. I am pleased to announce that the Department of Medicine once again had a successful presence at the Research Day on May 16th, 2013. About 37% of platform and poster presentations of fellows and residents were made by the members of the department. Of the platform presentations, Dr. Andrew Darlington was the first place prize winner and Dr. Garry McCulloch received fifth place. Among the poster presentations, Dr. Camille McGaw was the second place prize winner, Dr. Estela Thano received fourth place and Dr. Sumit Narula received the fifth place. I am very happy to see that the research productivity of our house staff remains excellent.



I invite you to read the focus section of this issue that discusses nutrition deficiency in the elderly. This is an important and timely topic that has clinical relevance to the care of rapidly expanding geriatric patient population.

An exciting development in our organization is the rebranding of our institution as University of Florida Health. Please read more about this on the last page of the newsletter.

The new academic year will not be less challenging than the previous ones. I am confident that the rewards and self-fulfillment the faculty and staff derive of practicing medicine at UF Health will continue to be as great if not greater than the previous years.

Arshag D. Mooradian, MD
Professor of Medicine
Chairman, Department of Medicine

Bijo K. John, MD, Melvin Bullock, MD, Lacie Brenner, MD, Camille McGaw, MD, and James Scolapio, MD
 Division of Gastroenterology, Department of Medicine
 University of Florida College of Medicine-Jacksonville

Nutrition Deficiency in the Elderly: Frequently Asked Questions

What is the prevalence?

Depending on the population investigated and the definitions used the data on the prevalence of malnutrition vary considerably. Using the Mini Nutritional Assessment (MNA), the prevalence of malnutrition in more than 10,000 elderly persons studied was 1% to 5% in the community and outpatient setting, 20% among hospitalized older patients, and 37% in institutionalized elderly patients.

Using protein-energy malnutrition as a criterion for malnutrition the prevalence ranged from 30-65% in hospitalized patients to 25-60% in patients living in nursing homes (NH) and long term facilities.

What does “failure to thrive” mean in the elderly?

The term failure to thrive was originally described in newborns and infants and was subsequently adapted to describe a state of decline in geriatric patients, with weight loss, decline in physical activities and or cognitive function and signs of depression with hopelessness and helplessness. Despite its own international Classification of Diseases, Ninth Revision (ICD-9) code since 1979, some authorities advocate abandoning the term and recommend targeting on four key areas predictive of adverse outcomes in older adults: impaired physical functioning, malnutrition, depression, and cognitive impairment. Irrespective of the definition used, early recognition and management of failure to thrive can reduce the risk of further functional deterioration, hospitalization, or nursing home placement.

How do we assess the nutritional state?

A comprehensive nutritional evaluation and screening includes a detailed history and physical examination including weighing the patient in addition to a more specific nutrition-oriented assessment.

History of recent weight loss, difficulties with eating or chewing food, physical impairment, living situation, social issues, alcohol intake and medication intake can provide valuable information and identify those at risk of malnutrition. In the elderly, unintentional weight loss of >5% in the past 1 month or >10% within the previous 6 months is associated with increased morbidity and mortality and post-operative complications. Additional data, which include a 24-hour food recall and food diaries although less specific may be useful. Subjective and recall history in elderly patients unlike in their younger counterparts may be misleading in the setting of dementia, delirium and advanced age.

Physical examination includes assessment of the skin, hair,

oral cavity and extremities which may provide clues to protein energy malnutrition and micronutrient deficiencies. The sensitivity of physical examination for nutritional assessment is limited by the physician’s ability to recognize and interpret these on routine examinations. The utility of body mass index which can be easily calculated has its limitations in the elderly patient population due to fluid overload or loss of muscle mass. Elderly patients with a BMI of <20 Kg/m² is associated with an increased 1 year mortality. On the contrary, a study comprising of approximately 1 million adults showed that irrespective of age those with a higher BMI >30 Kg/m² are at increased risk for cardiovascular diseases and overall mortality. Waist circumference may be a more useful tool in this population.

What laboratory tests can be used to assess nutritional status?

Albumin (half-life 15-20 days) level is routinely used for nutritional assessment; however, it is an acute phase reactant and is subject to inflammatory changes with cytokine mediated decrease in synthesis during periods of stress. Albumin synthesis is not routinely impacted with advancing age, though some studies have shown a modest decline with aging independent of comorbidities. In a study of 262 apparently healthy elderly with no acute infections, hypoalbuminemia with levels <3.5g/dL was noted in approximately 80% of adults with limited daily activity. Hypoalbuminemia has been validated in a few studies as a risk indicator for morbidity and mortality in older adults. Hypoalbuminemia has been associated with functional limitation, sarcopenia, increased health care utilization, frequent infections and poor post-operative outcomes.

Alternatively, its precursor, Prealbumin (half-life 2-3 days) may be used, as it may reflect short term changes more accurately. It has been used routinely to assess nutritional status among hospitalized patients and to monitor response to nutritional supplementation, but as in Albumin, it is unreliable in the setting of inflammation and malignancy. The levels of C-reactive protein (CRP) and Prealbumin follow an inverse relationship, with lower levels of prealbumin seen in inflammation.

Additional biomarkers such as hemoglobin, cholesterol levels and lymphocyte count have been used to assess nutritional status in the elderly and guide nutritional support but are equally unreliable and affected frequently by confounders.

Do elderly have reduced appetite and energy intake?

The “anorexia of aging” or physiologic anorexia is defined as the age-related decrease in appetite and energy intake. In the elderly, this decrease in energy intake overshadows the age-associated decline in energy expenditure and is responsible for weight loss in this population. Body weight and BMI increase throughout adult life until age 50 to 60, after which they both decline. In a prospective study of community-dwelling American men age 65 and older, subjects lost an

[Continued on Page 3](#)

average 0.5% body weight per year with 13.1 % losing an average of 4% body weight per year.

What are the associated changes in body composition that occur with aging?

Loss of skeletal muscle, or sarcopenia, is a well-known consequence of aging, with up to 3 Kg loss of lean mass per decade after age 50. The progression of muscle wasting is associated with an increase in fat accumulation termed sarcopenic-obesity. The mean body fat content of an 80-year-old individual is twice that of a 20-year-old of the same weight. Furthermore, the distribution of fat in the elderly tends to occur intra-abdominal, intrahepatic and intramuscular, all changes that predispose one to insulin resistance.

What are the ways to improve oral intake in the elderly?

Addressing comorbid conditions in elderly and optimizing treatment is paramount to the overall nutrition and well-being in this cohort of patients. Underlying dental health, oral hygiene and swallowing difficulties must be treated before other causes. Polypharmacy, which has been addressed earlier in this topic, should be minimized whenever possible.

Restrictive therapeutic diets should be minimized as much as possible. In one study, energy intake in the elderly improved when increasing the frequency of meals and mid-meal snacking. Adding 2 between meal snacks per day increased intake by 600 K cal/day and 12 g protein/day and was associated with shorter length of stay among hospitalized patients.

Oral supplementation with high energy and protein rich liquids are routinely employed both in hospitals and as outpatient. Oral supplementation had shown benefits in the post-operative period in hospitalized patients. Some of the commercially available oral supplements are shown in the Table below. Compliance in elderly was improved when low volume (60 ml x 3-4 times daily) energy and protein rich solutions were used in between meals with increased mean calorie intake. Such measures are more readily available and easier to achieve in institutionalized geriatric patients as opposed to elderly living alone at home with limited social support where compliance continues to be an issue. When available, liquid oral supplements are preferred over solids due to improved gastric emptying time, compliance and tolerability. A recent Cochrane meta-analysis evaluating the

benefits of oral supplements showed improved weight gain and mortality in older people with no evidence of improvement in clinical outcome, functional benefit or reduction in length of hospital stay with these supplements. Caution must be used while prescribing them on a regular basis as they can sometime worsen malnutrition when used as meal replacements instead of supplements.

Is there a role for appetite stimulants and anabolic agents?

Product (usually 8 fl oz./237 ml)	Protein per serving	Calories per serving
Ensure®	8.8	250
Resource®	9	250
Boost®	10	240
Sustacal®	14.5	240
Glucerna Snack Shake®	7	140

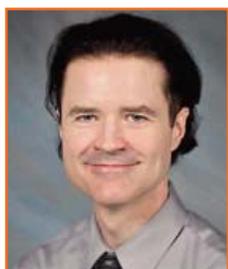
Megestrol acetate, a synthetic progesterone agent, at a dose of 800 mg daily over 12 weeks has been shown to improve appetite and well-being in NH patients with no overall increase in weight gain or survival. A meta-analysis involving 30 trials evaluating the role of Megesterol showed a benefit compared with placebo, particularly with regard to appetite improvement and weight gain in cancer patients. Adverse effects like adrenal suppression, hypoglycemia, congestive heart failure and deep vein thrombosis have been reported with use of megestrol in elderly patients hence must be used with caution.

Dronabinol, a cannabinoid derivative improves weight gain in elderly patients however its use may be limited in the older population due to its significant side effect profile.

Anabolic agents like Oxandrolone, testosterone and selective androgen receptor modulator (SARM) have been used with success in cancer and HIV patients with improvement in muscle mass, bone density, wound healing and decrease in weight loss. These must be administered only under supervision and cannot be recommended for routine treatment of anorexia and sarcopenia in elderly.

Ghrelin, an endogenous ligand for growth hormone secretagogue receptor, is negatively regulated by leptin. It increases food intake and decreases energy expenditure. It is still being evaluated as a potential agent for anorexia.

GME CORNER



Carlos Palacio, MD
 Associate Professor of Medicine
 Division of General Internal Medicine
 Associate Program Director
 Internal Medicine Residency

Providing Instruction on High-Value, Cost-Conscious Care

There is equivocal association between health care quality and cost. A recent systematic review by Hussey et al, reviewed 61 studies published between 1990 and 2012. Their results were not reassuring. In fact, only 21 studies (34%) reported that higher cost was associated with higher quality;

Continued on Page 4

18 studies (30%) reported a negative or mixed negative association; and 22 studies (36%) reported no difference or an imprecise, indeterminate association. The studies were heterogeneous in their methods and measures, limiting conclusions that can be drawn. However, this study (funded by the Robert Wood Johnson Foundation) does point to the fact that spending more money doesn't necessarily equate to better outcomes.

Improving quality of care while decreasing cost of healthcare is a national priority. One way of addressing this is by using performance measures that target low-value services. These are services for which harms likely exceed benefit, and those for which a trade-off between health benefits and expenditures is undesirable. An example would be colorectal cancer screening for patients older than 85 in whom any small benefit in detecting polyps or early colorectal cancer is outweighed by possible harm from colonic perforation or competing risk of death from other causes. Performance methods of assessing for low-value services still need to be developed and tested. An evidence base of this type may help physicians provide high-value care.

Health care expenditures are projected to reach 19.8% by 2020. \$765 billion of this spending (30%) has been identified as potentially avoidable with many of the avoidable costs attributed to unnecessary services. Approximately \$395 billion may be physician-controlled, with \$210 billion attributable to unnecessary services, \$130 billion attributable to inefficiently delivered care, and \$55 billion attributable to missed prevention opportunities.

Post-graduate trainees have historically received little specific training in the stewardship of healthcare resources and little feedback on resource utilization with its attendant effect on cost of care. In response, the Alliance for Academic Internal Medicine (AAIM), and the American College of Physicians (ACP) have created a curriculum which attempts to address this training gap. The curriculum consists of ten one-hour case-based sessions designed to be flexible enough to incorporate into the existing conference structure of a residency training program. The curriculum seeks to

incorporate principles of high-value, cost-conscious care into residency training programs. Slowing the increase of health-care costs while preserving high-quality care means that physicians must focus on medical interventions that provide good value (balancing potential benefits against potential harms and costs).

The AAIM-ACP Curriculum Development Committee has identified several metrics to assess utilization and effectiveness of the curriculum through surveys of participants who are and are not exposed to it. Additionally, they have developed a method to identify questions on high-value care in the Internal Medicine In-Training Exam so that a subscore for high-value care can be generated for each resident and the residency program starting with the 2012 examination. Comparisons can then be made between programs that implement the curriculum and those that don't.

Residency training is a good place to start education about high-value care. However, training about high-value care is not just limited to residency training. A broader audience including fellows, specialists, and practicing physicians may well benefit in the near future.

Further information about the ACP-AAIM curriculum on high-value, cost-conscious care can be found at: www.highvaluecarecurriculum.org

The curriculum is available for programs (including ours) to review and incorporate as appropriate into their didactic activities.

REFERENCES:

1. Hussey PS, Wertheimer S, Mehrotra A. The association between health care quality and cost: a systematic review. *Ann Intern Med.* 2013 Jan 1;158(1):27-34.
2. Baker DW, Qaseem A, Reynolds PP, Gardner LA, Schneider EC; American College of Physicians Performance Measurement Committee. Design and use of performance measures to decrease low-value services and achieve cost-conscious care. *Ann Intern Med.* 2013 Jan 1;158(1):55-9.
3. Smith CD; Alliance for Academic Internal Medicine-American College of Physicians High Value; Cost-Conscious Care Curriculum Development Committee. Teaching high-value, cost-conscious care to residents: the Alliance for Academic Internal Medicine-American College of Physicians Curriculum. *Ann Intern Med.* 2012 Aug 21;157(4):284-6.
4. Logio L, Dine CJ, Smith, CD; High-Value, Cost-Conscious Care: Less is More. *Academic Internal Medicine Insight.* 2013 11:1; 16-7.

A CLINICAL CASE

Tanya Reimschissel, DO, Assistant Professor of Medicine
Division of General Internal Medicine, Department of
Medicine, University of Florida COM-Jacksonville

Levamisole-Adulterated Cocaine Induced Vasculitis: A Case Report

CASE REPORT

A 46-year-old Caucasian woman presented to the Emergency Department with a one year history of multiple painful, purpuric skin lesions "rashes and blisters" on her face, nose, ear lobes, extremities and toes that worsened after nasal inhalation of cocaine. Necrotic skin ulcerations were treated

with surgical debridement at a local hospital. She gave a two-year history of polyarthralgias of knees and hands with subjective fever, chills, sore throat, and dry cough. Past medical history included hepatitis C, pericardial effusion, chronic pain and pericardial window, 4 months prior to admission. Physical examination revealed necrotic lesions of left heel, right second and third toe, and left second toe tips. Laboratory results included WBC- 4.1, hemoglobin of- 10.5, hematocrit of- 32.7, creatinine- 1.59 , anion gap- 19, phosphorus- 6.0, lactic acid- 3.4, hepatitis C antibody was positive. Urinalysis showed protein- 30

Other pertinent labs included: Positive P- ANCA and

atypical ANCA and positive proteinase 3 antibody (PR3), rheumatoid Factor, anti-beta2-glycoprotein 1 and apolipoprotein H. Pertinent negative laboratory findings included: ANA, C3, C4; ds DNA Antibody; Anti Smith Antigen IGG; ENA SSA (RO), SSB (LA) Antibody; C-ANCA; qualitative cryoglobulin, cryofibrinogen; anti-citrullinated protein antibody; Hepatitis A, B and HIV, SPEP and UPEP. Urine toxicology revealed cocaine metabolites and wound culture grew MRSA, enterococcus and Candida species. Skin biopsy of the left lower extremity showed epidermal erosion, mixed inflammatory infiltrate with lymphocytes, histiocytes, occasional neutrophils and eosinophils.

DISCUSSION

The diagnosis of ANCA vasculitis secondary to levamisole adulterated cocaine was made based on history and presentation of skin lesions and their location. Positive cocaine metabolites on urine toxicology. Positive P-ANCA, Atypical ANCA, PR3.

In 2008, 5.3 million people were using cocaine in the United States¹. Data from July 2009 estimated that 69% of cocaine obtained by the U.S. Drug Enforcement Administration is tainted with levamisole². Analysis of cocaine users in Seattle, Washington estimated 80% of users who tested positive for cocaine also tested positive for levamisole². Since 2009 levamisole has been linked to ANCA vasculitis in cocaine users¹. Massachusetts General Hospital ANCA laboratory reported 30 patients who presented between 2009-2010 with ANCA vasculitis in levamisole contaminated cocaine users⁴. Levamisole-induced vasculitis is more common in females¹. Levamisole was originally used as a broad-spectrum anthelmintic medication to treat worm infestations in humans and animals^{1,2}. In the 1970s it was used as a disease-modifying antirheumatic drug to treat rheumatoid arthritis². In 1990, the United States Food and Drug Administration (FDA) approved its use with 5-fluorouracil for colon-rectal cancer treatment^{2,7}. However, in 2000 the FDA withdrew levamisole for use in humans due to reports of agranulocytosis, thrombocytopenia, arthritis and vasculitis¹.

Levamisole is an agonist at nicotinic acetylcholine receptors of nematodes that results in paralysis of the parasite². It is also an immunomodulator that increases macrophage and neutrophil chemotaxis², T-cell lymphocyte function² and immune stimulating effects producing antineutrophil cytoplasmic antibodies leading to ANCA positivity⁷. Levamisole augments dopamine and endogenous opiates levels in the brain⁷ and is metabolized into aminorex, an amphetamine derivative with stimulant effects similar to cocaine^{1,2}.

The treatment of this disease is cessation of cocaine and supportive care including antibiotics, wound care, surgical debridement, amputation and skin grafts. Steroids and plasmapheresis have been used with some success^{1,5,8}.

CONCLUSION

Levamisole-adulterated cocaine use is becoming more prevalent in the United States. Health care providers should be educated to this emerging health risk. Patients presenting with retiform purpuric skin lesions involving the ears, face, nose and extremities may have levamisole induced vasculitis. A history of cocaine use should be investigated and the appropriate testing and treatment performed.

REFERENCES

1. Arora N, Jain T, Bhanot R, Natesan S. Levamisole-induced leukocytoclastic vasculitis and neutropenia in a patient with cocaine use: An extensive case with necrosis of skin, soft tissue and cartilage. *Addict Sci Clin Pract.* 2012; 7(1):19.
2. Lee K, Ladizinski B, Federman D. Complications Associated with Use of Levamisole-Contaminated Cocaine: An Emerging Public Health Challenge. *Mayo Clin Proc.* 2012;87(6):581-586.
3. Casale JF, Corbeil EM, Patrick AH. Identification of Levamisole impurities found in illicit cocaine exhibits. *Microgram J.* 2008; 6(3-4):82-89.
4. Stone J. Clinical spectrum of antineutrophil cytoplasmic antibodies. *UpToDate.* Jan 2, 2013.
5. Carter M, Amirhaeri S. p-ANCA-Associated Vasculitis caused by levamisole -adulterated cocaine: A Case Report. *Case Rep Emerg Med.* 2013; 5:878-903
6. Gross RL, Brucker J, Bahce-Altuntas A, Abadi MA, Lipoff J, Kotlyar D, Barland P, Putterman C. A novel cutaneous vasculitis syndrome induced by levamisole-contaminated cocaine. *Clin Rheumatol.* 2011;30(10):1385-1392.
7. Sanchez-Cruz A, Marrero S, Betancourt J et al. Cocaine Induced Vasculitis; Have We Found a Culprit? *Case Reports in Rheumatology.* Volume 2012, Article ID 982361.
8. Tran H, Tan D, Marnejon T. Cutaneous vasculopathy with levamisole-adulterated cocaine. *Clinical Medicine & Research.* 2013, Volume 11, Number 1:26-30.
9. Wiesner, O, Russel KA, Lee AS, et al. Antineutrophil Cytoplasmic Antibodies reacting with human neutrophil elastase as a diagnostic marker for cocaine-induced midline destructive lesions but not autoimmune vasculitis. *Arthritis Rheum.* 2004;Sep;50(9):2954-65.
10. Smith CM, Reynard AM. *Textbook of Pharmacology.* Phila, PA; 1992.

RX UPDATES

By: Andrew Gatton, Pharm.D.
PGY1 Pharmacy Resident

REMS: A New Strategy to Slow the Opioid Epidemic

Reprinted from Drug Update Volume 29, Number 4; September-December 2012 with permission.

The use of long-acting opioid medications for management of chronic, non-cancer pain has been increasing since the 1980s. Unfortunately, an epidemic of opioid misuse, abuse, addiction, and mortality has also been associated with this timeframe. To combat this "opioid epidemic," on July 9, 2012, the Food and Drug Administration approved a risk evaluation and mitigation strategy (REMS) program for extended-

release (ER) and long-acting (LA) opioid medications. The FDA enacted this program based on the growing prevalence of inappropriate use and overdose of these medications in the community. The objective of the REMS program is to decrease serious adverse outcomes resulting from inappropriate prescribing, misuse, and abuse of opioid analgesics, while also promoting safe and effective use of the medications, when needed for pain management.

Under the FDA Amendments Act of 2007, the FDA may require manufacturers to develop and implement a REMS program for medications that are efficacious, but have the potential to cause serious harm. Each REMS program may include different requirements based on the risks associated with the medication. The FDA may mandate REMS

Continued on Page 6

programs to contain one or more of the following items:

- MedGuides (standardized patient education leaflets)
- Communication plans
- Healthcare Professional letters (e.g., “Dear Doctor” and “Dear Pharmacist”)
- Continuing education (CE)
- Elements to assure safe use (ETASU), such as:
- Specialized training, education or certification of prescribers or other healthcare providers
- Certification of pharmacies
- Restrictions limiting dispensing to patients in certain settings
- Patient monitoring or registry

A list of the more than 100 products for which REMS programs exist can be found at: www.fda.gov/Drugs. Currently, more than 20 companies and greater than 30 products (NDAs and ANDAs) are affected by the new ER/LA opioid REMS program. At this time, short-acting opioids are not affected. Table 1 shows a list of affected products included in the Formulary at Shands Jacksonville.

Initially, many stakeholders expressed concern that the opioid REMS program would be unduly burdensome to prescribers, pharmacists and/or patients. As a result, the burden of the new ER/LA Opioid REMS program primarily falls upon manufacturers. The REMS program requires manufacturers of ER/LA opioid analgesics to make voluntary continuing education programs available to prescribers. It is

expected that manufacturers will meet this requirement by working with accredited CE providers to offer educational grants for training prescribers at no or nominal cost. The FDA expect manufacturers to make continuing education sessions available to prescribers by March 1, 2013.

The REMS program will also require standardized patient counseling documents that prescribers must distribute to patients. Patients will also receive an updated MedGuide from pharmacies with each prescription fill, which contains consumer-friendly information on the safe use and disposal of ER/LA opioid analgesics.

Table 1: Formulary Products Affected by the ER/LA Opioid REMS Program

Generic Name	Brand Name
Fentanyl transdermal system	Duragesic®
Methadone hydrochloride tablets	Dolophine®
Morphine sulfate controlled-release tablets	MS Contin®
Oxycodone hydrochloride controlled-release tablets	OxyContin®

At this time, healthcare providers are not required to complete an ER/LA opioid analgesic REMS training program to prescribe these medications. However, the FDA may eventually require such training if initial REMS assessments indicate a need. The FDA supports eventually linking this continuing education requirement to DEA registration; but at present, participation in prescriber education programs is voluntary.

MEET YOUR COLLEAGUES



Diana Mercado, MD, Assistant Professor, Division of Infectious Disease

Dr. Mercado earned her medical degree from the University of Philippines. She completed her residency in Internal Medicine and Pediatrics at Albert Einstein Medical Center and she completed her Infectious Disease fellowship at Drexel University both in Philadelphia, PA.



Ambar Patel, MD, Assistant Professor, Division of Cardiology

Dr. Patel earned his medical degree from the University of Florida in Gainesville. He completed his residency in Internal Medicine at the Medical College of Georgia and his fellowship in Cardiovascular Disease at the University of Florida College of Medicine-Jacksonville .



Vandana Seeram, MD, Assistant Professor, Division of Pulmonary, Critical Care & Sleep Medicine

Dr. Seeram earned her medical degree from the University of West Idies. She completed her residency in Family Medicine at McLaren Regional Medical Center and her residency in Internal Medicine and her fellowship in Pulmonary and Critical Care Medicine at the University of Florida College of Medicine-Jacksonville .



Siva Suryadevara MD, Assistant Professor, Division of Cardiology

Dr. Suryadevara earned his medical degree from the University of West Idies. He completed his residency in Internal Medicine and his fellowships in Cardiovascular Disease and Interventional Cardiology at the University of Florida College of Medicine-Jacksonville .

Successful Research Day

The Department of Medicine once again this year had a successful presence at the Research Day on May 16th, 2013.

About 37% of platform and poster presentations of fellows and residents were made by the members of the department. Of the platform presentations Dr. Andrew Darlington was the first place prize winner and Dr. Garry McCulloch received the fifth place prize. Among the poster presentations Dr. Camille McGaw was the second place prize winner, Dr. Estela Thanos received the fourth place prize and Dr. Sumit Narula received the fifth place prize.

In addition, Dr. Leighton James made an excellent presentation on behalf of Dr. Charles Heilig on the pathogenesis of diabetic nephropathy. Dr. Heilig was the 2012 Robert C. Nuss Researcher/Scholar Award recipient.

Congratulations to all the participants and especially the top prize winners.

Resident Graduation Ceremony Awards

We are pleased to announce that six members in the Department of Medicine were chosen as finalists for several awards during the 2013 University of Florida College of Medicine Resident Graduation Ceremony on June 19th, 2013.

Dr. Leighton R. James, Division of Nephrology & Hypertension, and Dr. Jeffrey House, Division of General Internal Medicine, were finalists in the faculty category for the Louis S. Russo Award for Outstanding Professionalism in Medicine. Dr. Cristian Landa, Division of General Internal Medicine, was the finalist for the College of Medicine Excellence in Student Education Award.

Dr. Andrew Darlington, Division of Cardiology, and Dr. Ronald Brown, Division of General Internal Medicine, were finalists in the resident category for the Louis S. Russo Award for Outstanding Professionalism in Medicine and Dr. Vishal Jaikaransingh, Division of General Internal Medicine, was the finalist for the Rosilie O. Saffos Outstanding Resident Teacher Award.

Among the finalists, the members of the department received

the following awards:

- Dr. Jeff House – Louis S. Russo Award for Outstanding Professionalism in Medicine, Faculty
- Dr. Cristian Landa - College of Medicine Excellence in Student Education, Faculty
- Dr. Andrew Darlington – Louis S. Russo Award for Outstanding Professionalism in Medicine, Resident

Please join me in congratulating the finalists and awardees.

Department of Medicine Chosen as Best Teaching Department

At the Senior Awards banquet in Gainesville in May, it was announced that the Department of Medicine on both the Jacksonville and Gainesville campuses was chosen as the best teaching department in the College of Medicine for the 2012-2013 academic year.

This is an annual award that is decided by a student consensus and reflects the department they feel best meets their expectations of teaching during their months of clerkship.

Congratulations to the department and thank you to all the faculty and staff who helped us earn this honor.

Dr. James Scolapio Appointed Associate Chair, Department of Medicine

We are pleased to announce that Dr. James Scolapio was appointed as Associate Chair in the Department of Medicine effective June 24, 2013.

Dr. Scolapio's contributions to the clinical excellence in this institution are widely recognized. He has effectively led the Division of Gastroenterology for many years and has served the department and the institution in multiple capacities. His academic achievements have earned him a national recognition. He is a dedicated educator and a role model for our faculty and trainees.

Dr. Scolapio will join Dr. Linda Edwards, Associate Chair, and Dr. Arshag Mooradian, Chair, to help the Department reach a new level of excellence and productivity.

UF HEALTH JACKSONVILLE

UF Health: New name signals new era in health care delivery

UF&Shands, the University of Florida Academic Health Center, is now University of Florida Health, university officials announced.

The new "umbrella" term reflects the health system's strong ties to UF, a key part of what differentiates the academic health center — with its focus on excellence in research,

teaching and patient care — from its competitors.

The move to UF Health grew out of extensive research conducted over the past year and represents the next stage in the organization's evolution as one of the nation's most successful academic health centers. The rebranding effort will help position the organization more powerfully among peers and competitors as a respected regional and national health care resource, said David S. Guzik, M.D., Ph.D., senior vice president for health affairs and president of UF Health.

Continued on Page 8

UF Health Jacksonville continued from Page 7

Broad name recognition will help attract and retain the most talented physicians, nurses, faculty, staff and students as well as secure research funding. That translates to better care, better health and better outcomes for patients.

"While our overall name is changing, our focus remains the same: to provide high-quality, patient-centered care that leads to outstanding outcomes," Guzick said. "We will continue to build on the teamwork and collaboration that is the foundation for our strength and success.

"UF Health represents who we are today," he continued.

"As an organization that does everything from leading-edge research to urgent MRIs on people and on horses, it's essential to unify our teaching, research and clinical care efforts under a single heading."

The name change does not herald a merger or acquisition between UF and Shands, nor does it alter day-to-day operations. Both are legally separate organizations whose governance and leadership structures remain the same. Employees will continue to be employed either by the university or by Shands. As UF Health is a collaboration of the UF Health Science Center and Shands, employees will help support the system's shared vision and goals, which were first outlined three years ago when the "Forward Together" strategic plan was unveiled.

The system's hospitals in Gainesville retained the Shands

name paired with UF Health. Examples include UF Health Shands Hospital, UF Health Shands Children's Hospital and UF Health Shands Rehab Hospital. However, the system's Jacksonville-based hospital, Shands Jacksonville, instead adopted a university-centric moniker (although it will remain a separate private hospital corporation working in close collaboration with the university).

"In Jacksonville, our hospital transitioned to a new name, UF Health Jacksonville," said Russ Armistead, chief executive officer for UF Health Jacksonville. "Research conducted in the fall of 2012 indicated that the hospital's tie to UF has positive brand recognition in the highly competitive Jacksonville market."

For the most part, the UF health-focused colleges and institutes retained their current names, such as the UF College of Medicine and the UF Institute on Aging. The exception is the UF Shands Cancer Center, which evolved to the UF Health Cancer Center. In Gainesville, the faculty group practice UF Physicians changed to UF Health Physicians.

"Three years ago, we put together a strategic plan that has helped us work together to better serve our patients and communities," Guzick said. "The UF Health brand embodies the achievements we have made in that process."

For more information, visit
<http://forwardtogether.ufhealth.org>.