



ACTION REPORT

BOARD OF MEDICAL QUALITY ASSURANCE

No. 34 - March 1988

End of 1987 Legislative Session Brings Changes In BMQA Laws

The Board sponsored three major legislative measures and two technical bills during the 1987 session. A third technical bill was carried over to next year.

Assembly Bill 782, authored by Assemblyman Curtis Tucker (D., Inglewood), authorizes the Board to substitute relevant postgraduate training for courses missed during medical school. It responds to a situation created by AB 1859 of 1985.

Under AB 1859, all applicants for licensure now must show they completed specific courses and clinical training in medical school. This includes 8 weeks each of surgery and medicine, 6 weeks each of pediatrics and obstetrics/gynecology, 4 weeks of psychiatry and 36 weeks of clinical electives.

A problem arose for some physicians trained outside the U.S. and Canada. Some foreign medical school curricula are short in one or more of the undergraduate clinical requirements. Under AB 1859, these applicants were required, in effect, to find a medical school which would admit them for one or two clinical clerkships. Many applicants were unsuccessful, and thus could not qualify for a California license.

Recognizing the need for flexibility in evaluating the overall content of the medical education, the Board sponsored AB 782. It gives the Division of Licensing authority to substitute post-graduate training for undergraduate clinical deficiencies. Applicants who already have completed the training may be able to proceed to licensing as soon as all other requirements are fulfilled. Those who have remaining deficiencies will be able to remediate in postgraduate programs instead of returning to medical school.

AB 783, also authored by Assemblyman Tucker, is intended to assure that physicians receive at least some postgraduate clinical training in general medicine. Under this law, any applicant who has not completed the required year of postgraduate residency prior to July 1, 1990 must include at least four months of general medicine as part of the residency.

The third major bill sponsored by the Board this year was **Senate Bill 1620**. Please see the accompanying article below.

A technical bill, **AB 1956**, authored by Assemblyman William Filante, M.D., restores a section which was inadvertently eliminated from the law last year, and clarifies the Board's authority to contract for expert medical consultants.

Finally, **AB 62**, authored by Assemblyman Wayne Grisham, gives the Board authority to collect license fees for registering spectacle lens dispensers.

New Law Tightens Reporting of Professional Discipline Peer Bodies and Others Now Must File Section 805 Reports

Governor Deukmejian recently signed into law Senate Bill 1620 which revises the hospital and health facility reporting requirements mandated by Business and Professions Code, Section 805.

This new law was authored by Senator Gary Hart, and was supported from its inception by the CMA and BMQA. It provides for stronger reporting requirements and more clearly defines which individuals and organizations are required to file reports.

Health facilities and health care service
Continued on Page 8

Special Pullout Section on Treatment of AIDS

This issue of the ACTION REPORT contains a special section on the clinical manifestations of the many opportunistic infections and related conditions which are found in patients with AIDS. It is designed to be removed and retained for reference.

We urge every physician, regardless of specialty, to become familiar with how to recognize these conditions. No specialty is immune from encounters with previously undiagnosed cases. Please write to us if you would like additional copies, or feel free to copy this material as needed.

RICHARD ANDREWS 1932 - 1987

Richard D. Andrews, member of the Division of Allied Health Professions since his appointment by Governor Deukmejian on March 11, 1985, died in Fresno September 11, 1987.

An attorney, Mr. Andrews was a lifelong resident of Fresno, where he was a partner in a general practice law firm. He received his Bachelor of Arts and Juris Doctor degrees from Stanford University, where he was on the editorial board of the Stanford Law Review.

Following two years of duty in the Air Force, he entered the practice of law in Fresno. During his career he was admitted to practice before all state and federal level courts including the U.S. Supreme Court.

Mr. Andrews was very active in civic, professional and political affairs. He was a member of the American Bar Association, as well as the California State and Fresno County Bar Associations. He also served as an appointee to the state Regional Water Quality Control Board, and Governor Reagan's Task Force on Federal Reclamation, in addition to his BMQA appointment.

Mr. Andrews is survived by four children.

Legislature Responds To Physicians Who Graduated After 1975 From Vietnam

Since 1975, the Board of Medical Quality Assurance has licensed 400 physicians who were trained in Vietnamese medical schools. Most of these physicians completed their training before the 1975 Communist takeover. Because many of these physicians were unable to bring with them the kind of documentation normally required of applicants for physician licensure,
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DISCIPLINARY ACTIONS

July 1, 1987 through October 31, 1987

Physicians and Surgeons

Copies of complete Decisions can be ordered by writing to: BMQA, Enforcement, 1430 Howe Avenue, Sacramento, CA 95825.

For quick, orderly processing, please send your request by letter and enclose a check based on \$2.00 for each copy of Decision requested. Please, no orders by telephone during the busy month following the Action Report.

BOONE, John D., M.D. (G-2682) - Los Angeles, CA
2234(a), 2306 B&P Code
Violated probation of prior discipline; practiced medicine while under suspension.
Revoked.
September 7, 1987

CHAO, Alfred W., M.D. (A-30346) - Alhambra, CA
726, 2234(e) B&P Code
Sexual misconduct while examining female patients. Prior disciplines.
Revoked.
September 16, 1987

DI GREGORIO, Michael, M.D. (G-45536) - Los Angeles, CA
2234(e), 2236(a)(b), 2238 B&P Code
Stipulated Decision. Federal conviction for prescribing controlled substances outside the usual course of his professional practice and not for a legitimate medical purpose.
Revoked, stayed, 5 years probation on terms and conditions.
July 29, 1987

GOLDSTEIN, Herbert, M.D. (G-3371) - Burlingame, CA
726, 2234(b)(c)(d) B&P Code
Stipulated Decision. Sexual misconduct with female patient.
Revoked.
July 29, 1987

GRIER, Raymond E., M.D. (A-32041) - Greensboro, NC
2234(b), 2242 B&P Code; 1399.522 Admin. Code, Title 16
Stipulated Decision. Prescribing dangerous drugs without good faith prior examination and medical indication; gross negligence in practice; inadequate supervision of physician's assistants.
Revoked, stayed, 3 years probation on terms and conditions.
September 7, 1987

JAIN, Kewal V., M.D. (A-36582) - Engelbert, Switzerland

480(c), 583, 2235, 2234(f) B&P Code
Procured license by misrepresentation.
Revoked.
September 27, 1987

JERNOW, Herbert I., M.D. (G-40767)
Whiteplains, NY
2305, 2234(e) B&P Code
Discipline by New York medical board for conviction of Medicaid fraud in 1978.
One year suspension, stayed, one year probation on terms and conditions.
July 30, 1987

KREBS, Ryan A., M.D. (C-40447) - Fullerton, CA
2237 B&P Code
Federal conviction for conspiracy to distribute controlled substances.
Revoked. Default decision.
July 29, 1987

LEVINE, Stephen M., M.D. (G-21183) - Los Angeles, CA
490, 2237, 2238, 2241, 2242, 2261, 2262 B&P Code
Stipulated Decision. Conviction for involuntary manslaughter related to furnishing of Demerol to addicted wife who died of overdose. False names in prescriptions, false medical records, prescribing to an addict, prescribing without good faith prior examination and medical indication.
Revoked, stayed, 5 years probation on terms and conditions, including 6 months actual suspension.
July 22, 1987

MILLER, Donald D., M.D. (A-18863) - Merced, CA
2234(e) B&P Code
Stipulated Decision. Lewd and lascivious acts with minor male students working at his ranch.
Revoked, stayed, 5 years probation on terms and conditions, including psychiatric treatment.
August 13, 1987

MORAN, Jeffrey, M.D. (A-33867) - Santa Ana, CA
726, 2234(b), (d) B&P Code
Sexual misconduct with female patient, and permitting patient to consume wine during psychotherapy sessions constituting gross negligence and incompetence.
Revoked, stayed, 7 years probation on terms and conditions, including 6 month actual suspension.
August 26, 1987

MORGAN, Arthur, M.D. (G-022203) - Springville, UT
2236, 2305 B&P Code

Discipline by Hawaii medical board for conviction of 40 counts of medical assistance fraud.
Revoked. Default decision.
May 9, 1987

ROBERTS, Lewis, A., M.D. (C-011253) - San Francisco, CA
DOB - 6/7/12
726, 2234(b) B&P Code
Stipulated Decision. Sexual relations with female patient; gross negligence.
Revoked, stayed, 5 years probation on terms and conditions, including 90 days actual suspension.
July 15, 1987

SUCHER, Michel A., M.D. (C-026800) - Scottsdale, AZ
2305 B&P Code
Stipulated Decision. Order by Arizona medical board for continuing treatment for substance abuse.
Revoked, stayed, 5 years probation on terms and conditions.
July 10, 1987

TALBOTT, Edmund J., M.D. (C-018360) - Big Bear Lake, CA
2234 B&P Code
Abandonment of patients in convalescent facilities constituting gross negligence.
Revoked, stayed, 5 years probation on terms and conditions.
September 9, 1987

WELCH, John R., M.D. (C-22100) - El Cajon, CA
725, 2242, 2238, 2234(b),(c),(d), 2237 B&P Code
Conviction for prescribing a controlled substance to a person not under his treatment for a pathology or condition. Excessive prescribing and prescribing without prior examination and medical indication, constituting gross negligence, incompetence and repeated negligent acts.
Revoked, stayed, 5 years probation on terms and conditions.
August 28, 1987

WITTE, Eric Henry, M.D. (G-49577) - Harrisburg, PA
2234(e) B&P Code
In applications for residency programs, respondent submitted forged letters of recommendations, forged and altered transcripts and false applications and altered diplomas. Claimed defense of psychiatric disorder.
Revoked.
May 24, 1986
Judicial review recently completed.

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AIDS

A PRIMER FOR THE PRIMARY CARE PRACTITIONER

SANDY POMERANTZ, M.D.
Internal Medicine Consultant
Sacramento AIDS Foundation

INTRODUCTION

A great deal has been published recently about AIDS, much of it from the standpoint of how AIDS is spread, how to detect exposure to the AIDS virus, and what are the signs which establish a clinical diagnosis of AIDS or AIDS-Related Complex (ARC).

Despite this volume of published material in both the medical literature and popular press, the Board of Medical Quality Assurance has noted increased anecdotal evidence that primary care physicians are not recognizing the early (or even late) signs of infection with Human Immunodeficiency Virus (HIV), and the various AIDS-associated illnesses to which the HIV-infected individual is prone. Even when AIDS is suspected, many primary care practitioners are not knowledgeable on how to diagnose and treat AIDS-related illnesses, nor do they always know to whom they can turn to get the answers they need.

As a service to the practicing primary care physicians of this state, the Board is publishing the following "Primer" for primary care practitioners. The Primer focuses on how to recognize and treat the most common AIDS-related illnesses. It is organized in such a way that it should be usable as a future reference guide.

The Primer was written by Sandy Pomerantz, M.D., of Sacramento, Assistant Clinical Professor of Internal Medicine at the University of California, Davis, and Medical Director of the Sacramento AIDS Foundation. Dr. Pomerantz and the Board would also like to thank the following physicians who have reviewed this Primer and provided valuable advice and comments:

Members, California Medical Association
AIDS Task Force
Pulmonary Medical Infectious Disease
Consultants, Sacramento
Neurologic Associates of Sacramento
Other AIDS-Aware Physicians in Sacramento

Reprints or extra copies of "AIDS: A PRIMER" are available free of charge by writing to the Board of Medical Quality Assurance, Attention: The Action Report Editor, 1430 Howe Avenue, Sacramento, California 95825.

THE DISEASES OF AIDS

The spectrum of diseases seen in HIV* infected individuals is broad. While some clinical syndromes are rare, others are quite common. Most physicians should have little trouble recognizing and treating these common HIV-associated illnesses once they become familiar with them. This primer will attempt to describe the more frequently seen illnesses, how they present, how to diagnose and treat them and what common adverse effects to monitor. [*A list of abbreviations and acronyms can be found at the end of this PRIMER.]

A good way to approach the syndromes seen in HIV-infected individuals is to break them into the different organ systems which are affected. To that end, the most common illnesses can be grouped into the following areas:

- I. Pulmonary
- II. Neurological
- III. Gastro-intestinal
- IV. Skin/Mucosal Surfaces
- V. Lymph Nodes
- VI. Fever of Unknown Origin
- VII. Retinal

I. Pulmonary

A. Symptoms: Fever, non-productive cough, dyspnea

B. Signs:

1. High temperature
2. Little, if any, auscultatory findings
3. Chest x-ray (CXR):
early - little or no findings
later - progressive bilateral INTERSTITIAL infiltrates; not always symmetric, not always bilateral
4. Arterial blood gases (ABG):
early - mild hypoxemia (pO_2 70 - 90 torr);
later - progressive hypoxemia with respiratory alkalosis
5. Gallium lung scan: usually quite "hot" at 48-72 hour interval even when CXR shows little to no disease.
6. Pulmonary function tests (if done): increased flow rates, decreased diffusion capacity

C. Etiology:

1. If bilateral with primarily an interstitial process, consider:

RANK ORGANISM

- | | |
|---|--|
| #1 to 90 | <u>Pneumocystis carinii pneumonia</u> |
| (That is to say, PCP is the most common initial pulmonary pathogen and must be the single most suspected etiologic agent) | |
| #91 | <u>Cytomegalovirus (CMV)</u> |
| #92 | <u>Legionella species</u> |
| #93 | <u>Mycobacterium avium intracellulare (MAI)</u> and/or <u>Mycobacterium Tuberculosis (MTB)</u> |
| #94 | <u>Toxoplasma gondii (tox)</u> |
| #95 | <u>Blastomyces</u> |
| #96 | <u>Histoplasma capsulatum</u> |
| #97 | <u>Coccidioides immitis</u> |
| #98 | <u>Nocardia</u> |

2. If unilateral and significant alveolar pattern:

- | | |
|------|--|
| #99 | MAI and/or MTB |
| #100 | pulmonary <u>Kaposi's sarcoma (KS)</u> - especially if accompanied by a pleural effusion |

3. Additionally, do not forget the common or ordinary bacterial pathogens - especially Staphylococcus aureus/Hemophilus influenzae and Streptococcus pneumoniae which are being seen in increased numbers.

D. Work-up:

1. CXR (PA + LAT); ABG; serum LDH; erythrocyte sedimentation rate (ESR)
2. Induced sputum for Gram stain, silver or other stains which rapidly identify pneumocystis cysts/coccytes, AFB smear, wetmount, culture for routine C&S, fungi and AFB.
3. If CXR negative, proceed to gallium lung scan and scan at 48-72 hours if patient's clinical status permits the time delay.
4. If CXR shows bilateral interstitial infiltrate, or if gallium lung scan positive at 48-72 hours*, then bronchoscope with lavage and brush, and if clotting parameters reasonable, endobronchial biopsy. Of course, if patient is able to raise sputum and it is positive on silver stain, bronchoscopy can be avoided. [*Especially if the LDH and/or ESR are elevated.]

E. Treatment:

In the clinical setting, if highly suspicious for PCP, in a high risk individual with fever, cough, dyspnea, mild hypoxemia and interstitial infiltrate, initiate treatment immediately. Pneumocystis organisms will be present at least 5-7 days after institution of effective treatment. They may even be present following a full 21 day course of treatment when the patient has already defervesced. For the initial episode of PCP, it is mandatory to obtain stain confirmation since:

1. this establishes the diagnosis of AIDS in an individual who has no other reason for immunosuppression, and allows access to state and federal benefits such as Medi-Cal/Medicaid, supplemental security income (SSI) and the like;

2. some health insurers may require a histologic diagnosis for the patient to receive the new drug, azidothymidine (AZT, Retrovir).

3. protocols for trials of new antivirals will require histologic/pathologic proof of clinical diagnosis.

Length of treatment: 14 to 21 days

Treatment failure: progression of disease by Day 5-6. Note: With all regimes, many patients continue to worsen for 3-4 days. By Days 5-6, however, patient's fever curve should be down with evidence of a clinical response. Radiologic findings often lag 48-72 hours behind clinical improvement. If no better by Day 5-6, certainly by one week, consider this a treatment failure and change to second agent.

In addition to the agents listed below, new treatments are expected to be available in the near future including 1) inhalation pentamidine and 2) trimetrexate, a new lipid-soluble analogue of methotrexate, in combination with folic acid (leucovorin).

F. Choice of Drugs:

1. Trimethoprim/sulfamethoxazole (Septra DS, Bactrim DS) Dose: 15-20 mg/kg of trimethoprim component divided into 4 daily doses for 21 days. Route: Initial intravenous (IV); subsequent to defervescence orally (PO). Advantages: If effective and if there are no adverse reactions, then treatment can be changed to PO for HOME USE.

Disadvantages: HIGH (50-75%) incidence of adverse reactions, which are:

- Drug fever
- Neutropenia
- Thrombocytopenia
- Erythroderma which can progress to toxic epidermal necrolysis (TEN) with Stevens-Johnson syndrome.

These reactions typically occur between Day 4 and Day 8.

In the author's personal experience TMP/SMX has been effective but he has been able to complete a 21 day course of therapy with TMP/SMX only three times in 75-125 episodes of PCP in some 40 patients over the last 3 years.

2. Pentamidine (Pentam) Dose: 4 mg/kg IV or IM every 24 hours for 21 days.

Advantages: effective, one time daily dose
Disadvantages:

a. IV use is the preferable route of administration. Arranging home IV therapy is difficult and sometimes dangerous. Intramuscular use is sometimes accompanied by sterile abscesses at injection site, is quite painful and may have higher incidence of hypo- and hyperglycemias.

b. Sudden hypotension. While in-house, monitor blood pressure every 15-20 minutes during infusion and for 1 hour afterwards. Warn

patient about getting up slowly. Do not use other drugs (e.g., antiemetics) which also can cause hypotension. If blood pressure drop is sudden and severe, treat with intravenous saline, Trendelenburg positioning, etc. Dopamine or other pressor agents are rarely required.

c. Late glycemias - both hypo and hyper have been reported. Monitor blood sugars carefully, at least via fingerstick each day and for any symptoms of hyper- or hypoglycemia. These reactions typically occur between Day 4 and Day 12.

d. Nephrotoxicity: more common in dehydrated patients. During first week of treatment give IV saline. Monitor blood urea nitrogen (BUN), creatinine and electrolytes. [In the author's experience this has never required discontinuation of treatment, even when BUN levels have hit the 50s, creatinine levels of 3.0 or so. All abnormalities were completely reversed once treatment was finished and fluids replaced.]

e. Neutropenia: Many patients infected with HIV have evidence of myelosuppression and may be on other therapies which induce neutropenia as well, (i.e., AZT, vinca alkaloid chemotherapy for Kaposi's sarcoma, alpha-2 interferon for KS, DHPG (Ganciclovir) for CMV retinitis, colitis, etc.). Folinic acid as a kind of "leucovorin rescue" may be of some help as may Lithium carbonate. If granulocytes drop below 750 or certainly less than 500, consideration must be given to changing therapies or adding more routine antibiotic coverage for the granulocytopenic patient.

3. Dapsone and Trimethoprim
While adverse effects of trimethoprim/sulfamethoxazole (TMP/SMX) are extremely common, they have not been as frequently observed with other sulfa compounds. Dapsone, an older sulfa used in treatment of leprosy, has been shown to be highly effective against pneumocystis organisms when used in combination with trimethoprim.

Dose: Dapsone 100 mg. PO qd x 21 days with trimethoprim at dose of 15-20 mg/kg in 4 divided doses (i.e., 300 mg PO qid).

Advantages:

- all PO meds
 - lower incidence of sulfa drug toxicities
- Disadvantages:

a. The same toxicities can occur as with TMP\SMX. [In this author's experience, only one person could not complete 21 day course.]

b. Anemia: Dapsone should not be used in glucose-6-phosphatase deficient (G6PD) individuals as this will cause methemoglobinemia. Even in people with normal G-6P levels, anemia may be profound, so monitor hemoglobin and hematocrit at a minimum of every two to three days.

c. Renal toxicity seems to be worse than with TMP/SMX; keep patient well hydrated.

d. Hallucinoses has been reported. Giving medication at bedtime may reduce altered mental status.

4. Fansidar (pyrimethamine/sulfadoxine): [author has not used]

5. Dimethyl sulfoxide (DMSO): [author has not used] Some studies suggest this is less effective than numbers 1-3, above.

While prophylaxis against recurrent PCP is increasingly being used, firm data to confirm its efficacy is not yet in print. Nevertheless, it is likely to appear soon showing some efficacy in preventing recurrence but also no effect on the survival curves of AIDS patients. Regimes are generally based on what agent(s) have been effective in treating the original clinical pneumonia, i.e., pentamidine parenterally or via inhalation, TMP/SMX T bid, Fansidar 1-2 x/week or Dapsone 50 mg qid.

In terms of treatment for other pathogens, empiric prescribing is hard to defend. If an organism is isolated, treatment appropriate to that organism is indicated. The finding of cytomegalovirus (CMV) inclusion bodies, not just CMV cultures on a bronchoscopically obtained specimen, is absolutely necessary to call it CMV pneumonitis. If inclusion bodies are found, treatment with the experimental acyclovir derivative, ganciclovir (DHPG), is indicated. Unfortunately, the data for efficacy of DHPG in CMV pneumonitis in AIDS are only about fifty percent, not as good as for its use in CMV retinitis. Nevertheless, it is worth a try.

II. NEUROLOGICAL

HIV is a primary pathogen in the nervous system. In addition, many opportunistic neurologic illnesses may occur. The differentiation must be made between HIV as a primary pathogen and other secondary opportunistic infections and cancers, as some of the latter are treatable. Unfortunately, the clinical presentations of these illnesses often overlap. In general, if focal long tract neurologic findings are present, a search for an opportunistic infection (or central nervous system [CNS] lymphoma) must be made.

Symptoms and signs can be grouped as follows:

A. Fever, headache, focal neurologic signs and symptoms. Consider:

1. CNS toxoplasmosis (toxo). CT scans often, but not universally, show ring enhancing lesion(s) with contrast (the "signet ring" sign) which, while not pathognomonic of CNS toxo, is highly suggestive (any microbial-induced abscess can appear this way). MRI lesions in the basal ganglia are also suggestive of toxo.

2. Progressive Multifocal leukoencephalopathy (PML)

3. Tuberculoma (secondary to MTB)

4. CMV meningo-encephalitis

5. Herpes simplex virus (HSV) meningo-encephalitis

6. CNS lymphoma

B. Fever (at times low grade), headache, photophobia, with or without seizures, with or without nuchal rigidity. Think: cryptococcal meningitis, aseptic meningitis or primary HIV meningitis.

C. A progressive spinal cord syndrome with or without a transverse myelitis, characterized by a neurogenic bladder with unilateral or bilateral flaccid motor weakness has been described. Primary etiologic pathogens are felt to be HIV itself,

with or without HSV and CMV. Diagnosis can be made by culture of any of these viruses from spinal fluid. It may respond to high dose Acyclovir (i.e., 300 mg IV every 6-8 hours) along with AZT.

D. Change in personality, progressive loss of short term memory, social isolation, mutism often accompanied by seizures and ataxia. Consider HIV encephalopathy (AIDS Related Dementia).

E. Peripheral neuropathy: Consider HIV and/or side effects of chemotherapy, especially vincristine.

F. Polymyopathy: Consider autoimmune phenomena with auto-antibodies against skeletal muscle (anti-sarcolemma antibodies).

Work-up of Central Nervous System Disease: Lumbar puncture (LP), CT with dye or preferably MRI (the latter is more sensitive and can show lesions not present on CT). MRI findings in HIV encephalopathy are highly characteristic: patchy white matter disease with widened sulci often extending deep into the cerebellum. By MRI, focal disease in basal ganglia is highly suspicious for CNS toxo as opposed to PML or CNS lymphoma. Spinal fluid should be sent for gram stain, AFB stain, India ink preparation, cell count with differential, protein, and VDRL as well as culture for bacteria, AFB, fungi and viral studies if available. Remember routine lab serologies for toxo either in serum or in CSF are unreliable as diagnostic examinations.

Work-up of Peripheral Neurologic Disease: CPK, aldolase, antibodies to skeletal muscle (anti-sarcolemma), electromyography and nerve conduction velocities.

Treatment: treat what you can. The most common treatable illnesses are toxoplasmosis, tuberculomas, cryptococcal meningitis and syphilis. If focal CNS disease is suspect and CT scan with contrast and/or MRI confirms its presence, initiate a two-week therapeutic trial of anti-toxo meds, then repeat CT with contrast and/or MRI. If lesions improve, brain biopsy may be spared as diagnosis is evident. If disease worsens during trial or there is no change on scans after two weeks, then brain biopsy is indicated.

Toxo treatment is: Pyrimethamine in 25-75 mg daily doses plus sulfadiazine one gram qid for life. As pyrimethamine is a folate antagonist, leucovorin is needed.

In sulfa allergic patients, or if sulfa reaction occurs, clindamycin in doses of 600-900 mg every 8 hours PO has been used with anecdotal reports of response. To emphasize, meds must be continued forever, since in all studies to date, if patient initially survived he/she:

1. will relapse as the disease recurs in time or,
2. will still have t. gondii organisms present in the brain at autopsy when such patients die of other opportunistic infections.

The acute HSV meningoencephalitis, and the acute CMV meningoencephalitis are both treat-

able - the former with acyclovir 800 mg IV every 6-8 hours, and the latter with DHPG, SMA/Kg IV every 12 hours.

In the few case reports of CNS tuberculomas, they were due to Mycobacterium tuberculosis (MTB) and not MAI/kansasii; 3 or 4 drug chemotherapy should be used. (See comments under Section VI. - Fever of Unknown Origin)

In cryptococcal meningitis: amphotericin B in doses of 0.3 - 0.5 mg/kg daily, and in overwhelming disease up to 1 mg/kg daily, has been used after initial test dose. Total dose is gradually increased to desired end point, then maintenance, 3 times/week. Watch for the usual "ampho"-toxicities. Of note, intrathecal administration of amphotericin B has been used with some researchers reporting excellent responses with marked decrease in toxicities. There are no reports of better results with systemic versus intrathecal amphotericin B at this time. One should note that this drug has severe side effects and it comes by its nickname, "amphoterrible" (and other more graphic epithets) with reason. Requires lifelong maintenance therapy.

III. GASTROINTESTINAL SYNDROMES

These can be grouped into symptoms referable to the upper GI tract, those in the lower GI tract, and those inducing liver dysfunction.

A. Dysphagia, hiccough: Consider candida esophagitis

Diagnosis: characteristic mucosal pattern; endoscopy with biopsy showing invasive yeast.

Treatment: Ketoconazole 400-600 mg per day x 6 weeks, then maintain on 200 mg daily forever. In treatment failures with these regimes, low dose (10-15 mg) of amphotericin B may be highly effective and much less toxic than when this agent is used in higher dose to treat systemic fungal diseases.

Other pathogens:

1. CMV causing ulcerations - Treatment: DHPG in dose of 5 mg/kg IV bid;
2. MAI/MTB;
3. Herpes esophagitis: treat with acyclovir 350 mg qid 8 hours.

Other diseases:

Kaposi's Sarcoma (KS) - see skin/mucosal surfaces.

B. Abdominal pain syndromes without diarrhea. Consider:

1. CMV - Treat with DHPG
2. MTB/MAI - see above
3. KS - see below
4. Cryptosporidium - see below. Biliary disease with obstructive pattern of liver function tests and a "sclerosing cholangitis" has been reported.
5. Abdominal lymphoma.

C. Diarrhea with/without cramps. Consider:

1. While not usually considered to be opportunistic infection(OI)s, the following are

common and can be treated with the usual agents: Shigella, Campylobacter, Giardia, Entamoeba histolytica and Blastocystis hominis.

2. Cryptosporidium/isospora belli - note: control may be achieved with tetracycline or TMP/SMX, but organisms are still found in stool using a modified acid fast stain. Spiramycin does not appear to be effective.

3. A sprue-like illness has been described with no clear etiology. Control with agents such as diphenoxylate with atropine may be difficult. In this author's experience there is no effective treatment.

4. Clostridium - oral vancomycin is the treatment of choice although Flagyl has also been used.

D. Liver dysfunction: consider all the systemic opportunistic organisms and neoplastic disorders seen in AIDS, and virtually all the treatments thereof, and you will rarely see normal liver function in a person with AIDS. However, the author has not seen liver abnormalities to the extent that they have affected a patient's clinical status except in three individuals with both disseminated MAI and cryptosporidial enteritis, whose terminal events included obstructive jaundice.

IV. SKIN/MUCOSAL SURFACES

A. Kaposi's Sarcoma (KS): This multicentric sarcoma derives from the endothelial cell of the lymphatics in skin and mucosal surfaces. Its characteristic hue is due to extravasation of hemosiderin into the false vascular slits or channels seen on microscopy. It may be associated with CMV infection.

When lesions are few in number and confined to skin or mouth, it may be best to leave them untreated. When lesions begin to accelerate in number or are found in GI tract, lungs or other viscera, treatment is incumbent. Modalities of therapy include:

1. Chemotherapy. The most common and successful regimen has been to use vinca alkaloids, namely vincristine 1.4-2.0 mg IV, to alternate weekly with vinblastine 4-10 mg IV. This avoids the common dose reductions needed when employing vinblastine alone due to vinblastine's increased myelosuppression. However, peripheral neuropathies are more frequent due to vincristine toxicity, and the appearance of these may be difficult to distinguish from the effects of HIV itself in the nervous system. In addition, single agent bleomycin has been used by others with some success.

2. Alpha-2 interferon. Recombinant alpha interferon has recently been released for treatment of hairy cell leukemia. It has been shown by a number of investigators to be effective in treatment of KS with results comparable to that of chemotherapy (1/3 remission, 1/3 stabilization, 1/3 no response). It is given at a dose much higher than what is used for hairy cell leukemia, namely 36-54 million units IM per day for 28 days then 3 times weekly. For the 1/3 who show regression of lesions, treatment is then continued. Common side effects: fever and an influenza-like illness essentially the same as serum sickness. Of note: myelosuppression is common, and may be dose limiting.

3. Radiation: Palliation of large lesions is

readily achieved and can be employed for cosmetically unappealing or painful lesions. While KS is not painful in general, if it occurs in confined spaces (i.e., ear lobe, nose, etc.) it can be exquisitely so. Radiation treatment has been helpful to quite a few of the author's patients. (A note of caution, however - palatine lesions when radiated are often associated with severe mucositis which can create more problems than the KS lesions themselves. This author personally does not recommend radiation in this area.)

4. In addition, some clinical investigators have used an intralesional injection of 0.1 cc of 1.0% 1 solution of normally reconstituted Velban with some success.

B. There are a host of other skin and mucosal syndromes which include:

1. Oral candidiasis - controlled with either Nystatin, clotrimazole mouth troches, or systemic ketoconazole at 200 mg per day. Be aware that aphthous ulcers may be candidal or herpetic in origin.

2. Gingivitis - a necrotizing gingivitis is not uncommon and can lead to severe problems requiring all teeth to be removed. Routine hydrogen peroxide mouthwashes may help prevent its occurrence. Betadine intraorally has been used for this as well. Also consider herpetic lesions.

3. Shingles - Varicella zoster can be a severe and recurrent problem at any stage of HIV infection. Use of acyclovir in doses of 600-800 mg orally every 6-8 hours helps. Do not use prednisone.

4. Florid seborrheic dermatitis. Use non-fluorinated steroid topically. Also try topical ketoconazole cream; some patients respond.

5. Watch for other syndromes: psoriasis, herpetic ulcerations, molluscum contagiosum, and do not overlook sypphilis.

V. LYMPH NODES

Patients with HIV infection will universally develop generalized lymphadenopathy. The nodes are multiple, often times symmetric, not fixed, and not hard. Biopsy will reveal follicular hyperplasia with an immunoblastic response. As time passes, the lymphadenopathy tends to diminish. The pathology on biopsy will involute and change to more of a lymphocyte-depleted node. This is often a prodrome to OI's, so with disappearance of previously known lymphadenopathy, watch carefully. In addition, the following generalizations, while not universal, are true more often than not:

(1) If one or a group of nodes rapidly enlarges, think lymphadenopathic KS or lymphoma.

(2) If femoral (not inguinal), abdominal (i.e., para-aortic and/or retroperitoneal) nodes develop, think lymphadenopathic KS or lymphoma.

(3) If hilar adenopathy develops, think lymphoma, MTB or MAI.

VI. FEVER OF UNKNOWN ORIGIN (FUO):

FUO with or without other signs such as anemia, liver dysfunction and splenomegaly: suspect disseminated MAI or lymphoma. Obviously many of the other OI's are included in differential diagnosis,

but MAI is most common. To evaluate, the best and most common way to isolate is not in sputum but in cultures of the buffy coat of the blood. Sputum, of course, may show AFB as well as stool, urine, bone marrow and liver, and rectal swabs are frequently positive. Unfortunately, disseminated MAI does not respond well to anti-tuberculous medication, even in the non-immunocompromised host, and in this author's experience is not a treatable OI. (Ansamycin and clofazamine which appear effective in-vitro are not generally effective in vivo.) Treatment of localized disease, such as scrofula or pneumonia, has included Isoniazid, rifampin, ethionamide and amikacin (ansamycin or clofazamine being added in 1 pt oho replaced) with good response in nine of the author's patients.

VII. RETINAL PROBLEMS

It is not uncommon to find "cotton wool" exudates in evaluation of a person with AIDS, especially those who have had or have PCP. These are generally asymptomatic, nonprogressive and may be a reaction to pneumocystis antigen(s). Some patients may complain of mild visual defects which tend to remain stable.

A much more virulent retinitis is seen secondary to CMV. It presents initially with dark spots in the visual field, and if left untreated, may rapidly progress to blindness. Ophthalmologic exam, including "slit" lamp exam on dilated pupils, is in order. If this opportunistic retinitis is confirmed, cultures of throat, blood and urine for CMV are indicated for confirmation (not just CMV antibodies, which are frequently elevated in HIV infected individuals). The experimental drug ganciclovir (DHPG) in doses of 5 mg/kg IV every 12 hours has been quite effective. This drug can be obtained directly from one pharmaceutical company (Syntex) and through clinical investigators, including this author. The major and most frequent problem with its use in patients with AIDS is neutropenia which is dose-limiting. Interestingly enough, thrombocytopenia is more often seen in other immunocompromised hosts, such as patients with renal transplants; nevertheless, platelet counts should also be carefully monitored.

GLOSSARY OF ABBREVIATIONS USED IN THIS PRIMER

ABG	Arterial Blood Gasses
AFB	Acid-fast Bacillus
AZT	Azidothymidine (Retrovir)
C & S	Culture and Sensitivity
CMV	Cytomegalovirus
CNS	Central Nervous System
CT	Computerized Tomography
CXR	Chest X-ray
DHPG	Ganciclovir
DMSO	Dimethylsulfoxide
FUO	Fever of Unknown Origin
G6PD	Glucose-6 Phosphatase Deficiency
HIV	Human Immunodeficiency Virus (formerly known as HTLV-III, LAV-1)
HSV	Herpes Simplex Virus
KS	Kaposi's Sarcoma
MAI	<u>Mycobacterium avium intracellulare</u>
MRI	Magnetic Resonance Imaging
MTB	<u>Mycobacterium tuberculosis</u>
OI	Opportunistic Infection
PCP	<u>Pneumocystis carinii</u> Pneumonia
PML	Progressive Multifocal Leukoencephalopathy
TEN	Toxic Epidermal Necrolysis
TMP/SMX	Trimethoprim/sulfamethoxazole (Septra DS, Bactrim DS)
TOXO	<u>Toxoplasma gonadii</u>

Disciplinary Actions

Continued From Page 2

ZANE, Murray, M.D. (G-007668) - La Habra, CA
490, 2236, 2234(e) B&P Code
Stipulated Decision. Conviction for false Medical claims.
Revoked, stayed 5 years probation on terms and conditions, including 90 days actual suspension.
August 10, 1987

VOLUNTARY SURRENDER OF LICENSE ACCEPTED WHILE CASE PENDING

SHEN, Anthony C.P., M.D. (G-022523) - Westminster, CA
July 24, 1987

SOROOSH, Farhang, M.D. (C-039705) - North Las Vegas, NV
October 26, 1987

SPINELLO, Guy V., M.D. (G-006825) - Honolulu, HI
July 31, 1987

STEVENSON, Melbourne H., M.D. (A-27912) - Palos Verdes Estates, CA
March 30, 1987

STONE, Richard B., M.D. (G-028055) - Scottsdale, AZ
September 21, 1987

APPLICANT CASES

Decisions after request for Statement-Of-Issues and Hearing by Applicants for Physician's License

BORANIAN, Dickran
2089, 2102 B&P Code
Stipulated Decision. Submitted false letter to CETEC University. Failed to meet the medical curriculum of section 2089 and the requirements of section 2102. Documents submitted not satisfactory to the Board. Application denied. Applicant agrees to satisfy specified terms and conditions, including 9 months additional clinical training plus an additional post-graduate year in the area of his choice, to qualify for licensure.

BORODULIN, German
480(a)(2), 2234(e) B&P Code
FLEX score invalidated for copying answers of nearby examinee. Application denied. Recently upheld on judicial review.

CHIN, Frank Tuin Wong
480(a)(1) B&P Code
Federal conviction for prescribing controlled drugs without medical cause. Conviction in Louisiana for Medicaid fraud.
Application denied.

MEISELMAN, Annette
480(c), 480(a)(3), 2261 B&P Code
Knowingly made false statements on her various applications to the Board. Inadequate medical education and training.
Application denied.

REFAE, Sayed
496(b) B&P Code
Ejected from FLEX exam for failing to comply with examination rules, after two prior warnings by proctor.
Application denied.

SHEIKH, Muhammed
2080, 480(c) B&P Code
Stipulated Decision. False statements in license application. Incomplete medical education.
Application denied.

STAMENKOVIC, Nadezda
496(b), 480(a)(2)(3), 2234(e) B&P Code
Ejected from FLEX exam for cheating.
Application denied.

PODIATRIST DISCIPLINE

GERALDI, Vincent, D.P.M. (E-2238) - Rialto, CA
725, 2234(b)(d) B&P Code
Stipulated Decision. Clearly excessive x-rays; inability to manage post-surgical infection; and incompetence in performing surgical techniques.
Revoked, stayed, 5 years probation on terms and conditions.
October 6, 1987

ROSS, Harvey, D.P.M. (E-1296) - Los Angeles, CA
810, 2234(a), (e), (f), 2261, 2262 B&P Code
Stipulated Decision. Filed false and fraudulent insurance claims and forged signatures of others as providers.
Revoked, stayed, 5 years probation on terms and conditions.
August 15, 1987

VAUGHN, Ori T., D.P.M. (E-2187) - Inglewood, CA
2234(b), (c), (d) B&P Code
Stipulated Decision. Mismanaged the care and treatment of four patients constituting gross negligence, incompetence and repeated negligent acts.
Revoked, stayed, 5 years probation on terms and conditions.
September 26, 1987

WEBER, Bennie B., D.P.M. (E-1441) - Lodi, CA
Stipulated Decision. Violated probation of prior discipline in his care and treatment of six patients.
Revoked, stayed, 4 years probation on terms and conditions.
August 20, 1987

CALIFORNIA PHYSICIAN'S DIVERSION PROGRAM TRENDS TOWARD HIGH RISK OF IMPAIRMENT

Recent trends in the use of certain drugs by physicians contacting the Diversion Program have prompted the program to take a closer look at the specialists using these drugs and their risk of drug impairment.

Based on the data collected by the program since its inception in 1980, there are two major specialties which are at high risk of impairment due to drug abuse. Diversion Program figures show that Anesthesiologists and Family/General Practitioners comprise nearly 40% of those physicians contacting the program with drug abuse problems.

The three most popular drugs of choice for these two groups of physicians are demerol, cocaine and fentanyl. More notably over the past 6 months, the program has seen an increase in the use of fentanyl by those physicians requesting participation. According to program data, fentanyl is the drug most often abused by anesthesiologists. Over the past 6 years, 27 physicians having problems with fentanyl have contacted the program. Of these 27, all but one have been anesthesiologists.

The following chart indicates the degree of fentanyl use among the physicians who have contacted the program since 1980.

Year	# of Physicians Who Contacted the Program	# of Contact Who Used Fentanyl	% of Contacts Who Used Fentanyl
1980	98	1	1.0
1981	80	3	3.8
1982	75	2	2.7
1983	84	5	6.0
1984	98	4	4.1
1985	93	3	3.2
1986	76	3	3.9
1987*	51	6	12.0

* first six months annualized

Note the substantial increase in fentanyl users who contacted the program during the first six months of 1987.

The Board continues to study and monitor the effectiveness of its diversion program. We will also continue to keep our readers advised of interesting trends and developments.

New Reporting Requirements

Continued From Page 1

plans currently are required to report to the Board of Medical Quality Assurance (or other appropriate board) whenever they have taken specified action to restrict the privileges of a professional staff member, if that action was taken for medical disciplinary cause or reason.

Until now, there have been unresolved questions about what sorts of organizations constituted "health facilities" and thus were required to report. For this reason, Section 805 has never been used to its full potential. In fact, in recent years the number of "805 Reports", as they are called, has gone down.

The passage of SB 1620 clarifies the existing reporting requirements. Among the changes the bill:

1. Clarifies and expands the definition of entities which are required to report disciplinary actions. It clearly includes health maintenance organizations and medical societies, and adds hospital service plans and any medical group of 25 or more members which has an organized peer review process.

2. Defines staff privileges to include any arrangement under which a professional might render care to patients of a reporting entity. This closes loopholes in current law under which, for example, a physician who had only temporary privileges or contractual arrangements with a hospital, could escape being reported to BMQA.

3. Defines the term "medical disciplinary cause or reason", and includes unprofessional conduct among the reportable offenses.

4. Clarifies when reports shall be made and toughens the law regarding voluntary resignations in lieu of discipline. For the first time, it specifies that a report shall be made within 30 days of the effective date of a summary suspension.

The Board believes that the reforms proposed by SB 1620 will make the disciplinary reporting requirements work in the way the Legislature originally intended.

Vietnam Physicians

Continued From Page 1

the Board has relied heavily on an AMA-sponsored faculty-council-in-exile to certify the medical training of these pre-1975 graduates.

Many Vietnamese-trained physicians and medical students remained in Vietnam after 1975. Approximately 30 persons who completed their medical school training in Vietnam between 1975 and 1980 have subsequently left the country and are now seeking licensure in California.

Unfortunately, when they fled Vietnam, most of these recent applicants were not able to bring the documentation necessary to verify their medical training. Subsequent attempts to obtain this documentation have not been successful. The AMA's faculty-council-in-exile is

unable to certify as to training obtained after 1975. Without verified evidence of successfully completing the licensing requirements, the Board has been unable to issue licenses to these applicants.

On September 29, 1987, Governor Deukmejian signed SB 1358, authored by Senator Ed Royce of Orange County. The bill creates a special committee of former faculty of the University of Saigon to verify the medical education and training of 1975-80 graduates and make recommendations for licensure to the Board's Division of Licensing.

The Committee consists of six members, appointed by the Board at its meeting in December, 1987. One member was selected from the Division of Licensing. The others were chosen from nominees who have knowledge of conditions at the University of Saigon following the change in government.

We expect the new committee to move quickly to evaluate the credentials of the approximately 30+ applicants who graduated from the University of Saigon (now Ho Chi Minh City) between 1975 - 1980.

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