



# SPS NEWS

The Official Publication of The Southern Pain Society

December 2010

## SPS Annual Meeting a Huge Success!

Here are just a few of the highlights from the annual meeting if you weren't able to join us this year:

- Dr. Perry Fine shared touching and helpful video vignettes from a patient with terminal cancer. This method, highlighting the patient's perspective, provided a powerful guide on how to be an empathic and effective physician in palliative medicine situations.
- Dr. Dan Doleys and Dr. Hans Hansen engaged in a spirited Pros and Cons 'debate' about spinal cord stimulator implantation. Although outcomes data can be interpreted through different filters, both agreed that careful and proper patient selection is key to a good SCS outcome.
- David Vaughn, JD, presented examples of Medicare audits with helpful suggestions on how to incorporate compliance practices in your own clinic.
- Dr. Greg Skipper informed with a review of drug screen options and interpretations, and entertained with an interesting look at how patients try to "cheat" on urine drug screens.
- Dr. Scott Fishman offered his expert perspective on REMS and the process of developing recommendations for opioid risk management.

These are just a few of the speaker highlights enjoyed by the audience, along with networking opportunities, conversations with industry reps across several product areas, and thought-provoking Q&A and commentary from attendees. Many attendees noted that they will be making changes in their practice based on information presented at the meeting including: improving documentation, reviewing and updating their opioid agreements and informed consents, increasing the use of appropriate urine drug screens, considering their use and monitoring of opioids in clinical practice, reading treatment guidelines with a more thoughtful/critical perspective, and reviewing their coding compliance. The following are some things to read, surf and view.

### Recommended Reading

- The Neuroscience of Psychotherapy: Healing the Social Brain – Louis Cozolino
- The Brain that Changes Itself – Norman Doidge, MD
- Exit Wounds: A Survival Guide to Pain Management for Returning Veterans and Their Families – American Pain Foundation
- Pain Management for Older Adults: A Self-Help Guide – Thomas Hadjistavropoulos & Heather Hadjistavropoulos, 2008
- American Geriatric Society Clinical Guideline Recommendations for the Pharmacological Management of Persistent Pain in Older Persons (especially for excellent recommendations re: use of acetaminophen) – JAGS, 2009; 57: 1331-1346.

### Recommended Surfing

- [www.PainAction.com](http://www.PainAction.com)
- [www.Painconcern.org.uk](http://www.Painconcern.org.uk)

### Recommended Viewing

- "The OxyContin Express" (2009)
  - Created by Vanguard documentary series on Current TV
- "Methadonia" (2005)
  - A film by Michel Negroponte

In the survey feedback, attendees also suggested several topics for future meetings, such as continued updates on legal and practice management issues, opioid risk stratification, and multidisciplinary care, among others. We strive to make the program up-to-date and relevant to your individual clinical practice needs, with awareness that we need to appeal to our broad multi-discipline base of mem-

bers and attendees. To submit your ideas for future meeting topics or speakers, please email one of the co-chairs for next year's meeting: Leanne Cianfrini ([lcianfrini@gmail.com](mailto:lcianfrini@gmail.com)) or Daniel Doleys ([dmdpri@aol.com](mailto:dmdpri@aol.com)). Continued on page 6

## Mission Statement

The Southern Pain Society is a regional section of the American Pain Society and endorses and supports the mission and goals of the American Pain Society. The Southern Pain Society's missions are to serve people with pain by advancing research and treatment and to increase the knowledge and skill of the regional professional community.

## SPS Board of Directors

**President:** Eric Pearson, MD

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Nominating: Todd Sitzman, MD, MPH

Program: Leanne Cianfrini, PhD, Dan Doleys, PhD

## SPS News Editorial Board

**Editor:** Leanne Cianfrini, PhD

SPS News is the official publication of the SPS, provided quarterly to its members. SPS may publish material dealing with controversial issues. The views expressed are those of the authors and may not reflect those of the SPS. No endorsement of those views should be inferred unless specifically identified as the official policy of the SPS. Submissions are welcomed. Publication is based on editorial judgment as to quality of material, timeliness, and potential interest to members.

# President's Message

Eric Pearson, MD



It is with honor and some trepidation that I take over as the president of the Southern Pain Society. I follow in the footsteps of those who have preceded me, and they have set the bar very high. Our immediate past president, Todd Sitzman, MD, has done a magnificent job in guiding and advancing our organization. I consider Todd to be both a mentor and a friend, and it is my hope to strive to achieve his level of excellence.

As a society, our mission statement describes serving those in pain by "advancing research and treatment and to increase the knowledge and skill of the regional professional community." Our professional community includes nurses, psychologists, physical therapists, physicians, and other health care practitioners that are involved in the care of those with pain. We have chosen to reach out to those who we serve through our newsletters and our annual educational meeting. This year's meeting was held in early October, 2010 in New Orleans and was entitled "Practical Pain Management in 2010". It turned out to be a resounding success based on attendance, quality of speakers, location, and extremely positive feedback. None of this success could have been possible without a lot of hard work from a team of individuals. There are two that I would like to recognize, Dr. Leanne Cianfrini and Dr. Geralyn Datz, who were the meeting co-chairs. I feel that without their dedication and unselfish time commitment, we could not have attained this level of achievement.

I am very excited to announce that next year's meeting will also be held in New Orleans around the first weekend in October. It is our goal to have this meeting become an annual event that will be considered *the* quality regional pain meeting in the country that all look forward to. By having the meeting in New Orleans again we hope to further enhance consistency and quality. The New Orleans location offers unique advantages: 1) it helps support a struggling community, and 2) is simply a fun city. To achieve our objectives as a society we need your help, and I ask that you take the time to consider contributing to our goals by becoming involved with the society, joining its committees, and helping with the planning of our annual meeting. In addition, we look forward to those of you who have an interest in writing articles to share in our newsletter -- contact Dr. Leanne Cianfrini with your written contributions. Another exciting area of member benefit is our website which has recently been restructured so that it is more user-friendly. We are offering members an opportunity to list a link to their pain center or practice. As you can see, the future for our society is exciting and I look forward your participation and to our continued growth.

## More Tidbits From Our Annual Meeting

Physicians tend to overestimate survival in terminal patients by a factor of 5.3 (and even more so for patients who die within 30 days).

To increase chances of a successful spinal cord stimulator trial, consider the “Three P’s”: Pain pattern, pain pathology, and psychological status (North et al. Practice parameters for the use of spinal cord stimulation in the treatment of chronic neuropathic pain. *Pain Med.* 2007; 8 Suppl 4: S200-75.).

One of the most important questions to ask a patient is the open-ended: “What would be the most useful way I can be of help to you today?” Brief interventions (even conversation!) make a huge difference in palliative care.

There are over 1,000 guidelines for pain treatment from multiple sources. Guidelines are here to stay and will continue to influence payment practices. We need to look with critical/thoughtful analysis of the guidelines, be aware of the authors and potential conflicts of interest, and, most of all, be active advocates for our patients and our profession.

A positive amphetamine detection in a urine drug screen can be prompted by benign use of Vicks Inhaler or EMSAM (transdermal selegeline). Request L and D isomer results to determine illicit vs. licit substance use.

Older adults actually prefer non-medication based pain therapies – don’t hesitate to promote self-management strategies.

It’s a good idea to review cautions about opioids and driving in a written informed consent document (Annas GJ. Doctors, drugs, and driving – tort liability for patient-caused accidents. *N Engl J Med.* 2008;359:521-5).

It’s time to review your business associate agreements – document that each employee and each associate has a plan to comply with the HIPAA Security Rule.

25% of patients who are allodynic during migraines will not respond to triptans.

An electronic health record system must meet 15 core measures and 5/10 non-core measures to qualify for federal stimulus reimbursement. For example, 50% of patients must have demographics recorded electronically; 80% of patients must have allergies recorded electronically. Does your EHR system measure up?

## From the Editor

Leanne Cianfrini, PhD



This quarterly edition of your newsletter welcomes the first letter from our new SPS President, Eric Pearson, MD. As his column mentions, our annual meeting held in October 2010 was a success. This newsletter is chock-full of highlights, informational tidbits, and candid photos from the meeting. Of course, the impact is more powerful in person, so we hope that our members will join us again

next year to partake in these educational sessions and networking opportunities.

We also are happy to share with you a member article submission. Regina McConley, PhD, commented that she was inspired by informal discussions and Q&A commentary at the annual meeting to assemble information about the important issue of suicide risk among chronic pain patients. She wanted to share the background and assessment tips with fellow SPS members for use in their own practice.

As we thank our prolific and enthusiastic psychologist colleagues who have contributed to our past two newsletters, we also remind our entire membership that we welcome submissions across all disciplines, levels of training, and practice models. A diverse array of topics will enhance communication within our society. So, have your voice heard – I’m looking forward to seeing a pile of articles in my inbox at [lcianfrini@gmail.com](mailto:lcianfrini@gmail.com).

## Newsletter Submissions

All submissions to SPS News should be typewritten and double spaced with title and name of author(s). The article should be copy-ready. Please include short biographical information.

### Submission Deadlines

Winter edition-November 1; Spring edition-February 1; Summer edition-May 1; Fall edition-August 1. Please submit your articles to [lpostal@southernpainsociety.org](mailto:lpostal@southernpainsociety.org).

# Evaluating Suicide Risk among Individuals with Chronic Pain

Regina McConley, PhD

Chronic pain is a salient factor associated with suicide risk among patient populations [1]. A recent review of the literature estimates that approximately 20% of individuals with chronic pain report suicidal ideation, which can include self injurious actions, preparation/planning, and suicide attempts [2]. There is also evidence to suggest that individuals with multiple pain sites, with certain types of pain (e.g., headache, abdominal, low back), and with pain of long duration are particularly at risk for suicidal ideation [1,3,4]. A large percentage of individuals have co-morbid pain and depression, which further heightens risk [5]. Given the associations between chronic pain, depression, and poor physical health, routine assessment of suicidal ideation and behaviors are a necessary addition to a thorough medical or behavioral medicine evaluation.

While there is evidence suggesting that many patients are willing to discuss these difficulties, perceived stigma related to thoughts about suicide may serve as a deterrent for others. One study indicated that approximately 45% of individuals who completed suicide had contact with a primary care provider in the month prior to suicide [6]. This finding suggests that individuals in primary care settings may serve as the principal source of contact for identifying individuals with suicidal behavior. Inclusion of self-report items on general patient health questionnaires may assist in screening for ideation in a non-threatening manner.

As a general precaution, carefully worded follow-up queries are warranted regardless of whether ideation is affirmed. It is likely that an approach incorporating both direct and indirect questions about self-harm contemplation yields useful information. Normalization of symptoms may elicit honest responses for those individuals who may not candidly express their emotional reactions [7]. A recent analysis of the responses of 152 primary care physicians to standardized 'sham' patients revealed three general types of suicide inquires: 1) **straightforward** (e.g., "Are you feeling like hurting yourself?"); 2) **supportive framing** (e.g., "Sometimes depression gets so bad that people feel like life is not worth living. Have you felt this way?"); and 3) **assumption of no problem** (e.g., "You're not feeling suicidal, are you?") [7].

In addition to chronic pain and illness, the following factors are associated with heightened suicide risk and should also be assessed in follow-up [8-13]:

- Psychiatric diagnoses
- Family history of attempts
- Catastrophizing

- Active substance use
- Active psychosis
- Low social support
- **Personal history of attempts**
- Impulsivity
- Recent psychiatric hospitalization
- Lack of access to care
- Loss ( e.g., relationship, physical function)
- Lack of stable source of income

Of note, female gender is associated with more frequent suicide attempts, while male gender is a risk factor related to suicide completion [14], with the observation that men are likely to use more lethal methods (e.g., guns) than women during their attempts. Additionally, older individuals tend to be less likely to endorse suicidal ideation, but are more likely to attempt suicide [14].

After identification of these potential risk factors, thorough assessment should also involve an examination of protective factors [12,15,16]. Deterrents to suicide include:

- Positive future focus
- Access to care
- Commitment to safety
- Religious beliefs
- Positive support system
- Restricted access to highly lethal means

Examination of the risk and preventive factors together are helpful in determining risk levels.

Assessment of suicidal ideation, intent, plan, lethality, and imminence of risk is challenging for even the most skilled clinicians. Here are some questions to practice out loud in order to increase your comfort level (adapted from 17):

- 1) With this much stress in your life, have you thought of hurting yourself?
- 2) Do you ever go to bed and wish that you won't wake up?
- 3) Have you ever tried to hurt yourself?
- 4) What do you do when you have thoughts of suicide?
- 5) What has prevented you from harming yourself so far?
- 6) Do you have access to guns, pills, or knives at home?

Regardless of whether the individual is then hospitalized or outpatient care is recommended, development of a thorough safety plan is instrumental in providing quality care for patients [18]. Ideally, the plan for safety should be constructed in collaboration with the patient. A well developed safety plan includes the following elements:

- ❖ Identification of warning signs, such as family conflict, financial stressors,
- ❖ Internal (favorite/soothing activities) and external (distraction which can involve another person) coping skills

- ❖ Knowledge of trusted personal (e.g., loved one) and professional (e.g., mental health counselor, psychiatrist) sources of help. Even reluctant individuals can recognize that the local ER and 911 are contingency plans.

Encouraging the patient to keep a copy of the safety plan in an easily accessible place (e.g., purse or wallet) is essential. Also, the patient should be encouraged to engage in their preferred coping strategies to facilitate regular stress reduction [19].

In addition, the following strategies are healthy practices for the care of each patient with suicidal behavior:

**Refer for mental health services.** If the individual is appraised as having suicidal behavior, referral for outpatient mental health services is warranted. Individuals at low risk can often be treated effectively with psychotherapy or psychotropic intervention. Individuals at high and moderate risk benefit from both psychiatric and psychotherapeutic care. Psychotherapists involved in patient care need to be aware that assessment of suicidal ideation is an on-going process that requires vigilance when there is a change in psychosocial factors.

**Provide Reassurance.** Individuals experiencing suicidal ideation often feel that they have few options and have historically been shown to have negative and distorted views about themselves, the world in general, and the future. Reassurance from another person that the situation is not hopeless is often a source of comfort to patients.

**Education.** The pervasive nature of suicidal ideation is concerning to both providers and social contacts (e.g., family and friends). Recognition of the signs and symptoms of depression and suicidal behavior is vital for providers, patients, families, and the community to ensure continued safety [16].

#### Resources:

The American Psychiatric Association **Practice Guidelines** for the Assessment and Treatment of Patients with Suicidal Behaviors [www.sprc.org/library/jcsafetygoals.pdf](http://www.sprc.org/library/jcsafetygoals.pdf)

**Suicide Prevention Toolkit** commissioned by the Western Interstate Commission for Higher Education Mental Health Program and the Suicide Prevention Resource Center [www.sprc.org/library/primer.pdf](http://www.sprc.org/library/primer.pdf) [www.sprc.org/library/primer.pdf](http://www.sprc.org/library/primer.pdf)

The US Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) is also a rich source of information and educational resources. Clinicians can download a copy of the **Suicide Assessment Five-step Evaluation Triage (SAFE-T) tool.** [www.sprc.org](http://www.sprc.org) [www.sprc.org/library/safe\\_t\\_pcktrd\\_edc.pdf](http://www.sprc.org/library/safe_t_pcktrd_edc.pdf)

*Many of the materials, including laminated copies of the SAFE-T card and patient information about suicide can also be requested. Some patient resources are also available in Spanish.*

#### References

1. Ilgen M, Zivin K, McCammon R, Valenstein M. Pain and suicidal thoughts, plans, and attempts in the United States. *Gen Hosp Psychiatry.* 2008;30(6):521-527.
2. Tang N & Crane C. Suicidality in chronic pain: a review of the prevalence, risk factors, and psychological links. *Psychol Med.* 2006;36:575-586.
3. Braden J & Sullivan M. Suicidal thoughts and behavior among adults with self-reported pain conditions in the national comorbidity survey replication. *J Pain.* 2008; 9 (12):1106-1115.
4. Spiegel B, Schoenlelds P, & Naliboff B. Systematic review: the prevalence of suicidal behavior in patients with chronic abdominal pain and irritable bowel syndrome. *Aliment Pharmacol Ther.* 2007;26:183-193.
5. Arnow B, Hunkeler E, Blasely C, et al. Comorbid depression, chronic pain, and disability in primary care. *Psychosom Med.* 2006;68:262-268.
6. Luoma J, Martin C, Pearson J. Contact with mental health and primary care providers before suicide: A review of the evidence. *Am J Psychiatry.* 2002;159:900-916.
7. Vannoy S, Fancher T, Melvedt C, et al. Suicide inquiry in primary care: Creating context, inquiring, and following up. *Ann Fam Med.* 2010;8(1):33-38.
8. Cheng A, Chen T, Chwen-Chen C, Jenkins R. Psychosocial and psychiatric risk factors for suicide. *Br J Psychiatry* 2000;177:360-365.
9. Conwell Y, Duberstein P, Caine E. Risk factors for suicide in later life. *Biol Psychiatry.* 2002;52:193-204.
10. Edwards R, Smith MT, Kudel I, Haythornthwaite J. Pain-related catastrophizing as a risk factor for suicidal ideation in chronic pain. *Pain.* 2006;126:272-279.
11. Saffier K, Colombo C, Brown D, et al. Addiction Severity Index in a chronic pain sample receiving opioid therapy. *J Subst Abuse Treat.* 2007;33(3):303-311.

12. Stroebe M, Stroebe W, Abakoumkin G. The broken heart: suicidal ideation in bereavement. *Am J Psychiatry*. 2005;162:2178-2180.
13. Wojnar M, Ilgen M, Czyz E, et al. Impulsive and non-impulsive suicide attempts in patients treated for alcohol dependence. *J Affect Disord*. 2009;115:131-139.
14. Spicer R, Miller T. Suicide acts in 8 states: incidence and case fatality rates by demographics and method *Am J Public Health*. 2000;90:1885-1891.
15. Dervic K, Oquendo M, Grunebaum M, et al. Religious affiliation and suicide attempt. *Am J Psychiatry*. 2004;161:2303-2308.
16. US Public Health Service The Surgeon General's call to action to prevent suicide. Washington (DC): US Department of Health and Human Services. 1999; <http://www.surgeongeneral.gov/library/calltoaction/default/htm>
17. Dehay T, Litts D, McFaul M, et al. Suicide prevention toolkit for rural primary care. Western Interstate Commission for Higher Education Mental Health Program and Suicide Prevention Resource Center. 2009; <http://www.sprc.org/library/primer.pdf>
18. Stanley B, Brown GK. (2008). *Safety planning: An intervention to mitigate suicide risk*. Washington, D.C: Veterans Health Administration Publication.

## President's Service Award



Charles R. Griffith, M.D., is a board-certified family physician with Wesley Medical Group. His clinic is located in Purvis, Mississippi. He serves as Wesley Medical Center's chief of medicine and is president-elect of the hospital's medical staff. Dr. Griffith received the SPS President's Award at the recent annual meeting.

Dr. Griffith received his bachelor's degree from the University of Virginia and his medical doctorate from Louisiana State University Health Sciences Center in Shreveport. He completed his internship and residency training at the University of Florida Family Practice Residency Program. Dr. Griffith practices traditional family medicine by seeing patients in his clinic, the hospital, a nursing home or their private residence.

Meeting photos (continued from page 1)



The welcome reception was a nice way to ease into the meeting -- good food, casual conversation, and a beautiful view of the river"



A gathering of SPS leadership: President Eric Pearson, Immediate Past President Todd Sitzman, and Past President Daniel Doleys



The vendor exhibits were well attended

## Membership Drive...We Need You!

Geralyn Datz, PhD

At the Board of Directors meeting in New Orleans in October, several new initiatives were discussed, one of which addresses our decrease in membership over time. There may be several causes for this decline, including leadership changes, economic concerns and lack of publicity for our organization. Many of our newer members might not be aware that the formation of SPS actually predates that of the American Pain Society (APS), and that as few as 20 years ago, SPS annual meetings routinely outpaced the attendance at APS! Given our strong history and the current need for pain medicine professionals to band together in the face of uncertain economic and health care pressures, the Board agreed that several steps were needed to increase membership:

1. Develop a greater online presence via the website and additional meeting/ organizational publicity
2. Release the SPS newsletter with more regularity to provide a service to our membership and alert them of new regional happenings
3. Recruit new members to the Board of Directors and committees to invite fresh ideas and resources
4. Conduct the annual meeting in the same location, New Orleans, again next year, as this location has traditionally yielded the best attendance and reviews, and services a wide range of recreational interests
5. Partner with other regional pain organizations and specialties including nursing and medical organizations to co-host future meetings and share cross-disciplinary knowledge
6. Expand our CME opportunities to multiple specialists including psychologists and nurses
7. Offer a membership discount for those who joined during our 2010 meeting: 2 years for the price of one

SPS realizes that membership is the lifeblood of our organization. **We encourage you to tell your friends and colleagues about SPS.** We encourage all specialties to participate and join: nursing staff, graduate students, residents and interns, physical therapists, hospice, primary care, surgeons, physical medicine and rehabilitation, physiatrists, psychiatrists, psychologists, and so on. It is important for our membership to reflect our diversity of interests and a multidisciplinary approach to pain management, which SPS recognizes as essential to success.

Advantages of SPS membership:

- Networking with local and regional colleagues

- Annual Membership List: printed access to our members' names, addresses and affiliations with future online search capabilities
- Cost effective: compared to larger organizations, SPS membership is offered at an approximate 40% savings
- Student, Intern and Resident rates: We are happy to support them by providing a student rate of only \$20/year

If you have additional ideas how to improve our membership, please email our president, Eric Pearson MD

[ejpearson@hotmail.com](mailto:ejpearson@hotmail.com) with your suggestions.

## Welcome to New Members!

Welcome to the following new members to SPS:

Michael E. Harned, MD, Lexington, KY  
Dominique M. Anwar, MD, New Orleans, LA  
Morris Alexander, PhD, Tupelo, MS  
Michael E. Zakaras, PhD, Gulfport, MS  
Regina L. McConley, PhD, MPH, Charlotte, NC  
Ikechukwu H. Okorie, MD, Hattiesburg, MS  
Martins T. Ugwu-Dike, MD, Columbia, MS  
Keith W. Blackman, MD, New Orleans, LA  
Mark D. Barhorst, MD, Houston, TX  
George S. Walker, MD, New Orleans, LA  
Joseph M. Howard, CCMA, Jackson, MS  
Rex B. Williams, MD, Ridgeland, MS  
Terry Braud, PA, Baton Rouge, LA  
Ashfaq A. Qureshi, MD, New Orleans, LA  
J. George Jiha, MD, Baton Rouge, LA  
Beau J. Bagley, MD, Birmingham, AL  
Vincent R. Forte, MD, Monroe, LA  
Amilcar J. E. Correa, MD, Slidell, LA  
George S. Stefanis, MD, Macon, GA  
Christina L. Paxton, PA, Newcastle, VA  
Theodore W. Nicholas, MD, Kill Devil Hills, NC

We are delighted to have you on board. Please let us know how we can serve you.



Southern Pain Society

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**Address Correction Requested**

[www.Southernpainsociety.org](http://www.Southernpainsociety.org)

## Website Marketing Opportunities!

As part of your SPS membership, we are offering the opportunity to include your practice's logo and website link on a new page of our SPS website. We will be listing SPS member clinics by state and city. Inclusion will be based on review of the appropriateness of the outside website content and SPS cannot specifically endorse the linked websites or products/services they offer. However, patients, community members, and other practitioners can search this page to find pain clinics in their region.

Our site ([www.southernpainsociety.org](http://www.southernpainsociety.org)) generates many viewers per month, and with this added search tool we can enhance our presence as a society, direct more viewers to our site through search engine listings, and increase marketing exposure for your clinic. So, increase your clinic's advertising exposure through this valuable member benefit – why not maximize the power of your membership dues? Submit your clinic's website link and logo for review to the webmaster at [lcianfrini@gmail.com](mailto:lcianfrini@gmail.com).



### More Meeting Photos:

Left: The lunchtime audience for Dr. Fishman's talk on REMS

Right: Meeting Co-chairs Drs. Leanne Cianfrini and GERALYN DATZ

