The Medical Society of the County of Queens
and The Academy of Medicine of Queens County

BULLETIN

Volume 12 • Issue No. 6 | *Over 200 Years of Service to the Medical Community of Queens County* | *Winter 2021-2022*

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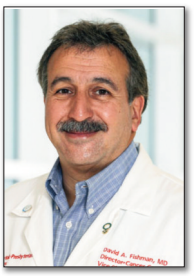
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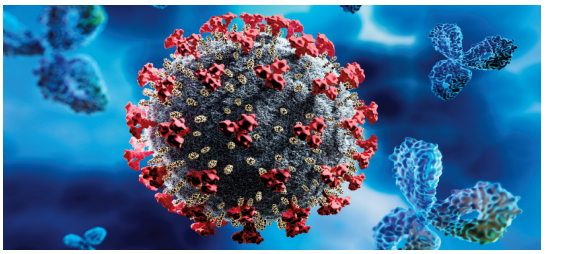
Letter from the President's Desk



Dear Friends
and Colleagues,

The COVID-19 pandemic has created a medical crisis never before experienced in modern medicine. Globally healthcare providers have been overwhelmed with over 240 million patients affected with COVID-19. While newly discovered therapeutics and treatment strategies have been developed and employed to optimize patient care many questions continue to be unanswered. A frequently asked question concerns the difference between immunization and immunity. As noted in the recent CDC update (10/29/21) "SARS-CoV-2 enters cells by binding to angiotensin converting enzyme-2 (ACE-2) receptors on the cell surface via the viral spike protein. Currently available serologic assays measure both overall production of antibodies against SARS-CoV-2 antigenic targets (binding antibodies) and functional ability to neutralize the SARS-CoV-2 virus via virus neutralization or pseudovirus neutralization tests (neutralizing antibodies). The antigenic targets most frequently assessed include those to the spike (S) protein, receptor binding domain (RBD) of the spike protein and nucleocapsid (N) core. IgM, IgA, and IgG isotopes may be developed against any of these antigens. Serum binding antibodies to S and RBD and neutralizing antibodies have all been shown to correlate with protection against symptomatic SARS-CoV-2 infection." Unlike other vaccines where immunity can be determined by standardized levels of neutralizing antibodies this at present is not the case for SARS-CoV-2 immunity.

FDA approved tests have demonstrated high sensitivity and specificity in detecting antibodies yet their ability to predict protection against the virus is unknown since threshold levels of neutralizing antibodies do not exist. Binding antibodies differ from neutralizing antibodies so present test results appear to have limited clinical utility. Again as noted by the CDC "multiple studies have shown that antibody titers correlate with protection at a population level; however, data are presently insufficient to determine an antibody titer threshold that indicates if an individual is protected from infection."



The next question is why not measure neutralizing antibody levels? The answer is that this technology is not widespread and is not yet available for clinical diagnostics. Presently there is no FDA-authorized or approved test that providers or the public can use to reliably determine whether a person is protected from infection. The optimistic view is that tests are under evaluation by the FDA for SARS neutralizing antibody detection which hopefully will have clinical value. ■

About Dr. Fishman

David A. Fishman, MD is an internationally recognized gynecologic oncologist, especially noted for his innovative research on the regulation of ovarian metastasis and in developing new methods for the detection of individuals at risk for ovarian cancer and the detection of early stage ovarian carcinoma. He is a Professor of Obstetrics and Gynecology at Weill Cornell School of Medicine. He became the MSCQ President on May 19, 2021.

contact: daf2037@med.cornell.edu



MEETINGS / CME / EVENTS

Please check with listed organizations for updates as events and schedules may change due to the pandemic.

Upcoming Meetings	Date / Time
MSCQ Board of Trustees Meetings All Board of Trustees Meetings are held on the 1st Tuesday of the month via Zoom, unless noted. Dates may change.	January 4, 2022 • 6:00 pm / virtual
Comitia Minora Leadership Meetings All Comitia Meetings are held on the 1st Tuesday of the month via Zoom, unless noted. Dates may change.	January 4, 2022 • 8:00 pm / virtual
First District Meetings Refer to emails from this organization.	Contact Ronald Blunt: bronxphysicians@gmail.com
MSSNY Council Meeting via Zoom, unless noted.	January 13, 2022
MSSNY House of Delegates	May 21, 2022 • 8:00 am Tarrytown, NY
PHYSICIAN ADVOCACY DAY	Tuesday, March 8, 2022 Albany, NY
AMA State Legislative Strategy Conference	January 13-15, 2022 Ritz Carlton Amelia Island, Amelia Island, Florida
AMA Annual Meeting	June 11-15, 2022 Hyatt Regency, Chicago, IL
AMA Interim Meeting	November 11-15, 2022 Hilton Hawaiian Village Honolulu, Hawaii

Upcoming Presentations

WCM Cancer Metabolism and Inflammation Symposium
JUNE 23-24, 2022

Belfer Research Building, Weill Cornell Medicine
413 East 69th Street (between First and York Avenues) New York, NY 10065

In-person symposium limited to 160 attendees. Covid vaccination required.

This 2-day symposium presented by the Weill Cornell Medicine Department of Pathology and Laboratory Medicine is focused on the metabolism of cancer and the inflammatory response that either drives tumor initiation or favors the creation of tissue microenvironments conducive to tumorigenesis and metastic spread. Key questions in cancer research, inflammation and the immune response, and promising new therapies will be presented and discussed by renowned leaders in the field.

Fees and Information:
212-746-8169 • yel9009@med.cornell.edu

For information about placing a CME program listing, please contact 718.268.7300.

For information about placing a CME program listing in the BULLETIN, please contact our office at: 718.268.7300.

Lung Cancer Screening

Joseph T. Cooke, MD
President-Elect



As the COVID pandemic evolves, an untold number of cancers are going undiagnosed or untreated. Patients postponed annual screenings. Cancer clinics and hospitals suspended biopsies, chemotherapy, and radiation treatments. Fewer screenings led to a decline in new diagnoses, which one study found fell by more than 50% for some cancers last year.

People didn't stop getting cancer; they stopped getting diagnosed. The National Cancer Institute has predicted almost 10,000 excess deaths over the next decade from breast and colorectal cancer alone because of pandemic-related delays in diagnosing and treating these two cancers.

Lung Cancer remains the leading cause of Cancer death in the United States. More than 200,000 people are diagnosed with this disease each year. Lung Cancer Screening can detect lung cancer at a earlier stage and save lives. COVID-19 caused significant disruption in lung cancer screening as well leading to a decrease in new patients screened and an increased proportion of nodules suspicious for malignancy once screening resumed. This takes on more significance as the USPSTF modified its recommendations for Lung Cancer Screening in March 2021.

The Original USPSTF lung cancer screening (LCS) criteria benefited only a narrow subset of lung cancer patients. LCS age threshold has now been lowered from age 55 to 50 and from at least 30 pack years to 20 pack years. This will double the number of people eligible for screening. Expanding criteria can potentially improve lung cancer survival in vulnerable subgroups, such as African-Americans and other minorities, who may otherwise not be eligible for screening. Data shows that both groups tend to smoke fewer cigarettes than White men. Data also shows that Black people have a higher risk of lung cancer than white people. These changes will mean that many more Black people and women who smoke will be eligible for this potentially life-saving screening.

It is incumbent upon us as physicians to encourage our patients to resume their age appropriate cancer screenings.

We also need to be aware of these new Lung Cancer Screening recommendations to ensure those who can benefit are screened. More African-American and women are eligible under these new recommendations. Screening needs to be implemented broadly and equitably. ■

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening

About the Author



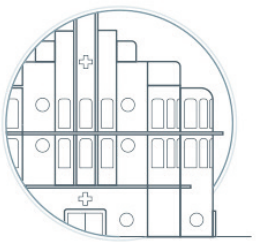
Joseph T. Cooke, MD
President-Elect
Dr. Cooke serves as Chairman of the Department of Medicine at NewYork-Presbyterian Queens and as Vice Chairman of the Weill Department of Medicine.
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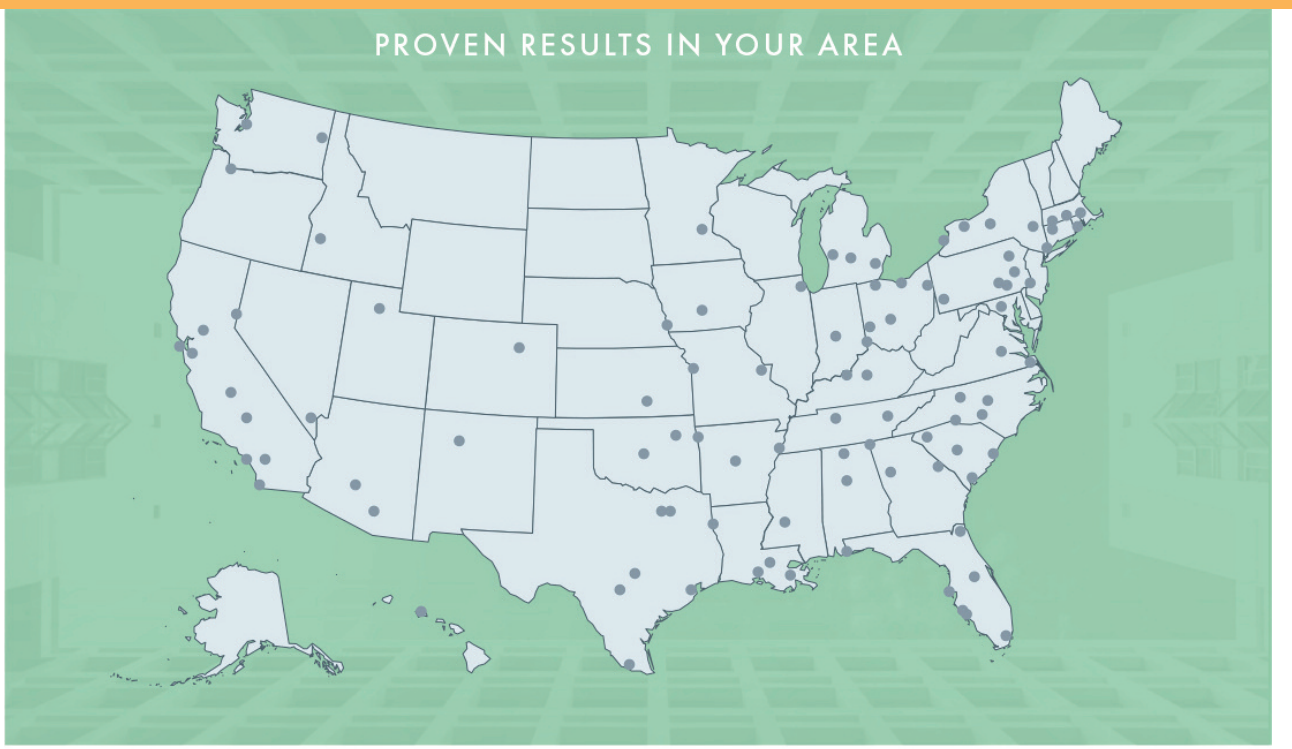
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Contact elaine@metropolis.tech or visit www.metropolis.tech to learn more

A Journey Through the Personal and Social Experience of Breast Cancer *(Submitted in October 2021)*

Louis J. Auguste, MD, MPH, FACS, FSSO

In this month of October, once again, we want to increase awareness of the threat of Breast Cancer in the world-wide community. Indeed, despite a recent decline in deaths due to this cancer, it remains the most common cancer diagnosed in women in the United States. It is estimated that in 2021, 281,550 women will be diagnosed with invasive breast cancer, representing 1 in 8 women. It is concerning also that under 50,000 women will be found to have non invasive or Stage 0 breast cancer, a drop of nearly 15,000 compared to three years ago, when 63,000 women were diagnosed in that stage, reflecting the fact that during the pandemic, women have been less willing to go out and be screened by mammography. Nevertheless, it is encouraging that over the past few years the overall 5-year survival of women with breast cancer has risen to 90 %. This dramatic improvement over the past 50 years can be attributed to earlier detection, identification and elimination of some known risk factors and more effective forms of therapy.

The keys to this success rests on this delicate balance between stage at diagnosis, tumor biology, the appropriateness of the therapy offered and delivered on one side and on the other side, it depends on the patient's biology, her genetic make-up, her ability to access care, her compliance and her tolerance of the treatment.

Beyond these generalities however, the journey of a woman newly diagnosed with breast cancer is a singular and personal experience that deserves careful considerations. That journey starts usually when she undergoes her annual screening mammogram, which is now officially recommended by the USPTF to start at age 50, although the American Cancer Society, the American College of Radiology, the American College of Obstetrics and Gynecology, among others still maintain that proper screening should start at age 40. In addition, these recommendations should be modified for women with first degree relatives who have had premenopausal breast cancer and for African American women as well, who tend to develop cancer at an earlier age. The customary post-mammography period of anxiety is followed by either a negative report or unfortunately, that of a malignant diagnosis.

A successful outcome during this journey does start from that first day. How that news is broken to the patient can trigger panic, denial all the way to refusal of treatment or enhance the patient's determination to defeat that disease. The revelation of the diagnosis, should be preferably done by a physician familiar with the intricacies of the diagnosis and the options for management. I believe that it requires a face-to-face encounter, with plenty of time to allow grieving, provide comfort, but mostly to reassure the patient that she will not be alone on this journey and that her team of physicians will be by her side, from the beginning to the end. One theme will be recurring through this short discussion is the insistence on the presence of a support individual, be it a spouse, a close relative or a friend, who can take notes, listen and retain the information that may escape the patient overwhelmed with her new diagnosis. Clear steps should be discussed and informative brochures or on-line information should be provided. Key to this success is that the physician be a good communicator, able to breakdown the medical jargon into easily understandable layman's terms. It also behooves the patient to step up and get some insight in her care, ask questions, ask for clarifications and also articulate her fears and wishes. Is the loss of hair a main concern? Is the patient the main bread winner? Has the patient recently experienced the loss of a close friend or family member? Is there food or lodging insecurity?

It is widely believed in public health that socio-economic factors account for 80% of health and medicine only 20%. Here also, the psycho-social profile of the patient deserves scrutiny and may determine the outcome of the disease.

Now armed with the diagnosis, the patient needs to take the next important decision. Where will she be treated and by whom? Should she stay local or go to the mega-specialized center advertised on TV and on the billboards? The care of the breast cancer patient requires an army of specialists, including a primary care physician, a radiologist, a surgeon, a medical oncologist, a radiation oncologist, a geneticist, a gynecologist, an oncology nurse or physician assistant, a therapist (oncopsychiatrist or psychologist) a social worker, a nutritionist, as well as a physical therapist. All these specialists can be assembled under one roof or be available in the surrounding neighborhood. The attraction of a specialized center may be tempered by access difficulties. How much will it cost me to travel to that center? How much do I have to pay for parking? Will my support team, family or friends, be able to visit me when I am hospitalized? If I have an emergency, will my doctor be available or will I be sent to a hospital that is not familiar with my case? Is similar care available closer to me? Are my physicians all board certified? Are the facilities where care will be rendered, all accredited by the National Cancer Institute?

Not least of all, am I comfortable with my team? Do they understand my language and my culture? Am I treated with respect?

- continued on page 7

A Journey Through the Personal and Social Experience of Breast Cancer *continued from page 6*

Louis J. Auguste, MD, MPH, FACS, FSSO

The recommendation of a trusted primary care physician, who have referred previous patients to a given specialist or of a friend who has recently gone through a similar experience can be a good place to start. That first visit is also an assessment, an interview of your prospective care giver.

The engagement of the patient in her care cannot be over emphasized. This has been carefully examined and generally four levels of engagement can be seen.

Level 1 is passivity. I don't need to know anything. My doctor will take care of me. He knows best.

Level 2 is when the patient at least takes some interest in understanding her situation but asks no question and has some gaps in her knowledge. She follows more or less her doctors' recommendation.

Level 3 is when the patient feels that she is part of her healthcare team. She understands the goals of her treatment and adheres reliably to the medical recommendations.

Level 4: At that level, the patient is fully activated and engaged. She educates herself and she becomes her own advocate. She reads and researches different options and participates in the decision making. Reconstruction or no reconstruction? What type of reconstruction? Genetic testing or not? Am I getting the right dose of the prescribed medication?

Several studies have shown that a fully engaged patient is less likely to be victim of a medical error or a poor health consequence due to poor communication between her providers. She is also less likely to be readmitted to the hospital within 30 days of discharge.

Never to be lost in this discussion is the importance of the support team. Besides the spouse or other family member, this support may come from a close friend, a clergy, another patient met during follow up visits, an in-person or on-line support group. It also can be in the form of a navigator, who will see that the patient gain access to transportation, timely testing and medications as well as help with the maintenance of health insurance to allow continuation of care. This support may also entail assisting with meal preparation, house cleaning when the patient may be too weak to carry them out. Finally, the literature supports that the availability of a person in which the patient can confide is also important to prevent depression and enhance the patient the patient's compliance with the treatment plans.

In this month of October, we would like to remind all physicians that taking care of the mental state of a patient can be as important as the actual medicines provided and to all women who will be unfortunate to face these difficult choices, that BREAST CANCER IS MERELY A BUMP ON THE ROAD AND NOT THE END OF THE ROAD. ■

About the Author



Louis J. Auguste, MD, MPH, FACS, FSSO, *Surgical Oncology/General Surgery; Clinical Professor of Surgery, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell; Chair/Board of Trustees, Medical Society of the County of Queens*
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CY 2022 Medicare Physician Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) released the final rule for the CY 2022 Medicare physician fee schedule. American Medical Association (AMA) staff are thoroughly analyzing the 2400+ page rule and will provide a comprehensive summary in the near future. Notably, the 2022 Medicare conversion factor will be reduced by approximately 3.85% from 34.8931 (2021) to 33.5983. This is largely a result of the expiration of a 3.75% increase to the conversion factor at the end of calendar year 2021, as averted in 2021 by Congressional action.

The AMA continues to strongly advocate for Congress to avert this significant cut and extend the 3.75% increase for 2022, as it further compounds the growing financial instability of physician practices due to the severe reduction in revenue caused by the continued COVID-19 PHE.

The text of the proposed rule can be accessed at: https://www.federalregister.gov/public-inspection/current

Link to the CMS Press Release: https://www.cms.gov/newsroom/press-releases/cms-physician-payment-rule-promotes-greater-access-telehealth-services-diabetes-prevention-programs

Link to the Physician Fee Schedule Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule ■

MSCQ Needs Your Support

Dear Valued MSCQ and Academy of Medicine Members,

We are writing to you at this time to ask for your support in what has been a difficult year for all of us. As we continue to traverse the tail-end of this global pandemic, which has hit the residents, physicians and businesses of Queens the hardest, we wanted to take this opportunity to remind you of the value our Medical Society/Academy of the County of Queens has brought to you as a member as well as underscore some unique circumstances which require unique support and generosity during this time.

The Medical Society/Academy of the County of Queens has continued to function and serve its members, despite the virtual environment required by this pandemic. During the past year, we have provided you fourteen opportunities for Continuing Medical Education, ranging from topics including "Rise in Suicide Rates, Reducing Amputations, Understanding Breast Diseases" which were well attended and appreciated by our members.

Additionally, the Medical Society of the County of Queens continues to be the voice of physicians in Queens. This year, we successfully submitted and had adopted a resolution to the Medical Society of the State of New York's House of Delegates, namely "Hospital Closures in Vulnerable Neighborhoods in NYS." This resolution was written in response to recent calls for down-sizing/repurposing of St. John's Episcopal Hospital in the Rockaways, however, also relates to a worrisome trend of hospital closures/down-sizing that has occurred throughout New York State in recent years. Our resolution called specifically for MSSNY to advocate for meaningful physician and patient input in any future discussions of hospital closure/down-sizing, and furthermore calls for advocacy to lawmakers to ensure such a mechanism is in place.

Unfortunately, during the pandemic, we saw a drop in new membership and a drop in renewal of membership of over 15%, resulting in a loss of dues revenue. The pandemic also prevented us from hosting our main fundraising event for two consecutive years now, our President's Gala, further reducing our revenue. Additionally, the unexpected flooding throughout Queens due to Hurricane Ida has left our building with significant damage which has been costly to repair.

Due to all of these reasons above, we hope you will consider supporting our Medical Society of the County of Queens. We recommend a base-level donation of $100 but if you are feeling more generous, we would always appreciate more. Your donations will allow our Society to continue to provide the valuable programing and advocacy that is so vital to our physicians and community in Queens.

Donations can be made by contacting the Society:
Gina Burgos at 718.268.7301 or gburgos@queensmedicalsociety.org

Sincerely,

Charles S. Lopresto, DO
2021-2022 Treasurer, Chair of Fundraising Committee

David A. Fishman, MD
2021-2022 President

Louis J. Auguste, MD, MPH, FACS, FSSO
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Thank You and Best Wishes for a Happy and Healthy 2022!

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Pinkus Szuchmacher, MD – 8/8/2021

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