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Academy of Medicine of Queens County

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THE BULLETIN

THE OFFICIAL NEWSLETTER OF THE MEDICAL SOCIETY OF THE COUNTY OF QUEENS

Welcome to our December 2023 issue of "The Bulletin". We aim to provide current and relevant information to our Society membership. Hopefully, we have met our goal. We need your feedback...Let us know what topics you would to like to see featured in our future bulletins. If you would like to share one of your current articles or perhaps write an opinion piece, we will gladly accept "all the news that's fit to print!"

Please send all comments and writings to qms@queensmedicalsociety.org.

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MEET OUR PRESIDENT



DR. CHARLES LOPRESTO

Charles Lopresto, DO is an Internal Medicine Hospitalist in the Department of Medicine at NewYork-Presbyterian Queens Hospital. He completed his undergraduate B.A. in Biology at Columbia College, Columbia University, his Doctor of Osteopathic Medicine Degree at Touro College of Osteopathic Medicine - New York and his Residency in Internal Medicine at Jamaica Hospital Medical Center. He is passionate about the intersection between Evidence Based Medicine and Legislation / Advocacy. He has maintained an active and broad level of participation in organized medicine groups to explore the above interests. In his free time, he enjoys exploring the culinary, arts and music scenes of NYC and playing Saxophone in several bands in the local NYC / Long Island area.

OVARIAN CANCER:

DETECTION OF EARLY STAGE DISEASE- HOPE VS. HYPE



DR. DAVID FISHMAN

All cancer patients can potentially benefit from the early detection of early-stage disease rather than the early detection of advanced stage cancer. This is especially true for women with epithelial ovarian cancer.

This year, approximately 24,000 women will be diagnosed with ovarian cancer and 14,000 will die from this disease. Unfortunately, 70-75% of women newly diagnosed with epithelial ovarian cancer (EOC) will have Stage III or IV disease with a predicted 5-year survival approximating 15%. This poor survival rate has remained essentially unchanged over the past 60 years despite the advent of aggressive radical surgical approaches and new therapeutic interventions.

In contrast, if EOC is detected when confined to the ovary (stage I), the 5-year survival approaches 90%, requires less radical and morbid operations, and may not require adjuvant chemotherapy. Risk factors for EOC include a family or personal history of breast cancer, EOC, or colon cancer, genetic mutations (such as in BRCA1 and BRCA2), endometriosis, and nulliparity. However only about 20% of individuals have a recognized mutation and family history alone misses about 50% of patients at risk.

Because of the extremely poor prognosis of EOC and at present there is no effective method to detect early stage EOC, women at high risk are counseled to undergo the most dramatic prevention technique- prophylactic bilateral salpingo-oophorectomy (BSO). While this procedure is effective in reducing risk of EOC, for pre-menopausal women the loss of fertility and sudden onset of menopause can have major short -term and long -term health issues.

Early detection of localized disease (Stage1) or a premalignant lesion followed by either chemoprevention or surgery should confer a substantial improvement in survival.
Evidence suggests that to develop effective strategies for early detection, it will be necessary to develop methods based upon the molecular, genetic, and biochemical events that regulate carcinogenesis, invasion and metastatic dissemination.
Recent discoveries in the pathogenesis of ovarian cancer have suggested that the histologically defined EOC subtypes could bedifferent diseases, with different precursor lesions and distinct biomarker expression profiles.
High-grade serous carcinoma (HGSC) is the most common and lethal form of EOC.
Considering the low prevalence of OC in the general population, any proposed screening strategy mustdemonstrate a minimum specificity (SP) of 99.6% and a sensitivity (SN) of >75% for early-stagedisease to achieve a positive predictive value (PPV) of 10% and avoid a high level of false-positive results.
Currently, women designated as high-risk for EOC rely on genetic counseling.
The serum marker CA125 is not diagnostic for ovarian cancer and exhibits a sensitivity of only50-60% for stage I disease in postmenopausal women. Current recommendations do not favor the use of CA125 for general screening.
Transvaginal sonography with Doppler vascular measures, and morphological indices lack the specificity required in a general population screening test yet can easily identify ovarian masses that may require surgical intervention.

Recent research suggests that most serous carcinomas likely originate from the epithelium of the distal fallopian tube (FT), not the ovary itself. Serous tubal intraepithelial carcinoma (STIC) represents the putative precursor of HGSC. A model for the growth, progression, and detection of occult HGSC was developed based on analysis of data from prophylactic operations in women with BRCA1 mutations. This model indicated that HGSCs spend one year at stage III-IV before becoming clinically apparent. Calculations based on the Brown and Palmer data show that HGSC spends 3.6 years as stages I-II, and 1.5 years as an in situ lesion, in agreement with a published mathematical model.
A recently published molecular evolutionary analysis identifies a window of 7 years between development of a STIC and initiation of ovarian carcinoma, with metastases following rapidly thereafter.
Therefore, a biomarker based screening test aimed at detecting Stages I-II of HGSC should be able to recognize the disease more than one year earlier than current diagnosis.

Whole-body imaging techniques such as magnetic resonance imaging and positron emission tomography currently lack the required resolution and sensitivity to detect early EOC changes.

Transvaginal ultrasound (TUV) screening has not been shown to reduce mortality from EOC, and leads to operations on ovarian masses which are primarily benign. This can be explained by the fact that, at least in regard to HGSC, TVS is detecting persisting solid or a complex ovarian mass that represents metastases of the primary FT lesion to the ovary detecting advanced stage disease. Therefore, for early detection of HGSC, optical imaging methods are needed for detection of primary HGSC when it is still located within FT and before it has spread to the ovaries.

They can be inexpensive, detect endogenous changes or work in concert with contrast agents to achieve higher detection sensitivity and specificity, and enable precise location of the disease. If such a FT imaging test would have high detection accuracy it could be used as a primary or second-line test following a biomarker-based screening test. The major drawback of high-resolution optical imaging is the need to gain physical access to the organ/tissue of interest, however imaging components can be miniaturized to facilitate access for minimally-invasive procedures. The FTs can be accessed in a minimally-invasive manner, by passing a falloposcope through a hysteroscope into the ostium of the FT, enabling physical access to both the FT and ovary for high resolution optical imaging. Imaging can performed using advanced optical imaging techniques such as optical coherence tomography (OCT) and multispectral fluorescence imaging (MFI), that can confirm and localize disease. Falloposcopy can be performed under local anesthesia or possibly light sedation.

The unmet clinical need is currently being addressed by our NCI supported research program as we aim to identify disease while it is still confined to the FT. Our approach utilizes experimental imaging combined with experimental biomarkers. Specifically, we will combine a first-line screening with protein markers with a second line minimally invasive falloposcopy with advanced optical imaging techniques.

It is our hope that these technologies will significantly help improve women's healthcare.

WILL GOVERNOR HOCHUL PROTECT ACCESS TO HEALTHCARE IN NEW YORK STATE?

DR. CHARLES LOPRESTO, DO

President MSCQ

All statements are Dr.Lopresto's own opinion, and not attributable to any other organization.

I can remember a time not too long ago when during the first wave of the COVID-19 Pandemic, our community opened their windows at 7 p.m. each evening, when shifts were changing in hospitals, and applauded healthcare workers' service, bravery and commitment to our community. Many called us heroes, however, we were simply going to work, and doing our best to do what we are passionate about, returning the sick to health. Since then, I am grateful that many parts of our lives have returned to "normal", and we continue to grow and heal as a community. Our Physicians are back in their offices and hospitals, ensuring our community is catching up on the things we missed during the pandemic such as elective surgeries, preventative care, screenings, vaccinations and routine care.

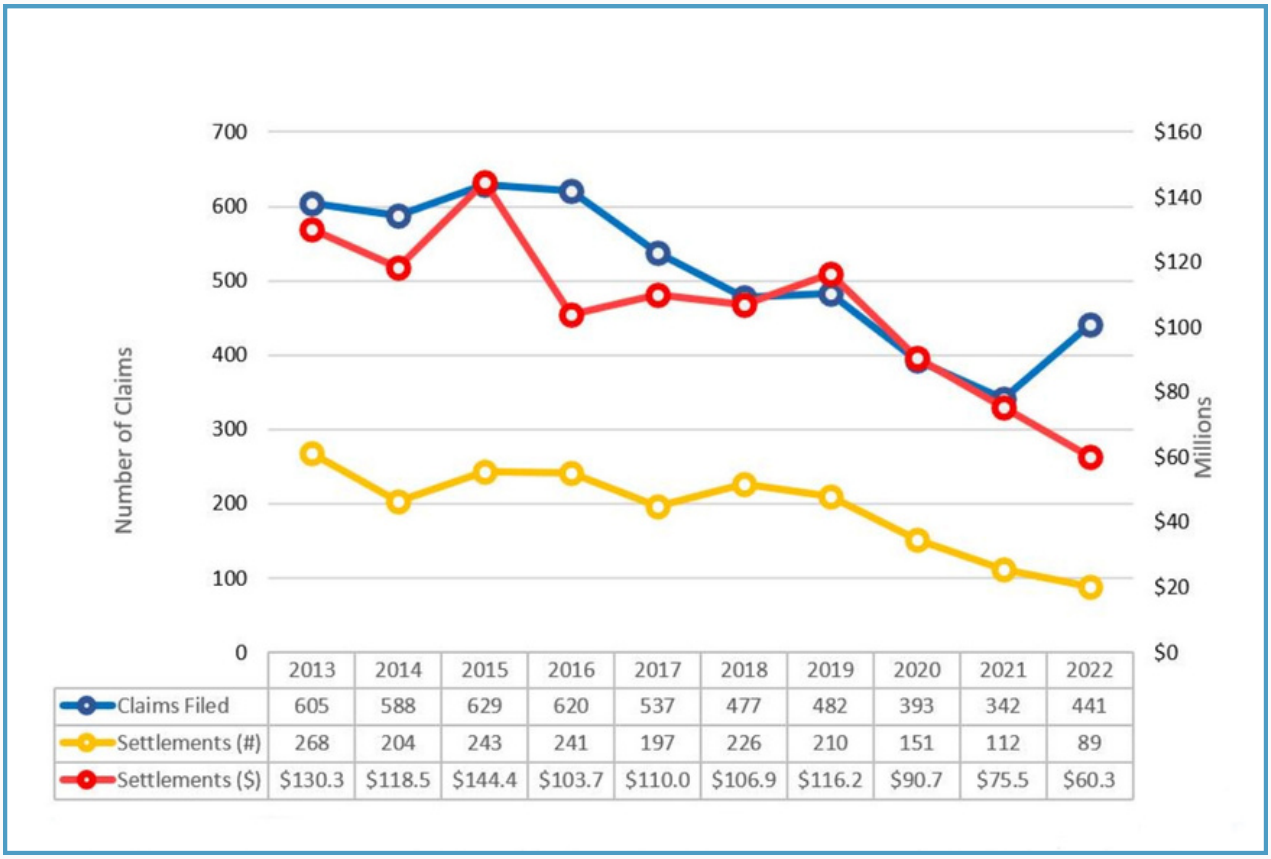
However, that return to "normalcy", and the way we deliver healthcare in New York State at large is being threatened by potential legislation that would result in an upheaval of the financial landscape pertaining to wrongful death medical malpractice lawsuits. As the President of the Medical Society of the County of Queens, I have been closely following New York State legislation A.6698 / S.6636, the so-called "Grieving Families Act", and what it might mean for the Physicians, the practice of medicine, and the patients I represent in Queens.

This legislation, recently passed by the New York State Legislature, which will be delivered to Governor Hochul's desk shortly, is not substantively different from similar legislation that the Governor vetoed in January. Governor Hochul identified several reasons for vetoing the earlier bill including that it "would increase already high insurance burdens on families

and small businesses and further strain already-distressed healthcare workers and institutions" which would be "particularly challenging for struggling hospitals in underserved communities". Despite her concerns, the New York State Legislature passed this current version, which still contains the most troublesome language, allowing medical malpractice wrongful death lawsuits to include non-economic damages including emotional distress. While part of my job is to be empathetic and develop therapeutic relationships with my patients and their families, and I respect the rights of families who have been affected by terrible circumstances of medical malpractice to litigate, the current version of this legislation is not good for physicians, patients and healthcare as a whole.

Furthermore, the Governor articulated her concerns that the previous version of this legislation she vetoed "passed without a serious evaluation of the impact of these massive changes on the economy, small businesses, individuals, and the State's complex health care system." This bill does not address these concerns. It would continue to enable the awards of new categories of damages that multiple actuarial studies show will lead to a nearly 40% growth in liability costs, which would be on top of the already unaffordable costs facing our physicians and hospitals. Studies from Diederich Healthcare show that from 2019-2021, New York had the highest cumulative medical liability payouts of any state in the country, $1.4 billion, nearly twice as much as the 2nd highest state (Florida) and the 3rd highest state (Pennsylvania). It also had the highest per capita liability payment, 33% more than the 2nd highest state (PA). These costs far exceed states like California and Texas, with whom New York competes to retain and attract needed specialty care physicians. Plainly put, it is too expensive to practice medicine in New York State as is, and physicians' practices, hospitals and other groups will not be able to absorb these extra costs that this legislation will incur.

You might think after an initial veto, the New York State Legislature's reintroduction and passing of this new version would be because there is a dire need to make these reforms. However, according to data from the Annual Claims Report from the New York City Comptrollers office, both the number of medical malpractice claims and their settlement amounts across New York City have been on a downward trend for the past 10 years. (See chart below)

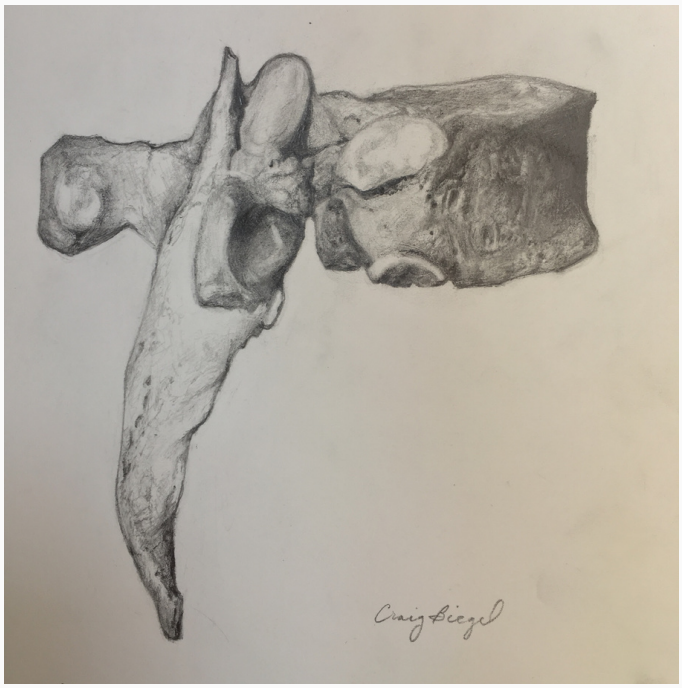


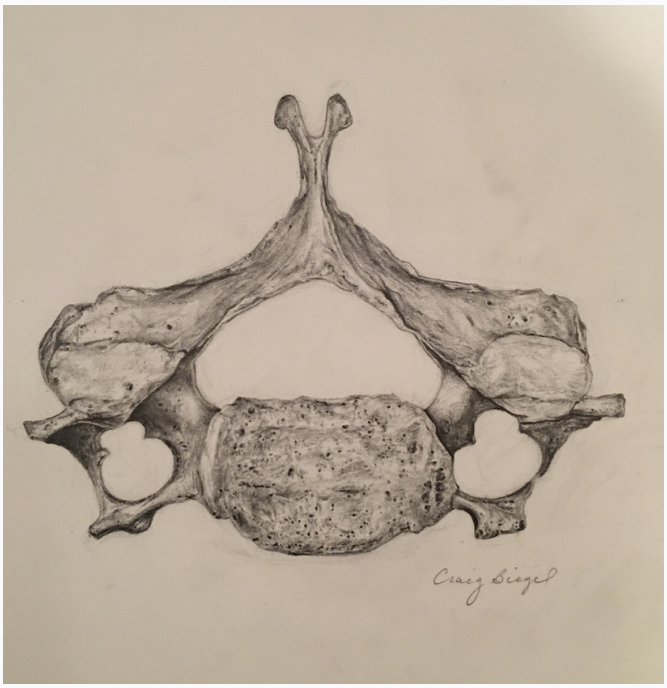
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Claims Filed	605	588	629	620	537	477	482	393	342	441
Settlements (#)	268	204	243	241	197	226	210	151	112	89
Settlements ($)	$130.3	$118.5	$144.4	$103.7	$110.0	$106.9	$116.2	$90.7	$75.5	$60.3

One way to interpret this trend is that Physicians are doing a better job of caring for patients, and patients are experiencing less medical malpractice overall. If this is true, who benefits from the proposals in this new legislation? Perhaps the trial lawyers who feel squeezed by decreased settlement amounts might have an answer.We call for Governor Hochul to veto the current version of this legislation, or partner with vested stakeholders to make substantive changes that would avert the pending upheaval of the financial landscape of the practice of medicine in New York State, ultimately resulting in reduced access to care. If you were one of the community members who stood up for Physicians back when times were tough, I urge you to stand with Physicians now by asking the Governor to veto A.6698 / S.6636, so that Physicians can get back to doing what we do best, taking care of patients.

MSSNY GRASSROOTS CENTER:

https://p2a.co/hn9SSVu





THE ART OF MEDICINE

DR.CRAIG BIEGEL, DO

Pictured here are two graphite-based drawings. The first illustration is a thoracic vertebra in oblique view. The second is a cervical vertebra in coronal view. My goal in these studies was to achieve a hyper-realistic effect through careful shadowing, particularly of the foramina within the contours of the bone.

Medical illustration has helped me appreciate form and function. It has also given me an opportunity to teach medicine through visual means. The connection between art and medicine is historically significant and continues to inspire my professional journey. It is something I will always keep with me throughout my career and enjoy sharing with others.

RELATIONSHIP BETWEEN COVID INFECTION, AUTOIMMUNE ARTHRITIS, AND CELIAC DISEASE



DR. AYMAN ATTIA-ALLA

One day I awoke to see my 6 year-old daughter having knee and foot pain so severe that she could not go to school. At the same time, my wife remarked that she noticed that my daughter was losing weight.

As an internist, the worst scenarios came to my mind and I thought this had to be one of the cancers like Leukemia or Sarcoma. I was unable to sleep or function seeing my 6 year-old child bedridden in pain.

We took my daughter to her pediatrician who initially suspected leukemia. He took blood tests and stated that weight loss in children is always abnormal and should be fully investigated.

Laboratory results showed a high ESR with no sign of malignancy or diabetes. At that time, I believed this was great news but later I found out that it was the beginning of a struggle with a mysterious, complicated, long-term disease.

Following a few MRIs we took her to a pediatric orthopedist who believed that she had some sort of arthritis and osteomyelitis, recommended NSAIDs, and referred us to a pediatric Rheumatologist. She needed NSAIDs a few times a day to control her pain and I felt like I was buying Motrin and Tylenol more often than milk and juice.

Her arthritis and osteomyelitis progressed to the point where she experienced a spontaneous foot fracture which necessitated casting, and she was absent from school for such a long time that the Department of Education commenced an investigation.

It then became more urgent to address her weight loss and lack of appetite. Subsequent blood work showed positive markers for celiac disease, so next we took her to a pediatric gastroenterologist at Northwell Hospital who recommended upper endoscopy and biopsy under general anesthesia.

Unfortunately, the biopsy came back consistent with significant celiac disease inflammation and the gastroenterologist recommended that she be on a gluten free diet for the rest of her life with zero wheat or wheat products. This meant no bread, pasta, or dessert. In addition, it was recommended that she cease dining out because of the cross contamination with gluten that could happen in a commercial kitchen.

We took her to the best pediatric Rheumatologists in the country, and they all agreed that she might have chronic multifocal recurrent Osteomyelitis and they recommended whole body MRI as a gold standard imaging modality for diagnosis and staging.

We called the large outpatient radiology centers in the city to obtain whole body pediatric MRI and they told us that they don't do it, it doesn't exist in their menu, and they thought that we were crazy. I then discovered that a Whole-body pediatric MRI takes about four continuous hours to perform, it is very expensive, and it needs general anesthesia with intubation to make sure the child doesn't move. Therefore, it is done only in a hospital setting.

Although as a physician I understood the necessity of the whole-body MRI, as a Father I was reluctant to subject my daughter to general anesthesia twice in one week and have her intubated for four hours for this procedure.

Finally, we found the Hospital for Special Surgery in Manhattan. The radiologists there were willing to take the chance to perform the MRI without general anesthesia. They were so creative distracting her and they did it in two sessions for a total of 3.5 hours. Sadly, the MRI confirmed the diagnosis. Now, we have two diagnoses, confirmed with biopsy and MRI, in a 6 years old healthy child.

It was obvious to me that it was not a coincidence and Covid was the trigger or the cause. I began to hear similar scenarios from different people.

My daughter was a completely healthy child until she contracted the Covid infection from her mother and three weeks later, the nightmare began. Neither my wife nor I have a family history of arthritis or Celiac disease.

All the rheumatologists suggested Tumor Necrosis Factors like Enbrel and Humira or Methotrexate injections. However, in reading about the side effects of these medicines I found that they can cause every medical disaster known to man from secondary malignancy to liver cirrhosis, pulmonary fibrosis, renal failure, infertility, serious infection, neurotoxicity, and immunosuppression and we were not willing to subject our daughter to the possibility of one or all of these devastating complications. As a result, we decided to look into alternative medicine.

We visited a homeopathic doctor who recommended homeopathic medicine and changing our daughter's diet to a very healthy non inflammatory diet. Her arthritis pain started to improve immediately but her celiac disease is a lifelong struggle, especially after we found that 80% of food products contain Gluten.

The current large propensity scores-matched study of a multi-institutional U.S. Collaborative Research Network showed that patients with a positive PCR test result for COVID-19 had significantly higher risks of autoimmune diseases including rheumatoid arthritis, ankylosing spondylitis, systemic lupus erythematosus, dermatomyositis, systemic sclerosis, Sjögren's syndrome, mixed connective tissue disease, Behçet's disease, polymyalgia rheumatica, vasculitis, psoriasis, inflammatory bowel disease, celiac disease, type 1 diabetes, and also mortality, when compared to "PCR test-negative" non-COVID-19 controls. The results were cross validated in another dataset from TriNetX. The results of subgroup analysis by sex and age were generally consistent. The results of subgroup analysis by race indicated some racial disparity. When compared to their non-COVID-19 counterparts, COVID-19 patients were associated with a significant higher risk of all autoimmune diseases and mortality in Whites, a higher risk of psoriasis and ankylosing spondylitis in Blacks, and a higher risk of systemic lupus erythematosus in Asians.
Also, some discrepancy in risks of autoimmune diseases was found between inpatient and outpatient COVID-19 patients. COVID-19 was associated with increased risks of all autoimmune diseases and also mortality among outpatients, while COVID-19 inpatients were found with increased risks of psoriasis and mortality, but significantly lower risks of systemic sclerosis and inflammatory bowel disease.

CHRONIC MULTIFOCAL RECURRENT OSTEOMYELITIS:

Chronic nonbacterial osteomyelitis (CNO)/chronic recurrent multifocal osteomyelitis (CRMO) is a chronic inflammatory bone disorder affecting primarily children.

CNO has been reported worldwide with female predominance. It is a rare disease, but lack of awareness of the condition has contributed to under diagnosis and reporting. The exact pathogenesis is unknown. Both genetic and environmental factors are thought to contribute to the underlying inflammation.

The main symptom is bone pain. CNO is also associated with other conditions such as psoriasis, palmoplantar pustulosis (PPP), inflammatory bowel disease (IBD), and spondyloarthropathy.

DIAGNOSIS

The diagnosis of suspected CNO/CRMO involves obtaining laboratory studies (complete blood count [CBC], C-reactive protein [CRP], and/or erythrocyte sedimentation rate [ESR]); imaging; and, in many patients, bon biopsy. Whole-body magnetic resonance imaging (WBMRI) is the gold-standard imaging modality for diagnostic and staging purposes.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis includes infectious osteomyelitis, Langerhans cell histiocytosis (LCH), and malignancies that involve the bone (e.g., leukemia, lymphoma, osteosarcoma).

MANAGEMENT

Nonsteroidal anti-inflammatory drugs (NSAIDs) are the first line of treatment for most patients. Additional treatment options for patients with active spinal lesions or in those who have persistently active symptoms and abnormal magnetic resonance imaging (MRI) findings despite NSAID therapy include tumor necrosis factor (TNF) inhibitors, bisphosphonates, and disease-modifying antirheumatic drugs (DMARDs). Patients are monitored with focal MRI studies and by physical assessment.

PROGNOSIS

The disease course can be variable, from mild, intermittent episodes to an unrelenting course with uncontrolled inflammation causing significant morbidity. Early diagnosis and treatment may prevent or decrease complications of the disease.

CELIAC DISEASE:

Celiac disease, also known as gluten-sensitive enteropathy, is a common immune-mediated inflammatory disease of the small intestine caused by sensitivity to dietary gluten and related proteins in genetically predisposed individuals.

Establishing the diagnosis of subclinical or asymptomatic celiac disease is of potential importance due to the risk of malignancy, the presence of unsuspected nutritional deficiencies, and the association with low-birth weight infants in affected mothers.

Patients may present with classic signs, including diarrhea with bulky, foul-smelling, floating stools due to steatorrhea and flatulence. These symptoms are paralleled by the consequences of malabsorption, such as weight loss, severe anemia, neurologic disorders from deficiencies of B vitamins, and osteopenia from deficiency of vitamin D and calcium.

EPIDEMIOLOGY

Celiac disease is not limited to individuals ethnically derived from European populations and has increasingly been found in populations of Northern Africa, the Middle East, India, and Northern China. The estimated global prevalence of celiac disease based on serologic studies is approximately 1 percent.

- High-risk groups
  First- and second-degree relatives of patients with celiac disease are at increased risk for celiac disease. Other high-risk groups include patients with one of the following:
    - Type 1 diabetes
    - Autoimmune thyroiditis
    - Several other autoimmune diseases
    - Down and Turner syndromes

- Pathogenesis
  Celiac disease is an immune disorder triggered by an environmental agent (the gluten component of wheat or related cereals) in genetically predisposed individuals.
  The genetic basis of celiac disease is supported by the frequent intrafamilial occurrence and the remarkably close association with the human leukocyte antigen (HLA) DR3-DQ2 and/or DR4-DQ8 gene locus.

- Clinical manifestations

  Patients with celiac disease may present with classic symptoms related to malabsorption, including diarrhea, steatorrhea, weight loss, and nutrient or vitamin deficiencies. However, the majority of patients with celiac disease exhibit only minor gastrointestinal complaints, have extraintestinal manifestations, or are asymptomatic.

- Associated conditions

  Celiac disease is frequently associated with dermatitis herpetiformis, selective IgA deficiency, and other conditions which have autoimmune features such as type 1 diabetes mellitus, thyroid disease, and other autoimmune diseases.

- Cancer risk

  Patients with untreated celiac disease are at increased risk for lymphoma and gastrointestinal cancer.

DIAGNOSIS

The diagnosis of suspected CNO/CRMO involves obtaining laboratory studies (complete blood count [CBC], C-reactive protein [CRP], and/or erythrocyte sedimentation rate [ESR]); imaging; and, in many patients, bon biopsy. Whole-body magnetic resonance imaging (WBMRI) is the gold-standard imaging modality for diagnostic and staging purposes.

Serological testing is the initial work up to be used followed by small bowel biopsy for positive serology.

Screening for celiac disease should be considered in:

1. Asymptomatic first-degree relatives of patients with a confirmed diagnosis of celiac disease. Serologic testing for celiac disease is recommended in adults with Gastrointestinal symptoms including chronic or recurrent diarrhea or constipation, malabsorption, unexpected weight loss, abdominal pain, distension, or bloating. Testing should therefore be performed in patients with symptoms suggestive of irritable bowel syndrome or refractory lactose intolerance.

2. Patients with iron deficiency anemia, folate or vitamin B12 deficiency, persistent elevation in serum aminotransferases, dermatitis herpetiformis, fatigue, recurrent headaches, recurrent fetal loss, low birthweight offspring, reduced fertility, persistent aphthous stomatitis, dental enamel hypoplasia, metabolic bone disease and premature osteoporosis, idiopathic peripheral neuropathy, or nonhereditary cerebellar ataxia.

SERUM BODY ASSAYS

· Anti-endomysial antibody (EMA-IgA)

EMA-IgA is moderately sensitive and highly specific for untreated celiac disease (sensitivity 85 to 98 percent; specificity 97 to 100 percent, respectively)

· Anti-tissue transglutaminase antibodies (tTG) (tTG-IgA, tTG-IgG).

Anti-tTG antibodies are highly sensitive and specific for the diagnosis of celiac disease (sensitivity 90 to 98 percent; specificity 95 to 97 percent)

The positive predictive value of a strongly positive TG2-IgA (>10 upper normal limit) combined with a positive endomysial antibody is approximately 100 percent.

TREATMENT:

Treatment of celiac disease is a lifelong gluten-free diet. A gluten-free diet reduces or eliminates symptoms for most patients, restores normal growth, and may reduce long-term adverse health risks. The diet should be guided by in-depth consultation with an expert dietitian.

FOLLOW UP:

Repeat tTG-IgA approximately every six months, then annually after it normalizes.

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MSSNY AND ME



DR. MICHAEL RICHTER, M.D.

Chair of BOT-MSCQ

Past President MSCQ 2015

I first became aware of the work that Medical Society of the State of NY (MSSNY) does when we were threatened with malpractice rates increasing by $50,000 over 5 years. I got on a bus to Albany to protest along with 500 of my collegues. There I met Dr. Deb Blenner, a fellow Med/Peds physician. Because of her enthusiasm, the work we were doing that day and our success, I signed up.

While I was president of the Medical Society of the County of Queens (MSCQ), HIP dropped 800 doctors, mostly in Queens and Brooklyn. I was one of them. So was Dr. Attia, who had hundreds of HIP patients. We scheduled a meeting with the CEO and CMO of Emblem. While most doctors remained dropped, we were able to secure Dr. Attia's patients.

Recently, the "Wrongful Death Act" threatened to raise insurance rates not only for physicians but for entire industries. Again, through advocacy, petitions and calls, through leadership from MSSNY and our chapter president, Dr. Joe Cooke, we prevailed.

Being a solo practioner in primary care, I never pursued networking. Patients were referred through friends, family and insurance lists. I met Dr. Lance Austien through the First District Branch (FDB). We were both helping patients fight opioid addiction through the use of buprenorphine, a drug that allows opioid addicted patients to lead a normal life. Lance calls me up one day and tells me there is an addiction practice that needs a part time physician. That work allowed me to have the necessary hours required to sit for the Addiction boards. We are both now board certified in Addiction medicine, something that would not have happened without MSSNY membership.

Membership in MSSNY has given me an opportunity to hone my leadership skills. Having not pursued the opportunity to lead since my chief residency position, I have since been the president of MSCQ, current Chair of the Board of Trustees and have a leadership position in the FDB. The challenge of leadership has made me a better communicator, a person who tries to seeboth sides of issues, to be fair and transparent and to come to the table with new ideas. I would like to thank the late Dr. Ralph Schlossman and Dr. Leah McCormick for their encouragement and guidance.

As if this wasn't enough, the CM Es available, the better understanding of how our state government works and the sense of doing something instead of just complaining about the physician's workload and the mostly unnecessary paperwork has empowered me and made me feel less helpless. Yes, there is something you can do!

It is said that in any given group, 10 % of the people do 50% of the work. That ratio becomes much smaller if you consider the number of physicians in NYS and the number of physicians active in the State Society. When out with a group of physicians, at a dinner, and I hear the complaining, I always ask if they are a member of MSSNY. The most common answer is no. The reason, mostly, is that MSSNY can't do anything because the system is rigged. Or that we no longer offer discounted medical insurance. It's very hard to convince someone who has made up their mind. We must try harder to educate physicians that MSSNY is the forum, not only to have a voice for ourselves but for our patients as well.

MSSNY.ORG

CONTRIBUTORS

DR. AYMAN ATTIA-ALLA



Dr. Ayman Attia-Alla, MD is an internal medicine specialist in Whitestone, NY and has over 30 years of experience in the medical field. He graduated from U Ein Shams, Cairo in 1992. His office accepts new patients and telehealth appointments.

DR. CRAIG BIEGEL



A New York native, Dr. Biegel is a general surgery resident physician at St. John's Episcopal Hospital in Far Rockaway. Dr. Biegel completed his undergraduate degree at Brooklyn College before attending the New York Institution of Technology College of Osteopathic Medicine (NYITCOM) where he obtained his Masters in Neuromuscular Medicine and his Doctorate in Osteopathic Medicine. He is a pivotal member of the surgical residency where his talents in the medical arts translate from paper to his daily work, both in patient care and the delicate nature of surgery. His aptitude for the medical illustrations are unique in a modernized and digital world, and one that he kindly shares with his colleagues in medicine.

DR. DAVID FISHMAN



David A. Fishman, MD is Professor of Obstetrics and Gynecology, Cancer Center Director and Director of Gynecologic Oncology and Vice Chair Obstetrics and Gynecology New York Presbyterian Hospital Queens. Dr. Fishman is an internationally recognized gynecologic oncologist, especially noted for his innovative research on the regulation of ovarian metastasis and in developing new methods for risk assessment and the detection of early stage ovarian carcinoma. He established The National Ovarian Cancer Early Detection Program in 1999 with a grant from the National Cancer Institute and philanthropic support. Dr. Fishman received his medical degree from Texas Tech School of Medicine and completed his residency and fellowship in Obstetrics and Gynecology and Gynecologic Oncology at the Yale University School of Medicine. Most recently he was Professor of Obstetrics and Gynecology at The Mount Sinai School of Medicine and the Director of Gynecologic Oncology Research within the Cancer Center. Dr. Fishman has authored over 230 scientific papers, abstracts, book chapters and several books on gynecologic malignancies. His research has received awards from the National Institutes of Health, National Cancer Institute, Society of Gynecologic Oncologists, Gynecologic Cancer Foundation, American Cancer Society, Society of Gynecologic Investigation, and the Berlex Foundation.

DR. MICHAEL RICHTER



I have been in private practice in Rego Park for the past 31 years, educated in Israel at the Technion, Israel Institute of Technology and completed a Med/Ped residency at Brookdale Hospital. The path here has been a fascinating journey. Honing the craft of Medicine as it has evolved has made this the most interesting life I could imagine. Adding a board specialty of Addiction Medicine has been especially rewarding, always reminding me that many of us are so fragile. The trust patients have in us has been an honor that every physician should appreciate.

CALENDAR

2023-2024

EVENTS	KEY DATES
First District Meeting	September 14 2023
MSSNY Nominations DUE	September 15
MSSNY Council Meeting	September 28
October Board of Trustee (BOT)/Comitia Meeting	October 3
November BOT/Comitia Meeting	November 7 (Election Day)
Budget Committee Meeting	December 5
December BOT/Comitia Meeting	December 12
24/25 BUDGET Presentation	December 12
Comitia Nominating Comm. Meet	December 12
Society/Academy Holiday Dinner	December12
January BOT/Comitia Meeting	January 9 2024
February BOT/Comitia Meeting	February 6
Nominations submitted to Comitia For Approval	February 6
March BOT/Comitia Meeting	March 5
MSSNY Advocacy Day	March 12 (tentative date)
MSCQ Doctors' Day	March 14
April BOT/Comitia Meeting	April 2
MSCQ Past President's Gala	April 6 (tentative date)
HOD Marriott Uniondale, NY	April 12- April 14
Ballot/Election commences	May 1
May BOT /ANNUAL Meeting	May 21
June BOT Meeting	June 4

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