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Let us know what you think.
Please go online to www.SurveyMonkey.com/AMPsurvey to help us evaluate our practice and the information in this issue of Our Health. As a thank you, you will be entered into a drawing for a $100 gift card for Amazon.com.

Welcome to Our Health
Electronic Health Records
Lead to Better Outcomes

You may have noticed your doctors carrying around laptops and digital tablets along with their stethoscopes these days. When they chat with you and tap away, they are not catching up on e-mail, they are recording your conversation digitally and storing it in an Electronic Health Record (EHR).

In this issue of Our Health magazine, we take a look at EHRs. Instead of storing your health record on hand-written notes in an old manila folder, AMP urologists can now access your notes in a digital database. The advantages of EHRs are many—more accurate diagnoses, easier sharing with other specialists, better communication with patients, etc. Learn more on page 4.

We also touch on important urology topics such as urinary incontinence, catheter care, vaginal prolapse, and safe recovery from abdominal surgery—plus, we take a fascinating tour of a very high-tech da Vinci Si robotic surgery machine.

We hope you share this straightforward information with a loved one or physician, so you can make more informed decisions about important health issues. Know that if you ever need to visit with one of our specialists, AMP has made it our mission to always provide comprehensive, compassionate care.

Howard J. Williams, MD, FACS
AMP Chief Executive Officer

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Please go online to www.SurveyMonkey.com/AMPsurvey to help us evaluate our practice and the information in this issue of Our Health. As a thank you, you will be entered into a drawing for a $100 gift card for Amazon.com.

New Lease
After Five Years of Symptoms, Finally a Cure!

www.ampofny.com
AMP Urology has several minimally invasive options to treat stress urinary incontinence (SUI) and cases of urgency or frequency that don’t respond to medication.

For SUI, two modern procedures are tension-free vaginal tape (TVT) and transobdurator tape (TOT). Both of these use a strip of mesh to support the urethra, to help it remain closed when a woman sneezes, coughs, or moves suddenly. We have found these procedures to be 90% successful.

Another option for SUI is an injection of a bulking agent such as Contigen, used to strengthen the bladder neck.

On the other hand, Botox is an injection just approved for widespread use in intractable cases of frequency and urgency. However, this injection must be given every four to six months.

Yet another option we offer for overactive bladder is sacral neuromodulation via the InterStim system. InterStim is an implant that sends mild electrical pulses to help control the nerves of the pelvic floor, offering more bladder control. Typically, we place a temporary implant first in an office procedure. If we see a good outcome, a permanent one can be fitted.

Urinary incontinence should never “just be put up with.” At the very least, a urologist should be consulted if you have symptoms because UI can be a symptom of another disease, as well as being troublesome in its own right.

Non-invasive treatments such as Kegel exercises are a good option for patients with low to moderate symptoms, although those with severe symptoms often will require medication and other more invasive methods.

Any motivated patient who is eager to put in the time and effort, and who is not looking for a quick fix, can benefit from Kegel exercises. In fact, determined patients often do extremely well with them. They can take a little practice to get right because just like any kind of exercise, there is coordination involved, but if a patient needs extra coaching, we’re always ready to help.

There are other non-invasive behavior modifications we use for UI, such as yoga and tai chi exercises, and we sometimes suggest caffeine and caustic foods be cut out because they can cause urgency.
Physician SPOTLIGHT

Vladimir Mouraviev, MD

Dr. Vladimir Mouraviev recently joined AMP Urology as Director of Research. A native of Russia, he completed his training and internship at Kirov State Military Medical Academy in Saint Petersburg before becoming a military surgeon.

Dr. Mouraviev completed his residency at the Department of Military Surgery of Kirov State Military Academy, specializing in urogenital injuries and reconstructive urology. He completed a PhD in uropathology and eventually became assistant professor in surgery and urology.

After receiving further training in oncological urology and endourology in Europe, Dr. Mouraviev completed clinical and research fellowships at Baylor College of Medicine in Houston, Texas; Vancouver Prostate Center in Canada; Duke University Medical Center in North Carolina, and the University of Cincinnati, Ohio.

At Duke, Dr. Mouraviev was Director of the Prostate Cancer Center Outcome Database, and he developed a concept for the focal therapy of prostate cancer, organizing three international symposia on this topic.

The author of more than 100 journal articles and four textbooks—and a reviewer for eight urology journals—Dr. Mouraviev is now a national and international authority in focal therapy of prostate and kidney cancer.

His research and practice focus on novel image-guided navigation systems for targeted biopsy and ablation using such technologies such as cryosurgery, high intensity focused ultrasound, and laser therapy. In addition, he is investigating new medicines for advanced prostate, bladder, and kidney cancer.

Urinary Incontinence

If you think urinary incontinence (UI) is an inevitable and untreatable aspect of aging—especially for women—think again.

Many people are reluctant to discuss UI because of shame or embarrassment, and this reticence may be driving the high sales for over-the-counter solutions, such as incontinence briefs, bed pads, and underwear liners.

But there are so many effective treatments for involuntary loss of urine, these products should be considered a last resort.

Generally, urologists divide incontinence into four categories. Stress incontinence describes leakage during coughing, sneezing, or exercising. Urge incontinence is when urine is passed at unexpected times. Some people are diagnosed with a mix of urge and stress incontinence, while others have an “overactive bladder,” also characterized by frequency and urgency.

About one-half of all women experience UI in their lifetime, and childbirth and menopause often contribute to the condition. But men get UI too, especially those going through prostate cancer treatment or who have an enlarged prostate.

UI is not just an embarrassing problem; it can be debilitating. If UI has stopped you enjoying life, it’s time to see a urologist!

Typically, a urologist will ask you about symptoms, pattern of urination, and medical history. He or she also might measure your bladder capacity and urine retention, perform a bladder stress test, check your urinary tract with a “cystoscope,” and/or test for an infection or stones (a “urinalysis”).

Once your doctor has made a diagnosis, specific treatments can be recommended:

Medication—Anticholinergic drugs, which block nerve receptors, can help overactive bladder or urge incontinence. Topical estrogen can rejuvenate female urinary tract tissues.

Minimally Invasive—These treatments control UI with implants, injections, or inserts. The “sacral nerve stimulator,” for instance, is a small electrical implant to control the bladder. Botox recently has been approved for UI. “Bulking agents” injected near the urinary sphincter help keep the urethra closed. And modern, small slings can help support the urethra.

Non-Invasive—These therapies include bladder retraining, which encourages self-awareness of urinary habits; Kegel exercises, a trusted way to strengthen the “pelvic floor;” and biofeedback, in which sensors are used along with exercise.

Simple lifestyle changes also might be recommended, such as cutting down on coffee, tea, and other caffeinated beverages, as these “diuretics” increase the need to pee. And smokers should know that nicotine irritates the bladder.

We want to hear from you. Send your urology health and wellness question to information@ampofny.com
Meet the Digital Doctor

By Howard J. Williams MD, FACS
AMP Chief Executive Officer

There’s no doubt that the microchip has transformed our world to an extent even greater than when the transistor was invented in 1947.

Smartphones, tablets, and laptops are commonplace. Our cars have become computers on wheels. And thanks to these technologies, we document and communicate our lives as never before.

So it should come as no surprise that the digital revolution has broken down the door to the medical clinic. In doing so, it has taken the recording, storage, and sharing of health records from the age of paper to the age of silicon in just a few years.

Electronic Health Records Improve Quality, Safety, & Efficiency

Essential Equipment

You may have noticed—on a visit to an AMP clinic or at your family doctor—that computers have joined stethoscopes as part of a doctor’s essential equipment.

When a doctor taps his or her computer screen during your visit, they are accessing your Electronic Health Record (EHR). In fact, EHRs have replaced paper records and those old manila folders at AMP Urology, transforming the way we deliver healthcare.

An EHR is sometimes called an Electronic Medical Record (EMR), but there is a crucial difference between the two. An EMR is the record of your visit made at a single office. An EHR refers to your complete health record, which can be shared with other specialists or even accessed by an emergency team in an ambulance or hospital.

Meaningful Use

Far from simply replacing paper records—and ensuring that jokes about doctors’ handwriting become obsolete—EHRs enable your medical information to be made available whenever and wherever it is needed. That will lead to improved coordination between providers and to healthier, more empowered patients.

To help hospitals and clinics make the switch from paper to silicon, the US government is offering incentives via the Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act of 2009.

What is the Meaning of “Meaningful Use?”

The US government is giving hospitals and clinics incentives to switch from paper to Electronic Health Records (EHRs). To receive the incentive, a healthcare provider must show that it is adopting EHRs for “meaningful use.” That means proving that EHRs are:

1) Improving the quality, safety, and efficiency of health care.
2) Engaging patients and family in their own healthcare.
3) Improving the coordination of care among providers.
4) Leading to more accurate diagnoses and better health outcomes.
5) Maintaining privacy and security of patient health information.

For more information on EHRs and “meaningful use,” visit www.healthit.gov.
In order to be eligible for the incentive, a provider must show that it has adopted EHRs for “meaningful use” and is meeting benchmarks to ensure EHRs lead to efficiencies, better outcomes, and lower costs:

✔ Healthcare safety and efficiency of healthcare.

There are too many advantages of EHRs to list here! Making a patient’s records more legible not only leads to safer prescribing but also more accurate billing. Sending e-prescriptions electronically is more precise and convenient. Then there are the plusses of electronic referrals, of clinical alerts and decision support for doctors, and of easier communication with laboratories.

✔ Engagement of patients and family.

Thanks to digital records, a doctor can reach out to his or her patients. Reminders can be e-mailed ahead of an appointment, and after care and self care instructions and web resources can be sent to you at home.

✔ Improvement of care coordination among providers.

If you are seeing multiple specialists or receiving care in an emergency or nursing care setting, your medical records can be shared instantaneously among authorized healthcare professionals. This increases the chance that one specialist will learn about a condition being managed by another, or that your urologist will be notified when you have been in hospital so he or she can follow up.

✔ Improvement of the accuracy of diagnoses and of health outcomes.

EHRs don’t just statically collect and store medical information the way that old manila folders do, they analyze and “push” information and alerts to your doctor. For instance, an EHR not only keeps a record of your medications, it can check for conflicts whenever a new prescription is written. In an emergency room, an EHR can alert a doctor to your life-threatening allergy.

✔ Maintenance of a patient’s health information privacy and security.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA) ensures that your medical records remain private and secure and that they are only shared with authorized providers. HIPAA requirements are embedded in the “meaningful use” EHR incentive program, and a provider must meet strict electronic security measures.

With increasingly “wired” health clinics, you might think the future is already with us, but there’s plenty more innovation to come. In the near future, EHRs might communicate with your digital Personal Health Record (PHR) with which you collect, store, and share your own health information.

We urologists sometimes require an incontinence patient to keep a “bladder diary,” for instance. One day that kind of health record might be written and shared on your smartphone!
Clinical Trials

Helping to Make Medicine Safe & Effective

Clinical trials are sets of carefully designed clinical research and development tests that collect information about the effectiveness, safety, dosage, and side effects of a drug or other medical treatment.

Because these trials are performed on real people, they are only done once non-clinical trials have gathered initial safety information and once the US Food and Drug Administration (FDA) has granted permission to proceed (visit clinicaltrials.gov for more information and for a national database of clinical trials).

Investigators initially enroll volunteers into small studies that monitor dosage levels and side effects. As more information is accumulated, the number of patients tested increases and the drug or treatment is tested against the “placebo effect” (a placebo is a fake treatment made to look like a real one) and against interventions already on the market.

Pharmaceutical companies and/or the government usually sponsor the trials, but they are conducted in collaboration with academic medical centers or large clinical groups, such as AMP Urology. Because our organization has more than 1,000 patient encounters per day, we offer a tremendous opportunity to recruit for and conduct clinical trials at the highest level.

AMP Urology’s clinical research is supervised and monitored by experienced urologists, radiation oncologists, pathologists, and clinical research coordinators, all of whom have worked on several trials over the past 20 years.

Most of AMP Urology’s trials are conducted at local clinical sites—in Syracuse, Oneida, New Hartford, and elsewhere—which are equipped with dedicated research space, personnel, and equipment.

For more information on AMP Urology clinical trials, contact Tonya Godfrey, Clinical Research Coordinator, at 315.478.4185 or tgodfrey@ampofny.com.

By Vladimir Mouraviev, MD, PhD
Director of Clinical Research

JUST THE FACTS TREATMENTS & OPTIONS AVAILABLE

STRIVE: Actual clinical trials being conducted at AMP Urology

A multicenter phase II, randomized, double-blind, efficacy and safety study of Enzalutamide vs. Bicalutamide in men with prostate cancer who have failed primary androgen deprivation therapy.

Sponsor: Medivation, Inc.

A phase II, open label study of the effect of GTx-758 as secondary hormonal therapy on serum PSA and serum free testosterone levels in men with metastatic castration-resistant prostate cancer maintained on androgen deprivation therapy.

Sponsor: GTx, Inc.

An international phase III randomized trial of autologous dendritic cell immunotherapy (AGS-003) plus standard treatment of advanced renal cell carcinoma (ADAPT).

Sponsor: Argos Therapeutics, Inc.

A randomized, phase II, open-label study evaluating DN24-02 as adjuvant therapy in subjects with high-risk HER2+ urothelial carcinoma.

Sponsor: Dendrion Corporation

Immune monitoring protocol in men with prostate cancer enrolled in a clinical trial of sipuleucel-T.

Sponsor: Dendrion Corporation

More at ampofny.com/research
Preoperative MRI May Spare Nerves

A preoperative MRI helps surgeons make more informed decisions about nerve-sparing procedures in men with prostate cancer, according to a study published in Radiology. The complete removal of the prostate is a common treatment for the disease, but it carries the risks of incontinence and impotence. “Preoperative MRI will be useful for surgeons who are uncertain whether to spare or resect nerves,” says Dr. Daniel Margolis, assistant professor of radiology, David Geffen School of Medicine at the University of California-Los Angeles.

Cancer Growth Slowed by BPH Drug

A drug commonly used to treat men with enlarged prostates may also delay the growth of prostate cancer. Dutasteride works by blocking the conversion of testosterone to dihydrotestosterone, the male sex hormone implicated in the development of prostate cancer. Furthermore, men treated with dutasteride were less likely to have cancer detected in their final biopsy, and they reported significantly lower anxiety throughout the study.

Volunteers are critical for the success of any research project.

If you are thinking of taking part in a clinical trial, or have been asked to do so by one of our medical personnel, you should be aware of these advantages:

1) Your decision is completely voluntary.
2) You might be compensated.
3) You will receive individualized attention.
4) The sponsor/drug company provides the medications.
5) You connect directly with the research coordinators.
6) You will be benefiting others in the future.
7) You can withdraw at any time.
8) Your information will be kept confidential.

Contact Tonya Godfrey, Clinical Research Coordinator, at 315.478.4185 or tgodfrey@ampofny.com about AMP Urology clinical trials.

Dose Finding Study: Also called a Dose Ranging Study, a clinical trial in which different doses of a drug are tested.

Double-Blind: An experiment in which neither subjects nor clinicians know who is receiving the real drug and who is taking a placebo.

Open Label Study: A study in which both the clinicians and patients know the drug or treatment being tested.

Phase I Trial: In this first-stage trial, a new drug or treatment is tested on a small group to evaluate its safety, determine a safe dosage, and identify side effects.

Phase II: In a second-stage trial, the drug or treatment is given to a larger group of people to investigate its effectiveness and further evaluate its safety.

Phase III: In a third-stage trial, the drug or treatment is given to large groups to confirm its effectiveness, monitor side effects, and compare it to other drugs.

Placebo-Controlled: Studies often compare the effects of a new treatment with the effects of a placebo (a medically inert, nonactive treatment). The study’s director must tell you if a study is using a placebo.

Placebo Effect: Still a controversial area of research, it appears that as many as one out of three people will feel better simply by taking a pill that looks like medicine.

Surveillance Trial: Also known as a “Phase IV trial” or post-market trial, this study follows the new drug once it is on the market to gather information about its effects in various populations.
Benign prostatic hypertrophy (BPH) is the medical name for the noncancerous enlargement of the prostate gland, a condition that affects more than 50% of men over the age of 60. BPH is a common complaint of old age, partly because the prostate does not stop growing throughout a man’s life. The older men get, the larger their prostates become! Because the prostate is positioned right next to the neck of the bladder, surrounding the urethra, troublesome BPH symptoms can occur if an oversize gland obstructs the flow of urine.

Few men experience problems in the early stages of the condition, but it is estimated that 90% of men older than 70 have some or all of the following lower urinary tract symptoms: weak stream, straining to void urine, hesitancy, urgent urination, and/or a need to wake from sleep at night to urinate (“nocturia”).

The good news is there are many kinds of effective medical interventions for BPH. They focus on either removing tissue, shrinking the gland, stopping further growth, or easing the passage of urine. Our infographic describes some of these therapies, from the most invasive (traditional surgery) to the least (a botanical remedy currently under research).

**Invasive**

**Open Prostatectomy**—The surgical removal of all or part of an enlarged, non-cancerous prostate. This surgery is generally reserved for men with a very large prostate. Robot-assisted surgery is making this surgery less invasive.

**Less Invasive**

**Transurethral Resection of the Prostate (TURP)**—The “classic” treatment for BPH, this surgery is performed under anesthesia. A “resectoscope”—a combined microscope, light, irrigator, and wire loop—is inserted into the gland through the urethra and electricity burns away tissue.

**Minimally Invasive**

**Transurethral Microwave Therapy (TUMT)**—In TUMT an “antenna” is inserted through the urethra and into the prostate to deliver microwave energy that heats and shrinks the gland. Cooling liquid is circulated near the urethra to protect it.

**Transurethral Needle Ablation (TUNA)**—TUNA shrinks the prostate with low-level radio frequency (RF) energy delivered to the gland via a small catheter inserted through the urethra.

**Green Light Laser Surgery**—Green light therapy uses a highly targeted, high-energy laser beam delivered via fiber optics to vaporize prostate tissue and cauterize blood vessels.

**Non-Invasive**

**Hormone Suppression**—Drugs such as finasteride inhibit testosterone, the male sex hormone implicated in prostate enlargement. (These are the drugs that also treat male pattern baldness!)

**Alpha-1 Blockers**—These drugs make blood vessels dilate and smooth the muscle of the prostate and bladder neck to help improve urine flow.

**Saw Palmetto**—This herbal remedy is extracted from the fruit of a palm-like tropical tree. It is thought to suppress testosterone, and it is an anti-inflammatory, although researchers are divided on whether it is truly effective.
Now Open for Enrollment
ADAPT Study
A Phase 3 Randomized Study of Autologous Dendritic Cell Immunotherapy (AGS-003) Plus Standard Treatment for Advanced RCC

Study Background
- Approximately 450 subjects to be randomized
- Newly diagnosed, synchronous, metastatic RCC subjects who are candidates for nephrectomy (Nx)
- Heng intermediate or poor risk (1-4 risk factors permitted)
- A small tumor sample will be obtained from all subjects during Nx
- A single leukapheresis to collect PBMCs will be required for subjects randomized to Arm A only
- All subjects will initiate standard therapy for one 6-week cycle after Nx, while subjects randomized to Arm A will initiate AGS-003 treatment prior to cycle 2.

Endpoints
- To compare OS between study arms
- To compare response rates, PFS and safety between arms
- To compare immunologic responses between arms

Patient Population
- Confirmation of metastatic RCC with a component of clear cell
- Measurable disease following Nx
- Karnofsky PS 80-100%
- No prior systemic therapy for RCC
- No history of or known brain metastases
- No evidence of autoimmune disease

Study Design

Arm A: AGS-003 (8 doses) + Standard Therapy* for 48 weeks (N=300)

Arm B: Standard Therapy* for 48 weeks (N=150)

AGS-003 quarterly + Standard Therapy* until PD

Standard Therapy* until PD

*Standard therapy initiates with 6-week cycles of sunitinib (50mg daily for 4 weeks, 2 weeks off). Other compatible agents may be substituted for intolerance or initial PD prior to week 48.

For More Information
ADAPT study: contact@adapt-study.com
About Argos: www.argostherapeutics.com
A New Lease on Life!

A Retired Nurse Becomes an Advocate for Cystocele Repair Surgery

By Martin Walls

As an emergency room nurse, you’d expect Rachel Ashton, 57, to have been right on top of her embarrassing medical situation. After all, she had spent her career understanding her patients’ symptoms and finding the most effective treatments to bring them relief.

But Ashton didn’t listen quite as well to signs from her own body.

Busy Coping

“I went five years coping with my urinary incontinence,” she admits. “Back then, I was busy with treating my chronic back pain, with farming, and with my career. I was putting others first, as nurses often do.”

As Ashton indicates, her incontinence began after she injured her back at her nursing job (from which she has since retired), damaging nerves in her pelvic region. “I had to do lots of physical tasks at the hospital. Lifting 300-pound patients was not out of the ordinary,” she says.

Exacerbating the stress on her pelvic region, Ashton’s physical labor didn’t ease up when she got home. The mother of three children, she helps her husband raise cattle and other animals on their small Central Square, New York farm.

Gradually, what with the nerve damage, having three kids (although Ashton says these were uncomplicated deliveries), and heaving lifting at work and on the farm, she noticed she was leaking urine whenever she bent over. “But pretty soon I was leaking all the time, even just walking around.”

Not Pretty

By the time Ashton went to a doctor about her symptoms, they had become so bad she felt ostracized.

“In the end, I didn’t even want to go out, even to do family functions. I’d just stay on the farm, caring for my cattle and my peacocks.”
“They’re easy to care for!”—to sell their chicks, eggs, and feathers.)

“My situation was self-imposed,” continues Ashton, explaining that the urine from her continuous leaking couldn’t even be soaked up with multiple sanitary napkins. “At work, I’d be using two or three pads and still have to change them every few minutes. It was not pretty.”

Frustrated by her symptoms, embarrassed by the odor, made uncomfortable by red raw skin around her groin, and unable to enjoy her husband’s intimate company, Ashton finally went to her gynecologist, who recognized her problem as one a urologist could help with.

Fixing the Problem
Ashton was referred to Dr. Joel Bass at AMP Urology. “Dr. Bass diagnosed me with a cystocele,” says Ashton, drawing on her medical knowledge to offer a definition. “This is a type of prolapse in which the bladder drops into the vagina because the fibers that hold the bladder in place are damaged. My case was severe; my bladder had dropped below my pubic bone.”

Her prolapsed bladder was the cause of Ashton’s incontinence. With so much leakage—and, counter-intuitively, trouble completely emptying her bladder—Ashton counts herself lucky that she wasn’t having recurrent urinary infections, the symptom that usually sends women to the doctor. “At the time, I was drinking plenty of water because of my pain medication, which helped my urine stay clean,” notes Ashton. But another form of self care—a common frontline treatment for urinary incontinence—proved ineffectual. “I’d been trying Kegel exercises, but in my severe case, these were doing no good,” says Ashton. “So I asked Dr. Bass what options he had to fix the problem for good.”

Feeling Hope
Dr. Bass recommended a surgical procedure in which a “sling” is fitted inside Ashton’s pelvic region to keep her bladder in its correct position and out of the way of the vagina. “The sling fitted inside me is made of synthetic mesh, and it’s tied into my hips,” explains Ashton. “It’s a little like a bra down there, ‘lifting and separating’ my bladder from my vagina!”

Ashton says she wasn’t nervous about the operation, for which she was admitted into the hospital overnight. But the lack of nerves wasn’t because she’s a nurse used to clinical situations. “By then I was at the end of my rope, and I was feeling hope rather than apprehension about the outcome of this procedure.”

Her positive attitude lead to a quick recovery, believes Ashton. “Within two to three months, I really noticed a difference, even when I coughed and sneezed,” she says. “These days, I don’t leak at all, and I feel 250% better!”

So Much Better
Her new lease on life includes a rediscovered intimacy with her husband. “Smelling of urine and having rashes down there isn’t exactly good for that,” Ashton admits. “My husband doesn’t notice the sling when he’s inside me, and this situation is so much better for sexual relations.”

Seven years after her cystocele repair surgery, Ashton only has to go to see Dr. Bass once a year. “AMP Urology has always treated me very well,” she says. “Dr. Bass gets embarrassed when I say, ‘You’re Number One! But I really think he’s one of the best doctors in Central New York. He keeps up with the research and studies, and he explains everything to his patients. Plus, his receptionist always remembers my name.”

Since her surgery, Ashton has become an advocate for prolapse repair as a cure for urinary incontinence.

“I even convinced my mother to get a sling, and she’s in her eighties!” says Ashton. “You’d be surprised how many women suffer in silence with the symptoms of bladder prolapse. But sling surgery has changed my life!”

For more information, visit the National Kidney and Urologic Diseases Information Clearinghouse online at kidney.niddk.nih.gov.

WHAT IS CYSTOCELE?

A cystocele occurs when the wall between a woman’s bladder and her vagina weakens and the bladder drops into the vagina. This prolapse can cause two kinds of problems: unwanted urine leakage and/or incomplete emptying of the bladder. Sometimes the opening into the urethra widens, causing urine leakage when a woman coughs, sneezes, or laughs.

A cystocele can result from giving birth or heavy lifting. Also, because estrogen keeps pelvic muscles strong, when a woman goes through menopause, the muscles around the vagina and bladder may grow weak.
Test Prep
How to Prepare for Your Out-Patient Urology Exam

Cystoscopy and urodynamics are two of the more common outpatient urological procedures performed by doctors and physician extenders at AMP Urology. These tests are used to diagnose the cause of a wide range of common lower urinary tract symptoms (LUTS), including blood in the urine (hematuria), painful urination (dysuria), inability to pass urine, or urgent urination.

Both these procedures are minimally invasive. A cystoscopy usually only takes only 10 minutes, although it could take longer depending on what the urologist finds or if other instrumentation is being used (such as for a biopsy). On the other hand, urodynamics takes about one hour to complete.

As with many medical tests, some special preparations are required, which are described here.

Of course, if you have questions or concerns about a test at any time, contact your AMP urologist, physician’s assistant, or nurse.

What is it?
Cystoscopy allows your doctor to look inside your urinary tract using a thin, lighted instrument called a cystoscope that is inserted into your urethra and slowly moved toward the bladder. Sometimes tiny surgical instruments are also inserted to remove samples of tissue (a biopsy), urine, bladder stones, small growths, or tumors.

Why Is It Performed?
Cystoscopy is performed for many reasons, including:

✓ To investigate blood in the urine, painful urination, urinary incontinence, overactive bladder, and/or urinary tract infections (UTIs).
✓ Look for a blockage in the urethra.
✓ To remove tissue samples, stones, or growths.
✓ To place a catheter.

How Do I Prepare?
✓ Tell your doctor if you are allergic to any medicines or latex; if you are taking blood-thinning medicine; or if you are or might be pregnant.
✓ Cystoscopy is sometimes performed with local, spinal, or general anesthesia. If this is the case, arrange for someone to drive you home, clear your schedule for the day, and have a friend or relative check on you once at home.
✓ You may be given antibiotics to prevent a UTI.
✓ In most cases, you will be able to eat normally in the hours before the test.
✓ Ask for instructions on emptying your bladder before the test. In certain situations, your doctor may order a urine test before your cystoscopy.
What Is It?
A urodynamic test is a simple procedure that helps a doctor assess how well your bladder and urethra are storing and releasing urine. At its simplest, you will be asked to pee while a nurse records the length of time it takes for you to produce a urinary stream, notes the volume of urine produced, and records your ability to stop the urine flow in midstream.

More complex forms of urodynamic testing might use imaging equipment to take pictures of your bladder, sensors to record muscle and nerve activity, or pressure monitors. In a variation of the test called a cystometry, for instance, a catheter is inserted into the bladder and pressure is measured as the instrument is filled with fluid.

Why Is It Performed?
Urodynamic tests are investigate a host of symptoms involved in stress and/or urge urinary incontinence, including:
- Urine leakage
- Frequent urination
- Painful urination
- Sudden urges
- Problems starting a stream
- Problems emptying the bladder
- Recurrent UTIs

How Do I Prepare?
- In most cases, you may eat, drink, and take all of your usual medications on the day of the test.
- Tell your doctor what medications you are on and if you are allergic to latex.
- The test will not require sedation, so you will be able to drive yourself home.
- Notify your provider if you have a UTI. Usual symptoms are fever, chills, burning during urination, and blood in the urine.
- Arrive at the clinic with a full bladder. Do not urinate at the clinic unless you absolutely have to.
- If you believe keeping your bladder full will be difficult, arrive a little early and drink water at the clinic to fill your bladder.
- If you wear padding or external catheters, bring extra supplies for after the test.
- Know that you will have to urinate with a nurse or doctor present.
Do's & Don’ts of Catheter Care:

- Frequently check the drainage tubing for kinks and loops.
- Keep the drainage bag below the level of your bladder when laying down, sitting, or standing.
- Twice a day, wash the area where your catheter enters your body with soap and water.
- After bowel movements wipe away from your catheter and wash your rectum.
- Wash your hands with soap before attaching the leg bag or night bag to your catheter.
- Empty your drainage bag every four hours, before you go to bed, when you know you won’t be near a bathroom, or whenever the bag is full.
- Write down the amount of urine drained if your doctor requests this information.
- Drink at least eight glasses of fluid each day.
- Always follow the detailed care instructions your caregiver provides you.
- Never pull on your catheter for any reason.
- When the catheter is not attached to a bag, never touch its end to any surface.
- Do not remove your catheter unless you have been taught how to by a medical provider.

Contact Your Doctor If You Have:

- Urine leakage around the catheter.
- Pain or fullness in your abdomen.
- Spasms in your bladder.
- A low urine flow.
- Signs of an infection, especially fever or chills.
- Urine that is cloudy, smells foul, or has blood or particles in it.
Viagra + Testosterone = No Magic Bullet

For men with erectile dysfunction (ED), adding testosterone to Viagra does nothing to improve erections, sexual performance, or physical intimacy, according to recent results from the Male Sexual Health Questionnaire (MSHQ).

Men with ED often have low testosterone levels, and testosterone is a well-known regulator of sexual motivation, so many experts have suggested testosterone replacement as a potential therapy for ED, used in conjunction with currently approved ED drugs such as sildenafil, better known as Viagra.

But the MSHQ—which followed 140 patients with ED, 70 of whom were given sildenafil and a testosterone gel, and 70 of whom were given sildenafil and a placebo—shows that there was no difference between the groups in any of the questionnaire responses, suggesting the additional treatment had no effect.

Surprising Numbers Sent to the ER by Genital Injuries

Almost 16,000 men and women visit emergency rooms every year because of serious genital injuries, according to a study reported by Fox News. Bicycles, furniture, and clothing are all items blamed, says Benjamin Breyer, an assistant professor of urology at the University of California-San Francisco.

The study, which appears in the Journal of Urology, analyzes a national database of emergency room visits caused by common consumer products, identifying all genital injuries to men and women 18 years and older between 2002 and 2010. The injured body parts include penises, testicles, bladders, kidneys, and female genitalia.

Sports products—such as bicycles, soccer balls, and baseball equipment—were the most common cause of injuries. People landing on their bicycle’s center bar is one example.

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DrGraberMD.com Turn to us, and turn a new leaf.
FDA Seeks Medical Apps Regulation

Want to monitor your blood pressure? Blood sugar level? Check the calories of your meal? Take a mental health screening test? An eye exam? Well, these days “there’s an app for that!”

In fact, according to the Kaiser Family Foundation, there are already 40,000 medical software applications (apps) available for download on smartphones and computer tablets—and these are being called the “early days” of medical app development!

Now, the US Food and Drug Administration (FDA) wants to regulate the market to ensure that medical apps are both safe and effective.

The benefits of using personal computers to monitor health are enormous, offering doctors the opportunity to check a patient’s signs and symptoms in real time and not just during a visit to a clinic.

Doctors are even embracing some apps because they see them as better alternatives to traditional (and expensive) medical devices. For instance, Dr. Orrin Franko, an orthopedic surgery resident at the University of California-San Diego, has invented a device that works with an iPhone app to measure the curve of the spine. It mimics a traditional medical device called a “scoliometer” — at a fraction of the cost.

But so far, the medical app market is something of an unregulated “Wild West,” and it is difficult to know which apps live up to their health claims and provide accurate information and which are the computer-age equivalent of snake oil.

To begin its regulation, the FDA is finalizing guidelines that will require mobile app developers making medical claims to apply for FDA approval, the same way that new medical devices must be proven safe and effective before they can be sold.

But developers are complaining that the approval process is expensive and much too slow for this innovative, entrepreneurial medical market.

New App Offers Information & Relief for IC Patients

A new iPhone and iPad application—the Interstitial Cystitis Network (ICN) Food List—aims to give interstitial cystitis (IC) patients an easy-to-use food list and database that they can use while shopping and eating out at restaurants.

IC is often triggered by citrus and spicy foods and cheeses, beans, breads, and yogurts, as well as drinks such as coffee, tea, and cranberry juice.

The app makes use of a database developed from published research studies and food lists created by support groups. The more than 250 foods in the list are divided into three general categories: bladder friendly foods, foods to try cautiously, and foods to avoid.

The app is available for iPhones and iPads at just 99 cents. Additional information can be found at: http://www.ic-network.com/apps.

Pregnancy Test Leads to Cancer Diagnosis

An Internet post by a man joking about his ‘positive’ pregnancy test appears to have alerted him to a testicular tumor, reports ABC News.

Taking a pregnancy test as a joke, the man was shocked to see two pink lines emerge, the sign—for a woman—that a bun is in the oven. Amused by this, the man posted the result on reddit.com, a popular Internet thread for the bizarre, humorous, and strange.

“You may have testicular cancer! Get to an oncologist!” was one of more than 1,300 comments the post received. Sure enough, medical investigation revealed that the man had a tiny lump in his right testicle.

The reason for this odd cause-and-effect? Pregnancy tests detect a hormone in the blood and the urine produced by a developing placenta in a woman’s womb, but in a man, presence of the hormone is also a sign of testicular cancer.
Urological Conditions Prove an Economic Burden

A new edition of *Urologic Diseases in America* (UDA) has been revised and updated for 2012, and among its revelations is the fact that conditions such as urinary tract infections, kidney stones, and prostate cancer are a major economic burden on Americans, resulting in healthcare costs close to $40 billion annually.

The UDA incorporates information from nine public- and private-sector databases covering outpatient and ambulatory care utilization. It contains a wealth of detailed information on the use of urological treatment resources and costs associated with urologic diseases.

Other findings from UDA show that nearly all patients with high-grade, noninvasive bladder cancer are not receiving the recommended care that would best protect them from disease recurrence; that clinical guidelines for benign prostatic hyperplasia were only being followed to a moderate degree across the US; and that sacral nerve electrical stimulation implants to treat urinary urge incontinence are less acceptable to the general public than expected from clinical trials.

- Urine contains nitrogen-rich “urea,” a fertilizer. In fact, you can apply diluted urine directly to your garden!

- Before modern cleaning agents, households sometimes used “lant,” or aged urine, which contains ammonia.

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Study Finds in Favor of PSA Testing
Routine PSA prostate cancer screening offers early warning to an extra 17,000 Americans each year that they have an aggressive form of the disease, called metastatic prostate cancer. The new study—published in Cancer—argues in favor of PSA testing. It concludes that in the three years before widespread PSA testing (1983-1985), men getting their first diagnosis of prostate cancer were three times more likely to learn they had late-stage, metastatic cancer than men diagnosed from 2006 to 2008.

Statins Could Help Prevention
Statins, taken to lower cholesterol, could also significantly reduce the risk of getting prostate cancer. According to researchers at the US National Cancer Institute, men with high cholesterol levels were 22% more likely than those with low or normal readings to suffer a prostate tumor and 85% more likely to develop a fast-growing form of the disease.

Hormone Therapy Cuts Deaths
For men with aggressive prostate cancer, hormone therapy cuts the overall risk of death, according to the Journal of the American Medical Association. “These results should be reassuring for patients who are thinking of androgen deprivation therapy for their prostate cancer,” says Dr. Paul Nguyen of the Dana-Farber Cancer Institute and Brigham and Women’s Hospital in Boston, Massachusetts, who was the study’s lead author.
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FSD—the Forgotten Disorder?

Discussing Sexual Health with a Urologist Is a Good Idea

A magazine about urology topics might not seem like the place to discuss female sexual health, but a recent study published in the British Journal of Urology International proves the link—a surprising number of women who visit urology clinics also report some form of female sexual dysfunction (FSD).

With all the ads for male erectile dysfunction treatments, you’d be forgiven for thinking FSD is a rare disorder, but according to the American Medical Association, more than 43% of American women experience some form of sexual dysfunction in their lifetimes.

Low Visibility

In fact, in its definition of sexual disorders, the World Health Organization makes no distinction between men and women, describing them for both sexes as “the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish.”

An individual might suffer from one or a combination of related sexual problems, including lack of desire, aversion to sex, failure of genital response, orgasmic dysfunction, and (in women) spasms of the vaginal muscles and painful intercourse.

One reason why FSD doesn’t have the same visibility as erectile dysfunction is because talking about female sexual desire and anatomy is still taboo in many cultures.

Another reason may be that, unlike men who see urologists for both urinary and sexual symptoms, women see urologists and gynecologists, and the former may be unaware of related or parallel symptoms of sexual dysfunction in their female patients.

Team Approach

But the BJUI study shows that a team approach to female sexual health is warranted. In their study of 587 female urological patients in a major US city, researchers found that 63% had some form of FSD. Major causes of FSD in these women were age, menopause, and the use of depression medication, specifically, selective serotonin reuptake inhibitors, or SSRIs.

Rooting out the cause of FSD might take some investigation, involving patient history (to look at the role of other illnesses and medications), physical examination (to look at issues involving muscles and blood flow), and laboratory tests (to assess hormone levels).

This comprehensive investigation might involve a urologist, a gynecologist, and a sexual health counselor. But as the BJUI study shows, it’s the urologist who might be the first specialist seen for both urological and sexual health complaints.

So if your sexual health is bothering you, know that an experienced, empathetic urologist is one of the best people with whom to begin your discussion of these issues.
The Four Types of FSD

The causes of Female Sexual Disorder are complex, often involving physical, psychological, and emotional factors, although doctors divide FSD into four categories:

- **Hypoactive Sexual Desire**—The prefix “hypo” means lack of something, in this case, a lack of sexual desire or the inability to respond to sexual stimulus.

- **Sexual Arousal Disorder**—The physical and emotional inability to achieve or maintain sexual excitement and a lack of genital response.

- **Orgasmic Disorder**—Difficulty or delay in achieving orgasm.

- **Sexual Pain Disorder**—This includes painful intercourse (dyspareunia) and vaginal spasm that prevents penetration (vaginismus).

Treatment Strategies for FSD

Male and female sexual disorders often have similar causes, and some of the treatments are the same for both sexes:

**Education**—Women and their sexual partners can benefit from accurate and honest information about female anatomy; sexual health and communication; and the effects of aging, illness, and medications on anatomy and desire.

**Hormone Replacement Therapy**—Estrogen replacement therapy may help in post-menopausal women, and testosterone can boost sexual desire in females.

**Kegel Exercises**—These simple exercises designed to strengthen the “pelvic floor” can improve the contraction and relaxation of the pelvic muscles.

**Medication**—Drugs (such as Levitra and Viagura) used to treat male erectile dysfunction by increasing blood flow to the genitals are now being tested as an FSD intervention.

**Topical Medications**—Lubricants can help in cases of painful intercourse, while topical medicines such as Sensual and Viagel can increase blood flow to the genitals thus increasing arousal.

If you have been told you need gallbladder surgery, ask your doctor about Single-Site da Vinci Robotic Surgery

Oneida Healthcare is the only hospital in Central New York performing Single-Site Gallbladder removals with the da Vinci Robotic Surgery System.

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*As with any surgery, these benefits cannot be guaranteed since surgery is unique to each patient and procedure.
Approved by the Federal Drug Administration in 2000, and now installed in more than 1,900 hospitals and clinics, the da Vinci robot-assisted laparoscopic surgery system is an excellent example of cutting-edge military technology being converted to civilian use.

In the late 1980s the Army’s Defense Advanced Research Projects Agency (DARPA) investigated a remote, robotic triage system that could save soldiers’ lives and keep Army doctors out of harm’s way.

A battlefield “surgical drone” never came to fruition, but the related idea of surgeons remotely manipulating robotic instruments with the help of a video feed led directly to Intuitive Surgical’s robotic system. Intuitive named its device after the Renaissance painter Leonardo da Vinci, who also designed robots (or “automatons” as they were once called).

The da Vinci enables a surgeon—seated at a console a few feet from the patient—to perform operations through tiny, “keyhole” incisions with high-level vision, precision, dexterity and control. In this article, we take you on a tour of the latest model—the Si—explaining its special features, as well as those found on all da Vinci models.

Learn more at intuitivesurgical.com or visit ampofny.com/urologists.
AMP Urology offers the following robotic procedures:

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- Radical Cystectomy (bladder removal)
- Pyeloplasty (reconstruction of the renal pelvis)
- Ureteral Reimplantation (reconnection of the ureter)
- Adrenalectomy (adrenal gland removal)

1. **Wide Touchscreen**
   A wide touchscreen helps the surgical team to collaborate and improves the view of anatomy and instruments.

2. **Safety Self-Checks**
   The da Vinci performs more than one million safety checks per second.

3. **Dual Console (Si System)**
   Used for both training and collaboration, the Si's dual console allows each surgeon to sit at an individual console and see the same high definition 3D images.

4. **3D HD Vision (Si System)**
   The da Vinci® Si sends high-resolution (1080i HD) 3D video images to the surgeon's console, offering visual sharpness, 10X magnification, true depth perception, and a virtual extension of the surgeon's hands and eyes into the patient's body.

5. **Fingertip Controls**
   Enhanced master controllers allow for precise control of instruments. Motion scaling enables seamless adjustments of hand-to-instrument movements.

6. **Ergonomics**
   The da Vinci is the only surgical system that allows doctors to operate while seated, reducing fatigue. Fatigue and patient trauma is further reduced by the robotic arms holding the camera and instruments steady.

7. **Footswitch Panel**
   The footswitch panel enables a surgeon to perform tasks such as swapping between different types of instruments.

8. **Touchpad**
   Surgeons control video, audio, and other settings at the touch of a button. Settings can be stored to a user profile, providing automatic recall for future surgeries.

9. **EndoWrist® Instruments**
   Modeled after the human wrist, EndoWrist instruments—used to perform cutting, cauterizing, and other operations—provide surgeons with natural dexterity and a greater range of motion than the human hand.

10. **Robotic Arms & Patient-Side Cart**
    The patient-side cart includes either three or four robotic arms that carry out the surgeon's commands. The robotic arms move around fixed pivot points, which reduces trauma to the patient and increases precision. The system requires that every surgical maneuver be directly controlled by the surgeon.
Getting to the Core

Simple Exercises for Post-Surgical Recovery

Exercise is an important part of recovering from abdominal surgery of any kind, especially invasive or open surgery. This is especially true if you have had “pelvic floor” surgery.

The muscles and connective tissue of the pelvic floor are unusual in that they don’t perform the duties of lifting or resistance that other muscles do, so in order to strengthen them after surgery, targeted exercises—often called “core strengthening” exercises—should be done. It’s important you talk with a doctor or physical therapist before performing the exercises described below, because they can be done only after your body has had proper time to heal. In some cases, a course of basic exercises might first be required—such as walking or Kegel exercises—before trying these workouts.

Your caregiver also will tell you to accompany your new exercise regimen with plenty of sips of water and appropriate rest between “reps” and to be aware of your new physical limitations. For instance, if you feel pain, stop the exercise immediately and talk with your doctor.

Pelvic Tilt
1) Lie on your back with a pillow under your head.
2) Bend your knees.
3) Breathing in, push your lower back toward the floor while slowly tightening the abdominal muscles.
4) Breathe out for a count of five to 10 seconds, then relax your muscles.
5) Repeat five to 10 times.

Heel Slides
1) Lie on your back with your knees bent and feet flat on the floor.
2) Pull your belly button into your spine and hold this position.
3) Slowly slide your right heel out until your leg is fully extended.
4) Concentrating on using your abdominal muscles, gently pull your leg back into the bent position.
5) Repeat the movement with your left leg.
6) Complete five repetitions with each leg.

Stomach Vacuum
1) Get on all fours with your knees directly under your hips and your hands directly under shoulders.
2) Take a deep breath in and allow your belly to hang loosely.
3) As you exhale, draw your belly button into your spine and contract your abdominal muscles.
4) Hold the contraction for 10 seconds, then relax.
5) Repeat the exercise five times.

Buttocks Lift
1) Try to keep your abdominal muscles squeezed tightly during this exercise.
2) Lie face up on the floor or bed with your head resting on a pillow.
3) Relax your arms next to your sides, palms down.
4) Bring your feet to about one foot from your buttocks so your knees are bent slightly less than 90 degrees, with your feet parallel and pointing straight ahead.
5) Squeeze your buttocks and raise them in the air, only as high as feels comfortable and no higher than needed to make a straight line with your body from your knees to shoulders.
6) Lower your buttocks slowly.
7) Repeat five times.

For more simple exercises to help you recover from surgery, visit livestrong.com.
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Visualizing a Cure

Meditation as a Treatment for IC/PBS

In the United States, more than one million women and men live with interstitial cystitis (IC)—sometimes called painful bladder syndrome (PBS)—which causes chronic symptoms of urinary urgency, frequency, discomfort, and pelvic pain.

Many IC/PBS patients have found meditation helps manage and alleviate their long-term symptoms. And in an age when alternative medicine is receiving more scientific scrutiny, research is backing up anecdotal evidence that meditation is a treatment option worth discussing with your urologist.

Besides, researchers argue, meditation is readily available, can be performed easily at home, has virtually no side effects, and at the very least offers other benefits, such as promoting relaxation, mindfulness, and increased concentration.

Focusing the Mind

Meditation is as old as human civilization; the earliest references to it arise out of 6th century BC India. There are many forms and methods of meditation—almost as many as there are cultures on Earth—but in general they share a practice of concentrated focus upon sounds, objects, visualizations, breathing, movement, or even the mind itself.

One method popular in the West is “guided imagery,” in which thoughts and suggestions (from a CD, instructor, or script) help guide your imagination toward a relaxed, focused state. By using all of your senses, guided imagery can make your body seem as though what you are imagining is real. For instance, guided imagery that asks you to imagine picking, peeling, and eating an orange in attentive detail can leave you salivating as if you were about to do the real thing.

Improving Symptoms

One study—published in the Journal of Alternative Complementary Medicine—set out to explore the effect of guided imagery on pelvic pain and urinary symptoms experienced by IC/PBS patients. In this randomized study, 30 women with IC were split into two equal groups. One group listened to a 25-minute guided imagery CD that focused on healing the bladder, relaxing the pelvic-floor muscles, and quieting the nerves involved in IC/PBS. The other group was simply asked to rest up for 25 minutes a day for eight weeks.

Both groups filled out pain questionnaires and kept a “bladder diary” detailing how often they went to the bathroom. The researchers found that more than 45% of the guided imagery group noted a moderate or marked improvement in symptoms, with pain scores and episodes of urgency significantly decreasing for this group.
A Guided Imagery Script for IC/PBS Patients

- Sit comfortably in a chair with your spine reasonably straight and your legs uncrossed. Close your eyes.
- Starting with your feet, tighten muscles in your toes, then hold and release them.
- Move up your ankles and calves, tightening the muscles, holding, and releasing.
- Move up the body in this manner slowly. As you release each muscle, you should begin to feel relaxed. Do this until you have reached the top of your head.
- With your eyes closed, visualize a ball of radiant light hovering a few inches above your head.
- Take a deep breath and visualize the ball of light gently descending through your head and filling your entire body.
- Imagine this light as a source of healing that can cleanse and heal your whole body.
- Let the ball of light pass slowly through your body until it reaches your bladder and passes into it.
- As the light moves through the inside of your bladder, begin picturing areas that are inflamed or irritated.
- Focus your attention on those areas one by one, calling on the light to heal each spot.
- When the ball of light has moved through your entire bladder, imagine your bladder looking healthy, with a smooth, pink surface.
- Now spend a few more moments visualizing yourself in a state of perfect, radiant health.
- Take another slow, deep breath and open your eyes.

Other Alternative IC/PBS Therapies Include:
- Counseling
- Massage Therapy
- Sleep Therapy/Medication
- Tai Chi
- Yoga

For more information on IC/PBS and its treatments, visit ic-network.com.

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Take Two
Another Use for Aspirin

It’s arguably the most useful drug in our medicine cabinets, known across the world since at least the 5th century BC to cure a variety of ills.

But before acetylsalicylic acid was known as aspirin, it was familiar to healers as a bitter powder (salicin) that could be extracted from willow bark. The Greeks used it to reduce fevers and ease pain, and so did the Sumerians, Assyrians, Cherokee, and Europeans.

In 1897, Felix Hoffmann, a chemist with German company Bayer, first turned acetylsalicylic acid from a folk cure into a pharmaceutical. Today, aspirin is used to relieve the symptoms of arthritis, lupus, and rheumatism; to lower fevers and relieve aches and pains; and to prevent heart attacks and strokes and reduce the risk of death from them.

Now, according to the Journal of Clinical Oncology, there’s one more use for this wonder drug. In a study of nearly 6,000 men who had localized prostate cancer and were treated with surgery or radiotherapy, those who took aspirin regularly (about one-third of those studied) were less likely to die of cancer than patients who didn’t take the drug. The study also notes that the aspirin-takers were less than half as likely to die of prostate cancer over a 10-year period than the non-aspirin group.

Another Reason to Eat Your Oatmeal!

This research began with a mystery: despite having similar rates of prostate cancer, why do men in Western cultures suffer from higher rates of advanced disease than men in Asian countries. The answer may well be diet. Specifically, a high fiber diet.

Foods high in fiber contain a chemical called inositol hexaphosphate (IP6), and when this compound was tested in mice by scientists at the University of Colorado Cancer Center, it was found to dramatically reduce the progression of cancer.

Specifically, IP6 slows prostate tumors by stopping them from making new blood vessels. Without blood, tumors can’t get the energy they need to grow. At the same time, researchers found that IP6 slowed tumors’ metabolism of glucose, a primary source of energy.

“The study’s results were really rather profound,” researcher Dr. Komal Raina told The Huffington Post. His team’s findings are published in Cancer Prevention Research.

Yay! Brussels Sprouts
A List of High Fiber Foods

Fruits: Raspberries, bananas, apples (with skin), and raisins

Grains & Cereals: Oatmeal, bran, whole-wheat spaghetti, and bread

Legumes & nuts: Lima beans, lentils, pecans, pistachios

Vegetables: Brussels sprouts, raw carrots, peas, broccoli

For more, visit mayoclinic.com/health/high-fiber-foods/NH00582
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