

Venezuela's Chapter Governor's Newsletter



July 2002 Vol. 3 No. 1

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EDITORIAL: Venezuela's Chapter Relationships (ACP) with Venezuela Scientific Societies. Dr. Israel Montes de Oca (FACP)

ACP Venezuela's Chapter began in the sixties, when ,on Dr. Henrique Benaim Pinto initiative, the first contact was established between

Venezuelan Internal Medicine Society (SVMI) and American College of Physicians (ACP). A special invitation was made to Dr. Wroblewski, the liver aminotransferases discoverer, to come to Venezuela as invited Professor, and give speeches on his liver enzyme basic work. That time represented a landmark in SVMI and ACP relationships; since then, ACP has contributed with SVMI from the scientific and academic point of view, and qualified ACP speakers have participated in Venezuelan scientific events.

Initially as an Affiliated Region, then as Venezuela Region, and currently as a Chapter, Venezuelan Organization managing has remained interested in maintaining important links with Venezuela's Scientific Societies. Dr. Simón Becker and Dr. Ramón Soto attached Venezuela's Chapter and SVMI activities, during their conducts. This criteria has prevailed for the present management.

ACP Venezuela's Chapter has also established scientific relationships with scientific societies for different Internal Medicine subspecialties in Venezuela, as those societies have had an important scientific and membership development. This was done to achieve better information on the subspecialty advances and complement Internist continuous medical education. Some joint meetings have already been carried out with the Latin American Internal Medicine Society (SOLAMI) (2001) and the Pneumology

Venezuelan Society (2002), both of which have been scientific successes. Next joint meeting - "Oncology for the Internist" - with the Oncology Venezuelan Society is scheduled to be held on October 24 and 25, 2003.

Another interesting aspect of the abovementioned association for scientific meetings is the internist participation in the programs. This would let other specialists know the high scientific level of our Internal Medicine Specialists and contribute to the increasing incorporation of Internal Medicine specialists in other scientific society meetings and programs.

Doctrinaire Article: "The Internist in Primary Care " Dr. Carlos Peña (ACP Member)

Clinical research has a clearly defined place in non-primary care, particularly in third care level. This consideration could possibly be applied to other specialty consultation for certain well defined ambulatory type medical care. Even the creation of well-organized clinical groups to embrace different aspects of a certain patient population with common characteristics is well known. When we review achievements and objectives of primary care in University Centers as ours, we can be faced up to pure numerical goals, in terms of number of patients cared for during a certain period, without knowing the health promotion politics, education,

achievement analysis, plans to improve medical care, evaluated patient fate, medical care efficacy, etc. However, primary care emerges as an indispensable element to acquire non-hospital and non-emergency skills, in the revised pre-grade teaching plan. Nevertheless, the lack of clear objectives in the program makes this element idealistic. We all agree that it is important but implementation is not clear or uniform. Without doubt, the internist is a fundamental protagonist for the creation of work-teams with the necessary tools to specify what is to be achieved. We must now ask ourselves how well trained we are to perform this enterprise, as primary health-care cannot lack of all the rigorous methodology we apply to other superior levels of health-care. We must know about prevalence and frequency of diseases or just symptoms, as at this level, treatments or diagnostic approaches are not always obvious. In fact, in many publications related with this topic, the symptomatic approach is not infrequent. It is necessary to know about prognosis, treatment or treatment results, place for the patients, level of resolution, health promotion program application, educational aspects in patient care, biostatistics management as an indispensable tool, human and non-human resources thorough evaluation, cost/benefit, and cost/efficacy studies.

We need to create multidiscipline groups for primary care assistance, where internists, residents and students are

indispensable for achievement; and to apply knowledge in evidence-based medicine, and critical analyses of literature to achieve a high grade of common problem resolution. This way, we will be able to improve the current system and medical care quality, diminish costs and improve resources utilization, and coherently interconnect with higher levels of assistance.

College News

1. The College has resolved on the organization name and logo change, after a great deal of deliberation. The new logo consists in the abbreviation ACP in capital letters, and the subtitle Internal Medicine, Doctor for Adults. All conferences, meetings and stationery will be identified with the new logo.
2. The College Annual Session was successfully held on April 2-5, at San Diego. Thousands of colleges attended the meeting, where several Internal Medicine topics were reviewed.
3. Next year annual session (2004) will be held at New Orleans on April 22-24. Members will receive the program shortly.
4. A breakfast meeting with all Latin American Chapter governors was held within the San Diego Annual Session Program. Dr. José Rodríguez Portales (Chile's Chapter Governor) coordinated the event, which also counted with the contribution of Dr. Harold

Sox, Annals of Internal Medicine Chief Editor. All Chapter activities were discussed. Venezuela's Chapter governor presented the results of a surveillance on why Internal Medicine Residents derive towards other sub-specialties when they graduate, instead of remaining as internists. Surveillance results were the following.

RESULTS OF A SURVEILLANCE FOR RESIDENTS GRADUATED FROM INTERNAL MEDICINE POSTGRADUATE PROGRAM (2002)

(1) Which is the main reason why you are leaving Internal Medicine and taking up another specialty?

The main reason was the income factor (90%)

(2) What does the sub-specialty offer to you that Internal Medicine does not?

More job opportunities and a wider field of work

(3) Which major easiness the subspecialty offers to you?

Updating and gaining of knowledge is easier within the subspecialty

(4) Then, What purpose you studied an Internal Medicine Postgraduate Course for?

To be able to enter a subspecialty postgraduate course easier

(5) Did some factor influence your decision to study a subspecialty?

Yes. Mainly the familiar factor as Internal Medicine demands more time and dedication.

(6) Why did you not take the subspecialty from the beginning instead of the Internal Medicine Specialty?

Because Internal Medicine allowed the physicians to define the subspecialty to follow.

(7) Do you not consider it anti-ethical to announce yourself as an Internist when you have abandoned that specialty in practice?

It is not anti-ethical (arguments were not given).

(8) If economical reasons were determinant, do you not think that when you complete the subspecialty you will have the same problems?

No because the objective to do the subspecialty was to continue to receive a salary that would be lost upon graduating from Internal Medicine Postgraduate Course.

5. Resolutions on the following topics were adopted at the Annual Governor's Meeting:

(1) Decreased number of Generalist Internists

(2) Internal Medicine Subspecialty representation in the Board of

Governors. This was not approved.

(3) Students debt reduction.

6. Important documents on Internal Medicine revitalization are being studied and analyzed at the College. New resolutions adopted to benefit the specialty will be known in the future.

Clinical Pearls in Internal Medicine

"Approach to the patient with abnormal liver function tests, and test result interpretation for patients with Autoimmune Disease, Hepatitis B (HB) and C (HC), and Hereditary Hemochromatosis" Dr. Andrés Albornoz (ACP Member)

I will address the case of patients without, or with unspecific or minimal symptoms, who are frequently referred for study due to altered liver function tests. We will learn about the tests we should ask for to make a diagnosis of Viral Hepatitis (B or C), Autoimmune Disease as Autoimmune Hepatitis, Primary Biliary Cirrhosis, Primary Sclerosing Cholangitis and Hereditary Hemochromatosis. Notice that a smaller but important percentage of patients with these conditions can have normal liver function tests.

HEPATITIS: For patients with increased serum aminotransferase levels and suspected viral hepatitis, specifically type B, we will ask for

HBsAg and Anti-HBc. If these two serologic markers are positive, three clinical situations must be entertained, one of which has normal serum aminotransferase levels.

Acute Hepatitis B: If we are dealing with an Acute HB, IgM anti-HBc, HBsAg, total anti-HBc and HBeAg give positive results, the latter only if assayed early in disease.

Chronic Hepatitis B: If a chronic HB is suspected we should corroborate the following: 1) Positive HBsAg for longer than 6 months; 2) More than 100,000 copies/ml of Hepatitis B Virus (HBV) DNA in serum; 3) Persistently or intermittently increased AST/ALT serum levels; 4) Liver biopsy shows chronic hepatitis.

HBs-Ag Carrier State: If we are dealing with an inactive HBsAg carrier, we should find the following: 1) Positive HBsAg for longer than 6 months; 2) Less than 100,000 HBV DNA copies/ml of serum; 3) Anti-HBe-positive serum; 4) HBeAg-negative serum; 5) Persistently normal AST/ALT serum levels; 5) Liver biopsy shows the lack of chronic hepatitis.

Hepatitis C: For hepatitis C virus (HCV) disease, HCV RNA and anti-HCV antibodies can be found both in acute and chronic disease, and also in patients with normal ALT/AST serum levels.

Acute Hepatitis C: For acute HCV infection, increased aminotransferase serum levels, and positive HCV RNA, and anti-HCV are characteristic but the following facts should be taken into

account: 1) A HCV RNA but not anti-HCV antibodies pattern is present during the first 2-4 weeks of acute infection; seroconversion to anti-HCV occurs subsequently; 2) When serum anti-HCV antibodies are present but HCV RNA is absent, infection is unlikely; 3) If anti-HCV antibodies and HCV RNA are simultaneously detected in serum, it may be difficult to differentiate chronic HC exacerbation from another type of hepatitis (e.g., acute hepatitis A virus infection) in patients with chronic HC.

Chronic Hepatitis C: Patients with chronic HCV infection have HCV RNA- and anti-HCV-positive serum with increased AST/ALT serum levels. The presence of HCV RNA in anti-HCV-negative serum is rare, and it specially occurs in patients undergoing hemodialysis or immunosuppression. Thirty percent of patients have anti-HCV and HCV RNA in their serum with ALT/AST normal serum levels.

AUTOIMMUNE HEPATITIS (AIH): This is a complex condition with genetic predisposition, triggering factors, autoantibodies, and immunoregulatory cascades. AIH is a chronic inflammatory liver disease of unknown etiology. The diagnosis of AIH requires aminotransferases serum level testing; the presence of γ -globulin, autoantibodies, such as antinuclear antibodies (ANA), anti-smooth muscle (SMA) or anti-LKM1; and the liver pathology. Generally, the application of definitive and probable diagnostic criteria to all patients suffices to make a diagnosis. However, if diagnosis is not

clearly established the atypical autoimmune score for adults should be used.

Definitive Diagnosis: IgG or γ -globulin serum levels >1.5 times the upper normal limit; ANA, SMA, or anti-LKM1 titers $>1:80$; without antimitochondrial antibodies, active viral infection or genetic disease; with alcohol ingestion less than 25 g/day; without drug abuse; and with interface hepatitis liver pathology.

Probable Diagnosis: Any degree of hypergammaglobulinemia; ANA, SMA or anti-LKM1 titers $>1:40$; or detection of other antibodies such as SLA/LP, anti-actine, anti-asialoglycoprotein receptor, anti-type 1 liver cytosol, etc.; without active liver disease, genetic disease or drug ingestion; with alcohol ingestion less than 25 g/day; without drug abuse; and with interface hepatitis liver pathology.

PRIMARY BILIAR CIRRHOSIS (PBC): PBC is supposed to be an autoimmune disease that causes granulomatose disruption of interlobular bile ducts, which results in a progressive duct number reduction. The resultant cholestasia ensues slowly and progressively, as well as fibrosis, cirrhosis and eventually liver failure. Diagnosis can be made by a positive antimitochondrial antibody (AMA) test in 95% of the patients and increased serum alkaline phosphatase (AP) levels; a typical history of chronic liver disease in middle-aged women with fatigue, pruritus or both; and granulomatous disruption of bile

ducts upon liver histological examination. Therefore, patients with an unexplained serum AP increase and normal biliary tract in the ultrasound should have an AMA test done. Diagnosis can be made if AMA titers are >1:40, serum chemistry has a cholestatic pattern and other diseases are excluded. Liver biopsy can be considered but it is not essential for diagnosis.

However, not all patients fit into this typical case of PBC. There are patients with AMA positivity and normal AP serum levels, who should be followed up and undergo liver biopsy if the liver function tests become abnormal. Some other patients show increased AP serum levels without autoantibodies (ANA, SMA, AMA, Igs). These patients should have a liver biopsy done for diagnosis. Finally, a group of patients with PBC have ANA and SMA positive serum but no AMA is detected; therefore, a liver biopsy is essential for diagnosis.

PRIMARY SCLEROSING CHOLANGITIS (PSC): Primary sclerosing cholangitis is a chronic liver disease of unknown etiology associated to an inflammatory bowel disease, and a cholestatic serum chemistry pattern. Diagnosis requires exclusion of secondary causes (prior surgery, cholangiocarcinoma, AIDS, caustic stenosis and ischemic stenosis due to transplantation, choledocolitiasis etc.) and endoscopic retrograde cholangiopancreatogram typical findings (multifocal stenosis of common bile duct and its bifurcation, and segmentary stenosis of intrahepatic ducts). Cholangiography with

Magnetic Resonance Image is a cost/effective, non-invasive alternative, without irradiation. Typical onionskin appearance is only observed in 50% of biopsy specimens and is not essential for diagnosis. Biopsy pattern could help to make a prognosis, although the New Mayo Clinic model is histology independent; however, prior Mayo Clinic model, King's College Multicentric model and Swedish model include histology as an important diagnostic element. Liver biopsy helps to exclude other causes of liver disease and clarify cases of PSC of small ducts in certain patients with normal ERCP, cholestasia and bowel inflammatory disease.

HEREDITARY HEMOCHROMATOSIS: Hereditary hemochromatosis is a genetic disorder with a predisposition to an abnormal increase in intestinal iron absorption, which results in complications such as cirrhosis, hepatocellular carcinoma, diabetes and heart disease. To make the diagnosis we have 1) indirect serologic markers of iron deposition in patients older than 20 years with suspected iron overload: percent saturation of transferrin in the fasting state should be greater than 45%, serum ferritin concentration must be elevated (useful if determined jointly with TS and in the fasting state); 2) genetic analysis to detect HFE gene mutation on chromosome 6 short arm for patients with abnormal iron profile and homozygous first grade relatives. Liver biopsy should be recommended for all homozygotes older than 40 years with liver disease, serum ferritin

higher than 1000 ng/ml, and other liver disease risk factors. Liver biopsy should also be performed to determine hepatic iron concentration and to rule out other liver disease causes.

Chapter News

- 1) Venezuela's Chapter 10th Annual Meeting was successfully held on May 20, prior to the 12th Venezuelan Internal Medicine Congress. National and international outstanding speakers updated knowledge on liver, and infectious diseases were updated. The event counted with the presence of foreigner guests as Dr. William J. Hall - speaker and also College representative in the meeting - Dr. Enrique Molina from Miami University, and Dr. Carlos Ramírez Ronda from Puerto Rico, all of whom also participated in the Internal Medicine Congress as speakers.

2. The first meeting for students was held on June 51 at the University Hospital. The program consisted of attractive semiology topics based on the Semiology Clinical Pearl method.

- 3) The Ninth Hospital Meeting for the Resident Scientific Meeting Program was held at "Carlos Arvelo" Hospital. The main topic was the Internist in Action.

4. The Minifellowship program will continue this year (2003). A notification was sent that the application reception period was

opened, up to June 15. The award will be granted to the Chapter Member that the Award Committee and Merck Sharp & Dohme representatives select. The minifellowship is supported by Merck-Sharp & Dohme Laboratories, through its foundation. Details on the selected Member and his/her program will be given in the next Newsletter.

- 5) Dr. Pedro Perdomo, Chapter Education and Informatics Committee Coordinator is developing our local web page, which will provide full information on Chapter activities and will allow Members to participate with their opinions.

- 6) Chapter Members have inquired as to how to settle membership fees in view of the exchange control en Venezuela. We are having talks with ACP on how to solve this important administrative problem. The selected solution will be informed by e-mail to you; therefore we urge you to send your e-mail address to Dr. Israel Montes de Oca (imontes@reaccium.ve).

- 7) Colombia Internal Medicine Congress will be held in August 2003. The Colombian Internal Medicine Association and ACP sponsor the event. Venezuela's Chapter has been invited to participate with speakers.

8) There are Scientific Events scheduled for the coming months.

A) Bioethics Committee Meeting jointly with Centro Médico de Caracas Medical Society to be held next July 29th. Dr. Claudio Urosa will coordinate the meeting and the topic will be "Professional Fees".

B) Scientific Program "Oncology for the Internist", jointly with Oncology Venezuelan Society, to be held on October 24-25. The summary of the program is the following: ACP-SVO "Oncology for Internists", October 24-25, 2003, Hotel Caracas Hilton. **Friday October 24:** Registration and Introduction. **General Aspects Module:** Infection and Cancer Relationship, Viral Hepatitis and Human Papillomavirus, Treatment for the Febrile Neutropenic Cancer Patient, Cancer Patient Pain Management, Nutritional Support and Waste Syndrome. **Oncology Clinical Syndromes Module:** Paraneoplastic Syndrome or Cancer Related Disease, Oncology Emergency Diagnosis and Treatment, Chemotherapy and Radiotherapy Complications and Secondary Effects, Diagnostic Signs for Cancer or Metastatic Tumors of Unknown Origin. **Conference-Lunch:** Cancer Markers. **Management for Specific Types of Cancer Module:** Thyroid Nodule Management; Thyroid Differentiated Treatment based on Risk Groups; Use of Algorithm for Prostate Cancer; Advances in Prostate Cancer Screening and Diagnosis; Hormonal Treatment for Prostate Cancer, Is it Always Indicated?; Differential Diagnosis and

Management of Monoclonal Gammopathies. **Cancer Screening, Prevention and Prognosis Module:** Lung, Breast and Colon Cancer Screening Criteria; New Perspectives for Breast Cancer Chemotherapy; Leukemia and Lymphoma Prognosis with New Therapies. **Saturday October 25: Cancer Image Diagnosis Module:** Image Invasive Diagnosis for Chest and Abdomen Neoplasia; PET Use in Oncology; What is New in Nuclear Medicine?; Is the Ultrasound Useful for Neoplasia or Metastasis Diagnosis? **Clinical Pearls in Oncology, Oncology Controversies:** Risk/benefit of Hormone Replacement Treatment; Internist, Endocrinologist, Gynecologist, Breast Cancer Specialist and Oncologist Interventions. **Conclusions.** Internists are invited to attend the event.

C) "Obesity and Community Education" will be scheduled for November 2003. The program and date will be announced in the next Newsletter.

9) The process for the new Venezuela's Chapter Governor election will start this year (April to November). The first part has already been carried out. Nomination Committee - composed of Drs Ramón Soto, Harry Acquatella and Régulo García Machado - received the candidates nominated by the members. Drs. Carlos Moros Gherzi and Francisco Fragachan resulted the candidates to be considered for the next voting, whose result has to be sent to

Philadelphia.

10) Award Committee presented the first and second award during the Ninth Annual Meeting held on September 20th: **First Award:** "Telomerase Activity in Peripheral Blood Leukocytes of Patients with Essential High Blood Pressure" by Drs. Antonio Tristano, María Eugenia Chollet, María L. Wilson, Haroution Adjounian, María Fernanda Correa and Adolfo Borges. **Second Award:** "Larynx and Other Anatomic Structures Preservation in the Treatment of Head and Neck Epidermoid Carcinoma" by Drs. Guillermo Paz-Combes, Esteban Garriga M., Esteban A. Garriga G., Ana Castañeda, Ramón Millán, Jesús García-Colina and Arturo, Nurse Carmen Ortiz and Clinical Psychologist María Contreras.

11) Venezuela's Chapter is proud to inform all Members that two awards and one acknowledgment were received during the 2001-2002 fiscal period. The awards were the following: 1) **Evergreen:** granted as a result of the Scientific Program intended for Residents; 2) **Excellence Award:** granted as a result of Chapter quality and activity. The acknowledgment was granted by the International ACP Committee, which considered that Venezuela's Chapter is the only ACP Chapter that has renovated the Minifellowships Program

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NOTICE: Opinions expressed in articles written by this issue collaborators are not necessarily that of the Chapter Board of Directors.

The English version of this Bulletin that appears in the College Web-Site is courtesy of Merck Sharp & Dohme Laboratories.

The Chapter Governor will receive any contribution or "Letter to the Editor".