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Volume 39 | Issue 1

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The Vanderburgh County Medical Society is an Alliance of Physicians dedicated to the promotion of the Art and Science of medicine, to the continual Improvement of Community Health, and to the Advocacy and Protection of the Patient Physician Relationship. The purpose of this organization shall be to unite and strengthen the local medical community, to inform the public on matters of health and medical care, and to promote the best in medical care in our community.

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PRESIDENT'S MESSAGE

JASON H. BREDEKAMP, M.D., F.A.C.E.P.
PRESIDENT

Hello, fellow VCMS members!

My name is Jason Bredenkamp, and I am honored to serve as your President for the next two years.

I am now in my twenty-sixth year of continuous practice in Emergency Medicine, having completed my residency at Resurrection in Chicago, IL, in 2000. I am currently Chairman of the Department of Emergency Medicine at Ascension St. Vincent in Evansville, IN, and Chief of Emergency Medicine at Ascension St. Vincent Warrick County in Boonville, IN.



Over the last few years, my interest in advocacy and policy has intensified. I have always been drawn to politics and have now channeled that interest specifically into healthcare. As such, I completed the ISMA Advocacy Boot Camp last year. This course, combined with my previous experiences, has provided me with valuable knowledge and insight into various current issues, including pre-authorization, insurance denials, scope of practice, and private equity in medicine, among other important topics.

During my upcoming tenure, my primary focus will be growing our membership. I am a firm believer that there is power in numbers, and for us to have a voice in the arena of medicine in the great state of Indiana, we must have a robust membership. Along those lines, I am asking all of you to spread the word and encourage your colleagues to join our society. We have many exciting ideas to ensure that your membership yields a valuable return on investment.

We are privileged to care for the citizens of southern Indiana and bear the burden of advocating for them—and for ourselves. I look forward to being available to you any time. Please do not hesitate to contact me with issues and ideas. I am thrilled about the journey ahead as your president of VCMS and look forward to what we will accomplish together!

Sincerely,

Jason H. Bredenkamp, M.D., F.A.C.E.P.
(815) 222-5643
BigPoppaMD@yahoo.com

AVIAN INFLUENZA: WHAT INFECTIOUS DISEASE PHYSICIANS NEED TO KNOW

ERIN DIGIROLAMO
MARCH 24, 2025

Avian influenza A viruses, particularly the H5N1 subtype, continue to grab headlines — raising concerns for the public, who is likely leery of another pandemic. Yet many infectious disease experts say that the risk for human-to-human transmission is low.

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Still, recent viral mutations have shown the pathogen's adaptability to mammalian hosts, prompting infectious disease, animal health, and environmental health experts to remain vigilant.

“For years, we’ve seen avian influenza circulating in birds, but 2024 brought an increase in infections among mammals — including cows, cats, and raccoons,” said David J. Cennimo, MD, an associate professor of medicine and pediatrics in the Division of Infectious Diseases at Rutgers New Jersey Medical School, Newark, New Jersey. “The more this virus infects mammals, the greater the opportunity for mutations that enhance mammalian transmissibility.”

H5N1 is not yet efficient at spreading between mammals; however, sporadic cases of transmission between cows and from cows to cats suggest a concerning trend. “Each time the virus adapts to a new mammalian host, it takes a step closer to potentially infecting humans more efficiently,” Cennimo told Medscape Medical News.

Another key concern is reassortment — the mixing of H5N1 with human-adapted influenza viruses such as H1N1 or H3N2, potentially leading to a novel, more transmissible strain. “While reassortments are rare, they could occur in an intermediary species like pigs, which have historically been effective ‘mixing vessels’ for influenza strains,” Cennimo explained.

Fortunately, H5N1 has shown limited ability to infect pigs so far.

Clinical Presentation

H5N1 in humans can present with a range of clinical manifestations with some needing intensive care and others showing mild or even subclinical infections. “One striking feature in recent case reports is the high prevalence of conjunctivitis, which is somewhat unusual compared to seasonal influenza,” Cennimo said. This raises the possibility of underdiagnosed or misdiagnosed cases.

For suspected cases, he recommends infectious disease specialists maintain a high index of suspicion, particularly in patients with recent exposure to birds or cattle. Infectious disease specialists should follow local health department protocols for reporting and testing suspected cases.

Oseltamivir remains the primary antiviral treatment for H5N1, with a recommended extended 10-day course for hospitalized patients, Cennimo said. “If a patient is severely ill, combination therapy with baloxavir could be considered, though data on its added benefit remain inconclusive.”

Biosecurity Measures for At-Risk Populations

Infectious disease physicians should advise individuals working closely with poultry, livestock, or wild game on preventive measures.

“Basic precautions such as hand hygiene, gloves, and masks should be standard when handling potentially infected animals,” Cennimo advised.

CONTINUED ON NEXT PAGE

He also noted that while the virus has been detected in unpasteurized milk, no human cases have been definitively linked to milk consumption.

Monitoring for the Tipping Point

A key factor enabling human-to-human transmission of H5N1 would be an adaptive mutation allowing efficient replication in human respiratory tissue. “Right now, H5N1 does not have that capability — but if it develops, we could see a shift in the pandemic potential of this virus,” Cennimo cautioned.

Cennimo’s recommendations for infectious disease physicians include:

- Suspect H5N1 in patients with recent exposure to birds, cattle, or infected animals.
- Test for influenza A subtypes and pursue additional H5N1 testing if H1N1 and H3N2 are ruled out.
- Follow public health protocols for notification and containment.
- Educate at-risk populations on biosecurity measures.
- Monitor evolving epidemiologic trends to stay ahead of potential transmission shifts.

“The threat of H5N1 is not just hypothetical. It’s a rapidly evolving situation that requires close monitoring and proactive preparedness,” Cennimo concluded.

Surveillance Remains Key

While vigilance for zoonotic events remains essential, there is currently no immediate threat of a pandemic, added James Lowe, DVM, MS, DABVP, professor of veterinary clinical medicine at the University of Illinois Urbana-Champaign.

Though the H5N1 virus can infect many species, including humans, how or whether it spreads varies greatly because the virus must bind to the sialic acid (SA) receptor, which differs across species. Consider these differences:

- Humans: SA receptors are deep in the lungs, making human infection rare but more severe because of where the virus replicates.
- Pigs: Have mostly human-like receptors and some avian-like receptors in their respiratory tracts. The longstanding theory was that bird flu would first infect pigs before jumping to humans, but the predominant transmission pattern has been the other way around.
- Poultry: Spreads rapidly and is highly lethal.
- Cattle: Infects the udder, but not the respiratory track.
- Marine mammals (eg, seals): Highly susceptible due to birdlike SA receptors in their respiratory tracts.
- Cats (and other wild carnivorous mammals): Causes neurological disease, not respiratory illness because the SA receptors are in the brain.

“These species differences explain why H5N1 is devastating in some animals while relatively benign in others,” Lowe said.

In short, livestock face the greatest threat from H5N1, but federal regulatory frameworks differ significantly for poultry and cattle. While poultry benefit from established federal disease-control programs, cattle infected with H5N1 fall into a regulatory gap. The US Department of Agriculture enforces strict containment policies for avian flu in poultry, primarily to safeguard exports. However, influenza type A was not historically considered a cattle disease, leaving cattle without a structured federal control program.

“As a result, H5N1 in poultry is well-controlled with no evidence of flock-to-flock transmission,” Lowe said. “But in cattle, we’re seeing what looks like an endemic disease pattern. Eliminating it entirely may no longer be possible.”

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Emerging Data

More viruses in animals mean higher risk for humans.

“Zoonotic disease spillover risk to humans increases with more virus activity in animals, but among the sporadic human infections, we have not seen any evidence of human-to-human transmission,” added Sarah Michaels, PhD, an infectious disease researcher at Tulane University in New Orleans.

If this were to happen, she said, “it would be a sign that the mutations were allowing the virus to be more easily transmitted. This is why it is important to continue robust surveillance systems to identify infections among people and animals. This allows us to detect animal epizootics, work rapidly to contain them, investigate new routes of transmission between animals, and offer guidance to reduce the likelihood of transmission to humans.”

In January, Centers for Disease Control and Prevention issued a Health Alert Network advisory to clinicians and laboratories to remain alert for sporadic H5N1 cases, particularly amid high seasonal influenza activity. Still, few additional H5N1 cases have been found, and have been attributed to contact with infected commercial poultry or backyard flocks.

Other influenza surveillance systems like emergency room admissions, public health laboratory testing and wastewater surveillance have also expanded to include H5N1 detection. Wastewater surveillance has identified some positive samples but isn’t able to distinguish human from animal infections.

“Human infections of H5N1 are rare, and testing should be prioritized for those with contact with known or suspected H5N1-infected animals,” Michaels said.

“The risk to the general public remains low, but infectious disease surveillance systems need to remain robust enough to detect any emerging changes in influenza A distribution or magnitude of human infections.”

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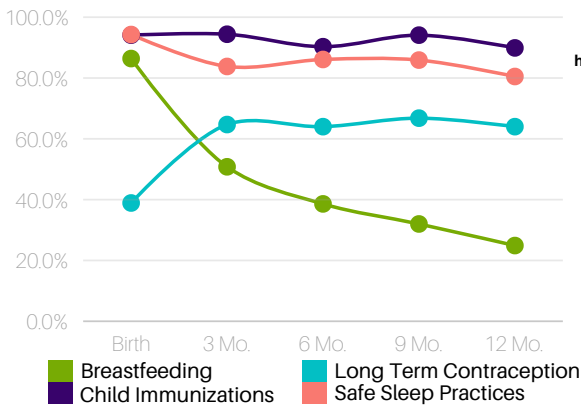
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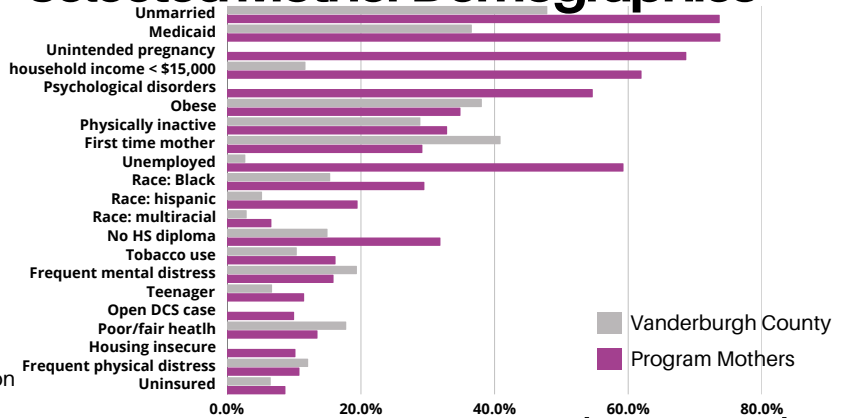
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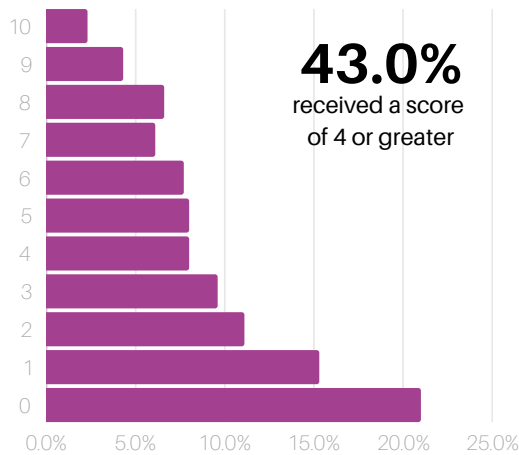
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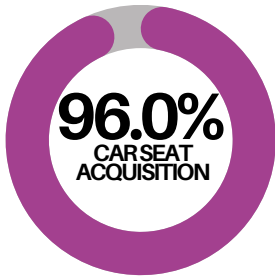
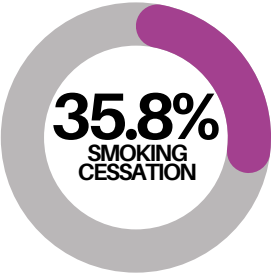
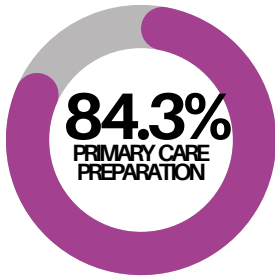
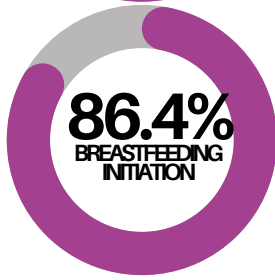
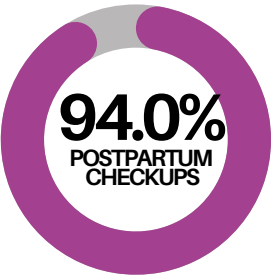
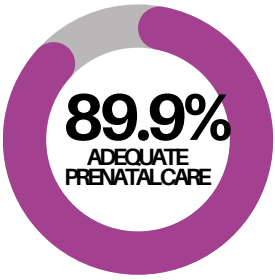
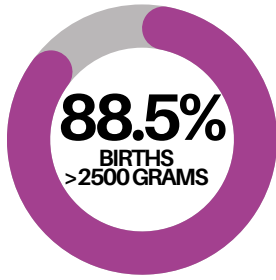
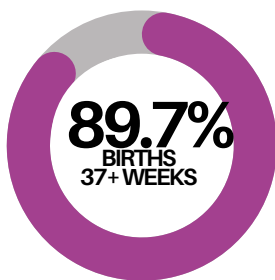
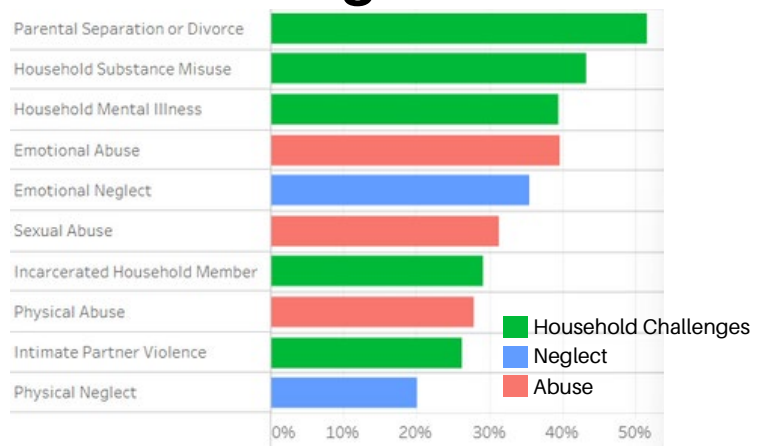
Selected Mother Demographics



ACE Scores (Mothers)



ACE Trauma Categories (Mothers)



BEYOND RESILIENCE: CONFRONTING PHYSICIAN BURNOUT AS A CHRONIC CONDITION

JOHN Q. YOUNG, MD, MPP, PHD
PHYSICIAN
MARCH 24, 2025

Practicing medicine is an incredible privilege. Our rigorous training allows us to combine science and compassion to heal and support patients through both challenging and healthy times. However, this privilege often comes with significant challenges, such as burnout and other struggles. Many doctors feel burdened by the time spent on electronic health records, drowning in documentation for nearly six hours for every eight hours of patient-care time.

This overwhelming taskload is compounded by workforce shortages and directly affects patient care. Initiatives like the Dr. Lorna Breen Health Care Provider Protection Act have provided essential support to address this issue. Named in honor of an emergency room physician who tragically took her own life in 2020 after battling COVID-19 and depression, the act allowed the Health Resources and Services Administration (HRSA) to direct over more than \$100 million over three years toward reducing burnout and fostering mental health and wellness among health care workers.

The act initially received bipartisan support and has already proven effective in delivering resources that tackle burnout. Regrettably, it was not included in a larger year-end funding package. Healthcare professionals deserve ongoing support because addressing physician burnout requires more than words of encouragement; genuine funding and structural changes are essential.

Pep talks about how resilience will not magic away burnout if we do not want healthcare organizations to lose the progress they have made in mitigating it, such as suicide prevention programs. These programs have become essential and will need even more attention in light of a new JAMA Psychiatry investigative paper that found that the burnout rate is higher for physicians than for the general population, and the suicide rate for female physicians is higher than that of both the general population and male physicians.

Burnout affects us all. Healthcare systems feel its economic effects through high turnover, recruitment costs, and early retirements. While we may not immediately see how burnout impacts our care, patients experience the effects through our emotional exhaustion, depersonalization, and decreased sense of achievement. Physicians reporting signs of burnout often have lower patient satisfaction scores and are twice as likely to make medical errors.

Healthcare leaders must not lose focus; burnout is at its lowest level since a COVID-related spike in 2021 but is felt throughout all medical specialties and practice settings. Some grapple with anxiety and depression, which brings us the highest suicide rate of any profession, with only about 15 percent seeking help.

How can we prepare colleagues and future doctors to manage their burnout and assist others? These questions have been humbling for me to answer, both personally and as a healthcare leader. My family has patiently watched me struggle and sometimes fail at it.

I have learned the hard way to combat these lows by closely monitoring my feelings and how I use my non-working hours. My most restorative time off is physical, not intellectual. I ensure that my family, friends, and religious community receive a large share of my time, attention, and love. I have sought roles that align with my calling—sometimes at a cost more than made up by “soul benefit”—and inspiring mentors and continuing education opportunities that expand my skills. These strategies, akin to managing a chronic condition with medication,

CONTINUED ON NEXT PAGE

require consistent practice and support from compassionate colleagues.

Still, the main driver of burnout is administrative tasks not centered on patients. Health systems must invest in care models that reduce hassles so physicians can prioritize clinical work and experience professional purpose.

We can invest in technology and redesign processes so physicians can focus on diagnosing, treating, and healing. Knowing that physicians who spend at least 20 percent of the week.) on their work passions are at lower risk for burnout, my department works toward a supportive environment, helping physicians and trainees identify where those interests meet departmental needs.

We need to create cultures and processes that make it possible to take time off with better coverage, attend trainings, and develop goals that align with our roles and values. Spending vacation time checking our inboxes contaminates restoration and erodes our empathy.

Our health system has adopted Stress First Aid, an organizational peer support and self-care model used to alleviate stress reactions in a stigma-free environment. Also called psychological first aid, the goal of the program is to offer safety, stability, and resources immediately after a stressful or life-threatening event so healthcare workers can cope with trauma. As of this writing, more than 25,000 of our healthcare workers have completed this training. The health system's Physicians' Resource Network and Employee and Family Assistance Program offer free and confidential collaborative counseling to assist staff with stress reduction, burnout prevention, and anger management skills.

Like so much in medicine, facing burnout is a practice that requires consistent resources, attention, and compassion. We need to ensure that programs like these can continue, ultimately honoring the memory of doctors like Lorna Breen.

John Q. Young is a psychiatrist and physician executive.

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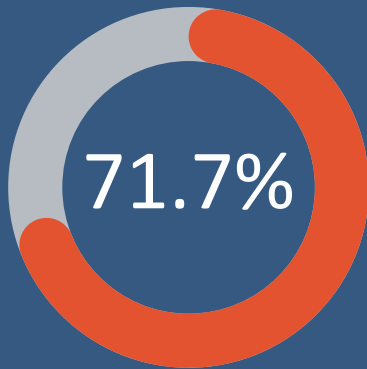
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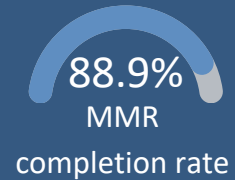
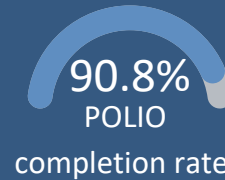
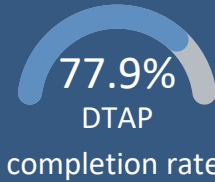
Vanderburgh County Immunization Rates

19-35 months



series completion rate
for 19-35 months

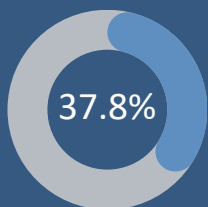
↓ Series completion rate
has decreased by 7.3%
since 2020



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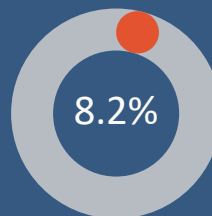
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11-12 Years



HPV 1
completion rate

↑ HPV 1 completion rate
has increased by 1.8%
since 9/30/2024



HPV 2
completion rate

↓ HPV 2 completion rate
has decreased by 2.6%
since 9/30/2024

Help us protect children by doing what you can to get kids caught up on recommended vaccines. During the last few years, there was a concerning drop in routine immunizations for children and adolescents. Routine [vaccination coverage](#) is rebounding, but unevenly and has not yet recovered among all groups. Efforts must be made to ensure that all school-aged children are up to date on their routine vaccines, have received recommended COVID-19 vaccines, and routine vaccination coverage is equitably distributed.

-CDC

Additional Resources
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Date Created 1/30/2025



CANNABIS IS INTERFERING WITH THE HEART

WENDY GLAUSER
MARCH 17, 2025

New research suggests clinicians should warn patients about the potential of cannabis to harm cardiovascular health. But how big a risk cannabis presents depends on the amount used and how much stock should be placed in observational studies.

Medscape[®]

The link between cannabinoids and cardiovascular disease, which used to be limited to evidence from preclinical studies, case reports, and case series, is now evident in epidemiological studies, researchers from Stanford reported in a recent paper in *Nature Reviews Cardiology*.

A large-scale US study from 2024 relied on survey data from more than 430,000 respondents and found that 4% of respondents who reported using cannabis daily had a 49% increased risk for myocardial infarction and a twofold increased risk for stroke. The added risk from cannabis was similar among those who also smoked tobacco and those who never used tobacco.

The effect was also dose-dependent. Among weekly users, cannabis was associated with a 3% increased likelihood of heart attack and a 5% increased risk for stroke.

Heart Attack and Stroke

The findings echo another Stanford University study from 2022, which analyzed UK Biobank data from 500,000 participants aged 40 years and found those who reported smoking cannabis were significantly more likely to have a heart attack than compared with nonusers (53% vs 45%).

Several studies have found an association between arrhythmia, especially atrial fibrillation, and cannabis use. A study published last year in the *European Heart Journal* showed the risk for new-onset arrhythmia in the first 180 days was 0.8% among more than 5000 patients who had filled a cannabis prescription vs. 0.4% for control participants, matched according to age, sex, and the use of other pain medications.

Although cannabis contains 100t cannabinoids, research from cell culture and mouse models suggest tetrahydrocannabinol (THC) can cause inflammation and oxidative stress inside the vasculature, explained Mark Chandy, MD, PhD, a cardiologist scientist and assistant professor at Western University in London, Ontario, Canada. He is a co-author of the Stanford study and the *Nature Reviews Cardiology* paper.

THC binds to the CB1 receptor, which is found in the brain, as well as in the myocardium, vascular endothelial cells, and smooth muscle cells. The CB1 receptor promotes atherosclerotic changes, Chandy explained, adding mouse models have found that cannabis increases atherosclerotic plaques. Scientists also theorize that cannabis might have a prothrombotic effect, increasing the risk of heart attacks and strokes.

When it comes to arrhythmia, the activation of CB1 and CB2 receptors can also lead to enzyme inhibition that could ultimately affect the heart's electrical conduction system.

Disturbing the Heart's Electrical Conduction

Chip Lavie, MD, medical director at the John Ochsner Heart and Vascular Institute in New Orleans, Louisiana, said that "vasospasm and constriction of blood vessels combined with high platelet aggregation" is the most probable mechanism explaining the association between cannabis and cardiovascular disease. However, he also said that studies show that cannabis can increase the heart rate. "Many studies show the benefits of a low resting heart rate," he explained.

CONTINUED ON NEXT PAGE

Lavie said that considering the evidence, he recommends patients avoid cannabis. If that is not possible, he advises patients to reduce their cannabis use and consume edible cannabis or oils, rather than smoking. Although there isn't enough evidence to show that consuming cannabis by edibles or oils is safer for the heart, burning cannabis adds toxins.

Chandy suggested cardiologists inform patients who use cannabis about the potential long-term cardiovascular side effects. "I would advise them not to use cannabis. At least, they should be able to make an informed decision about it and know the potential consequences of it."

Despite the emerging association between cardiovascular disease and cannabis use, "there isn't super strong evidence of causal effects," said Anders Holt, MD, a cardiologist at Copenhagen University Hospital, Copenhagen, Denmark, who led the study that found higher rates of arrhythmia among medical cannabis users. Mouse models frequently don't translate to human physiology, he said.

Weighing the Evidence

As long-term randomized controlled trials studying cannabis and the heart are not feasible or ethical, evidence comes from observational studies, which are prone to confounders. For example, those who consume cannabis recreationally may be more likely to engage in other activities, like alcohol consumption or high-caloric diets, which can have an impact on cardiovascular results.

Much of the evidence linking cannabis use with coronary artery disease is based on studies of participants being asked about recent cannabis use. Patients may misremember previous use, focus only on their use in the last week, or hide their cannabis use from doctors.

Holt's study was less prone to recall bias, as it relied on medical prescriptions, rather than self-reported data. Still, there could be important differences between patients who fill medical cannabis prescriptions and those who don't.

Big picture, however, it may not matter whether the association between cannabis and an increased cardiovascular disease risk "is due to the lifestyle, or the selection of these patients, or the active components," suggested Holt. "We know that people who use cannabis are at an elevated risk, so maybe they should be getting a more vigilant approach."

Talking to Patients

Holt said it would be reasonable "to bring up emerging evidence that puts into question whether medical cannabis is entirely safe for the heart" when talking to patients about lifestyle changes, they can make to reduce their risk for cardiovascular complications.

Despite the increased risk for arrhythmia, Holt said his study doesn't imply that medical cannabis shouldn't be used for chronic pain, however. For one, the overall absolute risk for arrhythmia remains low. For another, treating pain allows patients to engage in activities that are good for their overall health, and cannabis could be safer than alternatives. "There is very good evidence that nonsteroidal anti-inflammatory drugs (NSAIDs), antiepileptic drugs, and opioids are not ideal for the heart either."

In addition to discussing why patients use cannabis, Chandy suggested cardiologists discuss with their patients how much cannabis they consume and the route of administration. "One of the good things about legalization is that we now have labels to indicate approximately how much THC is inside," said Chandy.

Chandy is especially concerned about synthetic cannabinoids, created in labs to bind more tightly to the CB1 receptor and create more intense psychedelic effects. "The data is more limited on the synthetic cannabis but given that it's binding so tightly to the CB1 receptor, I would expect that it would cause more cardiovascular disease."

He also worries that the effects of cannabis will become more pronounced in the coming decades as research shows more young people are using cannabis. "Just like with cigarettes, it's not just how much, but how long you're exposed to it."



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