50 Year Anniversary

2022 Annual AMHE Scientific Program

The Theme is

"Impact of Covid-19 on Medical Practice today and beyond "

This activity is Sponsored by

and approved for 24 Category 1 CME credits

Hato Rio, Royal Decameron, Panama

July 27th – July 30th 2022

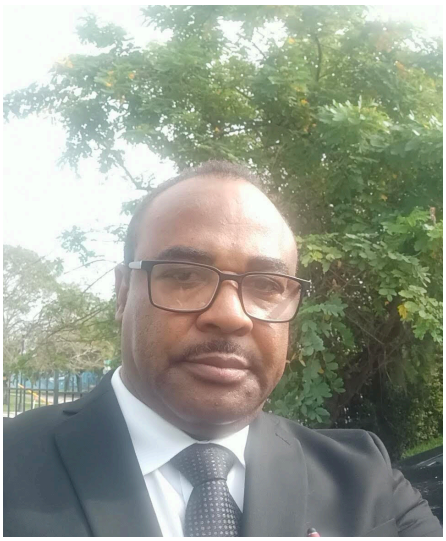
Dear Colleagues,

It is a pleasure and an honor to welcome you to our 49th Annual Scientific Convention. We are here in large part because of the vision of the founding fathers of this great association: Dr. Lionel Laine, Dr. Laurent Pierre Philippe, Dr. Roger Derosena, and Dr. Franceome Novembre. We will always be grateful to them.

We have made enormous progress in the caliber and execution of the scientific sessions and that is due to a team of loyal members, who year after year, devoted their time and expertise to ensure the delivery of a high academic experience. We are fortunate to have the top lecturers in their respective fields and we thank them enormously for their service. I assure you that the scientific sessions will continue to be very informative and practical.

A special thanks to the scientific committee and kudos to Dr. Eric Jerome for his leadership on this committee.

Sincerely,
Karl E. Latortue MD
Président CEC



Dear Colleagues and friends

The annual convention of the AMHE has always been a time of renewed friendship and knowledge acquisition thru various social activities and well elaborated academic lectures. This year, taking advantage of the more favorable atmosphere of the post COVID -19 era, we are pleased to meet again to pursue and celebrate the work of our founders and forefathers.
Fifty years ago, an organization was born: the AMHE. Thru storms and thunders, we have navigated and were able to stay the course on the itinerary toward our current destination. what a wonderful journey it has been for all of us!

During the convention, twenty-four CME credits will be allotted to the participants this year. Many great speakers have ben featured in the program and will deliver state of the art lectures on a wide variety of topics.

As we take a pause to recharge our batteries and celebrate the milestone, let's pull our strength together for the next fifty years, and let's say thanks to all of you who have guided us thru those years and have joined hands with us in order to move the association in the right direction.

We want to wish you all a pleasant convention week at Hato Rio and May you all return home safely after the wonderful life time experience of the Panama gathering!
May God bless Haiti our mother land! May God bless your home, your family and your homeland of residence, wherever it may be!

Jean-Rony Jean-Mary, M.D.
AMHE president Elect.
Convention committee CME coordinator

This year, the large AMHE family is meeting in Panama for its annual convention. This is a year of great importance to us as the AMHE celebrates its 50 years of existence. This is an opportunity for us to pay tribute to those who, before us, carried out the destiny of this association. We salute the memory of those who left us and who passed on to us a legacy to safeguard.

The AMHE is organizing its 49th annual convention this year. The theme of the convention is « Impact of Covid 19 on medical practice : Today and Beyond ». This theme reminds us that we are still in the era of covid 19 and the medical world is facing challenges caused by the pandemic.

Indeed, for the last two years, the pandemic has called into question our knowledge and know-how. Covid 19 is causing a heavy burden on the health system and affecting the delivery of health care. The system is overloaded; inequalities and disparities in access to care become even deeper. Experts question the role of covid 19 in the emergence of certain pathologies and in the aggravation of others. This increases the pressure on the health system. The pandemic affects the overall health of the population and forces the medical world to adjust its practice according the evolution of the pandemic.

As the same time, the medical world has seen the appearance of new RNA vaccines, a new technology that is revolutionizing the vaccine approach. New tools are made available to doctors. The purpose of this scientific activity is to demonstrate how covid 19 influences our practice. During this congress, speakers will discuss lessons learned from the pandemic, new developments in treatment and changes in our practice in the covid era and in the post-pandemic era.

Speakers at the 49 th congress are experts in their field. They gladly agreed to come and share their experience with us. The program is open to medical specialists, family doctors, nurses and general health professionnals. This activity is accredited by the Dade County Medical Association, Miami Florida. Participants can claim up to 24 continuing education credits.

I especially thank the members of the scientific committee who worked hard to make this congress possible, in particular Dr Eric Jerome for his exceptional work. A special thank goes to Dr Karl Latortue, Dr Harold Laroche, Dr Rony Jean Marie and Mrs. Marie Bruno who each worked in their own to allow us to experience a pleasant week.

I welcome everyone. Good time in Panama!

Schiller Castor, MD, M.Sc, CCMF
Vice President of the AMHE

Chers Collègues et Ami/es,

Aout 1972 – Aout 2022, Cinquante ans déjà! Que d'eau a coulé sous les ponts! Que de belles réalisations aussi! Création progressive de nouveaux chapitres à travers l'Amérique du Nord et… même des tentatives en Europe et en Afrique!

Dès ses débuts, et jusqu'à maintenant, le premier des objectifs de notre Association est : « Aider le médecin haïtien en terre étrangère à organiser sa vie professionnelle et sociale ».

Cela ne s'est jamais démenti au fil des années. Pour preuve, ce congrès est le 49ème de la série dont le premier a eu lieu en aout-septembre 1974 organisé par le Chapitre de Montréal, mon Chapitre d'appartenance. L'organisation de ces congrès a évolué dans le temps. Pour reprendre les mots d'un de nos anciens présidents, le congrès de 1990 à St-Sauveur (*au Québec*, *Canada*), semble avoir été le point tournant de beaucoup de réflexions. Ce remue-méninges a mené à la rédaction du « Guide officiel des congrès annuels de l'AMHE », ce, pour nous éviter d'avoir à réinventer la roue à chaque fois.

Nous suivons l'actualité de la pratique médicale, tant dans le choix des thèmes de nos congrès que dans nos publications.

Le choix du thème de 2022 est: Impact de la COVID-19 sur la pratique médicale aujourd'hui et au-delà. Les programmes scientifiques de nos congrès, comme celui de cette année, ont toujours été de haut niveau pédagogique.

En ce qui concerne nos publications, notre journal scientifique (*Journal de l'AMHE*) a fait sa première parution en janvier 1973. Ce journal a aussi évolué dans le temps pour devenir maintenant une publication en ligne (*on-line*) « AMHE Newsletter ».

Les vignettes de cette rubrique retrospective nous relatent de façon chronologique, la création de chacun des chapitres, leur fonctionnement, le maintien de leur existence en tant qu'association de professionnels, à but non lucratif, … pendant 50 ans! Elles nous ont rappelés certaines de nos réalisations entre autres, des bourses d'étude (*scholarship funds*) attribuées à des étudiants d'origine haïtienne, des activités de prévention-santé (*Foires santé*) et bien d'autres encore.

Vous en saurez davantage sur les membres fondateurs de l'association, leur vision globale etc. Ce sera l'occasion pour vous de revivre par la pensée, le chemin parcouru par notre Association, les défis relevés et les obstacles surmontés. Comme vous le savez, pour pouvoir aller de l'avant, il faut connaître d'où l'on vient. J'en profite donc pour faire appel à la relève.

Pour demeurer inclusive et ouverte à tous les professionnels de la santé d'origine haïtienne, l'association a officiellement changé de dénomination en 2015. L' « Association médicale haïtienne », nous a permis de garder le même acronyme, AMHE. Elle est toujours prête à vous accueillir pour continuer à tracer le chemin pour les générations futures.

En conclusion, notre association a besoin de vous tous, sans exception. N'oublions pas notre devise, l'Union fait la force. C'est ce sur quoi nos ainés se sont basés, pour nous laisser cet héritage. Rendons hommage à tous ces pionniers et toutes ces pionnières.

Bon cinquantième anniversaire à l'AMHE!

Bon congrès 2022!

Le comité de formation continue

Dre Marie-Françoise Mégie
Membre du comité scientifique de l'AMHE
Sénatrice du Québec
au parlement du Canada

Message of the Chair,

Dear Colleagues, dear Friends

This is with great joy that I also welcome you to the 49th Annual AMHE Scientific Program. The Scientific Commission has worked very hard to gather an outstanding group of lecturers devoted to the latest cutting-edge science. Let's acknowledge these pillars of the organization for their time and dedication. The theme of this presential and virtual conference is "Impact of Covid-19 on Medical Practice today and beyond". This viral pandemics started in 2019, has continued to impact medical delivery of care. Our society has found necessary and useful to expose any new development in medical science in the understanding of this epidemics and outline therapeutic options for medical practice.

In the program, we are showcasing three State of the Art Memorial Lectures, one devoted to Dr Constant Pierre-Louis an AMHE strong upholder, a second for an AMHE friend Dr. Paul farmer, the third for our memorable teacher Dr Rene Charles. On Saturday we shall remember the Great Dr. Rodrigue Mortel

We have started this program with the Urology symposium to tackle some Men health issues followed by a full Primary Care approach to cancer prevention and treatment with direct consultation from NYU.

An outstanding surgery section touching on cancer, laparoscopy and trauma has been designed by a specialist at Zucker school of Medicine. The Psychiatry group will feature many great lectures with emphasis on PTSDs an issue related to the pandemics and other social trauma. NIH is part of the team.

A cardio renal section is devoted to Hypertension, heart failure and renal protection to be delivered by a Johns Hopkins authority. Gastroenterology and pulmonary diseases will be well represented with input from two Physicians of Mount Sinai Icahn School of Medicine.

This conference will be broadcasted so different hospitals in Haiti including the State University will have the choice of participating. Medical Students will also be in the audience via Zoom.

This is first salvo of the 50-year Anniversary of the AMHE, the Medical Association of Haitians, Abroad and we want everyone to enjoy this activity.

We wish all of you a superb congress.

Eric L Jerome, MD, FACP, FASN
Program Chair
AMHE Scientific Commission
Société Francophone de Néphrologie, Dialyse et transplantation(SFNDT) Conseil d 'Administration(France)

Scientific Commission

Éric L. Jerome, MD, FACP, **FASN**
Director of Central Brooklyn Dialysis Center
NYMH-NY-Presbyterian Hospital, Renal Division
SFNDT Council (France)

Schiller Castor, MD, M.Sc., CCMF
Emergency Medicine / Family Practice
Chargé d'enseignement de Clinique
Université of Montréal

Michèle David, MD, FACP, MPH, MBA
Internal Medicine and Pulmonary Critical Care
MIT medical
Chief of clinical quality and security

Alix Dufresne, MD FACP, FACC
Chief of Cardiology Department
Interfaith Medical Center
State University of New York

Dre Marie Françoise Mégie
Family Practice
Professeur agrégé de clinique,
University of Montreal

Elizabeth Philippe, MD
Primary Care Medicine
Florida Medical Society

FIU

Rony Jean Marie, MD
Psychiatry
Dade County Medical Center.
CME Coordinator.

Thierry Momplaisir, MD, FACC
Director of Cardiac Catheterization Laboratory
Mercy Fitzgerald Hospital
Melbourne Florida

Angelo Gousse
Clinical Professor of Urology –
Herbert Wertheim College of Medicine – FIU
Voluntary Professor of Urology –
University of Miami, Miller School of Medicine

Special Thanks to the AMHE Administrative Staff:
Marilyne Estime
Under the Leadership of the Administrator, Mrs. Michael Bruno

List of Speaker's and Topics

Angelo Gousse, MD
Stratification of Hematuria Evaluation based on Risk of significant pathology: AUA Guidelines

Raphael Carrion, MD
Clinical Options in the Management of ED : Has the COVID-19 pandemic undermined ED Management**.**

Raymond Leveille, MD
Treatment of Renal Cell Carcinoma

Jean Joseph, MD
Prostate Cancer Risk Assessment in African Americans: Where are we now?

Jean Willam Pape, MD
COVID-19 and HIV in Haiti

Vladimir Berthaud, M.D
HIV & Tuberculosis.

Amos Charles, M.D
Health Care Disparities during Covid -19 Pandemic

Shella St.Fleur, M.D
Management of Leukemia during COVID 19**.**

Gardithe Joseph Duroseau, M.D
Breast Cancer Screening and Therapy

Remy Prosper, M.D
Colon Cancer Screening and Management

Ninoutchka Dejean, MD
Cervical Cancer Screening and Therapy

Jean Claude Desmangles, M.D
Management of Diabetes Mellitus type 1

Mildred MG Olivier, M.D
Diabetic Retinopathy

Ana Duarte, M.D
Manifestations of skin conditions in brown/dark skin subjects.

Herold Duroseau, M.D
Peri operative Anticoagulation Management Coagulation disorders

Anthony Gonzales, M.D
Advances in Bariatric Surgery

Bernard Poulard, M.D
Robotic Surgery in a Safety Net Institution: way of the future.

Louis Joseph Auguste, M.D
Triple Negative Breast Cancer: New Opportunities for Treatment

Patrick Dorvilus, M.D
When do you refer to Endoscopic Ultrasound

Consandre Romain, M.D
Endoscopic Approach to biliary/pancreatic neoplasms

D'Andrea Joseph, MD
Trauma during Covid-19

Roosevelt Clerisme, M.D
New Treatment in Management of Bi-Polar Disorder

Jean Lud Cadet M.D
PTSD in Post COVID-19 Patient

Naushira Pandya, M.D
Options in Alzheimer's Treatment

Jean Rony Jean Mary, M.D
Diagnosis and Management of Intellectual Disorders

Claude Vertus, M.D
Impact of Covid 19 Sur la Sante Maternelle

Mario St. Laurent, M.D
Covid 19 in Children

Laurent Bordes, M.D
Non convulsive Seizure Disorders

Girardin Jean Louis M.D
Sleep Disorders in African Americans

Garly R. Saint Croix, M.D
Hypertension: Correctible causes.

Alexandra Bastiany, M.D
Cardio Vascular Disease In Women: the role of interventional Cadiology

Hancy Seide, M.D
New Algorithm in the Diagnosis and Treatment of Supra-ventricular Tachycardias

Michel Ibrahim, M.D

The insights into pathophysiology and treatment if heart failure with preserved ejection fraction

Robert Odler Jean-Louie, M.D
Hypertensive Emergencies in Critical Care.

Raymonde Jean, M.D
New approches in elevation and treatment of pulmonary embolism.

Michele David, M.D
Update In Severe Asthma.

Bernard Jaar, M.D
Renal Protection In CKD

Janice Desir M.D
Management of CKD

Gerard Taylor Dalvius, M.D
Acute Kidney Injury in Covid Patients In French Territories

Natoushka Trenard, MD
Respiratory Failure in Covid Patients

Herve Boucard, M.D
Management of GI Bleeding

Michel Jose Charles, M.D
PPI risk: separating fact from Fiction.

Garvey Rene, M.D
Current Trends in the Diagnosis and Management of NSTEMI.

Thierry Momplaisir, M.D

Structural Heart Disease: The Case for Transcatheter Intervention: New paradigms in 2022.

Haiti Program Speakers and Topics

Nancy Charles-Larco, M.D
Update in Fhadimac Action in Diabetic Care

Inobert Pierre, MD
Clinical care at St Boniface Hospital

Ralph Ternier, M.D
Medical CarePaul Farmer Mirebalais Hospital

Marie Carole Cadet-Day, M.D
Health Care in Haiti

Guiteau Jean-Pierre, M.D (HRC-CORI)
Haitian Red cross Performance during the pandemic

Jerry Chandler, MD
Involvement of Diaspora in Disaster Relief in Haiti

Bernard Pierre, MD, Dean of SNP
Faculty de Medicine and Pharmacie
An Update on Accreditation

Moderator's

Schiller Castor, MD
Elizabeth Philipe, MD
Ducarmel Augustin, MD
Eric Jerome, MD
Micheline Dole, MD
Yves Manigat, MD
Bernard Poulard, MD
Rony Jean Mary, MD
Margaret Donat, MD
Schiller Castor, MD
Micheline Dole, MD
Thierry Momplaisir, MD
Lucien Mocombe, MD
Carline Guirand, MD
Herve Boucard, MD
Harold Laroche, MD
Maxime Coles, MD
Pierre Paul Cadet, MD

ABSTRACTS

****

Angelo E Gousse M.D, Professor and Chairman of Urology

Hematuria Evaluation: A Stratified Approach:

AUA Guidelines Recommendations

Blood in the urine with the naked eye is called gross hematuria. When the blood is visible only under a microscope, it is called microscopic hematuria.

- Clinicians should define microhematuria as ≥3 red blood cells per high-power field on microscopic evaluation of a single, properly collected urine specimen. (Strong Recommendation; Evidence Level: Grade C)
- Clinicians should not define microhematuria by positive dipstick testing alone. A positive urine dipstick test (trace blood or greater) should prompt formal microscopic evaluation of the urine. (Strong Recommendation; Evidence Level: Grade C)
- Hematuria remains one of the most common urologic diagnoses, estimated to account for over 20% of urology evaluations.
- Indeed, screening studies have noted a prevalence range of microhematuria (MH) among healthy volunteers of 2.4%-31.1%

- GU Malignancy is diagnosed in 3 % of patients being evaluated for Microhematuria depending on the specific population.
- In patients with microhematuria, clinicians should perform a history and physical examination to assess risk factors for genitourinary malignancy, medical renal disease, gynecologic and non-malignant genitourinary causes of microhematuria. (Clinical Principle)
- Clinicians should perform the same evaluation of patients with microhematuria who are taking antiplatelet agents or anticoagulants (regardless of the type or level of therapy) as patients not on these agents. (Strong Recommendation; Evidence Level: Grade C)
- In patients with findings suggestive of a gynecologic or non-malignant urologic etiology, clinicians should evaluate the patients with appropriate physical examination techniques and tests to identify such an etiology. (Clinical Principle)
- In patients diagnosed with gynecologic or non-malignant genitourinary sources of microhematuria, clinicians should repeat urinalysis following resolution of the gynecologic or non-malignant genitourinary cause. If microhematuria persists or the etiology cannot be identified, clinicians should perform risk-based urologic evaluation. (Clinical Principle)

  In patients with hematuria attributed to a urinary tract infection, clinicians should obtain a urinalysis with microscopic evaluation following treatment to ensure resolution of the hematuria. (Strong Recommendation; Evidence Level: Grade C)
- Clinicians should refer patients with microhematuria for nephrologic evaluation if medical renal disease is suspected. However, risk-based urologic evaluation should still be performed. (Clinical Principle)
- Following initial evaluation, clinicians should categorize patients presenting with microhematuria as low-, intermediate-, or high-risk for genitourinary malignancy based on the accompanying tables
- Clinicians should not use urine cytology or urine-based tumor markers in the initial evaluation of patients with microhematuria. (Strong Recommendation; Evidence Level: Grade C)
- Clinicians may obtain urine cytology for patients with persistent microhematuria after a negative workup who have irritative voiding symptoms or risk factors for carcinoma in situ. (Expert Opinion)
- In patients with a negative hematuria evaluation, clinicians may obtain a repeat urinalysis within 12 months. (Conditional Recommendation; Evidence Level: Grade C)

- For patients with a prior negative hematuria evaluation and subsequent negative urinalysis, clinicians may discontinue further evaluation for microhematuria. (Conditional Recommendation; Evidence Level: Grade C)
- For patients with a prior negative hematuria evaluation who have persistent or recurrent microhematuria at the time of repeat urinalysis, clinicians should engage in shared decision-making regarding need for additional evaluation. (Expert Opinion)
- For patients with a prior negative hematuria evaluation who develop gross hematuria, significant increase in degree of microhematuria, or new urologic symptoms, clinicians should initiate further evaluation. (Moderate Recommendation; Evidence Level: Grade C)

****

Jean W Pape MD, Professor of Medicine Weill Cornell Medical College, New York, NY, Director, Centres GHESKIO Port-au-Prince, Haiti

Title: COVID-19 and HIV in Haiti

Introduction

Haiti had good reasons to fear the COVID-19 pandemic. It severely affected the best health systems in the world with a high mortality rate among hospitalized patients particularly older ones and those with co-morbidities. The arrival of the pandemic in Haiti at a time of the country's worsening political and economic situation and the increasing violence and security issues could create the perfect storm. The Haitian health system is weak and cardiovascular disease is now the major cause of national mortality. In addition, HIV/AIDS could be another factor of vulnerability. Could the pandemic be worst in patients with HIV? Could the pandemic affect HIV/AIDS and other health programs?

Methodology

This presentation will present national data on COVID-19, HIV/AIDS, tuberculosis and cholera. It will look at the overall national impact of the COVID-19 pandemic, the level of knowledge of the population about the disease and their interest for vaccination.

It will specifically evaluate the outcomes of COVID-19 in HIV/AIDS patients and its impact on HIV/AIDS and other health programs.

Results

In spite of all our fears, the COVID-19 pandemic has had a mild course in Haiti with 835 deaths as of June 1, 2022, half in the West department where 63% of all the cases were identified. Factors accounting for this will be explored. Older patients and those with comorbidities specially with diabetes were more likely to die. HIV/AIDS patients were less likely to mount the high IgG antibody response seen in HIV-negative persons but most likely repeated contacts with the virus boosted their immunity but it never reached the level of non-HIV -infected persons. In meta-analysis of hospitalized patients outside of Haiti, HIV was a risk factor for both more severe COVID-19 disease and death. This could not be documented in Haiti. Vaccination remains a huge challenge in the country.

HIV/AIDS is well controlled in Haiti. From the 1st cause of death in over 2 decades, AIDS is now the 7th cause of national mortality. The COVID-19 pandemic as well as the ongoing catastrophic political and economic situation had a negative impact on HIV/AIDS, TB and other health programs.

Conclusion

The COVID-19 pandemic has been mild in Haiti but together with ongoing severe political and economic factors, it had a negative impact on HIV/AIDS and other health program

Vladimir Berthaud, MD, MPH, FACP, FIDSA, DTMH

Title: HIV and Tuberculosis

Tuberculosis remains the major cause of death among persons with HIV (PWH) in low- and middle-income countries. In the United States, the majority of tuberculosis cases are among foreign-born individuals. The clinical manifestations of tuberculosis in PWH depend largely on the immune status and can go underrecognized. In this short presentation, we will discuss the impact of HIV on tuberculosis; review the clinical presentation, diagnosis, and treatment of active and latent tuberculosis in persons with HIV; and discuss the timing of antiretroviral therapy in HIV-associated tuberculosis. At the end of this session, learners will become more familiar with co-management of HIV and tuberculosis

****

Shella Saint- Fleur Lominy, MD, PhD

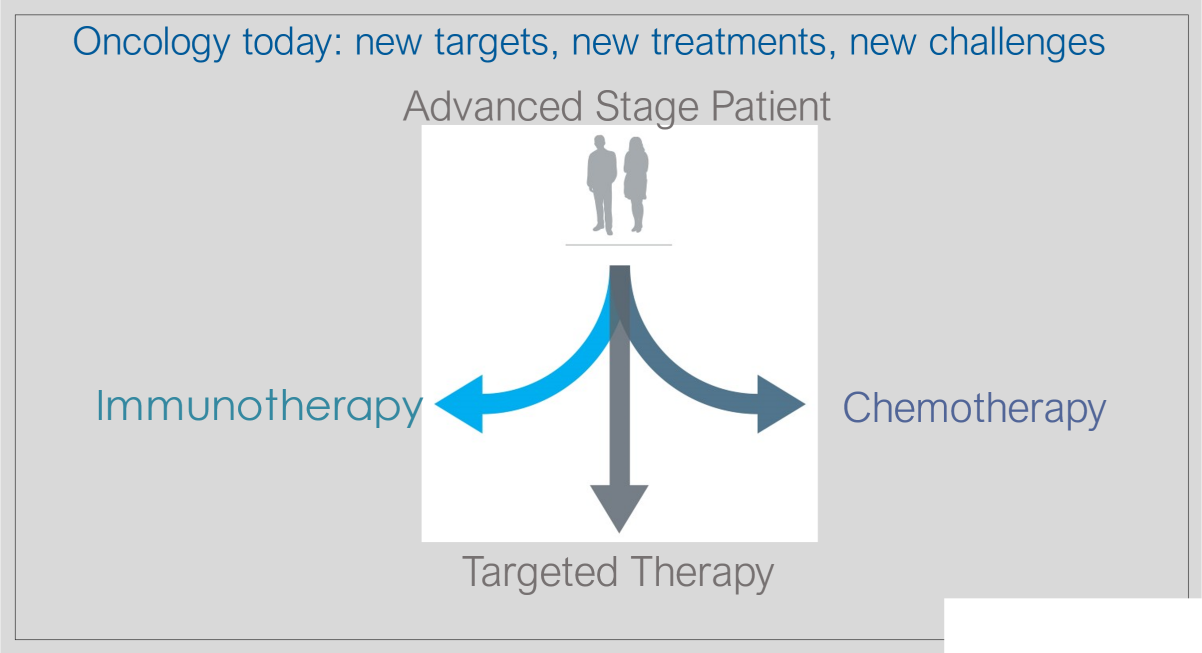
Assistant Professor, Medicine
Program Director, Hematology and Medical Oncology Fellowship

Management of Leukemia during COVID 19.

There is an estimated 60,000 new patients diagnosed with leukemia, every year in the United States. Leukemia also results in about 24000 death a year. Whereas there are different treatment approach for different types of leukemia, in general, they are associated with immune suppression putting patients at risk for infection. Very early in the COVID-19, it became clear that cancer patients and particularly those with hematological cancers were at increased risk of developing COVID-19 infection and complications. The goal of this presentation is to review some of the challenges associated with management of leukemia during the COVID-19 pandemic. Some of the challenges are related to shifted medical resources leading to delay in care, pause in clinical trials and change in therapy. Other challenges include comorbidities and other risk factors associated with poor cancer outcomes and COVID-19-related mortality. Improved resources at health centers caring for populations at risks of complications are needed to help mitigate the effects of these challenges.

Gardith Joseph Duroseau, MD

Breast cancer in the era of Precision Medecine:



Audience will learn on new therapy targeting :

Estrogen receptors

Her-2 Neu

Immunotherapy for Triple negative Breast cancer

PARP -inhibitor for BRCA1-2 carrier

Genomics

Prospere Remy, MD, FAGA
Assistant Professor
Icahn School of Medicine at Mount Sinai

The annoyance of the preparation for colonoscopy or else should not be a handicap for colon cancer screening.
Colon cancer is the second leading cause of cancer death in general, after lung cancer. In New York City, more than 1,100 New Yorkers die from colorectal cancer each year. That could be easily prevented with an effective method of colorectal cancer prevention and early detection.

We know how much was the impact of COVID-19 , particularly in the health care practitioners community. The American Cancer Society recommended a pause in screening in general from January 20 to April 20, 2020. As a result, this caused a drastic disruption in cancer screening services (Breast 94%, Colon 86%, Cervix 94%).

Postponing cancer screening should not equate to avoiding cancer screening and this why:
Approximately 4.4% of men (1 in 23) and 4.1% of women (1 in 25) will be diagnosed with CRC in their lifetime.
In 2022, there will be 149,500 new cases of CRC in the US.
53,000 deaths in 2022
35% of adults 50-75 years old were never screened.

The current recommendation from the US Preventive Services Task Force supports a starting age of 45 for the average risk person.

Reasons to consider 45 years as a starting age for screening:

- Large burden CRC in young adult
- Accounts for 10-12% of all CRC
- Incidence of 45-49 years old similar to 50-54 years old
- Cost effective
- Complications in this age group are low
- Younger adults present at a later stage than older adults

Guidelines and Recommendations for stopping screening:

Beyond 75 years should be individualized	Strong
Beyond 75 years should be individualized	Conditional/Low

Screening is considered an individual decision	Grace C
75-85% of screening should be considered for individual without prior screening	Weak
> 75 year individuals whose life expectancy is estimated < 10 years	N/A

The tools for screening colonoscopy should be based on the risk profile and preference of each individual.Any type of screening is better than none.

Screening Tools

A. non-invasive colorectal cancer screening tests

- gFOBT
- FIT
- FIT-DNA
- Capsule Endoscopy
- CT Colonography
- Blood test (septin 9)
- Breath test chromography

B. invasive colorectal cancer screening tests

- Flexible Sigmoidoscopy
- Colonoscopy

The inconvenience of colon cancer screening should not be the only reason not to get screened for colon cancer with so many tools at our disposal. It would be inconceivable now for an average risk individual to die from colon cancer.

Herold Duroseau, MD

Peri-operative Anticoagulation

Anticoagulant therapy represents a challenge for prescribing physicians and surgeons. Patients have to be evaluated carefully to avoid unwanted,often life threatening
hemorrhagic situations depending on their age, disease, medications they are taking and their health condition
Patients need to be assessed closely and monitored before,during and after surgery.
The different anticoagulant medications will be reviewed and recommended on how, when as well as the appropriate dosage they are to be administered

****

Anthony Gonzalez, MD

Title: Advances in Bariatric Surgery

Since the inception of the gastric bypass in the 1960's, there has been tremendous progression in medicine and surgery. Bariatric surgery has been no different with the addition of new procedures and minimally invasive techniques to improve outcomes, reduce post-operative complications and shorten the recovery period. Dr. Anthony Gonzalez, Chief of Surgery at Baptist Hospital of Miami and Medical Director of Bariatric Surgery for Baptist Health South Florida, will describe the current state of metabolic and bariatric surgery, its weight-loss and co-morbidity resolution outcomes, including its improvement on longevity of life.

Jean-Bernard Poulard, MD, MBS, FACS

Robotic Surgery in Safety Net Hospitals

Over the past 40 years one of the major evolutions in surgery has been the introduction and spread of minimally invasive access to organs and structures that previously required big incision and significant physical collateral damage with inherent complications of pain, infection, slow healing, debilitation, long hospital stays and other not so welcome long-term complications. The subsequent introduction of a Robotic platform with significant innovation in instrumentation, imaging optics and remote operation for minimally invasive surgery has further transformed many procedures in the surgical specialties to become the de facto standard of care. As with all innovations, despite the reluctance of organized surgery initially, there is now an acceptance of the inevitable as some larger health systems are acquiring their 12th robots and updating their fleet to the newest generation of robots. The For-Profit and well-off Not for Profit institutions have retooled and modernized, despite the significant capital investment necessary for the change. Having one company (Intuit, Da Vinci System FDA approved) provide the platform and instruments with monopoly pricing presents a financial challenge for many smaller systems. Safety-Net Hospitals and Critical Access Hospitals, lacking the financial resources and depending on the taxpayers for support, without a vocal and powerful constituency and lacking advocacy to demand modernization of their approach to surgical care, tend to be left behind or join very late and on a limited scope. We will present the story of two hospitals in a safety-net system and their journey with their robotic programs. Hopefully the lessons learned from their experience can serve other similar institutions embarking on the Robotic trip to modernization.

Louis J. Auguste, MD, MPH, FACS, FSSO
Clinical Professor of Surgery/ Zucker School of Medicine at Hofstra/ Northwell

Title: Triple Negative Breast Cancer: New Opportunities for Treatment

Breast cancer remains the most common cancer detected in women. However, the risk of dying from this cancer has declined over the past few years, not only because of earlier detection but also because of better understanding and treatment of the disease. Indeed, thanks to immunohistochemistry and microarray analysis, we understand now that breast cancer is not one disease but a host of diseases affecting the mammary cells. The simplest and most commonly used classification includes the following types: Luminal A and Luminal B, which are Estrogen and/or Progesterone receptor Positive (ER+) (PR+), HER2neu (+), which display an amplification of the Human Epidermal Growth Factor Receptor and the triple negative breast cancer (TNBC) that shows no HER2 amplification and no expression of the sex hormonal receptors. Numerous studies have shown that the hormonal receptor (+) breast cancers have much better prognosis, than the other two. The previously dismal outcome for HER (+) has been mitigated by the wide availability of effective immunotherapies, such as trastuzumab and pertuzumab. Yet treatment for the TNBC remains a challenge.

TNBC represents 12% of all breast cancers in the US. From an epidemiologic point of view, they have been found to be associated with pre-menopausal status, obesity, African-American ethnic group and the presence of BRCA gene mutation. They are not associated with the traditional hormonal risks of breast cancer. Histo-pathologically, these tumors tend to have a high nuclear grade, along with high mitotic activity and proliferation index. An in-situ component is rarely present. From a radiologic and clinical point of view, TNBC is more likely to present as a mass than as micro calcifications and the so-called interval breast cancers are more often than not, triple negative.

The treatment is somewhat stage dependent, although the unique biology of the tumor is always an important consideration, because of its high risk for recurrence and distant metastasis as well as its relatively high mortality. An early Stage I or II TNBC can be ap-

proached with either a lumpectomy or a mastectomy. However, adjuvant therapy is indicated for any tumors >0.5 cm. In these patients, long term adjuvant hormonal therapy is not an option. However, a recent Chinese study has shown that a year-course of Capecitabine, following the traditional adjuvant therapy (AC+T), can reduce both local and distant recurrence, as well as the overall mortality.

The possibility of metastatic disease is a serious concern, since the tumor at that stage is very resistant to conventional therapy and almost always results in death. An early trial with Olaparib was very promising, but a larger study showed no overall benefit. Subsequently, it was demonstrated that the patients, harboring a BRCA mutation were still likely to benefit from treatment with a PARP inhibitor. More recently, genomics has allowed to probe into further stratification of the TNBC. Tumors carrying PD-L1 or PD-L2, can now be treated with pembrolizumab, which has been shown to induce significantly more complete tumor response than chemotherapy alone. These encouraging results have led to several studies using pembrolizumab both in the neo-adjuvant and the adjuvant settings. Thus, it has become standard to ascertain the BRCA status and Next Generation Sequencing for patients presenting with TNBC. These trials open new doors on the possibility of success in the management of this still deadly type of breast cancer.

DR. RONY JEAN-MARY, M.D.

SCOPE OF INTELLECTUAL DISABILITIES. ABSTRACT AND OUTLINE. .

125.000 children are born with mental disabilities every year in the US. There are .6.5 millions mentally disabled people in the USA, In a fast pace society like ours, we tend to forget that there are plenty of people who are born with special conditions , who can not keep up or are completely lost in their day to day ability to function and enjoy the same capacity of actions that the rest of us have. This mental disabilities have a cost on parents, on the individual himself and on society in general. This lecture will help us to better understand the plight of living with mentally disabled patients and the impact it can have on families and on the community at large.

J. Roosevelt Clérismé, M.D

Title: New Management of Bipolar Disorder

Bipolar disorder is characterized by extreme fluctuations in mood that can have life-changing consequences. These mood swings can affect sleep, energy, activity, judgment, behavior and the ability of one to think clearly. In the manic phase, the patient has a hyperinflated ego that makes them believe that actions have no consequences. This state of mind may lead to financial and legal issues, disruption in relationships, conflict with supervisors, just to mention a few effects. In the depressive phase, the patient has a lack of interest in self-care, fatigue and poor concentration that may affect school or work performance. The ego is deflated to the point where low self-esteem may lead to suicide. When the illness is complicated by psychotic symptoms or substance abuse, the negative consequences are magnified and treatment requires more expert skills. Although the diagnosis appears to be simple, a lot of clinicians may miss subtle presentations.

Despite the availability of several mood stabilizers, a large percentage of patients either fail to respond to treatment or show only partial response. These outcomes may have a serious impact not only on the patients and their family, but also on the healthcare system and productivity in general.

After this presentation, participants will be equipped with the tools to understand the different clinical presentations of bipolar disorder and the factors contributing to statistically poor responses to treatment. They will learn the different strategies — pharmacologic, as well as nonpharmacologic interventions — to address this issue. Participants will know when to use combination pharmacotherapy or refer patients for more specialized interventions, like cognitive behavioral psychotherapy, electroconvulsive therapy, etc.

Jean Lud Cadet, M.D.

Title: COVID19, Post-traumatic stress disorder, and long-term psychiatric sequelae

COVID-19 infections are still highly prevalent throughout the world. The disease has impacted more that 550 million people worldwide and has caused the death of more than 5 million individuals. SARS-CoV-2, the virus that causes COVID-19 continues to mutate and the prevalence of the infection might remain high despite of vaccines that provide short term protection against severe disease. In addition to the acute medical, neurological, and psychiatric complications of COVID-19, there are also long-term neuropsychiatric sequelae of the illness. In the per-acute settings, COVID-19 infections are associated with a high prevalence of psychiatric symptoms that include anxiety, depression, fatigue, and post-traumatic stress disorder (PTSD). The mechanisms that cause PTSD in the presence of COVID-19 are not well understand but probably involved a cascade of events that include the activation of stress hormones that can interact with specific receptors in the frontal cortex and hippocampus. Importantly, PTSD has also been observed in front-line workers, in family members of COVID-19 patients, and in children of those patients. The long-term sequelae of COVID-19 measured at 6 to 12 months after the acute infection also include a high prevalence of anxiety, depression, and PTSD. The prevalence of PTSD is reported to be around 30% in various populations including Chinese and American patients. These long-term sequelae might be related to persistent epigenetic changes in the brains of these patients. Physicians who take care of COVID19 patients should be aware of these possibilities and refer patients to psychiatrists immediately if there is evidence of overwhelming anxiety, isolation, fear of touching surfaces, and recurrent nightmares.

Dr. CLAUDE VERTUS JR, MD

Title: Impact of COVID-19 on maternal health

Background

Since the inception and spread of SARS-Cov-2 infection throughout the world, the toll of people who died is very high, more than 6 million. Many mitigation approaches have been undertaken to tackle the COVID19 pandemic. Despite of all, the health systems were overwhelmed. The SARS-CoV-2 infection had a horrible impact on maternal, reproductive, and mental health. In USA. The impacts this pandemic on maternal health has changed the paradigms and implies new approaches for clinicians, global health specialists and policy makers.

Methods

A thorough review and analysis of the available literature about the impacts of SARS-CoV-2 infection on maternal health was done such as, scoping review, systematic review, and meta-analysis.

Results

All the studies concluded that pregnant women were at increased risk of COVID-19 severe disease. However, data are insufficient to conclude whether pregnancy increases the susceptibility to SARS-COV-2. Because SARS-Cov-2 does not have a high level of viremia and the placenta does not co-express high levels of angiotensin-converting coenzyme 2 (ACE2) and transmembrane serine protease 2 (TMPRSS2), intrauterine transmission seems to be rare. Pregnant patients with COVID-19 infection are 3 times more prone to be admitted to ICU, incur invasive ventilation, and develop a preeclampsia like syndrome with a ratio s-Flt-1/PlGF normal and Uterine artery pulsatile index (UtAPI) scores typical of normal preeclampsia

Conclusion

SARS-CoV-2 infections impacts on maternal health entail changes in the prevention and management of pregnant patients with COVID-19. COVID-19 in pregnancy needs to be prevented. Prediction and prevention of preeclampsia are paramount via screening of maternal risk factors and measurement of biomarkers. Global health specialists and policy makers must address the issues of health systems' resilience and global health security for the next pandemic

Mario St Laurent, MD FAAP: Multi Inflammatory Syndrome

Fever / Diarrhea/ Vomiting / Sore throat

HPI: 12 years old black male came in with history of watery diarrhea, non bloody, no foul smelling 2-3 times a day. Vomited x 2 with sore throat and low-grade fever. Was treated three days prior at the nearest urgent care and discharge home on Motrin

PHM: Negative, Born in Haiti, arrived in US 10 years ago, 2 weeks ago had a cold and was teste positive for COVID 19.

OE: Alert active ambulating in no acute distress, well hydrated

VS: T 100.6 Wt. 111 lbs. HT 62,25" RR24 BP 90/50

MULTISYSTEM INFLAMATORY SYNDROME- C (MIS-C) COVID 19

On March 11, 2020, prior to Dr Tedros Ghebreyesus of WHO declaring COVID 19 a pandemic, people were dying in China and Europe mysteriously and the medical world got caught by surprise.

Adults were dying at an alarming rate as a result of :

- Acute respiratory failure secondary to severe lung Injury
- Cardiac Failure

CDC investigators are assessing reported cases and children's health outcomes to try to learn more about specific risk factors for MIS-C, how the illness progresses in children, and how to better identify MIS-C and distinguish it from similar illnesses.

Next steps

Children appeared to be less likely than adults to be infected or to have severe illness early in the COVID-19 pandemic; however, as the outbreak has progressed, larger numbers of children are getting infected. It's unknown whether this increase in COVID-19 cases among children will also increase cases of MIS-C. CDC and state partners are still monitoring for additional cases and will adapt MIS-C recommendations as needed.

MULTISYSTEM INFLAMATORY SYNDROME- C (MIS-C) COVID 19

1. Kidney Failure
2. Severe Neurologic Dysfunction
3. Psychiatric disorder leading to suicide

Children meanwhile were doing well, even if they had the virus, they recovered within a few days with no sequalae.

PE: HEENT. Hyperemic Tonsillar area, no exudate

Neck: Supple, no anterior cervical node palpable
Lung: Good AE bilaterally, no rale no rhonchi , no wheezing.
Chest: No retraction, no tenderness.
CVS: S1,S2, normal, no murmur
Abd: Bowel sound slightly increased, no guarding, no rebound, no organomegaly, no tenderness.
CNS: 2-12 cranial nerve intact, no neurological deficit.
Skin: no apparent cutaneous lesion

IMP: 1-GE. / 2-Acute Tonsillitis

Plan: Throat C/S for Beta Strep
Zofran ODT 4 mg q8 h prn
Augmentin ES 600 mg q 12h

MANAGING NON CONVULSIVE SEIZURES

Abstract

The reason for the presentation is to help diagnose early and manage Non-convulsive seizures, Partial-complex seizures, Localization related epilepsy. Failure to diagnose Non Convulsive Seizures will cause Mismanagement or insufficient treatment, prolonged hospital stay, multiple admissions. EEG is often unavailable; it is not indispensable when patients have obvious cortical defect in current or previous imaging.

It is a clinical call. When Non-Convulsive Seizures is the presumptive diagnosis in Altered Mental Status, the physician or the neurologist should start treating with anticonvulsants, while concomitantly addressing the cause for decompensation i.e. pneumonia, hypoxia, hypoglycemia, electrolytic imbalance, UTI, etc.

This will prevent Status Epilepticus, shorten hospital stay, as well as reduce cognitive sequelae,

BORDES P. LAURENT MD, NEUROLOGIST
DR ROHAN PH. GEORGE, JR. DR. RAVINDI GUNESEKARA

Alexandra Bastiany MD

Abstract

Medical researchers have largely taken a “bikini approach” to women’s health care, in which women’s health research focuses on breasts and the reproductive system. This presentation will review the subtleties of heart disease in women.
Up to 65% of women (and approximately 30% of men) have ischemia with no obstructive coronary artery disease (CAD) on invasive coronary angiography performed for stable angina. This is commonly known as ischemia with no obstructive CAD (INOCA) and can be due to coronary microvascular dysfunction or coronary vasospasm. Despite the absence of obstructive CAD, those with INOCA have an increased risk of all-cause mortality and adverse outcomes, including recurrent angina and cardiovascular events. These patients often undergo repeat testing, including cardiac catheterization, resulting in lifetime healthcare costs that rival that for obstructive CAD. Patients with INOCA often remain undiagnosed and untreated. This presentation will discuss the symptoms and prognosis of INOCA. It will also offer a systematic approach to the diagnostic evaluation of these patients, and will summarize therapeutic management, including tailored therapy according to underlying pathophysiological mechanisms.

Michel Ibrahim, MD
Advanced Heart Failure and transplanted Cardiology.

Title: Insights into the Pathophysiology and Treatment of Heart Failure with Preserved Ejection Fraction.

Heart Failure with Preserved Ejection Fraction (HFpEF) is a complex heterogenous clinical syndrome. It now represents the leading form of newly diagnosed heart failure. Because of its complexity and heterogeneity, it is often misdiagnosed and poorly managed. This also may explain, why unlike heart failure with reduced ejection fraction, there is very little evidence-based treatment. Exercise intolerance which manifests as dyspnea is usually the most common presentation of this disease process. It is important to be able to discern HFpEF from other mimickers such pulmonary embolism, pulmonary hypertension, and/or other causes of dyspnea. It’s also important to be able to understand the different risk factors that are associated with HFpEF such hypertension, obesity, atrial fibrillation, obstructive sleep apnea and diabetes among others as they should be managed. HFpEF can also be the initial presentation of other types of cardiomyopathies like cardiac amyloidosis, valvular heart disease, hypertrophic cardiomyopathy and is-

chemic cardiomyopathy, which to each their specific treatment. In terms of HFpEF specific treatment strategies, symptomatic relief with diuresis have been the mainstay of therapy but it has not shown to have any effect on mortality. Subsequently, mineralocorticoids have been shown based on previous controversial trials that it could have mortality benefit in the treatment of HFpEF. It remains a good treatment strategy for resistant hypertension which could contribute to the development of HFpEF. New agents over the past couple of years have shown in different trials to be beneficial in patients with HFpEF notably the SGLT2 inhibitor class which, also used to treat diabetes, another HFpEF risk factor and furthermore is known to have some diuretic effect. Sacubitril/valsartan has also been shown to have some benefits in a sub-group of patients with HFpEF notably women with lower Left Ventricular Ejection Fraction. HFpEF treatment is not a one size fit all approach. Treatment strategies must be tailored to the HFpEF phenotype, and co-morbidities such atrial fibrillation, diabetes, hypertension, Obesity, sleep apnea must be managed. Finally, I believe the management of HFpEF should be done in a multidisciplinary fashion with cardiologist, primary care physician, dietician, nutritionist, endocrinologist, pulmonologist and bariatric surgery if needed.

****

Raymonde Jean, MD

Title: New approaches in evaluation and treatment of pulmonary embolism

Summary:

Pulmonary embolism (PE) is a challenging cardiovascular disease with a major global burden. It is a common and often fatal complication of venous thromboembolic disease. The incidence of symptomatic PE is about 0.5 to 1 per 1,000 people; and it increases with advancing age

The presentation of acute PE ranges from asymptomatic to sudden death. Pulmonary embolism requires prompt diagnosis and management. Imaging plays an important role in the diagnosis and management of these patients. Multi-detector computed Tomography pulmonary angiography (CTPA) is the most commonly used modality to confirm or exclude PE.

Risk stratification plays also a major role in management of suspected and confirmed PE. According to the 2019 guidelines of the European Society of Cardiology, the European Respiratory society (2019 ESC/ERS); risk stratification of patients with acute PE is classified as high, intermediate and low risk. Recent studies have emphasized the management of PE to be guided by risk stratification.

Conventional treatment of PE mainly refers to anticoagulation therapy, including parenteral unfractionated heparin, low molecular weight heparin and direct oral anticoagulants.

Advanced therapies such as systemic thrombolysis, catheter directed therapies, surgical pulmonary embolectomy and mechanical circulatory support have a role in a subset of patients presenting with intermediate and high-risk PE.

Natoushka Trenard, MD

T

Title: Respiratory Failure In COVID

The 2019 novel coronavirus outbreak started in the Chinese city of Wuhan and swiftly spread worldwide leading the WHO to declare a Global Health Emergency on January 30, 2020 and a global pandemic by March 11. Viral pneumonia-induced acute respiratory distress syndrome is one of the most common and severe complications of acute infection. In 2022 our approach to respiratory failure is supported by evidence -based interventions that improve mortality and recovery time. Despite some controversy, the same supportive measures shown to be effective in classical ARDS have been instituted for COVID ARDS which includes low tidal volume ventilation, strict fluid management, high PEEP, proning, paralysis and ECMO. A literate review evaluating these strategies in patients with respiratory failure from COVID-19 will be presented along with recent data that has shown variable patient responses to established therapy and vaccination. Although strides have been made in improving inpatient management of respiratory failure in COVID-19, outpatient management for ongoing symptoms remains elusive.

MICHELE DAVID, MD, FACP, MPH, MBA

TITLE: UPDATE IN SEVERE ASTHMA

Asthma is a very prevalent airway disease. Severe asthma is a life-threatening condition that affects a small % of patients with asthma. Severe asthma presents in about 3%–5% of adult asthmatics. Severe asthma has a high economic burden and accounts for more than 60% of the total asthma-related medical expenses. The appropriate management of SA can be challenging. Insights into severe asthma have facilitated understanding of the disease pathophysiology, leading to new development of biological treatments and a paradigm shift in the management of severe asthma Currently, novel biologics targeting several molecules, such as immunoglobulin E, interleukin (IL)5, and IL4/IL13, have emerged, and many new drugs are under development. These have brought a paradigm shift in understanding the mechanism of severe asthma and have also provided new treatment options.

The global initiative for asthma (GINA) has added an important addition to the resources to assist practitioners treating patients with asthma in 2022. The 2022 update of the *Global Strategy for Asthma Management and Prevention* incorporates new scientific information about asthma based on a review of recent scientific literature by an international panel of experts on the GINA Science Committee. This comprehensive and practical resource about one of the most common chronic lung diseases worldwide contains extensive citations from the scientific literature and forms the basis for other GINA documents and programs.

https://ginasthma.org/gina-reports/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7492516/

Bernard Jaar MD, MPH

Interventions to Slow Progression of CKD

Interventions to Slow Progression of CKD

Bernard G. Jaar, MD, MPH
Nephrology Center of Maryland
Johns Hopkins Medical Institutions

July 29, 2022

OBJECTIVES

1- Briefly describe the burden of CKD in the U.S.

2- Discuss advances in the care of CKD patients to slow progression

3- Discuss strategies to improve cardiovascular outcomes in CKD patients

Case Presentation: Mr. D.

- 31 y/o male referrred for CKD
- PMHx:
  - Bilateral ureteral reflux (surgical repair)
- Family Hx: no kidney disease
- Social Hx: born / raised in Baltimore. Married. Electrician. No smoking / ETOH / illicit drugs. No environmental exposure
- Meds: Famotidine OTC PRN

Case Presentation: Mr. D.

- Labs on July 2005:
- Hemoglobin 15.0
- Creatinine 2.3 mg/dL → eGFR 35 cc/min/1.73m²
- 24 hour urine protein: 4 gram
- Kidney US: L 11.6 cm, R 9.7 cm. Mild left hydro.
- Kidney Nuclear scan (split function):
  - Left 63%
  - Right 37%

CKD Stage G3B A3

CKD Definition

- Structural or functional abnormalities of the kidneys ≥ 3 months, as manifested by either:
  - Kidney damage, with or without decreased glomerular filtration rate (GFR), defined by
    - Pathologic abnormalities
    - Markers of kidney damage in blood, urine, or imaging tests
  - GFR < 60 mL/min/1.73m²

KDOQI Guidelines

CKD Classification

Stage	Description	GFR (mL/min/1.73 m²)
G1	Kidney damage with normal or ↑ GFR	≥ 90
G2	Kidney damage with mild ↓ GFR	60-89
G3a	Mild to moderate ↓ GFR	45-59
G3b	Moderate to severe ↓ GFR	30-44
G4	Severe ↓ GFR	15-29
G5	Kidney failure	< 15 (or dialysis)

Refer to Nephro →

KDIGO Guidelines

Janice Desir, MD, MPH

Title: Management of Chronic Kidney Disease (CKD) in the Aftermath of COVID

CKD is a serious public health concern affecting both the US and international community. Advanced disease can result in high economic burden for the healthcare system and more importantly, cause an overall decrease in the quality of life of patients. The COVID-19 pandemic amplified this already serious condition, resulting in increased morbidity and mortality for those with pre-existing and new onset renal disease. The aim of this talk will be to understand the spectrum of COVID-19 related acute kidney injury (AKI) and its impact on the progression of CKD. We will discuss the effect of COVID-19 among renal transplant and pediatric patients and explore early findings on the impact of long COVID and renal disease. Lastly, we will address new measures for health equity in kidney disease in relation to the NKF-ASN task force recommendations that clinical laboratories use the new 2021 CKD-EPI equation without a race variable to report estimated GFR and creatinine.

Gerard Taylor Dalvius, MD

Title: Acute Kidney Injury related to COVID 19

The mortality linked to COVID 19 infection mostly attributed to its pulmonary involvement and the thrombo-embolism state induced by the inflammatory response. Acute kidney injury is well known as a bad prognosis factor in sepsis also in COVID 19 as demonstrated in several papers. The fact that this infection could only attack the kidneys is also real. Through this lecture we tried to develop the relation between the physiopathology of both organs' involvement (lungs and kidneys). Presentation of cases to illustrate what authors shared in review according to AKI and COVID 19 With the same main histologic findings of this new entity so called COVAN (Covid associated Nephropathy) and the renal endpoint also. Identifying favoring factors is a new field of searching in this context. We talk about the relation between APOL1 genes mutation and collapsing glomerulopathy. The kidneys involvement shall be automatically find out with people suffering from COVID 19 infection even asymptomatic respiratory form. Finally, the need to looking for SARS-COV2 variants more susceptible to induced AKI could help.

Herve Boucard, MD, FACG, AGAF

Title: GI Bleeding: Etiology and Management

GI bleeding is a fairly common medical condition with significant morbidity, mortality and financial health care burden. UGI bleeding is a lot more common than lower GI bleeding despite available treatments for H. pylori and peptic ulcer disease. This lecture will review the causes of both acute and chronic GI bleeding as well as the medical and endoscopic management of this problem. Peptic ulcer disease still remains the predominant etiology of GI bleeding despite the ubiquitous availability of proton pump inhibitors. How can the physician help?

Haiti Program

Nancy Charles-Larco, MD

Title: UPDATE IN FHADIMAC ACTION IN HAITI

FHADIMAC (Fondation Haïtienne de Diabète et de Maladies Cardiovasculaires) is a non-profit Haitian organization servicing the Haitian community for the past 35 years: March 1987-March 2022. Late Dr Rene Charles, the principal founder of FHADIMAC was the pioneer in the fight against Diabetes in Haiti.

FHADIMAC is declared Public Charity by the Haitian Ministry of Public Health in 1999 confirming our tax-exempt status including for import duties. FHADIMAC has signed an MOU with the Haitian Ministry of Health (MSPP) since 2010 recognizing FHADIMAC as the entity providing technical assistance to health facilities in the management of Diabetes and Cardiovascular diseases. FHADIMAC is the only private institution playing an active role in the fight against diabetes, hypertension, and cardiovascular disease (CVD) in Haiti. It provides basic, vital care to thousands of patients who are unable to afford the cost of long-term treatment for these chronic diseases.

FHADIMAC has impacted the management of these conditions through its educational and sensitization programs. FHADIMAC is promoting a patient-centered care by having many activities doing:

- Early detection through screening and sensitization
- Meticulous monitoring to detect early complications
- Management of complications to help the patient have a better quality of life
- Constant psychological support to encourage the patient

During the Covid-19 period, FHADIMAC had to adapt her work to continue educate, manage, support, train and advocate.

Unfortunately, with the insecurity situation, roadblocks, kidnapping, manifestations … it is becoming very difficult to continue working following our mission which is “to help people affected by diabetes and cardiovascular diseases to live better with their conditions”.