

➔ Abstracts

Articles appearing in the February 2018 issue

Expanding incentives for coordinated, patient-centered care: Implications for neurologists

Historically, payment for cognitive, nonprocedural care has required provision of face-to-face evaluation and management as part of general ambulatory or inpatient care. Although non-face-to-face patient care (e.g., care via electronic means or telephone) is commonly performed and is integral to patient-centered care, appropriate reimbursement for this type of care is lacking. Beginning in 2017, Centers for Medicare and Medicaid (CMS) has taken a large step forward in reimbursing an increased number of cognitive care and non-face-to-face codes. CMS has also included language indicating that non-physician providers (i.e., nurse practitioners and physician assistants) can perform many of these services independently. The 2017 fee schedule thus creates new payments for non-face-to-face, patient-centered services, and may allow neurologists to reach out to more patients through nonphysician providers. As health care in the United States moves toward value-based incentives, these newly supported non-face-to-face services will provide neurologists with new tools to deliver sustainable, high-value care.

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Neuroradiologic manifestations of Erdheim-Chester disease

Background We describe the neuroradiologic features of a cohort of patients with Erdheim-Chester disease.

Methods We assessed patients at Mayo Clinic Rochester between January 1, 1990, and July 31, 2016, with pathologically confirmed Erdheim-Chester disease (n = 53).

Results Neuroimaging, including head CT (n = 17), brain MRI (n = 39), orbital MRI (n = 15), and spine MRI (n = 16), was available for 42 participants. Median age at diagnosis was 55 years (interquartile range 46–66) with higher male prevalence (33:20). Neurologic symptoms were identified in 47% (25/53); BRAFV600E mutation in 58% (15/26). Median follow-up was 2 years (range 0–20) with 18 patients deceased. Radiologic disease evidence was seen in dura (6/41), brainstem (9/39), cerebellum (8/39), spinal cord (2/16), spinal epidura (2/16), hypothalamic-pituitary axis (17/39), and orbits (13/42). T2 white matter abnormalities (Fazekas score ≥1) were present in 21/34 patients. Diabetes insipidus was present in 30% (16/53); 8 had abnormal hypothalamic-pituitary axis imaging. Radiographic evidence of CNS involvement (i.e., dural, brain, including Fazekas score >1, or spinal cord) occurred in 55% (22/40) and was unassociated with significantly increased mortality.

Conclusions Erdheim-Chester disease commonly and variably involves the neuraxis. Patients with suspected Erdheim-Chester disease should undergo MRI brain and spine and screening investigations (serum sodium, serum and urine osmolality) for diabetes insipidus to clarify extent of neurologic disease.

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