L-R Claudette J. Shephard, M.D. and G. Scott Morris, M.D. presented Maury W. Bronstein, M.D., a plaque from the Memphis Plan. The reception was held at Mr. and Mrs. Brad Martin home.

Quarterly Newsletter

Editor
Walter Rayford, MD, PhD

Executive Assistant
Janice P. Cooper
Welcome to the third edition of the **Bluff City Medical Society (BCMS) Quarterly Newsletter**. If you did not get the opportunity, please request a copy of the first edition from Janice Cooper. She can be reached at 901-344-8010 or email Bluffcitymed@yahoo.com. We would love your thoughts and comments about these newsletters as we continue to find ways to communicate to our valuable membership.

Jarvis D. Reed, MD  
President

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Physician Spotlight – Beverly Williams-Cleaves, M.D.

Few people would claim to “fall madly in love” with deductive reasoning and internal medicine. But, it is exactly that love for the field and dedication to the practice that have made Beverly Williams-Cleaves, MD, one of the leading physicians in the specialty of endocrinology.

The Memphian native graduated from Manassas High School in 1961, and pursued higher education at Howard University in Washington, D.C. In 1969, Dr. Williams-Cleaves became only the second African-American female to graduate from the University of Tennessee Health Science Center (UTHSC) College of Medicine. She returned to the east coast and began her internship and residency at Beth Israel Hospital in Boston, Mass., where, according to her, she “had an epiphany that pointed very clearly and exclusively to endocrinology.” This vision and desire manifested itself into the study and treatment of diabetes.

In 1975, Dr. Williams-Cleaves returned to UTHSC to share her love and help train the next generation of doctors. She currently serves as an associate professor in the division of endocrinology and leads the endocrine outpatient clinics at the Medplex-Clinic.

Dr. Williams-Cleaves has positively affected not just her patients but the community as well. In 2011, she opened the Comprehensive Diabetes and Metabolic Center of Excellence at the Good Health Institute in Memphis to provide support and care in one location for patients with diabetes and other metabolic disorders. She has also hosted community health fairs and educational outreach programs as well, to help citizens prevent diabetes.

She is a member of the American Diabetes Association, the Healthy Memphis Common Table, and the Bluff City Medical Society. Consistently ranked as one of “America’s Top Doctors” in national guides and publications, the UTHSC community has also recognized Dr. Williams-Cleaves commitment. This year, she is being honored with the UT College of Medicine Outstanding Alumnus Award.

Dr. Williams-Cleaves has shown that love and passion for your profession can affect not only your own life, but also the well-being of your community. When she is not practicing in her field, she spends time with her husband of 24 years, Calvin. They have three children and two grandchildren.

BREAST CANCER UPDATE

Sonia M. Benn, MD
Hematology/Oncology

With the exception of skin cancers, breast cancer is the most common malignancy among American women. In the United States an estimated 230,480 new cases of invasive breast cancer will be diagnosed in 2011, and 39,000 women will die of breast cancer this year. 1 in 8 women will develop invasive breast cancer in her lifetime and 1 in 35 women will succumb to this disease. These figures, however, do represent a declining number of breast cancer deaths over the last 2 decades, especially in women less than 50 years of age. It is believed that the decreased number of deaths is multifactorial including earlier detection, increased awareness and superior treatment options. Presently, in the United States, there are over 2.5 million breast cancer survivors.

There are a number of risk factors associated with the development of breast cancer including age, ethnicity, genetics, family and personal history. The likelihood of developing breast cancer increases with age. Caucasian women have a higher incidence of breast cancer than African American women though African American women
are more likely to die of this disease. Approximately 5% to 10% of breast cancers are hereditary. Two decades prior, no gene had been identified as having an association with breast cancer. Currently, it is well known that the most common inherited mutation is in the BRCA 1 or 2 gene, which if present can increase the lifetime risk of both breast and/or ovarian cancer by as much as 85%. Other genetic mutations, though significantly more rare, exist and can lead to inherited breast cancer: ATM, p53, CHEK2 (Li-Fraumeni syndrome), PTEN and CDH1. The overall risk of developing breast cancer is increased if there is a family history of this disease, most notably in a first-degree (mother, sister, or daughter) relative. This risk is increased even further if the first-degree relative has bilateral disease or developed breast cancer prior to menopause. Once a woman is diagnosed with breast cancer or has a personal history of endometrial, ovarian or colon cancer she has a higher likelihood of developing a new breast cancer. Other risk factors include dense breast tissue, LCIS, previous radiation exposure, oral contraceptives, postmenopausal combined hormonal therapy, and obesity.

Several decades ago, only one randomized clinical trial of screening mammography for breast cancer had been completed. Presently, there are at least 8 trials that are responsible for the current recommendations in spite of the recent controversy. The American Cancer Society and National Cancer Institute recommend annual screening mammograms for women beginning at age 40 in addition to annual clinical breast exams performed by a health professional. Annual mammograms should be done as long as a woman is in good health, defined as without serious illnesses and a suitable candidate for treatment of breast cancer if detected. Women in their 20s and 30s should have clinical breast exams performed by a health professional every 3 years. MRI and mammograms should be offered to women starting at age 30 if at high risk of developing breast cancer. High risk is defined as a greater than 20% lifetime risk. Women included in this category are those with BRCA 1 or 2 gene mutation or who have a first degree relative with the BRCA 1 or 2 mutations, prior chest radiation exposure between the ages of 10 and 30, or a 20% - 25% or greater lifetime risk according to the risk assessment tools based on family history.

If an abnormal density concerning for an underlying malignancy is detected on imaging study then a biopsy should be performed. It is important to determine if the breast cancer has estrogen and/or progesterone receptors as well as overexpression of HER2. HER2/neu is a protein that is a member of the ErbB protein family known as the epidermal growth factor receptor family. HER2 is a cell membrane surface bound receptor tyrosine kinase and is involved in the signal transduction pathways leading to cell growth and differentiation. Overexpression of HER2 gene is associated with increased disease recurrence. About 20% to 25% of women with breast cancer are HER2/neu positive and subsequently, typically have more aggressive tumors, but can benefit from drugs targeted to HER2; whereas, women with estrogen and progesterone receptors tend to have a better prognosis and are more likely to respond to hormonal therapy than women without these receptors. A potentially helpful test for early stage, estrogen receptor and lymph node positive tumors is OncotypeDX which looks at an array of 21 genes in the tumor cells to determine a recurrence score which ranges between 0 and 100. This test estimates and assigns recurrence risk as low, medium or high. Oncotype DX is being evaluated in the clinical trial setting to determine whether a molecular test can assign women with early stage breast cancer to the most effective and appropriate treatment. Presently, it is typically utilized as an adjunct to other important factors when determining therapeutic options. Mammaprint test is also used for early stage breast cancer but in ER positive and ER negative tumors to determine the risk of distant recurrence. It assesses the activity of 70 different genes. The decision to perform this test must be done prior to surgery due to required collection and storing techniques.

Staging of breast cancer is based on the primary size of the tumor, presence or absence of lymph node and/or distant organ involvement. Localized small breast tumors without lymph node involvement are stage I tumors whereas tumors with distant spread to other organs most commonly lungs, bone, liver and brain are stage IV. Larger primary tumors or tumors that have spread to regional lymph nodes are stage II or III. Based on clinical assessment and extent of disease, further imaging studies may be obtained to appropriately stage the disease. These tests may include bilateral breast MRI, whole-body CT scan, bone or PET scan.

In the mid 1970’s, approximately 75% of women diagnosed with breast cancer survived with the relative 5 year survival rate being 76% for Caucasian women and 62% for African American women. Over the last decade, 90% of women diagnosed with breast cancer were expected to survive at least 5 years, 91% of Caucasian women and 78% of African American women. In general with respect to stage of disease, the 5 year survival rates for women with breast cancer are 98% for localized disease, 84% for disease spread to regional lymph nodes and 23% for distant metastases.
Treatment for breast cancer involves a definitive surgical approach for women with limited and locally advanced tumors. In the past, mastectomy was the only surgical option for breast cancer. Today, options for surgery range from lumpectomy (breast-conserving surgery) to total mastectomy and at minimum axillary lymph node evaluation (sentinel lymph node biopsy).

Radiation therapy is recommended following breast conserving therapy and sometimes after mastectomy in cases of high tumor burden and/or close and positive resection margins. Radiation can be delivered as external beam radiation or brachytherapy (internal beam radiation).

Ongoing clinical trials continue to lead to the emergence of new therapeutic options and treatment strategies for patients. Therapeutic options include chemotherapy administered neoadjuvantly (prior to surgery), adjuvantly (after surgery when there is no evidence of cancer) or palliatively, hormonal therapy, ovarian ablation, targeted therapy, and anti-angiogenic therapy.

Combination chemotherapy and/or hormonal therapy remain the standard of care as a curative approach when combined with definitive surgery. In the mid 1970’s evaluation of tamoxifen, a selective estrogen receptor modulator, was just underway. Currently, hormonal therapy with tamoxifen or an aromatase inhibitor (anastrozole, exemestane or letrozole) is standard of care for estrogen receptor positive breast cancer. Similarly, decade’s prior, clinical investigation of combination therapy was just beginning. Today, there are numerous clinical trials that are helping to establish the best treatment approach, whether this includes continued use of combination chemotherapeutic drugs or combination of chemotherapy drugs and targeted agents. Targeted therapies such as the antibodies trastuzumab (Herceptin) and lapatinib (Tykerb) are already being utilized in clinical practice. Research is being conducted to determine the potential benefit of another monoclonal antibody pertuzumab, which inhibits dimerization of HER2 and HER3 receptors. In addition to the HER2 (ErB) pathway, other signaling pathways are also being investigated with agents that inhibit the PI3K/AKT molecular pathway, which is involved in cell survival and implicated in angiogenesis and agents that inhibit the mTOR (mammalian target of rapamycin) protein kinase that regulates cell growth, proliferation, motility and survival and protein synthesis and transcription. One of the more promising agents being investigated is TDM1. TDM1 is an antibody-drug conjugate consisting of the antibody trastuzumab linked to the cytotoxin mertansine (DM1).

It is an exciting time for development of these new targeted agents in HER2 positive breast cancer with trastuzumab, an antibody that target HER2, pertuzumab which targets both HER2 and HER3, TDM1 which targets HER2, and lapatinib which is a dual kinase inhibitor of EGFR and HER2. Neratinib and afatinib are also oral dual kinase inhibitors in ongoing trials.

In spite of some recent controversy, bevacizumab (Avastin), an anti-angiogenic agent, showed a trend toward overall survival benefit in triple negative breast cancer patients in the second line setting. Bevacizumab is administered in conjunction with chemotherapy.

Chemotherapy is also offered in the palliative (non-curative) setting to patients with a good performance status. Eribulin, a synthetic analog of a compound derived from a sea sponge, is an antitubulin agent that showed an overall survival advantage when compared to salvage therapies used in women with metastatic disease.

It is the desire of both researchers and clinicians to continue to enroll patients in clinical trials in order to develop superior and less toxic therapies. Knowledge gained from these clinical investigations have allowed clinicians to better understand that no two breast cancers are exactly alike and breast cancer patients differ with respect to response to treatment, which is likely attributable to metabolism, absorption and elimination of current therapies in addition to differences in gene expression and variation. Some of these specific tumor characteristics can be ascertained through evolving genomic technology. The continued development of newer chemotherapies and targeted agents will hopefully eradicate racial differences seen in breast cancer survival rates and also continue to decrease breast cancer morbidity and mortality in general.

References:
The American Cancer Society
The National Cancer Institute
Some forms of hair loss are preventable

External Follicular Alopecia

Lisa Akbari
Trichologist

Hair loss is becoming somewhat of an epidemic, affecting men and women of different ages and ethnic backgrounds. Problems that result in hair loss and changes in hair density stem from either internal or external complications.

External follicular alopecia can develop in the same pattern as internal follicular alopecia however, for treatment options, it is important to identify and differentiate between the two. Hair loss stemming from internal complications causes disruptions in the normal hair growth cycle and can cause the follicle to shrink over time.

The World Trichology Institute focuses on hair loss stemming from external factors. Whether the origin is external or internal, these disruptions, temporary or permanent, lead to varying degrees of hair loss that can affect an individual’s psychological and sociological well-being. However, some forms of hair loss are preventable.

Ninety-five percent of hair loss sufferers that come to the World Trichology Institute experience hair loss caused by external factors. This type of hair loss is preventable; if detected and treated early enough it can be reversed. For this reason, it is very important to prevent damage to the epidermis, which houses the mouth of the hair follicle.

Follicular Epidermis Alopecia (FEA) is a form of hair loss that occurs in the epidermal layers of the scalp, where the mouth of the follicle rests.

It is important to keep the mouth of the hair follicle healthy and free from follicular pollutants. There are three main types of follicular pollutants that block hair from emerging from the follicle: cosmetic, environmental, and scalp. Cosmetic follicular pollutants include hair products with a high molecular weight and additives that are difficult to rinse clean from the scalp. Environmental follicular pollutants are dust, dirt, and debris from the air. Scalp follicular pollutants include waste from sweat, some cases excessive oil from the sebaceous glands and peeling of the epidermis known as dandruff. These pollutants can solidify resulting in a partial or complete blockage of the hair follicle.

Although FEA can develop on any area of the head, it most commonly appears in the crown or around the front hairline area. FEA is predominately found in women, but can also occur in men and children. Because FEA develops on the surface of the scalp, women are the more likely candidates; women tend to unknowably do more

1 FEA develops in two ways, and is usually temporary:

1. When the hair shaft has emerged from the mouth of the follicle and is trapped between the epidermis and a dense wax of pollutants on the scalp surface. Microscopically this appears as an ingrown hair, pushing back unto the scalp and contributing to the buildup.

2. When a blockage has formed within the mouth of the follicle and follicular unit preventing the hairs from emerging. Microscopically, this appears as a dense plug filling the mouth of the follicle.

Both scenarios occur when scalp, cosmetic, and environmental pollutants solidify, forming a dense waxy substance. The texture of the hair shaft and the thickness of the substance blocking that hair shaft will determine whether the hair will fully emerge. However, once the substance is clarified away the hair will be free to emerge from that particular follicle.

There is one case when FEA can be permanent

When the dermis is exposed, allowing for the destruction of the dermal papilla as scar tissue develops.
negative things to their scalp surface when styling their hair. In cases where the dermis has been damaged, permanent loss can occur due to scarring. Because hair loss is non-life threatening, it is often overlooked as a serious issue. However, the amount of effort, time, and money hair loss sufferers are spending as well as the negative effect on the individual’s self-esteem are serious issues. Therefore, patients should be proactive in preventing scalp damage by employing a daily healthy scalp regimen and avoiding abuse of harsh chemicals, styling tools, and products. Because the hair follicle is still active, those that are already suffering from externally caused hair loss can have their hair restored with proper treatment. Proper treatment includes making sure there is a clean, acidic, and stimulated environment on the scalp.

With proper examination and treatment this category of hair loss can be eradicated and thousands of women, men and children will be spared the trauma of preventable hair loss.

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