BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **STUART Z. LANSON, M.D.** Holder of License No. **7318** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-04-0769A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on August 11, 2005. Stuart Z. Lanson, M.D., ("Respondent") appeared before the Board with legal counsel Paul Giancola for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 7318 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-04-0769A after receiving a complaint involving Respondent's care and treatment of a 60 year-old female patient ("ND"). ND presented to Respondent on March 25, 2005 with complaints of recurrent upper respiratory infection, recurrent sinusitis and fatigue. ND related problems with lack of energy and decreased cognitive function, memory and concentration. Respondent reviewed some of ND's old records and noted considerations of chronic fatigue syndrome, fibromyalgia, depression and arthritis of the left hip. On examination Respondent noted multiple angiomata, swelling of the nasal mucosa, uvula and soft

palate, and a positive Romberg sign. Respondent performed a complete history and physical as well as a number of tests, including allergy tests, pulmonary function, blood work and a pulmonary diffusion test.

4. Respondent diagnosed ND with vasculitis based on her membrane diffusion abnormality and he also diagnosed immune dysregulation. Respondent recommended ND undergo oxygen therapy for the vasculitis and immunotherapy (presumably for immune dysregulation.) Respondent did not order sedimentation rate ("sed rate"), urinalysis or tissue biopsy – the conventional allopathic workup for vasculitis. All laboratory testing ordered by Respondent was normal and, under allopathic medical standards, ND did not have vasculitis. Respondent submitted ND's chart for review to the peer review program of the American Academy of Environmental Physicians ("Academy"). Academy unanimously endorsed Respondent's diagnosis and treatment as consistent with their standards. Respondent is also licensed as a Homeopathic physician, but the Homeopathy Board determined Respondent was not practicing homeopathy and declined to investigate Respondent.

5. Respondent testified he has practiced in Arizona since 1973, first in otolaryngology for twenty years and then in environmental medicine for the past thirteen years. Respondent testified he is board certified in ear, nose and throat through the American Board of Otolaryngology and is board certified by the American Board of Environmental Medicine. Respondent testified that education in the environmental medicine specialty is done through the American Academy of Environmental Medicine and its curriculum is approved by both the American Academy of Family Physicians and the Accreditation Council for Continuing Medical Education. Respondent noted that MICA approves and insures his evaluation and treatment modalities and Medicare pays for the evaluations and treatments. Respondent also noted Medicare has routinely

audited him multiple times and he passed the audits. Respondent testified he forwarded ND's records to an internationally recognized expert in environmentally triggered vasculitis and implant sensitivity who provided a detailed letter with supporting literature approving of Respondent's evaluation and treatment plan.

6. Respondent testified his workup of ND consisted of a detailed history with collaborative physical findings and pulmonary plythesmography. Respondent testified he based his diagnosis on information from a textbook in environmental medicine on small vessel vasculitis, articles on environmentally triggered vasculitis, and continuing medical education courses on the subject. Respondent noted vasculitis in ND is an inflammatory condition of the microcirculation or small vessel vasculitis, involving mostly the skin, though he could not rule out segmental or regional involvement. Respondent testified the condition is caused by both immune and non-immune mechanisms, such as chemical exposure and is manifested by the acneform lesions along with a list of signs and symptoms ND gave Respondent when she gave her history – including recurrent edema, recurrent nasal stuffiness, extremity vascular spasm, cold susceptibility, tonsillectomy, increased sense of smell, recurrent myalgias, recurrent sinusitis, recurrent headaches, non-specific colitis, recurrent bronchitis, recurrent arrhythmias, and purple spots on her skin, possibly purpura.

7. Respondent testified vasculitis may be the underlying pathology of ND's condition that is responsible for the above listed symptoms, due to increased blood flow and oxygenation of the tissue, creating a dysfunction of organ systems. Respondent testified the recommendations for oxygen and IV nutrient therapy are well-accepted modalities taught in the American Academy of Environmental Medicine's core curriculum and these modalities are approved by MICA and paid for by Medicare and various other health plans. Respondent also noted the Board had dismissed previous complaints for

this diagnosis and he used the same modalities in those cases. Respondent testified ND received an appropriate workup, diagnostic workup, and plan and treatment based on the standards of care in his specialty. Respondent also noted his diagnosis is well supported and ND's treatment was never carried out.

8. Respondent testified he saw an average of thirty to forty patients per week and most of his patients are referred by other patients and others are referred by other physicians. Respondent testified one to two percent of his patients are diagnosed with vasculitis. Respondent was asked if the American Board of Environmental Medicine is a board recognized by the American Board of Medical Specialties ("ABMS"). Respondent testified it was not, but noted that to be certified by the American Board of Environmental Medicine a physician must be certified by a board that is recognized by ABMS.

9. Respondent testified he would not describe himself as an expert in vasculitis, but agreed it was a very serious condition that can be life-threatening. Respondent was asked how he would classify the vasculitides in general. Respondent testified vasculitis has been described involving large, medium and small sized vessels, whether or not there is necrosis, the immunologic basis of vasculitis. Respondent testified that doctors who specialize in environmental medicine realize that many of the small vessel vasculitis, which is what they see clinically, are non-immune related, usually from chemical exposure and the vast majority of patients Respondent sees who have vasculitis have it from chemical exposure. Respondent was asked to list the cardinal features that a standard textbook of medicine would suggest to diagnose small vessel vasculitis. Respondent testified they would usually be petechiae, spontaneous bruising, purpura, hemorrhage, ecchymosis, decreased circulation (where patients have impaired function related to decreased circulation of various organ systems.)

10. Respondent was asked what diagnostic modality would differentiate vasculitis from other conditions that could produce ND's symptoms and what would a textbook of medicine suggest ought to be done as a basic workup for vasculitis. Respondent testified a biopsy of the lesion, a sed rate, inflammatory markers, various immunologic studies, depending upon the thought of what type of vasculitis it would be. Respondent noted for example, if it were a small vessel vasculitis and cold was related to the trigger, than coagulants would be ordered to see if the patient had that type of problem. Respondent noted there are blood tests, like an anti-neutophilic cytoplasmic antibody, that could be ordered. Respondent was asked if he did a sed rate with ND. Respondent testified he did not. Respondent was asked whether a sed rate was a fairly standard marker for vasculitis. Respondent testified it was, and if he had seen ND in follow-up he would have eventually ordered that test. Respondent noted he routinely ordered sed rates on patients if he is entertaining a vasculitis diagnosis, but he usually sees the patient in follow-up and never had that opportunity with ND.

11. Respondent was asked if it would be within the standard of care to order a urinalysis in a patient suspected of having vasculitis, particularly since small vessel vasculitis could produce renal manifestations. Respondent testified it would. Respondent was asked if he considered a biopsy, which is frequently used, to diagnose ND's small vessel vasculitis. Respondent testified he did not and did so only occasionally in patients when he has diagnosed vasculitis. Respondent was asked why he did not consider biopsy in ND. Respondent testified he did not entertain the diagnosis until he got the membrane diffusion capacity and then he never saw ND back in follow-up in order to follow through with ordering laboratory tests. Respondent was asked if the modalities used to diagnose small vessel vasculitis in a standard textbook of medicine would include pulmonary membrane diffusion capacity. Respondent testified they would not.

12. Respondent was asked to describe the scientific basis for the pulmonary plythesmography and membrane diffusion capacity. Respondent testified membrane diffusion capacity measures the gases across the alveolar-capillary membrane and if the lung is normal, then decreased diffusion would indicate endothelial swelling of the capillary. Respondent noted there are studies to show this is the case; for example patients with Raynaud's phenomena will have decreased membrane diffusion. Respondent testified endothelial dysfunction is associated with small vessel vasculitis. Respondent testified he did pulmonary plythesmography in his office routinely in patients who present with bronchitis and asthma and problems with allergy. Respondent noted the advantage of using that modality or test when seeing patients is that it gives an idea of the endothelial status of the capillaries and the lung, which could reflect what is going on in the rest of the body.

13. Respondent was asked if he was speaking about the test as measuring the diffusion of gases across the alveolar-capillary membrane, and, if so, what are the possible reasons why this might be abnormal, other than vasculitis. Respondent testified he was speaking about the test in this way and the other reasons it could be abnormal are emphysema, sarcoidosis, resection of a lung, pulmonary emboli, fibrosis, anemia, congestive heart failure, collagen and vascular disorders and drug therapy. Respondent was asked if, since ND was a smoker, it not be unreasonable that the history of tobacco exposure could also cause an abnormal membrane diffusion capacity. Respondent testified this would not usually happen unless there is pulmonary disease where there is thickening of the alveolar-capillary membrane, if there is fibrosis, interstitial fibrosis. But, with bronchitis the patients that undergo membrane diffusion capacity have normal results.

14. Respondent was asked if ND had bronchitis and, if she did, would a history of smoking result in her having a normal or abnormal membrane diffusion capacity. Respondent testified ND did have bronchitis and she would usually not have a membrane diffusion capacity below the eighty percent figure, unless there is scarring or fibrosis in the lung. Respondent was asked what he did to rule out other causes of pulmonary disease or other causes of abnormal membrane diffusion capacity. Respondent testified he only saw ND twice and she did not follow-up, so he never had the opportunity to evaluate her. Respondent was asked about ND's complaint that in two visits she ran up a bill of $6,000 and whether it was a reasonable approach to order so much testing when the standard of practice would be to start out with some very simple things if he thought ND had vasculitis – such as doing a sed rate or a urinalysis. Respondent testified when he first saw ND his impression was that she had chronic sinusitis and allergic rhinitis and bronchitis, recurrent sinus infections and profound fatigue. Respondent testified the standard of care in environmental medicine when dealing with such a patient is to look for environmental triggers that might be causing the problem.

15. Respondent testified that although he mentioned briefly to ND that, based on her history, he thought she had a vasculitis he did not really indicate it in his notes as a diagnosis until after he did the membrane diffusion capacity. Respondent testified the workup on a patient suspected of environmental triggers is to do testing and the expense to ND was based on the allergy testing looking for environmental triggers as the cause of recurrent sinusitis and bronchitis. Respondent testified he performed the allergy testing in his office. Respondent was reminded of his earlier testimony that the membrane diffusion capacity is not a test that would be found in a textbook of medicine as the diagnostic modality of choice for vasculitis and was asked if he was practicing allopathic medicine. Respondent testified he was. Respondent testified he also held a

homeopathy license, but what he was doing was not homeopathy. Respondent was asked for a reference to a journal that other allopathic physicians are likely to read that would support the use of pulmonary plythesmography as the diagnostic modality to diagnose vasculitis. Respondent testified he gave several references on Raynaud's phenomenon and pulmonary diffusion to the Board's investigator. Respondent was asked if ND had Raynaud's phenomenon and he testified she did.

16. Respondent was asked the modality of therapy he proposed for ND. Respondent testified he proposed an allergy workup with allergy testing, and then subsequent immunotherapy, along with oxygen therapy and intravenous nutrient therapy. Respondent testified oxygen therapy is a multi-step procedure where the patients breathe oxygen at six liters a minute for two hours, repeatedly over a period of time. Respondent noted studies show that by breathing oxygen patients develop so-called "switch phenomena." Respondent was asked if he had a reference in a peer-review journal commonly read by allopathic physicians that describes this form of therapy and supports it. Respondent testified it is in the textbook of environmental medicine and in the continuing medical education courses given by the Academy. Respondent was asked if, in his experience, it was a common modality employed by allopathic physicians. Respondent testified multi-step oxygen therapy is not, but hyperbaric oxygen, which is a variant of this type of therapy, is.

17. Respondent was asked if he could cite to a source other than the textbook of environmental medicine, such as *The New England Journal of Medicine* or *Annals of Internal Medicine*. Respondent was unaware of any such source. Respondent was asked if he was practicing alternative complementary medicine. Respondent testified environmental medicine is regarded as allopathic medicine. Respondent was asked what advice he gives patients about the nature of his practice and the nature of the testing and

procedures he is going to do. Respondent testified his patients are given total informed consent about his practice and are given information about the modes of evaluation and the types of testing. Respondent testified he discusses with his patients the principles of environmental medicine that environmental physicians are obligated to follow in the work-up and treatment of the patient and that the first principle in environmental medicine is to reduce the total load on the immune system by finding the environmental triggers. Respondent testified he is looking for the cause of the patient's problem and patients are aware the testing is mandatory to determine the environmental triggers that could be causing their problems.

18. Respondent also testified another very important principle is the concept of biochemical individuality – a patient may come into the office with fibromyalgia, but may have a different reason for that problem than another person with the same diagnosis. Respondent testified he strives to find the differences in the patients. Respondent testified there are six principles he tries to follow that are described to the patient up front so the patient understands his practice is a little different and not pharmaceutically based. Respondent was asked if he regarded the Mayo Clinic as an authoritative and recognized allopathic diagnostic and treatment center. Respondent testified he did. Respondent was asked how he responded to ND's going to the Mayo Clinic after seeing Respondent and her being diagnosed after an extensive work-up as having fibromyalgia with no evidence of vasculitis. Respondent testified he knew ND had fibromyalgia when she walked into his office and gave him two to three minutes of history and he does not disagree with the Mayo Clinic's diagnosis.

19. Respondent testified in environmental medicine physicians try to go further than making diagnosis by trying to find the cause of the patient's complaints. Respondent noted he explained this to ND on her first visit. Respondent testified that if

the Board looked closely at the records from the Mayo Clinic it would see in reviewing ND's history, multiple symptoms and signs that are right out of the article he supplied on small vessel vasculitis. Respondent testified ND's overwhelming fatigue is a common finding when grouped with all of ND's other symptoms and yet the CT scan was normal in regard to showing any chronic disease. Respondent testified ND had recurrent acute sinusitis indicating immune dysregulation and she did not have any immunity to fight off infection from her allergy.

20. Respondent was asked if vasculitis is an inflammatory process. Respondent testified it was. Respondent was asked if certain laboratory tests will reflect inflammation. Respondent testified they could. Respondent was asked if he ordered the CRP test in the record and whether it was within normal limits. Respondent testified he ordered the test and he believed it was within normal limits. Respondent was asked if he would have expected it to be elevated. Respondent testified when there is an immune vasculitis you usually see an elevated sed rate, but with chemical vasculitis the inflammatory markers are not always apparent. Respondent noted ND worked in the salon industry, had a long history of chemical exposure, and had physical signs of chemical exposure so you may not see inflammatory markers in episodic or recurrent vasculitis. Respondent testified the biggest thing on ND's history was the acneform lesions he never saw and they could be the only finding in cutaneous vasculitis that would be seen in chemically exposed patients.

21. Respondent was asked if he based his diagnosis of vasculitis on ND's decreased diffusion. Respondent testified it was an ancillary test and his diagnosis was really based on ND's history. Respondent was asked if he ever considered any reason for the chronic sinusitis other than vasculitis – such as a fungal infection. Respondent testified you see fungal infections in the CT scan as abnormalities, but since he only saw

ND twice he never had the opportunity to follow-up and evaluate ND with some of the tests he would normally have liked to have done.

22. Respondent was asked if he spoke with ND in reference to the cost of his service. Respondent testified his office manager meets with patients after he sees them to review the costs and patients sign a statement that they are aware of the charges[1]. Respondent was asked if he did these extensive tests on every patient who presents for an environmental evaluation. Respondent testified he did not and the reason he did so with ND was because of her pulmonary history – she had a past history of severe bronchitis and respiratory problems and she complained of shortness of breath.

23. Respondent was asked why he prepared lipoic acid drops for ND. Respondent testified the drops were to treat fatigue and body pain. Respondent was asked to cite to a common allopathic journal that discusses the efficacy of such treatment for body pain and fatigue. Respondent testified the treatment was recently presented at one of the environmental medicine meetings as a form of treatment, but he could not cite to a common allopathic journal that discussed this treatment. Respondent testified that common allopathic journals do not publish articles discussing using nutrients for treating illnesses.

24. The standard of care required Respondent, in diagnosing vasculitis, to employ a standard allopathic approach and standard accepted testing before embarking on a course of unconventional treatments not recognized generally by allopathic practitioners.

25. Respondent deviated from the standard of care because he did not employ a standard allopathic approach in diagnosing vasculitis and embarked on a course of

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[1] The Board extensively questioned Respondent about his billing practices, but determined there was not enough evidence to support a finding that Respondent charged or collected an excessive fee.

unconventional treatments not generally recognized by allopathic practitioners.

26. ND was subject to the potential harm of undergoing unnecessary and unconventional treatment. ND was also subject to potential harm because vasculitis can be life-threatening and, if not treated in the appropriate fashion, the patient can have significant pulmonary, renal or other consequences.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for misdiagnosing vasculitis, in part on the basis of unconventional testing, and for recommending unconventional therapy.

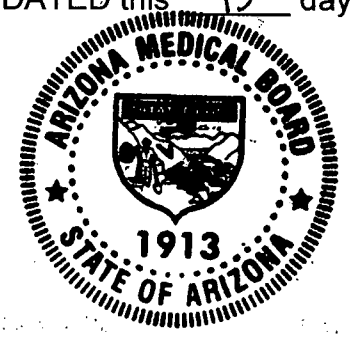
RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days

after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 13th day of October, 2005.



THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of October, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 13th day of October, 2005, to:

Paul Giancola
Snell & Wilmer, LLP
One Arizona Center – 400 East Van Buren
Phoenix, Arizona 85004-2002

Executed copy of the foregoing mailed by U.S. Mail this 13th day of October, 2005, to:

Stuart Z. Lanson, M.D.
Address of Record

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