



# SAPA JOURNAL



## The Society of Army Physician Assistants

P O Box 07490, Fort Myers, FL 33919 Phone & Fax (239) 482-2162

Vol. 20, NO. 5 A Civilian Organization Representing Army PAs SEP/OCT 2008

### National PA Week October 6 - 12 2008



Fort Sam spotlights role, contributions of PAs

By Elaine Wilson  
Fort Sam Houston Public Affairs Office

Physician assistants from every service gathered at Fort Sam Houston Thursday for a celebration in honor of Physician Assistant Week.

The national observance, held each year from Oct. 6 to 12, serves as a time to raise awareness of the role of PAs and to highlight their many and varied contributions to the health care system.

Locally, military leaders take the opportunity each year to spotlight the importance of PAs to the military medical team.

“Not only will (being a PA) change your life in the military, but it will change your life when you get out,” guest speaker retired Lt. Col. (PA) Donald Parsons told the PAs in attendance, mostly students from the Interservice Physician Assistant Program (IPAP), Academy of Health Sciences here. “There are jobs in every state of the union in just about any specialty you want to practice in. It’s a tremendous opportunity for any of you.”

Army PAs serve as the primary medical provider to Soldiers in battalion and division-level units and also provide garrison health care to Soldiers, Family members and other eligible beneficiaries.

Through the IPAP, the Army trains about 150 Soldiers a year as well as service members from the Air Force, Navy, Coast Guard, U.S. Army Reserve and National Guard. Graduates of the challenging, two-year program earn a master’s degree from the University of Nebraska and, for Soldiers, a commission as a first lieutenant in the Army Medical Specialist Corps.

Parsons, Deputy Director of Combat Medic Training, encouraged the PAs to make the most of their training at Fort Sam Houston in preparation for an increased role on the battlefield.

“The world-changing events since 9/11 have changed our community immensely,” Parsons said. “They made our profession much more predominant. When we have a conflict, we find ourselves on the battlefield, taking care of injured combatants.

“The majority of you will have the opportunity to go overseas and serve in combat theater,” he said. “Trauma medicine will become a major part of your life. I encourage you very strongly to get as much experience (in trauma) as you can.”

----- continued on page 7

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The SAPA Journal staff and SAPA Board of Directors encourages membership participation in this publication. Feel free to use this forum to present your views on any topic you desire. The publication of clinical articles on any subject is also solicited, however, to reduce our workload, we do request articles be presented typed, double-spaced format, and on CD, Microsoft Word format. The editor reserves the right of final acceptance of articles as well as the right to serialize articles which are too lengthy to be included in a single issue.

NOTE: I will accept articles via e-mail. editor

The SAPA Journal is the official publication of the Society of Army Physician Assistants. The views and opinions expressed herein are not necessarily those of the editors, SAPA, the SAPA Board of Directors or the Department of the Army unless explicitly expressed as such

**This is not an official Army Publication.**

## TRAINING OF A LIFETIME

By LCDR Irwin W. Fish MPAS, PA-C, APA

Charleston, SC , Sept 8, 2008 Today the crew of the NOAA ship “ Ronald H. Brown” has the training of a lifetime. Bud Calkin, inventor and owner of SKEDCO makers of the SKED Rescue System of Portland, Oregon visited the ship to demonstrate the new rescue system that the ship had recently purchased. Mr. Calkin explained and demonstrated that with the use of this system one person can rescue an injured mariner from a confined space with full immobilization of the patient’s spine. The advantage being also the ability to fit a full sized man up and down through a ship’s scuttle while maintaining splinting of the spine. Bud Calkin stated that this system is currently in use by the U.S. Army Special Forces, Marines, Navy, and countless fire and rescue companies around the world.

The Army alone has purchased no less 100, 000 of the systems and have made them standard equipment on all medivac helicopters. Many of the crew members had the opportunity to handle the SKED with a willing volunteer (the Ship’s Medical Officer LCDR Fish).



LCDR Fish 200lbs and six foot; fits down an 18 inch scuttle on the main deck of the Ron Brown assisted by Bud Calkin of SKEDCO  
<Claustrophobic’s nightmare! Ed.>



LCDR Fish shown strapped in the Oregon Spine splint and SKED.



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## LOST MEMBER, EMPLOYMENT OPPORTUNITY

I can’t look at your membership list so I am looking for Maggie Joplin former President of SAPA 1995? I have a job opening at our clinic in Pendleton Oregon for 2 Ex-Army PA’s. One must be a women to work with my wife Dr Juliet Markham-Textidor OB/GYN, the other one to work Primary Care/Urgent Care. Big dollars for the right Army Trained PA. Send Resume to:

Cesareo Textidor PA-C

COO, Center for Women & the Family  
PO BOX 1438

Pendleton, Oregon 97801

Office #541-278-0108

Fax#541-278-2434

Submitted by Hal Slusher, SAPA Exec. Dir.

# The SAPA Scholarship Program

## Reflections on the Past and a Look to the Future

Since its inception, SAPA has considered providing educational financial aid to members and their families a crucial member service. These scholarships provide monetary assistance to the recipients and allow SAPA members a vehicle to invest in the future of our profession and the lives of the scholarship recipients. I cannot give you an exact amount of scholarship dollars that SAPA has awarded since the late 1970s; however I feel safe in saying that this figure is in the tens of thousands of dollars. The satisfaction that each SAPA member can take from this program is the heartfelt thanks that SAPA has received from numerous scholarship recipients and statements of how our assistance has helped them achieve their educational goals.

From the late 1970s until around 1990 the SAPA financial resources were supported by member dues and proceeds of the annual Army PA Conference. Our financial resources were limited. But even through those years, after all the bills were paid, SAPA insured that we offered scholarships with whatever funds we had available. The SAPA financial fortunes began to improve around 1990 due in part because of increased support from pharmaceutical companies and SAPA becoming the sole sponsor of the annual Army PA conference. This resulted in an increase in funds available for our scholarship program and number of grants awarded. Over the past ten years or so, pharmaceutical financial support began to diminish. Funds to support the scholarship program then began to be supported by raffles, auctions at the annual conference and conference proceeds. The numbers of scholarships and their size were determined by the SAPA Board of Directors (BOD) based on the financial condition of the SAPA general fund.

During the SAPA BOD meeting in Apr 2008 a momentous decision was made. The SAPA BOD established a separate scholarship fund, separate from the general operating fund. Now all funds raised for scholarships, whether by fund raising events or individual donations will go into that fund. The prospects for the future in what SAPA can do with our scholarship services to SAPA members and their families is indeed unlimited.

Becoming a PA was a life changing event for each of us. It allowed us to provide a level of health care to our fellow man at a level most of us never dreamed of. It also has allowed us to reach a financial standard of living that we probably did not envision reaching. Then there is the fact that we all were at

the right place in time and were privileged to be part of the birth of a new profession in the health care field. Very few people can say I was a part of the birth and maturing of a career field. I guess I could compare it to how an astronaut might feel. I would like to ask each you to reflect on what I said in this paragraph. I would further challenge each of you to give thought and consideration to supporting the SAPA scholarship program with your donations. I consider a donation to this fund an investment in not only our future but in the next generation. SAPA is a 501c6 non-profit organization. All donations are tax deductible. Unlike many organizations that deduct operating expenses from a donation, donations made to the SAPA Scholarship fund will be used 100% to fund scholarships.

Anyone wishing to make a donation to the SAPA Scholarship fund please use the following steps:

1. Send donations to:

Society of Army Physician Assistants  
P.O. Box 07490,  
Ft. Meyers, FL 33919-6402

2. Make your check payable to SAPA and in the memo block put- Scholarship Fund

3. If you wish to make the donation in memory of or In honor of someone, please enclose a short note with your check indicating your wishes. If you wish your donation will be listed as anonymous.

4. On receipt of your donation—The Executive Director will send your check to the Treasurer and forward the information of your donation to the newsletter editor for publication in the newsletter.

In closing I would challenge each of you to support the SAPA Scholarship fund. Give back a small amount of the bounty that our great profession has afforded you and be a part of our profession's future. I would like to set a goal of \$25,000 by the time of our conference in Apr. 2009. Help us achieve our goal.

Stanley H. Shank  
Class # 4  
SAPA Past President

## **The ResQGARD®: a New Device for Combat Casualty Care to Augment Circulation and Blood Pressure in Hypotensive Spontaneously Breathing War Fighters**

Authors:

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### ***Introduction***

This primer highlights an important new device, the ResQGARD® that can enhance circulation to the heart and brain in the case of the spontaneously breathing hypotensive Soldiers. The ResQGARD is an inspiratory impedance threshold device (ITD) manufactured by Advanced Circulatory Systems, Minneapolis, Minnesota, that is useful to buy time between the onset of injury and when more definitive therapy is available. A better understanding of this device, which is based upon the fundamental mechanisms that regulate blood pressure during hemorrhage and hypotension, will help optimize care in war fighters wounded in battle. This simple non-invasive countermeasure helps protect against life-threatening hypotension by restoring central blood volume through enhancement of venous blood flow back to the heart with each inspiratory effort.

### **The Physiology**

One of the primary mechanisms that cause severe hypotension in the wounded war fighter is a reduction in cardiac filling and stroke volume in the setting of

significant blood loss. Increased negative intrathoracic pressure during spontaneous inspiration represents a natural mechanism for enhancing venous return and cardiac refilling. (Figure 2) The ResQGARD is designed to non-invasively harness the body's natural physiology to increase venous return and stroke volume, serving as an effective countermeasure against cardiovascular collapse. Taking advantage of this natural physiology, application of this new device during spontaneous inspiration causes an immediate increase in arterial blood pressure in the setting of severe hypotension. The inspiratory resistance induced by the ResQGARD results in a greater vacuum within the thorax during each inspiration and subsequently enhances refilling of the heart and lowering of intracranial pressure. These two mechanisms (refilling of the heart and lowering of intracranial pressure) contribute to the increase in blood flow to the heart and brain when using the device. Application of the device can therefore be used to rapidly increase blood pressure in hypotensive spontaneously breathing Soldiers when more definitive therapy is not yet available. It has some additional advantages as it does not cause hemodilution and can be immediately removed, unlike many other types of resuscitative measures, following hemodynamic stabilization.

The ResQGARD has been tested in animal models of hemorrhagic shock and heat stroke, in human volunteers, and in hypotensive patients in the emergency department and in dialysis clinics [1-11]. In pigs in hemorrhagic shock the ResQGARD increases systolic and diastolic blood pressure, enhances blood flow to the heart and brain, and extends the 'golden hour' of survival [6,7,10] (Figure 3) In volunteers tested at NASA a prototype of the ResQGARD, an Impedance Threshold Device (ITD) with a resistance of 7 cm H<sub>2</sub>O, was well tolerated, increased cardiac output in normal subjects by 1.5 L/min, and prevented symptoms associated with acute orthostatic hypotension [1,2,4]. The ITD has inspiratory resistance of 7 cm H<sub>2</sub>O and no expiratory resistance. In volunteers tested at the US Army Institute for Surgical Research the prototypic ITD has been shown to increase blood flow to the brain and significantly delay the onset of hypotension in volunteers subjected to severe hypotension induced by lower body negative pressure to simulate hemorrhagic shock [1,3,9].

In hypotensive patients the ResQGARD increases

systolic blood pressures and is well tolerated [2,5,8,11]. In the absence of an IV, hypotensive patients treated by medics outside the hospital or medical personnel in the emergency department with the ResQGARD benefit immediately. With ResQGARD application there is a rise in mean arterial pressure by ~10 mmHg within 5-10 minutes [5,11]. (Figure 4) These patients did not receive concurrent fluid therapy as no IV line could be placed. When fluid resuscitation therapy is given concurrently, systolic blood pressures rise even faster to nearly 20 mmHg within 10 minutes. (Figure 5) The work of breathing associated with the ResQGARD has been measured and it is equal to the amount of work needed to breathe naturally at rest [4]. As such, it does not require much energy to breath through the ResQGARD and it is generally well tolerated for at least 30-60 minutes.

**How to use it**

The ResQGARD is simple to apply and can be used with either a mouth piece or a face mask as shown in the Figure 1. When used with a facemask it can be held in place by an optional head strap. After inserting the ResQGARD into the mouth or applying the facemask and ResQGARD, instruct the hypotensive soldier to breath in through the device as they normally would, at a rate of ~12 times/minute. The user will feel the slight resistance with each inspiration, this is helping to increase blood return to the heart and increase blood pressure. Oxygen can be applied at up to 6 L/min to the small nipple attached to the ResQGARD. The ResQGARD can be used on Soldiers getting other therapies. A resuscitator bag can be attached to the ResQGARD if needed to provided assisted ventilations. Remove the ResQGARD if it causes respiratory distress or once the blood pressure has been restored. The device can be used for 30-60 minutes. Longer application can be performed as long as the Soldier does not complain of difficulty breathing.

**When to use it**

Indications

The ResQGARD should be used in spontaneously breathing symptomatic Soldiers who are hypotensive (systolic blood pressure <110mmHg) feel faint, or feel lightheaded. The ResQGARD can be used to treat

multiple causes of low blood pressure as described in Table 1.

Table 1: Causes of Hypotension Treatable with the ResQGard
blood loss
heat stroke
dehydration
severe orthostatic hypotension
other potentially reversible causes of low blood pressure and low blood flow including early stages of sepsis

If there is ongoing uncontrolled bleeding, stop the bleeding before applying the device. The ResQGARD should not be used in unconscious Soldiers unless they are intubated, still breathing, and hypotensive. The ResQGARD can be used when lying sitting, standing, or walking. The ResQGARD may be particularly helpful in the setting of severe limb injuries after a tourniquet has been applied.

Table 2: Contraindications to ResQGARD Application
uncontrolled bleeding
an open chest wound
lack of spontaneous respiration
agonal breathing at rates of < 8 breaths/min
complaints of difficulty breathing
congestive heart failure, when cause of hypotension

**Summary**

The ResQGARD can be used to treat symptomatic hypotensive Soldiers who are breathing spontaneously. It is FDA-approved as a circulatory enhancer for the treatment of relative hypovolemia and hypotension suffered by people as a result of reduced central blood volume. It is lightweight, easy to use, durable, and well tolerated. It can be used to 'buy time' by providing a critical bridge to more definitive repair of the primary injury and ultimate survival.

Editors note; I have not included the lengthy reference list for space conservation, anyone desiring the reference list may request it by email at <sapa.editor@gmail.com>

There were two photos with this article showing how the device is applied, again for space considerations they have been omitted.

.....continued from the front page....

As Parsons looked to the future, PAs from each branch of service took turns highlighting the past.

The profession dates back to the mid-1960s, when physicians and educators recognized a shortage and uneven distribution of primary care physicians, according to the American Academy of Physician Assistants Web site. To expand the delivery of quality medical care, Dr. Eugene Stead, of Duke University Medical Center, N.C., put together the first class of PAs in 1965. He selected Navy corpsmen who received considerable medical training during their service and the Vietnam War. Since that time, the role of PAs has evolved both in and out of the military.

“It is a great job,” Parsons said. “I’ve had a wonderful time being a PA for the last 31 years. I expect all of you will have the opportunity to do the same thing, whether through a military or civilian career.”

Retired Col. (Dr.) Candice Castro, (IPAP instructor), said she first encountered PAs early on in her career and quickly realized their importance.

Among other tasks, “they have to train medics, provide medical care, be a subject matter expert on equipment and supplies and operational matters,” she said.

Castro said she eventually became an instructor of PAs, which was the “best thing that ever happened to me.”

“Now that I’ve retired and am an instructor, it makes me very proud to see many of my former students are instructors now,” she said, adding that seven of them were in attendance.

The guest speakers were followed by a cake cutting in honor of PA Week and a trivia contest for the students.

For more information about the Army PA program, visit the IPAP Web site at <http://www.samhouston.army.mil/ipap>.

[This article and accompanying photograph contributed by LTC Pauline Gross](#)

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### **Hal’s view from the other side of the table**

I have received an excellent article from Hal Slusher sharing his recent experience with thoracic surgery.

It is several pages long, however, it is well written and I do not want to edit it to a shorter version, as I don’t know what I could possibly leave out without taking important ‘stuff’ away.

Look for it in its entirety in a future issue.

**OCTOBER**

### **Editor’s note:**

My sincere thanks to those who have taken the time and effort to submit articles and information for publication.

I have not as yet serialized any of the longer articles but may have to do that. I presently have two articles that are queued which are each in excess of 4 pages in length not including the references pages.

I urge the submitters to not despair, your works will be published in due time.

Concerning reference lists, if there are more than 2 or 3 references, I will not include them in the journal, however, if the reference list is desired by a reader, I will provide the same via e-mail at their request.

I am trying to avoid serialization because of the two month lag between issues, as such, the full impact of the presentation would be greatly diminished, if not lost.

Editorialists are generally limited to five or six hundred words for each editorial. I am NOT suggesting any limitations to length of articles, however, a few shorter ones here or there would certainly be a great help in organizing the layout of the publication.

LCDR Fish’s article in this issue is an excellent example.

The publishing schedule is such that frequently timely notice of events gets lost, a perfect example is the recognition of PA Week, noted in this issue, and giving honor to our veteran’s on November 11th has been somewhat offset.

The following holidays are hereby acknowledged and saluted: Veterans Day, Thanksgiving Day, Christmas Day and New Years, with special recognition for Election Day!

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### **?COMING SOON! 1st Annual SAPA CASINO NIGHT!!!!**

All Proceeds Benefit SAPA Scholarship Fund  
5 Card Stud, Texas Hold’em, Blackjack, Roulette!  
?FANTASTIC PRIZES!

Keep your eyes open for details, coming soon!!  
Remember-WHAT HAPPENS AT SAPA STAYS AT SAPA!

Reedy, Karen J.

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### **LOST MEMBERS**

Every year we elect individuals to attend the House of Delegates Session at the annual AAPA conference. These delegates represent the views and concerns of the SAPA constituency. The number of delegates authorized is determined by the number of Fellow members in the chapter. If you know of prior members who have let their membership lapse, encourage them to renew their SAPA and AAPA membership and declare SAPA as their constituent chapter!

**2008**

**SOCIETY OF ARMY PHYSICIAN ASSISTANTS**

**P. O. BOX 07490**

**Fort Myers, FL 33919**

**First Class**

**ADDRESS SERVICES REQUESTED**

**INGROWN TOENAILS (onychocryptosis)**

I was recently working in a clinic as a locums and had a patient presenting with an ingrown toenail.

I had the medical assistant (not many nurses available anymore in rural health clinics) set the patient up for a procedure.

I was surprised that she was ready for me to completely remove the toenail, as that was what she was used to.

I cannot remember the last time I removed an entire nail to treat an ingrown toenail.

I have found that just 'wedging' the nail is sufficient to provide excellent correction and relief, the healing time is greatly reduced and the entire procedure is much easier for the patient, if not for the provider.

Procedure:

After cleaning the toe and acquiring sufficient anesthesia with a lidocaine digital block (you never, never, never use lidocaine with epinephrine on a digit) it is quite simple, using a 4.5 inch straight metzembalm scissors or a sterilized straight nail clipper (preferred) to excise approximately 1/4 to 1/2 inch strip along the edge of the nail, removing the portion which is 'ingrown'.

You must cut the nail completely to the base, then work the 'wedge' loose from the base with a small hemostat.

At this point, I like to 'kill' the the nail forming matrix to prevent recurrence of the problem

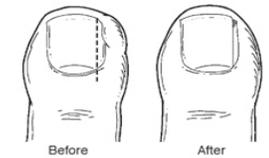
This can be accomplished in several methods, electrocautery is probably the best and cleanest method.

If that cannot be done, the matriectomy can be accomplished utilizing a silver nitrate stick or a 20% phenol solution applied with a cotton tipped applicator. The latter is becoming very difficult to obtain but is the most effective in preventing re-growth of the nail.

The matrix at the base of the nail bed, now exposed by having removed the nail wedge, is cauterized by one of the above methods by burning the proximal matrix under the epinychium. If you use silver nitrate be certain you do not leave any of the material under the nail fold.

The toe is then cleansed once more and a bulky dressing applied. The patient is instructed to begin soaking the toe tid starting the 2nd day post procedure.

I always place my patients on an appropriate antibiotic and analgesic.



John Wootton PA-C

This short tutorial was added as 'filler' as I had nothing else that would fit. It is approx 500 words in length, see my note on page 7.

**I wish each and every one a Merry Christmas and a prosperous and Happy New Year**

**If you do not celebrate Christmas, then have a happy winter holiday.**  
**Editor**





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