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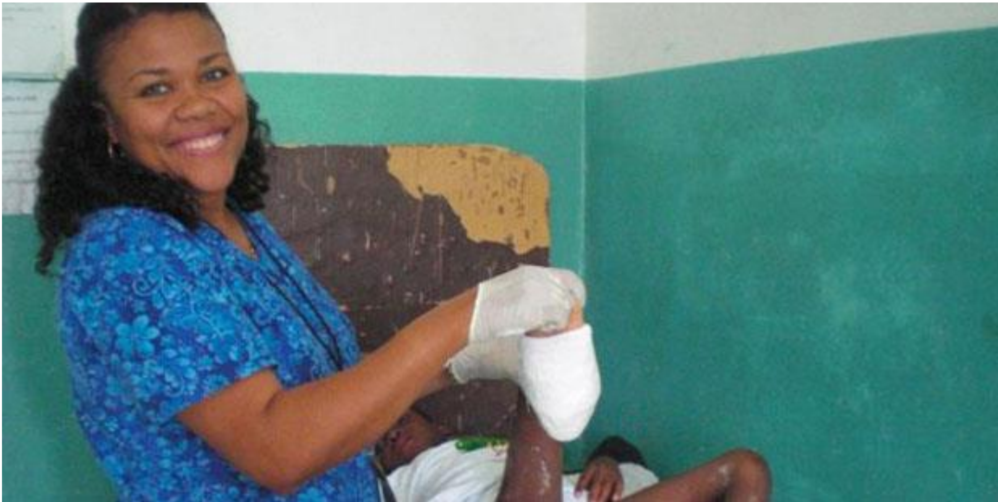

AMHE NEWSLETTER

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Can we offer a Total Knee Replacement, free of Opioids use?

Maxime Coles MD

Advances in the field of Orthopedic Surgery have instilled new improved surgical techniques and have allowed surgical teams to expose the patient undergoing a total knee replacement to a faster recovery in an almost post-operative Opioid-free atmosphere. The length of stay has diminished over the years to a point that many centers offer presently this surgical procedure in an outpatient setting. This has become the state-of-art for many hospitals eager to implement such new "fast-tracks" protocols.

We know well that a total knee replacement is a very common procedure. More than 765,000 TKA's are performed in the United States annually and many believed that the number may almost double to 1.5 million by the year 2030. While so many joint replacement are being done, it adds to this opioid epidemic seen in the country. Better surgical techniques with specialized cuts by robots have allowed a perfect prosthetic fitting, providing a stable joint reconstruction. Pain management has become a problem for the patients and the surgeons involved in the procedures.

Post-surgical opioids are regularly prescribed to almost all patients undergoing a total knee replacement. It was proven as well that half of the same patients were still receiving narcotics six months after the surgical procedure. The need to search for a more potent medication or more

In this number

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specialized techniques to minimize the use of Opioids, was discussed.

Recent studies have investigated how a non-opioid, long-lasting local analgesic (bupivacaine liposome injectable suspension) injected in the surgical wounds can provide pain control. This is why we will see why the "Phase 4 PILLAR Study" has shown promising hope in reducing the need for opioids in a patient undergoing Total Knee Replacement.

Pain management after surgery has a significant impact on the post-op recovery. It is encouraged to discuss these issues with a patient undergoing surgical treatment. The local effect of EXPAREL in the surgical site has also provided analgesia. Many who have benefited from such procedure in the past have shown their fear in a long hospitalization with possibly a higher risk of infections and complications in the peri or post-operative period like bleeding with or without the use of a tourniquet.

Over the years, we have taken in consideration these facts, in an effort to minimize the loss of blood and to control pain. Pain management in the last decade has also contributed to newer approaches in facilitating a faster recovery. Different techniques in epidural or regional anesthesia as well as General anesthesia have enhanced the use of peripheral nerve blocks.

We have certainly overprescribed opioids after such procedure in order to control pain to a point that we, as orthopedists. have definitely contributed to this crisis of dependence and addiction in the United States. We looked for a way the decrease the need for opioid in increasing our interest on a non-opioid post-surgical pain management strategy. We will deliberately review the post-operative management used by many leading institutions in the country.

May the lector remember the way we addressed this opioid epidemic in one of our past AMHE newsletter. One surgeon has to ask himself how to avoid using Opioid in his practice and review the alternatives.

Most institutions have used the LIA Approach which has provided a satisfactory pain management response in the first 48 hours during the post-operative period of a Total Knee Replacement. A mixture of local anesthetic agent usually "Ropivacaine" combined with a corticosteroid like "Betamatasone", Epinephrine, Morphine and antibiotics have been used to reduce the need for opioids alone or in combination with local or regional anesthesia. It becomes difficult to show differences in the pain management when many protocols are being used.

The LIA protocols have facilitated an early 48 hours free of pain to patients during their rehabilitation on the "fast track" and has not increased the rate of infection or other complications like bleeding. It was found to be a safe way to insuring early pain control, avoiding anesthetic blocks or Opioid medication. Institutions have used a mixture of 50 cc of saline mixed to 300 micrograms of Epinephrine with 10 mg of Morphine sulfate, 6 mg of Betamethasone sodium phosphate sulfate, 100 mg of Tobramycin and 200 mg of Ropivacaine injected in the joint and the soft tissue around the knee like the Pes Anserine, the posterior capsule, the quadriceps tendon, the collateral ligaments after a through irrigation of the knee joint itself and the placement of the desired prosthetic components.

This cocktail was used in all the cases for years while epidural anesthesia has been preferred to a general anesthesia with a blood loss prevention protocol. Optimization of the orthopedic patient to keep a hemoglobin (Hb) at 13g.L, Hypotensive anesthesia with the use of a tourniquet during the procedure, Plugging the femoral canal with autologous bone grafts after proper bone cut and tunneling to fit the prosthesis at the femoral site have contributed enormously to this successful approach. Finally, Tranexamic acid (TXA) has been used, mixed with saline in different protocols in one or two doses intravenously or intra-articularly assuring a successful

outcome to a Primary or a revision knee replacement. This was also used successfully in hemophilic patients with satisfactory results.

In this protocol, patients undergoing joint replacement are able to be mobile on the first day post op with crutches or walker. Anti-thrombolytic prophylaxis is performed additionally with a low weight molecular heparin (LWMH) for a four week-period. No opioids are used after the first day after surgery until discharge on acetaminophen or non-steroidal anti-inflammatory medications.

This is the way orthopedist have learned in the eve of this opioid epidemic, a way to eliminate the abuse of narcotics in search for pain control following Total Knee Replacement. More institutions are adopting such protocols.

Maxime Coles MD

References:

1- Barlow T, Griffin D, Barlow D, Realpe A. Patients' decision making in total knee arthroplasty: a systematic review of qualitative research. Bone Joint Res. 2015; 4(10): 163-169.
2- Goesling J, Moses SE, Zaidi B, et al Trends and predictors of Opioid use following total knee and total hip arthroplasty. Pain 2016; 157(6): 1259-1265.
3- Mont MA, Beaver WB, Dysart SH, Barrington JW, Del Gaizo DJ Local infiltration analgesia with liposomal bupivacaine improves pain scores and reduces opioid use after total knee arthroplasty: results of randomized controlled trial. J Arthroplasty 2017:1-7, doi: 10.1016/ j arth 2017.07.924.
4- Breindahl T, Simonsen O, Hindersson P, Brodsgaard Dencker B, Brouw Jorgensas a post-operative analgesia en M, Rasmussen S. Autologous Blood Transfusion after local infiltration analgesia with Ropivacaine in Total Knee and Total Hip Replacement. Anesthesiol Res Pract: 2012: 458795
5- Essving P, Axxalson K, Kjelberg, Wallgreen O, Gupta P, Dhanevar R, Lundin A: Reduced Morphine consumption and pain intensity with local infiltration analgesia (LIA) following Total Knee Arthroplasty: Acta Orthop2010; 81:354-360.
6- Inacio MCS, Paxton EW, Graves SC, Namba RS, Nemes S, Projective increase in Total Knee Replacement in the United States, an alternative projection model: Osteoarthritis Cartilage 2017: (25): 797-1803.
7- Ma LP, qi YM, Zhao D X: Comparison of local infiltration anesthesia of sciatic nerve block for pain control after total knee arthroplasty: a systematic review and meta-analysis.
8- Train J, Schwarzkopf R: Local infiltration anesthesia with steroids in total knee arthroplasty: a systematic review of randomized control trials. J Orthop. 2015; 12: S44-50.

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Rony Jean-Mary, M.D.

QU'EST-CE QUE NOUS VOULONS VRAIMENT EN TANT QUE PEUPLE ? POURQUOI BRULER LES AMBULANCES ET SACCAGER LES HOPITAUX.

J'ai eu bien du mal à trouver cette semaine un sujet qui intéresserait tout le monde et ferait l'unanimité au près de nos chers lecteurs. Au fil du quotidien, aussitôt qu'un un sujet est monté sur le tapis et semble occuper le devant de la scène, déjà en vient un autre qui le détrône pour se voir à son tour relégué au second plan l'instant d'après..j'ai pensé à l'actualité en Haïti où, depuis des semaines, chacun reste inflexible sur sa position et semble s'arc-bouter en mode stand still, attendant que le camp d'en face finisse par bouger ,et qu'on puisse crier victoire de son coté. L'école n'a pas rouvert ses portes et est restée fermée sans qu'on ne sache pour combien de temps. La rentrée des tribunaux généralement fixée au deuxième lundi d'octobre, n'a pas eu lieu cette année. Et les édifices publics sont nettement paralysés. 'L'économie est en chute libre et l'inflation, aux dernier barreaux, a été estimée à 19.5 %.Il ne semble y avoir aucun dénouement en perspective.

Dans ce bras de fer qui nous renvoie à 1986 et à 2004, et dont beaucoup peuvent encore se souvenir, on commence à se dire peut- être à quoi bon continuer à marcher et à protester puisque rien de tangible n'a été enregistré au cours des trente cinq dernières années, depuis que nous défilons dans les rues, marchant et protestant. A première vue, admettre que 1986 et 2004 ont échoué est une dure réalité à la quelle on semble devoir s'accoutumer. La récolte des fruits n'a tout simplement pas répondu à la promesse des fleurs. La seule différence est dans le fait qu'en 1986, la lutte était au tour d'un régime politique vétuste qui avait fait son temps et qu'on cherchait à déraciner à tout prix pour rentrer et vivre sous une ère de modernité , et plus digne de l'humain que nous sommes. La censure brutale, les disparitions et les emprisonnements prolongés, tous symboles de la dictature, en un jour étaient balayés d'un revers de main. Mais il n'y avait aucun projet de société viable, à même de transformer les mentalités et d'offrir à la fois un modus vivendi et un modus operandi différents de ceux auxquels on était habitué jusque-là. Ceux –là mêmes qui prônaient le changement, mais qui n'avaient aucune pratique du pouvoir pour avoir été trop longtemps en dehors du giron des affaires, étaient pris au dépourvu au moment de l'effondrement du régime. .

En 2004, Il y avait une caravane dite de

changement qui n'était cependant qu'une stratégie montée de toutes pièces pour forcer le plus de gens à monter à bord. Le pouvoir donnait sa réplique et mettait aussi du monde dans les rues. Il faut dire que ce n'était guère une lutte contre un système ou contre une certaine pratique jugée rétrograde, et qui rappelait trop de mauvais souvenirs d'un temps échu pourtant encore présent a l'esprit, mais une lutte dirigée contre un seul homme, devenu du jour au lendemain, l'âne de la fable sur qui il fallait crier Haro, et abattre à tout prix. Pour beaucoup, une fois coupée la tête du poisson, on pensait pouvoir sauver le reste du corps, et jugeait que tout allait finir par rentrer dans l'ordre. C'était croire que des canards sauvages, comme par un simple coup de baguette magique, pourraient se transformer en enfants du bon Dieu. La caravane a laissé tout le monde sur sa faim. Sauf pour quelques rares d'entre ceux montés à bord, qui se sont vus décrocher des franchises douanières illimitées pour des temps indéterminés ou qui ont atterri dans des postes ministériels de seconde importance. .

Aujourd'hui, Comme par un châtiment du destin, nous en voila encore à ce carrefour de manifestations, de marches, de révolutions, et de contremarches à n'en plus finir. Cette fois –ci, la lutte est différente en ce sens qu'elle renvoie au changement de tout un système à travers un homme qui semble le personnifier. Si je résume bien, en 1986, la lutte était contre le système. Il n'y avait pas trop de haine contre Le président en personne quoique lui-même produit d'une tyrannie cleptomane et sanguinaire .

En 2004, elle était contre un homme . Et à présent elle s'attaque au système à travers l'homme qui le personnifie. Dans notre présente lutte, Ce n'est pas l'homme qu'il faut changer mais le cœur de l'Haïtien qui doit apprendre à aimer son pays, à ne pas détruire ce qui reste de patrimoine national, à ne pas investir ailleurs les maigres ressources du pays Ce qu'il faut changer, c'est le système qui laisse voler impunément, qui accorde trop de privilèges à un petit nombre de citoyens au grand mépris du reste d'entre nous, qui centralise tout, et ne laisse aucune capacité décisionnelle aux zones périphériques.

Il faut un système aux yeux bandés qui laisse pencher la balance à droite ou à gauche, de quelque coté que cela tombe, mais où règnent la droiture, la justice et l'équité . On casse et on détruit non par sauvagerie ou par insouciance mais parce qu'on ne se sent pas concerné. C'est la justice qui élève une nation, Car elle porte les citoyens à croire en son destin. Les rues sont pleines à craquer et tout le monde exige que les dilapidateurs de fonds publics soient punis, qu'un exemple soit enfin tracé, pour que les générations futures tirent des leçons de ce qui se passe aujourd'hui et fassent un meilleure gestion des biens de la RES publia. Nous reconnaissons la justesse de leur mouvement et le bienfondé de leurs arguments .Mais ils n'ont pas besoin de tout casser et de tout détruire sur leur passage. Les casses qui ont eu lieu à l'hôpital général des cayes cette semaine les jets de pierre qui ont brisé les vitres et les fenêtres de la FHADIMAC a port-au-prince, tout comme l'incendie qui a détruit certaines ambulances en pleine exercice de leurs activités, ne sont guère rassurantes. Ce sont des actes condamnables. Les manifestants ont besoin de se rappeler qu'ils auront encore besoin de ces ambulances et de tous ces édifices qu'ils détruisent aujourd'hui, afin de mieux construire la société moderne qu'ils prétendent en appeler de toute leur force.

Rony Jean-Mary,M.D,
Coral Springs,FL,
Le 14 octobre 2019

Reynald Altéma, MD

SALT INTAKE AND CARDIOVASCULAR COMPLICATIONS.

Several population studies have clearly demonstrated the benefits derived from lowering salt intake in the diet[1,2,3,4] irrespective of gender, ethnic group, presence or absence of hypertension. Lowering of blood pressure is associated with reduction of morbidity and cardiovascular complications with the caveat that the best blood pressure is the lowest at which one can function. Estimates are that worldwide the average intake of salt varies from 9 to 12 gm per day. Above studies show that a reduction to 5-6 gm of salt, i.e. 2gm of sodium (the amount of sodium is about 40% of total salt content) does have positive effect. However further sifting of the data reveals that responsiveness to salt follows an ethnic pattern, leading to the concept of salt-sensitive versus salt-insensitive groups. However, such distinction may be a misnomer because benefits are noticed overall. What is not debatable is that some ethnic groups tend to be very susceptible to salt intake and are subject to disproportionate complications. Hence modulation of dietary intake has become a widely recommended intervention. Dietary Approaches to Stop Hypertension, coined DASH[4], is a cost-effective means to be proactive. The latest and most aggressive guideline as per WHO[4,5] goes so far as to indicate that an intake of <1.5gm of sodium would be appropriate for populations at risk, namely blacks, people with insulin resistance, obese individuals or even those with high visceral fat in the absence of classic enlarged abdominal girth-this is seen especially in the Indian subcontinent[6]. Unlike the deleterious effects of sodium, in the absence of end-stage renal function, a diet high in potassium (as well as magnesium) is also beneficial to reduction of blood pressure. Fruits and nuts are the sources of potassium and magnesium respectively[7].

With all of the above overwhelming data, it comes as a surprise that a trickle of studies have come up with results claiming that a low salt diet is associated with negative cardiovascular outcome[8,9,10]. The explanations offered vary from low salt causing a decrease in insulin sensitivity, an increase in aldosterone and catecholamines to an increase in refined sugar intake causing damage due to its toxic metabolites.

The question is what gives? How come we have such diametrically opposed data? The best answer against these studies can be found in large population studies from all over the world that keep showing the efficacy of a low salt diet approach. United Kingdom, Finland, Japan have all adopted similar recommendations and over the years have recorded noticeable reduction in cardiovascular complications[11,12,13]. The question still remains, how come? Studying people on low salt diet by definition implies looking at a skewed population. People on low salt diet usually are engaging in such a practice because of the advice of their physicians. As we stated above, the taste buds of the average citizen are such that the consumption of salt is far higher than necessary. Hence someone on low salt diet more than likely has hypertension, metabolic syndrome, endothelial dysfunction to begin with. Framing the data to show reduced insulin sensitivity is the equivalent of blaming the therapeutic intervention and ignoring the pathogenesis. Patients frequently use this as an excuse to refuse insulin by pointing out that people on insulin tend to lose their limbs. No study to date has documented patients with normal insulin sensitivity developing insulin resistance on a

low salt diet. If this could be proven, then one would have a valid argument. However, knowing the state of the art on this matter, it's hard to conceive that such intervention would result in the very pathology we are trying to prevent. As far as increase in aldosterone and catecholamines concentration, long term, this is not a complication of low salt intake[4]. The issue of carbs will be discussed later.

The one true iatrogenic complication that is encountered is the development of electrolytes disturbance when diuretic is used for treatment of hypertension. Hypokalemia and hypomagnesemia do carry arrhythmogenic properties. Not infrequently hypokalemia is paid attention to but not so much with hypomagnesemia, yet it can cause lethal arrhythmia[14]. A good rule of thumb is to look for and or treat empirically hypomagnesemia in the presence of diuretic-induced hypokalemia so long as patient has normal renal function. The correction of hypomagnesemia is crucial in the presence of persistent hypokalemia because the latter will not be corrected unless the former is, and it can also cause deterioration of CHF occasionally[14].

The issue of cardiovascular complications of low salt diet is reviewed by Cogswell who did a meta-analysis and concluded that, "The application of Hill's criteria to the putative association between low sodium intake and an increased risk of cardiovascular disease indicates that the association is not causal[15]…" This was a rigorous exercise of verifying and evaluating the reported results and not a mere opinionated assessment and as such, it gives her analysis scientific validity and heft. Fig 1 lists Hill's criteria she used to probe the different studies and she found them wanting, not well designed and without robust proof.

Fig 1

HILL'S CRITERIA FOR EVALUATING WHETHER AN ASSOCIATION IS CAUSAL.

STRENGTH

What is the degree to which the exposure (low sodium intake) is associated with the outcome (cardiovascular disease)?

CONSISTENCY

Has the association "been repeatedly observed by different persons, in different places, circumstances, and times"?

SPECIFICITY

Is the observed association limited to the exposure and outcome?

TEMPORALITY

"Does a particular diet lead to disease or do early stages of disease lead to those with peculiar dietetic habits?"

BIOLOGIC GRADIENT

Is there a dose–response relationship between the exposure and outcome?

PLAUSIBILITY

Is there a physiological basis for the observed association?

COHERENCE

Does the "cause-and-effect interpretation" of the association "seriously conflict" with "generally known facts about the natural history and biology of the disease"?

EXPERIMENT

"Is the frequency of associated events [outcomes]" affected by actions to prevent the exposure?

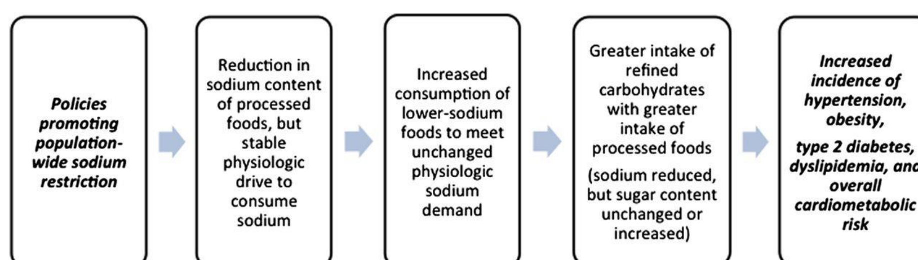
ANALOGY

Does an exposure with a similar action (physiologically) cause the outcome?
*Adapted from Hill.[16]

Cogswell, M et al *N Engl J Med* 2016; 375:580-586

DiNicolantonio purports that low salt diet can induce more refined sugar intake as hypothesis without proof [8]. This is his hypothetical explanation:

Unintended consequences of population-wide sodium restriction.23.



James J DiNicolantonio, and Sean C Lucan Open Heart 2014;1:e000167

openheart

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He references himself in a previous paper he wrote but it is a reprise of a hypothesis and there is no scientific proof provided[17]. I have yet to meet a patient consuming refined carbs, like soda, and eschewing potato chips or other salt-laden junk food. No one is disputing the havoc that refined carbs are creating and the obesity epidemic associated with this habit. However low salt consumption is not a culprit. The real problem that we clinicians face is patients not adhering to a low salt diet. It has been advocated that the best way to have patients accept this advice is a gradual decrease of the salt consumption. Overall, the evidence is robust that lowering salt intake is beneficial and there are decades of positive results to back the contention of a reduction of cardiovascular complications throughout the world for all ethnic groups.

References.

1. He Feng J, Li Jiafu, MacGregor Graham A. Effect of longer term modest salt reduction on blood pressure: Cochrane systematic review and meta-analysis of randomized trials. *BMJ* 2013; 346: f1325.
2. Elliott Paul, Stamler Jeremiah, Nichols Rob, Dyer Alan, R, Stamler Rose, Kesteloot Hugo et al. Intersalt revisited: further analyses of 24 hour sodium excretion and blood pressure within and across populations *BMJ* 1996; 312 :1249.
3. Borah PK, Kalita HC, Paine SK, et al. An information, education and communication module to reduce dietary salt intake and blood pressure among tea garden workers of Assam. *Indian Heart J*. 2018;70(2):252–258. doi: 10.1016/j.ihj.2017.08.008.
4. Rust P., Ekmekcioglu C. (2016) Impact of Salt Intake on the Pathogenesis and Treatment of Hypertension. In: Islam M.S. (eds) Hypertension: from basic research to clinical practice. *Advances in Experimental Medicine and Biology*, vol 956. Springer, Cham.
5. Sacks FM, Svetkey LP, Vollmer WM, et al. Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop Hypertension (DASH) diet. *N Engl J Med* 2001; 344:3-10.
6. Harpreet SB, et al. Comparison of Relative Waist Circumference between Asian Indian and US adults. *Journal of Obesity*. Volume 2014, Article ID 461956, 10 pages.
7. Karppanen H. Minerals and blood pressure. *Ann Med* 1991 Aug:23(3):299-305.
8. DiNicolantonio JJ, Lucan SC. The wrong white crystals: not salt but sugar as aetiological in hypertension and cardiometabolic disease. *Open Heart* 2014; 1: e000167.
9. Oparil S. Low sodium intake — cardiovascular health benefit or risk? *N Engl J Med* 2014; 371:677-679.
10. Graudal N, Jürgens G, Baslund B, Alderman MH. Compared with usual sodium intake, low- and excessive-sodium diets are associated with increased mortality: a meta-analysis. *Am J Hypertens* 2014; 27:1129-1137.
11. He FJ, Pombo-Rodrigues S, Macgregor GA. Salt reduction in England from 2003 to 2011: its relationship to blood pressure, stroke and ischaemic heart disease mortality. *BMJ Open* 2014;4: e004549-e004549.
12. Karppanen H, Mervaala E. Sodium intake and hypertension. *Prog Cardiovasc Dis* 2006; 49:59-75.
13. Udagawa K, Miyoshi M, Yoshiike N. Mid-term evaluation of “Health Japan 21”: focus area for the nutrition and diet. *Asia Pac J Clin Nutr* 2008;17: Suppl 2:445-452.
14. Ahmed F, Mohammed, A. Magnesium: The Forgotten Electrolyte-A Review on Hypo-magnesemia. *Med Sci (Basel)*. 2019;7(4):56. Published 2019 Apr 4.
15. Cogswell, ME, et al *N Engl J Med* 2016; 375:580-586.
16. Hill AB. The environment and disease: association or causation? *Proc R Soc Med* 1965; 58:295-300.
17. DiNicolantonio, JJ, Lucan, SC, O'Keefe, JH. An unsavory truth: sugar, more than salt, predisposes to hypertension and chronic disease. *Am J Cardiol* 2014; 114:1126–8.

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Wednesday October 9th 2019

Dear Friends,

The world is currently witnessing another calamity unravelling in the Bahamas. As a result of Hurricane Dorian, thousands of Haitian-Bahamians are now facing the prospect of dying from diseases, hunger and neglect, as they will also need to be sheltered from the elements.

The AMHE (Association Médicale Haitienne à l'Etranger) and the AMHE Foundation, with vast knowledge in dealing with similar crisis in the past are joining other civic, artistic, professional and/or social organizations in a coalition to mitigate the threat looming over our Brothers and Sisters in Bahamas.

The AMHE has already established contacts in Nassau Bahamas and the mission has already been deployed. Your contribution, however small or big, will change the course of events and it has special meaning for the recipients. Your organizational or individual monetary support are paramount.

You may contribute and participate in this effort through basically two options:

1) You may send your contribution by check or money order to AMHE Foundation at 8142 Driggs Hill, West Palm Beach FL 33411, or
2) To use a credit or debit card go to the webpage GoFundMe.com. Click on Search and type: AMHE Foundation/Dorian and you will be on the site

AMHE Foundation is a 501 (c) (3) Charitable organization. All donations are fully tax-deductible. An acknowledgement of your gift will be sent to you to claim your tax deduction.

Please share this letter with your family members, your friends, your employees and, all acquaintances.

All participants and donors in the fund raising will be notified of the use of the funds collected.

You may contact us at Info@AMHEFoundation.org

Yours truly

AMHE Foundation

La AMHE a perdu un ami dans la personne de Maitre Pierre C Labissiere, Pere de notre ami et confrere, membre de l'Association Medicale Haitienne a l'Etranger. Jean Claude Labissiere MD. Nous voulons souhaiter nos condoleances a lui et a ses neuf freres et soeurs et a tous les amis eprouves par ce deuil. Haiti a perdu un de ses grands avocats et beaucoup d'entre nous ont perdu aussi un pere. Lee funerailles seront chantees en Haiti le 26 Octobre 2019. Que la terre te soit legere Maitre Pierre C Labissiere.

Maxime Coles MD.

Texte produit en Haiti par le cabinet Oxilus:
Le Cabinet OXILUS et l'Équipe OXILUS émus de la chute du Météore Pierre C. LABISSIÈRE

La profession d'Avocat en Haïti, comme toute autre libérale, a son histoire émaillée sans doute de séquences d'histoire nationale. Du fait, ceux/celles qui y ont vocation ou prétention s'avisent á bon droit de s'abreuver á la source d' aînés progressistes pour ne pas faire fausse route. Sur un tel parcours, se laissait croiser une étoile , un colosse, un puits de science, un Météore, Me Pierre C. LABISSIÈRE.

Ce patrimoine humain a servi avec brio la cause du droit et de la justice de son pays. Son savoir pétillant, son esprit d'ouverture, son sens de partage et de vulgarisation des connaissances juridiques, sa disponibilité, son accessibilité, ses lumineuses consultations á tout sollicitant immortalisent dans la mémoire de la postérité le grand aîné de la Rue Capois.

Émus devant sa dépouille, le Cabinet OXILUS et l'Équipe OXILUS saluent le passage au pôle de l'éternité de cette Âme peu commune rappelée aujourd'hui par l'Auteur de la vie, le grand Yaweh et Dieu de l'univers.

La mort n'étant pas une contrariété quand la vie a été loyale, nous souhaitons que soit équitablement réparti entre ses héritiers, dont les deux fils avocats, le riche Actif moral de l'aîné exemplaire!

Condoléances les plus émues aux familles éplorées, au Cabinet Labissière, á la Confrérie de Port-au-Prince !

Que l'âme de Me Pierre C. LABISSIÈRE repose en paix!
Jacquenet OXILUS, av.

A son of the AMHE, Patrick Day, Welterweight boxing champion sustained a head injury after knocking out blows in a championship fight and is undergoing surgical treatment. Please pray for his recovery. He is the son of Phillipe Day MD and Lisa Day. May God guide the hands of the Neurosurgeons. Please, add him to your prayers.
Maxime Coles MD

Paul Verlaine

Il pleure dans mon coeur

Il pleure dans mon cœur
Comme il pleut sur la ville ;
Quelle est cette langueur
Qui pénètre mon cœur ?

Ô bruit doux de la pluie
[…]

hellopoetry.com / poem / 1975809

Dear AMHE Members, Family, and Friends,

The news coming out of the Bahamas is getting worse by the minute.

As hurricane Dorian reared its ugly head in the Caribbean Sea, Abaco and Grand Bahama suffered the brunt of the storm. Unfortunately, the 14,000 Haitians living in those islands saw their already precarious lives and their hope for better days vanish before their eyes.

We MUST ACT QUICKLY to bring relief to our Haitian brothers and sisters.

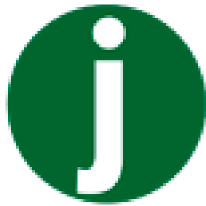
AMHE wasted no time in the aftermath of this tragedy. We have been working relentlessly to deliver relief to those left reeling, but we can do much more with your support. We need you to empower our ability to serve those in dire need now.

At this time, AMHE leaders have already contributed nearly 15,000.00 and have already sent first aid items to this cause. We need to raise $50,000.00 within the next two weeks. Please join us in this endeavor.

Donate now to the AMHE Dorian Fund at **amhe.org**.

Fraternally yours,

Joseph Pierre-Paul Cadet, MD
AMHE President



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Published on the AMHE Facebook page last two weeks
Articles parus sur la page Facebook de l'AMHE durant la dernière semaine

AMHE a ajouté 40 nouvelles photos de 5 octobre à l'album AMHE FL Chapter 10-5-19 — à Renaissance Fort Lauderdale-Plantation Hotel.Publié par Maxime Coles · 5 octobre · AMHE GL Assembly - The CDC says only 31% of men and 65% of women wash their hands after using the restroom. - The AMHE would like to wish a happy birthday to Bishop Sansaricq. - Trois generations de Chery. MC - An aspect of Haiti et son development. MC - Haiti, terre de nos aieux et ses 11 millions d'habitants. MC - And the Vaping epidemic is taking more victims. Now 1080 sick and 23 dead. MC -
Knee arthroplasty in an opioid-free postoperative period
And more…

Upcoming Events

AMHE's bio just got a bit stronger and a bit more interesting.

On November 9, 2019, the Haitian Roundtable has selected AMHE to receive the 1804 Cathrine Flon Award. It is an extreme honor for AMHE to be this year's receipient of the 1804 Catherine Flon award.

It would be great if you considered attending this event to applaud AMHE at the 6th Annual Haitian Roundtable event.
Ticket are available for purchase at Event Brite

AMHE
Central Executive Committee