COMMONWEALTH of VIRGINIA

Dianne L. Reynolds-Cane, M.D.
Director

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April 25, 2013

Leila Haddad Zackrison, M.D.
Optimal Health Dimensions
11166 Fairfax Blvd. #405
Fairfax, Virginia 22030

UPS OVERNIGHT MAIL

RE: License No.: 0101-045689

Dear Dr. Zackrison:

This letter is official notification that an informal conference of the Virginia Board of Medicine ("Board") will be held on **Thursday, July 25, 2013, at 9:15 a.m., at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Henrico, Virginia**. The conference will be conducted pursuant to Sections 54.1-2400(10), 2.2-4019, and 2.2-4021 of the Code of Virginia (1950), as amended ("Code").

A Special Conference Committee ("Committee") will inquire into allegations that you may have violated certain laws and regulations governing the practice of medicine and surgery in Virginia. Specifically, you may have violated Sections 54.1-2915.A(3)[1], (13), and (16) of the Code in your care and treatment of Patient A from 2003 through 2007, in that:

1. In or about May 2003, you diagnosed Patient A with reactive arthritis/ spondyloarthropathy. The patient was HLA B27 negative, making this diagnosis less likely, although it would not exclude this diagnosis. However, the clinical presentation and lack of radiographic findings such as sacroiliitis are not supportive of a diagnosis of chronic reactive arthritis.

2. In or about August 2003, you diagnosed Patient A with systemic vasculitis, although the patient's records lacked physical exam findings suggestive of vasculitis, and

[1] Prior to July 1, 2003, Section 54.1-2915.A(3) was codified as Section 54.1-2915.A(4) as written to include gross ignorance or carelessness in the practice, or gross malpractice. After July 1, 2003, it was rewritten to include intentional negligent conduct in the practice that causes or is likely to cause injury to the patients.

inflammatory parameters (erythrocyte sedimentation rate and C-reactive protein) were noted to be normal on several occasions.

3. On or about February 2005 you diagnosed Patient A with calcium pyrophosphate dihydrate ("CPPD") disease/pseudogout and prescribed colchicine to treat the condition, although the basis of the diagnosis in the patient's medical records is unclear. Medical records do not include radiographic documentation of chondrocalcinosis, synovial fluid crystal analysis, or subjective report of episodic joint swelling suggestive of pseudogout.

4. In regards to your diagnosis and treatment of Patient A for Lyme disease beginning in or about October 2003:

a. You diagnosed Patient A with Lyme disease although medical records do not note a history of symptoms/signs compatible with the diagnosis, such as erythema migrans skin lesions, arthritis of the large weight bearing joints, carditis, Bell's palsy, acute radiculopathy, or lymphocytic meningitis.

b. You diagnosed the patient with Lyme disease, although numerous serologic tests for Lyme infection, including Western blot and ELISA, were negative.

c. After initial lab tests (Western blot and ELISA) were negative, you ordered repeat tests on approximately 16 occasions, with each result being negative. Moreover, on approximately nine occasions you ordered polymerase chain reaction ("PCR") tests on urine, although this test is not approved by the U.S. Food and Drug Administration to diagnose Lyme disease.

d. On two occasions for durations of approximately three months each (November 6, 2004 to February 13, 2004; and July 28, 2006 through November 2, 2006), you treated Patient A with long-term antibiotic therapy (ceftriaxone). However, Patient A did not meet Infectious Diseases Society of America ("IDSA") Guidelines-established criteria for diagnosis of Lyme disease, and prolonged courses of ceftriaxone have not been demonstrated to be beneficial. This type of treatment placed Patient A at risk for infection from a PICC line as well as antibiotic side-effects. Moreover, ceftriaxone therapy was administered to the patient in pulsed dosing, five days a week, in contradiction of IDSA Guideline evidence-based recommendations.

e. You appeared to base the duration of antibiotic treatment for the patient's diagnosis of Lyme disease on normalization of antibody titers, although the presence of IgG antibodies does not distinguish between active infection and prior exposures, and it is very common for protective IgG antibodies to persist for many years following vaccination or recovery from an infection.

5. In regards to your diagnosis and treatment of Patient A for salmonella, salmonellosis, and/or reactive arthritis due to chronic salmonellosis beginning in or about May 2003:

a. You diagnosed the patient with salmonella without any positive cultures of blood, stool, or urine to support the diagnosis. Although the patient had multiple positive serologic screens for salmonella, such tests cannot distinguish between past and present infection.

b. Despite the lack of usefulness of serologic tests for salmonellosis, you ordered such tests on approximately nine occasions.

c. Although Patient A lacked any culture-confirmed evidence of salmonella infection, you treated her with ciprofloxacin for approximately five months (May 5, 2004 through October 18, 2004).

6. In regards to your diagnosis and treatment of Patient A for babesiosis and/or reactive arthritis due to babesiosis beginning in or about January 2004:

a. You diagnosed the patient with babesiosis without positive identification of the parasite on thin blood smears and in the absence of suggestive clinical signs and symptoms of the disease, such as history of tick exposure in an endemic area for babesiosis or history of blood transfusion, and presentation of the patient with fever, hemolytic anemia, or thrombocytopenia as well as nonspecific symptoms such as headache, chills, myalgias, and arthralgias.

b. You apparently diagnosed the patient with babesiosis based on a positive Babesia microti PCR on one occasion, a positive Babesia microti IgG on two occasions, and a persistently positive WA1 IgG. However, on multiple occasions the patient had negative Babesia microti PCR results, raising the issue of a false positive or contaminated specimen. Moreover, serologic tests cannot distinguish past from current infection. Finally, you did not consult with or refer the patient to an infectious diseases specialist who would be more acquainted with the reliability and significance of such assay results.

c. After ordering an initial blood test for Babesia antibodies, you ordered repeat tests on approximately 17 occasions, although the patient never had positive identification of the parasite on thin blood smears and she no longer had exposure to potential infection from Babesia during the time she was under your care.

d. Even if your diagnosis of bebesiosis had been correct, you incorrectly and excessively treated Patient A with antibiotics for this disease. Standard treatment for babesiosis lasts 7 to 10 days, unless continued parasitemia on blood smears is

documented. However, without such test results, you treated the patient with antibiotics during the following approximate date ranges:

Medication	Date(s)
Biaxin	2/16/04 to 5/5/04 2/3/06 to 6/20/06 5/21/07
Atovaquone	2/16/04 to 5/5/04 3/3/05 to 5/21/07
Ketek	4/13/05 to 5/13/05
Clindamycin	4/21/06 to 9/15/06
Azithromycin	6/20/06 to 7/25/06 (intravenous) 4/21/06 to 5/21/07 (oral)

7. On or about February 2006, you diagnosed Patient A with suspected Bartonella infection, although repeated testing for Bartonella was negative. Furthermore, you failed to consult with or refer the patient to an infectious diseases specialist regarding her lab results.

8. On or about October 13, 2003, you diagnosed Patient A with "candida yeast infection of stool/gut," although no supporting information such as culture reports substantiated this diagnosis. Moreover, although you lacked culture evidence of candida infection, you treated the patient with fluconazole for a one-year period (October 13, 2003 to October 18, 2004).

9. Although an established diagnosis of one or more active infections was not supported in the patient's medical records, as discussed above, you treated Patient A with antibiotics for multiple conditions on an approximate continuous basis from approximately late 2003 to mid-2007. During this time period, there was no consistent documentation in the medical record supporting sustained improvement in the patient's physical or cognitive function. Moreover, the records lack a treatment plan to document improvement, to reevaluate the success of therapy and to help guide its duration, and to reconsider the appropriateness of your initial diagnoses for Patient A.

Please see Attachment I for the name of the patient referenced above.

The Board has engaged the services of Janet E. Lewis, M.D., and William A. Petri, Jr., M.D., Ph.D., whose curricula vitae and written reports are included in the material enclosed with this letter. Dr. Lewis and Dr. Petri will be present at the informal conference to serve as experts in rheumatology and infectious diseases, respectively, which will include providing their expert opinions regarding your standard of care.

After consideration of all information, the Committee may:

1. Exonerate you;
2. Place you on probation with such terms it deems appropriate;
3. Reprimand you; and
4. Impose a monetary penalty pursuant to Section 54.1-2401 of the Code.

Further, the Committee may refer this matter for a formal administrative proceeding when it has failed to dispose of a case by consent pursuant to Section 2.2-4019 of the Code.

You have the right to information that will be relied upon by the Committee in making a decision. Therefore, I enclose a copy of the documents that will be distributed to the Committee for its consideration when discussing the allegations with you and when deliberating upon your case. These documents are enclosed only with the original notice sent by UPS overnight mail. These materials have been provided this date to your counsel, Harrison Pledger, Esquire.

To facilitate this proceeding, you must submit eight (8) copies of any documents you wish for the Committee to consider to Reneé S. Dixson, Discipline Case Manager, Virginia Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia, 23233, by **June 27, 2013**. Your documents may not be submitted by facsimile or e-mail. Should you or Adjudication Specialist Tracy Robinson wish to submit any documents for the Committee's consideration after **June 27, 2013**, such documents shall be considered only upon a ruling by the Chair of the Committee that good cause has been shown for late submission.

Absent good cause to support a request for a continuance, the informal conference will be held on July 25, 2013. A request to continue this proceeding must state **in detail** the reason for the request and must establish good cause. Such request must be made, in writing, to me at the address listed on this letter and must be received by 12 noon on **May 9,2013**. Only one such motion will be considered. Absent exigent circumstances, such as personal or family illness, a request for a continuance after **May 9,2013**, will not be considered.

Relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as laws relating to the practice of medicine and other healing arts in Virginia cited in this notice can be found on the Internet at **http://leg1.state.va.us.** To access this information, please click on the *Code of Virginia* for statutes and *Virginia Administrative Code* for regulations.

In its deliberations, the Committee may utilize the Sanction Reference Points System, as contained in the Sanction Reference Manual. The manual, which is a guidance document of the Board, may be accessed at **http://www.dhp.virginia.gov/medicine**. You may request a paper copy from the Board office by calling (804) 367-4513.

Please advise the Board, in writing, of your intention to be present. Should you fail to appear at the informal conference, the Board may proceed to a formal administrative hearing in order to impose sanctions.

If you have any questions regarding this notice, please contact Tracy Robinson, Adjudication Specialist, at (804) 367-4694.

Sincerely,

William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

Enclosures:
Attachment I
Informal Conference Package (5 volumes + supplement)
Map

cc: Tracy E. Robinson, Adjudication Specialist, APD
Lorraine McGehee, Deputy Director, APD
Harrison Pledger, Esquire (***w/enclosures by UPS***)
Sharron Squires, R.N., Senior Investigator (139030)