Personal Physician CARE

Individualized Attention. Comprehensive Care.

Edited by Rachel Lazris
Content by PPC providers

Your Health

Osler Quote of the Month:

"Learn to see, learn to hear, learn to feel, learn to smell, and know that by practice alone can you become expert"

Volume 4 **July-August 2025** **Number 3**

Table of Contents

Your Health

Health Myth of the Month
Sunscreen

Every newsletter will have a segment exploring health myths, using data and facts to debunk something that has been normalized in the medical liturgy. Today we'll take a closer look at sunscreen. The fear of skin cancer has evolved over time and become, like many other health concerns, an epidemic, requiring frequent evaluations, surgeries, freezing, and of course prevention. Only since the American College of Dermatology (ACD) hired a publicity agency (true story!) and Congressional lobbyists, did the skin cancer epidemic begin. But just how successful have all these interventions and preventions been?

In fact, skin cancers fall into two types: those that will kill, and those that won't. The latter group (squamous and basal) have dramatically increased in number since we started looking for them through skin exams (despite an increase in sunscreen use) leading to copious surgeries, dermatology visits, and freezing. But, there is no evidence that these screenings reduce deaths while many harms are documented to have occurred. We have not seen convincing reduction in melanoma deaths either, only more diagnoses, and melanoma tends to become less common as you age.

Sunscreen may prevent some cancers, but studies show they do not reduce cancer deaths. What they do prevent is absorption of activated Vitamin D and other sun-dependent processes within skin that help our immune system fight cancer, infections, and even diseases like diabetes. This is why some nations, like Australia, have begun to curb routine sunscreen use. Because sunburn-related cancers often take around 30 years to develop, the use of sunscreen in the elderly (when vitamin D is crucial) is counterproductive. We need sun, at least 20 minutes a day, and we can't get it when we block our skin with sunscreen.

Certainly sunscreen has a place, such as at the beach or during prolonged outdoor activities in the sun, but it is best used selectively rather than as a daily reflex. Overuse can cause more harm than good. Like the Dermatology Association, the sunscreen industry will tell you otherwise but it is worth remembering these messages often come from those who profit most from their acceptance!

News from PPC:
Hospital Help

In Maryland, hospitals do not allow primary care providers to see you or even to consult on your care, nor do hospitalists reach out to primary care providers, meaning that the provider who knows you best will be excluded from your care plan. At PPC, we are fighting for a place at the table, because we know from experience and from multiple studies that without primary care in the hospital, outcomes are far worse and harm is far more likely to occur.

We have developed a form to fill out and bring to the hospital, which can be found at the office or on our website under resources, and we implore you or your family to email us when in the hospital so we can be involved, as well as to demand the hospitalist reach out to us. We want to be there for you!

Long Term Care Corner
What Matters to You

We seem to be always looking for something wrong with you, some numerical abnormality we derive through blood tests or vital signs, some new memory diagnosis, some problem with your health rather than with you as a person. We toss drugs and tests at you, have you see specialists, and we monitor you excessively, all of which often does not add any days or quality to your lives. But do we ever ask: What do you want?

Medicare has begun to contemplate changing our annual Wellness visit to just this format, basing at least one visit a year on you and not on what we want to do to you. We would ask you what your goals are, how far you'd like to go with testing and treatment, and how we can best meet your needs aside from simply measuring and fixing things. We know that a palliative approach to care among long-term care residents increases lifespan and quality even as it decreases medical surveillance and intervention. And we can't palliate you until we know what you want! So make sure we ask what you want. That's your surest path to your best outcome.

Medication Factoids
Prolia

As with all drugs designed to "fix" bone density, Prolia, a twice a year injection pushed hard by many doctors, has its pros and cons. On the plus side, it can increase bone density and, for a brief time, decrease fracture risk by about 3/1000 people within the first 3 years of use. But on the negative side, using Prolia beyond 5 years increases fracture risk, stopping Prolia reduces bone density below what it had been before starting, and Prolia has ample side effects including the loss of teeth and destruction of the jaw. Ask any dentist about Prolia and they will shudder.

Bone density is not always a meaningful barometer of bone health. Many flexible people who never break bones have low density, and many dense bones easily shatter. When we improve density with Prolia, we are preventing the body from eliminating unhealthy bone which builds up over time, making our bones more dense but far less healthy.

The best path to good bone health is exercise, diet, Yoga, and stretching. This will reduce fracture risk even if it doesn't improve density. And of course, prioritize fall prevention!

Testing Corner
Monitoring Atrial Fibrillation (Afib)

Cardiologists now are claiming that we have an Afib epidemic; more of it is occurring than ever before. They are insisting all people with afib take blood thinners or get the Watchman procedure, which we discuss in The Last Word. As noted in our last newsletter, as we are treating more people for afib, stroke risk is increasing due to bleeds in the brain, as are significant bleeds elsewhere from blood thinners. So, really, should we be looking for more afib as cardiologists have implored?

Smart watches and afib devices are detecting even small amounts of afib, and doctors frequently place a heart monitor on people for 24 hours to look for afib, even in the absence of symptoms. A recent report shows that they are sending afib monitors to people's homes to increase the number diagnosed! All of this only creates fear and leads to more intervention, without any evidence of benefit from this approach other than to those that sell blood thinner drugs or Watchman devices.

Simply gathering more health data is not necessarily useful and potentially dangerous. When we have symptoms, looking for problems makes sense. When we don't, especially as we age, finding abnormalities that may occur rarely is not likely to help us be healthier or live longer and will trigger overtreatment and over testing. Beware of all these devices that promise to discover ailments that you are better off not knowing you may have.

Nutrition Corner

The Pink Himalayan Salt Trick

Ophrah and other celebrities have been touting the benefits of poorly-tested weight-loss drugs, and in our In The News section we reveal new dangers associated with them, something we've discussed before. Now some notables are recommending the Pink Salt Trick, which is a nutritional weight loss concoction you can make yourself.

The idea is that Pink Himalayan Salt, which contains multiple beneficial minerals, can help reduce appetite and break down fat when mixed with lemon juice and warm water and consumed once a day. Typically it's recommended to put the juice of half a lemon and a half tsp of pink salt into warm water. I tried it and nearly gagged, but others have found it to be beneficial. In the end, there is little downside from this drink although no evidence of efficacy. And you can add turmeric, cinnamon, apple cider vinegar, and even tart cherry juice to make it even less tasty but more potent!

In the News

- If history repeats itself with our pharmaceutical industry, new GLP-1 weight loss drugs will be sold to millions of people with great promise (now doctors are prescribing $50 billion of these a year!) before we fully understand their dangers. We have discussed many dangers already in prior newsletters, but a new study finds that users of them have a 7% higher risk of retinopathy, a dangerous eye disease. Also, by causing dry mouth, these drugs can cause periodontal disease, what is now called Ozempic teeth. I am sure more is to come!

- A new study of COVID boosters showed that the European booster was far more effective than the American booster, the former cutting the risk of death in elders by 30% and the latter not decreasing any meaningful outcomes. But wait, let's look at the numbers! Deaths in Europe in the unvaccinated were 1/100,000, and in vaccinated 0.3/100,000. Even the authors acknowledge that death is so rare in COVID now that these numbers are difficult to interpret. And that is the real take home. COVID has become a mild cold, and vaccination thus provides no real benefit.

- Sticking with COVID, a large study shows that healthcare workers vaccinated with influenza vaccine had a decrease in lost work days, while those vaccinated with the COVID booster were sicker and missed more work days. This is yet more evidence showing a lack of efficacy and potential harm with the COVID booster.

- As discussed more in the Last Word, the expensive Watchman procedure for afib has little long-term data, but a new study shows a 4/1000 immediate deathrate, something likely higher since deaths are usually under reported. Longterm death rates may be much higher, and at best this procedure decreases symptomatic stroke by 6/1000. The findings for blood thinners are no better in afib, so treatment seems worse or at least no better than no treatment despite the fact we are spending more than $50 billion for treatment.

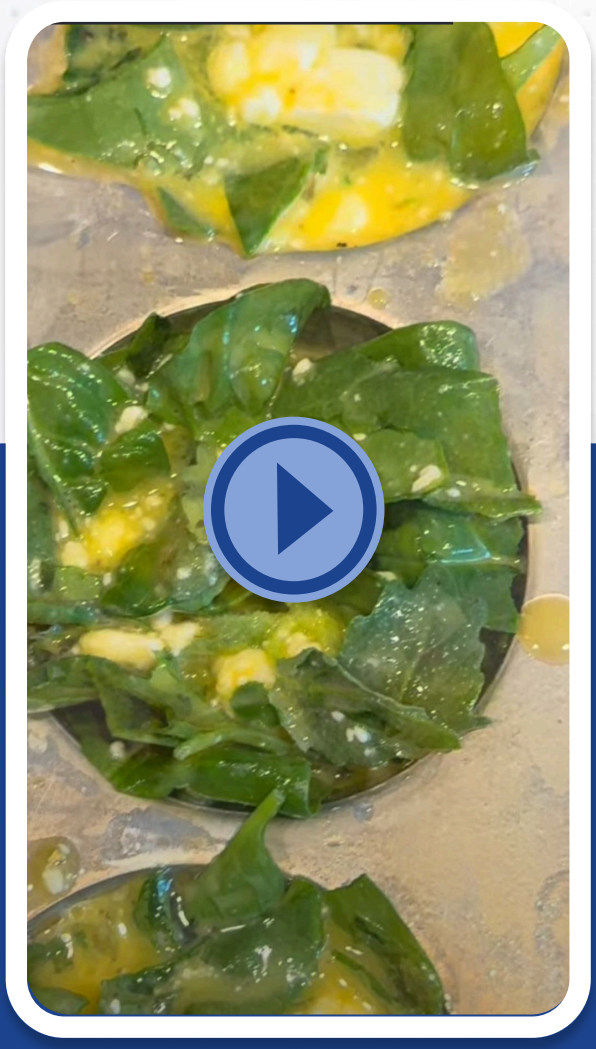
- Some good news! A big study shows that heart attack deaths have decreased over the past 50 years from 350/100,00 to 40/100,000, largely from our ability to ameliorate heart attacks urgently in the emergency room. But other forms of heart disease deaths have actually increased during the same period, from 70/100,000 to 125/100,000. So, we are not preventing or treating heart disease effectively in the cardiologist office despite hundreds of billions spent on drugs, tests and procedures, but can fix the consequences of heart attacks urgently. While this is good news, it's time we stop our sick care system and start focusing of preventive care like diet to actually target the true cause of cardiac deaths.

- Beware of observational studies that make grand claims without verification! A new one suggests that certain vaccines reduce dementia risk. And yet they did not randomize people (those who get vaccines tend to be healthier, so this is a salient confounding variable to skip) nor was the study long enough to truly show anything meaningful.

Recipes of the Month

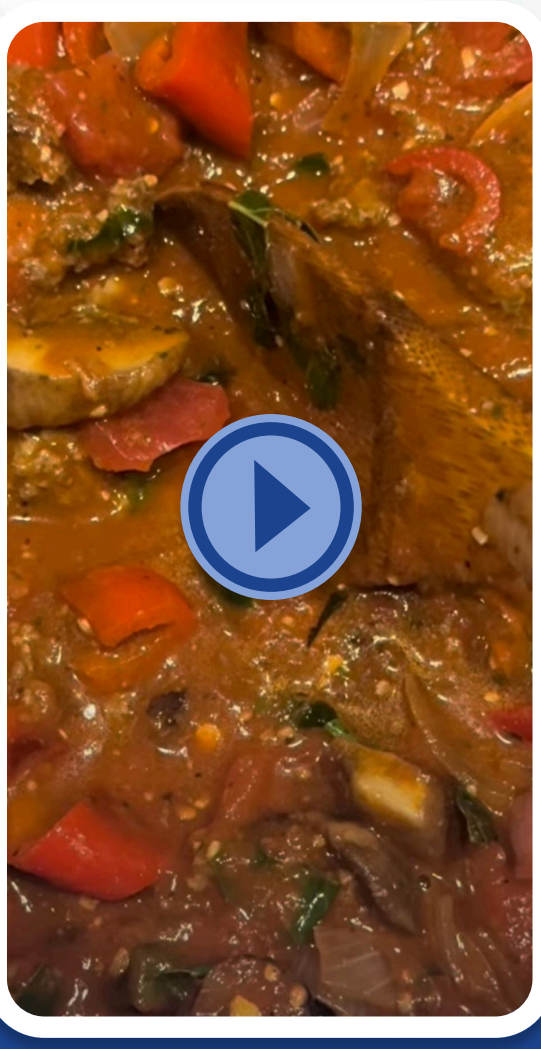
Today we have two recipes to share. Click the video link and then the pdf of the recipe to learn more.

Eggbites With Spinach



Download

Spaghetti Sauce



Download

All Recipes Will Be On Our Website. Check Out Our Nutrition Videos, Nutrition Information, And Join Our Nutrition Program That Is Filled With Tasty Perks!

The Last Word
The Watchman for Afib

Insurance is now spending $5 trillion on US healthcare (up from $4 trillion just a couple years ago) even as life expectancy decreases and chronic diseases escalate. Much of that spending is for cardiology drugs, tests, and procedures, most of which have no proven efficacy and carry significant risk, such as carotid dopplers, stress tests, catheterizations, stents, and blood thinners. Now we have a new addition to the cardiac armamentarium called the Watchman, a device that claims to help reduce stroke in atrial fibrillation. It only costs insurance $5 billion in 2024, or $25,000 per implantation (much of it landing in the pockets of the very doctor who suggested you get it), and which has had only a few short-term industry-sponsored studies demonstrating its efficacy. (Just as a point of comparison, Medicare paid $24 billion in 2024 for Eliquis and Xarelto, the blood thinners used to prevent stroke in afib, plus tens of billions for all the bleeds they cause.) The Watchman tells us a lot about how health care information is disseminated and how profits often trump truth when it comes to physician prescriptions for care.

The reason afib causes stroke is that clots can form in the heart. Blood thinners reduce the chance of clot but cause bleeding. The Watchman is a device that is implanted in the heart to reduce clot formation, although just how long that will persist and just what damage it does to heart muscles is unknown. Most of us in geriatrics see very few strokes in our afib patients who are not treated. Of course, studies are conducted on very select people, and just how much afib constitutes risk is unknown. Many people have transient or rare afib, others are more persistent. But drug company studies don't consider such nuance. And during the last 10 years that we have been giving these medicines, stroke incidence has risen.

The stroke risk from afib has often been overstated, creating a narrative that can feel frightening. That is why we spend at least $50 billion a year on its treatment/diagnosis and why cardiologist tell patients that they will get a stroke with it unless they use blood thinners or the Watchman, even if they have afib briefly. Yes, afib increases risk of stroke, but how one defines stroke determines the extent of risk. Cardiology calculators and protocols greatly inflate the risk by using drug-company studies that define stroke as a dot on a CT scan that is typically not even noticed. When we use a more clinically relevant definition, which is a stroke you notice, then the risk is much smaller. And of those strokes, most of which are small, 70% fully resolve in a few months. The basic math is that people with afib have a 2% risk of symptomatic stroke per year and that is reduced to 1.4% on blood thinners. However, what they don't tell you is that with blood thinners the risk of a bleeding stroke (where you bleed in the head) is about as high as the reduction in ischemic stroke, about 6/1000, and bleeding strokes are rarely reversible. Also, when a person is at risk of falling, the risk of sustaining a serious bleed is even higher (15% a year), and the risk of a bleeding stroke or death from bleeding is about 2% a year.

What about the Watchman, which is alleged not to trigger bleeding? The few studies on the Watchman do not look at symptomatic stroke, but asymptomatic strokes are reduced. Is there a downside? Yes, as the study in our In The News section shows, about 4/1000 people are known to die from the Watchman immediately, and many more may die and not report the death. In fact, based on recent data, given the overall frailty of Medicare recipients receiving a Watchman, at 5 years death occurred in 44% of recipients, bleeding in 15%, and ischemic stroke in 7%, numbers that should invite pause.

By exaggerating the risk of afib, and then either convincing people to take dangerous blood thinners or be exposed to a procedure that may increase death, afib tells us a lot about healthcare. There are doctors who derive compliance through fear and the use information from deceptive drug company data. And when cardiologists order a Watchman, they earn thousands of dollars, something called self-referral. Similarly, when they prescribe blood thinners, they usually conduct other tests on the patient (echoes, stress tests) that similarly generate revenue through self-referral. Thus, the Watchman illustrates an important lesson. Sometimes myth and profit are more powerful determinants of treatment than science and common sense, especially when financial incentives are involved.