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HEALTH FOR LIFE

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Special points of interest:

- Does screening for prostate cancer prevent death and is there a down side?
- How good are medicines for dementia? How good are lifestyle changes?
- Can screening help us avert heart disease and strokes?
- Kidney disease is common in the elderly, but is it dangerous?
- Learn about the value of nurse practitioners in a geriatric practice.

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CAN DIET POSITIVELY IMPACT MEMORY AND HEALTH AS WE AGE?

An anti-inflammatory diet can improve memory and decrease disease.

Can good nutrition help people stay healthy as they age? And what is good nutrition? A series of new studies demonstrate that a diet filled with whole grains, vegetables, fruits, nuts, beans, fish, oil, and lean meat (and low on processed foods and white flour/sugar) can improve memory and substantially decrease the absolute risk of developing Alzheimer's Disease and dementia.

Many studies of "Mediterranean Diets" have shown a significant drop in heart disease and death along with improved memory. Another study this year showed that eating spicy foods can reduce the risk of death, and certain spices (turmeric, pepper, garlic) have medicinal effects. Most of these positive effects likely are more profound than prescription medicines and supplements.

These diets work by lowering inflammation in the body, and thus improving immune function while decreasing the development of cancers and blocked arteries. The size of the brain has also been shown to increase in people who eat this type of diet, while chemicals that cause depression decrease. People on this diet typically have more energy, feel better, and are mentally sharper. Such diets may even help our gut bacteria, which can significantly impact our overall health.

What is the down side of this diet? Many people prefer the ease of pills to food, but these foods taste good and are very accessible. Of course, the food and pharmaceutical industry may be irritated if everyone ate well! But clearly food is the medicine of life. Along with exercise, it is the best treatment we have to offer.

IS YOUR BLOOD PRESSURE LOW ENOUGH?

The SPRINT study says to lower blood pressure below 120. Is this a good thing?

What is the ideal blood pressure when people age? The SHEP study from many decades ago showed it is best to keep systolic pressure (SBP, the high number) below 160 to avoid strokes. Many studies since SHEP have found that when pressure is too low (SBP under 120) both strokes and heart attacks can actually ***increase***, as can death. In fact, over a million elders have been looked at in a variety of studies that confirm the danger of lowering blood pressure too aggressively, especially when people have kidney disease or a history of past stroke or heart attack.

Now comes the SPRINT study which has made front page news by telling us that if we push blood pressure below 120 we can decrease cardiac death by 25%. In fact, this small study (2500 people over the age of 70) found that while there was a reduction in death of 3.5/1000 with aggressive blood pressure treatment (96.5% of people did not benefit), a similar number of people experienced life-threatening low blood pressure and kidney disease. Also, the design of the study, using only people at high risk of heart disease and adding medicines that help heart disease independent of blood pressure, make even these modest improvements dubious.

More concerning, lowering blood pressure too aggressively in the elderly increases fatigue, dizziness, falls, mental decline, and medicine burden. Thus, pushing blood pressure too low likely causes more harm than benefit among many. Common sense in this case is more valuable than picking target numbers. Individualized strategies that emphasize symptoms and a patient's other medical conditions alone should dictate treatment.

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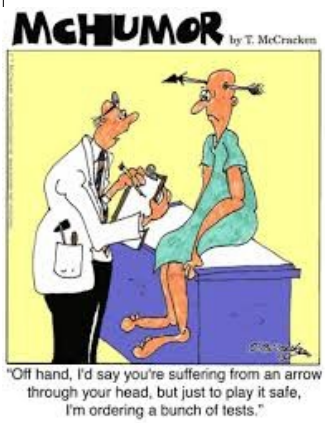
Heads you get quadruple bypass, tails you go on a baby aspirin.

Check out Dr. Lazris's blog about what's new in health care at ***curingmedicare.com***



"Off hand, I'd say you're suffering from an arrow through your head, but just to play it safe, I'm ordering a bunch of tests."

MEDICARE CORNER: QUALITY METRICS, ARE THEY USEFUL?

A recent *New York Times* article (1/16) discussed the overwhelming burden of measurements and metrics in the field of health care. In fact, metrics have come to dominate medical care in the past few years. Doctors are judged by a series of "quality indicators" to which we are required to adhere. A large portion of our income will be determined by these measures of quality, virtually none of which have been shown to have any meaningful significance, and all of which are not individualized to the specific patient being seen.

Much of a doctor's visit is involved with us having to check boxes on our computerized notes to prove we have provided quality care. Quality is defined by us staring at the computer screen and asking our patients a series of questions often irrelevant to their particular needs, ordering medicines and tests, and not discussing these issues with our patients or even having time to consider what the patient wants to talk about.

Did the patient get immunized? Did she get a mammogram and colonoscopy, is her blood pressure and sugar low enough, is she on the medicines that Medicare has determined would benefit her? Even if patients do not want, or even could be harmed by, the "quality" care prescribed by Medicare , we will be punished for noncompliance. To be compliant with metrics it's better to over-treat and over-test our patients, and not give them any choice even if they feel worse with aggressive care, then to discuss these issues and offer our patients a choice.

Clinical practice guidelines are a dangerous waste of time for doctors and our patients. Patient centered care and shared decision making encourages us to talk to patients about risk/benefits of interventions, to individualize care, and to ultimately let each patient decide. It is the very antithesis of the quality care being peddled by Medicare. It is time we change course and give power back to the patient and not to generic metrics.

KIDNEY DISEASE: NOT SO IMPORTANT?

Many of my patients are told that they have kidney disease, that they must see kidney doctors, that they need to watch what they eat, that dialysis could be in their futures. The truth is, many do have kidney disease. A recent study showed that over 50% of people 70 and older have kidney disease by our current criteria.

Aging results in a gradual decline in kidney function, and this is normal; it will rarely lead to problems. Very few people labeled with kidney disease will ever develop serious problems or need dialysis. Only .7 people out of 1000 develop end stage kidney disease despite their diagnosis. And seeing kidney doctors and changing diet does not change that reality.

Do we really have to add more diagnoses to our elderly patients when 99.73% of people labeled as having kidney disease do just fine, and seeing kidney doctors does not help them and could cause stress and over-treatment? It is time to use more common sense and stop labeling elders with diseases that are more phantom than real.

EXAM CORNER: CAROTID SCREENING

The carotid artery, sitting in front of our neck, supplies the brain with blood. Any sudden blockage of those arteries will lead to a major stroke. This has caused many doctors and patients to advocate carotid screening: periodically listening to the arteries, and even doing ultrasound tests on them, to look for blockage. If there is blockage, then it can be repaired surgically before a stroke occurs. On the surface, like many screening tests, this approach seems to make sense.

But reality is much different. Most "positive" screening tests identify either no disease, or identify disease that would have caused no harm if left alone. With positive screens, patients must undergo more dangerous tests and potentially dangerous surgery that has never been proven to be effective.

A recent study showed that having a severe carotid blockage (>90%) in someone without symptoms does not increase the risk of stroke, meaning that fixing that blockage likely will not benefit the patient. In fact, the chance of causing a stroke or heart attack with asymptomatic screening is **higher** than the chance of preventing a stroke. Bottom line: it is best to wait for symptoms to occur before being tested.

BENFIT/RISK CORNER: THE PROS AND CONS OF PSA TESTING

While screening for cancer may save lives, such tests can falsely identify many people who must undergo more tests and procedures to prove they are ok, unnecessarily causing harm. Medicare has decided that PSA (prostate cancer) testing is so deleterious that doctors who perform the test may be penalized.

What are the pros and cons of PSA testing? On the plus side, some people may be identified and treated early enough to avoid having the cancer spread. In fact, the rate of metastatic prostate cancer has increased since PSA testing has diminished.

But PSA screening has never been shown to reduce death. Most lethal cancers have already spread by the time PSA detects them. The main cancers that PSA picks up are indolent; they will never be deadly. In fact, it is felt that over a million men have been treated for prostate cancer unnecessarily due to PSA testing, since over 50%of men over the age of 60 have harmless prostate cancer that would be picked up and treated with PSA testing. Overtreatment of prostate cancer has not reduced death rate, but has caused very serious side effects in many men who undergo such treatment.

Dr. Welch of Dartmouth, who has written prolifically about the pitfalls of PSA testing, wrote an article in the *New York Times* imploring Medicare not to penalize doctors for ordering a PSA. Ultimately, he argues, it is a patient's decision. It is the responsibility of doctors to provide patients with an accurate risk/benefit profile of the test, but after that discussion doctors need not be penalized if patients choose to get a PSA. There are many "acceptable" tests paid for and endorsed by Medicare that are just as perilous as PSA. We should encourage shared decision making, not punitive mandates for health screening, since there is not a single right answer

HEALTH PROMOTIONAT PPC: CCM NOTES

At PPC we value the role of health prevention. Both in the office and at our facilities, we believe in seeing patients regularly, discussing the pros and cons of tests and treatments, reviewing recommendations, and devising an individualized medical plan based on the specific needs of each patient.

Medicare now pays for a CCM (chronic care management) code enabling us to review, discuss, communicate with, and treat patients and their famlies without having to make face to face contact. This helps us to further health promotion in many ways. We encourage all of our patients to sign the CCM permission sheets.

Immunization, screening, end of life issues, testing, treatment, medications, acute illness; all of these can be addressed by email communication or through chart reviews and discussions with nurses. CCM is certainly a step in the right direction, and now we can better focus on health prevention.

DRUG CORNER: DEMENTIA DRUGS

There is a great deal of confusion about how to treat Alzheimer's and other dementia. We have discussed this before, and now the confusion has only intensified. New drugs are available, including expensive combination pills with Aricept and Namenda, and long acting versions of Namenda. Do they work?

The short answer is: probably not. The studies done on Aricept show a strong placebo effect, with some improvement on memory test scores but negligible improvement in care-giver scores (meaning no one notices any improvement). This small effect largely diminishes in a year, and there is no impact on the disease itself. Namenda's results are even less impressive, despite marketing to the contrary. No dementia drug has had impressive results.

A year-long study of the combination of Aricept and Namenda showed no benefit, even though ads claim otherwise. There are side effects as well. So is it worth it? Frankly, it may be safer, cheaper, and equally effective just to take a placebo. Drug companies and many specialists want us to believe that drugs can cure the incurable. Diet, exercise, compassion, and socialization are much better treatment options.

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Borrow Dr. Lazris's two books: Curing Medicare and Interpreting Health Benefits and Risks

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PPC'S NURSE PRACTITIONERS

At PPC we have 4 excellent nurse practitioners who help manage our patients both in the office and at our assisted living facilities. Our nurse practitioners are trained in geriatric medicine. They first get a nursing degree before undergoing a rigorous program of clinical medical care, especially in the long term care arena. Most have extensive experience taking care of elders both as nurses and NP's, and they work very well in a medical team.

A recent study in the Annals of Long Term Care demonstrated the value of having NPs in long term care facilities. Concluded the study: "The inclusion of NP's on the care team has been associated with fewer hospitalizations and emergency department transfers; improved health status, behavior, and satisfaction with care; and increased quality of care among LTC residents." We have found that NPs spend more time in each facility. They get to know the nurses, patients, and families very well, and this helps them to make very informed decisions and to practice patient centered care.

At PPC Dr. Lazris and the NPs work together to provide both comprehensive and acute medical treatment to our patients who live in facilities. We believe this enables the best care possible. Whether in a facility or in the office, NPs are a great boon to our health and satisfaction. **We welcome Allison Carew as the newest nurse practitioner on our team.** Check the website to learn more!

THE BACK PAGE: CARDIAC SCREENING

Heart disease remains the number one killer of the elderly. As we age our blood vessels become more clogged by plaque and we are prone to sudden blockages. Can this be prevented? Are there tests we can undergo that can reveal heart disease before it is lethal, and are there procedures such as heart stents that can help us to live longer and avoid a heart attack?

Many patients without symptoms of heart disease see cardiologists regularly, get periodic stress tests, have cholesterol tests and treatment, and have stents put in blocked arteries, and even have bypass. Do they live longer? The answer for the total group is no, by virtue of many studies. A few people (1-2%) live longer, a few more die unnecessarily directly from the harm of the tests and procedures. Most get no benefit at all but get side effects, injuries, and stress from the testing, while many are inaccurately labeled as having heart disease.

Stress tests are notoriously inaccurate, even though Medicare continues to pay for them and doctors are financially rewarded for ordering them. Many of my patients think they should get them regularly for "thorough" care, and their cardiologists are happy to oblige. But of people who have heart attacks, 80% or more of them would have a normal stress test. That is because most heart attacks do not occur in areas of blockage that would be picked up by stress tests; they occur in relatively open arteries. Thus, getting a stress test and being told it is normal does not imply that a patient should be reassured. It really means nothing.

Similarly, abnormal stress tests can be deceiving and lead to potentially dangerous over-testing and over-treatment. Most abnormal stress tests in asymptomatic people are false positives; up to 80% of people with abnormal tests have no heart disease, but they may have to undergo potentially dangerous tests (such as catheterizations) or be put on unnecessary medicines. Of those that are identified as having blockages, there is little evidence that fixing those blockages with stents or bypass surgery helps prevent heart attacks or longevity in most cases; in fact it can cause great harm.

That makes sense, since most heart attacks do not occur in blocked arteries. Still, many cardiologist insist on opening blocked arteries despite the high risks and low benefits, and many patients believe that such aggressive posturing is both thorough and life saving.

A new test called cardiac calcium score may be more accurate in assessing who is at risk for heart attacks. While Medicare does not pay for this test (while it does pay for the much more expensive tests we have discussed), it only costs $40. Low calcium scores indicate little plaque in the arteries, and there is virtually no risk of heart attack in the next 5 years. High calcium scores indicate a lot of plaque and an increased risk of heart attack. In the latter situation, taking medicines such as statins may help prevent heart disease, while in the former statins are of no value. But regardless, whether tests are positive or negative, if you have symptoms of heart disease, it is important to be checked out.