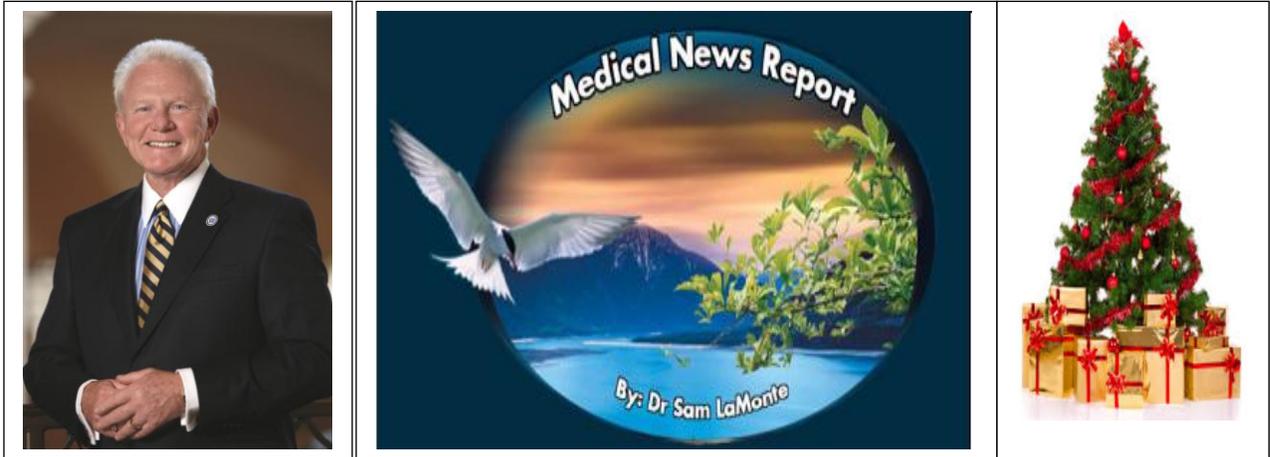


The Medical News Report, December, 2014



Sam La Monte, M.D., FACS

Advances in Medicine and Healthcare Report #35

WEBSITE

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Welcome to December report. I have continued to provide you with a more reader friendly format, so now you can click on the subjects and the hyperlink will take you right to that subject. You can print it out by clicking on a pdf. link at the end of the report. Have a wonderful Christmas.

Subjects:

- 1. Can artificial sweeteners make you gain weight?**
- 2. Clinician's fatigue by giving into patient's request for unnecessary antibiotics.**
- 3. Prostate Cancer-Part 4--Staging options for treatment.**
- 4. Loss of the sense of smell and the risk of cardiovascular disease death.**
- 5. Is a blood test coming to detect future cancers?**
- 6. When is it time to switch doctors?... common complaints of patients.**
- 7. Life Expectancy continues to climb.**
- 8. What is the optimum systolic blood pressure to maintain?**



Merry Christmas!

- 1. Can Artificial Sweeteners make you gain weight?**



Yes, says some of the latest research on such sweeteners such as **saccharin and **aspartamine**. They can interfere with **gut bacteria** that actually allow the other sugars you consume (and they are hidden everywhere) to be better absorbed, thus cancelling out any benefit of drinking or eating low calorie artificial sweetener products, especially soft drinks. With better intestinal absorption of sugar, this raises the blood sugar and predispose to pre-diabetes. The doctors (Samadi and Siegel) on the Fox News show "Housecalls", said **sweeteners also continue to keep you addicted to the taste of sweets**, since these products are sweeter tasting than regular glucose, fructose, etc. Natural sugars are still not good for us, but **Agave** is the only one that is natural and does not raise the blood sugar. I have previously discussed the harms of sugars extensively.**

Medical News Report #4

Now it appears, we are fooling ourselves by drinking artificially sweetened products. In fact, the doctors on Housecall, state that the pediatricians at the NYCLangone Medical Center recommend **NO DIET DRINKS FOR CHILDREN, AND IF a CHILD IS GOING TO DRINK AN OCCASIONAL SODA, JUST DRINK THE REGULAR SOFT DRINKS. If a person is drinking a large amount of "diet"**

drinks, it should be minimized while trying to lose weight. This information is controversial, but certainly, if you are pre-diabetic or diabetic, discuss this with your doctor.

Also, artificial sweetener lovers, these substances are made from **GMOs (genetically engineered organisms). This issue has become a world-wide concern and is banned in most countries, but not ours!!!! It is quite controversial, although the National Institutes of Health state, that GMOs are safe. Read what they say. You decide.**

www.nlm.nih.gov/medlineplus/ency/article/002432.htm

There is evidence in children that these products may be boosting the epidemic of type 2 diabetes.

Further information about artificial sweeteners:

www.hsph.harvard.edu/nutritionsource/healthsource/healthydrinks/artificialsweeteners

I would also suggest you tune into the Doctor shows on Sirius/XM channel 81 radio, which also originates from the NYC Langone Medical Center. These experts have call in shows, which are quite informative. Most medical subjects are covered from A-Z.

HAPPY HANUKKAH Dec. 16-24, 2014



The Menorah: The Chanukah miracle involved olive oil, so that's the fuel of choice. But you can use any candle that will burn until one-half hour after nightfall. Electric menorahs are good for decoration, but you need the old-fashioned one to fulfill the mitzvah.

How:

1. Get everyone around the menorah.
2. Light the shamash ("attendant") candle.
3. While standing, recite the blessings found in the prayerbook.
4. Light the candles. On the first night, set one candle to the *far right* of the menorah, and add each night towards the left. Each night, light the newest candle first, and continue lighting from left to right. Add from right to left, light from left to right.
5. Place the shamash in its place on the menorah, and sing the "Haneirot Halalu" and/or "Maoz Tzur" Chanukah hymns.
6. Linger around the candles for about half an hour (except for Friday afternoon). Share some Chanukah stories with your family, enjoy a *dreidel* game, and indulge in some hot latkes!

For more information, check out our Menorah Wizard.

2. Unnecessary antibiotic prescriptions for viral respiratory infection by fatigued clinicians



I have discussed the diagnosis and treatment of colds, viral upper respiratory infections, and sinusitis in report 2.

www.themedicalnewsreport.com/report2

A new study has shed some light on how clinicians fall into the trap of letting well-meaning parents or patients that insist antibiotics be prescribed for what appears to be a viral or allergic sore throat, cough, or stopped up sinuses. Doctors have to defend the reasons why an antibiotic is not indicated if a viral infection is diagnosed. We do have rapid strep tests in the office (there is a only a 5% chance there is a false negative result). I have also discussed when a cold becomes a bacterial sinusitis in report 12.

www.themedicalnewsreport.com/report12

A recent study measured how many antibiotic prescriptions were written in the first hour of a doctor's schedule and the fourth hour. 25% more prescriptions were written in the fourth. Analysis of the time spent with each patient was shorter at the end of the schedule. Doctors admitted fatigue was a factor, and were more likely to recommend an antibiotic inappropriately to prevent a lengthy explanation that antibiotics were not indicated.

As an ENT surgeon, I told patients to return if they worsened with a viral infection. Some of those patients, in a small number, did need a prescription. Antibiotic resistance continues to be an increasingly serious problem, and doctors are facing bacteria that are resistant to all antibiotics except very toxic ones.

A new factor has popped up in doctors giving in to patient's requests....patient satisfaction questionnaires. As doctors are becoming employees, their salary is partially based on these surveys. Physician groups are currently requesting that patients take more responsibility for their care along with the doctors (patient-centered care). Why should a patient downgrade a doctor on a survey because the doctor refused to give the patient an inappropriate antibiotic? Many physician groups are concerned about this. This is just one example of why doctors get worn down and frustrated.

Where is the legal reform??.... another omission that is unfair and needs to be included. Insurance premiums are going up as much as 20% in 2015. The "Affordable Care Act" is oxymoron.

Ref. NEJM (New England Journal of Medicine), 2014, MedPage.

3. Prostate Cancer-Part 4—Staging and considerations for Type(s) of Treatment

Staging determines the choice of treatment, the extent of the cancer, and the probable 5 year survival rate. Most prostate cancers do not kill the patient. Other causes

frequently are the cause of death. It is for that reason, one of the choices, especially for more senior patients may be to NOT TREAT THE CANCER. It is a real option after 75 years of age.



I have previously discussed general information, the PSA test, and the Gleason Score in the past 3 reports.

[www.themedicalnewsreport.com#32,33, and 34](http://www.themedicalnewsreport.com#32,33,34)

It is not easy for patients to decide on a treatment plan for this cancer. There are many options when considering therapeutic regimens.

A.FACTORS

The oncologist has many factors to consider:

1. Patient status, co-morbidities (other diseases)
2. Age (healthy enough to tolerate therapy or have a Expected life expectancy of less than 10 years.
Older patients might consider not treating a slow growing cancer.
3. Stage of the tumor (I,II,III, and IV)

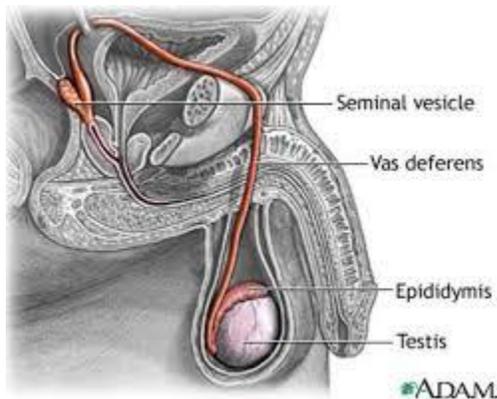
4. PSA number (LESS THAN 10 or over 10)
5. Gleason score (6 or less vs. greater than 6)
6. Results of imaging studies (CT, MRI, PET, ultrasound)
7. Side effects frequently play a major role in a patient deciding on a choice of treatment. These must be openly discussed.
8. Patient's willingness to drive or be driven to a treatment facility daily for radiation.
9. Patients may need to continue a part or full time job during the treatment.
10. Patient's ability to make co-pays.

B. STAGING of all tumors is critical to determine the proper treatment(s) and is used to communicate with other doctors (other oncologists and referring doctors). A patient should consider consulting at least a surgeon and radiation oncologist to discuss the option(s) for treatment (urological/surgical, radiation, and medical). I would also recommend talking to a medical oncologist just in case any chemo is contemplated.

The prostate cancer staging system uses the T,N,M rating.

T=tumor N=nodes M=metastases

T=tumor (the size, position in or out of the prostate)
T uses a 1-4 rating based on the extent of the tumor,
T1-found incidentally during a prostatectomy for BPH (enlarged prostate), T2-found on one side of the prostate, T3-both sides, T4- to the outer capsule or through it involving the seminal vesicles or the immediate surrounding tissue such as the bladder, rectum, and urethral sphincter.



The seminal vesicles (and Cowper's glands) provide the liquid for sperm during orgasm as seen in the drawing above.

The **PSA number and the Gleason scores are taken into consideration in staging.** The cutoff for the PSA is less than 6, 6-10, 10-19, 20 and greater. The Gleason score is separated from 6 or less, 7, 8 or greater. The higher the scores, the more malignant the tumor, the survival rates is reduced.

Knowing the tumor is male hormone sensitive or not is important in determining medical therapy.

N=nodes (indicates the lymph node spread, either one or more).

The N uses X,0, and 1 (this is easier to follow, since the X means the nodes were not assessed, 0 means no nodes, and 1 means one or more nodes involved.

M=metastasis (spread to other parts of the body, including the lymph nodes, bone, lungs, liver, or brain

M uses 0,1a,1b, and 1c (indicating no spread to other organs, to bone, and to other organs).

If you want to see how complicated this system is, but absolutely necessary. See below:

[What Is the TNM Prostate Cancer Staging System?](#)

Determining the extent of prostate cancer is important for predicting the course of the disease and in choosing the best treatment. The Whitmore-Jewett method or, more commonly the TNM (tumor, nodes, metastasis) staging system is used to describe a cancer's clinical stage, or how far it has spread. This Health Alert provides an explanation of this important prostate cancer staging system.

The TNM system assigns a T number (T1 to T4) to describe the extent of the tumor as felt during a digital rectal exam (DRE). The N number (N0 to N1) indicates whether the cancer has spread to any lymph nodes, and the M number (M0 to M1) indicates the presence or absence of metastasis (spread to distant sites). The T and M designations are divided into subcategories (designated a, b, and c) that provide further detail on the extent of the cancer.

The TNM clinical stage is used to help determine appropriate prostate cancer treatment options. Here's a description of this important staging system:

T1: Tumor cannot be felt during DRE or seen with diagnostic imaging

- T1a: Tumor found incidentally during surgery for benign prostatic hyperplasia (BPH) and is present in less than 5% of removed tissue
- T1b: Tumor found incidentally during BPH surgery but involves more than 5% of removed tissue
- T1c: Tumor found during needle biopsy for elevated PSA

T2: Tumor can be felt during DRE but is believed to be confined to the gland

- T2a: Tumor involves one half or less of one side of the prostate
- T2b: Tumor involves more than one half of one side but not both sides
- T2c: Tumor involves both sides of the prostate

T3: Tumor extends through the prostate capsule and may involve the seminal vesicles

- T3a: Tumor extends through the capsule but does not involve the seminal vesicles
- T3b: Tumor has spread to the seminal vesicles

T4: Tumor has invaded adjacent structures (other than the seminal vesicles), such as the bladder neck, rectum, or pelvic wall

N0: Cancer has not spread to any lymph nodes

N1: Cancer has spread to one or more regional lymph nodes (nodes in the pelvic region)

M0: No distant metastasis

M1: Distant metastasis

- M1a: Cancer has spread to distant lymph nodes
- M1b: Cancer has spread to the bones
- M1c: Cancer has spread to other organs, with or without bone involvement

The American Cancer Society explains staging on their website as well.

www.cancer.org/prostatecancer/stages

D. OPTIONS FOR TREATMENT

SURGERY---Surgeons--"a chance to cut is a chance to cure". Robotic surgeons call their surgery "nerve sparing", however, the tumor may dictate that a nerve can't be spared. Even if the nerve is spared, it may be injured and temporarily not function. The current studies are difficult to analyze, but in general, robotic surgery has fewer side effects than a radical prostatectomy. If one compares the results of cure and side effects by a VERY EXPERIENCED robotic surgeon to a less experienced surgeon, there can be a big difference in side effects. Robotic surgery can be recommended if the tumor is confined to less of the prostate, thus giving a better chance for sparing the nerves for erection and bladder and bowel control. This is appealing to younger men for obvious reasons. If the tumor is extensive, a more radical procedure will probably be recommended. However, all treatments will have these side effects to some degree.

RADIATION THERAPY--"you don't have to be cut on". Radiation has about the same percentage of side effects as surgery, except since the rectum is irradiated, there are usually more intestinal side effects.

There are two different isotopes used (**photon vs proton**). Proton delivers more defined radiation to the gland sparing surrounding tissues, thus appearing to be superior, but follow up 2 years later has not proven that there is any difference in results regarding cure and side effects, temporary or permanent.

How serious side effects are depends on individual patients, therefore, it will be difficult to make the comparison between the two leading techniques for prostate cancer (IMRT vs. PT), but ongoing studies are under way. We must go by the research evidence, not what well-meaning patients say. The cost for proton therapy is 3 times as expensive as IMRT. The equipment costs millions more than IMRT, and most big cancer institutes are investing in them, but there are other cancers where the proton therapy is definitely better, so it is no surprise they are adding proton therapy. This is big business. Either treatment is covered by Medicare, but I am anticipating seeing a cut in reimbursement for proton therapy (IMRT=\$ 12-15,000 vs PT=\$35-40,000). Robotic surgical equipment and technical costs are not covered more than a radical prostatectomy (the hospitals eat cost), so why would Medicare pay so much more for this technique when it so far has not proven to be significantly better? Who is greasing the palms? With healthcare reform trying to reduce costs, there is no excuse.

Complications and side effects need special consideration. I will discuss this next month.

You need to know the treating physician's personal complication rates, the percentage of side effects in their patients, and what can be done about them.

Very enlarged prostates---Some men have such large prostates, it may be recommended to shrink the gland before any treatment can be performed. This can be achieved by oral medication (5 alpha reductase inhibitors shrink the prostate and keep it from growing, but not the cancer—

Proscar, Avodart, and Jalyn). I will discuss the subject of enlarged prostates (benign) in a future report.

www.webmd.com/men/enlarged-prostate-types-medications

If the disease is confined to the prostate and does not penetrate the capsule, a curative treatment will be recommended with a greater than 90% (up to 99%) chance of cure regardless of whether surgery or radiation is chosen.

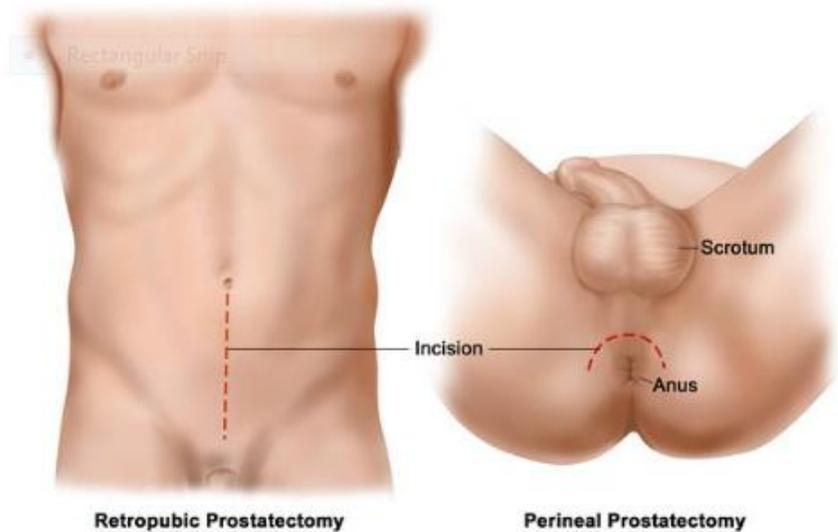
If the disease has spread locally or to the nearby nodes, a more aggressive treatment plan will be recommended.

SURGERY

Radical prostatectomy either with robotic or open surgery is offered. It is beyond the scope of this report to discuss surgical management in detail.

The radical prostatectomy is approached in 2 ways, either through the abdomen or perineal (between the scrotum and the anus), as seen in the drawing below.

Radical Prostatectomy



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Two types of radical prostatectomy. In a retropubic prostatectomy, the prostate is removed through an incision in the wall of the abdomen. In a perineal prostatectomy, the prostate is removed through an incision in the area between the scrotum and the anus.

www.cancer.gov/cancertopics/pdq/treatment/prostate/Patient/page4#Keypoint16

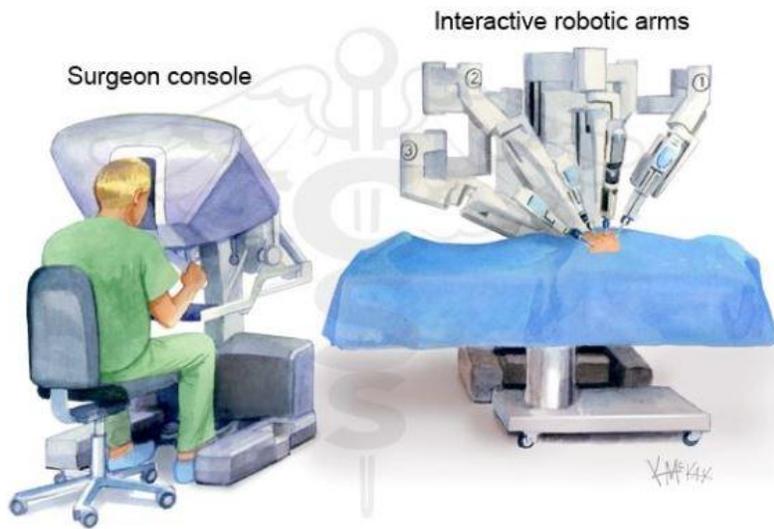
www.davincisurgery.com

www.mountsinai.org/patient-care/urological-areasofcare/robotic-prostate-surgery

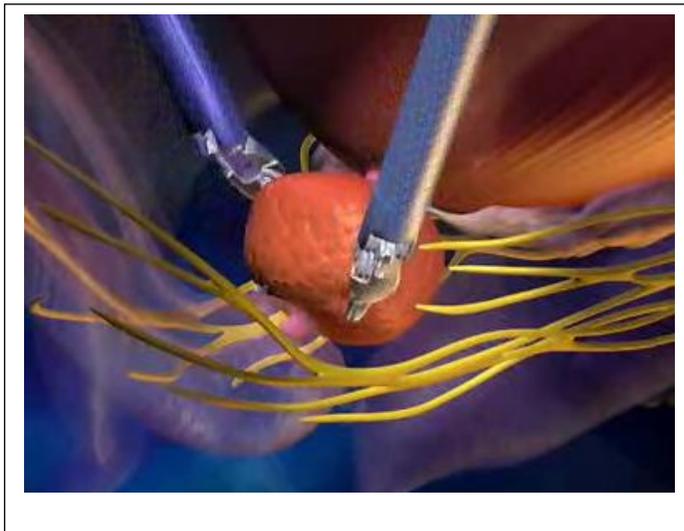
For a video animation of the procedure for Robotic Da Vinci surgery:

www.miamiroboticprostatectomy.com/davinci.html

There is less trauma to the tissues, less bleeding, and potentially less trauma to the nerves, and it is performed endoscopically through tiny incisions in the abdomen.



Incision with the Da Vinci Robotic Surgical Technique



RADIATION THERAPY—different options

Radiation treatments vary as well. It is based on the technique and the isotope used. Standard external radiation (convolutional radiation therapy, IMRT (intensity modulated radiation therapy), brachytherapy (radiation needle implants) and other variations using photons are all being used. IMRT is the most popular although a study from the internet site, Medpage, in 2013 reported no benefit over the standard RT, and felt the difference in cost did not justify the more advanced type of treatment.

Proton Therapy requires less radiation, because of the precision of protons, and the tumor is the only organ receiving radiation (except for some scatter), as opposed to IMRT that does irradiate some of the surrounding tissues slightly. Keep in mind, most of these patients being treated with primary RT are those with earlier less advanced prostate cancers. The cure rates are similar, but are the side effects?

I have read a huge number of articles about the pros and cons of each of these treatments. The best medical journals state there is no advantage of proton over the other techniques of radiation for the treatment of localized prostate cancer regarding cure or side effects, but most compare after 2 years. It may be there are fewer temporary side effects, but there are no reports yet to settle the issue.

There is ongoing research to compare these techniques (IMRT vs PT) in different age groups, stages, and percentage of side effects. In time, one technique may be

proven to be better with more cures and less side effects in the next few years.

Dr. Nancy Mendenhall,etal, a recognized authority in radiation oncology at the University of Florida, recently wrote an article (Journal of International Radiation Oncology) reporting on 200 patients (which is a small number) who were treated with proton therapy, and these patients had an excellent response with a low percent of side effects just as efficient as IMRT.

A recent study reported that proton therapy has already added \$350 million to healthcare costs in the US.

I am confident these outstanding doctors would not support proton therapy as another excellent option for several site specific cancers. We just can't say it is any better when it comes to prostate cancer treatment YET.

Being informed is vital to make a good decision.

ANTI-HORMONAL THERAPY

Many patients will be placed on lifelong anti-testosterone hormone therapy to help prevent recurrence. Most of these tumors are **testosterone sensitive, meaning the tumor can be accelerated by male hormone. It is not thought, however, to cause prostate cancer. Side effects of this hormonal treatment will cause some breast tissue growth and tenderness, loss of some body hair, and other feminizing side effects.**

CONSIDERATION FOR NO TREATMENT

This is a real consideration for both the doctor and patient especially if the tumor is less malignant, deemed to be slow growing, and the age of the patient is 75 or older. The

overall health of the patient is a very serious consideration. These tumors likely will not be the cause of death. Why put up with side effects from treatment especially incontinence. The family must understand this is a legitimate choice.

Metastatic disease will be discussed in future reports.

en.wikipedia.org/wiki/testosterone

www.cancer.org/cancer/prostatecancer

www.cancer.gov/cancertopics/types/prostate



4. Loss of sense of smell (anosmia) and the risk of dying

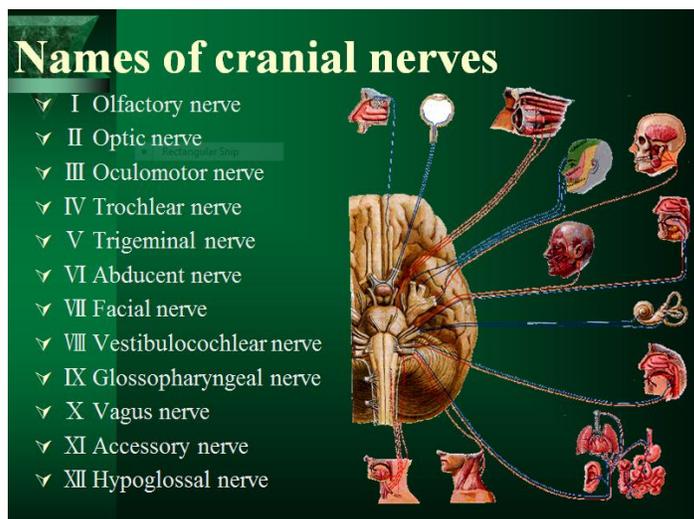
The sense of smell is one of the 5 senses (smell, sight, taste, hearing, and touch). We gain great pleasure in smelling great food, wine, flowers, and it is a defense against harm such as the smell of smoke, etc. Without it, the quality of life is affected. Smell is necessary for taste. These two senses are integrally associated with each other. Getting a cold will cause the sense of smell and taste to diminish, even though the taste nerves are intact.

Losing the sense gradually happens with aging, and occurs more in some than others. However, those that lose

itFASTER are three times more likely to die from cardiovascular disease. This is an indicator that strongly correlates, so if you have smell troubles, get checked for cardiovascular disease.

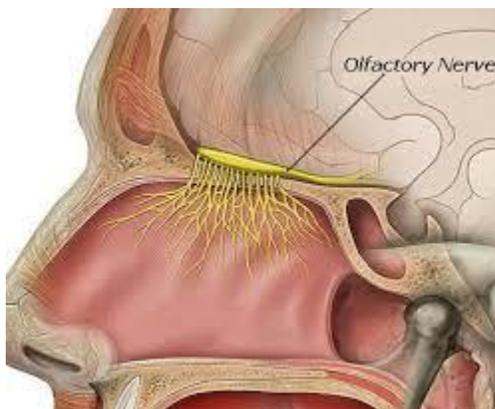
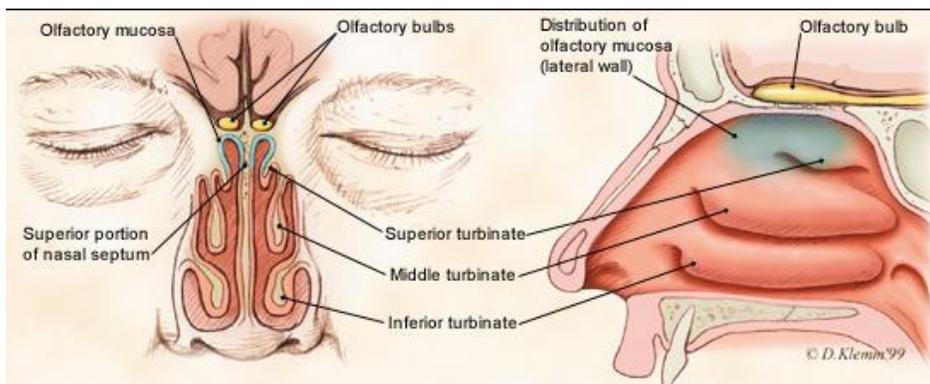
The University of Chicago reported that over 3000 patients from ages 57-85 were studied for the sense of smell. 5 years later, 430 were dead, and 39% of those who developed loss of smell died compared to 19% who did not. This makes it a more potent risk factor than heart failure for heart attacks.

The olfactory nerve is one of the twelve cranial nerves and is actually an outpouching of the brain, starting in the limbic system of the brain (amygdala), which is the center for emotion. It is a fact that smells give true emotional pleasure. Have you ever had a massage while inhaling fumes of lavender or eucalyptus oil? Yum! After 60, more than half of the population starts to slowly lose this sense. That is dangerous if you can't smell gas or smoke (something to think about with folks up in age if they live alone).



The twelve cranial nerves (see above). The first cranial nerve is the OLFACTORY NERVE. This nerve, known as the olfactory bulbs, traverses the floor of the anterior cranial vault traveling through small holes (cribriform plate) in the skull to the nose, which is the weakest point of the skull and prone to damage with head and facial injuries. Loss of smell with head injury is not uncommon if the fracture occurs in this area.

As the smell nerves travel to the lining of the upper nose (superior turbinate in the below drawing), there are chemoreceptors in the lining (mucosa). These are the sensors that send signals to the brain.



Obstruction of the upper nose from polyps, allergic swelling, or inflammation from colds and sinusitis can interfere with smell and taste. These disorders are the most common cause of loss of smell. However, medications and head or nasal trauma can also cause anosmia (the medical term). Of course age is a factor. In fact, there are 60,500 neurons in the olfactory nerve at age 25 and only 14,500 at age 95. Women have more fibers than men. 90% of Alzheimer's patients have significant abnormalities of smell and taste, because of neurodegeneration.

Causes of anosmia

Head trauma, nasal/sinus disease, anesthesia, medications, toxic chemicals exposure, antidepressants, heart meds, antibiotics, anti-inflammatory meds, cocaine, neurological disease (MS, Alzheimer's, Parkinson, etc.), or radiation to the area can cause the loss of smell. At times, the cause is unknown.

Treatment of anosmia

Nasal cortisone and decongestants may help if nasal allergies are severe. Zinc has long been thought to help, but there has never been a good study on the subject. B vitamins also are important for good nerve function.

www.webmd.com/brain/anosmia

5. Is a blood test coming to detect future cancers?

In the Journal of Experimental Biology, Merck Medicus reports that it is possible to look at the genome of human lymphocytes and see breaks in the DNA that will

predict possible cancers in the future or at least those that are higher risk. If you had this test, and you were a smoker, would that convince you that your habit may be harming your DNA and might cause cancer sometime in the future? Would you quit? Would you lose weight, would you exercise, would eat correctly? All of the above clearly increase the risk of cancer and cardiovascular disease and yet 17% still smoke, obesity is epidemic, and most do not exercise regularly.

Comparing normal patients to cancer patients show very different DNA character, in that specific breaks in the DNA can be shown in cancer patients. Of course, this is just one experiment, but likely will be the first of many to come.

Reference: The Journal of Federations of Experimental Biology, October, 2014

6. Is it time to switch doctors? Common complaints of patients!



In an era when patient-centered care is being encouraged, patients deserve to have a SATISFYING and GOOD relationship with their doctors. In my, opinion, this takes time, honesty, and sometimes stating your expectations with your doctor. Primary Care Physicians (PCP), P.A.s,

and Nurse Practitioners tend to be more down to earth and friendly. Patients that are referred to a specialist may be disappointed that they are more business-like and appear more distant. Remember, you already have a long relationship with your PCP, and it will take more than one visit to get to know a new doctor. Everyone has particular likes in a physician. But there are expectations that are pretty standard. Here are common complaints:

1. **The wait time is excessive** (does the staff come out and explain why the doctor is running behind?) One way to prevent this is to be their first patient on the schedule.

2. **Won't answer your questions or does not explain to your satisfaction** the situation and why they have chosen a certain treatment. You must be willing to tell them you do not understand. Don't be embarrassed or feel you are asking "stupid" questions.

3. **Rude or condescending**. If you are being talked down to, don't put up with it. Tell the doctor or the staff.

4. **Not treating my health concerns as urgent**. No illness is trivial, but doctors are seeing sick people all day, and they can assume more minor problems are not urgent. Tell the doctor you are very concerned.

5. **Not being kept informed**. If you are waiting weeks to find out test results, that is not acceptable. On the other hand, some tests have to be sent to special labs, and take longer. Call the office and get an explanation why it is taking so long. Also, with electronic medical records, it should not be a problem getting records from another doctor in the future. That is why I recommend patients consider a clinic or affiliated practice, because all the doctor's records are stored on the same

computer system. However some electronic record systems are not compatible with others.

I have access to my own records through the group of doctors I see (Northeast Georgia Medical Group). I was in a large multispecialty clinic (165) in Pensacola, and not only did I have access to the other doctor's records, we were all partners. That is the great value being in a multispecialty group practice.

6. Made patient's feel uncomfortable. If you do not have a good working relationship with the doctors and their staff, you are not going to be happy. The staff can be the real problem. Tell your doctor if the staff is not meeting your expectations.

7. Not sure advice and care is totally adequate or satisfactory. If I felt that way, I would be gone in a second.

8. Did not respect me or my needs. This is a deal breaker.

9. Did not feel there was mutual trust. Be honest with each other. Never lie about taking meds or doing what the doctor instructed. Never withhold information regarding taking illegal drugs, excessive alcohol, or taking supplements.

10. Angry if you ask for a second opinion. Run!!!!

11. No eye contact, staring at the computer or medical records instead of you. This created a real problem for me recently, and I fired my cardiologist. Because the record keeping is so intensive, doctors are filling out the record while talking to you. One of the principles of medical care is **OBSERVATION BY THE DOCTOR**. Many subtle signs of illness can be picked up with this technique. Ask them to put the computer down or switch doctors (or at least tell their staff). Doctors are

so pressed to fill out more documentation, thanks to Obamacare.

12. Dismiss my caregiver or friends and relatives that come with me. There is a reason someone brings another person into the office. It usually is for reassurance but also to have a second set of ears. Remembering what the doctor said is a real challenge. These are common complaints and if you have checked many of these off, it is time to look for another doctor. Because many doctors are not taking new patients that are Medicare or Medicaid, think twice and see if you can remedy the problem.

I don't usually give advice, but I did this time. Doctors are human and under more stress thanks to our healthcare system. Most are no longer in charge as they have become employees. There is managerial pressure to see a minimum number of patients, create a certain revenue stream, with numerous other standards. You may be seeing the transition of the healthcare professionals. How is it working out for you??

I am not making excuses for doctors who do not have a "bedside manner", but patient care is a "two way street". If a patient is demeaning, arrogant, does not follow instructions, does not take their medicine as prescribed, doesn't take responsibility for their own behavior, the patient is missing the partnership with their doctor(s) that creates the best experience for both patient and doctor.

7. Life expectancy continues to climb

Even though the average weight of Americans continues to rise, so has the life expectancy. In 2012, men lived an

average of 76.4 years and women 81.2 years. With the type 2 diabetes/obesity epidemic, I would rationally conclude that the life expectancy will start plateauing, however, not yet. There will always be a lag in these statistics.

Reference: National Health Statistics Center

8. What is the optimum systolic blood pressure to maintain when being treated for hypertension?

The internet site, Medscape, this month reported that on optimum blood pressure level for patients. Although both the systolic and diastolic blood pressures are very important, the latest recommendations state that keeping the **systolic pressure between 130-139mm of mercury is optimum**. You have probably been told 140/80 is optimum. These new guidelines are different for different groups. This is your doctor's decision.

The hard part is keeping the blood pressure constant. It is impossible!!

Hard, exercise, anger, etc. raise the blood pressure . The only way we could know how our pressure rises and lowers during the day. It is well known with obstructive sleep apnea, the pressure can rise to dangerous levels, and when blood pressure rises we are more at risk for a heart attack or stroke. Keeping calm and pacing yourself is probably the best you can do to keep your pressure (and pulse) in the normal range.

Blood pressure medicine has a bell shaped curve as it works. I check my blood pressure at night and first thing

in the morning. Strokes and heart attacks occur frequently during the early morning hours, therefore nighttime pressure is just as important as daytime. Here is what the Harvard Health Blog states:
www.health.harvard.edu/blog/new-guidelines/managingbloodpressure

What's new

In a nutshell, here is what the new guidelines recommend:

- among adults age 60 and older with high blood pressure, aim for a target blood pressure under 150/90.
- among adults age 30 to 59 with high blood pressure, aim for a target blood pressure under 140/90
- among adults with diabetes or chronic kidney disease, aim for a target blood pressure under 140/90.

Take-home messages

Although the new guidelines address an area of controversy—how low should blood pressure go—they don't change the basics:

Know your blood pressure. Take advantage of any chance you have to get your blood pressure checked. For example, many pharmacies have blood pressure devices that you can use for free. Or consider using a home blood pressure monitor.

Consider high blood pressure to be a reading of 140/90 or greater. If you have high blood pressure, you need to act. This might mean just getting another couple readings in the next few weeks. If it is much above 140/90, call your doctor's office to arrange an appointment soon.

Lifestyle changes are important. Since our lifestyles are often what lead to high blood pressure, changes can help control blood pressure. Key places to focus are getting more exercise, improving diet, losing weight if needed, not smoking, and reducing stress.

Tailor treatment to your needs. No matter what the guidelines say, your blood pressure treatment and goals should be tailored to you personally. For example, a very old and frail person is more likely to feel better and have less fall risk with fewer medications and a blood pressure higher than 150 or even 160.

Everyone should have a blood pressure monitor at home. They are available at any pharmacy.

THIS COMPLETES THE 2014 REPORTS. WHAT A YEAR! WE WILL CONTINUE TO PROVIDE YOU WITH THE LATEST UPDATES AND INFORMATION IN MEDICINE AND HEALTHCARE. Merry Christmas and Happy Holidays! **STAY HEALTHY AND WELL, MY FRIENDS, DR. SAM**

