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This is the month for love. It is always a great time to love one another, especially in these difficult times that we live in. Love of your God, love of our country, family, and friends is always in vogue. Happy Valentine's Day!

This is the beginning of the 4th year of my report. I have relearned an enormous amount of medical information and updated my knowledge in the last 5 years. I hope I have brought you much needed information to allow you to be more informed about many medical subjects and to encourage you to become your own health advocate. I have stated that you must become a serious partner in your own healthcare in this era of patient-centered care, ad nauseaum. Always discuss any of my report information with your doctors. Thank you for reading!!

Subjects for February, 2014

1. New Information on Controlling Lipids:

Ezetimibe(Zetia)-a fat blocker) plus Statins provide better control for cholesterol levels—a reversal of findings; exciting research on once a month injection for bad cholesterol

2. A Major Transformation in Mainstream Medicine-what you need to know

3. PTSD—Part 2—our military and the public; acute grief, complicated grief, and depression

4. Another chapter on Headaches-tension and cluster types

A footnote: I apologize for not including side effects of prostate cancer treatment this month.

Next month, I will report on this.

1. Statins/Ezetimibe(Zetia) combination works better to lower cholesterol levels-a reversal of previous findings; Exciting new research!

There are two important issues in play:

a. Statins and a fat blocker ezetimibe (Zetia), an intestinal fat blocker,have been proven to lower LDL/ cholesterol levels better when added to statins than statins alone as reported at the recent annual American Heart Association's meeting. A drug, Vytorin (Zetia/simvastatin), combines these two drugs, and was very popular until studies a few years ago reported that the fat blocker did not improve cholesterol levels (lower LDL and higher HDL) any better than a statin alone. (It is always better to take fewer drugs, if for no other reasons of one drug interfering with another. In fact, if you take several meds per day, you have increased that possibility greatly.)

If your statin is not controlling the cholesterol (LDL less than 100mg/dl, you might talk with your doctor about considering adding Zetia to the statin instead of increasing the dose of the statin to stay away from the higher doses more likely to cause muscle damage (up to 5% of patients).

b. The second issue comes from recent studies and guidelines for cholesterol management that were supported by some national Cardiology organizations. They stated that the actual level of cholesterol was not as important as just taking a statin and managing other co-morbidities that increase the likelihood of cardiovascular (heart attacks, etc.) and cerebrovascular disease (stroke). This has been extremely controversial since these recommendations were published.

www.themedicalnewsreport.com#23, 24.I extensively reported on thesestatin guidelines in past reports.

However, in recent reports, it is clearly stated that the lower the cholesterol the better. The ratio of the LDL/HDL is also important. The lipid profile and use of statins to treat cholesterol was covered in previous reports as well. www.themedicalnewsreport.com #3, 4

Lowering the cholesterol (triglycerides-need other meds) and blood pressure can reduce the risk of heart attack, stroke, and death by as much as 25-35%. It can reduce the risk of a recurrent stroke by 40%. www.mayoclinic.com/cholesterol

There are also studies that report taking more than one cholesterol lowering drugs (fibrates, Lovaza, niacin, Lopid, fish oil) can increase the chances of side effects of statins (muscle problems), therefore that will be taken into consideration when deciding to take other cholesterol lowering medications. Zetia is not in this group and does not cause muscle damage. BTW, a recent study regarding fibrates and Lovaza for reducing triglycerides stated that Lovaza alone was just as effective. Taking as few meds as possible is wise!! Drug side effects and cross-reactivity are a real problem!

Blood studies to keep an eye on if taking statins—liver and kidney studies every 6 month checkups of liver studies is now not recommended (after a couple of baseline studies prove to be normal), but perhaps yearly makes good sense. Talk to your doctor.

The European Society of Cardiology recommends the following if you are having side effects of statins:

a. Take a break from the statin for 10-14 days.

b. Switch to another statin and a lower dose.

c. Take it easy when exercising, as this can aggravate the muscle side effects (even muscle cell death).

d. Take the supplement, Co-enzyme Q-10, to possibly prevent side effects of statins.

e. Take magnesium supplements. The dose was not cited, but it is very important for muscle metabolism.

f. Avoid grapefruit juice if taking statins, as it can increase the absorption of statins and cause toxicity.

g. Avoid these drug interactions with statins (Cardarone, Lopid, Mevacor, HIV drugs, antifungals, the antidepressant nefazadone (Serzone).

Some of these additional drugs have not shown additional benefit in reducing cardiovascular disease or death. This is still being studied.

Exciting new Research! A monthly injection to reduce bad cholesterol (LDL)!

There are two competing drug companies working hard to get approval for their new approach to lowering cholesterol. It is the use of monoclonal antibodies to block the release of LDL-cholesterol from the liver by blocking a

protein (PCSK9). Alirocumab and Evolocumab are once a month injections apparently with a great influence on lowering cholesterol in those who have statin intolerance or who can't reduce their cholesterol with statins and Zetia alone. Adding this injection showed as much as 63-75% more reduction if added to the usual drugs or even alone. I suspect the injection will be very expensive, the 2 drug companies estimate that there will 36 million Americans who will potentially qualify for its use.

There is even a vaccine being studied to reduce cholesterol, and I will have more to say about that in the near future.

Reference-Reuter's health

2. A major transformation in mainstream medicine-what you need to know!

Like it or not, mainstream medicine listened once again to the academicians, and they have created a new mantra--guidelines for medicine care. What does this mean? Because medicine has continued to be more and more complicated, academic medicine has been pushing to create guidelines and (guidance is a better word) for the diagnosis and treatment of most medical diseases and disorders.

I have spent the last 4 years working on guidelines for post-treatment surveillance and management for cancer

survivors for primary care doctors (PCPs). Family doctors are not usually comfortable monitoring cancer patients. They need guidance to get comfortable with this responsibility, if they accept it. This has become necessary because of a shortage of oncologists, and it isn't going to get any better, even with nurse practitioners and PAs. Cancer doctors are reaching out to the PCPs to follow patients as they get past the first couple of years of close monitoring. That does not mean you are not to see your oncologist. This is also happening across the fields of medicine. It is also necessary with nurse practitioners without direct physician supervision (19 states have legalized the practice).

Guidelines (or better termed guidance-NOT RULES) for physicians to follow are being created. Is this cookbook medicine? In a way it is. Doctors are trained to use their considerable knowledge and experience to decide what is best for patients, but many err and do not follow up-to-date recommendations. Hence the guidelines!! Most specialty medical and surgical organizations are busy creating guidelines for just about every disease. On the surface, these guidelines are just what is needed, because they come from evidence-based studies that have proven ability to accomplish the mission. That means a research project(s) has to back up what is recommended.

The drawbacks I see:

1) Will a doctor be in trouble if they don't follow the guidelines? I suspect, the doctor will have to document why they went another route. This takes time, and could expose the doctor to scrutiny by the legal profession and federal regulations. If these are guidelines and not rules, they should not be strictly held to these guidelines. This could create problems.

2) How often will these guidelines need to be updated? This process of evidence-based medicine could become very difficult to stay current (and costly). I am concerned that articles in the medical literature are already 1-3 years old when they are published. Updating them will be a chore. That is why doctors go to conferences to hear the latest or read it online as I do. That is the value of my Medical News Report.

3) Will hospitals insist that these guidelines be followed? (Insurance companies, federal medicine--Medicaid/Medicare)? Will reimbursement be a factor? These are worrying practicing doctors. The pressure being put on doctors today is going to reach a boiling point.

4) These guidelines are not perfect. It was just reported that guidelines for diagnosing Celiac disease miss many new patients who don't present with diarrhea. Only 27% of patients in a recent study reported that diarrhea was the presenting symptom. Anemia, osteoporosis, and abdominal bloating were more common. This changes the playing field, and only points out that constant updating of guidelines are absolutely necessary if we are to lean more heavily on guidelines in medicine.

3. PTSD in the military and the public part 2; grief, complicated grief, depression, and suicide.

Last month, I discussed some of the salient points on this disorder, which has devastated so many of our returning military heroes, but this disorder is even more common in regular Americans.

A. General information

Post-traumatic stress syndrome says it all. It is a certified psychiatric disorder that occurs in as many as one third of those in combat, however, anyone (male, female, or child) is at risk to this if they experience a stressful event for example from a death, accidents, rape, sexual harassment, natural disaster, or actual military experiences, family traumas, etc. Even emergency personnel can experiencePTSD. The PTSD Foundationwww.ptsdusa.orghas a questionnaire on their website that can be filled out and submitted and evaluated and returned to you. Check it out.

There are different categories that must be present to meet the criteria for the diagnosis. Pre-existing mental disorders can complicate these criteria. Those who are going into harm's way need to be screened by the military for high risk (research is ongoing). This has not been done in previous wars, and not even the current military engagements in the Middle East.

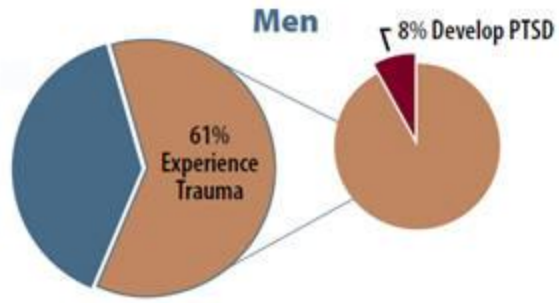
Most of PTSD research in the last decade has been performed on recent veterans (Middle East conflicts), and the older literature is 20 plus years old (Vietnam, Korea, WWII). That literature pointed out that 37% of WWII vets had PTSD, 80% Korean vets, and 67% of previous POWS.

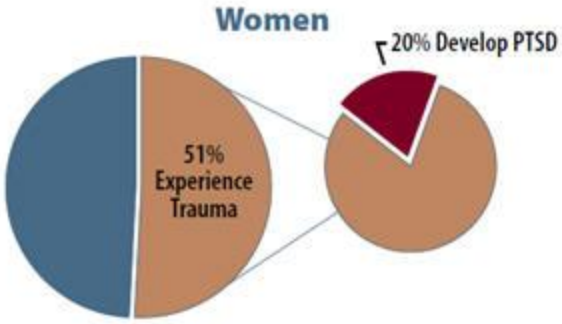
The VA puts out an 8 page booklet for patients and families:

www.ptsd.va.gov/public/understanding_ptsd/booklet.pdf.

More senior veterans are suffering just as much from previous wars, and they have been somewhat ignored compared to recent veterans.

Statistics for men and women experiencing a trauma and the chances of experiencing PTSD are in this diagram.





God Bless Chris Kyle

Go see American Sniper, about Chris Kyle, a true American hero, who had 4 tours in the Middle East. His PTSD was well portrayed and how it affected him and his family. It is a true tragedy that he was murdered by a veteran suffering from PTSD after he was discharged. Chris was trying to mentor this vet. God bless our military.

There is a significant percentage of the population that hascriteria for PTSD, but have not been disabled by them. Only 40% of those with symptoms in the military seek treatment, and 60% going undiagnosed and treated. Suicide has taken the central stage as the lethal complication of this disorder with attempting or completing suicide.This will be discussed in detail next month.

It is estimated that one third of the homeless are veterans. This is a national tragedy that has been overlooked by the VA. The VA has been in trouble for decades and finally the longstanding mismanagement and incompetence have been brought out by a whistle blower....Big government breeds these drawbacks. It is still difficult to get service connected for PTSD, and even years go by before they get disability benefits if at all. Hopefully that will change.

Women, who have had sexual harassment throughout their military career have been especially overlooked, as so many are afraid to come forward because of the ridicule they receive from male military superiors and/or repercussions. The military has recently labeled it sexual trauma to include unwanted contact, sexual innuendo, groping and rape, but lack of paper documentation has created a real impediment. 10% of the military are female now (2.2million). More than 280,000 females have returned from deployment. VA health centers only recently opened women's rest rooms(gives you an idea of how far they have to go). Many VA clinics lack staff to even treat sexual assault. (ref.--Institute of Medicine). Just this

month, the VA announced they would open mental health services to reservists and the National Guard. Imagine the numbers!! Women are encouraged now to apply for disability for prior sexual events. It has been a "dirty secret" and unfortunately rampant even to this day. It is no longer a man's military!

In the general population 33,000 Americans die each year of suicide (attempts are hard to estimate) with 7.7 million with PTSD (an estimation). 5000 vets commit suicide each year. More than half of all people will experience at least one traumatizing event in their lifetime. In the military, most on the front lines are exposed to multiple events.

Foster care for just one year between the ages of 14-18 have a 25% risk of PTSD. 60% of foster care who experienced sexually abuse, and 42% who were physically abused will have PTSD. These rates demand more funding for more extensive research on prevention, identification, and treatment of PTSD.

The recovery rate from PTSD for veterans is only 28.2% compared to the general population which is 47%.

B. Symptoms (some of the major)/ Signs of PTSD:

1. Disturbing flashbacks of events;nightmares.

2. Avoidance or numbing of memories of the event.

3. Hyper-arousal from sudden noises or memories. PTSD causes an overactive adrenalin response and influence future responses to be over-reactive.

4. High levels of anxiety. (can be confused with an anxiety disorder).

5. Females more likely to have PTSD, and with the sexual harassment issue added, the numbers reported will escalate.

6. Patients try to avoid talking about events, avoiding thoughts and emotions even developing amnesia except during a flashback.

6. Phases-acute if less than 3 months, chronic if more than 3 months, and delayed if years later.

7. Although, the emphasis is on veterans, these symptoms include those innatural or terrorist disasters, mobbing,catastrophic health issues such as cancer and vascular (heart stroke) survivors, shootings in classrooms from demonstrations, schools, movie theaters, violent acts, family violence and emergency/ ICU personnel.Survivor's guilt is very common.

8. Stressor eventswill create an acute episode, death of loved ones, serious injury, etc. which create intense fear, horror, or powerlessness. Bullyingis another cause for children and adults. Conceivably being obesecould trigger the problem. There are recent studies that quoted a 3X greater chance of food addiction as a means of coping in patients with PTSD. In fact, the greater the number of PTSD symptoms, the higher the food addiction. (Ref. JAMA Psychiatry)

9. When these events occur they are felt in the present (not as a past event).

10. Those with PTSD have a hard time coping with routine or non-combat life creating enormous family dysfunction issues. They can have adverse behavior in the children to manage their own emotional dysregulation. Children experiencing these traumas can lead to PTSD when they become adult.

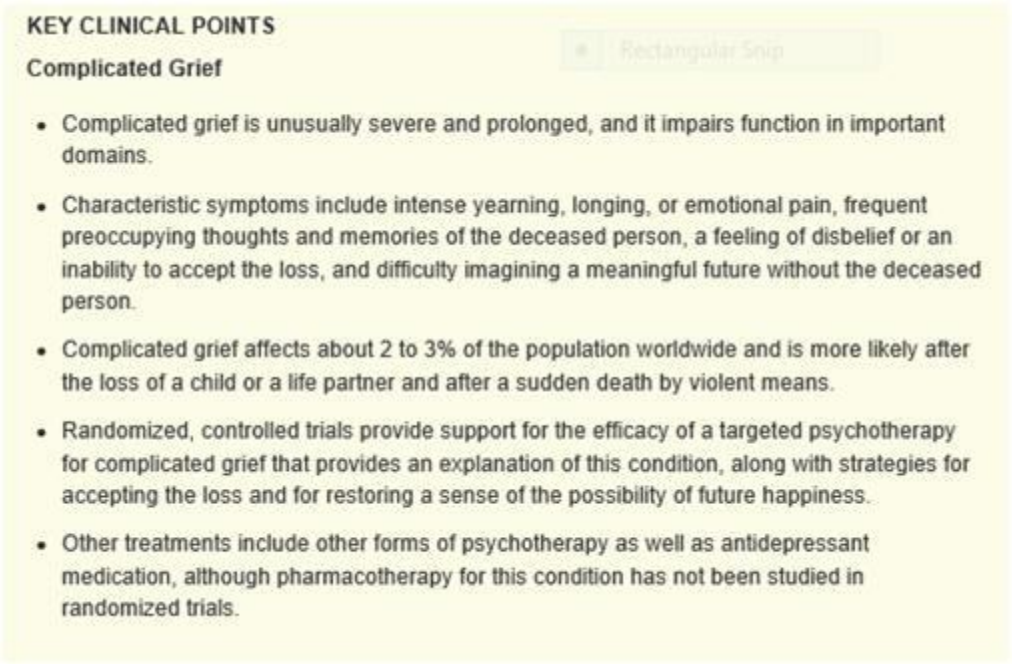
C. Acute Grief, Complicated Grief, and Depression

I have discussed signs, symptoms, and management of depression in previous reports. www.themedicalnewsreport.com reports 15 (bullying), 13 and 8 (bipolar and unipolar depression).

Depression very commonly occupies a major aspect of patients dealing with PTSD, and be the mechanism that creates fertile ground for suicide attempts and completions. It must be differentiated from acute grief and complicated grief.

After a traumatic event, especially the loss of a loved one will necessarily create the emotion of grief (bereavement), which is normal, however when it becomes prolonged and extreme, it is defined as complicated grief, and it requires assessment and consideration for treatment.

Here are certain key points in complicated grief:



KEY CLINICAL POINTS

Complicated Grief

- Complicated grief is unusually severe and prolonged, and it impairs function in important domains.
- Characteristic symptoms include intense yearning, longing, or emotional pain, frequent preoccupying thoughts and memories of the deceased person, a feeling of disbelief or an inability to accept the loss, and difficulty imagining a meaningful future without the deceased person.
- Complicated grief affects about 2 to 3% of the population worldwide and is more likely after the loss of a child or a life partner and after a sudden death by violent means.
- Randomized, controlled trials provide support for the efficacy of a targeted psychotherapy for complicated grief that provides an explanation of this condition, along with strategies for accepting the loss and for restoring a sense of the possibility of future happiness.
- Other treatments include other forms of psychotherapy as well as antidepressant medication, although pharmacotherapy for this condition has not been studied in randomized trials.

10-20% experience complicated grief losing a partner, and it is even higher with the loss of a child, if the death is

sudden, if it occurs from suicide, homicide, or an accident, and is highest in women over 60. There is a fine line between complicated grief and depression, and therefore must be assessed by an specialist. This type of grief increases the risk for substance abuse and suicidal ideation. It can lead to health issues and last 1-2 years or more. With acute grief, the person remains in reality, whereas in complicated grief, it may create an inability to accept the reality of the death, isolate themselves, with the loss of a sense of self.Friends and relatives become frustrated that the person remains in this emotion. These victims have a higher percentage of pre-existing emotional problems. This is also true for PTSD.

These disorders are a spectrum withoverlap of these conditions. That is why I am covering all of these disorders together.

Psychotherapy is the answer. There are many types of therapy, and it requires experts to determine the best type.Ref. NEJM, Jan 8, 2015; Merck Medicus

D. Genetics/Neuroendocrine abnormalities--Research

There is a hereditary susceptibility to depression and PTSD, estimated to be about 30% of the variance. Depression in a parent increases the risk of PTSD, depression, and suicide. There is some evidence a part of the brain in these patients have a smaller amygdala (part of the limbic system of the brain—emotional center). The prefrontal cortex is involved as is the hippocampus. These areas are involved in the neurotransmission of chemicals such as serotonin, norepinephrine, dopamine, and others. When these levels of chemicals are interfered with, depression can occur. There is also evidence that there are lower levels of cortisol/adrenalin in these patients, which can suppress the hypothalamic activity (loss of memory) in PTSD. It has recently been demonstrated that with third

trimester traumas, the cortisol levels in their infants is lower than normal, and could create health issues in the neonate. (I will discuss adrenalin andcorticosteroids when I report on the adrenal gland, in the ongoing series on Endocrine Organs).

It is also known that the 60% of these genetic variances overlap with panic and anxiety disorders as well as the influence on the body by alcohol, nicotine, and substance abuse dependence.

The chemical GABA (gamma-amino-butyric acid) is a major inhibitor of neurotransmitters in the brain. Abnormalities of this receptor gene and a severe childhood trauma may increase the severity of PTSD in that person when they reach adulthood. This is ongoing research. There is also estrogen linked to PTSD and may be the reason this syndrome is more common in females.

There is an opposite reaction of these chemicals in major depression that does not include PTSD. Although depression can be part of the syndrome, these levels are not commonly checked in clinical practice, but the symptoms will allow the clinician to appreciate which is the major issue and where the treatment should be directed.

PTSD costs the VA (the taxpayer) $48 billion per year to diagnose and treat PTSD.

Next month, I will report on the dynamics of suicide and treatment of these disorders.

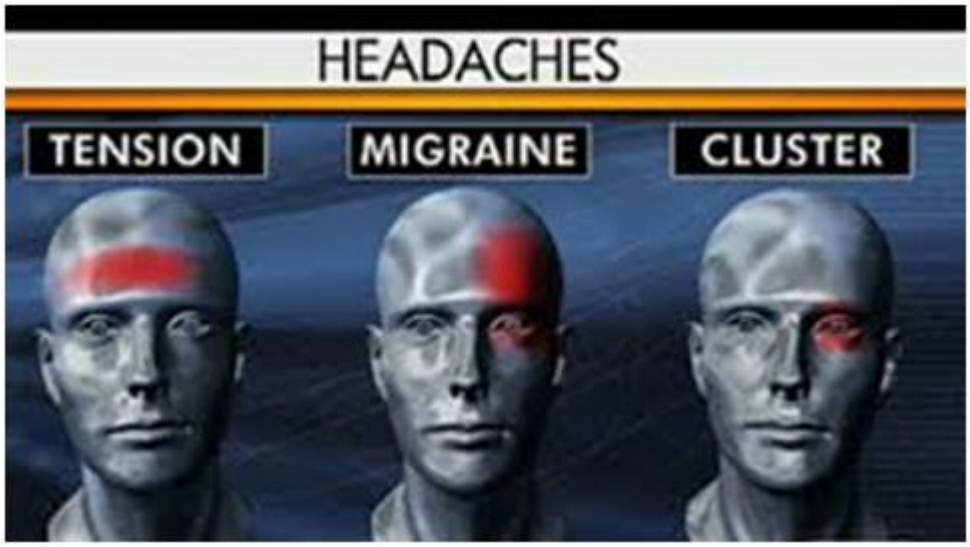
References—American Psychiatric Association

Crisis line is 1-800-273-TALK

www.veteranscrisisline.netwww.ptsd.va.gov

www.nimnh.nih.va.gov/healthtopics/depression

4. Headaches continued-tension and cluster type

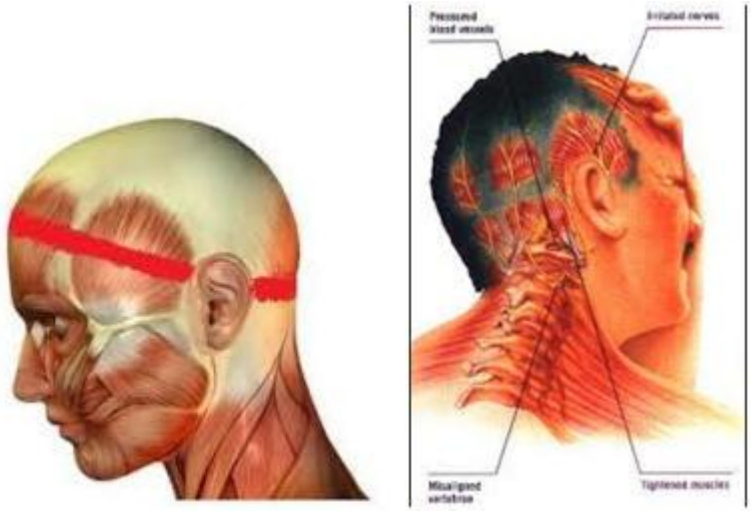


For a general discussion on headaches and migraine, I refer you back to Report # 26 and #29,

www.themedicalnewsreport.com

I.Tension headaches are well named, and by far are the most common type.

Description-The pain begins with spasm in the muscles of the upper neck which creates pressure and tightness in the entire neck and shoulder group of muscles. Most people show tension somewhere in their body, and the neck and shoulders is by far the most common area. Half of the population has this type sometime in their life. It is twice as common in females. Oddly, most patients don't necessarily realize the tension is coming from the neck, because the pain is the predominant symptom which is usually felt as a tight band around the head (left slide)



In addition to major posterior (back of the neck) neck muscle tension, there are muscles in the forehead (frontalis) and temples (temporalis) that spasm and cause the pain by squeezing on the sensory nerves of the lining of these muscles and in the scalp. Some describe it as pressure or a throbbing pain. It can be confused with a migraine, and in my practice, I felt that many of these

types of headaches had a vascular component, thus the name tension-vascular headache, but these headaches are not associated with auras, neurological abnormalities, visual changes, or nausea and vomiting (symptoms are typical migraine). They are not as incapacitating as migraines, but can be severe. They can come and go, while migraines do not.

The causes of tension headaches can occur from too little sleep, missing meals (hypoglycemia), anxiety, anger, eye strain, and a host of cervical abnormalities (arthritis, pinched disc, sitting in one position too long at a computer, even sleeping with the neck in an improper angle). See slide on the right above!

The physician needs to rule out migraine, sinus headache, and neurological causes, and other types of headaches, but the diagnosis is usually made with the history. CT and MRI scans are normal. The American Headache Society (via the American Board of Internal Medicine Foundation) is calling for fewer CT and MRI scans in stable headaches or ones that are clearly migraine, however, as pointed out in the medical internet site Medscape, that is controversial since a fourth of brain tumor patients can have isolated headaches. The other ¾ have associated seizures, cognitive abnormalities, and other neurological symptoms. I would suggest that the decision be made by your primary care and/or a neurologist.

II. Cluster headache, another type of vascular headache

occurs on one side of the head and are severe. They often can be associated with pain behind or around the eye with tearing. The eye may be red and it can be associated with a runny nose on the side of the headache.

Cluster headaches may involve pain around one eye, along with drooping of the lid, tearing and congestion on the same side as the pain

It rarely can be associated with a droopy eyelid, a smaller pupil on that side, sweating on the same side of the face, and usually lasts from 15 minutes to as long as 3 hours.The pain can radiate into the jaw and neck, possibly confusing it with a tension headache. These are one of the few headaches that are more common in males 4:1. These are much rarer headaches, but are somewhat classic in presentation when they occur.

Even other symptoms of a migraine may occur, but movement does not make the headache worse and nausea and vomiting is rare, which is very common in migraines. These headaches occur in "clusters of time", up to several separate times in one day, or every day for several days or weeks and then not appear for days or months.

With an MRI, there may be dilation of the ophthalmic (eye) artery and there may some PET scan abnormalities in the cavernous sinus (venous blood cavity inside the skull). The cause is unknown, but clearly this is an atypical type of vascular headache. Activation of the trigeminal nerve (a cranial nerve (through the hypothalamus) that sends sensation to the face in three branches) can create many of the signs of a cluster headache.

Triggers can come from alcohol, histamines, stress, menstruation, nitroglycerin, and even smoking (nicotine).

Clearly other neurological abnormalities (brain tumor) including migraines need to be ruled out.

Consider an ophthalmology or neurological consult.

III. Treatment of tension headaches can be as simple as acetaminophen (Tylenol), NSAIDS (Aleve, Ibuprofen, etc.) muscle relaxers (Soma Compound, Flexeril, Valium, etc.). Evaluation of the neck with X-rays can demonstrate many of the abnormalities (cervical arthritis, disc narrowing, etc.). If there are symptoms (numbness) radiating into the arm or hand with or without weakness, a more thorough evaluation by an orthopedist or neurosurgeon may be in order. Physical therapy, acupuncture, heat, ice are valuable. Antidepressants help as well. Chiropractic management is also commonly sought and can be quite helpful.

Behavior changes help—more sleep, relaxation methods (yoga, meditation, massage), better nutrition, less caffeine, deal with stressful situations, express yourself, and regular exercise is a great outlet.

IV. Treatment of cluster headaches acutely can be helped with breathing oxygen with a mask and can relieve the headache in 70% of patients. Injectable sumitryptan (Imitrex) or dihydroergotamine (Migranal) (both are migraine medications), Corticosteroids, verapamil (Calan),

lithium (Eskalith), valproic acid (Depakin), melatonin, and topiramate (Topamax) all have been effective.

Heart patients can have complications from the sumitryptan and ergotamine, and there are many medications that have cross-reactivity especially with selective serotonin reuptake inhibitors (SSRIs-antidepressants). With intractable cluster headaches certain deep brain stimulation procedures are being studied.

References:

www.medicinenet.com/headache

www.mayoclinic.org/symptoms/headache

www.headaches.org (American Headache Foundation)