Strong Work

I revisited the 80-page annual handout that is updated and available on tomsloanmd.com and some time after reading this smaller, 2018 update, you might look at those 80 pages again, as they contain good material to put you skillfully in charge of the healthcare jungle.

Halfway through my career, I take pleasure in seeing you carefully selecting high-value testing, treatments and procedures for things that keep arteries and brains healthy, as well as the few elective surgeries that are home runs and the small number of screening tests that work well.

It is good to see more of you saying no to things that are a bad deal, selecting best specialists and after-hours care if it just cannot wait to see me in the office. Though none of this is glamorous, it is what I think best separates you from medical mischief and disappointing outcomes – keep up the good work or hop on the band-wagon if need be.

I appreciate just how decent so many of you are to work with. We are modestly reconfiguring the practice, choosing patients that best fit so that *all* patients receive our full attention for what we hope is best care.

Lots of Choices

We now have three hospitals and over 1000 doctors in this immediate area – wow! The thousand-doctors part is easy to reason through – we continue to be interested in finding the ones with talent who act in your best interests, not hospital, group, financial or self-interests.

Over the years, you and I have partnered together in this and our ever-changing list of preferred specialists is updated based on results and feedback. I have no interests, affiliations or motives except that my life is best when your life is best – let me know the good, bad and ugly; it does affect our list.

There is irony in our hospitals as follows: I am an old-hand who trained at virtually all of the medical center hospitals and both of the medical schools downtown. In the past, my highest regard was for Methodist, then St. Luke's, then Memorial-Hermann, but the world has changed mightily.

Out here, in my opinion, the best hospital is Memorial-Hermann, partly because they have been here so long and it takes many years to build a hospital and create the systems that work well.

The other reason is, in this brave new world, Memorial-Hermann wound up having a lot more talent at winning the money game. It got so bad the St. Luke's Episcopal system left the business by selling out and allowing new owners to keep the name. I am pleased we have Methodist and St. Luke's as well as an MD Anderson presence out here and I think all of these excellent institutions can be selectively chosen as a good place to be a patient, though my default would be Memorial-Hermann. The single clear exception is if you think you are having a stroke, then I suggest St. Luke's, as they have the better acute stroke program.

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I continue to believe it is best to wait and be seen in the office if you should, but if not, Memorial-Hermann Emergency Room at the end of Woodlands Parkway, across from Walmart, remains best for most things, even if you live 25 miles from there. The quality of care is worth the drive.

Just a reminder, if you call us by 10 AM, we will see you *that day* if your problem is office-appropriate. My recommendations are how my family and I play it and for your sake make up the formula I think will serve you best: office, nearest ER if severe, Woodlands Parkway ER if not life threatening, Memorial-Hermann, unless stroke, then St. Luke's; other options in selected cases – an easy formula.

Medical Issues - New

To fast or not to fast? The medical literature now endorses what we have always known and that is that most lab is not altered by not fasting and the sugar and cholesterol profile may actually give *more useful* information than fasting lab, which we previously favored, because results would be standardized. Bottom line, except when I specifically request fasting lab, either way is fine.

Hepatitis C Treatment has become so good that we will now do one time Hepatitis C screening on all of you born between 1945 and 1965 (as guidelines advise). If you were not born then but had a blood transfusion before 1993 or ever used drugs by injection, please request this test.

New Shingles Vaccine

Many of you have received the "old" shingles vaccine, which was the best vaccine we had at the time, but it suffered from being only 58% effective and was also a live virus vaccine which some immune-compromised patients should not take.

A new vaccine called Shingrix is available that is 98% effective. The experts are recommending this two-shot series be given two to six months apart to all patients over age 50 who are not allergic to any of the constituents of the vaccine, regardless of whether they had the old vaccine or whether they have had shingles before.

Currently, people over age 50 would be generally considered to have had chicken pox even if they do not recall that being the case – some cases are subclinical and can cause shingles. People with immune compromise can safely receive this vaccine.

Though serious adverse events are no more common than placebo, I am surprised this newer vaccine *does* have fairly common, more than a little incidence of pesky side effects like muscle aches, sore, swollen arm, tiredness, fever and such. This may affect your preference for when to get this recommended vaccine.

New Blood Pressure Guidelines

A somewhat big change in blood pressure guidelines has been issued by the American College of Cardiology and the American Heart Association. There have also been other considerations about blood pressure in recent years that merit a brief conversation.

These guidelines now suggest anything over 130/80 be considered high blood pressure. The science has always supported the idea that over 130/80 does have increased problems associated with blood pressure, so this is a legitimate consideration.

If the top number is between 130 and 140, medication is only advised for people who are at higher risk for heart attack, stroke and other problems. Lifestyle modifications are also important in the form of weight loss, as well as the DASH Diet which is a diet composed of lower salt, an increase in fruits, vegetables, wholegrains, beans, nuts and the purposeful inclusion of a serving per day of low fat dairy. Alcohol should be two or fewer servings per day and sugar limited.

It is now appropriate to consider the goal for everyone to be under 130/80 and home blood pressure readings are to be given more preference than office readings – though they both still matter.

Given that this is true, I recommend that all patients with high blood pressure own two kits that go over their upper arm – Omron is a good name-brand and readily available.

Blood pressure should be taken enough times with both instruments in the same arm within a minute to ensure that these machines, which are subject to mechanical failure, are giving accurate readings. After developing evidence that the two machines read within ten points of each other (blood pressure can vary that much from moment to moment) then it is reasonable to use only one machine. Thereafter, when readings are in doubt you can utilize the second machine as quality control.

Everyone with blood pressure of 140/90 should be on medication with a goal to get under 130/80, though it remains the case that, over the age of 60, sometimes too much medical mischief in the form of the blood pressure going too low is caused by these ambitious goals. It can be appropriate to "settle" for a top number as high as 150 and whatever bottom number accompanies the 150.

As I said, these are fairly substantial changes and we will cautiously dip our toes into the water over time and move toward these changes with appropriate caution.

News on "Moderate" Alcohol Consumption

Mary and Ralph have been married a long time and enjoy having eight to twelve servings of alcohol per week. Perhaps in the past, all of us would consider this to be very reasonable. Imagine Ralph's surprise when his doctor reviewed information with him that called that into question.

For years I have been concerned that our national conversation on alcohol has been flawed in that, while everyone knows that drinking entirely too much is a crummy idea, we have not emphasized that "moderate alcohol consumption" (defined as **eight to twelve servings per week**) is associated with

potential health risks. I think it is a mistake for me not to be clear about these risks. For those who drink more than that, we already know the risk is high. (One "serving" equals 12 ounces of beer, five ounces of 12% wine, or one shot (1 ½ ounces) of 80 proof spirits.)

Recent guidelines in the United Kingdom, based on the science to date, have recommended no more than eight servings per week for men and women and I want to say I agree with these suggestions.

In a minute I will list the lengthy number of conditions that alcohol can cause, but let me say that I believe whatever you choose to do is your own business – I see my job as trying to provide information and making it as accurate as I can.

I am not wanting to slight those who drink entirely too much, but they have surely read and surely know that they are simply no good at having a little, probably an inherited tendency. Their only good remedy is to stop drinking entirely unless they are strategically satisfied with the idea that they have a high probability of being harmed by alcohol within the only life they have been granted.

Appreciate that though some of the long laundry list I will provide may only pertain to heavier drinking, some specifics serve to illustrate how that is not entirely the case. First, *any* regular weekly drinking is associated with an increased rate of breast cancer in women, so here is a small amount of alcohol that has consequences – less than even the eight servings per week.

Impressively, an excellent MRI-based study done over thirty years demonstrates 3.4 *times* the odds of hippocampus atrophy with **eight to twelve servings of alcohol per week**. Hippocampus atrophy is implicated in dementia and, in fact, the same study found a faster decline in lexical fluency.

I prefer science findings like this, but I will tell you in my many years of practicing, I feel like I have seen moderate alcohol consumption (8-12 servings per week) result in harm to some patients, especially in the 60-90 age group.

As I said, it is entirely your choice, but heavy and even moderate alcohol consumption would make me more comfortable if you were couching it with something along the lines of, "I know that going to the casino and losing week after week is depleting my family's savings, but that's okay, I really like casinos," or, "I know that 55-year-olds who hang-glide have a pretty high morbidity and mortality rate, but that's okay, it really gives me a thrill," or, "I have worked hard my whole life to earn a good retirement and enjoyment of my golden years, and I know that with my alcohol consumption I am putting those years at risk, but that's okay, I enjoy the alcohol that much."

If that's truly your personal, strategic thought, I have no qualms with you being the decider, but I am bothering to write this to give you information that doesn't give you an unpleasant surprise at the age of 68.

One of the problems with alcohol studies is the difficulty of being certain how much alcohol it takes to account for the following symptoms or conditions. Please be aware there is not any question that alcohol can and does do all of the following, but rather it's at what amount? I tried to provide the MRI study actually shrinking an important part of the brain with even modest amounts of alcohol as a clear-cut

example that more harm than we might like or appreciate can occur. The fact that even smaller amounts of regular alcohol intake increases breast cancer is certainly cause for pause.

Also a word on "self medicating": Although it is true that those with anxiety, depression and some other conditions might come home at night and have some alcohol that seems to give temporary relief, the truth is, it makes anxiety, depression, fragmented sleep and insomnia *worse* over days and weeks and I occasionally see patients where the amount of alcohol in the situation makes this unsustainable and they are feeling very badly. We have very effective alternatives so, when ready, ask me and we can work on it.

The "cardio-protective" benefits of alcohol have recently come under some dispute and in any event, I can assure you that modern science has excellent cardio-protective talents that do not include any need whatever for alcohol to help.

Good luck and let me know if you have questions.

Conditions associated with alcohol use:

Dementia, burning nerves, damaged nerves that affect posture and balance, testicular shrinkage, muscle weakness, brain damage that causes unbalanced walking, accidents, depression, suicide, growth of red blood vessels on skin, breast enlargement in men, pot-belly, malnutrition, enlarged red blood cells, loss of muscle, low testosterone, a number of cancers to include mouth, esophagus, liver, breast and others, heart failure and atrial fibrillation. In some settings, increased heart attack, ulcers, gastritis, esophagitis, liver failure, erectile dysfunction, decreased libido, fragmented sleep and a host of other problems.

HEADLINE: INCOME INEQUALITY HARMS THE HEALTH OF AFFLUENT PATIENTS!

Many of you are pretty good health care nerds and made insightful comments from your reading of last year's article on learning to live with diagnostic uncertainty.

This year's article from The New England Journal of Medicine demonstrates how affluent people are disproportionately harmed by over-diagnosis and treatment of conditions destined to cause no harm in their particular case.

Such articles dismay me a bit, not only for the good point they make, but also because they usually limit what they term "over-diagnosis" to those whose destiny was to never be harmed. I think it is also harmful when we find a problem early that unfortunately leads to eventual death, but we took away the remaining time for being carefree and unaware by our "early discovery".

For the most insightful of you, such an article will build on the theme that, of course we want the great things medicine has to offer, but we cannot get "best" unless we safeguard against getting hurt by trying "too much", which is more than best health care can deliver – we have to find that balance.

LIGHTNING ROUND

I like it when you bring lists of problems to a visit so we can pursue your priorities. Be sure to start our visit by saying, "I have three things today", so I can tailor our efforts to available time. The 11 AM work-in clinic is so busy that only one problem can be addressed, but annual exams and other follow-ups provide time for more.

It is not my style to ask you to come in often throughout a year, so if you are not doing well, I'm counting on you to pick up the phone and come see me. This is true whether we need to discuss blood pressure or you are just not feeling well or whatever.

Medications can cost "too much" and any time that's the case, don't hesitate to come see me and we can go over your meds to see about reducing the costs – there are often other ways to do it.

I'm not a fan of Lifeline Screening and other such things typically offered in the community, as they tend to use less good technology. If you need that screening, we would usually have already done it. If you don't need it, the screening can increase false-positive findings that cause more harm than good.

Given that my career has included patients who have died on bicycles as well as been crippled and badly injured, etc. my only request would be that you treat the decision to get on one more like a decision to start riding a motorcycle rather than thinking it resembles a decision to join the gym.

I am not a possessive doctor and am delighted for you to see all kinds of specialists and get second opinions. Because I am concerned that sometimes there is too much healthcare, I feel like I see some patients who visited a specialist fourteen years ago and no longer have the problem, yet continue to see the specialist each year, usually at the specialist's suggestion.

I would discourage that unless you have an active, ongoing problem that is in their field. For whatever reason, this is probably most common with cardiologists and urologists, though many of *those* continued relationships make perfect sense while other specialties can also be unnecessary.

Death, taxes, vacation plans and plans to retire. Given that only one of those is actually inevitable, I am a firm believer that it remains useful to spend a little time each year contemplating the unpleasant subject that none of us lives forever. If hospice or palliative care becomes a good idea along the way, it seems reasonable, before we get sick, that we have devoted 5% of our planning time to a good death and left 95% for vacation, retirement and tax planning.

Priorities: Good life, good death, taxes.

And now on to a good article.

Income and Cancer Overdiagnosis — When Too Much Care Is Harmful

H. Gilbert Welch, M.D., M.P.H., and Elliott S. Fisher, M.D., M.P.H.

Income has long been known to be an important determinant of health. Four decades ago, the Whitehall study of British civil servants revealed that higher employment grades were associated with better physical and mental health and lower mortality.[1] In 2016, an analysis in which data from U.S. tax returns were linked with Social Security death records confirmed that higher income is associated with greater longevity throughout the U.S. income distribution.[2] It found little evidence, however, that people with higher incomes live longer because they receive more medical care.

In fact, there are reasons to wonder whether wealthier people receive too much care. There has been a growing recognition among U.S. physicians that the conventional concern about too little medical care needs to be balanced with a concern about too much.[3] People with higher incomes would seem to be at higher risk for overutilization — whether because of their greater ability to pay for services, their expectations or demands, or more aggressive marketing by the health systems that serve them.

Cancer screening is one area in which overutilization can cause harm, resulting in overdiagnosis and potentially unnecessary treatment — particularly for cancers for which the reported incidence is sensitive to observational intensity. Observational intensity refers to the combined effect of multiple factors: the frequency of screening and diagnostic exams (including physical exams, imaging, and laboratory testing), the ability of exams to detect small irregularities, and the threshold used to label results as abnormal. Observational intensity can have a dramatic effect on the apparent amount of disease — particularly for cancers that have a substantial reservoir of indolent, subclinical forms.[4]

We used data from the Surveillance, Epidemiology, and End Results program to examine incidence and mortality trends for four types of cancer whose reported incidence is known to be sensitive to observational intensity: breast cancer, prostate cancer, thyroid cancer, and melanoma.[4] The combined incidence of these cancers has been rising in all U.S. counties, but there hasn't been a parallel increase in cancer-specific mortality — which suggests that considerable overdiagnosis may be occurring. Using 2000 U.S. Census data, we compared incidence and mortality among white people (to avoid confounding by race) in high- versus low-income counties (those with median family incomes greater than $75,000 and less than $40,000, respectively). This type of analysis probably underestimates the effect of a person's family income on reported cancer incidence, since county-level median income is an imprecise measure.

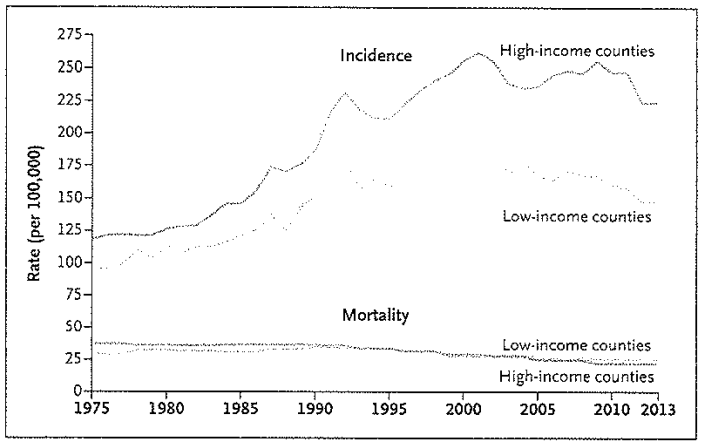
We found that high-income counties have experienced markedly greater increases in incidence than low-income counties since 1975 (see graph). This trend was also evident for each of the four cancers individually (see the Supplementary Appendix, available at NEJM.org). What explains this pattern? We hypothesize that the proximal cause is that wealthier people are exposed to increased observational intensity: they are likely to be screened more often and by means of tests (such as magnetic resonance imaging) that can detect smaller abnormalities, undergo more follow-up testing, and undergo more biopsies, and they may be served by health systems that have a lower threshold for labeling results as abnormal. More cancers are therefore found.

By contrast, the graph also shows that combined mortality from the four cancers is similar in high- and low-income counties, suggesting that the underlying disease burden is actually similar. What's more, mortality hasn't been increasing — as one might expect given the increasing incidence in some areas — but rather decreasing, reflecting decreasing mortality from breast and prostate cancer in particular. We believe most of the decrease in mortality from breast and prostate cancer can be attributed to improved treatments, many of which were informed by the discovery that these are largely hormonal tumors. The finding that since 1990, mortality has decreased by slightly more in high-income counties (40%) than in low-income

counties (25%) probably reflects better access to these improved treatments in wealthier areas. Although it's possible that the mortality trends can be explained by higher rates of screening resulting in fewer cancer deaths in high-income counties, such a benefit would have come at a cost — using these data, 5 to 10 overdiagnosed patients for every death averted.

The underlying cause of the difference in cancer incidence between high- and low-income counties is less clear. Affluent people may expect, and demand, more testing — enabled by their greater ability to pay. Alternatively, the fee-for-service health systems in those markets may be the driving factor: systems serving relatively wealthy and healthy populations may see offering more testing as a good way to attract consumers, produce more patients, and increase business. It's also possible that both explanations are at work, creating a mutually reinforcing cycle that promotes testing as the path to health.

Some of the resistance to moving toward a more sustainable (and affordable) health care system comes from people who fear they will be forced to give something up. Our findings offer the possibility that what may be given up is unnecessary care. Excessive testing of low-risk people produces real harm, leading to treatments that have no benefit (because there is nothing to fix) but can nonetheless result in medication side effects, surgical complications, and occasionally even death. The psychological effects of overutilization and overdiagnosis are also worrisome: turning people into patients may undermine their sense of resilience, which is fundamental to health. We believe that giving up excessive testing — not to mention unwarranted medications, unnecessary referrals, and avoidable hospital stays — could lead to better health.



Incidence and Mortality Trends for Breast Cancer, Prostate Cancer, Thyroid Cancer, and Melanoma in High- and Low-Income Counties in the United States, 1975–2013.

Because income and cancer-incidence trends (particularly for melanoma) may be confounded by race, the data here are for white people only. High-income counties have a median family income of more than $75,000, and low-income counties have a median family income of less than $40,000, according to 2000 U.S. Census data.

Getting there will require more balanced incentives. For example, physicians working under accountable care organization payment models are less likely to deliver low-value care than those working under traditional fee-for-service models.[5] Financial conflicts of interest (such as those of physicians who receive proceeds from breast and prostate care centers) could be minimized or, at the very least, exposed. And physicians can promote a more nuanced view of medical care, particularly for people who are well. Although we have much to offer people who are sick or injured, physicians have overstated medicine's role in promoting health. In so doing, we may have unintentionally devalued the role of more important determinants of health for people at every income level — healthy food, regular movement, and finding purpose in life.

Disclosure forms provided by the authors are available at NEJM.org.

From the Dartmouth Institute of Health Policy and Clinical Practice, Geisel School of Medicine, Hanover, NH.

1. Marmot MG, Shipley MJ, Rose G. Inequalities in death — specific explanations of a general pattern? Lancet 1984;1:1003-6.
2. Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. JAMA 2016;315:1750-66.
3. Sirovich BE, Woloshin S, Schwartz LM. Too little? Too much? Primary care physicians' views on US health care: a brief report. Arch Intern Med 2011;171:1582-5.
4. Welch HG, Black WC. Overdiagnosis in cancer. J Natl Cancer Inst 2010;102:605-13.
5. Schwartz AL, Chernew ME, Landon BE, McWilliams JM. Changes in low-value services in year 1 of the Medicare Pioneer accountable care organization program. JAMA Intern Med 2015;175:1815-25.

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