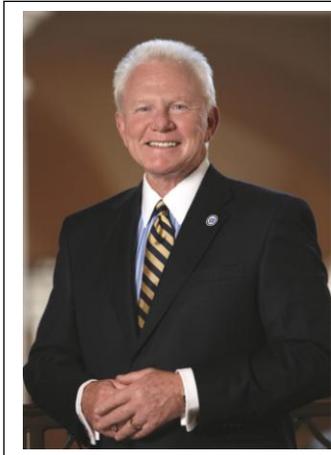


The Medical News Report, November, 2014



Sam La Monte, M.D., FACS

Advances in Medicine and Healthcare

Report #34

WEBSITE

www.themedicalnewsreport.com

For a free monthly subscription

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Subjects:

- 1. Simple Rules for a Healthy Heart Diet**
- 2. Blood Thinner Scandal—Big Pharma is at it again**
- 3. A New Less-addictive Narcotic approved by the FDA**
- 4. Healthcare Update-Obamacare, Medicare**

5. The Endocrine System—Part 3—Parathyroid glands, Calcitonin, Vitamin D, and

Calcium Metabolism for healthy bones, muscles, nerves, cell function

6. Prostate Cancer--Part 3--Diagnosis—general information and the Gleason

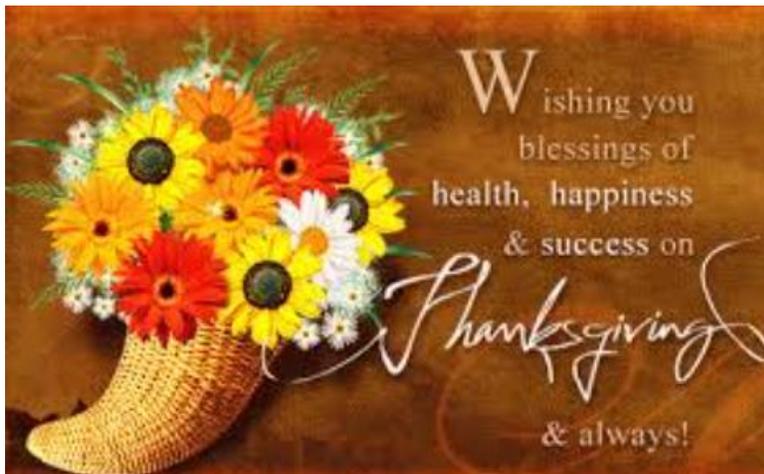
Score for aggressiveness of cancer

7. This year's Nobel Prize in Medicine—Implications for Alzheimer's disease

8. Some personal thoughts about Ebola

I hope many of you experienced the beautiful leaves changing. The First Annual Fall Fest was a big success. Over 2000 visitors enjoyed a chamber of commerce day in Sky Valley. What a great month up here. The leaves are now falling. It is supposed to snow tomorrow night (Oct 31).

This month turns our minds to Thanksgiving and a time for family. With the world in complete turmoil, I can only pray for peace in the world, recovery for our country, and new governance in our Congress and greater wisdom from the White House. We are in a make or break time for the America as we know it. Happy Thanksgiving! God bless America!



AT THE END OF THIS REPORT, I HAVE MADE SOME PERSONAL COMMENTS TO FOLLOW UP ON THE RECENT EMAILS I HAVE SENT YOU ABOUT EBOLA

1. Simple Rules for a Heart Healthy Diet

Medscape—Cardiology, an internet site that I follow closely has distilled the issue down to simple terms. This is not brain surgery. Here are the facts:

- a) Americans eat too many calories.**
- b) We eat too much saturated fat in pizza, chips, processed meats, and red meat. We eat too many carbohydrates in desserts, colas, candy, and starches (white stuff-potatoes, pasta, rice, breads).**
- c) We don't eat enough vegetables and fruit.**
- d) We don't exercise enough.**
- e) We depend on medications TOO MUCH (blood pressure, diabetic meds, statins, Lovaza etc.) to control our cholesterol, triglycerides, and blood sugar too much. One study stated that patients that depend on pills tend to eat 10% more calories on average**

than those who use diet as the main action to keep healthy. These meds DO NOT give you a free pass to the buffet.

- f) We don't manage our stress well.
- g) We do not get enough sleep.(need at least 7-8 hours)
- h) We are fast becoming the most obese country in the world.
- i) As many as one third of patients don't take their medications as prescribed or not at all.
- j) We are not role models for our children regarding a recommended healthy diet.
- k) We drink too much alcohol and still smoke.
- l) To reduce calories, we use artificial sweeteners. They cause problems with changing the gut bacteria that actually allows sugar to be better absorbed, thus cancelling the small benefit of sweeteners. It is being hypothesized that it is actually increasing type 2 diabetes.

So, we must reverse these things to give ourselves a shot at a long life. Do Americans really care? Are we in denial? Are we too busy to pay attention to our health? What is your answer? It is simple, don't abuse the above, eat more vegetables and fruit, and get off the couch and off the electronics. (I am guilty of the last one, obviously!)



2. Big Pharma is at it again—oral anticoagulants--the blood thinners—hiding the truth!



Feature

Dabigatran: how the drug company withheld important analyses

An investigation shows how the manufacturers of a blockbuster anticoagulant stroke drug withheld from the regulators important analyses regarding how to use the drug as safely and effectively as possible.

Big Pharma has been caught again withholding information about a drug, and this time, it is very serious. Dabigatran (Pradaxa) is one of the new anticoagulants on the market. These new fixed dosage drugs were touted as a big advantage over Coumadin, including reducing the risk of bleeding by 40% and not needing a blood test to be sure the drug level was correct. These new meds were said to be more effective keeping the patient anti-coagulated and minimizing bleeding risks. Coumadin requires a weekly blood test for safety (prothrombin time), and it does have a significant risk of bleeding. The pharmaceutical companies market the drug and do not recommend blood test monitoring.

The pharmaceutical company Boeringer-Ingleheim marketed the new oral anti-coagulant Pradaxa to be safer than Coumadin and did not require monitoring of blood levels of the drug. Through the Freedom and Information Act, the British Medical

Journal, found documents that clearly showed that monitoring blood levels of Pradaxa would make the drug safer. Bleeding from any of these anti-coagulants can be catastrophic, including gastro-intestinal and cerebral hemorrhage.

When the FDA approved these drugs, they questioned the lack of blood level testing, but because these oral anticoagulants were supposedly 40% more effective in preventing stroke and embolism than warfarin (Coumadin), they apparently let it pass. Was there a payoff?? What was the federal government thinking? Why would Big Pharma lie? MONEY!

The files of the pharmaceutical company documented that some patients needed less than 150mg. for adequate anticoagulation. The drug company also had records that showed there was considerable fluctuation of blood levels with this drug on the same dose, which is very undesirable.

The bottomline...a test needs to be made available commercially to monitor the initiation of this drug in patients to find out what dose gave maximum benefit without an increased bleeding risk. It turns out there is an experimental test to monitor the blood levels called the **Hemoclot plasma test, and needs to be made available to your doctors.**

There is no test to quantitate the risk of bleeding with Pradaxa.

This company clearly felt recommending blood level tests would make their marketing more difficult and influence their bottom line.

For now, if you are on one of these oral anticoagulants because you have **atrial fibrillation (not from a valve problem) or need to prevent emboli because you have**

had **deep vein issues** in your legs, or have **carotid or intracranial artery evidence of stenosis**, you need to ask your doctor about this issue. **DO NOT STOP YOUR ANTICOAGULANT WITHOUT SEEING YOUR DOCTOR AND DISCUSSING YOUR OPTIONS.** Abruptly stopping anticoagulants can have a rebound clotting effect. Soon, there will be better evidence of what range the plasma levels need to be maintained. For safety, it is recommended a loading dose be started, and then with blood levels be drawn to determine a maintenance dose. It is always a balance between preventing a clot and not increasing the risk of bleeding beyond an acceptable level. I will discuss this entire issue in the coming months.

Reference-MedPage, Medscape, and the British Medical Journal



**3.The FDA has approved a New “less-addictive”
Narcotic Pain Reliever (Oxycodone/Naloxone)**

The FDA has approved the first narcotic combined with an additional drug used to block the euphoria of **oxycodone**. The drug is **naloxone**. This is used to treat narcotic addicts because it blocks some of the “high” in the brain center. I have been waiting for the FDA to approve this drug for years. This can be used for serious chronic pain. There are millions of patients with chronic debilitating pain that would greatly benefit from this medication.

250 million prescriptions for pain killers were written in 2013. Addiction is a major problem. But how does a physician help a patient in constant pain? There are pain management doctors today that are invaluable, and I will discuss them in a future report. Ask your doctor about referring you to a doctor who is **board certified in pain management**. There are no regular doctors out there that can just decide to be a “pain doctor”. These doctors wind up being “pill pushers”. These doctors need to lose their licenses for abuse of their profession. That does not mean doctors can’t prescribe pain meds and do everything they can to help. But with chronic pain, a specialist should be considered. **Naloxone/oxycodone (Tarinix XR)** was approved to prevent addicts from crushing narcotic pills and snorting the powder. BUT, addicts will find their drugs somewhere. One pharmaceutical company has created a hard-to-crush oxycodone tablet. Everyone must know if you take narcotics for long, you will need to take more and more to get the same pain relief (it is called **tachyphylaxis**), and then the addiction begins. Oxycodone, a synthetic codeine, is a time release drug, and a wonderful pain killer for a short period. I performed hundreds of surgeries that required

significant pain relief for a week or so. After a week or so, I tried transitioning them to less powerful pain meds. Patients need to understand that procedures cause pain. Expecting to be pain free is not what someone should expect.



This pathetic excuse for a doctor was selling prescriptions to patients, overdosing patients with oxycodone and tranquilizers, and indirectly caused the death of several patients. His bogus pain management clinic was closed and he was found guilty of 2 counts of manslaughter, 180 counts of selling narcotic prescriptions to addicts. This person was an anesthesiologist and on the weekend saw an average of 120 patients a day. It took 3 years to bring this disgrace of a doctor to justice. He remains in jail awaiting his sentence of 15 years for second degree manslaughter. There are many more out there like him. Shame!

Reference-Medscape

4. Healthcare Update-Obamacare, Medicare, etc.

Healthcare continues to dominate the concerns of Americans (along with unemployment, the economy, Ebola, and the threat of terrorism). Although there are close to 10 million Americans who have signed up for health insurance, many of these people had insurance

already. In fact, many, who were told their insurance was dropped because it didn't meet the stringent rules of Obamacare, were given a chance to re-sign. Many younger people under 26 are still on their parent's insurance. Are they going to be ready to be responsible for their own insurance at 27? No one has been fined yet for not buying insurance. I am impressed that a good percentage of younger people have signed up, which was the secret to the success of the program. Small business has been given another year of grace before they are required to have insurance for their employees. Hundreds of businesses have dropped employees below 30 hours, so they don't qualify for benefits. Many low priced policies are limited regarding the option of doctors and hospitals. Meeting their deductibles and co-pays has become a huge issue. The problem continues to exist, and these folks still wait until their disease has progressed before they see a doctor. The feds won't give a number of those who are behind on premium payments. I suspect it is thousands if not more.

Obamacare is not about healthcare savings for millions and reform as advertised. It is about coverage. There is no reform (making healthcare more accessible at a cheaper price for all). Medicine has not become more efficient and cheaper. It will be 2020, so say the experts, before we know if healthcare is costing less. I am not hopeful. I can promise you one thing....doctors are making less, and working more hours trying to make up for the loss. Patients are waiting longer to be seen, and the time spent with their doctor has decreased. You are seeing nurse practitioners and PAs

instead of your doctor. That is not all that bad, if they have a doctor there to back them up (17 states do not require that).

Those of you who are still working at 65 and have good insurance with their employer do not necessarily need to join Medicare just because they are 65. If they have a poor policy, of course, join Medicare. Another option is to join Part A (hospital bills) of Medicare, because it is free. You do not need to join Part B (physician's bills) or Part D (drugs). Most think it is mandatory, but it is not unless your company has a policy that says they will no longer cover you at 65. Bigger companies usually do not require you to drop the company insurance.

One last thing.....[the Federal Government's Inspector General \(IG\)](#) announced that in 16 states the cost of healthcare is rising in hospitals that employ physicians. The last time I researched it, over 60% of physicians were employed. Private medicine is dead! Concierge' medicine is an option. I will report on them in the future.

Big hospitals have better bargaining power with insurance companies and, in one report, Blue Cross Blue Shield was reimbursing certain hospital/doctor complex 25-30% more than the competitors. Do you really think they are going to pass that savings along to the consumer?

Obamacare has been successful in many ways, but not in what it said it was created for: lower price, more access, and better medical care. Ref: Medscape General Surgery

Go to:www.medicare.gov for your answers and talk to your insurancecompany.



Times have changed!!

Hard to believe what you can read in the media. Look at this ad back in the 50s.

5. Endocrine System-- Parathyroid glands, Calcitonin, Vitamin D and calcium metabolism

SUMMARY: This report on the parathyroid glands is another in a series about the ENDOCRINE SYSTEM, which is the organ system responsible for secretion of HORMONES-THYROID, CALCITONIN, PARATHORMONE, ESTROGEN, TESTOSTERONE, INSULIN, CORTISONE, GROWTH HORMONE, OXYTOCIN, ADRENALIN, THE HORMONE THAT CAUSES OVULATION, MELATONIN, ETC. In fact, I refer you to Wikipedia for an exhaustive list of hormones, most of which you have never heard of. Just type in endocrine glands in Wikipedia (no direct link). I also refer you to last 2 reports #30 and #31 about the governing system of the endocrine glands (the

hypothalamus of the brain and the pituitary gland, an outpouching of the brain). Click on the link:

www.themedicalnewsreport.com

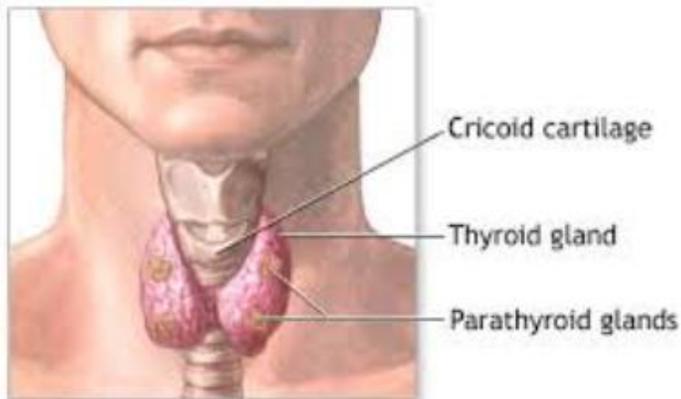
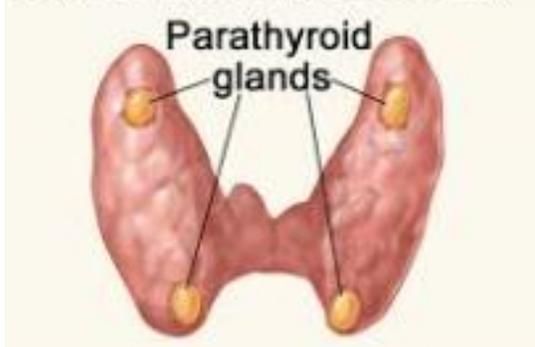
These glands are vital for the body to function.

Deficiency and excessive hormone creates serious disorders in growth, body type, health, diabetes, sexual development, lack of the body to respond to stress, sleep, etc. The reason I am reporting on this organ system, will give you a much better picture of how your body functions. A sub-specialty of Internal Medicine is devoted to this....Endocrinology. Having discussed the brain, pituitary, and the thyroid, this month, I will report on parathyroid glands.

The ANATOMY of the Parathyroid glands—There are four tiny glands that are embedded in the thyroid gland (see diagram on left below). These glands are intimately attached to the trachea. A back view is shown on the left and the diagram on the right shows the front view with the regional anatomy). These four glands are each about the size of a piece of rice.

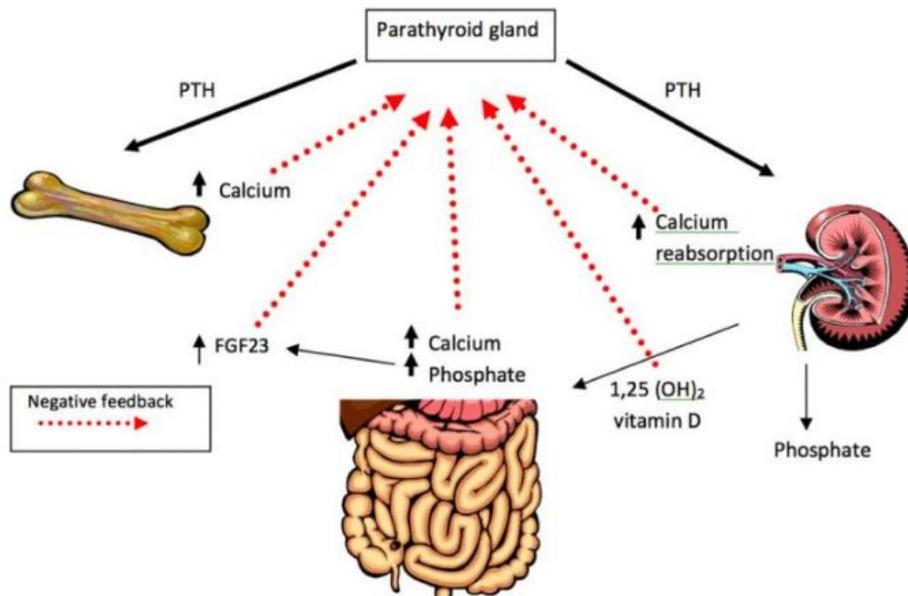
THE FUNCTION--These glands are responsible for maintaining **normal calcium levels in the blood** and are also involved with how bone either releases or takes in calcium. Without these glands, the calcium levels will drop to dangerous levels. The hormone is called **PARATHORMONE**.

Thyroid gland (back view)



The Function of the Parathyroid Glands

Look at the complex function of the parathyroid glands with the body organs to either remove or retain calcium in the system. The diagram is below. It does not include Calcitonin, which it should.



The level of calcium in the blood is controlled by parathormone, Vitamin D, Calcitonin:

1. Parathormone stimulates bone deposition of calcium.

It also stimulates the **small intestine** to retain calcium from the diet and also stimulates the **kidney** to reabsorb calcium. These three organs provide for steady blood levels of calcium. We call this normal homeostasis of calcium.

2. Vitamin D is absorbed and stored in the liver, and when needed also plays a major role in calcium levels, because it is needed to produce parathormone. **3.**

3. Thyrocalcitonin, another hormone secreted by the thyroid gland, stimulates release of calcium from bone. It is released when the calcium levels lower and are also released by stomach hormones (**gastrin and pentagastrin**), which make the intestines absorb more calcium from the diet.

Think of thyrocalcitonin as an antagonist of parathormone. The former releases calcium from the bone and thus the blood calcium rises, and parathormone stimulates calcium to deposit in the

bones. It is this complex interaction of parathormone and calcitonin, and vitamin D (and the parathyroids, the intestines, bone, and kidney) that keeps bones strong, nerves and the brain functioning normally and allows for normal cardiac and neural metabolism. Note that the diagram above omits calcitonin.

Diseases of the parathyroid glands:

1. Primary Hyperparathyroidism--elevated calcium (hypercalcemia).

Causes--The most common cause is a benign growth of one or more parathyroid glands. Since these glands are the size of a piece of rice, and identification requires a special scan. This disorder causes that particular gland to secrete **too much parathormone and will cause hypercalcemia**. There are less common causes of this disorder including a) **familial**, b) **being bedbound for long periods of time**, c) **excess calcium in the diet (greater than 1200 mg/dl per day)**, d) **hyperthyroidism**, e) **kidney failure**, f) **medications such as lithium for bipolar disease and thiazides (a group of diuretics)**, g) **Infectious diseases such as tuberculosis**, h) **Paget's disease of the bone**, i) **and sarcoidosis also can cause this disorder.**

Women over 50 are most prone to this disorder.

Symptoms and Signs of hypercalcemia may be minimal for some time. **Thirst and excessive urination** (just like in diabetes), **bone pain** (because the bones are losing calcium), **kidney stones, muscle cramps or weakness**, and even **depression** can occur. **Upset stomach, nausea and vomiting, and constipation** also may appear. Depending on how high the calcium level climbs (greater than 12mg/dl), surgical removal of the

enlarged parathyroid gland is recommended. **About 1 in 4 patients will need surgery.**

Medical treatment includes calcitonin, dialysis, diuretics, bisphosphonates (these are the medications used to treat osteoporosis and will be discussed with that disorder in the future). Intravenous fluids, and glucocorticoids (cortisone) may be necessary.

2. Secondary Hyperparathyroidism can be caused by **cancer**, especially metastatic **breast and prostate cancer** to the bones. These tumors make the bones lose calcium, thus raising the blood level of calcium. **Multiple myeloma, Hodgkins lymphoma and lung cancer** can secrete parathormone-like hormones.

3. Hypoparathyroidism(hypocalcemia-low calcium)
Causes—it is caused by damage to or removal of these glands during **thyroidectomy**, especially in cancers that require more extensive surgery. This happens in 1-2% of thyroidectomies. All patients are monitored for this post-op. There are two tests that the surgeon/nurse can do at the bedside (**Chvostek's sign**—tapping the facial nerve in front of the ear, and using a blood pressure cuff to put pressure on the arm which will make the hand to spasm (**Trousseau's sign**). Of course, blood levels can be drawn as well. In 30 years, I experienced one case that had transient low calcium, probably due to bruising of these tiny glands. IV calcium will immediately

Other less common causes low calcium are:a) **autoimmune**, **magnesium depletion**, b) **vitamin D deficiency**, c) **acute pancreatitis**, d) **special types of**

prostate and breast cancer (osteoblastic), and chemotherapy (cisplatin, 5 FU, and Leukovorin). I will explain osteoblastic and osteoclastic metastatic tumors when I report on the subject of bone metastases in the future. For now, an osteoblastic tumor causes bone formation and pulls calcium out of the blood, thus lowering the calcium level.

Symptoms include tetany (spasm of the muscles), muscle cramps. The EKG will show a specific electrical abnormality (prolonged Q-T interval).

Treatment includes calcium and parathormone. Finding the underlying disease creates the differential diagnosis that doctors will investigate when a patient demonstrates low blood calcium.

A diet rich in calcium, eating Tums, and taking calcium supplements will alleviate the problem without a treatable underlying cause. Green leafy vegetables, meat, and fortified food products such as cereal and dairy products.

Be sure you consult with your doctor about taking supplemental calcium, because excessive intake of calcium increases the likelihood of stomach trouble and kidney stones.

Osteoporosis will be discussed when I report on menopause at a later date.

Reference-Mayo Clinic, Cleveland Clinic, Medline, Wikipedia (if you type in parathyroids, these websites will be available).

6. Prostate Cancer-Part 3

Risk Factors and The Gleason Score—how it plays a role in Treatment

Summary—This is the third installment on prostate cancer. See www.themedicalnewsreport.com #32 and #33

I have discussed general information on the prostate and how symptoms of cancer are similar to benign enlargement of the gland. In the future, I will report on the management of BPH at a later date. Last month, I reported on the controversy of the PSA test. In fact, the feds don't recommend routine screening with the PSA, and just this week the Canadian government came out with the same recommendation. But, these governments still recommend that you discuss this with your doctor. Even the American Cancer Society feels it is the decision between you and your doctor. Remember! Routine screening implies no symptoms.

Not ordering a PSA does not mean you don't need a routine digital rectal exam and consideration for a stool specimen for analysis for abnormal DNA and blood for the early detection of colorectal cancer. This month I will review some facts about prostate cancer and the GLEASON SCORE, which helps oncologists decide the aggressiveness of a cancer on transrectal prostate biopsies.

Risk factors--Americans could prevent close to 90% of prostate cancers with a proper diet, reports Johns Hopkins (Prostate Health Briefing). **One in six men will be diagnosed with prostate cancer and one in thirty six will die from it.** This is the most common cancer diagnosed in men. The most potent risk factor is AGE, since the older a man gets, the higher the chance,

especially black Americans. Family history plays a key role especially with a father or brothers.

A **gene HPC1 mutation** is the most common gene abnormality, but gene testing is still not readily available. Multiple prostate infections are **NOT A RISK FACTOR**. **90% of prostate cancers are diagnosed in the local or regional stage** (I will discuss this next month with options for treatment). If the cancer is treated at the local or regional stage, the survival rate is close to **100%**. If it metastasizes to bone (most common site, and it can be the only clinically apparent disease) and other distant organs, **28%** survive 5 years. Most men with prostate cancer die of other causes rather dying of prostate cancer, especially if they over 70. However, the aggressiveness and stage of the disease must be assessed before watchful waiting is an option.

The average age of diagnosis is 68.

The factors increasing the risk of prostate cancer below that are controllable:

- 1. Mostly vegetables and fruits**
- 2. Lean meat, limited charred meats**
- 3. Charring any meat, chicken or fish, and BBQ {all of these cause the formation of nitrosamines and amines which are carcinogenic}**
- 4. Minimum intake of preservatives {especially nitrosamines in processed meats}**
- 5. Low fat intake**
- 6. Low carbs**
- 7. Adequate exercise**
- 8. Normal weight maintenance.**
- 9. Smoking increases the risk.**
- 10. Vasectomy is thought to be a factor, albeit minimal.**

11. Taking testosterone is thought not to cause cancer, but if taken by men, it adds fuel to the fire if the cancer is testosterone sensitive. IT SHOULD BE NOTED THAT OF THE SUPPLEMENTS RECALLED BY THE FDA, 60% CONTAINED UNLAWFUL PRESCRIPTION MEDICINE IN THEM, AND TESTOSTERONE AND ANDROSTEROIDS WERE 2 OF THE MOST COMMON. This could secretly fuel a prostate cancer.

12. Obesity causes 10% of all cancers and is a significant risk factor in prostate cancer.

13. Type 2 diabetes is linked through obesity and insulin resistance.

How does a high fat diet and diabetes cause problems?

It correlates with an **insulin-like growth factor (IGF-1)**, hormone metabolism, and free radical formation...all factors in oncogenesis (oncogenescausing cancer). We also know that obesity has caused an epidemic of type 2 diabetes, which is caused by insulin resistance (the insulin does not adequately lower blood sugar and accumulates at a high level). High insulin levels correlate with a higher risk of prostate cancer.

Are there any supplements that might lower the risk of prostate cancer?

Selenium (not to exceed 200 micrograms per day), vitamin D and E, Omega 3 fatty acids (some studies say it is the ratio of Omega 3 and 6 that is crucial—much more Omega 3) are thought to help. More research is needed to substantiate findings in small studies. There is also a study out that states Omega 3 can help prevent recurrence in prostate cancer.

Lycopene (a carotenoid) found in tomato sauce is thought to reduce oxidative stress. I HAVE DISCUSSED ANTIOXIDANTS AND OXIDATIVE STRESS IN A PAST

**REPORT—see Medical News Report
#10www.themedicalnewsreport.com**

Polyphenols in green tea is known to be an excellent anti-oxidant.

Although not specifically stated for prostate cancer, there is increasing evidence that a chemical in **turmeric (curcumin) used to make curry** is another very potent anti-oxidant and some studies show a decreased risk. The dose needed is not known yet, because the studies have been in the animal model only.

I HAVE STATED TIME AND AGAIN THAT THE NATURAL FORMS OF THESE SUPPLEMENTS IS FAR SUPERIOR TO TAKING PILLS, SO BE CAREFUL IN MAKING THE SUPPLEMENT INDUSTRY ANY MORE RICH THAN THEY ALREADY ARE. Plus the contaminants in these pills and capsules may totally counteract the benefit (heavy metals, rat excrement, arsenic, etc.).

THE GLEASON SCORE

Definition---This is a technique the pathologist uses to grade the degree of how malignant the prostatic biopsies are. A biopsy would not have been performed if the PSA was not elevated (as discussed last month), so biopsies of these patients assume there is a high index of suspicion for cancer. Once the biopsies (usually 10-12 separate biopsies) are examined under a microscope, the grade or score is given based on how malignant the cell is. The higher the number, the higher grade the tumor cells are. Tumors are usually graded a) differentiated b) moderately differentiated c) poorly differentiated. The more poorly differentiated tumors are the most aggressive. In the 1980s, a doctor named Gleason, came up with this scoring system.

The scores-

1-5 is considered questionably malignant and correlates with a high percentage of local pre-cancers (with no spread) or very low grade malignancy. Most low grade tumors are extremely slow growing and if these patients are older, they most likely will die of other diseases long before the cancer could kill them. These patients could be considered for watchful waiting and re-biopsied in 3-6 months. These patients and their families are sometimes reluctant to wait, and this is a dilemma. Obviously, the age of the patient is a big factor.

Where the real controversy begins is with a score of 6. Seeing a score of 6, doctors have to consider waiting and re-biopsing or proceeding with treatment. Second opinions are really necessary in this case. If the score is 7-10, physicians would recommend treatment, assuming patients are in good enough physical shape to undergo treatment.

Studies have shown that about 20% of tumors with a Gleason score of 6 will have more advanced disease than predicted by a Gleason score alone. Even though these scores are guidelines, it requires a knowledgeable patient and a very experienced oncologist(s). There has never been a better place for second and third opinions (surgeon, radiation therapist, and a medical oncologist should all be consulted before a decision is made. Refrain from anyone else influencing you, because many men will be very biased by their particular treatment.

In reading a review article in the Journal of Oncology, doctors from Johns Hopkins state that the Gleason score underestimates the magnitude of the cellular

malignancy, and that is why other criteria must be factored in, such as clinical stage, PSA level, and how much of the prostate contains cancer.

In the end, as this same article points out, many patients want treatment for fear of advancing disease. This is a real concern that can't be overlooked and can be increased by a treatment-happy doctor. Even the type of treatment is very difficult to decide on. There are several studies that not surprisingly show that surgeons recommend surgery and radiation oncologists recommend radiation more often. **Tumor Boards keep the discussion of a case from specialty bias. I would never have cancer treatment without it. I certainly did when I had my throat cancer.**

There is a lot to consider when at advanced age a patient is diagnosed with a very slow growing tumor. Most physicians determine treatment acceptability on the basis of a man having at least a 5-10 year life expectancy. One other fact of life is THE LEGAL PROFESSION. Don't think they don't influence overtreatment decisions, especially if the doctor has already been sued. Doctors are human. We need legal reform!!!

References: Journal of Oncology 2012, American Cancer Society, New England Journal of Medicine, The Johns Hopkins Department of Urological Oncology

7. The Nobel Prize winners for Medicine 2014- Implications for Alzheimer's disease



The Nobel Prize in Physiology or Medicine

The Nobel Prize winners are Drs. O'Keefe, Moser and Moser. They made several discoveries on cells that appear to act as a GPS for the brain. This discovery of a positioning area in the brain may have serious implications for dementia diseases such as Alzheimer's disease. This may be the area of the brain that runs afoul allowing patients to get lost and forget how to get from one point to another.

Below there is a diagram of the brain with 2 critical points of neuroanatomy-the [hippocampus](#) and the [enterorhinal cortex](#).

Storing information in the brain about locations allows us to retrace our paths. Some people are very adept at this. But patients with Alzheimer's lose their ability to recognize familiar locations and are easily lost.

These doctors found that there are cells in the hippocampus that are activated when the animal model was at certain places and other cells activated at another place. This was discovered by John O'Keefe in 1971, and in 2005, both Drs. Moser discovered another type of cell called "[grid cells](#)" in the nearby

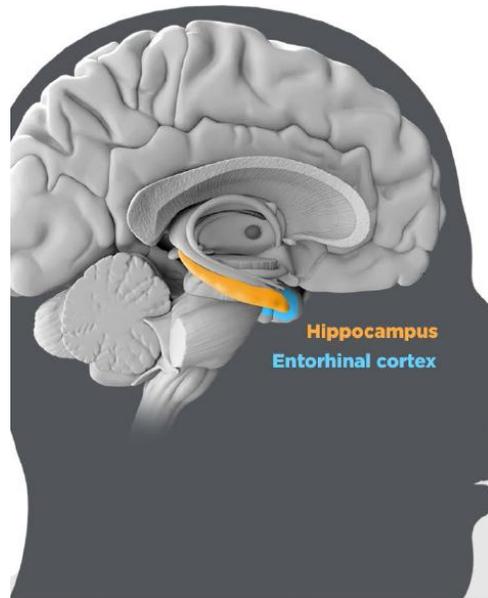
entorhinalcortex that generate a **coordinate system** and allow positioning and path finding thus allowing position and navigation.



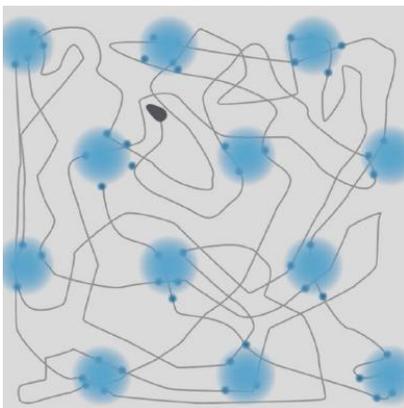
Photos: D. Bishop, UCL and G. Mogen/NTNU

2014 Nobel Prize in Physiology or Medicine

The **Nobel Prize in Physiology or Medicine 2014** was awarded with one half to **John O'Keefe** and the other half jointly to **May-Britt Moser** and **Edvard I. Moser** "for their discoveries of cells that constitute a positioning system in the brain".



Having a sense of place and an ability to navigate are fundamental to our existence. It is also interlinked with a sense of distance that is based on knowledge of previous positions. Thus a **cognitive map** can form in the brain, represented by the diagram below.



Multiple locations are arranged over time creating this coordinate system. This allows for spatial navigation. This system has been discovered in humans. The future for research must begin to find ways to protect these cells in patients with Alzheimer's disease.

Reference: Press Release from the Nobel Assembly of the Karolinska Institute in Stockholm, Sweden.

8. Personal Thoughts on Ebola is on all of our minds. We can only hope and pray US assistance in West Africa will be enough. Protecting our country has become an issue that is controversial, but the CDC is doing a great job containing this disease....at least now. Don't blame hospitals that are not prepared for a massively infectious outbreak. It is virtually impossible unless the patient is truthful. I posted an article by an ER doctor that makes several great points on my www.Facebook.com/samlamonte page that is worth reading. Ebola has increased the need for added protection for the hospitals and personnel. Also on my Facebook is a video from the DOCTOR WITHOUT BORDERS, which tells us, we were warned in March about this Ebola virus being very different. No one listened. It took an Ebola victim to come to the US, to get things mobilized. It did wake us up, but please realize Ebola is much less deadly than most Influenza outbreaks (50,000 die on bad years). But in 1918, the Spanish Flu pandemic killed between 10-20 million people. It is scary, but I am convinced we are still learning about this Ebola disease. The public has a right to be protected, and it appeared our government

was willing to concentrate on West Africa at the expense of the US.

I wish politics did not get into this issue, and now a nurse in Maine is creating a "rights" issue over being quarantined. No one has the right to potentially expose others. If volunteers want to go to West Africa, they need to know the sacrifices they need to make. If they need to be compensated for 3 weeks of quarantine, OK! An experimental vaccine may be ready in a few months, but the success and complications of that shot will not be well-known for some time. In France, they are paying volunteers \$895 to be tested with an experimental vaccine. 50 students have already signed up. The CDC says keeping Ebola in West Africa is the best way to prevent it from spreading. I agree, but in the meantime, let's protect our own country, whatever it takes. Collateral damage in the US is not acceptable to me.

Happy Thanksgiving!!



Stay healthy and well, my friends, Dr. Sam