

THE VIRGINIAN

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VIRGINIA CHAPTER NEWSLETTER

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FROM THE PRESIDENT

Joe Powers

A Question of Priorities

The Advocacy Program actively supported by your Chapter has a primary objective: increased funding for MG/Autoimmune Research, particularly through the National Institutes of Health. That's fairly straightforward, non-controversial and certainly not "political" in any sense.

Patient support groups – including MGFA – do not have sufficient resources for all the basic research needed to develop improved therapies, medications, preventive measures – or a cure. Many research proposals go unfunded – and undone. Not only is the research lost, but the opportunity as well to develop medical specialists experienced in dealing with these challenging diseases.

In addition to MGFA's own research program, the MG community's next best hope of achieving more research support is to actively work through the National Coalition of Patient Support Groups to obtain additional Congressional funding of NIH programs. That effort initially resulted in the first, most comprehensive plan for NIH programs supporting MG/Autoimmune Diseases. They also began to focus Congressional attention on the need to do more for the 22 million autoimmune patients – recognizing that autoimmune diseases rank in the top 10 leading causes of women's deaths. The NIH Plan also focused on the paucity of research funding for MG – still less than NIH expends for janitorial/maintenance services. Many of the nearly 80 autoimmune diseases receive no funding, no research – and no hope for their patients. Perhaps you can

understand and share our impatience. When patients are suffering, there's no time for individual or bureaucratic complacency and indifference.

Unfortunately the outstanding work accomplished by the NCPAG and the Autoimmune Diseases Coordinating Committee led by Dr. Noel Rose, M.D., Ph.D. is now threatened by serious Congressional budget cuts affecting all NIH programs – certainly precluding the research expansion needed.

The rationale given for the reduction includes the war on terror, the threat of bio-terrorism, Iraq, Katrina, the economic downturn following 9/11, tax cuts – and last but not least, the threat of Avian Flu Pandemic. No doubt all those issues impact the federal budget – and the availability of funding for medical research.

Recognizing that many folks will have different views regarding these issues, we would make a serious mistake not to recognize that we live in a very dangerous world – threatened by both terrorism and disease – that now requires extraordinary measures from all of us as citizens, both private and corporate – as well as the Congress.

The argument for less research funding because of these issues, however, is not valid. Congress has other "cost cutting", waste-saving, and revenue creating options that should be considered based on a set of specific priorities – but it will be up to you and me as citizens to insist on healthcare as a priority.

Congress – and the American voter – has a number of options that should be considered, some of which may require a personal and corporate sacrifice.

Here is a list of options that Congress – and we as citizens – should consider:

Eliminate "Pork Barrel", "Earmark" Spending.

Over 15,000 "special spending" items in 2005 were funded by Congress to the tune of nearly \$27 billion – the equivalent of NIH's entire budget! While some of these projects may be good, even useful, are they necessary?

Are they a priority? Since there was no "cost/benefit" analysis or serious evaluation by Congress of their merits, we'll never know. But as taxpayers, we'll pay for them. The "earmark" process approaches Congressional negligence – borderline malfeasance. Senator McCain of Arizona, a conservative Republican observed, "the Congress has given in to its worst "pork barrel" instinct." In 1982, the highway bill had 10 "earmarks". In 1987, there were 150 and President Reagan vetoed the bill. In 1998, there were 1,400 "earmarks" funded! In 2005, there were 6,300 included in the total of 15,268 special spending items – just enough to double NIH funding. Passage of the President's request for a line item veto capability would be a step in the right direction.

Re-price the Prescription Program

The program may well price itself out of existence – some \$200 plus billion more than the original estimates – in part because Congress refused to negotiate volume discounts from the pharmaceutical companies. But when the Committee Chairman, responsible for passing the legislation, immediately retired thereafter from Congress to accept a lucrative position with the Pharmaceutical Association, it raises questions as to whether the public's interests were served – or private and corporate interests. It's not too late to reverse these costs and save money that could be used for research – not just personal and corporate profit.

Re-design NASA Program versus NIH Reductions

Although it's nearly sacrilegious to suggest cuts in NASA's Manned Space Flight Program to the moon, scientists have said the estimated \$39 billion cost could be cut in half by use of robotic and remote instrumentation – a savings of nearly \$20 billion. Even the new NASA Administrator, Mike Griffin, has voiced concern over the Shuttle Program describing it as a "mistake", needing further evaluation. An additional \$20 billion saved from this

program could produce an MG, ALS, or MS cure!

Questionable Programs

The Synfuel Tax Rebate program allows a near fraudulent process of treating coal, chemically sprayed with diesel oil or other chemicals, to be priced as a synthetic fuel, pegged in comparison with oil at 2004 prices – not today's oil prices allowed the "Synfuel-Coal" producers to cumulatively rack up billions in tax credits. An extension of this tax credit is now being considered by Congress – in a measure contrary to the original 1980's legislation intended to encourage development of true – not "make believe" – synthetic fuels. Closing this loop hole results in more funds for research.

And then, of course, there is the multi-billion farm subsidy program that was originally intended to help the small family farmer – but has subsequently been hijacked by large corporate farms that through a loop hole are allowed to collect multiple payments to subsidiaries – contrary to the law's intent – although they are really just one big corporation. Thus, another example of lost funding that could have been used for research.

Taxes? Means Testing?

Tax cuts versus Tax Increases are always sensitive issues – and they need to be with annual deficits running over \$350 billion – and the National debt headed over the \$2 trillion mark. Congress needs to prioritize and justify spending programs – including tax cuts – based on a common sense rule: you don't spend what you don't have. That might imply tax increases, both corporate and individuals. It might also imply eventual "means testing" for Medicare services or prescription drugs.

Recognition that we are in a war of survival requires that we re-examine the world around us in terms of priorities – and the need for all to sacrifice.

Freedom from terror and freedom from disease does not come without a personal price.

As we go through life, each of us adopts a set of values and priorities. As an MG patient we hope one of your priorities will be to join with us in this Advocacy Program that fights for needed research. We need your

continued support and help. Because of your support and help, you and your Chapter will make a difference. With sustained resources for medical research, one day we'll begin to see that Promised Land – a cure for MG, Cancer, heart disease – but it will need sacrifices we're willing to make, based on priorities.

What will your priority be?

ADVOCACY ACTIONS **Congressional Caucus Being** **Established**

AARDA (American Autoimmune Related Diseases Association) has taken the lead to establish a Congressional Caucus to support NIH research programs. The objective is to develop Congressional leadership that will participate more actively in securing needed funding for autoimmune diseases through NIH. Candidates for leading the caucus in the Senate are Biden of Delaware, Specter of Pennsylvania and Shelby of Alabama. House leaders being considered are Kennedy of Rhode Island, Tiahrt of Kansas and Upton of Michigan – a mix of both Republicans and Democrats.

AARDA is developing a "Powerpoint" presentation as well as "Fact Sheets" that can be used in briefing Congressional representatives and their staff. The briefing materials are being furnished to members of the NCAPG (the National Coalition of Autoimmune Patient Groups). Your Virginia Chapter actively participates and supports NCAPG and will be using the briefing materials in presentations to the Virginia and West Virginia Congressional delegations. It's intended that these briefing materials be widely distributed at the "grass roots" level for MG/Autoimmune patients to contact their Congressional representatives at the local levels for the most effective results.

Autoimmune/Congressional **Conference Scheduled**

AARDA has also scheduled a two day Congressional Conference that is being held 29th and 30th of March in Washington, DC and will include a research forum "on the latest findings in autoimmune disease research". A

Congressional Briefing and lunch will be held on the second day at Capitol Hill. Dr. Steven Katz from NIH NIAMS has been asked to participate and brief the attendees. A reception and dinner has also been scheduled with invited speakers Rep. Patrick Kennedy and actress Kellie Martin.

National Health Council **Critical of Budget Cuts**

The National Health Council (NHC) has vigorously voiced its opposition to Congressional budget cuts affecting NIH research programs as well as reductions in the Medicare/Medicaid appropriations. Objections to the planned NIH re-organization were also strongly expressed to Rep. Joe Barton (R-TX) as Chairman of the responsible subcommittee. NHC specifically requested rejection of the proposal to "slash funding lines for NIH...that could lead to Institute-wide confusion, a lack of focus for researchers in specific research centers and less accountability and transparency in how resources are utilized. NHC expressed concern that the reductions would impede medical technologies, leading to a "stand still in advances" that would be "devastating, even life-threatening" to patients with chronic diseases and/or disabilities.

The NHC is comprised of 115 National health-related organizations – including fifty of the nation's leading patient groups, as well as the Association of American Medical Colleges.

Although the 06/07 NIH budget appear to be "straight-lined" at \$28 billion, the "devil is in the details" of the 27 NIH Institutes and cost centers. Twenty-four showed reductions totaling \$263 million. What is not clear is the amount set aside for the "Global Fund for HIB/HIV, malaria, and tuberculosis" or the \$418 million for Pandemic Influenza. It would appear that these funding requirements – that may total in excess of \$1.5 billion – will displace prior funding commitments, thus reducing or eliminating other research efforts. In other words it does not appear that NIH was actually given any additional funding for the "Global Fund or for Pandemic Flu. It would appear that they were directed to absorb the

additional requirements in contrast to other agencies (i.e. Defense) that are given “supplementary” funding for new requirements. And, that’s a problem.

National Academy of Science Report Cites Decline in Scientific Research

Entitled “The Gathering Storm”, the National Academy of Sciences report expressed concerns over inadequate funding of Scientific and Engineering research that has persisted for several decades. The concern is that the U.S. is losing its world competitive economic edge. The report, requested by Congress, was put together by an exceptional team of scientists – three of whom were Nobel Prize winners – and leaders of the academic community. Their recommendations call for a \$70 billion dollar investment over the next 10 years in research programs and in education reforms leading to the training of more scientists and engineers. The full report can be found at www.nap.edu/catalog/11463 – and is further evidence of the need for **increased** rather than decreasing funds for science.

The report indicated that science and engineering funding is about .8% of GDP (Gross Domestic Product) – and that medical research is not much better at around 1.5% of GDP. If these trends are allowed to continue, the U.S. will lose its scientific lead with serious impacts on the economy – and jobs.

We hope, if space permits, to bring you more about the report’s findings in an upcoming edition.

New Hope for People with Autoimmune Disease

Autoimmune diseases are “friendly-fire” disorders in which the body’s immune system mistakenly identifies cells or tissue as “foreign” and attacks them. Among these serious ailments are rheumatoid arthritis (RA), multiple sclerosis, **myasthenia gravis**, and Crohn’s disease. Now Dr. Nathan Karin and colleagues in the Technion Israel Institute of Technology’s immunology department have discovered that the body possesses a second set of beneficial antibodies that suppress the activity of the self-destructive ones. Furthermore, using genetic

manipulation, they were able to boost the restraining activity of the beneficial antibodies.

Their work was published as the lead article in the November [20]03 issue of *Immunology*. Based on these findings, Karin has developed a novel platform for the development of new therapies, and has applied for a patent.

A properly working immune system is able to recognize an autoimmune attack. In response, it activates the beneficial antibodies that suppress the self-destructive immunity. But if the immune system is not working properly, the beneficial antibodies are not activated, allowing the self-destructive ones to run their damaging course.

In trials on animals with induced RA, the researchers were able to expand the number of beneficial antibodies, which resulted in a marked suppression of the autoimmune disease; eliminating the beneficial antibodies hastened the progress of the disease.

Most importantly, the researchers were then able to verify this process in a double blind clinical study. The study consisted of 22 patients suffering from RA, a control group of 10 with osteoarthritis (which is not an autoimmune disease), and another control group of 12 healthy patients. More than 70% of the RA patients had beneficial antibodies, which shows their systems were fighting the disease. By contrast, none of the healthy and none of the osteoarthritis patients possessed any beneficial antibodies, presumably because they had no need for them.

These findings will likely lead to two complementary therapies: the first will be drugs consisting of novel antibodies that will assist the beneficial antibodies. The second will be vaccines to boost the autoimmune system’s beneficial antibodies.

Source: AMPS: Quest Jan-Feb. 2004. Reprinted from Pacific Northwest Chapter, MGFA. Fall/Winter 2005.

Review Suggests Heart Checks in MG

People with myasthenia gravis (MG), a disease in which the immune system attacks the part of each muscle fiber that receives nerve signals, aren’t usually told they’re at risk for heart disease. But researchers at the Cooper Hospital -

University Medical Center of the Robert Wood Johnson Medical School in Camden, NJ, say they recommend that physicians set a **“low threshold for pursuing cardiac investigations in patients with MG with unexplained fatigue or exercise intolerance, especially if disproportionate to other signs of MG.”**

In a comprehensive review of some 60 studies of MG and heart abnormalities conducted since the early 20th century, the authors found that various types of abnormalities are probably more common in this disease than they are in the general population.

Maya Guglin and colleagues say that inflammatory heart disease (myocarditis), rhythm disturbances, blocks of conduction signals through the heart, contraction abnormalities, and cardiac disease secondary to respiratory dysfunction have all been noted in people with MG over the years. They caution that many of the studies were conducted without taking into account the patients’ ages and other factors besides their MG that may have contributed to their heart problems. And the diagnostic criteria for MG have changed, meaning some patients may have been included in MG studies in past decades that wouldn’t have MG by today’s criteria.

Nevertheless, the article, published in the June 2003 issue of the *Journal of Clinical Neuromuscular Disease*, sounds a cautionary note and suggests a need for further investigations to determine the scope and possible causes of heart disease of MG.

Source: AMPS: Quest Jan-Feb. 2004. Reprinted from Pacific Northwest Chapter, MGFA. Fall/Winter 2005.

Epigenetics: A New Research Field

Noting differences between identical twins, which are “triggered” by environmental influences, new research reported in the July 05 issue of the *Proceedings of the National Academy of Sciences* offers an explanation of how altered genetic settings may account for the development of chronic diseases. MG patients already know that autoimmune diseases – including MG – are most often “triggered” by an environmental factor, i.e. a viral or

bacterial infection, certain drugs, pollutants, even emotional stress.

Two scientists, Mario F. Fraga and Manuel Estellen of the Spanish National Cancer Center in Madrid, have described how enzymes in a cell attach a molecular “decoration” to a gene that either activates or deactivates that gene. “Histone acetylation activates a dormant gene, - DNA methylation deactivates that gene. Once altered, these genetic settings, although not passed on hereditarily, they can remain throughout a lifetime. Depending on that gene’s particular role, the altered setting can be very important – if for example the gene when “turned off” protects against cancer or when “turned on” leads to a predisposition of MG or some other disorder. By studying identical twins who have the same genetic composition – and noting the “altered differences” that occur; scientists are beginning to understand more fully how the “environment” contributes or influences disease or health outcomes.

In an earlier report sponsored by the American Autoimmune Related Diseases Association (AARDA) prepared by Dr. Jennifer F. Nyland, Ph.D. and Dr. Noel R. Rose, M.D., Ph.D. of Johns Hopkins University, specific chemical and physical triggers were described, exclusive of viral or infectious agents.

Copies of that report are available from our Chapter, and if space permits, in a future issue, we’ll attempt to summarize the findings – and cautions – for you.

New Directions Proposed In Autoimmune Research

Alba is developing a peptide for treating autoimmune diseases, including Type 1 Diabetes, MS and Celiac Disease. Called “Zonulin”, the protein can be used to block the passage of antigens that cause autoimmune diseases. They can also be used to deliver drugs such as insulin. Zonulin regulates “tight junctions” that act as barriers between cells in the linings of the lungs, blood vessels, skin cells and the gastrointestinal tract. Zonulin is used to open or close those “tight junctions” to either deliver a drug – or to deny antigen access. Initial animal

experiments have been successful in “shutting down” Type 1 Diabetes. “We’re turning the entire science upside down. We’re proposing a radical departure from the field of autoimmunity.” according to Dr. Blake Patterson, co-founder of the firm. Alba scientists are associated with the University of Maryland’s School of Medicine, the Pediatric Clinic at the University of Trieste, and Mount Sinai School of Medicine. A paper covering the research was published by PNAS, 22 February 05, Vol. 102, #8.

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Dr. Alessio Fasano or Cris Jeffers

New Autoimmune Drug

HGS and GlaxoSmithKline Kline Pharmaceuticals have agreed to split expected development costs of \$100 million for a new autoimmune drug, called LymphoStat-B that’s targeted at Rheumatoid Arthritis (RA) and Lupus. Although there are a number of RA drugs available, there are currently no approved drugs specifically for Lupus (which a number of our MG patients have contracted). There are two forms of Lupus:

- Erythematosus Discoid Lupus which is characterized as a less severe form affecting a facial rash and treated with corticosteroid creams.
- Erythematosus Systemic Lupus is more threatening, potentially affecting joints, skin, kidneys, heart, lungs, pancreas, circulatory system, and brain. It is “managed” by a wide spectrum of optional therapies depending on symptoms and severity: anti-inflammatory drugs (NSAIDS), anti-malarial drugs, Prednisone, intravenous gamma globulin, and immunosuppressive drugs.

HGS discovered a protein called BLyS that normally assists in attacking viruses and bacteria – but sometimes erroneously attacks healthy tissue, cells and organs. LymphoStat-B however prevents or inhibits BLyS from attacking the body – thus limiting the damage. Mid-stage human testing for

RA showed promise in 31% of 283 patients. Fall testing extended to Lupus patients however has not fully met mid-term study goals of reducing symptoms at 24 weeks; at 52 weeks symptoms were reduced in a subgroup of patients representing 75% of the study’s patient population. More research is underway.

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Mourning the Loss of Health

By Karen N. Sanders, M.Ed., LPC)

Diagnosis of MG can be earth shattering, and worse still the word “incurable” strikes fear into even the most hardened of us all. It might not be a great consolation, but one important thing to bear in mind is the fact that you are NOT alone! Many have walked this road before you; they know and can empathize with you, as only those in the same position can fully understand. It is important that you try to reach out to others and share your innermost fears, why not join a list such as MMP (an on-line support group) and meet other Myasthenics, you’ll discover that there is life after MG, and that life does really go on, keep the faith!

Grieving the loss of health involves the same stages as grieving the loss of a loved one, a marriage, loss of job, etc.

The first stage is Denial. Denial actually serves a good purpose for a while. It serves as a buffer between us and reality of the diagnosis. It takes time for the news to sink in. During this denial stage, it is also normal to isolate while we deal with the news and the implications that it is going to have on our lives. With MG, some of us are so glad to have a diagnosis (other than that we are crazy!) that we actually sort of bypass this stage and move on to...

Anger: “WHY ME???” What did I do to deserve this???” is a common feeling when the denial stage is worked through. We feel like this is NOT fair! Sometimes we become angry at God for “allowing this to happen.” Again, this is a normal stage of grieving. We are angry at our bodies for not doing what they would before, angry that we may

have to depend on others for the first time. Eventually, anger gives way to...

Bargaining: In this stage, we want a reprieve. We ask God to take it away. We will do ANYTHING!!! Just make this go way - at least for a while. This stage is usually brief and leads the way to stage four which is...

Depression: They reality has set in. We are forever stuck with a strange, incurable, neuromuscular disease that is affecting every aspect of our lives. This is where we squarely face our losses. This can be income from well paying jobs, changes in relationships, or loss of independence. We can stay stuck in this stage for a long time. On top of the depression, we feel guilty for not being able to do everything we previously did. It takes time to work through this very normal stage of grief! Eventually this will give way to...

Acceptance: This is where we sit back and take stock of what we still have. The illness is real. It is not going away. Our lives are different. What do we do now??? This is where some are able to find a new direction. OK, this is what I have to work with. How can I still have a meaningful life, despite this illness? Many people are able to use this stage as a springboard to a much greater good.

It is normal to bounce back and forth between stages. As long as the backward movement is not prolonged, this is not too much of a program.

The stages of grief were identified and expounded upon by Elizabeth Kubler-Ross who recently passed away at the age of 79.

Source: AMPS: *The Myasthenic Meeting Place*.

www.myasthenicmeetingplace.org.uk/lossofhealth.htm Ontario Chapter: 8/05
(Reprinted from CT Nutmeg 1/06)

(Editor's Note: One great way to deal with MG is to become actively engaged in helping others through your Chapter or support group - become a participant rather than a bystander. Join our advocacy effort to get more research funding. You can do that just by a phone call or email to your Congressional representatives - and that will help you and others! You can contact Phyllis (pma8n@adelphia.net),

Joe at 434/589-3704, or Damon at 703/730-0505 and we'll get you started.

Proven Stress Reducers

Don't rely on your memory. Write down appointment times, when to pick up the laundry, when library books are due, etc. ("the palest ink is better than the most retentive memory." - Old Chinese Proverb)

Plan ahead. Don't let the gas tank get below one-quarter full, keep a well-stocked "emergency shelf" of home staples, don't wait until you're down to your last bus token or postage stamp to buy more, etc.

Don't put up with something that doesn't work right. If your alarm clock, wallet, shoe laces, windshield wipers - whatever - are a constant aggravation, get them fixed or get new ones.

Be prepared to wait. A paperback can make a wait in a post-office line almost pleasant.

Pollyanna-Power! For every one thing that goes wrong, there are probably 10 or 50 or 100 blessings. Count 'em!

Simplify, Simplify, Simplify.

Make friends with non-worriers. Nothing can get you into the habit of worrying faster than associating with chronic worrywarts.

Create order out of chaos. Organize your home and workplace so they you always know exactly where things are. Put things away where they belong and you won't have to go through the stress of losing things.

Add an ounce of love to everything you do.

Become more flexible. Some things are worth not doing perfectly and some issues are well to compromise upon.

Eliminate destructive self-talk. "I'm too old to..."; "I'm too fat to..." etc.

"Worry about the pennies and the dollars will take care of themselves." That's another way of saying: take care of the todays as best you can and the yesterdays and the tomorrows will take care of themselves.

Do one thing at a time. When you are with someone, be with that person and with no one or nothing else. When you are busy with a project, concentrate

on doing that project and forget about everything else you have to do.

If an especially "unpleasant" task faces you, do it early in the day and get it over with. Then the rest of your day will be free from anxiety.

Learn to delegate responsibility to capable others.

Have a forgiving view of events and people. Accept the fact that we live in an imperfect world.

Source: AMPS: *Oklahoma Chapter MGFA (Reprinted from MG Chapter of Illinois, 12/05)*

Thymectomy - 100 Years Later

By Dale Wurtenberger

Thymectomy trials were approved for funding by NIH. The first report connecting the thymus to myasthenia gravis was in 1901 when German neurologist Hermann Oppenheim found a thymic tumor in the autopsy of a myasthenic patient. This report prompted German surgeon, Ernst Sauerbruch, to perform the first thymectomy for a myasthenic with an enlarged thymus. In 1939, Alfred Blaylock reported a positive clinical response for a series of myasthenics with thymic tumors undergoing a thymectomy. Later he reported positive results from thymectomies on patients who did not have thymic tumors. Thus began the treatment of myasthenia gravis with a thymectomy.

In recent years doctors have started questioning the necessity of a thymectomy in all myasthenia gravis patients. Some research shows that 50% of patients (without a thymoma) undergoing a thymectomy improve. Other research does not support these findings. Since myasthenia gravis symptoms fluctuate, would they have improved without surgery? Is a thymectomy beneficial to patients who test seronegative to the AchR antibody? Too many questions have never been adequately answered.

What is known is 10-15% of myasthenics have a thymoma, and an additional 60-70% of myasthenics have hyperplasia. There is no question to the necessity of a thymectomy when a thymoma (a growth in or on the thymus) is present. Thymic hyperplasia is an enlarged thymus, which may or may not

turn into a thymoma. Hyperplasia and atrophy are indistinguishable on imaging studies such as a CT scan. This is one of the reasons thymectomies are routinely suggested.

Nearly one hundred years after the first thymic tumor was reported, physicians and scientists from around the world joined together to study the efficiency of thymectomy in myasthenics who do not have a thymoma. The Executive Committee of the Thymectomy Clinical Trial, Drs. John Newsom-Davis, Gil Wolfe, Henry Kaminski, Gary Cutter and Fred Jaretzki, are to be applauded for all their hard work. They have gathered 62 centers around the world who have committed to participate in the study. One of their main goals was to get backing from the National Institute of Health. In May 2005 they announced that they have qualified for funding from the National Institute of Health and the thymectomy clinical trials could begin as soon as the Spring of 2006.

MGNet sincerely thanks everyone committed to this project.

Source: AMPD: MG Net Chapter
Reprinted from the Oklahoma Chapter of MGFA Newsletter, March 2006

MED NOTES

New Technology Improves Cancer Detection

Digital Mammography, a relatively new technology, is reported to be more effective in detecting breast cancer than the use of "screen film mammography". Over 28% more cancers were found using Digital Mammography, particularly in women 50 years or younger. The results were based on a trial involving over 1300 women at the University of Virginia's Health System conducted by Dr. Jennifer Harvey, M.D., as reported in the on-line New England Journal of Medicine. Each year breast cancer kills more than 40,000 women in the U.S. – over 7,500 women in Virginia were diagnosed with breast cancer last year.

Although 18% of breast cancers occur in women in their 40's, most occur when older than 50. There is increased risk among women with a family history of breast cancer. More aggressive tumors are found in African-

American women and are more likely to die of this cancer. Being overweight increases the risk, as well as use of alcohol or smoking – and radiation therapy. Self examination and clinical breast exams should begin while in women's 20's. According to Dr. Harvey, "women of increased risk should talk with their doctors about the benefits and limitations of starting mammograms when they are younger, having additional tests such as breast ultrasound, MRI or Digital Mammogram – or having more frequent exams". More information is available at: www.uvahealth.com.

New Gold Standard for Exams

You'll really be taken care of if you sign up for the "Executive Health Physical", now available at the Virginia Hospital Center – particularly if you're "timed deprived", meaning time is in short supply on your schedule. Recognizing that good – really good, comprehensive medical care requires a "revolutionary approach", particularly if you serve celebrities and the "most well known" persons in the D.C. area. The Virginia Hospital Center has designed a very thorough program to help patients "take control of managing their health".

It all begins with a "town car" and chauffeur to pick you up, and return you to your home or office at the end of the exam. You'll be met at the hospital by your very own "personal escort" who will always be with you, helping you to navigate the hospital complexities as the physical exam progresses from one station to another. After a detailed medical history by a lead physician, an entire range of diagnostic tests will be completed:

- Blood & Urine Tests, of course
- Audiologic & Pulmonary Screenings
- An Exercise Stress Test & EKG
- Chest CT Scan – plus Abdomen & Pelvis Scans if needed
- Coronary Artery Calcium Scan
- Ultrasound Vascular Screening
- Ophthalmologic Exam
- Echocardiogram

- A Colonoscopy, plus any other specialty check-up that may be warranted.

Each of these tests will be in sequence, scheduled – so no waiting. You'll also have your own "private suite with telephone, broadband internet and flat screen television" should you need to keep up with other commitments. And of course, "meals individually prepared to your tastes" will be provided, respecting "most dietary, religious and ethnic requirements". At the conclusion of all this, you'll be given a thorough "debriefing".

Recognizing that medical care now requires many different specialties and technologies that need to be coordinated, the "Executive Health Physical" will integrate all of the required data that establishes a "baseline" needed to properly care for the patient. In a previous newsletter, we described "Boutique Medicine" – medical practices that provide very focused, intensive care of the patient as well as very comprehensive exams. Our newsletter of Fall 2003 reviewed the book, "**Big Doctoring in America - Profiles in Primary Care**" by Fitzhugh Mullan which emphasized the need and the role of the primary care physician in providing more effective, coordinated patient care. Obviously, comprehensive integrated medical care is to the patient's advantage. Unfortunately, unless you're quite well-to-do, it's also expensive. The Executive Health Physical costs \$3300!

One has to ask if these, albeit well intentioned approaches to medical practice are symptomatic of a multi-tiered health care program:

- For those who can afford the very best
- For those who can afford only routine care
- For those who are uninsured and can't afford anything – or hardly anything.

No matter which group we belong to, medical care is obviously priceless. Unfortunately, 46 million uninsured Americans struggle to obtain medical care. Surely that must be one of our nation's priorities.