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**OLDIE...AND...BADDIE**

OLDIE.

Published "way back" in March, 2003.

BADDIE?

Well, the content is clearly relevant but the message could be more joyous!

Alexander et al. [*Annals of Internal Medicine*. 138(2003):472] questioned a group of prospective jurors on their perceptions concerning physician disclosure (or lack thereof) to insurers regarding their patients. What they found is, to say the least, eye-opening...

When asked if they think it is "okay for my physician to misrepresent the facts about my health to my insurance company in order to get me the health care I need," 265 out of 551 respondents said YES. Just over 50% of those who said YES endorsed misrepresentation in this context!

Opining on the appropriateness of their physician lying to an insurer to get them the health care they need, 218 of 544 gave a thumbs up to the concept and 52% who did so found this to be a suitable course of action.

It gets worse...

Questioned as to whether "my insurance company is more concerned with saving money than with improving and maintaining my health," 77% said YES... and, moreover,

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30% of those who said YES...and 20% who said NO...blessed the notion of overt physician deception of insurers.

We already know from earlier studies that a significant share of practitioners rationalize misrepresentation as a Robinhoodesque – if you will – manner, and now we know that there are more than a few patients who may be egging them on this regard.

BADDIE, right?

More to the point, the matter of prevalent antiselection is now crystal clear...and the need for telephone interviews thus affirmed like never before...because not only are MD reports unspeakably slow and expensive, but now we know what may be going down behind the scenes due to a widely-held “end justifies the means” premise.

## TAMOXIFEN

We all know that tamoxifen is widely used in the management of patients with breast cancer who are estrogen-receptor positive (the substantial majority being so).

Fischer and his colleagues now report [*Journal of the National Cancer Institute*. 97,22(2005):1652] that when over 13,000 subjects free of BC were given either tamoxifen or placebo, and followed 7 years, those on Tamoxifen had 42% fewer invasive breast cancers than their peers given “sugar pills.”

That’s HUGE!

Another new study on women with harmless lobular carcinoma in situ (LCIS) of the breast, treated appropriately conservatively, found that tamoxifen reduced the risk of a second – but this time invasive – carcinoma by 100% (*more details in Hot Notes™...you do get Hot Notes™, right?...it’s free, too! – email Esther at [ledesmae@aol.com](mailto:ledesmae@aol.com) and get on the list for this monthly as well*).

Back to Fischer et al., we find that the incidence of osteoporotic fractures in the tamoxifen recipients was 32% lower than in the participants who drew the “short straw.”

The bad news?

Some excess uterine carcinomas in the tamoxifen users... and then there is also the small increased risk of deep venous thrombosis/PE.

The authors want their article to be a starting point for further research leading to an overhaul of prevailing clinical recommendations on this subject.

But – call me crazy – I intuit that we will see a lot more prophylactic tamoxifen in women at increased risk for breast cancer based on family history, proliferative benign breast disease, etc.

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Grainger and Schofield [*Circulation*. 112(2005):3018] did a piece on the potential for tamoxifen in the prevention of heart attacks.

Did you know that tamoxifen's multiple beneficial effects on cholesterol synthesis and oxidation (making it harmful) rival those of some statins?

Not only that, tamoxifen exhibits anti-inflammatory effects as well...and inflammation is more and more on center stage as a major culprit provoking events in atherosclerotic disease patients.

Wonder if the next thing will be tamoxifen prophylaxis against unstable coronary artery disease in both genders!

## RELATIVE COSTS: CABG vs. PTCA

Hlatky and 10 coworkers in cardiology centers nationwide examined the costs of bypass vs. angioplasty in multivessel coronary disease.

PTCA is initially 35% less costly than CABG, a function of the relative complexity and circumstances inherent in the bypass procedure.

After 12 years of care post-surgery, mean cumulative costs were almost identical (CABG = \$122,997 vs. PTCA = \$120,725).

Of course, costs were much, MUCH higher in aggregate if the patient had diabetes, heart failure or some other comorbidity.

For more on this, see Hlatky. *Circulation*. 110(2004):1960-66

## DEPRESSION AND (APPARENT) CARDIAC DISEASE

Jiang and Davidson [*American Heart Journal*. 150(2005):871] reviewed the use of antidepressant therapy in patients with CAD.

Because of the profound links between CAD and depression – going in both directions (depression = more CAD events; CAD = greater incidence of depression) – the notion of using a heart-safe antidepressant whenever indications of depression are detected in this context has got to be appealing.

Heart-safe rules out tricyclic antidepressants, of course... and rules in, first and foremost, the SSRIs.

We know SSRIs are used widely, across many domains of medicine, many times in persons without depression and even in persons free of anything DSM-IV calls psychiatric disease. Now we see another potential context for SSRI use we need to be alert to...

...that being, someone with a vague history of chest pain or dizziness or fainting...who goes on Prozac®...or one of its kindred...right about that same time.

This combination argues for one of two scenarios:

- Chest pain not cardiac – final diagnosis panic attacks or equivalent
- Chest pain cardiac – final diagnosis CAD and coexisting depression

Exercise caution with cardiac-appearing risks using SSRIs. Focus on clarifying the nature of the cardiac history – as in: inpatient? workup? any cardiac meds?

**THE MEDICARE  
LEGISLATION EVERYONE  
IS RAVING ABOUT (ONE  
WAY OR THE OTHER!)**

An extended Letter to the Editor in *Broker World* magazine [January, 2005, page 10 and beyond] makes some sobering points about the “landmark” Medicare legislation.

I thought I would share a few of his observations, for better or whatever:

- The bill was passed by Congress at 3:00 AM – many who said AYE confessed later they’d never really read much of the text of the bill
- The bill was written by an ex-politician and present day drug-company lobbyist ...who entered lobbying for pharma companies just after the President signed the legislation
- The law prohibits Medicare from negotiating drug prices – which is quite a bind since they are the #1 purchaser of Rx (I understand some new legislation is being planned that would change this provision and maybe others)
- Drug sales will increase by \$12 billion a year because of this law’s impact

Ouch...

**THE CHALLENGE**

Challenge?

From your CEO...

Reduce wastage (lost sales) but also maintain favorable morbidity.

How does a chief underwriter respond to this?

Many ways, including making darned sure the underwriters are as knowledgeable as possible when they are deciding who gets insurance and who doesn’t.

Which is why we created State of the Art Continuing Education...and why many health companies continent-wide are enrolling.

Major point ALWAYS raised by the budget watchers: What’s the cost?

Annual enrollment for our CE program is \$5000 for the whole company. Now here is the true cost per underwriter, per course:

Number of underwriters in your company	Cost per underwriter, per course, per year, to enroll in our CE Program
10	\$27.78
20	\$13.89
30	\$9.26
40	\$6.94

Is it worth a fraction of one APS to provide a comprehensive educational course on a key impairment – based on the latest literature, styled for easy learning and containing BEST CASE criteria – to an underwriter who is your last defense against lost sales and bad morbidity?

We figure the answer has to be YES.

For more information or for a free sample course, please contact Esther at LedesmaE@aol.com or at 414-423-0967.

## COLONOGRAPHY...AND AN IMPORTANT POINT

Colonography is a computed tomography (CT) procedure that is gaining momentum as a way to track down occult colonic neoplasia...as a screening test, and likely in a high risk population.

When Chin et al. [*American Journal of Gastroenterology*. 100(2005):2771] in Australia did a series of 432 of these tests, they detected 146 extracolonic (that is, outside the colon) lesions. Some of these were VERY clinically relevant:

- One noninvasive bladder cancer
- Six potentially-serious aortic aneurysms
- One splenic aneurysm

Then there were a bunch of kidney, liver and ovary cysts as well as benign lung nodules and nonfunctioning adrenal adenomas...in some cases, of course, confirmed as “cysts” or “benign” after further expensive testing.

What is the take home message here?

It is rather common, when doing CT scans and many other procedures as well, for physicians to find incidental lesions. A share will have significant risk implications. Thus, we need to READ THE WHOLE PROCEDURE REPORT – when it is recent or there is another indication to retrieve it – and take careful note of what comes next (interventions, therapies, recommendations given after the procedure)...which, of course, is most expeditiously ascertained on a teleinterview.

## WHILE WE'RE ON COSTS OF TREATMENT...

A 12 cardiologist study [Kauf. *American Heart Journal*. 151(2006):206] compared the costs of treating an acute myocardial infarction in 8 countries.

Highest cost for an MI?

The Netherlands at \$6772, followed by the USA at \$4949 (edging out Germany at \$4930).

Best deal?

Argentina at \$1201.

What about an angioplasty (with stenting to reduce the risk of restenosis)?

Here the USA passed Holland and grabbed the “top spot” at \$13,746, with the Dutch a respectable – *depending on how you see it!* – second at \$6772.

And the cheapest place to get the job done (quality notwithstanding)?

Argentina at \$3137 or, if you don't fancy long flights, \$4464 just across the world's longest undefended border.

## POLYCYSTIC OVARY SYNDROME (POS)

POS is strongly linked to the metabolic syndrome.

When Legro et al. [*Journal of Clinical Endocrinology and Metabolism*. 90,6(2005):3236] followed patients with POS, they had significantly higher mean hemoglobin A1-c levels than those who were free of this condition.

Moreover, the annual rate of developing impaired glucose tolerance (IGT) was 16% per year...which means that the eventual incidence of diabetes will be considerable.

Rider on the ovaries?

Maybe...for openers...there is much more that needs to be considered whenever one underwrites polycystic ovaries:

- Is metabolic syndrome present?
- Is the proposed insured (at least) pre-diabetic?
- Are liver enzymes normal?
- Does she have non-alcoholic fatty liver?

## BENIGN PROSTATIC HYPERPLASIA (BPH)

Very comprehensive review of this subject by McNaughton-Collins and Barry in *The American Journal of Medicine* [118(2005):1331].

Let's try some pearls here, in bullet point format, highlighting *need-to-know* stuff for health underwriters:

- BPH means benign prostatic hyperplasia – not hypertrophy!
- Anatomic BPH is present in 8% of men at 30-39 and up to 50% at 50-59. However, clinically-manifest BPH is evident in only a small share of these individuals, ranging from 4% to 20% in various studies.
- BPH has NO relationship to prostate cancer. Which means that, ethically anyway, a rider put on the prostate for BPH should not disqualify the patient for payment for treatment of prostate cancer...that is, as long as the basis for the rider was confirmed BPH and not uninvestigated urinary tract symptoms (see the distinction?).
- When the only ostensible BPH symptom is getting up at night several times to urinate (nocturia), this is a RED FLAG that demands full investigation.
- Pelvic pain does not occur in BPH – it does in prostatodynia, a condition of psychiatric origin which is a lot more common than most people think (and one we covered, along with vulvodynia and interstitial cystitis – sister conditions – in a CE course which we will send for free to any chief underwriter who wants to get a look at the quality of our CE program!).
- BPH is managed with Rx or surgery. Rx is usually either an alpha-blocker or a 5-alpha-reductase inhibitor (as in finasteride or Proscar® – which may also be seen in the context of prostate cancer – so be alert).

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- If both drugs are given, it is a WORST CASE of BPH.
- Surgery is with transurethral section – or TURP – and every so often they find an unsuspected carcinoma, so you should SEE all TURP pathology reports unless the follow-up is inconsistent with cancer.
- TURP usually does the trick – only 5% will need re-operation thereafter.

*Hope these tidbits help!*

## MORE FREE STUFF?

Sure...a complimentary section of the new – and truly unique – Risk Concepts LLC laboratory manual for health underwriting. Nothing this good has ever been done on lab testing for health underwriters.

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## BODY PIERCING

All you have to do is look around at the “younger generation” and the prevalence of visible piercings (at most sites, anyway...unless you're on certain Australian beaches!) becomes rather apparent.

Donna I. Meltzer, MD, reviewed this subject in *American Family Physician's* November 15, 2005 issue [72,10(2005):2029].

Some bullets may be enlightening:

- The infection risk in tongue studs is very low – however, rare cases develop a cellulitis (Ludwig's angina) that needs multimodal treatment.
- Multiple ear piercings are much more prone to complications than solitary ones...poor healing and serious infection needing fluoroquinolone antibiotics are not uncommon, and sometimes there is abscess formation.
- Earlobe piercings often lead to keloid formation, which can provoke various interventions including surgery, intralesional corticosteroid injections, even laser therapy.
- Nose piercing raises the specter of necrosis of the cartilaginous intranasal septum...*and when a history of this disorder is present, be sure to remember the OTHER prevalent case: snorting cocaine!*
- Nipple piercing sequelae are not well studied as of yet, but delayed infection is a definite issue.
- Male genital piercing has a raft of complications, as does the same ornamentation of female “privates.” In the case of the women, there is also a fairly high risk of condom breakage, the implications of which need not be aired out further.

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- There have been reports of infective endocarditis, a very serious event, incited by infections from nipple and navel piercings.
- And you need to know that piercing “guns” are often unsterilized between procedures, so there is the attendant risk of Hep B and C as well.
- The risk of hepatitis B and C are much higher in tattooing than in body piercing...but the increased risk is real with piercings, and any liver enzyme elevations must be carefully evaluated.

### Disclaimer

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## Rx NEWS

- Studies show that at least 5 anticonvulsants have value in treating alcohol abuse/dependence and preventing relapse to same. They are carbamazepine, valproic acid, gabapentin, vigabatrin and topiramate. Just one example of widespread off-label use of these (and many other) drugs.
- Two new anti-asthma drugs are now being prescribed: Asmanex® (mometasone) and Xopenex® (levalbutrol). Both inhaled.
- Riluzole – approved only for amyotrophic lateral sclerosis (a/k/a Lou Gehrig's disease, a catastrophic illness) – is now being shown to have definite value in both treatment-resistant depression and generalized anxiety disorder.
- Modafinil – originally for narcolepsy – has proliferated, if you will, into many domains of treatment, most recently cocaine addiction.
- Rimobanant is likely to be the first of a potential new series of drugs known as endocannabinoid receptor blockers, which have considerable efficacy in weight-loss. The original insights here came from the fact that *cannabis sativa* – also known as marijuana, pot, and medicine, to some – is associated with the “munchies,” and thus, logic says, if the area of the brain where munchie-ism is induced could be somehow turned down, weight loss might ensue. It did. This drug is in clinical trials.
- Febuxostat may be coming along to challenge allopurinol's dominant role in treating hyperuricemia and gout.
- Sildenafil (Viagra®, in the context of erectile dysfunction) has treatment value in Raynaud's phenomenon...and the message here is that the whole “-fil” family may be having more and more novel uses

**unrelated** to their original role.

- Tolvaptan looks to be the first “vaptan” (vasopressin antagonist) for treating heart failure. It will be distinguished as an “aquaretic” rather than a diuretic... and bet that it will cost more, too!
- The final point here is about omeprazole (the generic PPI) and its first cousin esomeprazole (which is still proprietary). A professor from Oregon Health Sciences Center asked an intriguing question in the October, 2005 Letters to the Editor section of *The American Journal of Medicine*. Seems he has issues with the fact that proprietary Nexium® was 7 times as expensive as generic omeprazole and the only putative advantage to the newer agent related to healing esophageal erosions, rather than subduing reflux – the primary use of the PPIs.
- One might add a “tip” offered up in the January 1, 2006 *American Family Physician*, which says that “there is no significant difference between... equivalent doses of esomeprazole and omeprazole.”

## HEALTH INSURANCE IN 2025 A.D.

A one-pager in the November 15 *American Family Physician* [72,.10(2005):1989] calculates that if health insurance premiums continue in the direction they are going while national wages follow their present vector, in 2025 the average cost of a family health insurance premium will surpass the average annual household income...!!!

Maybe we have some work to do here...if we don't want an imposed solution after November, 2008!

Thanks for reading *HEALTH e-SCAN*™. I hope to hear your thoughts on this bimonthly and how I can make it even more productive for you.

Happy New Year,  
Hank