

Message from the Alliance *for* Retired Americans Leaders



Alliance Stands with Victims of Texas Elementary School Shooting and Their Families



Robert Roach, Jr.
 President, ARA

Just ten days after a mass shooting in Buffalo, Alliance President Robert Roach, Jr., expressed his condolences after

at least 19 elementary school children and two teachers were **murdered at Robb Elementary School** in Uvalde, Texas.

In condemning the carnage, President Roach said, "The members of the Alliance join with all Americans who were devastated by this most recent, terrible gun violence in Texas in calling for an end to the heinous bloodshed. Our thoughts are once again with the deceased,

the injured and all of their loved ones.

We send our deepest wishes for healing to everyone affected by this senseless attack, this time at an elementary school." "We need the United States Senate to take appropriate and aggressive action on gun safety immediately. We must protect American citizens, families, workers, teachers, and especially children, from this incessant violence. And we must act without delay to keep guns out of the hands of criminals and the mentally ill."

FCC Addresses Annoying Robocalls From Other Countries

Americans will soon get **fewer robocalls from abroad** after four FCC commissioners voted unanimously last week to require



Rich Fiesta,
 Executive Director, ARA

more stringent caller-ID for people from other countries placing calls to people in the United States. The Federal Communications Commission receives more complaints about robocalls than anything else. Already this year there have been about 43,800 robocall complaints made to the commission.

The new rules ensure the companies that help connect phone calls from outside of the U.S. to residents use the stringent "STIR/SHAKEN" caller ID authentication protocols. The rules also require phone companies to stop illegal robocalls or face harsh

consequences.

"Given the number of robocalls seniors and others receive, the FCC's new rules should be a huge relief," said Richard Fiesta, Executive Director of the Alliance. "Next, we need Congress to allow the collection of fines from the worst perpetrators."

Executive Director Fiesta Addresses Coalition of Black Trade Unionists

Executive Director Fiesta traveled to Los Angeles this week for the Coalition of Black Trade Unionists (CBTU) Retirees' Conference and General Conference. He provided an update on numerous federal issues affecting retirees, including Social Security and the importance of the retiree vote in the midterm elections.

Who Controls Oil and Gas Prices in the United States?

The United States is one of the world's biggest oil producers, so why have gasoline prices soared to all-time highs and oil prices recently hit their highest levels since 2008?

Who Sets Oil and Gas Prices?

Richard Joswick, head of global oil analytics at S&P Global Platts, told *Newsweek* that the price of oil and gas is not controlled, "it's market pricing" and it depends mostly on supply and demand for the product.

Joswick explained that markets move together, based on a few main benchmarks that determine the price for multiple grades of crude oils, including varieties and blends. There are three main

benchmarks to look at, according to Joswick—dated Brent being the most important for crude oil, the New York Mercantile Exchange (NYMEX) for gasoline and the Intercontinental Exchange (ICE) price for diesel.

The main factors impacting gasoline prices at the pump, according to the American Petroleum Institute (API), are the cost of global crude oil (61 percent), refining costs (14 percent), distribution and marketing costs (11 percent) and federal and state taxes (14 percent).

How Much Is U.S. Gasoline Taxed?



Gasoline in the U.S. is subject to both federal and state taxes. Federal taxes include excise taxes of 18.3 cents per gallon on gasoline and 24.3 cents per gallon on diesel fuel, plus a "leaking underground storage tank" fee of 0.1 cents per gallon on both fuels.

State taxes vary from state to state, and include things like excise taxes, environmental taxes, special taxes, and inspection fees, but they exclude state taxes based on gross or net receipts. State taxes on gasoline range from \$0.0895 per gallon in Alaska to \$0.576 per gallon in Pennsylvania.

Who Owns the Oil

and Gas in the U.S.?

Oil and gas resources in the United States are generally privately owned, not by governments as in some other parts of the world.

The high oil prices have helped U.S. oil companies like ExxonMobil and Chevron post bumper profits.

Oil and gas rights may belong to private landowners, corporations, Native American tribes or federal, state or local governments that own the land that the minerals lie under... [Read More](#)

Read More: [Why can't the US stop soaring oil and gas prices.?](#)

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Medicare Rights Annual Trends Report Outlines Key Challenges Facing People with Medicare

This week, the Medicare Rights Center released our annual helpline trends report, *Medicare Trends and Recommendations: An Analysis of 2020-2021 Call Data from the Medicare Rights Center's National Helpline*. Drawn from our direct experience with beneficiaries and their caregivers, including through our national helpline and online reference tool, the report outlines key challenges facing people with Medicare and recommends ways to improve the program.

In 2020 and 2021, Medicare Rights staff and volunteers addressed nearly 42,000 questions through the helpline while **Medicare Interactive** (MI), our online Medicare reference tool, fielded more than 5.5 million questions. Several key trends stood out, including:

- ◆ Medicare enrollment and affordability challenges, often exacerbated by COVID-19
- ◆ Difficulty appealing Medicare Advantage (MA) and Part D denials
- ◆ Problems accessing and affording prescription drugs
- ◆ The need for a comprehensive Medicare dental benefit

In the coming weeks, we will examine each theme in *Medicare Watch*. We begin with the report's first trend, mitigating COVID-19's impact on Medicare enrollment and affordability.

Medicare Enrollment, Affordability, and COVID-19

In 2020-21, calls related to enrollment and affordability comprised 52% of Medicare Rights' total helpline questions, a 21% increase over 2019. While

enrollment questions are always common, COVID-19 brought a new urgency to the topic.

Callers often needed help due to pandemic-related employment changes such as layoffs, reductions in work, and the termination of employer-sponsored health benefits. All expressed concerns about the immediacy of their coverage during this uncertain time. For some, there was no quick remedy; they had to wait until the next General Enrollment Period to sign up. Although some were eligible for the Part B Special Enrollment Period (SEP), which can allow for more timely enrollments, that application process was uniquely challenging: the closure of Social Security offices and employer human resources departments often meant paperwork and processing delays.

We also saw a pandemic-related increase in the number of individuals seeking assistance with Medicare costs, driven in part by unexpected layoffs and reductions in income. For example, there was an increase in inquiries surrounding the Qualified Medicare Beneficiary (QMB) program, which helps enrollees cover Medicare costs, including Part B premiums and cost-sharing. In 2019, 68% of Medicare Rights' low-income program inquiries and referrals were QMB-related, while 74% were in 2020.

Medicare Improvement Opportunities

While most people new to Medicare are automatically enrolled because they receive Social Security when they



become eligible, a growing number are not. These individuals must actively enroll,

taking into consideration specific timelines, complex Medicare rules, and their existing coverage. Far too many people make honest mistakes when trying to navigate this confusing system. The consequences of such missteps are significant and may include lifetime late enrollment penalties, higher out-of-pocket health care costs, and gaps in coverage and access.

The pandemic increased the likelihood of these experiences as it caused more Medicare-eligible individuals to unexpectedly face urgent, complicated enrollment decisions during a time of great stress and upheaval. Those same disruptions—like job loss, illness, and increased caregiving obligations—also reduced incomes, making Medicare cost assistance and affordability protections ever more critical.

Yet, eligibility rules and administrative systems remain woefully outdated, leaving many who need help paying for Medicare with nowhere to turn. For example, the QMB program has restrictive income and asset limits in most states, leaving many beneficiaries who need help just outside of the eligibility range. At the same time, the lack of an out-of-pocket (OOP) cap in Original Medicare and Part D leaves beneficiaries far too exposed to financial risk. While Medicare Advantage plans have an OOP maximum, the threshold is too high.

The consequences of these two factors can be dire. People who cannot access care, whether

because they do not have coverage or cannot afford to pay for care, are more likely to avoid medical treatment. This can undermine health and financial security by leading to worse outcomes and higher costs in the future.

Policy Recommendations

To improve Medicare enrollment, Medicare Rights strongly supports the BENES 2.0 Act (**S. 3675**). This commonsense, bipartisan bill would require the federal government to notify people approaching Medicare eligibility about basic enrollment rules, which would help prevent costly enrollment errors. In addition, we support better remedies to mistaken delays in Part B enrollment, including through increased use of equitable relief and limits to the amount and/or duration of the Part B late enrollment penalty.

To improve affordability, we support easing access to Medicare's low-income assistance programs by eliminating asset tests, easing income eligibility thresholds, and modernizing burdensome application processes. We also support establishing a standardized, affordable OOP cap across the program, while also addressing the underlying drivers of high and rising health care and prescription drug costs.

Together, these changes would begin to improve the access to and affordability of Medicare coverage and modernize the program for current and future generations.

Read the full report

Limited Drug Importation from Canada Approved

Both the Trump and Biden Administrations have supported importing drugs from Canada, which are generally much less expensive than the same drugs in the U.S.

While it never happened under Trump, the Food and Drug Administration (FDA) has now given approval for pharmacists and drug wholesalers to import

prescription medicines from Canada for up to two years as part of state programs aimed at bringing down drug costs.

In April, the FDA began discussions with five states - Florida, Colorado, Vermont, Maine, and New Mexico - to begin the test program.

According to a report



by *Axios*, a Washington, D.C. news service, "The guidance lays out requirements

for importing drugs from wholesalers licensed by Canadian regulators and for testing and labeling the drugs. It excludes some controlled substances, biological products, and infused drugs."

However, there is skepticism by some that the program will work. Canada has said from the time this idea was first discussed that its market is too small to make a dent on U.S. drug prices, and many drug suppliers there have said they won't participate.

Medicare Rights Joins Calls for Increased Funding for Home and Community-Based Services

Last week, Medicare Rights joined hundreds of national, state, and local organizations **in a letter** urging the U.S. Senate to include robust investments in Medicaid Home and Community-Based Services (HCBS) in the next legislative package. Last year, the U.S. House of Representatives passed a bill that would invest \$150 billion in HCBS, and the letter encourages the Senate to pass the same provisions.

HCBS helps people live safely in their homes and communities. Covered services can include assistance with daily activities, like eating and personal care, as well as help getting out into the community, grocery shopping, and other essential tasks.

In recent years, states have begun spending more on HCBS than institutional care. According to the Kaiser Family Foundation's **report on HCBS enrollment and spending**: "Factors contributing to this trend include beneficiary preferences for HCBS, the fact that states are encouraging HCBS as an alternative to typically more costly institutional care, and states' community integration obligations under the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision. In *Olmstead*, the Supreme Court held that the unjustified institutionalization of people with disabilities is illegal



discrimination and violates the Americans with Disabilities Act." But while HCBS is popular and preferred by recipients, it is also optional for states while institutional care is a mandatory part of Medicaid; this can **lead to waiting lists** for HCBS.

Investment in HCBS is long overdue and vital to provide greater sustainability for states, individuals who rely on HCBS, their family caregivers, and the paid workforce providing these critical services. At Medicare Rights, we know that increasing HCBS investments would improve the lives of beneficiaries and those of the people who provide in-home care, both paid and unpaid,

increasing **the financial security**, quality of life, and well-being of those within the system. And it would have **positive effects on the Medicare program as well**, keeping beneficiaries out of hospitals, the emergency room, and nursing facilities. We continue to urge Congress to pass legislation that invests in HCBS, **expands access to dental, vision, and hearing services**, and **reduces the cost of prescription medicines**. It is not too late to take these steps to increase access to high-quality, affordable care and improve the lives of older adults, people with disabilities, and their families.

Seniors, worried about inflation affecting your retirement? Read this

For retirees on a fixed income, inflation can have a significant influence on their ability to maintain their budget. That's because as inflation rises over time, that fixed income will lose value.

That could mean that retirees need to scale back their spending or even make drastic changes to ensure that they don't run out of money. Inflation spiked 7.5% in January 2022, the highest annual increase in 40 years.

Two-thirds of older Americans are worried that inflation will negatively impact their inflation, **according to a survey by American**

Advisors Group. However, by planning ahead, it is possible to minimize some of the impact of inflation on your nest egg.

What Is Inflation?

Inflation is the rate at which prices of goods and services increase in an economy over a period of time. This can include



daily costs of living including, such as gas for your car, groceries, home expenses, medical care and transportation.

Inflation may occur in specific segments of the economy or across all segments at once.

There are multiple **causes for inflation**, but economists typically recognize that inflation occurs when demand for goods and services exceeds supply. In an expanding economy where

more consumers are spending more money, there tends to be higher demand for products or services which can exceed its supply, putting upward pressure on prices.

When inflation increases, the purchasing power of money, or its value, decreases. This means as the price of things in the economy goes up, the number of units of goods or services consumers can buy goes down... **Read More**

Frayed Relationships Could Leave Elderly Vulnerable to Scammers

Older adults who are lonely or unhappy with their relationships may be more vulnerable to scammers, new research suggests.

The study shows that "the quality of older adults' interpersonal relationships has an impact on their financial vulnerability at a later time," said study co-author Duke Han, a professor of family medicine, neurology, psychology and gerontology at the University of Southern California Keck School of Medicine.

Having **social connections** may help guard against financial abuse, in addition to its other benefits, according to the research.

"This study points to a specific factor -- social functioning -- that

could allow us to predict, and ultimately prevent, vulnerability to financial exploitation before it happens," said co-author Aaron Lim, a postdoctoral fellow in Han's research lab. Both Han and Lim spoke in a school news release.

The **study** included 26 adults, all at least 50 years old with an average age of 65. The researchers evaluated each participant's overall health, mental functioning, depression, anxiety and prior history of financial exploitation.

The team then collected data at two-week intervals for six months, measuring how well the participants' relationships were functioning. They did this by asking how frequently they had



argued with someone, felt rejected, felt lonely, wished their relationships were better and wished they had more friends.

Questions to estimate vulnerability were also included, such as, "How confident are you in making big financial decisions?" and "How often has someone talked you into a decision to spend or donate money that you did not initially want to do?"

"When a person reported a spike in problems within their social circle or increased feelings of loneliness, we were much more likely to see a corresponding spike in their psychological vulnerability to being financially exploited two weeks later," Lim said.

These results may provide insight on how to protect against common scams, from phishing emails to calls in which a scammer pretends to be the recipient's grandchild in urgent need of money.

Lim suggested adult children and grandchildren watch for social upsets in their older loved ones' lives, including the death of a close friend or an argument with a family member, to help protect them during these vulnerable times. Organizations that support seniors can also provide additional opportunities for social connection.

The findings were published recently in the journal ***Aging & Mental Health***.

Burned Out by Covid and 80-Hour Workweeks, Resident Physicians Unionize

In the early weeks of the pandemic, Dr. **Lorenzo González**, then a second-year resident of family medicine at Harbor-UCLA Medical Center, ran on fumes, working as many as 80 hours a week in the ICU. He was constantly petrified that he would catch the covid-19 virus and guilt-ridden for not having enough time to help his ailing father.

In April 2020, his father, a retired landscaper, died of heart and lung failure. González mourned alone. His job as a doctor-in-training put him at high risk of catching the virus, and he didn't want to inadvertently spread it to his family. Financial stress also set in as he confronted steep burial costs.

Now, González is calling for better pay and benefits for residents who work grueling schedules at Los Angeles County's public hospitals for what he said amounts to less than \$18 an hour — while caring for the county's most vulnerable patients.

"They're preying on our altruism," González said of the hospitals. He is now chief

resident of family medicine at Harbor-UCLA and president of the Committee of Interns and Residents, a national union that represents physician trainees and that is part of the Service Employees International Union.

"We need acknowledgment of the sacrifices we've made," he said.

Residents are newly minted physicians who have finished medical school and must spend three to seven years training at established teaching hospitals before they can practice independently. Under the supervision of a teaching physician, residents examine, diagnose, and treat patients. Some seek additional training in medical specialties as "fellows."

These trainees are banding together in California and other states to demand higher wages and better benefits and working conditions amid intensifying burnout during the pandemic. They join nurses, nursing assistants, and other health care workers who are unionizing and threatening to strike as **staffing shortages**, the **rising cost of living**, and inconsistent supplies



of **personal protective equipment** and **covid vaccines** have pushed them to the brink.

More than 1,300 unionized residents and other trainees at three L.A. County public hospitals, including Harbor-UCLA, will vote May 30 on whether to strike for a bump in their salaries and housing stipends, after a monthslong negotiation deadlock with the county. Since March, residents at **Stanford Health Care**, **Keck School of Medicine at the University of Southern California**, and the **University of Vermont Medical Center** have unionized.

"Residents were always working crazy hours, then the stress of the pandemic hit them really hard," said **John August**, a director at Cornell University's School of Industrial and Labor Relations.

The Association of American Medical Colleges, a group that represents teaching hospitals and medical schools, did not address the unionization trend among residents directly, but the organization's chief health care officer, Dr. Janis Orlowski, said

through a spokesperson that a residency is a working apprenticeship and that a resident's primary role is to be trained.

Residents are paid as trainees while they are studying, training, and working, Orlowski said, and the association works to ensure that they receive effective training and support.

David Simon, a spokesperson for the California Hospital Association, declined to comment. But he forwarded a **study** published in JAMA Network Open in September showing that surgery residents in unionized programs did not report lower rates of burnout than those in nonunionized programs.

So far, none of the new chapters have negotiated their first contracts, the national union said. But some of the longer-standing ones have won improvements in **pay, benefits, and working conditions**. Last year, a resident union at the **University of California-Davis** secured housing subsidies and paid parental leave through its first contract. ... **Read More**

Why Seniors Should Hope for a Smaller Social Security Raise in 2023



It's hardly a secret that these days inflation is wreaking havoc on a lot of people's budgets. With everything from gas to utilities to apparel to groceries costing more, many consumers are struggling to make ends meet.

Seniors are in a similar boat. Many retirees who get the bulk of their income from **Social Security** are having a hard time keeping up with living expenses, and that's coming on the heels of the program's most generous cost-of-living adjustment (COLA) in decade

In fact, recent estimates indicate that seniors on Social Security may be in line for an 8.6% COLA in 2023. Of course, it's too soon to say with certainty what next year's COLA will look like because that number is based on inflation data

from the third quarter of the year, and, well, we're just not there yet.

But either way, it seems likely that seniors on Social Security will see their benefits rise substantially in 2023. Whether that's a good thing, though, is up for debate.

Why seniors shouldn't hope for a giant raise

There are two types of raises employers commonly give out. One is a cost-of-living raise, and the other is a merit raise. Merit raises are based on performance and tend to be the more generous of the two. After all, the point of a cost-of-living raise is to simply increase wages just enough to make it possible for workers to keep up with rising expenses, whereas a merit raise might actually help a given employee get ahead financially.

In the context of Social Security, there's no such thing as



a merit-based COLA. Rather, COLAs are based on inflation data, and their purpose is to help seniors retain their buying power as living expenses go up

But when COLAs rise substantially, it's only because living costs are doing the same. And often, even when Social Security gets a nice COLA, it's not really enough to help seniors stay afloat.

That's why Social Security recipients really shouldn't want a large COLA for 2023. If that 8.6% raise comes to be, chances are, rising living costs will make it so that seniors are still behind financially even once their benefits go up.

Part of the reason for that is the way COLAs are calculated. Simply put, COLAs are based on data from the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W).

But the CPI-W isn't really reflective of the costs seniors commonly face.

For years, senior advocates have proposed using a senior-specific index -- the CPI-E, or Consumer Price Index for the Elderly -- to calculate COLAs and make them more equitable. But that idea has yet to gain traction to the point where it becomes reality.

Seniors have long been losing buying power

Seniors on Social Security have been **steadily losing buyer power** since 2000. And a large COLA for 2023 won't necessarily do much, or anything, to address that issue. That's why hoping for a large COLA really doesn't pay. Instead, what seniors should hope for is that lawmakers change the way those raises are calculated to begin with.

In the hands of Republicans, Social Security is at serious risk

The Trump administration launched a major attack on Social Security, putting some older adults and people with disabilities at extreme risk. **The Washington Post** reports on how attorneys at Social Security imposed excessive fines on scores of Social Security recipients who received benefits inappropriately. Now, in an op-ed for **The Miami Herald**, Max Richtman, the head of the National Committee to Protect Social Security and Medicare, writes about how Senator Rick Scott of Florida wants to privatize Social Security, effectively undermining the ability of tens of millions of vulnerable Americans to afford basic necessities.

Because Social Security is a national treasure, beloved by Republicans and Democrats alike, Senator Scott is not outright speaking about doing

away with Social Security or Medicare. But, Scott's proposal to require Congressional reauthorization of federal programs every five years would allow for just that. He would require Congress to re-enact Medicare and Social Security every five years to continue them. Since Senator Scott now chairs the National Republican Senatorial Committee, his proposals are likely to have a lot of influence in Congress.

Some years ago, Senator Scott proposed privatizing Social Security. If Congress privatized Social Security, it would put people's benefits at serious risk, open to the vicissitudes of the market. Richtman projects that as many as one in three older adults could be impoverished. Moreover, without Social Security and Medicare, local governments and businesses



would lose significant revenue.

Social Security and Medicare are **earned benefits**. Voters should beware of any proposals that would remove Social Security's critical guarantees, cut their benefits, or otherwise make it harder to be assured of a regular income stream and health insurance.

So far, Republicans have not been successful at privatizing or otherwise cutting Social Security. But, here's a taste of what the Trump administration did to undermine Social Security.

Trump's Social Security agency imposed excessively harsh penalties on vulnerable older adults as part of its anti-fraud program. The Biden administration's acting Social Security commissioner is now investigating those acts. And, Democrats in Congress are

seeking an investigation into this possible abuse of authority. They want to prevent future behavior of this sort and help the people who were harshly penalized.

What did the Trump administration do exactly? It imposed huge fines on scores of poor older adults and people with disabilities who received Social Security benefits improperly. The penalties appear to be an abuse of the administration's authority.

The attorneys working in the Social Security Administration in 2018, when Trump was president, did not follow standard protocols for recouping funds inappropriately paid to Social Security enrollees. In determining penalties for fraud, they should have looked at individuals' income. Instead, they charged these individuals more than twice what they inappropriately received in Social Security benefits.

2023 Medicare Part B Premiums to Reflect Lower-Than-Expected spending on Alzheimer's Drug

When Medicare Part B Premiums skyrocketed at the beginning of this year TSCL and other seniors' organizations protested that the increase was way too much and that it would seriously harm seniors with lower incomes.

The huge increase came about because of the anticipation that Medicare would cover a new Alzheimer's drug called Aduhelm that was extremely expensive.

We covered that story earlier this year but suffice it to say that

the drug was, and is, very controversial and had received a contentious approval from the FDA.

Ultimately, Medicare decided that it would cover the cost of the drug only in limited circumstances and as a result, that amount of money Medicare had anticipated spending on the drug far exceeded the actual amount being spent.

Earlier this year Health and Human Services Secretary Xavier Bacerra told Medicare to consider



lowering the Part B premium this year.

However, it was determined that the legal and administrative hurdles to do so were too high so it was announced last week that the overpayments this year will be factored into the Part B premiums next year.

Medicare **officials calculated** that if the current situation around Aduhelm had been factored into at the beginning of the year, premiums

would have increased 8% instead of the actual increase of 14.5%.

The calculation means that older adults paying average premiums for outpatient services will pay roughly an extra \$116 this year due to the impacts of a single, expensive drug.

It is possible seniors will not see a decrease in premiums next year, but instead premiums may hold steady or increase at a slower rate than they otherwise would have, Medicare officials said.

The Average Retiree Falls \$2,538 Short of the Max Social Security Benefit. Here's Why

In 2022, the maximum monthly Social Security benefit is \$4,194. This would provide a generous \$50,328 in retirement income for those who receive it.

Most people won't come anywhere close to maxing out their benefits, though. In fact, the average monthly retirement check is just \$1,657, which means the typical senior gets \$2,538 per month less than the biggest possible check. So, the big questions are, why do so many people fall so short, and will you get anywhere close to the max benefit?

Here's why most seniors don't come close to maxing out their Social Security checks

The average **Social Security** benefit is far smaller than the maximum benefit because retirement income is based on average wages over the course of your career.

See, Social Security benefits are meant to replace around 40% of pre-retirement income for most workers and less for the wealthiest employees because the benefits formula is progressive. The Social Security



Administration:

- ◆ Collects data on wages earned each year.
- ◆ Adjusts the wages for inflation.
- ◆ Applies a formula that gives retirees benefits equaling a percentage of their average wages over their 35 highest-earning years.

This is how the standard benefit is calculated. Then, this standard benefit is adjusted based on how old a person is when they start getting Social Security checks for the first time.

There is, however, a maximum wage that counts each year when your Social Security earnings record is created. If you earn above the maximum wage, any extra dollar of income doesn't have Social Security taxes taken out of it, and it doesn't count when your average wage or benefits are determined. The maximum average wage, called the wage base limit, exists to prevent people who earn millions a year from getting huge Social Security benefits....**Read More**

RI ARA HealthLink Wellness News

Betting on 'Golden Age' of Colonoscopies, Private Equity Invests in Gastro Docs

Mariel needed a new gastroenterologist.

Having just moved back to San Antonio, the 30-something searched for a doctor to manage her Crohn's disease, an inflammatory bowel condition that is successfully managed with medications and lifelong monitoring — including regular colonoscopies.

Mariel booked an appointment and learned she would be on the hook for a \$1,100 colonoscopy — about three times what she had paid for the same test in a different state. Almost three-quarters of the bill would be a

“facility fee” for the in-office procedure at a colonoscopy clinic. (KHN agreed not to disclose Mariel's last name because she is concerned speaking out might affect her doctor's willingness to manage her medical condition.) Preventive colonoscopies are covered without patient cost sharing under the Affordable Care Act, but colonoscopies for patients with existing conditions, like Mariel, are not. **A 2019 study found** patients with inflammatory bowel diseases, including Crohn's disease, incur



about \$23,000 in health care costs a year. Medication treatments alone can cost tens of thousands of dollars annually.

But shopping around proved frustrating. Although San Antonio has plenty of gastroenterology offices, **more than two dozen of them** are controlled by the same private equity-backed group. In 2018, one of the nation's largest independent gastroenterology practices, Texas Digestive Disease Consultants, **announced a**

deal with the Chicago-based private equity firm **Waud Capital** to expand by offering management services to other physicians. At the time, the Dallas-based practice had 110 locations, mostly in Texas — including San Antonio. Today its management group, **the GI Alliance**, operates in a dozen states with more than 400 locations — and is **growing fast**.

With market dominance comes the business opportunity to set and maintain high prices. “It's pretty much the only game in town,” Mariel said... **Read More**

U.S. Making It Easier to Access COVID Treatment Paxlovid

Getting ahold of the COVID-19 antiviral treatment Paxlovid could get easier, the White House announced on Thursday.

“We want to make Paxlovid as widely available across the entire country, so that if you do end up getting a breakthrough infection, you're still protected against serious illness,” said White House Covid-19 Coordinator Dr. Ashish Jha.

Paxlovid and vaccines are credited with a declining rate of deaths from COVID, despite an

infection rate that has quadrupled since late March. Currently there are 105,000 confirmed infections in the U.S. daily, a number that is likely undercounting actual cases because of unreported positives on at-home test kits. Jha estimated the true case numbers to be around 200,000 or more daily.

The first test-to-treat site backed by the federal government is opening in Rhode



Island and more are scheduled to open in the coming weeks in Massachusetts and New York City,

according to the *Associated Press*.

Those sites will provide patients who test positive with immediate access to the drug. The U.S. is also sending authorized federal prescribers to several Minnesota-run testing sites next week, so that they, too, can test-to-treat.

Meanwhile, federal regulators have sent more clear guidance to physicians, so that they can more effectively determine how to manage Paxlovid's interactions with other drugs a patient may already be taking.

While cases of COVID-19 may be surging, this is the first time during the pandemic that infections and death rates have not trended together... **Read More**

High-Tech Pacemaker Reads Body Signals, Dissolves After Use

Researchers are another step closer to bringing heart patients a temporary "smart" pacemaker that simply dissolves once it's no longer needed.

Pacemakers are devices that are implanted to help control certain abnormal heart rhythms, by sending electrical pulses to the heart muscle. They are normally permanent, but in some cases patients only need temporary heart pacing for a matter of days.

Last year, researchers at Northwestern University **reported initial success** in developing an alternative to the temporary pacemakers used today: a wireless, "dissolving" pacemaker made of materials that biodegrade over a few weeks.

At that point, the focus was on the pacemaker itself, said researcher John Rogers, who is leading the development of the technology.

The pacemaker is a thin, flexible device composed of an encapsulating layer that contains electrodes. The bottom of each electrode is exposed and adheres to the heart's surface.

Now the researchers have added **components that allow the pacemaker to be self-contained**: a network of thin, wireless sensors and a control unit worn on the skin. They work together to monitor the heart's electrical activity and other body processes, such as breathing rate, and control the heart's pacing.



The system is also designed to pick up problems like a pacemaker malfunction, then alert the patient. Meanwhile, all of

this vital information can be streamed to a smart device, allowing doctors to check on patients remotely.

That's in contrast to the way **temporary heart pacing** works today, Rogers explained.

Traditional permanent pacemakers consist of a battery-powered pulse generator that is implanted under the skin of the chest and connected to the heart via wires called leads.

When patients need heart pacing for only a short time, doctors use an external pulse generator, rather than implanting

one. But patients still need electrodes sewn onto the heart, equipped with leads that exit the chest and connect to the generator.

That system works well, Rogers said, but there are small risks -- such as a lead becoming dislodged or causing an infection. Plus, it keeps patients tethered to hospital equipment.

The wireless system could allow them to move around, and perhaps recover at home, according to Rogers.

"We envision a future where patients are released earlier from the hospital," he said.

Much work remains first, however. The technology has so far been tested in animals and on human heart tissue in the lab -- not yet in patients... **Read More**

Her 2-Year-Old Niece Noticed Something Wrong During a Video Chat. It Was a Mini-Stroke.

Exhausted at the end of a workday, Dawn Turnage plopped into a comfortable chair on her patio to soak up some sun before going to bed early.

Her phone buzzed. It was a FaceTime call from her sister, April Washington.

Washington was calling because her 2-year-old daughter, Naomi, wanted to talk to "Aunty Dawn" – or "TeTe," as the youngster calls her.

As much as Turnage enjoyed chatting with her niece, the timing was terrible. She had felt so wiped out on her drive home from work that she'd called a friend to make sure she wouldn't fall asleep.

For more than a week, Turnage had been dealing with extreme exhaustion and nonstop headaches. During the day, she'd chug sodas, hoping they would perk her up and diminish the pain in her head. They didn't.

She also had been dropping things, and her vision had worsened. Sometimes her computer screen was blurry or too dark. She ordered a glare guard and planned to have her vision checked.

Turnage blamed her problems on a stressful schedule. At the time, she had two jobs, one during the week with the housing authority in Columbus,



Ohio, and on the weekend with the parks and recreation department in Westerville. (She has since moved to

Youngstown.) The stress led her to overeat, and she'd gained weight – something else she blamed for her fatigue. She knew the added weight wasn't helping control the high blood pressure she'd been diagnosed with a year before.

This week, though, her mantra was: "I have to push through. I have to push through."

So surely she could handle a few minutes chatting with her niece.

"TeTe, why is your face

crooked?" Naomi asked.

"What do you mean?" Turnage asked.

Naomi asked again, pointing to the screen.

Washington, a physician assistant, heard her daughter and went to see for herself. Sure enough, the right side of Turnage's mouth was turned down, making her face look lopsided. Factoring in Turnage's high blood pressure and other issues, Washington feared her sister was having a stroke. Her husband called their other sister, Damika Withers, who lived near Turnage, to help....[Read More](#)

Vitamin D Supplements Won't Help Prevent Diabetes

(HealthDay News) -- While vitamin D may have other benefits, preventing type 2 diabetes in high-risk adults does not appear to be one of them.

A new [Japanese trial](#) found no significant difference among study participants who used a vitamin supplement and those who took a placebo.

"Although treatment with eldcalcitol [an active form of vitamin D used to treat osteoporosis in Japan] did not significantly reduce the incidence of diabetes among people with prediabetes, the results suggested the potential for a beneficial effect of eldcalcitol on people with insufficient insulin secretion,"

the researchers said. For the study, Tetsuya Kawahara from the University of Occupational and Environmental Health in Kitakyushu, Japan, and colleagues assessed whether [eldcalcitol](#) could reduce [type 2 diabetes](#) risk in 630 individuals with impaired glucose tolerance. They were compared to 626 participants who received a placebo.

The individuals were recruited from three hospitals in Japan between 2013 and 2019. With an average age of 61, about 46% were women and 59% had a family history of type 2 diabetes. They were tested for diabetes every three months over three



years. The upshot: Researchers found no meaningful differences between the groups.

About 12.5% of the eldcalcitol group developed diabetes compared to 14% of the placebo group. Blood sugar levels returned to normal in about 23% of the eldcalcitol group and 20% of the others, the findings showed.

The report was published online May 25 in the [BMJ](#). After adjusting for other influential factors, the investigators did find that eldcalcitol may prevent type 2 diabetes in some [prediabetic patients](#). The finding is unclear

and more research is needed, the study authors noted in a journal news release.

The study also found a significant increase in both lower back and hip bone mineral densities in individuals who took [vitamin D](#).

Not clear is whether the dose the team chose was the appropriate one for preventing diabetes or whether the results could be applied to all ethnic groups.

About 480 million people worldwide have type 2 diabetes, and the number is expected to reach 700 million by 2045. About a half-billion people have impaired glucose tolerance or prediabetes....[Read More](#)

Lidocaine Infusions May Ease Tough-to-Treat Migraines

A multi-day intravenous infusion of the local anesthetic lidocaine appears to offer some pain relief to patients battling otherwise untreatable daily migraines.

That's the takeaway from a [new study](#) that examined the effectiveness of lidocaine infusion treatment -- a much debated therapy that requires a hospital stay -- as a means to address "refractory chronic migraines" (rCM).

A diagnosis of rCM means patients have suffered at least eight [migraines](#) a month for a minimum of six months without responding to standard

treatment and prevention strategies.

Those first-line treatments include standard pain killers and beta blockers; corticosteroids; antidepressants; anti-convulsants; calcium blockers; Botox injections, and/or noninvasive electrical stimulation.

"Lidocaine is a local anesthetic -- a numbing medicine -- but also reduces inflammation in studies," said study author Dr. Eric Schwenk, director of orthopedic anesthesia at the Sidney Kimmel Medical College at Thomas Jefferson



University in Philadelphia. The findings suggest that chronic migraine patients experienced pain relief for about a month after

hospital treatment with IV medications including lidocaine, he said.

Between 1% and 2% of the population get the chronic [migraine headaches](#).

The researchers looked at hospital records for just over 600 patients, most of them women (average age: 46).

All had been admitted to a Philadelphia hospital between 2017 and 2020 for lidocaine

infusion treatment, typically for five to seven days.

Prior to treatment, patients had experienced moderate to severe headaches for about 27 out of every 30 days. Each migraine attack was at least four hours long.

Upon admission, lidocaine infusions were initially started at 1 mg per minute, then increased up to 4 mg per minute. (Other IV medications were administered at the same time, including ketorolac -- a nonsteroidal anti-inflammatory drug -- and the corticosteroid methylprednisolone.)...[Read More](#)

Not Just 'Gluten-Sensitive': What People With Celiac Disease Want You to Know

Hayden Bishop can't help but feel terribly self-conscious when she goes out to eat with friends and family.

Bishop has celiac disease, a serious autoimmune disorder in which even the least exposure to **gluten** creates an antibody response that damages the small intestine, resulting in debilitating symptoms.

Unfortunately, the gluten-free diet fad has led some folks to become quickly annoyed at apparently finicky eaters or fussy restaurant patrons -- and a new Harris Poll has found that not many Americans understand that for people with celiac disease, gluten-free is a medical need rather than a dietary option.

Even minute exposure to gluten can cause terrible rashes to erupt on Bishop's body, as well as nausea, brain fog, migraines, and constant constipation and diarrhea.

"We always talk about how we feel like we're a burden just to eat at a restaurant with friends or with work or traveling," Bishop, 29, of Los

Angeles, said of celiac disease patients. "You have to ask all these questions, and a lot of time people eyeroll or they just flat out tell you, 'Don't eat out.'"

"I don't think people understand what that really means," Bishop continued. "You have to eat. A lot of times with work and social events, you've got to travel and you've got to be out away from your house for an entire day. And when you can't even buy a rotisserie chicken at Whole Foods because it's cooked on shared equipment and has wheat in it, what do you eat?"

The new poll, conducted on behalf of the nonprofit organization Beyond Celiac,



found that only half of Americans know anything about celiac disease.

No medication to treat celiac

Only a quarter (24%) understand that it's an autoimmune disease. Just over half (53%) understand that there's no medication available to treat celiac disease, and that the only way to control it is to adhere to a 100% gluten-free diet.

That means no foods that have been exposed to any amount of wheat, barley or rye, the grains that contain the protein gluten.

Celiac disease goes beyond gluten sensitivity. People who are sensitive to gluten might have similar symptoms, but they don't endure the sort of intestinal damage that happens with celiac disease.

"There is this notion that most

people who are asking for gluten-free foods is because of some kind of a diet fad or something like that," said Dr. Alan Ehrlich, a board member of Beyond Celiac and an associate professor of family medicine with the University of Massachusetts Medical School.

Ehrlich also has celiac disease, suffering minor reactions once or twice a month and a fairly severe reaction once every couple of months.

"Often, when I go to a restaurant, they will ask me, 'Is this a preference or an allergy?' And I'll say allergy because they treat it differently," Ehrlich said. "But, you know, ideally they would just treat everybody who wants to have gluten-free food pretty much the same way, you know, to be strict in terms of avoiding cross-contamination."...[Read More](#)

Got Long Covid? Medical Expertise Is Vital, and Seniors Should Prepare to Go Slow

Older adults who have survived covid-19 are more likely than younger patients to have persistent symptoms such as fatigue, breathlessness, muscle aches, heart palpitations, headaches, joint pain, and difficulty with memory and concentration — problems linked to **long covid**.

But it can be hard to distinguish lingering aftereffects of covid from conditions common in older adults such as lung disease, heart disease, and mild cognitive impairment. There are no diagnostic tests or recommended treatments for long covid, and the biological mechanisms that underlie its effects remain poorly understood. "Identifying long covid in older adults with other medical conditions is tricky," said **Dr. Nathan Erdmann**, an assistant professor of infectious diseases at the University of Alabama-Birmingham's school of medicine. Failing to do so means older covid survivors **might not receive appropriate care**.

What should older adults do if they don't feel well weeks after becoming ill with the virus? I asked a dozen experts for advice.

Here's what they suggested.

Seek medical attention. "If an older person or their caregiver is noticing that it's been a month or two since covid and something isn't right — they've lost a lot of weight or they're extremely weak or forgetful — it's worth going in for an evaluation," said **Dr. Liron Sinvani**, director of the geriatric hospitalist service at Northwell Health, a large health system in New York.

But be forewarned: Many primary care physicians are at a loss as to how to identify and manage long covid. If you're not getting much help from your doctor, consider getting a referral to a specialist who sees long covid patients or a long covid clinic. Also, be prepared to be patient: Waits for appointments are lengthy.

At least 66 hospitals or health systems have created **interdisciplinary clinics**, according to Becker's Hospital Review, an industry publication. For people who don't live near one of those, virtual consultations are often available.



For specialist referrals, ask whether the physician has experience with long covid patients.

Also, **more than 80 medical centers in more than 30 states** are enrolling patients in a four-year, \$1.15 billion study of long covid that is being funded by the National Institutes of Health and is known as RECOVER (Researching COVID to Enhance Recovery). Older adults who choose to participate will receive ongoing medical attention.

Pursue comprehensive care. At the University of Southern California's, physicians start by making sure that any underlying medical conditions that older patients have — for instance, heart failure or chronic obstructive pulmonary disease — are well controlled. Also, they check for new conditions that may have surfaced after a covid infection.

If preexisting and new conditions are properly managed and further tests come back negative, "there is probably an element of long covid," said **Dr. Caitlin McAuley**, one of two physicians at the Keck School of

Medicine clinic.

At that point, the focus becomes helping older adults regain the ability to manage daily tasks such as showering, dressing, moving around the house, and shopping. Typically, several months of physical therapy, occupational therapy, or cognitive rehabilitation are prescribed.

Dr. Erica Spatz, an associate professor of cardiology at the Yale School of Medicine, looks for evidence of organ damage, such as changes in the heart muscle, in older patients. If that's detected, there are well-established treatments that can be tried. "The older a person is, the more likely we are to find organ injury," Spatz said.

At the Shirley Ryan AbilityLab in Chicago, a rehabilitation hospital, experts have discovered that a significant number of patients with breathing problems have atrophy in the diaphragm, a muscle that's essential to breathing, said **Dr. Colin Franz**, a physician-scientist. Once inflammation is under control, breathing exercises help patients build back the muscle, he said...[Read More](#)

Dangerous Tanning Is on the Rise, Suntan Myths Persist: Poll

(HealthDay News) -- While most people probably know it's not safe to get a sunburn, many may not realize that tanning also increases the risk of skin cancer and premature skin aging. A new survey of more than 1,000 U.S. adults by the American Academy of Dermatology (AAD) found a sharp rise in both **tanning** and number of **sunburns** last year, compared to 2020. And as the summer season begins, the AAD is encouraging people to **protect themselves**.

"A tan is your body's response to injury," said Dr. Elizabeth Bahar Houshmand, a Dallas-based dermatologist.

"When you tan, you are intentionally putting your health at risk," she said in an academy news release. "If you want to look tan, consider using a self-tanning product, but continue to use

sunscreen with it."

The AAD recommends seeking shade, especially between 10 a.m. and 2 p.m. when the sun's rays are strongest. Seek shade if your shadow appears shorter than you are, Houshmand advised.

Wear sun-protective clothing, such as a lightweight long-sleeved shirt and pants, a wide-brimmed hat and sunglasses with UV protection. Clothes with an ultraviolet protection factor (UPF) on the label provide more protection.

Apply a broad-spectrum, water-resistant sunscreen with an SPF of 30 or higher to all exposed skin. Broad-spectrum sunscreen provides protection from both UVA and UVB rays.

About 1 in 5 Americans will develop skin cancer in their lifetime, and 197,700 new cases of melanoma, the deadliest form



of skin cancer, are expected to be diagnosed in the United States this year, according to AAD. In this recent survey, 63% of respondents reported

getting a suntan last year, up from 54% in 2020. About 33% were sunburned in 2021, compared to 25% in 2020.

One blistering sunburn during childhood or adolescence can nearly double a person's risk of developing melanoma.

About 28% of sunburned survey respondents said their burn was bad enough that their clothes felt uncomfortable. Top places for getting burns were the face, arms, shoulders and neck.

And nearly half of respondents believed one or more tanning myths, the survey found. About 22% wrongly said a base tan will prevent a sunburn and 18% said it would decrease the skin cancer

risk. One in 5 said they thought tanning was safe as long as they didn't burn and 13% thought tanning was healthy.

About 53% said people with tanned skin look healthier.

About 39% of respondents were unaware of one or more sunburn risks. Among those: that it is possible to get sunburned on a cloudy day or through a car window; that people with dark skin can burn, and that sunburns increase skin cancer risk.

"This increase in sunburns is very concerning," Houshmand said. "Both tanning and sunburning damage your skin. The more you tan and sunburn, the more this damage builds up over time, increasing your risk of premature skin aging, including age spots, sagging and wrinkling, and skin cancer."

Type 2 Diabetes Speeds Aging in the Brain

Type 2 diabetes is linked to memory and thinking problems, and a new study suggests it's because the disease makes the brain age faster.

Looking at data from 20,000 middle-aged and older adults, **researchers found** that -- consistent with **past studies** -- people with type 2 diabetes generally did worse on tests of memory and thinking skills than those without diabetes.

Beyond that, MRI scans

revealed differences in brain regions related to those skills: People with diabetes had more tissue shrinkage -- akin to a 26% acceleration in normal brain aging.

It's well-known that brain tissue gradually shrinks as we age, with certain areas withering more and faster than others.

The new findings show that people with diabetes have atrophy in the same brain areas as other people their age, said senior



researcher Lilianne Mujica-Parodi. But that aging effect happens faster.

"It's like losing 10 years,"

said Mujica-Parodi, a professor at Stony Brook University School of Medicine in New York.

The findings -- published May 24 in the medical journal *eLife* -- add to a body of research on **diabetes and brain health**. That includes many studies linking diabetes to a faster decline in mental sharpness

during older age, and a higher risk of dementia.

In **type 2 diabetes**, the body cannot properly use the hormone insulin, which allows body cells to consume glucose (sugar) for energy. As a result, blood sugar levels are chronically high -- which can damage blood vessels and nerves throughout the body. People with the disease are at risk of such serious complications as heart disease, kidney disease and stroke. **Read More**

Monitoring Blood Pressure at Home Can Be Tricky. Here's How to Do It Right.

Knowing your blood pressure is a basic part of good health. But monitoring it at home can get complicated.

"It sounds easy -- you buy a device, smack the cuff on your upper arm and push a button, right? It's not so easy," said Dr. Daichi Shimbo, co-director of the Columbia Hypertension Center in New York.

High blood pressure is a common condition in adults that's associated with "really bad consequences," such as heart attacks, strokes and dementia, Shimbo said. To diagnose and track it, doctors often ask people to check it at home. But even professionals can get tripped up on the proper procedures for

home blood pressure monitoring.

Here's help with some of the basics.

What exactly do those numbers mean?

The top number in a reading measures systolic pressure, the force against artery walls when the heart beats. The bottom number, diastolic pressure, measures that same force between beats.

Dr. Karen Margolis, senior research investigator at HealthPartners Institute in Minneapolis, puts it this way: "The top number is when your heart is squeezing. The bottom number is when your heart is relaxing." If you're using a



stethoscope, where a heartbeat sounds like "lub-dub," the "lub" is the squeeze, and the "dub" is the relaxing.

The original measuring devices used mercury-filled tubes, delineated in millimeters. So blood pressure is expressed in millimeters of mercury.

Modern digital monitors don't use mercury, but the principle is the same: A cuff around your arm cuts off blood flow in the artery inside your elbow. As the cuff is loosened, the "whoosh" of blood starting to flow again provides the systolic reading. When the noise stops, that's the diastolic number.

The American Heart Association and American

College of Cardiology recognize five categories of blood pressure in adults. A reading of less than 120/80 is considered normal.

Where do I start?

Margolis and Shimbo agreed that proper self-monitoring of blood pressure starts with a validated device. Both co-authored a 2020 policy statement from the AHA and American Medical Association about home blood pressure monitoring.

Many devices tout Food and Drug Administration clearance. But the FDA does not validate the accuracy of devices it clears to be sold on the market, Shimbo said....**Read More**

Diabetes Drug Metformin Disappoints in New Breast Cancer Treatment Trial

(HealthDay News) -- A landmark clinical trial finds that a hoped-for treatment for early-stage breast cancer isn't the answer in most cases.

The **international trial** tested the inexpensive diabetes medication **metformin** and found that it did not stop or prevent the spread of the most common types of breast cancer, despite hope that it might do so.

"The results tell us that metformin is not effective against the most common types of breast cancer and any off-label use for this drug for the treatment of these common types of breast cancer should be stopped," said study leader Dr. Pamela Goodwin. She is a medical oncologist and clinician scientist at Sinai Health Lunenfeld-

Tanenbaum Research Institute in Toronto.

The randomized, double-blind **trial** was the largest of its kind to date, tracking more than 3,600 breast cancer patients from Canada, the United States, Switzerland and the United Kingdom.

Previous observational and preclinical studies had suggested metformin might help reduce development of some cancers and increase survival.

Researchers had theorized that the drug, which is used to treat diabetes or high blood sugar, might improve patient metabolism and insulin levels, leading to reduced growth of cancer cells, or that it might affect cancer cells directly.



In the study, trial patients were treated with two pills a day. Some received metformin and others received an inactive placebo. However, adding

this drug to standard breast cancer treatments did not improve outcomes for either hormone receptor-positive or -negative cancers, the findings showed.

The researchers did find one positive outcome in a less common but aggressive type of breast cancer called **HER2-positive breast cancer**. The investigators found evidence that taking metformin for five years might lead to a reduction in deaths in these patients. About 20% of all breast cancers are of this type.

A potential next step will be to conduct a clinical trial of metformin in patients with HER2-positive breast cancer.

"Metformin is not beneficial for use in most common breast cancers, but in the cases of HER2-positive breast cancer, our findings suggest it may be beneficial," Goodwin said in a news release from the Lunenfeld-Tanenbaum Research Institute.

"These results need to be replicated in future research before metformin is used as a breast cancer treatment, however, it could provide an additional treatment option for HER2-positive breast cancer."

The findings were published May 24 in the ***Journal of the American Medical Association***... [Read More](#)

Prostate Cancer May Raise Risk for Blood Clots

(HealthDay News) -- Doctors need to be aware that prostate cancer raises a man's risk of serious and potentially deadly blood clots by about 50%, researchers say.

All cancer patients are at increased risk for **venous thromboembolism (VTE)**, a dangerous but treatable blood clot in the veins that is a leading cause of death in cancer patients.

Prostate cancer is the most commonly diagnosed cancer in middle-aged and older men. Previous research has suggested that men with prostate cancer are two to three times more likely to develop VTE than those without cancer, the researchers noted in their study, published May 24 in

the online journal ***BMJ Open***.

In light of significant improvements in prostate cancer care over the last decade, researchers wanted to reassess the risk of VTE in prostate cancer patients.

The greatest risk of VTE is in the first six months after prostate cancer diagnosis, they discovered.

"Physicians treating men with prostate cancer should be aware of the marked increase in VTE risk in these men, particularly in the first six months following cancer diagnosis, to help ensure timely VTE diagnosis," Yanina Lenz, of Bayer AG in Berlin, Germany, and colleagues wrote.



The investigators analyzed 2007-2017 data from Sweden to assess VTE rates among more than 92,000 men with prostate cancer and a comparison group of more than 466,000 men without the disease.

They found that 3.2% of the prostate cancer patients developed VTE within about five years after their cancer diagnosis, compared with 2.1% of men in the comparison group.

That means that about seven in every 1,000 men with prostate cancer would develop a VTE each year, compared with around four of every 1,000 men without prostate cancer.

After accounting for other

factors that could affect VTE risk -- such as heart disease and income -- the researchers concluded that prostate cancer patients had a 50% higher risk of VTE in the five years after their cancer diagnosis than those of the same age without prostate cancer.

"The magnitude of increased VTE risk among men with prostate cancer seen in our study is lower than that seen for other cancer types as seen in previous studies, and is likely attributable to the high proportion of men with localized disease and at low risk of cancer progression," Lenz and colleagues said in a journal news release.

Protein helps older adults maintain muscle mass

Older adults should work to ensure they maintain muscle mass. While people can lose muscle mass beginning in their 30's, people in their 60's lose muscle mass more rapidly. Anahad O'Connor writes for the ***New York Times*** about the value of protein and resistance exercises to help older adults maintain muscle mass.

Loss of muscle mass as you age--sarcopenia--can jeopardize your health. It increases your risk of falling, breaking bones and becoming physically disabled. That, in turn, can mean

loss of independence and a poor quality of life.

Protein can be a solution to retaining muscle mass as you age. There are plenty of foods you can eat to ensure you have enough protein in your diet, including avocados, nuts, milk, yogurt, eggs, lentils, hummus and fish.

Combining protein with resistance exercises, such as squats, lunges, pushups and weight-lifting, is the best way to go for your muscles. That will lessen the likelihood of your



getting sarcopenia. Walking and other aerobic exercise are also helpful.

How much protein do you need? Some experts recommend eating 1 to 1.2 grams of protein daily for every 2.2 pounds you weigh. That's about 60-70 grams of protein a day if you weigh 133 pounds. But, other factors contribute to the calculation, including exercise and physical health.

How should you include protein in your diet? It's best to consume foods with protein

throughout the day rather than in bulk. That way your body better absorbs the protein

Are protein supplements advisable? You should not need to take protein supplements if you eat a healthy diet with protein-rich foods. If that's not possible, whey protein is recommended by some as a good protein supplement. It has lots of amino acids and can be easily absorbed. But, the data is not clear that it has any effect on muscle mass.