



The Concierge Medical Practices of

Lenholt & Schlossberg

A New Direction in Health Care

News

VOLUME 1 • ISSUE NO. 3

A NEW DIRECTION IN HEALTH CARE



Line up for your flu shot

Dear _____:

Welcome to the latest edition of our practice newsletter. We hope you have had a refreshing summer and are looking forward to the coming holiday season, Southwest Florida style.

The holidays also herald the coming flu season, which peaks through the winter. We will be providing complimentary flu vaccinations to our members, and hope to have our supply of vaccine by the time you receive this newsletter. The vaccine is recommended for most patients greater than 50 years of age, and for many younger patients who have chronic medical conditions or wish to avoid the flu. Feel free to contact your physician if you are not sure whether the vaccine is right for you. You can also call the office to arrange for a flu shot appointment.

Speaking of "calling the office," we are reminding everyone that the office phone number is (239) 566-3100. Embarq had originally assigned us a different number (417-9897), but changed it unexpectedly when we opened. Now, only the new number will get you through to us.

We also want to be sure you are aware that both of us now have admitting privileges at the NCH Healthcare and the Physicians Regional Healthcare Systems. Please contact us if you have any questions about the hospital facilities in Naples. We have on-going relationships with many specialists at all the facilities, and are committed to providing personalized coordinated care, partnering with the best specialty care available.

We thank all our patients who have turned in your "Member Surveys." Your candid responses gave us insight into what is most important to you about our new practice, and what we can do to enhance our services. Please let us know if you have not received a survey to complete.

We wish you a happy, healthy "season," and pledge to provide the best medical care to you throughout the year.

Sincerely,

Laura S. Lenholt M.D.

Leonard A. Schlossberg M.D.

A Perspective on the Diabetes “Epidemic”

As you are likely aware, the incidence of diabetes has been steadily increasing. Over one million cases are diagnosed annually in the United States. The fact that adolescents, and even children, are being diagnosed with Type 2 diabetes — which is usually considered an adult disease — has dismayed parents and physicians.

Although this “epidemic” of diabetes has become a public health concern, the best public health approaches to its prevention are matters of controversy and of unknown effectiveness. For instance, do changes in school menus really alter kids’ eating habits substantially? Should restaurants offer more heart-healthy and diabetes-healthy menu choices? Would we really eat them if available?

More fundamental and complex issues include an assessment of the real significance of this rise in diabetes, and an evaluation of the true health risks of the disease.

There is no doubt that the occurrence of diabetes is on the rise, but the reasons for this are not simple. The societal increase in obesity is just part of the story. Although obesity does increase the chances of developing diabetes, most obese persons do not develop the condition. Patients with Type 2 diabetes are often not particularly overweight.

Less well recognized is that the diagnostic criteria for making a diagnosis of diabetes have become more strict. We now diagnose the condition at a fasting sugar of 126 mg/dl or greater, compared to 140 mg/dl or greater several years ago. We also label patients as having “pre-diabetes” at levels between 100 and 126 mg/dl — again, lower than before.

Finally, we test (screen) more patients for diabetes. All patients in our practice are tested at least once a year. Thus, the increase in diabetes results in part from how we define and look for the disease.

Given the new, stricter guidelines for diagnosis, we are finding patients with early and milder forms of the disease. In the past, patients often had advanced diabetes by the time the diagnosis was made. We recognize that most patients with “pre-diabetes” or “mild” diabetes can control blood sugar with consistent healthy changes in diet and regular exercise. The progression in severity can be slow, or seemingly

non-existent. The feared complications of kidney failure, severe nerve damage or blindness rarely occur in these patients.

For patients whose blood sugar remains elevated despite lifestyle changes, newer medications (tablets or insulin) can control the condition with fewer side effects and inconveniences than in the past. When possible, however, lifestyle changes are always preferred over medications because potential long term adverse effects of medications will be avoided. The recent controversy about possible risks of the medication Avandia for diabetes underscores this concern.

Recent research in the treatment and outcome of diabetes has led to a broader perspective on how to approach this condition. We realize that the greatest threats to health in diabetes are heart disease and stroke. Although we recognize that blood sugar control is critical, measures to prevent cardiovascular complications are equally important, and often underemphasized.



Patients with Type 2 diabetes tend to develop atherosclerosis (arterial plaque) at earlier ages than non-diabetic patients. Although we do not know all the reasons for the elevated risk, many studies have shown that the cardiovascular risks can be reduced by attention to blood pressure and cholesterol, smoking cessation, and possibly aspirin. Physicians need to focus on these issues at least as seriously as on the control of blood sugar.

Indeed, nutritional recommendations in diabetes now emphasize elements of a heart-healthy diet. We encourage patients to increase whole grains, fruits and vegetables. Dietary fats should be of the poly- and mono-unsaturated type. The focus is not necessarily on carbohydrate reduction, but on eating carbohydrates that are high in fiber, which tends to blunt the rapid rise in blood sugar after high carbohydrate meals.

Although the “epidemic” of diabetes certainly has become a major public health concern, we recognize that many patients will do well by changing lifestyle patterns, and not need medications. Our understanding of the health risks of diabetes has focused efforts on reducing cardiovascular risks in these patients. Nutritional recommendations now reflect this new perspective.

- Leonard A. Schlossberg M.D.

To Eat Fats or Not to Eat Fats???

Although Hamlet's dilemma was more profound, in today's world of nutrition the questions of whether to eat fat and, if so, which ones and how much, has provoked considerable debate. From the AHA low fat diets, to the high fat Atkin's diet, to an approach that balances "good" fats and "bad" fats, the state of our knowledge continues to evolve.

What are fats anyway? They are molecules with long chains of carbon atoms with varying numbers of hydrogen atoms attached. Fat is a storage form of energy and can be metabolized to produce glucose, which our bodies use for immediate energy. Fats are also important components of all cell membranes and precursors to important hormones.

Current thinking places fats on a continuum of "good" to "bad" as it relates to health. Both trans fats and saturated fats raise LDL cholesterol levels, which can lead to narrowing of the arteries with plaque, and are therefore considered to be "bad" fats.

Most trans fats are man-made by heating polyunsaturated fats in the presence of hydrogen. This process is called hydrogenation, and changes the configuration of the molecule. The result is a product that is more stable and therefore less likely to spoil. This extends the shelf life of products made with them. For example, trans fats are found in many margarines, candy bars, chips and ready-made baked goods such as cakes, cookies, pies and donuts. You will see them under ingredients as "partially hydrogenated" oils. As of 2006, the trans fat content of food is required to be listed on the food label.

Saturated fats are molecular chains of single-bonded carbon atoms "saturated" with as many hydrogen atoms as possible. These fats are found in milk, cheese, butter, ice cream, animal fat and some oils, including palm and coconut.

Monounsaturated and polyunsaturated fats are considered "good" fats. Compared to saturated fats, they tend to lower LDL cholesterol and reduce coronary heart disease. The names describe the fact that their carbon chains

have some carbons with double bonds between them, thereby decreasing the number of hydrogen atoms attached to the chain. In monounsaturated, this occurs once; in polyunsaturated, it occurs multiple times.

Foods highest in monounsaturated fats include olive, canola and peanut oils, avocados and almonds. Foods highest in polyunsaturated fats include safflower, sunflower and corn oils. These are the types of fat found in a Mediterranean diet. Interestingly, all of the above oils have a mixture of the different types of fat; the category under which they are listed is the fat that predominates.

A special type of polyunsaturated fats is the omega 3 fatty acids. In these fats, the molecular structure reveals a double bond at the third carbon from the end of the chain — hence the name omega 3. They are considered "essential" fats, meaning they must be obtained in the diet because they can't be manufactured in the body. Good sources of omega 3s are salmon, flax seeds, walnuts, and canola and soybean oils. Intake of these fats has been associated with reduced blockages in coronary arteries. They also protect against sudden cardiac death due to their antiarrhythmic effects.

Current dietary recommendations are to avoid trans fats and limit saturated fats. Further, between 25% and 35% of your calories should come from fat, preferably "good" fats. For someone eating a 2000 calorie diet this means eating 55 to 78 grams of "good" fat daily.

Remember, it is important to read food labels so that you know what you are eating. Some suggestions include: switch from butter to olive or canola oil in cooking, eat salmon once or twice a week, and snack on walnuts instead of a donut, candy bar or cookie. Indeed, changing your diet in this way may allow you "to be" for a longer and healthier life.

- Laura S. Lenholt M.D.

FYI... To help you make better food choices

OLIVE OIL

1 tbsp	14 grams
Calories	120
Total fat	14 grams
Saturated fat	2 grams
Trans fat	0 grams
Cholesterol	0 mg
Polyunsaturated fat	1 gram
Monounsaturated fat	11 grams
Sodium	0 mg



WHIPPED BUTTER (UNSALTED)

1 tbsp	7 grams
Calories	50
Total fat	6 grams
Saturated fat	3.5 grams
Trans fat	0 grams
Cholesterol	0 mg
Poly fat	1 gram
Mono fat	1.5 grams
Sodium	0 mg



SMART BALANCE

1 tbsp	14 grams
Calories	80
Total fat	9 grams
Saturated fat	2.5 grams
Trans fat	0 grams
Cholesterol	0 mg
Polyunsaturated fat	2.5 grams
Monounsaturated fat	3.5 grams
Sodium	90 mg



Mammogram vs MRI?



Recent studies have reported on the usefulness of breast MRI, in addition to mammogram, in screening women at high risk for breast cancer. High-risk women include women with mutations in the breast cancer genes BRCA1 and BRCA2, and women with a strong family history of breast or ovarian cancer. Strong family history implies two or more first-degree (mother, sister, daughter) or second-degree (grandmother, aunt) relatives with breast or ovarian cancer, male relatives with breast cancer, and breast cancers occurring at age less than 50 years. In this population — with a high likelihood of developing breast cancer — MRI has performed well, detecting more cancers than would have been detected by mammogram alone.

Why, then, has MRI not been recommended for breast cancer screening in the general population? This requires an explanation about the performance of tests — meaning how well they actually do what we want them to do.

In this case, we want the test to detect all cancers at the earliest possible stage, while at the same time not ever seeing normal structures as abnormal. In medical terms, we want to limit the false negative and the false positive results. The downside of false negatives is obviously not

finding the cancer when it is there, thereby reducing the ability to treat at an early stage. The downside of false positives include submitting a women to further procedures such as a biopsy, with the attendant worry and anxiety, possibility for complications, and increased cost for something that ends up being benign.

MRI has more false positive results than mammogram. In the general population, with a low likelihood of disease, this would result in a high number of biopsies in women that do not have cancer. This tips the risk/benefit ratio away from MRI.

Although the mammogram is not a perfect test, it currently is considered to be the best for screening the general population, and has been responsible for approximately half of the reduction in mortality from breast cancer that has been noted over the last 15 years.

- *Laura S. Lenholt M.D.*



The Concierge Medical Practices of

Lenholt & Schlossberg

A New Direction in Health Care

2230 Venetian Court • Naples, FL 34109
(239) 566-3100 • www.lenholtschlossberg.com

Presorted
First Class Mail
US Postage
PAID
Naples, FL
Permit # 293

WHAT'S INSIDE

*A Perspective on
the Diabetes "Epidemic"*

Mammograms vs MRIs?

To Eat Fats or Not To Eat Fats?