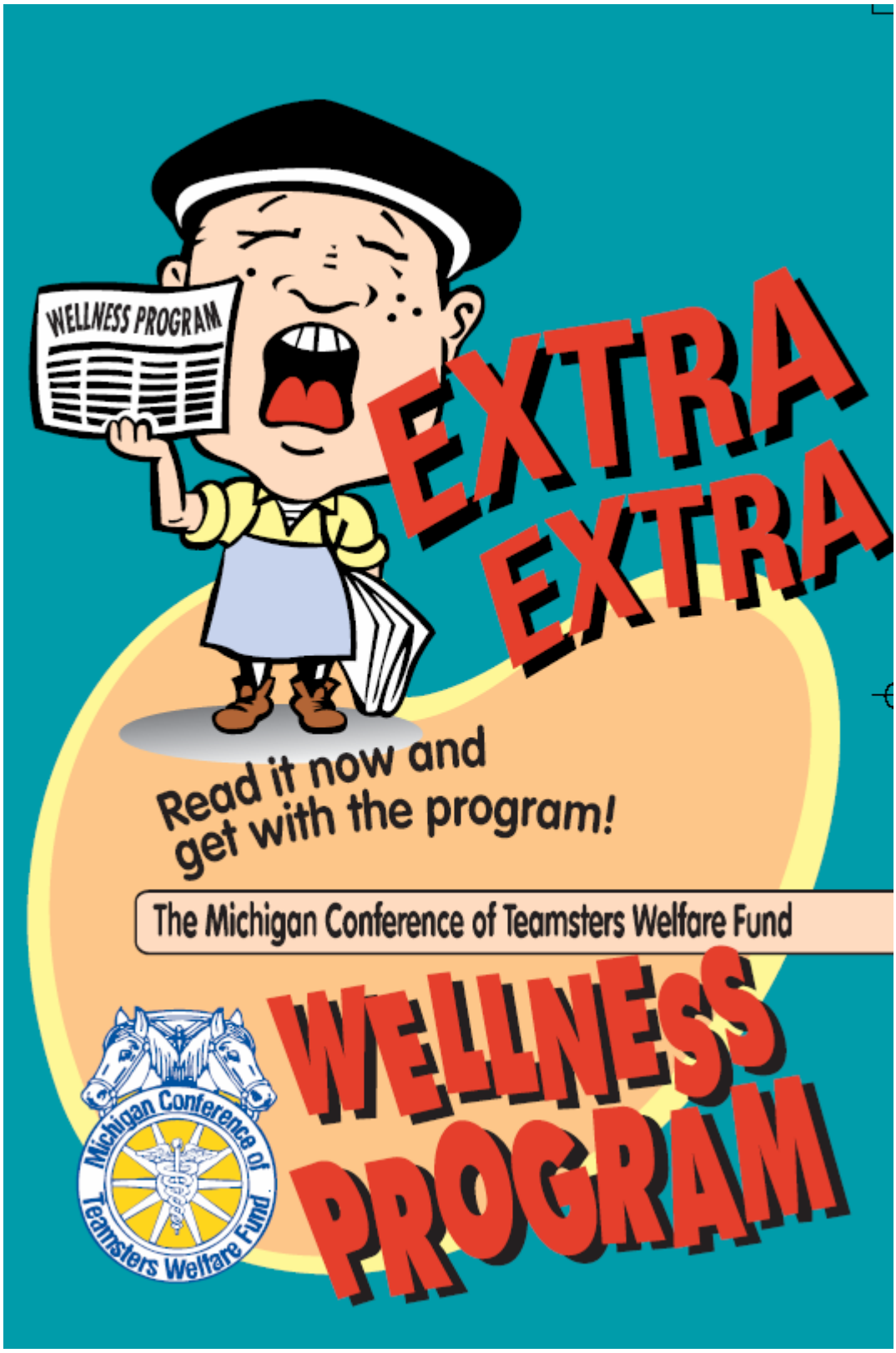
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Wellness Program

Elliotte D. Moss, MD
Fund Medical Director

In 1982, the Michigan Conference of Teamster's Welfare Fund was one of the first insurance carriers in the state of Michigan to offer a wellness program. Adult participation was remarkable, exceeding 75%, with pediatric almost 100%. The diagnostic evaluations used in the '80s were excellent for their time; however, they do not compare to the outstanding tools available today. A discussion of a few of the many targeted disorders evaluated during your wellness exam are now considered in terms of these advanced improvements in technology.

Despite the accuracy and ease in diagnosis of arterial hypertension, those first found to have an elevated blood pressure in the 1980s were much less likely to achieve a medically controlled target level. These targets, during that period, were less demanding as we, as physicians, were unaware of the importance in achieving levels as close to 120/80 if possible. There were a limited number of medications with a significant number of undesirable side effects. Today, we have well over 50, commonly used, well-controlled drugs that offer more than 90% of us a well-controlled blood pressure with minimal side effects.

In 1987, although primitive by today's standards, mammography became the central player in breast cancer diagnosis. It allowed for the detection for abnormal breast lesions years before they could be discovered by manual examination. Today's technology is so advanced by comparison, that we now can often discover breast cancers 5 to 10 years before they are noted on a digital exam. Therapeutic advancements have kept pace with technology, offering 90% cure rates if the disease is discovered in an early stage. Because of technology, we are finding more than 70% of the cases at this early stage. This allows less aggressive surgery and less toxic complementary medicines. Yes, that means that under the best of circumstances, nine out of ten women who get an early diagnosis of breast cancer should be cured.

The most diagnosed cancer in men is of the prostate. In 1982, the only method of diagnosis was by digital rectal examination. This usually meant a diagnosis at a more advanced stage with less than a 50% cure rate. Today, with a combination of (PSA) blood test, digital rectal examination, and ultrasound guided biopsy, as with the case of breast cancer, we now can diagnose this disease at least five to ten years earlier. This translates into a 75% or higher cure rate.

Wellness Program

From this limited discussion, you can see that the last 20 years have brought a dramatic improvement in our ability to make early, accurate diagnosis during wellness exams. These improvements translate into significant quality of life enhancements. It should, therefore, be obvious that as a result of these advances, your Fund is offering a benefit too valuable to ignore.

The features covered under your Wellness Program will be described in sequence as we progress through this presentation. In general, it consists of a periodic evaluation provided by your primary health care physician. It increases in frequency and complexity as you age. It is directed at the diagnosis of the most common, important medical disorders at their earliest asymptomatic stages. It is intended and hoped that diagnosis at these early stages makes these disorders susceptible to successful treatment.

The chart below represents a quick reference guide to recommended screening procedures and at what age they should be performed at your Wellness examination.

	20 – 40 yrs.		40 – 50 yrs.		50 – 65 yrs.	
	Male	Female	Male	Female	Male	Female
Physical Exam	Every 3-5 yrs.	Every 3-5 yrs.	Every 2-3 yrs.	Every 2-3 yrs.	Every 1-2 yrs.	Every 1-2 yrs.
Laboratory Studies Include Blood Test Fasting	Every 3-5 yrs.	Every 3-5 yrs.	Every 2-3 yrs.	Every 2-3 yrs.	Every 1-2 yrs.	Every 1-2 yrs.
Pap Smear		Yearly		Yearly		Yearly or adjusted if normal 3 yrs. in a row
EKG			Every 2-3 yrs.	Every 2-3 yrs.	Every 1-2 yrs.	Every 1-2 yrs.
PSA Labs and DRE (Digital Rectal Exam)			Yearly if African-American		Yearly	
Mammogram		Baseline at age 35-40		Yearly or every other year depending on your Dr.'s opinion.		Yearly
Yearly Colonoscopy or Sigmoidoscopy					Every 5-10 yrs.	Every 5-10 yrs.
Fecal Occult Blood Test					Yearly	Yearly
*Immunization	If you currently have congestive heart failure, asthma, or chronic lung disease you should discuss with your physician whether you should receive the pneumonia vaccination along with the flu vaccination.					

*Copayments and deductibles under your plan apply. Adult Immunizations are not part of the Wellness Program

Learn More For You and Your Family

Prostate Cancer

Approximately 190,000 new cases are diagnosed per year. It is the second leading cause of death in men from all cancer diagnoses. Risk factors related to prostate cancer are advancing age, positive family history, with higher rates of disease seen in younger men of African American origin.

The American Cancer Society recommends annual digital rectal examination over the age of 40 and starting at age 50, an annual Prostate Specific Antigen blood test (PSA). The use of PSA is still controversial, as it has not, as yet, been proven to reduce mortality.

Statistics clearly tell us that treatment of early stage disease is associated with 15 years survival rates of 85% and greater, and increased PSA levels often are the direct cause of biopsy diagnoses in greater than 70% of early stage disease. It seems logical, until further studies prove otherwise, to continue to use annual PSA testing over the age of 50, and even consider its use earlier, possibly starting at age 40 for those with positive risk factors.

Also remember that causes of prostate disease, such as infection, will elevate the PSAs. Do not assume you have a cancer until these other disorders have been ruled out and a biopsy confirmation has been completed. In other words, do not be fearful of having a false-positive PSA elevation, as it is easy to differentiate this from a true prostate neoplasm (cancer with ultrasound directed biopsy).

Stay healthy with diet and exercise

Obesity & Abnormal Lipids

Fasting blood studies are the vehicle by which we evaluate abnormal blood fats (lipid levels). These levels are measured in terms of height, weight, and muscle mass in addition to positive and negative risk factors. Abnormally high lipid levels are closely correlated, as are the previous disorders discussed here, to peripheral vascular disease, heart attacks, stroke, renal failure and limb loss. Early diagnosis, during a wellness exam, can have a significant impact on the treatment through weight reduction as well as through control of the abnormal blood lipids. Treatment consists of modification of physical activity as tolerated, reduction in total calories, as well as certain fat calories along with, as required, the administration of specific medications to reduce serum fats. Once again, as discussed under the heading of diabetes, it is extremely important to get reliable information at the time of your wellness examination by giving the laboratory a reliable specimen. This is a blood specimen that is taken following a minimum of at least an eight-hour fast because with shorter fasting intervals give us falsely elevated results.

Diabetes Mellitus

Diabetes is the abnormal regulation of blood sugar with a resulting increase in its measured serum levels. The presence of Type II diabetes, the one usually associated with an adult onset can be without symptoms for many years. There is often a familial relationship. As with arterial hypertension there appears to be an increasing incidence of diabetes with advancing age. It is closely associated with diets high in calories, carbohydrates, fat and obviously secondary obesity and physical inactivity. It is diagnosed easily by one or two simple blood sugar evaluations in the fasting state. Currently the diagnosis is made if two fasting sugars greater than 128 mg/dl are found on blood testing. Values that are between 116 and 128 mg/dl are now considered pre-diabetic or a tendency to develop diabetes or glucose intolerance. The importance of these numbers is they have the same association but to a lesser degree with complications that we see in full-blown diabetes. These blood sugars are done as part of the serum testing with blood drawn at all wellness exams in adult patients. An important reminder to those of you wishing to get value from these exams is that at least an eight-hour fast is necessary for this test to give an accurate result. Even a morning cup of coffee without any sugar can create false abnormalities in these tests.

Two classes of complications are commonly discussed in relationship to poorly controlled blood sugar in diabetes mellitus. The first, microvascular disease, which most frequently occurs in the kidney and in the vessel supplying the retina resulting in renal failure and the need for dialysis and transplantation and the loss of vision, with the need for intensive photocoagulation therapy by an ophthalmologist are experienced. The second, neuropathy is also seen in this category and is associated with loss of sensation, most frequently in the longest nerves of the body (those of the feet) with secondary changes commonly seen due to trauma of the toes and feet. If numbness in the feet is already being experienced, podiatric foot care is suggested by the American Diabetes Association. Also, if a patient has already been diagnosed as a diabetic, a yearly medical eye examination is suggested. Please be advised that these two services are not provided under the Wellness Program and are covered according to your regular plan of benefits.

Large vessel disease is associated with stroke, heart attack and peripheral vascular disease with associated limb loss as a result of arterial occlusion. Both categories of vascular complication as discussed here are impacted quite significantly by an early diagnosis as well as intense management of

elevated blood sugar and elevated cholesterol. It appears that elevated cholesterol has a greater impact on large vessel disease whereas elevated blood sugar has a more significant effect on small vessel disease. Wellness exams with early diagnosis can have a significant impact on both these points by demonstrating the need for control of both aspects of diabetes mellitus.

ANECDOTE

Within the last ten years there have been more large impact studies on the effect of medications as they relate to diabetes mellitus, blood sugar control and cholesterol control. There are so many different categories of medications that have been proven to have a significant positive effect in terms of reduction of diabetes complications that as many as five different categories of drugs may be used at any one point in time if we are to follow the positive results of these studies. Beta blockers such as metoprolol and atenolol have been demonstrated in diabetics to have a very significant reduction in post heart attack recurrences, particularly in diabetics. ACE inhibitors such as lisinopril have been demonstrated to have long-term impact on the reduction of kidney failure as well as cardiac failure particularly in diabetics, no matter whether their blood pressure is elevated or not. Statin drugs utilized in the reduction of cholesterol have been proven to reduce acute cardiac events as well as stroke in the general population, but much more significantly in the diabetic. In addition, aspirin has shown to be effective in diabetics as well as in the total population, of vascular disease patients. So it would not be uncommon, in addition to diet and the diabetic specific medication, to have an individual taking an ACE inhibitor, a beta blocker, a statin drug and an aspirin. This is not over medication, this is just good medicine. Do not be surprised if you see this as part of your prescriptive future.

Get a clean bill of health
Colon Cancer

Colorectal cancer is the second most common cancer in the United States for both male and female. Physicians and lay persons are becoming increasingly aware of most colorectal cancers and most resulting deaths are preventable through screening. Colorectal cancer has several features that make it ideal for screening. The first is it is both common and serious. Secondly, it has a readily identifiable, slow growing precursor lesion called the adenoma, the removal of which prevents progression to cancer. Thirdly, colorectal cancer, once developed, is believed to have a relatively slow progression, from early to later stages, making it curable over an extended period of time by surgical intervention. Fourthly, currently recommended prevention tests are widely available.

People who are over the age of 50 with no identifiable risk factors for colon cancer are considered at average risk. The preferred screening strategy is a colonoscopy every five to ten years. The second strategy is a flexible sigmoidoscopy every five years, plus yearly or annual fecal occult blood testing. Other less commonly used strategies are double contrast barium enema and under extensive discussion, but not ready for current use, is CT colonography or virtual colonoscopy, a form of CAT scanning.

In comparing fecal occult blood testing with sigmoidoscopy to full colonoscopy, there is significant data available pointing to the superiority of colonoscopy. The reason for this relates to the fact that fully half the polyps, and possibly 40% of the cancers, are beyond the reach of a standard sigmoidoscope. They are, therefore, not seen and not detected visually by this methodology. The occult blood testing is really a screen for existing cancer as polyps rarely bleed, but unfortunately, even this misses up to half of the cancers as the timing and extensive bleeding may be missed. An anecdotal analysis of approximately 14 cancers found in my own practice by colonoscopy on approximately 2,000 patients disclosed that about half of these (eight) would not have been discovered by sigmoidoscopy because they were too proximal or out of the reach of the standard shorter sigmoidoscope used in the office setting. In addition, none of these cases had a special circumstance that would have suggested, after a normal sigmoidoscopy, to add a more extensive colonoscopy to the screening sequence.

Therefore, in my experience, at least half the cancers would have been missed had they not been found on the colonoscopy. This seems to be the general sense of the medical and sub-specialty gastrointestinal community at the time of this printing.

In summary, the two currently recommended strategies covered by your Wellness Program are fecal occult blood testing yearly after the age of 50, along with sigmoidoscopy every five years or alternatively, fecal occult blood testing yearly after the age of 50 with colonoscopy every five to ten years.

There are occasional infrequent familial relationships which increase the colon cancer risk (approximately 15% of the time). In these circumstances, which are beyond the scope of this presentation to discuss, more frequent, earlier testing is required. The applicable situation to our population is where a first degree family member had a presentation of colon cancer prior to the age of 60, a colonoscopy screening should begin at an age ten years prior to the time of diagnosis in the related case. Example, if your father had colon cancer at the age of 55, you should be screened starting at age 45, and the intervals thereafter should be five years rather than ten, if the studies are negative. In addition, if any colon cancer is found in a first degree relative, despite the age of onset, a colonoscopy is the preferred method of screening and should probably begin at age 40 rather than age 50. Lastly, if an adenomatous precursor polyp is found on a routine study, follow-up colonoscopy should be done at less than ten years, anywhere from every two to every five years, depending upon the number of polyps and their size. Once again, it is clear that we have a current technology, although imperfect, which offers much in the way of early detection and successful treatment of a lethal disease if we only avail ourselves of the opportunity to be screened.

Thank goodness I had that mammogram

Breast Cancer

Following skin cancer, breast cancer is the most frequently diagnosed tumor in women in the United States today. It is second only to lung cancer in annual death rates. About 180,000 new cases are found yearly and about 45,000 women die from this disease on an annual basis.

Simply being a woman, combined with advancing age, increases your risk for breast cancer. The risk continues to increase over your lifetime. Most women affected by the disease have no known additional risk factors other than these. This, therefore, makes screening extremely important for the entire female population.

Obviously a personal history of prior breast cancer increases the risk that a woman may have additional lesions in the same breast and in the remaining uninvolved breast at a rate beyond, but not substantially so, the usual for woman at a standard risk. In addition, relatives, such as mothers, sisters, daughters or two or more close relatives, such as cousins, with a history of breast cancer, especially if that was diagnosed under the age of 40, increases your risk by relationship for this disease. If a previous breast biopsy has been noted to have one of three predisposing benign, but significant, breast disorders, close follow up and increased risk are known to exist. Lastly, and very infrequently, sporadic genetic mutations in certain families have demonstrated an extremely high rate of breast cancer in first-degree relatives. This occurs in less than 5% of women suffering from breast cancer.

Recommendations are that if you are 40 years of age or older and of usual risk as described above, you should obtain a regular mammogram every one to two years. In addition, although less sensitive, a monthly breast self-exam and a yearly breast exam by your primary care physician are suggested. After age 50, most experts suggest woman receive a mammogram on a yearly basis.

Obviously, a mammogram is designed to find breast cancer before a lump can be felt. Hopefully, five to ten years before. It is the best method to detect breast cancer in early stage. No other methods are equally as effective. There are numerous new ideas currently being evaluated, improved and tested, but none as yet are reliable enough to be considered the equal of a properly done mammogram read by an expert radiologist. Therefore, until such time, this still remains the gold standard.

Mammograms are not 100% perfect; they can detect non-cancerous abnormalities, which may lead to biopsies and the associated anxiety. This is a reasonable price to pay, at least in my opinion, for finding the disease in early state. Mammograms have a miss rate that is reasonable and understandable from a physicians point of view because certain women have breasts which are too dense to be properly penetrated in order to resolve distinct calcifications and separate breast lesions at an early stage for diagnosis. These individuals can be clearly labeled at the time of their mammogram and may have, in addition, carefully performed ultra- sounds in regions where breasts are too dense for mammogram accuracy. The addition of this ultrasound in properly selected patients enhances accuracy and is currently being performed in most dedicated breast imaging centers. In the heavily publicized case of Suzanne Somers, she, in essence, had a normal mammogram, but because of the density of the breast tissue, it was suggested she have a supplemental ultrasound. It was this ultrasound that found a relatively advanced mass that was not palpable, again, because of the architecture of the breast. This sequence of events occurred because she utilized a state-of-the-art, dedicated Single-Service Breast Center, which carefully attended to these special circumstances. It is possible for the rest of us to achieve this special level of attention. In point of fact, it is available at numerous breast centers, particularly in the Metropolitan Detroit area.

Certified Single-Service Breast Centers offer several benefits. They usually provide a careful physical exam immediately prior to the mammogram. This identifies suspicious regions on which the radiologist can then focus attention during his or her reading. The evaluation of the mammogram by the radiologist is done before the patient leaves the center, allowing for supplemental pictures to be taken, if necessary, at the same sitting. If the x-ray does not show what is known to be a palpable lesion, either by the evaluator in the center or the referring physician, an ultrasound can be done the same day completing the diagnostic regimen, and most important of all, resulting in a clear determination, either positive or negative, as to whether there is an abnormality. There are a few other supplemental studies which are currently available and too complex to describe in this presentation, but suffice it to say that this is not the end of the road for breast imaging and despite its sophisticated and constantly improving picture, the current state of the art is excellent and certainly deserves your attention.

Good news! 90% Successful treatment rate

Arterial Hypertension

This is the most frequently diagnosed abnormality of major significance during a wellness exam. Also, it is the most significant abnormal finding. Its successful treatment is not only possible; it has the greatest reward.

Treatment to target (in most cases a reading less than 140 over less than 90. However in diabetics and certain other situations, a reading of less than 130 over less than 80) successfully reduces the incidence of subsequent stroke, cardiac failure, renal failure and, to some degree, acute heart attacks. Successful treatment is possible in greater than 90% of cases, combining lifestyle modification as well as medication. Treatment is not only rewarded with reduced risk, but is also usually well tolerated with minimal to no significant side effects.

The increased frequency of arterial hypertension due to aging, causes up to 20% of us over the age of 65 to have the disorder. This means that periodic wellness exams continue to be important throughout life. Risk factors contribute to the frequency and severity of arterial hypertension, such as obesity, advancing age, abnormal lipids, diabetes mellitus, poor exercise capacity, sodium intake (salt) and the smoking of tobacco. As a result, the modification of these additional factors makes the treatment to target much more likely to be successful.

Treatment is clearly significant in terms of stroke reduction, prevention of heart failure, avoidance of end stage renal failure and the associated needs for dialysis, with the extension of good quality life by between 10 and 20 years.

ANECDOTE (LIFESTYLE CHANGES)

We often overemphasize the importance of sodium restriction. Its benefit is not equivalent in all of us. Certain groups of individuals are more likely to elevate their blood pressure in response to an unrestricted intake of table salt. The typical American diet consists of about 15 to 20 gm. of sodium chloride daily. The percentage of sodium and chloride in the combined compound is approximately 50-50. So when we speak of sodium chloride as 20 gm. we are speaking of about 10 gm. of sodium and 10 gm. of chloride. So whenever diets are discussed, we have to reduce the sodium content by half when the origin reference is to sodium chloride. Restrictive diets suggest we use less than 5 grams of sodium chloride daily.

This translates into no use of the saltshaker whatsoever, either in the preparation of food for cooking or in the addition at the table. In addition, most canned and prepared packaged foods must be eliminated from the diet. A trial of this diet for approximately ten days to two weeks is not unwarranted and maybe in one out of five of us it could be very effective in reduction of blood pressure. I therefore suggest that you consider this if the opportunity arises, but if no significant reduction of blood pressure occurs at the end of that period, it seems quite reasonable to utilize salt in a reasonable fashion without restriction thereafter.

The use of alcohol on the other hand, if more than two drinks per day, is often related to reflexive increases in blood pressure. I strongly suggest that if you use three or four drinks per day, which is not uncommon, that you take a sabbatical for at least two to three weeks and then determine the response. You will be quite surprised that reductions as much as 10 to 20 mm Hg are often experienced.

The most important lifestyle alteration is exercise with associated weight loss. Again, a 5 to 15 mm Hg reduction in average overall blood pressure is commonly seen when 10 to 20 pounds are lost in association with 30 minutes, five days a week of aerobic exercise. This is extremely valuable and should not be overlooked.

Pediatric Care

The evaluation of wellness from the time of the newborn baby's first exam through our childhood, progression through middle school and graduation from high school, is a series of normal landmarks of growth, physically, emotionally, and cognitively, and can be mapped in direct relationship to the standard immunization schedule. As can be noted below, a series of immunizations given within the first year allows the pediatrician to see the child at least three times on some schedules and up to four or five times on others. Boosters and completion of standard immunization schedules provide for another exam prior to entry into elementary school with an additional exam at the time of entry into middle school. If this schedule is followed, a series of six to eight wellness exams are given through a standard childhood. This should be more than adequate in the detection of any significant abnormalities requiring attention. Obviously, specific disease processes occurring between these wellness exams will require additional visits, but in terms of the wellness concept, most children following contacts during their routine immunization schedule should have excellent preventative health care.

Shown below is a recommended childhood immunization schedule approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family physicians. Each vaccine is listed under routinely recommended ages.

Range of Recommended Ages | **Catch-up Immunization** | **Preadolescent Assessment**

Vaccine	Birth	1 mo	2 mo	4 mo	6 mo	12 mo	15 mo	18 mo	24 mo	4-6 yrs	11-12 yrs	13-18 yrs
Hepatitis B (1)	Hep B #1	Only if mother HBsAg-										
		Hep B #2			Hep B #3				Hep B Series			
Diphtheria, Tetanus, Pertussis (2)			DTaP	DTaP	DTaP		DTaP			DTaP	Td	Td
Haemophilus Influenza Type b (3)			Hib	Hib	Hib	Hib						
Inactivated Poliovirus			IPV	IPV	IPV					IPV		
Measles, Mumps, Rubella (4)						MMR #1				MMR #2	MMR #2	
Varicella (5)						Varicella			Varicella			
Pneumococcal (6)			PCV	PCV	PCV	PCV			PPV		PPV	
Vaccines below this line are for selected populations												
Hepatitis A (7)									Hep A series			
Influenza (8)					Influenza (annually)							

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2003, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible.

Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form can be found on the Internet: http//www.vaers.org/ or by calling 1-800-822-7967.

1. Hepatitis B vaccine (HepB). All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is hepatitis B surface antigen HBaAg-negative. Only monovalent HepB can be used for the birth dose. Monovalent or combination vaccine containing HepB may be used to complete the series. Four doses of vaccine may be administered when a birth dose is given. The second dose should be given at least 4 weeks after the first dose, except for combination vaccines which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the immunization series (third or fourth dose) should not be administered before age 24 weeks.

Infants born to HBsAg-positive mothers should receive HepB and 0.5 mL of Hepatitis B Immune Globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1-2 months. The last dose in the immunization series should not be administered before age 24 weeks. These infants should be tested for HBsAg and anfi-HBs at 9-15 months of age.

Infants born to mothers whose HBsAg status is unknown should receive the first dose of the HepB series within 12 hours of birth. Maternal blood should be drawn as soon as possible to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). The second dose is recommended at age 1-2 months. The last dose in the immunization series should not be administered before age 24 weeks.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP). The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. The final dose in the series should be given at age ≥ 4 years.Tetanus and diphtheria toxoids (Td) is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. Haemophilus influenzae type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB4D or ComVax9 [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months, but can be used as boosters following any Hib vaccine. The final dose in the series should be given at age ≥ 12 months.

4. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11 -12 year old visit.

5. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children, (i.e. those who lack a reliable history of chickenpox). Susceptible persons aged ≥ 13 years should receive two doses, given at least 4 weeks apart.

6. Pneumococcal vaccine. The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children age 2-23 months. It is also recommended for certain children age 24-59 months. The final dose in the series should be given at age ≥ 12 months. Pneumococcal polysaccharide vaccine (PPV) is recommended in addition to PCV for certain high-risk groups.

7. Hepatitis A vaccine. Hepatitis A vaccine is recommended for children and adolescents in selected states and regions, and for certain high-risk groups; consult your local public health authority. Children and adolescents in these states, regions, and high risk groups who have not been immunized against hepatitis A can begin the hepatitis A immunization series during any visit. The two doses in the series should be administered at least 6 months apart.

8. Influenza vaccine. Influenza vaccine is recommended annually for children age ≥ 6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, diabetes, and household members of persons in groups at high risk; and can be administered to all others wishing to obtain immunity. In addition, healthy children age 6-23 months are encouraged to receive influenza vaccine if feasible because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy persons age 5-49, the intranasally administered live-attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). Children receiving TIV should be administered a dosage appropriate for their age (0.25 mL if age 6 to 35 months or 0.5 mL if age ≥ 3 years). Children age ≤ 8 years who are receiving infuenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).

Cervical Cancer

Approximately 15,000 new cases of invasive cervical cancer are diagnosed each year in the United States and approximately 4,000 individuals die from this disease annually. Cervical cancer is an ideal disease process for routine screening. Early, preinvasive disease, is reliably discovered at the time of a properly performed Pap smear. At this stage, cancer of the cervix is 100% curable. The recommendations of the American College of Obstetricians and Gynecologists, as of 1988, are the following:

1. Annual pelvic examinations and Pap smears for:
   A. All women who have been sexually active.
   B. All women who have reached the age of 18 years old.
2. After three consecutive normal, properly performed Pap smears, done on a yearly basis; the interval between Pap smears may be extended from annually to approximately every three years, this being at the discretion of the physician, based upon the patient's risk factors.

Such routine screening is an excellent method of discovering both early preinvasive (100% curable), as well as early, small volume invasive disease with greater than 70% curability results. In other words, there is a long period of latency between preinvasive and invasive stages of this disease, often considered to be as long as five years, and the invasive stage remains curable for an extended period of time. This gives us an extremely long window during which time Pap smears may detect the abnormalities requiring biopsy and proper treatment.

Skin Cancer

Most skin cancers are not life threatening; these being diagnosed as squamous cell and basal cell types. They may cause local deformities, both before and after therapy; so early diagnosis leads to better cosmetic result. Most of these are found on exposed surfaces of the arms, legs, neck and face, obviously a direct relationship to sun (radiation). The more significant lesions (melanomas) are also found on sun-related exposed regions and are noted to be found in greater frequency in those individuals of a lighter complexion (particularly red-headed, light complected individuals).

Melanomas, thankfully, are being diagnosed in an earlier more curable stage because of physician and ancillary-assistant care education .

Screening is not complex and simply requires a careful examination by eyes and hand lens by an experienced physician during your annual wellness exams with more frequent exams for those who have had previous positive diagnoses. In addition, those with a high concentration of brown moles of a particular type should be referred for annual expert dermatologic screening. A note of caution is that in most cases, physicians are not going to take a hand lens and examine every square inch of your exposed, as well as unexposed, body surface area. Therefore, it is a good to supplement examinations done as part of your wellness benefit by taking, on an annual basis, with the assistance of either a friend or spouse, a hand-held magnifying glass and carefully going over your entire body skin regions, with particular attention paid to the soles of the feet and the palms of the hands, as well as to the typically sun-exposed regions. Any suspicious areas (moles changing in size, color or breaking down with ulcerations) should be reported to your physician for further attention..

"No thanks, I quit"

Carcinoma of The Lung

Approximately 150,000 die annually from this disease. Thus, less than 12% of those diagnosed survive the illness. All past attempts at screening strategies have been proven to lack benefit. None are yet proven to be at all helpful in diagnosing this disorder any earlier, or improving survival by treatment at an earlier stage. These have included annual, or even semi-annual chest x-rays, as well as analyzing expectorated material by induced or un-induced cough for abnormal cytological cells. A new strategy in people who are over age 60, particularly those who are female, are being evaluated as we speak, particularly those that have 40 or more pack years of smoking. The pack years of smoking is calculated by multiplying the number of packs per day by the number of years smoked. This study involves a new form of rapid CAT scanning, which has the ability to find lung lesions as small as 1 centimeter and clearly distinguishes them from normal structures. The results of this study will be available for analysis by the year 2005 and hopefully they will be of some benefit. Currently this strategy is being utilized in a sporadic fashion and cannot be recommended as reliable.

So, in summary, it is clear that this is a lethal disease in the majority of patients and that it is more than 85% associated with long-term cigarette smoking in the range of 40-50 pack years. Since there is no effective screening and minimally effective treatment strategies, the only recommendation that I can give you at this time is to quit smoking. The sooner you can do it the better and hopefully long before you reach age 50 or 40 pack years of smoking.

Wellness Program Features

So why not take advantage of this excellent cost-free program and schedule your wellness examination today. You have got nothing to lose and so much to gain from early detection. Covered features of this program include:

Women's Health Program

- Mammograms
- Cervical cancer screening - Pap smear. (Discuss newer liquid based techniques with your physician.)
- Periodic physical examination including family and personal history, health habits, height/weight, blood pressure, blood sugars (diabetes screening), cholesterol, triglycerides (lipid panel), skin cancer screens, breast cancer screens, and pelvic examination.
- Stool occult blood test. (Discuss more accurate no touch techniques with your physician.)
- Flexible sigmoidoscopy screening
- Colonoscopy screening

Men's Health Program

- PSA tests
- Stool occult blood test. (Discuss more accurate no touch techniques with your physician.)
- Periodic physical examination including family and personal history, health habits, height/weight, blood pressure, blood sugars (diabetes screening), cholesterol, triglycerides (lipid panel), skin cancer screens, testicular cancer screens, and digital rectal examination.
- Flexible sigmoidoscopy screening
- Colonoscopy screening

Children's Health Program

- Well baby and child physical examinations
- Immunizations as designated by the American Academy of Pediatrics

All co-payments and deductibles are waived when utilizing the services of the Wellness Program.

Michigan Conference of
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