



Doctor Dread

Taking It on the Jaw

I followed the infection underneath his breastbone like a trail of bread crumbs all the way up to his jaw. The trail teemed with pus, the army of white blood cells that had marched through the walls of blood vessels to fight invading microorganisms. I had never seen anything like it before. Bacteria had waged a protracted war with his body's immune system—and won. I wondered how fifty-year-old Victor Baca could have developed such a virulent infection.

Ten days earlier, Victor had been in perfect health. Then he started complaining of back and shoulder pain and a sore throat. The symptoms kept him in bed and unable to go to work. Even so, he didn't seek medical attention. But as the pain worsened, Victor realized something was terribly wrong, and he called 911. The dispatcher alerted an ambulance. Paramedics arrived, found him critically ill, and went to work immediately. Despite their aggressive intervention, including cardiopulmonary resuscitation (CPR), Victor slipped away, causes unknown.

As I often do in cases involving unusual infections, after the autopsy I consulted Dr. Mark Wallace, an infectious disease specialist and an internal medicine physician, who also happens to be my husband. An infectious disease specialist

tracks down bacteria and viruses, decodes their defenses and their weaknesses, and figures out what will kill them. Mark believed—and I concurred—that all the evidence proved that a bacterial infection had originated in Victor’s mouth, shockingly, from the most ordinary of health problems: a common dental infection.

This infection probably migrated from a decayed tooth into the surrounding bone and tissue in his jaw and caused an abscess, a cavity containing pus surrounded by inflamed tissue. Many of us have probably had an abscess at one time or another. They can show up externally (in the gums or in a hair follicle) or internally (in an organ), and some types are more severe than others.

Once a pocket of pus breaks through the thin bone surrounding the tooth sockets, bacteria can spread through the tissue planes of the neck and into the chest. By the time Victor sought medical attention, bacteria had likely reached his bloodstream and caused multisystem organ failure. This infection was the source of all his pain—and the cause of his death.

Before penicillin was discovered in 1928, bacterial infections like Victor’s were the leading cause of death in the United States. Today, due to widespread use of antibiotics, head and neck infections rarely kill, unless you have no access to, or reject, basic medical or dental care. For some unknown reason, Victor decided not to see a doctor, even as the unchecked infection spread to his chest and the pain became excruciating. What began as a run-of-the-mill oral infection became a fight for survival. Eventually, Victor’s organs ceased functioning, and he died. The tragedy was compounded by the fact that Victor’s death could easily have been prevented. A routine course of antibiotics provided in a timely manner would have stopped the infection in its tracks.

Checked Out

As with the case of Victor Baca, I’ve seen firsthand the terrible complications that can arise when people don’t go to the doctor, ignore a physician’s advice, or decide to take medical matters into their own hands. Another example from my case files is that of Kim Atani, age forty-eight. She was a woman who could have lived a long, normal life had she received proper medical care. Kim, who was

blind, and her husband, Simon, were living in their Orlando home when Simon found her collapsed on the bedroom floor. He called 911, and Kim was rushed to the hospital, where she later died. Her body was sent to my morgue to be autopsied.

Some of the most important information any physician—forensic pathologists included—can have is a medical history. But Kim arrived at the morgue without any medical records. I had to rely solely on observation to figure out why she died.

Clearly, something terrible had been happening. Her teeth were fractured at the gum line. She was also covered with bedsores, oozing craterlike wounds that can become seriously infected. Medically known as “decubitus ulcers,” bedsores develop quickly as tissue dies when blood flow is impaired by the continuous pressure of body weight on the soft tissues sandwiched between bone and a firm surface. There was also gangrene, or dead tissue, which appeared as large, black, shriveled areas across her left foot. Gangrene is caused by progressive loss of blood to an area, and there are two types: wet and dry. Both are caused by poor blood flow, but in wet gangrene, the tissue is also infected with bacteria. Kim had wet gangrene. Gangrene is often associated with advanced cases of diabetes.

I dissected Kim’s wet gangrene and discovered that the infection had burrowed down to her bone. If discovered in time, a limb so acutely diseased would have been amputated to prevent the spread of a life-threatening infection.

With my scalpel, I made the standard Y incision, a deep cut from shoulder to shoulder across the chest, followed by a straight line down to the pubic bone. I then opened the torso like you’d open a jacket or sport coat. Ribs were cut so I could gain access to the organs, which are removed, weighed, and dissected during the autopsy.

After opening her up, I could see that her body harbored several other possible killers. Her kidneys and liver were damaged, and her coronary arteries were more than 95 percent blocked. These findings were pieces of the puzzle that, along with her blindness, periodontal disease, and gangrene, began to fit a pattern. It appeared to me that Kim Atani had been suffering from long-standing untreated diabetes.

Diabetes is a metabolic disorder. Its hallmark is a failure to metabolize glucose, or blood sugar, carried by the bloodstream to fuel every part of the body. The failure is caused by problems with the hormone insulin. Either the body doesn't make any (or enough) insulin, or cells don't respond to insulin properly. In either situation, glucose is unable to enter cells. It starts amassing in the bloodstream, where it can reach concentrations over ten times the normal level. Over time, elevated glucose causes widespread organ damage, like that which I observed in Kim Atani.

To confirm that Kim had diabetes, I would need to know her blood sugar levels. Testing for blood sugar is easy to do when you're living—blood is drawn and checked for its glucose concentration—but it's more complicated when you're dead. After you die, your blood sugar begins to drop continuously toward zero. I can't even test for glucose levels in the blood because the blood breaks down right after death and interferes with testing. But I can test for glucose by using eye fluid drawn into a syringe—a procedure that can make you shudder if you've never seen it before. Each adult human eye contains about one-fifth of a teaspoon of jellylike fluid called vitreous humor. This fluid is very reliable for testing because it is isolated and protected, and therefore less subject to contamination or cell breakdown.

I collected eye fluid from Kim's eyes and sent it to our toxicology lab. Glucose levels in the eye decrease after death, too, so a finding of elevated glucose would strongly indicate diabetes. Sure enough, when the toxicology report came back, it revealed that Kim's eye-fluid glucose was 378—massively elevated for a postmortem level.

Once I put all the facts of the case together and reviewed her tissues under a microscope, it was clear to me that over time, elevated glucose had caused widespread organ disease. It not only left Kim blind but it also caused a loss of sensation in her extremities and impaired her blood flow. Gangrene set in and allowed a deadly infection to take hold. The infection invaded her bloodstream, causing sepsis—an often fatal condition.

Sepsis takes its name from the Greek word meaning “to putrefy.” Known for generations as “blood poisoning,” it generally means bacteria have breached the

natural barriers of the skin and organs to enter the bloodstream. Once there, they produce an overwhelming infection, the biological equivalent of tossing a grenade into your body. Blood pressure drops, vessels leak, and the lungs and kidneys fail. The result can be septic shock so severe that no amount of intravenous fluid or medication can reverse the condition. This is what happened to Kim Atani.

Normally, a case like this would be closed, but I had to get to the bottom of why she had not sought medical care. Was it a case of negligence on the part of her husband, Simon? Could his inaction have contributed to her untimely death? If it was found that he had acted negligently, charges could be brought against him.

I called Simon and told him that his wife had had diabetes. He was in denial about it, but more from ignorance about the disease than anything else. I pointedly asked why she didn't seek medical care and why he didn't seek medical care for her. He told me that his wife had had some bad experiences with doctors, that she refused to see one, and that she hated the medical establishment. There was nothing he could do to get Kim to see a doctor, and so he vowed that he would do what he could to take care of her. In the end, and after confirming her fear of the medical system, I believed him. He was sincere and really cared about his wife.

Many people make choices that ultimately lead to their demise, and at autopsy, my findings reflect this. As a medical examiner, I'm one of the few people given permission to look behind the curtain of someone's life, and what I observe is often senseless and tragic. I don't judge how people live, but I will say this: Not going to the doctor when you have a major health issue is your decision, but missing needed care might mean I'll be the doctor you'll eventually visit.

Kim Atani and Victor Baca suffered not only from deadly but treatable illnesses; they also may have suffered from latrophobia or odontophobia. These are medical terms that describe a fear of doctors or dentists, respectively, in which people put off getting medical attention, making excuse after excuse, until sometimes it's too late.

Why do we fear doctors? I think one of the big reasons is that we're filled with dread that some serious problem might be found and we're afraid of hearing bad news. It's scary to be a patient. It's even scary for *me* to be a patient! Though we like to think we'll live forever, we're all here temporarily. Seeing a doctor brings us face-to-face with our own mortality.

There are other reasons we avoid seeing a doctor. Maybe you don't think your symptoms are important. Maybe you're concerned about wasting a doctor's time. Or maybe you don't want to spend the money because you're uninsured. I can't tell you how many people I've autopsied because they didn't want to incur a medical bill.

Or maybe you're a man. Men in this country are much less likely to see a doctor than women are. Their reluctance may be one reason why the life expectancy of men is eight years shorter than that of women. Men repress pain, ignore symptoms, and deny sickness, in part to demonstrate their manhood. Society conditions men to "tough out" illness. They don't want to feel like wimps or go to the doctor for nothing. If a man does see a doctor, it's often because a woman in his life has made him go.

How Not to Die from Latrophobia or Odontophobia

No one likes to get sick. It means that you can't do the things you enjoy or the things you live for. When you're sick, you don't feel like doing much of anything, except lying in bed. You might get better on your own, but then again, you might not. If you stay sick long enough, sooner or later you'll have to go to the doctor, whether you want to or not.

Wanted: A Great Doctor

If you're afraid of doctors, one of the best ways to get over your fear is to be under the care of one you like and trust. To find that kind of doctor takes a bit of

sleuthing. Here's what I do: I look for a doctor who is geographically convenient, and I won't go to any doctor who is not board certified in his or her specialty or subspecialty. Board certification means that a doctor has had extra training after medical school and internship in an approved training program to become an expert in a field of medicine such as family practice, internal medicine, or gynecology, then has passed a rigorous qualifying examination ("the boards").

Personality is important to me, too, so I ask around to get a feel for what a doctor is like. Nurses are a great resource, since they're the ones who work with doctors day to day and see how they treat patients. I also ask friends, family, coworkers, and colleagues. Another good source is the website of the American Medical Association (www.ama-assn.org) with its DoctorFinder link. It gives you basic professional information on virtually every licensed physician in the United States. Of course, if you belong to a managed health-care plan, your choices are limited to doctors who are a part of that plan.

I also want a doctor who treats me with respect and doesn't sugarcoat things. What you need most is good communication. You end up telling a doctor a lot of intimate details about your life. If you feel uncomfortable doing so, that's your signal to find another one.

Here are ten questions to ask when choosing a new doctor:

1. Are you board certified in your specialty?
2. What type of health insurance do you take? (If applicable, find out if the doctor accepts Medicare.)
3. How frequently do you see patients who have the same health problems as I have?
4. Do you refer patients to other doctors for special problems as needed?
5. Will I need to go to another location for blood tests or are lab tests done in your office?
6. If yours is a group practice, who are the other doctors and what are their specialties?

7. Who sees patients for you if you are out of town or not available?
8. Which hospitals do you use? Will you take care of me in the hospital if I'm admitted? If not, who will? (Make sure you're comfortable being treated at one of these institutions, should the need arise.)
9. How far in advance do I need to make an appointment to see you?
10. If I've got a problem (say a drug reaction or a treatment side effect) can I speak to you or your covering physician within a reasonable time frame?

The M.D. or the M.E.?: When to See Your Doctor

It's not a good idea to rush off to the doctor for every little ache and pain, but many symptoms are signs that the situation could be serious. If you try to outlast your medical problems, you may be making more trips to a doctor in the long run or, worse yet, a trip to the morgue. Here's what happened when one of my patients passed his symptoms off as little more than the flu.

Murder or Malady?

Michael Peterson's body was about to be embalmed. Embalming is the centuries-old process by which a person is made to look alive after he's dead. Michael's blood would be drained and replaced by about four gallons of preservatives, his mouth would be wired shut, and since the eyes sink back into their sockets after death, cotton would be stuffed between his eyes and eyelids. Unlike Michael, you don't have to be embalmed after you die, unless there will be an open-casket ceremony. If you do your spadework, you'll find there are other options regarding your disposal. You can go the cremation route, in which your body is cooked at a temperature of around 2,500 degrees. On average, it takes an hour and a half for you to burn. Your ashes are returned to your loved ones in an urn, which can be displayed on the mantle or sprinkled over your garden. Whether you're embalmed and entombed or your ashes are fired from a cannon,

the price tag for your funeral may run from \$5,000 to \$10,000. Disposing of their dead is, for many families, one of the most expensive purchases they will ever make, right behind buying a car or funding a college education.

Just as the morticians were ready to carry out Michael's funeral wishes, the phone rang. It was my office calling, ordering the funeral home to halt any and all procedures on the body. Surfacing like swamp bubbles were allegations that Michael had been murdered. Had Michael been embalmed, potential evidence would have been destroyed, and the autopsy would be more difficult.

Fifty-year-old Michael Peterson had been in the hospital, fighting to stay alive despite failing kidneys. Before illness struck, things had been looking up for this retired truck driver. He had just asked his ex-wife Katharine to marry him again, hoping to pick up where they'd left off fourteen years earlier. But their wedding was not to be. On the seventh day in the intensive care unit (ICU), with Katharine at his side, Michael lost his battle. The hospital recorded his death as natural, due to kidney disease.

But Michael's hospital roommate had a different opinion, and the next morning what he told the nurse changed everything. The roommate alleged that Katharine had murdered Michael. I couldn't ignore the allegations, so I decided to bring Michael's body in.

As his body was being transported to my morgue, I reviewed the details of the accusations. According to my investigator's report, the roommate heard some kind of gasping, as if Michael was struggling to breathe. Gradually the breathing became more ragged. The disturbing sound stopped suddenly. The roommate believed Katharine had smothered Michael with a pillow. He then claimed he saw Katharine rush past his bed and into the hallway. "She told the nurse, 'He's gone, he's gone,' and then ran out of the hospital."

According to the U.S. Department of Justice, almost 15 percent of all murders are committed by a member of the victim's family, a fact we know all too well in the morgue. The allegations sounded like they could have been credible, so I took them seriously. Michael's daughter told us that after the couple divorced, Katharine had never really left the picture. Their relationship was argumentative

and stormy, further lending credence to the roommate's accusation. I began to wonder: Did Michael Peterson die of natural causes as the hospital believed, or did his ex-wife give Mother Nature a little push? Unlike the majority of autopsies I do, I would not cut open Michael Peterson's body to examine his internal organs. The hospital records contained enough information to show that Michael had died of acute kidney failure.

I would concentrate on the outside of the body in a search for signs of foul play.

The first thing I spotted was a huge bruise on the back of Michael's left shoulder. The mysterious injury was clearly not from the alleged murder, but I wanted to get to the bottom of it before continuing the exam. I returned to my investigator's report and discovered that there was more to Michael's story. He had been feeling ill, with some flu-like symptoms. On top of that, he had suffered an accidental fall four days before he was admitted to the hospital. The fall happened in the apartment he shared with his ex-wife.

Getting up from the couch, he felt faint and fell onto a coffee table, smashing his left shoulder. In terrible pain, he dragged himself over to the couch to lie down, and he remained there for four days, unable to get up and suffering from what he believed was simply the flu. Day in and day out, Michael's only sustenance were the ice cubes Katharine fed him, and that was the extent of the care he received. Eventually, he began drifting in and out of consciousness. Michael's back also had bedsores that had penetrated to the tissue underneath his skin.

Lying motionless on the couch for four days not only instigated Michael's bedsores but also triggered a potentially fatal condition called rhabdomyolysis, a fancy name for muscle breakdown. When you lie stationary for an extended period of time, your skeletal muscles can begin to physically deteriorate, especially muscles weakened by injury or the flu. As these muscles break down, the muscle cells release a protein called myoglobin that spills into the kidneys. Myoglobin wends its way through the meshwork of the kidney capillaries, accumulates in the tubules, and blocks the flow of fluid through the organs. The damaged kidneys can't filter toxic substances out of the body or regulate body chemistry. In Michael's case, these changes ultimately resulted in multiple organ failure.

Rhabdomyolysis, while occasionally fatal, is treatable in its early stages. Had Michael gotten medical care sooner, his condition could have been reversed.

I returned to the main reason for my examination—the hunt for physical evidence of suffocation that would prove Michael Peterson was murdered. I examined Michael's head and neck, looking for any kind of trauma. But I could find no such evidence. I knew that pillows are often used in suffocations because their soft surface leaves no marks on the body. At least that's what killers think. But suffocation can leave clues, literally right under the victim's nose. These clues can be pillow fibers or injuries in and around the mouth. But I could find nothing of the sort on Michael. There was no evidence that Michael was suffocated. Michael's hospital roommate, who I learned was sedated at the time, was wrong. Katharine did not murder her ex-husband. Most likely what the roommate heard behind the separation curtain were simply the last, labored gasps of a dying man.

My examination was finished, but one question remained unanswered. Why had Michael spent four days on his couch without getting medical attention, especially since his ex-wife was with him the whole time? Before long, my investigators uncovered the last remaining piece of the puzzle: an emergency response report filed just one day after Michael's fall. It revealed that Katharine, rather than acting neglectfully, had indeed called 911. Paramedics arrived and attempted to take Michael to the ER but he refused, insisting that he merely had a flu bug. Legally, emergency medical teams aren't allowed to treat anyone who is unwilling to be helped.

With Michael's stubborn refusals, the paramedics could do nothing but leave. He continued to lie on his couch, day in and day out. On the fourth day, he lost consciousness, and Katharine again called paramedics. This time, the unconscious Michael was in no condition to object. But they were too late. In the end, I ruled that Michael's death was not a homicide as had been suspected by the roommate nor natural as deemed by the hospital, but accidental—caused by a fall and muscle damage.

Lack of timely medical care can lead to disaster! Even if you aren't afraid to go to the doctor, it's important to figure out when you need to go. Here are two

axioms to follow. Seek medical attention immediately if: (1) you experience any symptom that causes an interruption in your day so severe that you can't go on with what you've planned; (2) you experience any symptom that wakes you up at night and is so bad that you can't sleep through it.

What kind of symptoms might interrupt your day or your sleep? To help identify a serious under-the-radar health problem, I've rounded up the most common covert conditions that warrant a doctor's attention, and they're listed in the table on page 25.

Many of these signs represent a significant medical emergency, and you should head straight to the emergency room. If you're experiencing symptoms such as chest or upper abdominal pain or pressure, dizziness or shortness of breath, uncontrolled bleeding, or severe vomiting, a visit to the ER is a must. Deep cuts or wounds that might require stitches are another "must go" situation. The faster you get treated, the better your prospects for survival and recovery. Lost moments can result in death. The ER, however, should not be used for sniffles and sneezes, earaches, and chronic diseases or routine care you'd normally see your doctor for.

Get Checked

Do you really need a checkup once a year? The answer to this simple question is not without controversy. On one hand, maybe not, says the U.S. Preventive Services Task Force, a government agency that studies the efficacy of medical procedures and tests. On the other hand, many primary care physicians recommend annual physicals.

I come down on the side of *yes*, we do need annual physicals, if for no other reason than to build a relationship with your doctor and talk about preventive health. Research says that people who have good relationships with their doctors are more satisfied with their health care—and get better care.

Your yearly checkup is a great opportunity to get counseling from your doctor about personal health habits. Getting a doctor's help to change bad habits may

DON'T IGNORE THESE SYMPTOMS!

Symptom	What It May Mean
Difficulty breathing, shortness of breath	Obstructive pulmonary disease (asthma or emphysema), bronchitis, heart problems, panic attacks, pneumonia, a blood clot in the lungs (pulmonary embolism), pulmonary fibrosis, anemia, upper airway obstruction, overdose, or collapsed lung
Chest or upper abdominal pain or pressure	Heart attack, tearing of the aorta, pancreatitis, pulmonary embolism, inflammation around the heart, gallbladder attack, ulcers, or pneumonia
Fainting, sudden dizziness or weakness	Heart attack, stroke, abnormal heart rhythm, heart valve abnormalities, or seizures
Changes in vision	Stroke or transient ischemic attack (TIA), bleeding in the inside of the eye, or clotting of the blood vessels of the eye
Confusion or changes in mental status	Infection, head injury, low blood sugar, medication interaction or overdose, meningitis, or encephalitis (inflammation of the brain)
Any sudden or severe headache	Stroke, blood vessel inflammation (vasculitis), meningitis, brain tumor, ruptured aneurysm (weakened blood vessel), brain abscess, uncontrolled high blood pressure, or bleeding on the brain after a head injury

Uncontrolled bleeding	Cancer, leukemia, low platelets, or liver failure
Severe or persistent vomiting or diarrhea	Gastritis (inflammation of the lining of the stomach), gallbladder attack, appendicitis, hepatitis, pancreatitis, obstruction of the bowel, infection in the abdominal cavity, or pregnancy
Coughing blood	Tuberculosis, cancer, pneumonia, bronchitis
Vomiting blood	Inflammation of the esophagus or stomach, ulcers, varices (torn blood vessels at the end of the esophagus), or cancer
Suicidal or homicidal feelings	Depression, mental health problems
Unexplained weight loss	Overactive thyroid (hyperthyroidism), depression, liver disease, cancer, diabetes, tuberculosis, AIDS, or disorders that interfere with how well your body absorbs nutrients (malabsorption disorders)
Unexplained changes in bowel habits	Bacterial or viral infection, parasitic infection, inflammatory bowel disease, colon cancer, or medication side effects
Unusual weakness or fatigue	Heart attack (especially in women or the elderly), heart failure, anemia, low thyroid (hypothyroidism), liver or kidney disease
Loss of consciousness after a fall	Bleeding around the brain (subdural hematoma), especially in people on blood thinners

Thirst and frequent urination	Diabetes mellitus, diabetes insipidus (inability to concentrate urine)
New onset of seizures	Brain tumor, bleeding on or in the brain, or vasculitis (inflammation of the blood vessels in your brain), blood electrolyte abnormalities, stroke, meningitis, or encephalitis
Persistent fever	Tuberculosis, endocarditis (bacterial infection of the heart valves), vasculitis, tumor, lymphoma, lupus, or malaria (if you've traveled to malaria-prone regions of the world), other infections
Trouble swallowing or painful swallowing	Esophageal cancer or throat cancer, infection of the throat or esophagus, neurologic problems, or AIDS
Persistent hoarseness	Throat cancer or other malignancies
Severe, incapacitating back pain	Myeloma, metastatic cancer, leaking aortic aneurysm or torn aorta, epidural abscess (abscess around spinal cord), shingles, or slipped or herniated discs
Hot, tender, or swollen joints	Joint infection, acute arthritis, gout, or vasculitis
Severe diarrhea	Infection due to viruses, bacteria, or parasites, inflammatory bowel disease (Crohn's disease or ulcerative colitis), or AIDS

Is It Heartburn or a Heart Attack?

I call it the “pink stomach syndrome.”

At autopsy, the person’s stomach is coated with a bright pink paste. This tells me, before I even dissect the heart, that the decedent probably died of a heart attack.

How do I know? Many supposed cases of indigestion are actually a symptom of a heart attack. People are often too willing to assume that “it’s just something I ate,” and they pop some Pepto-Bismol pills or take the liquid for relief, when they’re really having a heart attack. Later, the person is found dead. If there’s an autopsy, there will be traces of the antacid in the stomach—hence the pink stomach syndrome.

Yes, heart attacks do sometimes announce themselves with a Fred Sanford moment. “This is the big one, Elizabeth,” as Sanford, played by Redd Fox on the 1970s sitcom *Sanford and Son*, used to say as he clutched his chest and gazed heavenward. But the severe crushing pain people imagine when they think of a heart attack is not always present. For 30 percent of people who die from heart disease, indigestion or another seemingly unrelated symptom was their only warning. Passing off sudden or severe indigestion is a recipe for disaster.

The typical pain of a heart attack is squeezing pain in the chest, a feeling of fullness, or pressure that lasts for several minutes. These signs may be accompanied by light-headedness, shortness of breath, sweating, or nausea. The pain may radiate to either shoulder, the back, the arms or the hands, the neck, or the jaw. If you experience any of these symptoms, it’s important to call 911 immediately, take an aspirin (unless you have an allergy to aspirin or have been told not to take it by your doctor), and go to the emergency room by ambulance. Don’t attempt to drive yourself.

The only way to safely rule out a heart attack is to be seen by a doctor as soon as possible and allow diagnostic tests to be run. The most important thing

to remember when dealing with chest discomfort is this: Every moment counts. If your pain is caused by a heart attack, the longer you wait to seek treatment the more severe the damage to your heart could be. Don't fool around with chest pain. Your life could be at stake.

save more lives than often-repeated diagnostic tests. In other words, does your doctor help you quit smoking or simply give you a chest X-ray to see if you've dodged the bullet one more year? Does he or she seem worried that you're eating a bunch of stuff dietitians forbid?

The annual physical is also time to have your cholesterol, blood pressure, and blood sugar tested. Ideally, your total cholesterol level should be less than 200 mg/dl; your HDL (the "good" cholesterol) 35 mg/dl or higher; and your LDL (the "bad" cholesterol) less than 100 mg/dl. Normal blood pressure is 120 over 80, and normal fasting blood sugar is less than 100 mg/dl. Keeping your cholesterol, blood pressure, and blood sugar within healthy ranges through diet, exercise, and sometimes medication will help maximize your longevity.

Your primary care physician can also keep you up-to-date on immunizations and other screening tests you might need, based on your health status, risk factors, and your family history of certain diseases. Adult vaccinations are an often-overlooked component of a preventive program. In the tables on pages 30, 32, and 34, I've listed the screening tests and vaccinations you may need, but always check with your doctor to see which ones apply to you and how often you should have them.

Get the Most Out of Your Next Doctor's Visit

A doctor's appointment is a visit most people dread. Just the thought of putting on one of those gowns that fits like a bib is enough to make you want to cancel your appointment altogether. But don't worry. Instead of dreading a date with

MAJOR SCREENING TESTS FOR WOMEN: WHAT YOU NEED AND WHEN

Screening Test	When
Body mass index (BMI) measurement	Each health-care visit.
Blood cholesterol test	Regularly, starting at age forty (earlier if you have diabetes, high blood pressure, family history of heart disease, or you smoke).
Blood pressure measurement	At least every two years. High blood pressure was traditionally defined as 140/90 or higher, but recent data says that you should try to keep your blood pressure near normal, which is 120/80.
Blood glucose (sugar) test	Starting at age forty-five, every three years.
Colorectal cancer screening	Starting at age fifty, every one to ten years depending on the test used.
Clinical breast exam (CBE)	Starting at age twenty, every three years; yearly after age forty.
Mammography	Starting at age forty, yearly.
Pap test	Starting at age eighteen to twenty, yearly. After age thirty, every one to three years, depending on the test used and past results.
Dental exam	Twice a year. (People with gum disease may be more likely to have a heart attack, stroke, or thickening of the arteries. Oral bacteria

	have been found in arterial plaque and can induce a process that leads to blood clots.)
HIV test	At least once; additional testing is important if you have risk factors.

Source: U.S. Department of Health and Human Services

your doc, you can make it a positive and beneficial experience by preparing for your appointment in advance. This helps your doctor diagnose, prevent, and treat any condition that may be troubling you.

When my doctor-husband goes to the doctor, he brings his written medical history, a list of any medicines he's taking, and other medical information, such as recent test results. He's active in his own health care—as we all should be. So prepare for each and every doctor's appointment.

For starters, write down each medication you're taking, who prescribed it, when it was prescribed, and for what condition. Jot down the strength of the medicine, how much you take, and when. Add to this list any over-the-counter (OTC) drugs you're taking or have taken recently, such as vitamin supplements, antacids, or aspirin products.

Whether going in for a routine examination or for a particular problem, you're sure to have questions. Write them down and have them on hand so you can remember to read them to your doctor.

If you're seeing your doctor for a specific medical problem, provide information about your symptoms. Reporting your symptoms is one of three main ways your doctor figures out what's wrong with you. The other two are the physical examination, in which your doctor looks and feels and listens; and tests, from taking your temperature to doing blood tests to running sophisticated scans. But most of the time, an accurate description of your symptoms will lead your doc to the correct diagnosis, even if he later confirms it with the exam and tests.

MAJOR SCREENING TESTS FOR MEN: WHAT YOU NEED AND WHEN

Screening Test	When
Body mass index (BMI) measurement	Each health-care visit.
Blood cholesterol test	Regularly, starting at age thirty-five (earlier if you have diabetes, high blood pressure, family history of heart disease, or you smoke).
Blood pressure measurement	At least every two years. High blood pressure was traditionally defined as 140/90 or higher, but recent data says that you should try to keep your blood pressure near normal, which is 120/80.
Blood glucose (sugar) test	Starting at age forty-five, every three years.
Colorectal cancer screening	Starting at age fifty, every one to ten years depending on the test used.
Prostate specific antigen (PSA) test and digital rectal exam (DRE)	Starting at age fifty. Ask your doctor about this since testing is controversial.
Abdominal aortic aneurysm	If you're between the ages of sixty-five and seventy-five and have ever smoked (one hundred cigarettes in your lifetime), be screened once for abdominal aortic aneurysm, which is an abnormally large segment of your aorta, the major vessel from the heart.

Dental exam	Twice a year. (People with gum disease may be more likely to have a heart attack, stroke, or thickening of the arteries. Oral bacteria have been found in arterial plaque and can induce a process that leads to blood clots.)
HIV test	At least once; additional testing is important if you have risk factors.

Source: U.S. Department of Health and Human Services

I once autopsied a woman who went to her doctor and described only one symptom: lower abdominal pain. Not long afterward, she died of meningitis. She had never mentioned any symptoms of meningitis, such as fever, headache, stiff neck, and vomiting, so the doctor treated her abdominal pain. The clues you provide are what guide your physician. In the absence of clues, it's tough for your doctor to get it right. You, the patient, will get much better treatment if you supply the information about what you feel and what you sense in your own body. If you're in pain, for example, be as specific as possible about the type of pain you feel. Is it a dull ache, a throbbing ache, a sharp stabbing pain, or a more generalized discomfort? Where? Do you feel the pain only in one place, or does it occur in different places? List these. Does the pain begin in one spot and then seem to move to another? If so, describe it. Also, write down when the pain occurred and how long you've had it. Some problems can come on without pain, of course, so it's important to report any changes you think are significant. Think about it: Who knows your body better than you? Be honest with your health-care professional.

You can follow a few other simple directions to ensure that your visit will be a productive one. Take notes, or have someone come with you to help you understand and remember the information. If there's anything you don't understand, be sure to ask the doctor to explain or illustrate it. Ask for written instructions, too. When you think you understand, restate what you heard so there is no

VACCINATIONS TO PREVENT DISEASE

Shot	When You Need It
Measles-mumps-rubella (MMR) shot	At least once if you have never had this shot as an adult and were born after 1956 (otherwise you have immunity). There have been recent outbreaks of mumps in the United States, and the potential for measles imported from other countries remains high.
Tetanus-diphtheria (Td) shot	Once every ten years. A new tetanus-diphtheria-whooping cough (pertussis) vaccine, DTaP, should be substituted for one of the tetanus-diphtheria boosters before age sixty-five. This vaccine will also help to protect young people with whom you come in contact.
Flu shot	Every year after age fifty or sooner if you have lung, heart, or kidney disease, diabetes, or cancer; you are a health-care worker; or you are infected with HIV. I recommend all adults receive the influenza vaccine annually. Influenza and its complications remains one of our largest and most preventable killers.
Pneumonia shot	Once at age sixty-five for healthy adults. Those with chronic illnesses should receive vaccines earlier and may need repeat doses.

Hepatitis B shot

If you engage in risky sexual behavior, have had any sexually transmitted disease within the last six months, have injected street drugs, work at a job that involves contact with human blood or blood products, or travel to areas where hepatitis B is common. This vaccine, given once as a three-shot series, is now universally given to children.

Shingles vaccination

If you are sixty or older, strongly consider this one-time vaccine since shingles can be a devastating, painful illness.

**HPV vaccination
(for protection against cervical cancer)**

Three shots, given in a series, for girls eleven or older or for women age thirteen to twenty-six who have not been previously vaccinated.

Source: U.S. Department of Health and Human Services

question about its accuracy. If the doctor uses words or terms you don't know, ask for a translation. Virtually all medical lingo can be put into easily understandable language. When you participate in the process and help your doctor figure out what's wrong, you'll get much better health care. It's your body, and you've got to take responsibility for it.

TURN THE TABLES: Know Your Cancer Risk for Better Protection

My grandmother had breast cancer, raising the possibility that this cancer runs in my family. To get a sense of your own cancer risk, find out the types of cancer that occurred in your family and bring this to the attention of your doctor. If your family history puts you at higher risk, you may need to be screened more often.

Can You Trust Your Diagnosis? When to Ask for a Second Opinion

In 2006, a large growth was found in my ovaries. My doctor suspected I had ovarian cancer, which is among the most insidious and deadly of cancers. To say I was terrified is to understate the case. I had just remarried, yet in a heartbeat the rhythm of my new life changed. Mark's first wife had died of ovarian cancer; here he was, possibly facing the disease anew with me. It was a very scary time for both of us. We went about our days, acutely aware that a disease of such proportion would disrupt our lives. All the plans, all the hopes we had for the future were put on hold.

I was referred to an oncologist for a second opinion. I asked him many different questions. He laid out all my options and reaffirmed that I needed surgery to determine whether I had cancer. Had I not liked the options, I wouldn't have hesitated to get even a third opinion.

It's always a good idea to get a second opinion when you're facing surgery, you've been diagnosed with a serious illness, or you're at all uncomfortable with your doctor's recommendations. You want to have confidence in your treatment. Don't be embarrassed or feel that you may insult your doctor if you seek another opinion. Say something like this: "I think I'd like a second opinion, do you mind?" Or, "I value your advice, but I'm thinking about getting a second opinion." Occasionally, a doctor will get angry. If that happens to you—run away, fast! You need a doctor who supports decisions that are in your best interest.

Be sure to get an objective second opinion, too. You need an independent evaluation of your case from a physician who is totally unconnected to your doctor. Also important: Make your medical history available to the doctor providing the second opinion.

As for my situation, after my surgery my doctor called to tell me fabulous news: Further tests had found no cancer. When I heard this, every muscle in my body relaxed. I smiled and cried at the same time. Now I could get on with my life.

If you're living with a fear of doctors, the cost to your health could be high. When problems are discovered early, the prognosis can be very good. Your physician plays a critical role in your overall health, but he can't help you if you refuse to see him. Medicine can be wonderful, but it's useless if you won't avail yourself of its healing power.

LIFE LESSONS: Oral Sex Can Lead to Head and Neck Cancers

For much of my medical career, I was taught that head and neck cancers were caused by smoking, heavy alcohol use, and particularly a combination of the two. Now there's a new culprit on the block: human papillomavirus (HPV), the virus that causes cervical cancer. HPV infections appear to multiply the risk of certain head and neck cancers, particularly those of the tonsils, according to researchers. Studies have found that a certain strain of HPV was present in tumor cells in people's mouths and throats and might have been transmitted through oral sex. Medical experts say the HPV vaccine, which is highly effective against cervical cancer, might also lower the incidence of tumors in the head and neck.