Protecting Yourself in Age Management

Dr. Rob Kominiarek DO FACOFP
The Ten “Doc” Commandments

1. Never talk money. Too much and you make people jealous. Too little and you look weak and unsuccessful.
2. Action is your only language
3. Everyone has a price. Never let your guard down
4. Never inject your own supply
5. Separate your professional life and private life
6. Do not extend credit in house
7. Never treat family
8. Reduce liability
9. Be careful who you associate with professionally and personally
10. Avoid debt
Protecting Yourself in Age Management

1. Social Media
2. Insurance
3. Behavior
4. FDA / DEA / OARRS / Medical Boards
5. Prescriptions
6. Testing
7. Contracts
8. Online Reviews
9. Documentation
Protecting Yourself in Age Management

Social Media

Keep your professional life and personal life separate
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Social Media

Keep your professional life and personal life separate
Protecting Yourself in Age Management

Do not accept insurance in your Gero-Protective Practice
Protecting Yourself in Age Management Behavior
Protecting Yourself in Age Management Behavior

- Nothing less than professional behavior with patients and staff
- Solid boundary function
- Alcohol
- Drugs
Protecting Yourself in Age Management

FDA / DEA / OARRS / MBs

• Use only FDA approved medications
• Avoid prescribing opioids and benzodiazepines
• You are being followed
• Your state tracks your controlled prescriptions
• Your state talks with other states
• Your Medical Board is not your friend
• CBD oil is considered marijuana
Protecting Yourself in Age Management
Prescriptions

• Do not get high on your own supply
• Do not keep controlled substances in your office
• Do not write for any controlled prescriptions for family
• If you require a controlled medication, establish a relationship with a colleague
Protecting Yourself in Age Management
Testing

JUST
DO IT
<table>
<thead>
<tr>
<th>Hormone Testing</th>
<th>Results</th>
<th>Range</th>
<th>11.27.17</th>
<th>10.14.16</th>
<th>1.17.17</th>
<th>5.5.17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth Hormone</td>
<td>8.99 N</td>
<td>5 ng/ml</td>
<td>0.1 LN</td>
<td>0.1 LN</td>
<td>0.1 LN</td>
<td>0.1 LN</td>
</tr>
<tr>
<td>Somatomedin C (IGF-1)</td>
<td>159 L</td>
<td>&gt; 200 ng/ml</td>
<td>188 L</td>
<td>167 L</td>
<td>201 L</td>
<td></td>
</tr>
<tr>
<td>IGF BP-3</td>
<td>3900 L</td>
<td>4000 ug/L</td>
<td>2727 L</td>
<td>3295 L</td>
<td>3226 N</td>
<td></td>
</tr>
<tr>
<td>DHEA-S</td>
<td>255.6 N</td>
<td>255 ug/dL</td>
<td>308.5 HN</td>
<td>472.6 HN</td>
<td>327.2 HN</td>
<td>231 N</td>
</tr>
<tr>
<td>Testosterone Free</td>
<td>23.77 N</td>
<td>21 ng/dL</td>
<td>29.6 HN</td>
<td>35.6 HN</td>
<td>30.5 HN</td>
<td>20 N</td>
</tr>
<tr>
<td>Testosterone Total</td>
<td>9.8 N</td>
<td>690 ng/dL</td>
<td>1444 HN</td>
<td>1173 HN</td>
<td>1036 HN</td>
<td>777 N</td>
</tr>
<tr>
<td>Dihydropyrostosterone (DHT)</td>
<td>35.6 N</td>
<td>&lt; 55 ng/dL</td>
<td>81 HN</td>
<td></td>
<td>67 N</td>
<td></td>
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<tr>
<td>Sex Hormone Binding GB</td>
<td>25 N</td>
<td>&lt; 45 nmol/L</td>
<td>31.3 N</td>
<td>1.4 N</td>
<td>1.6 N</td>
<td>1.6 N</td>
</tr>
<tr>
<td>Prostatic PSA</td>
<td>1.530 N</td>
<td>&lt; 4.0 ng/mL</td>
<td>1.4 N</td>
<td>1.6 N</td>
<td>1.6 N</td>
<td>1.6 N</td>
</tr>
<tr>
<td>Estrone (E1)</td>
<td>32.2 N</td>
<td>12-72 pg/mL</td>
<td>99 HN</td>
<td></td>
<td>89 HN</td>
<td></td>
</tr>
<tr>
<td>Estradiol (E2)</td>
<td>49.8 HN</td>
<td>7.6-42.6 pg/mL</td>
<td>63.5 HN</td>
<td>49.7 HN</td>
<td>59.8 HN</td>
<td>52.4 HN</td>
</tr>
<tr>
<td>Pregnenolone</td>
<td>16.1 L</td>
<td>110 ng/dL</td>
<td>72 LN</td>
<td>33 L</td>
<td>27 L</td>
<td>163 N</td>
</tr>
<tr>
<td>Progesterone</td>
<td>0.99 N</td>
<td>0.8 ng/ml</td>
<td>0.3 L</td>
<td>0.3 N</td>
<td>0.3 N</td>
<td></td>
</tr>
<tr>
<td>FSH</td>
<td>0.4 LN</td>
<td>7 mIU/ml</td>
<td>0.2 LN</td>
<td></td>
<td>0.2 N</td>
<td></td>
</tr>
<tr>
<td>LH</td>
<td>0.07 LN</td>
<td>5.1 mIU/ml</td>
<td>0.1 LN</td>
<td></td>
<td>0.1 LN</td>
<td></td>
</tr>
<tr>
<td>Prolactin</td>
<td>5.8 N</td>
<td>14 ng/ml</td>
<td>*</td>
<td></td>
<td>10.5 NN</td>
<td></td>
</tr>
<tr>
<td>Copper</td>
<td>88 N</td>
<td>72 - 166 ug/dL</td>
<td>64 L</td>
<td></td>
<td>74 N</td>
<td></td>
</tr>
<tr>
<td>Zinc</td>
<td>118 N</td>
<td>95 mcg/dL</td>
<td>71 L</td>
<td></td>
<td>91 N</td>
<td></td>
</tr>
<tr>
<td>Insulin</td>
<td>1.8 N</td>
<td>&lt; 25 mIU/L</td>
<td>3.0 N</td>
<td></td>
<td>5.9 N</td>
<td></td>
</tr>
<tr>
<td>Iron</td>
<td>95 N</td>
<td>&lt; 160 ug/dL</td>
<td>*</td>
<td></td>
<td>117 N</td>
<td></td>
</tr>
<tr>
<td>TSH</td>
<td>3.755 H</td>
<td>&lt; 2.5 uIU/mL</td>
<td>2.5 N</td>
<td></td>
<td>2.56 HN</td>
<td></td>
</tr>
<tr>
<td>T3, Free</td>
<td>2.9 N</td>
<td>&gt; 2.5 pg/ml</td>
<td>2.5 N</td>
<td></td>
<td>2.6 N</td>
<td></td>
</tr>
<tr>
<td>T4, Free</td>
<td>1.20 LN</td>
<td>&gt; 1.5 ng/ml</td>
<td>1.19 LN</td>
<td></td>
<td>1.14 LN</td>
<td></td>
</tr>
<tr>
<td>rT3</td>
<td>15.6 N</td>
<td>8-25 ng/dL</td>
<td>16.6 N</td>
<td></td>
<td>15.4 N</td>
<td></td>
</tr>
<tr>
<td>TSH Index</td>
<td>3.9 N</td>
<td>(HAP) 1.3 - 4.1 (PI)</td>
<td>2.66 N</td>
<td></td>
<td>2.7 N</td>
<td></td>
</tr>
<tr>
<td>T3/rT3 Ratio</td>
<td>18.5 LN</td>
<td>&gt;20</td>
<td>15.0 L</td>
<td></td>
<td>16.8 L</td>
<td></td>
</tr>
<tr>
<td>TPO</td>
<td>29 N</td>
<td>&lt;35</td>
<td>15 N</td>
<td></td>
<td>13 N</td>
<td></td>
</tr>
<tr>
<td>ACTH</td>
<td>*</td>
<td>35 pg/ml</td>
<td>19.9 N</td>
<td></td>
<td>31.5 N</td>
<td></td>
</tr>
<tr>
<td>Cortisol AM</td>
<td>17.7 HN</td>
<td>11.1-15 ug/dL</td>
<td>6.9 LN</td>
<td></td>
<td>9.1 N</td>
<td></td>
</tr>
<tr>
<td>Homocysteine</td>
<td>10 N</td>
<td>&lt;10.0 umol/L</td>
<td>8.1 N</td>
<td></td>
<td>8.9 N</td>
<td></td>
</tr>
<tr>
<td>hs-CRP</td>
<td>0.9 N</td>
<td>&lt;1.0 mg/L</td>
<td>0.40 N</td>
<td></td>
<td>0.36 N</td>
<td></td>
</tr>
<tr>
<td>Hemoglobin A1c</td>
<td>5.7 HN</td>
<td>&lt; 5.0 %</td>
<td>*</td>
<td></td>
<td>5.7 HN</td>
<td></td>
</tr>
<tr>
<td>Vitamin D3</td>
<td>76.7 N</td>
<td>&gt;60 ng/mL</td>
<td>65.7 N</td>
<td>62.1 N</td>
<td>74.7 N</td>
<td>80.7 N</td>
</tr>
</tbody>
</table>

* The IDEAL RANGE is at the 50th percentile of optimal. Treatment is geared to 50th-75th percentile

L = Low       LN = Low-Normal  N = Normal    HN = High-Normal   H = High
Protecting Yourself in Age Management

Contracts

If you are not using contractual agreements between you and your clientele, and consent forms, it is time to start.

- Testosterone consent
- AI consent
- Peptide consent
- HGH consent
- Statin consent
- Procedural consent
Protecting Yourself in Age Management
Online Reviews

Bad reviews cost you business
Protecting Yourself in Age Management Documentation

Keep track of EVERYTHING
Do your notes look like this:

Name:
DOB:

Last visit: 6/2/15
Due for visit: YES  NO

Renewal Last Paid: 6/16
Renewal DUE:

Last Labs Done: 11/19/16
Labs Due:

Balance:

Patient needs: 1/19/16
As these needs to...
Impression:

Partial Androgen Deficiency, Vitamin D Deficiency, Pregnenolone Deficiency, DHEA Deficiency, Fatigue, Subclinical hypothyroidism, Short term memory deficit, Vitamin B Deficiency, Muscle spasms

Medical Decision Making:

After examination and review of laboratory and questionnaires a mutually agreed upon medical plan was instituted to correct the multiple hormonal deficiencies and excesses in stages. After an extensive conversation with Joey expressed a sincere desire to continue with therapy to correct his multiple deficiencies. I discussed quite extensively that nutritional compliance is of the utmost importance for weight management. I advised Joey to follow up with his primary care physician and specialists for continuity of care. We discussed extensively his history and the use of hormones/medications to improve his hormone symptoms and the potential risks and benefits of the use as related to his medical history. After about a 2 hour examination/discussion with questions and answers, Joey elected to proceed with a therapeutic approach utilizing therapy with the goal of bringing his levels to the median. He was given our monthly follow up questionnaires to fill out every 30 days for the next 3 months to help assess his response to continued testosterone therapy. Joey had been suffering with decreasing energy, fatigue that is often unrelieved by rest, irritability, decreased exercise tolerance, a decreased sense of well-being, lack of drive and assertiveness and a poor response to stress, poor concentration that has progressed over the last several years, all symptoms of testosterone declination. We extensively reviewed the literature as it applies to Joey's medical conditions.

Testosterone deficiency is an important clinical condition that affects men of all ages. No accepted level denotes a deficiency and only symptoms denote a deficiency and there is no useful biologic parameter that reflects androgen activity. It is also well known that blood levels have no correlation with symptoms of hypogonadism. Additionally, variable phenotypes of androgen insensitivity exist, owing to mutated androgen receptors. Modulation of androgen effects is related to the CAG repeat polymorphism in exon 1 of the androgen receptor gene. Clinically, the CAG repeat polymorphism relates to the variations of androgenicity in various tissues and psychological traits. Decreased receptor site sensitivity results in androgen resistance and increased symptoms as well. Treatment with testosterone, SERM, or an LH analog provides relief from symptoms for many affected individuals and improves general health parameters. Mortality and incident coronary artery disease are inversely associated with serum testosterone concentrations as is severity of coronary artery disease. Established benefits of testosterone therapy in hypogonadal and eugonadal men include improved sexual desire and function, improved energy, mood and vitality, increased lean mass, decreased waist circumference, decreased inflammatory visceral fat and cytokines, and increased bone mineral density and improved glycemic control. Individualized hormone replacement therapy aimed at normalization is associated with significant improvements in serum triglycerides, LDL-C, total cholesterol, total cholesterol/HDL-C ratio, decrease in CIMT and atherosclerotic lipid profile, increase in CO, increase in EF, decrease in CVD, increased lean body mass, decreased inflammatory visceral fat, improvement in energy levels and emotional reaction, improved psychological well-being, improved skeletal mass and osteopenia/osteoporosis scores, decreased fatigability and greater vitality.

Fertility: The patient is also advised that testosterone can cause testicular atrophy (shrinkage in size) and infertility, although that is usually reversible upon discontinuation of testosterone. However, infertility may be permanent, although it is very rare. We advise men to consider postponing treatment with testosterone if he desires to maintain fertility and to resume testosterone at a later time when fathering children is no longer anticipated. Transdermal testosterone cream can transmit to the spouse and children and we have advised the patient of the harm of transference to others and how to avoid transference to others. Testosterone can increase hemoglobin and red blood cells which some term thick blood or polycythemia. This increase in red blood cells, however, is not the blood disorder polycythemia but is rather termed erythrocytosis. However, many doctors mistakenly may think it is polycythemia, a blood disorder that is harmful. Over 50 years of studies do not show any harm of testosterone induced erythrocytosis.

Joey has been suffering with thinning hair, sensitivity to cold, dry skin, muscle fatigue and weakness, fatigue, feeling depressed and or moody, apathy, difficulty losing weight, and periods of constipation all symptoms of low thyroid function. A trial of combination therapy is may be trialled to relieve these symptoms. Recent studies have confirmed
that even mild thyroid disease can affect the metabolism. Despite normal laboratory results, patients with subclinical hypothyroidism warrant treatment of their symptoms. Evidence of an association between subclinical hypothyroidism and cardiovascular disease is mounting. The impact of thyroid hormone on lipid levels is primarily mediated through triiodothyronine (T3). The resulting decreasing T3 levels seen in hypothyroidism may result in increased serum cholesterol levels. Current data suggest that normalizing even modest TSH elevations may result in improvement of the lipid profile. As essential elements of DNA-binding proteins that regulate transcription, thyroid hormones influence the utilization of essentially all substrates, vitamins, and hormones. Replacement does of T3 sufficient to return levels to a normal, enhance left ventricular function and normal expression of T3 responsive genes, thus supporting the therapeutic utility of combination therapy. The Journal of Endocrinology and Metabolism found that even suppressive doses of levothyroxine therapy that lowers TSH to hyperthyroid levels, has no significant effect on bone metabolism or bone mass. Additionally, genetic variants of deiodinase activity are associated with decreasing activity at various end organs as a result of one of 2 common single nucleotide polymorphisms (Thr92Ala), these changes in deiodinase activity play an important role in the individual response to replacement therapy. A significant reason as to why some individuals fail to respond to L-T4 therapy alone and feel significantly better on combination L-T4/L-T3 replacement therapy.

In patients with subclinical hypothyroidism, the presence of TPO antibodies is associated with an increased risk of developing overt hypothyroidism. Many physicians use the TPO antibody test as a diagnostic tool in deciding whether to treat a patient with subclinical hypothyroidism and the Mayo Clinic and numerous studies endorse this practice. Thyroid disease may be present for years before the clinical manifestation of hypothyroidism becomes evident. The highest TPO levels are observed in patients suffering from hashimoto’s thyroiditis.

Peptide therapy aimed at normalization of the serum IGF-1 is associated with significant improvements in serum triglycerides, LDL-C, total cholesterol, total cholesterol/HDL-C ratio, decrease in CIMT and atherogenic lipid profile, increase in CO, increase in EF, decrease in CVD, increased lean body mass, decreased inflammatory visceral fat, improvement in energy levels and emotional reaction, improved psychological well-being, improved skeletal mass and osteopenia/osteoporosis scores, decreased fatigability and greater vitality.

In adults the goals of are to restore normal body composition, improve muscle and cardiac function, normalize serum lipid concentrations, and improve quality of life. GH in randomized placebo-controlled studies has shown to enhance energy, self-esteem, social function, general well being, improve memory and cognition, normalize lipid profiles, improve body composition, increase physical capacity, improve heart function with increased myocardial mass and reduced LV size with improvements in hemodynamics, energy and metabolism, reduced CIMT, and improve bone mineral density. An increase incidence in cancers or re-growth of tumors has never been found in any study to date.
Protecting Yourself in Age Management

Pilots are only one medical away from losing their job.

Doctors are only one investigation away from losing theirs.