NEWSLETTER

OF THE ASSOCIATION OF FORMER *PAHO/WHO STAFF MEMBERS*

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SIXTH GENERAL MEETING

The Sixth Annual General Meeting of the Association of Former PAHO/WHO Staff Members was held on 16 November 1995. The members attending were welcomed by the AFSM President Hans Bruch, by Dr. David Brandling-Bennett, Deputy Director of PAHO, and by Mr. Michael J. Custy, from the PAHO Office of Personnel. Dr. José María Salazar Bucheli was elected ad hoc Chairperson for the meeting.

Dr. Brandling-Bennett conveyed to the participants the greetings of the Director, Dr. George A. O. Alleyne. He talked about the priorities selected for action, the goals to be achieved and the present structure and functions of the Organization. He described the level of continuity of action in relation to the previous 12 years with adjustments made in order to comply with priorities set forth by the by the PAHO Governing Bodies and by the Ninth General Program of Work of WHO. Some clouds remain due to the present financial situation of the countries of the Region.

In his report to the AFSM members the President reviewed the state of the Association and summarized the different activities carried out during 1995. In the absence of the Treasurer, the President indicated that he would read his financial report concerning the status of the Association and proceeded to do so.

In the election held at the General Meeting the following members were voted to the Board of Directors : Jaime Ayalde, Hans A. Bruch, and Flora García Early.

After the business meeting two representatives of the United Seniors Health Cooperative (USHC) presented a seminar on “Long -Term Health Care Insurance : To Buy or not to Buy”. A summary of this presentation will be sent to AFSM members at a later date.

ELECTION OF OFFICERS

At its meeting of 30 January 1996, the Board of Directors elected the following officers for the current year:

President	Jaime Ayalde
Vice-President	Hans A. Bruch
Treasurer	Renate Plaut
Secretary	Jean S. Surgi
Asst. Secretary	Flora Early
Members at Large	Dana Dashiell
	Carlos H. Daza
	Maria Mercedes Segarra-Hines
	Federico Varela

At the end of this meeting, Maria Mercedes Segarra-Hines submitted her resignation from the Board of Directors, indicating that the pressure of other commitments did not allow her the time she needed to work with the AFSM. At the meeting of the Board of 27 February, and in accordance with the bylaws of the Association, Mrs. Hortensia Saginor was elected to fill the vacancy.

SOCIAL ACTIVITIES

On 1 October an afternoon picnic was held, for the purpose of visiting with good friends and acquaintances and enjoying good food and refreshments at the residence of Hans Bruch.

This provided an oppor-tunity for members of the Association and their families to become reacquainted with former colleagues, to share fond memories of "when we were young", and to greet old friends.

The fall picnic and the spring luncheon constituted the Association's principal social activities for the year. We hope to have more members participating in similar events which will be organized during 1996.

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MEDICARE ELIGIBILITY FOR NON-U.S. CITIZENS

by Renate Plaut

During the last pre-retirement seminar held at PAHO, the AFSM observer learned that persons who do not qualify for Social Security benefits may nevertheless be eligible for Medicare benefits, if certain conditions are met. Potentially, this applies to all former staff who, while working at PAHO, were either G-4 visa holders or legal permanent resident aliens and are not eligible for Social Security based on their spouse's employment.

A brief summary about Medicare eligibility and enrollment is given below:

Medicare is the United States health insurance program for people age 65 or older, certain people with disabilities who are under 65, and people of any age who have permanent kidney failure. It provides basic protection against the cost of health care, but it does not

cover all medical expenses or the cost of most long-term care.

COVERAGE

Medicare has two parts. They are:

Hospital Insurance, also called "Part A" Medicare, which is financed by a portion of the payroll (FICA) tax that also pays for Social Security; and

Medical Insurance, also called "Part B" Medicare, which is partly financed by monthly premiums paid by people who choose to enroll.

Medicare Hospital Insurance can help pay for inpatient care in a hospital or skilled nursing facility, home health care, and hospice care. Except for home health care, each is subject to a benefit period, which measures the use of services covered by Medicare Part A.

Medicare Medical Insurance helps pay for doctor's services and many medical services and supplies that are not covered by the hospital insurance part of Medicare, such as ambulance services, outpatient hospital care, and X-rays.

Medicare should not be confused with Medicaid. Medicaid is a different program, run by the States, designed primarily to help people with low income and little or no resources.

ELIGIBILITY

Part A: Medicare Hospital Insurance

In general, people 65 or older who are entitled to Social Security benefits based on their own or their spouse's employment are eligible to sign up for Medicare Hospital Insurance without having to pay any premiums. People 65 or older who do not qualify for (free) Medicare may buy Part A coverage for a monthly premium if they also enroll and pay the monthly premium for Part B (see below). Premiums are adjusted every year. For 1995, the premium for Part A was $261.00 per month for people who had not made any contributions to Social Security.

Part B: Medicare Medical Insurance

Almost anyone who is 65 or older - or is under 65 but eligible for hospital insurance - can enroll for Medicare Medical Insurance by paying a monthly premium.

Aliens who are 65 or older and are not eligible for hospital insurance must be lawfully admitted permanent residents and must live in the United States for five years before they can enroll for medical insurance. Premiums are adjusted every year; they are the same for citizens and non-citizens. For 1995 the premium for Part B was $46.10 per month, provided one signed up as soon as one became eligible. The monthly premium for Part B increases 10% for each 12-month period for which one was eligible but did not enroll. To buy Part A coverage, one must enroll and buy coverage for Part B as well; both parts can be discontinued at any time. The enrollment periods are quite narrow; they are the same for Part A and Part B.

It is very important to note that the *period for enrolling in Medicare extends from three months prior to a person's 65th birthday to three months after, provided the person*

has legally resided in the country for at least five years. This five-year period includes any period in which the person has remained in the country with a green card, G4 visa, or any other ,visa authorizing the person to legally reside in the country. At any rate, he or she must have a Resident Alien card upon submission of the application.

However, between January 1 and March 31 of each year, Medicare accepts requests for late enrollment. Once such applications are approved, claims for reimbursement can only be submitted for medical expenses incurred after July 1 of the year of approval.

The above summary deals with only some general aspects of Medicare eligibility and enrollment. Former staff residing in the United States may want to obtain more detailed information and to find out what kind of health care costs are covered by Part A and Part B and what is not covered by Medicare. To this end, Social Security may be contacted at its toll-free number, **1-800-772-1213**, between 7:00 a.m. and 7:00 p.m. on any business day. (The best times to call are early in the morning or late in the afternoon, late in the week, and toward the end of the month.)

An analysis of how Medicare complements the coverage provided by our own WHO Staff Health Insurance should assist in deciding whether or not to buy Medicare Medical Insurance, and whether or not it seems worthwhile to buy Medicare Hospital Insurance for those not eligible to sign up for free.

However, the Congress of the United States is currently finalizing legislation to modify Medicare, and the Fourth Joint Meeting on Staff Health Insurance of WHO has proposed some changes which, at this writing, may have been signed by the Director-General. Both of these sets of changes may need to be considered in deciding whether or not to buy Medicare coverage.

Stay tuned!

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PAHO STAFF

The director of PAHO has announced the following new appointments:

Dr. Stephen J. Corber as Director, Division of Disease Prevention and Control (HCP) . Dr. Corber, a national of Canada, obtained both his Bachelor of Science and his Medical degrees from McGill University in Montreal, Canada. He also was awarded a Doctorate in Public Health at the University of Liverpool in England and was named a Fellow of the Royal College of Physicians in Community Medicine at the University of Ottawa. His international experience includes work in Peru, Papua New Guinea and the United States. He is Clinical Associate Professor of the Department of Epidemiology and Community Medicine of the University of Ottawa.

Ms. Bryna Brennan as Chief of Public Information (DPI) in Washington D.C. Ms. Brennan, a national

of the United States of America, obtained a Bachelor of Arts degree from New York University and a Master's degree in International Public Policy from Johns Hopkins School of Advanced International Studies (SAIS) in Washington, D.C.

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LETTERS FROM THE FIELD

Louis J. Lovelace (from Escondido, CA)

Please refer to the information Bulletin No. HQ/FO-95-58 concerning the new Staff Health Insurance rules and rates for 1996. I should like to say that I do share your concern regarding the possible long term impact of the decrease in the rates. As we all know, we had better be more protected than less in this area. Also, the conditions may be somewhat different in the Americas. So, we can hope for the best.

Rafael Miranda Franco
(from San Juan, Puerto Rico)

Les felicito por la edición del Verano 1995 del "Newsletter" de la AFSM. Está muy interesante y uno se mantiene al tanto sobre lo que acontece en la OPS, asi como sobre compañeros activos y retirados. Muy buenos los concejos sobre salud del amigo Jaime Ayalde para nosotros los "viejitos".

Es de lamentar que no se publique una versión en español y que la Asociación no tenga más miembros entre los retirados que viven en la América hispano parlante. Al presente la AFSM es un "club" de un grupo de pensionados que residen en Estados Unidos con unos pocos en otros países. Ojalá ésto se pueda resolver tal como se menciona en el "Newsletter".

Otra sugerencia es que en la junta de Directores haya alguien que no resida en Estados Unidos, quien estaría dispuesto a colaborar activamente y viajar de vez en cuando a Washington para reuniones.

Un cordial saludo y los mejores deseos para los amigos de la Junta de Directores.

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OBITUARIES

We regret to inform our colleagues of the death of Alicia Landerer, wife of Lucio Landerer, on 29 December 1995.

Our sincere condolences to the family.

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Be sure not to miss a most comprehensive article of interest to all men over 60 by Dr. Ayalde, which follows next.

Also a fascinating list of successes achieved by the UN in its first 50 years. Remember, you were a part of it!

YOUR HEALTH MATTERS !

Jaime Ayalde

Until recently very little attention has been paid to cancer of the prostate, but the situation appears to be changing. Very important celebrities and political figures have decided to "go public" with this problem, thus providing an excellent service not only to their local communities but to the nation as a whole. That has been the case of Senators Alan Cranston, Robert Dole and Ted Stevens, and just recently Mayor Marion Barry (The Washington Post, November 16, 1995) joined those ranks. Fortunately, prostate cancer is usually curable when diagnosed early as appears to be the case of Mr. Barry, according to Dr. Michael Manyak, Acting Chairman of Urology at George Washington University Medical Center.

On February 2, 1995, PAHO organized a seminar on "The Prostate" with Dr. Hernando Salcedo as main speaker. Dr. Salcedo served in the Navy as a Medical Officer and was Associate Professor of Urology at George Washington University. Interestingly enough, the seminar was attended not only by men, as expected, but also by a number of women. This is an illustration that problems of the prostate affect not only men but also "the women who love them." Spouses or partners of prostate cancer patients often suffer greater psychological distress than the men themselves, according to a study (Cancer, Vol. 73, No. 11, June 1, 1994).

Except for skin cancer, prostate cancer is the most frequent cancer diagnosed in American men, and it ranks second behind lung cancer as the leading cancer killer in men. In the United States, a man is diagnosed with prostate cancer every three minutes, and every fifteen minutes a man dies of it. We don't know what causes prostate cancer, but a number of factors are involved: age, hormones, hereditary genes and the environment. Prostate cancer is rare in men who live in China or Japan, but when these men move to Hawaii or California their rate of prostate cancer goes up to the level of that of an American man. African-American men have two times more cancer of the prostate than European-Americans.

Geography appears to be another risk factor for prostate cancer. In the United States, age-adjusted mortality rates are higher in the northern states than in the south. The lower rates in the south have been attributed to the larger source of vitamin D, which is the everyday exposure to the sun's ultraviolet rays. Vitamin D is a hormone known to have anticancer properties.

The American Cancer Society estimates that in 1994 more than 200,000 new cases of prostate cancer were discovered and 38,000 men died of the disease in the United States. The experts estimate that, by the year 2000, the incidence of prostate cancer is expected to increase by 90 percent; prostate cancer deaths are expected to go up by 37 percent. The increase in the number of new cases of prostate cancer over the past decade is partly attributed to the use of a powerful blood test, the prostate specific antigen (PSA) test, that allows better detection of the disease when used in combination with other methods.

There is a certain level of disagreement in the widespread use of

the PSA test, but the fact remains that before the advent of the PSA most prostate cancers were detected at advanced stages when cure is not possible. Yearly screening of every man over the age of 50 is expensive but perhaps no more than yearly mammograms to detect breast cancer. And the proportion of deaths caused by prostate cancer in men with the disease is similar to the proportion of women with breast cancer who die from the disease (The Johns Hopkins White Paper on "Prostate Disorders," 1995).

The two cancers are relatively comparable but lower funding has been provided to prostate cancer research and fewer routine examinations are done in men. The "entry point" to the system is the Digital Rectal Examination or DRE, and many men are reluctant to accept that invasion of privacy. On the other hand, knowledge and emotions play a role. Breasts have a function recognized by society, they have cosmetic importance as sex symbols, and of course they are visible and accessible for self-examination. Not so with the prostate. More health education is needed on this subject.

Prostate Cancer: Diagnosis

Unlike benign prostatic hypertrophy (BPH), the prostate cancer generally begins its growth away from the urethra and may advance without clinical symp-toms. If symptoms are present, these are similar to those of BPH (frequent urination, weak flow, dribbling); plus blood in the urine or ejaculate; pain in the back; less rigid erection; decrease in the amount of fluid ejaculated.

The goal is to reach a diagnosis even before above the symptoms are present. Annual *screening of men without symptoms* will be instrumental in achieving this goal. The screenning includes:

- Digital Rectal Examination (DRE) starting at age 40;
- Prostate Specific Antigen (PSA) starting at age 50, according to the American Cancer Society. (The only exceptions to these guidelines are men with a life expectancy of less than 10 years who are unlikely to benefit from treatment of early prostate cancer.) There is a "magic number" that is the value of 4, below which the PSA value is considered normal. The number refers to nannograms of the enzyme per milliliter of blood. PSA rises more rapidly in men with prostate cancer, so yearly tests permit the monitoring of the rate of change (PSA velocity). With the value of 4 is a guideline, most doctors adjust the findings dividing the PSA by prostate size measured by ultrasound (PSA density). Other experts increase the limit considered normal according to age: 60-70 years of age to 4.5 ng/ml; 70-80 6.5 ng/ml (PSA and a Man's Age).

A recent study says *no* to routine screening of men without symptoms (Krahn et al., "Screening for Prostate Cancer: A Decision-Analytic View," JAMA, Vol. 272, No. 10; Sept. 14, 1994). The biggest problem of this study is that the conclusions are based on a one-time screening. The study does not determine whether the recommendations by the American Cancer Society to annually test men older than 50 years

is correct or incorrect. The bottom line is: discuss this matter with your clinician, ask him about the potential for trade-offs associated with screening and treatment, and you, the patient, decide whether you want to be tested or not.

In the case of *men with symptoms* further tests may be needed, such as:

- Transrectal Ultrasonography (TRUS), which can determine the size of the prostate and possibly show the location of an area of cancer;
- When cancer is suspected a needle biopsy of the prostate is carried out;
- Other routine tests such as urinalysis, blood test for anemia and acid phosphatase;
- Cardiovascular and pulmonary functions if surgery is contemplated;
- Bone scan (Radionuclide Scintigraphy) with a gamma camera;
- CAT scan (Computed Tomography);
- Magnetic Resonance Imaging (MRI);
- Chest X-ray (to establish presence or absence of cancer in a man's lungs);
- Pelvic lymphadenectomy (some doctors question the value of this procedure, as it is invasive and has potential side effects).

Choice of Treatment

Treatment of prostate cancer depends on the clinical stage of the cancer and the age and general health of the patient.

There are two main clinical methods to classify prostate cancer: the Whitmore-Jewett system and the TNM staging system. They are based on the extent to which cancer has grown. The pathologists on their part use the Gleason Score, which is based on how the cells look under the microscope. How well are they differentiated ? A low Gleason score of 2, 3, or 4 is good; high Gleason score of 8, 9, or 10 is not. What about the middle range? It is difficult to predict what course the cells will take? The information provided by the *Clinical stage* and the *Pathologic stage* helps the specialist to predict the seriousness of the cancer and the need for treatment.

Watchful Waiting is most often recommended for men whose cancers are unlikely to spread during their lifetime and for men who are unlikely to live for 10 years.

Radical Prostatectomy is performed if the cancer has not spread to the pelvic lymph nodes. Developed at Johns Hopkins in 1904, the procedure has been greatly improved during the last fifteen years by Dr. Patrick Walsh of Johns Hopkins who developed the "nerve sparing" radical prostatectomy.With this technique, postoperative incontinence and frequency of impotence have been greatly reduced.

Radiation Therapy is used for prostate cancer in men with other

illnesses and in men with more advanced disease.

Androgen Ablation is used for Metastatic Disease, as are other methods including castration, diethylstilbestrol, and transurethral resection in cases of urethral obstruction.

The Take-Home Message

- For men over sixty: Have your regular annual check-up, including the DRE and PSA. Discuss the findings with your clinician and have additional tests (TRUS) performed by a urologist/surgeon if necessary.
- If the findings are positive for prostate cancer more tests will be necessary to establish the clinical stage of the cancer. Modern biopsy techniques will permit the pathologist to establish the Gleason score.
- Educate yourself! Learn about your own cancer - your clinical stage, PSA level and Gleason score. Explore your options!
- Always obtain a second opinion.

If prostate cancer surgery is contemplated, select a doctor who uses the nerve sparing techniques, who has a high rate of success, and who performs this type of operation often. Does he screen his patients carefully? A man whose cancer cannot be cured by surgery should not be subject to theexpense and ordeal of an operation.
uggested reading

- "The Prostate, a Guide for Men and the Women Who Love Them" by Patrick C. Walsh, MD, and Janet Farrar Worthington, Science Writer, a Johns Hopkins Health Book (Baltimore, 1995)
- "The Prostate, Facts and Misconceptions" by H. Salcedo, MD, a Birch Lane Press Book, Published by Carol Publishing Group (New York, 1993)
- "The Johns Hopkins White Papers" on Prostate Disorders, updated every year by The Johns Hopkins Medical Institutions, Baltimore, Maryland.

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Off the shelves

Long distance travel for work, intellectual challenge or plain entertainment has always been high in the "to do list" of our colleagues in the AFSM. A high proportion of this travel involves east-west or west-east displacement with the known consequences on their biological clock or jet-lag. Now you can get an over-the-counter drug, Melatonin, as an antidote. Melatonin, a hormone produced by the pineal gland, has been flying off the health store shelves faster than the Concorde! You can get more information about it in the Melatonin Miracle (Simon & Schuster, 1995). There are restrictions to its use: anyone on steroid medication and those with severe allergies, pregnancy, autoimmune diseases and cancer of the immune system should not take melatonin. But for those who can take it the benefits are endless, including effective birth control, treatment of Alzheimer's, Parkinson and cataracts, lower cholesterol level and prevention of breast cancer, as claimed by the sales people and reported in Environmental Nutrition

Newsletter, November 1995. Too good to be true?

Fruits and vegetables have been traditionally recognized as excellent sources of food to help the human body to defend itself.

Broccoli has been in the news because it contains sulforaphen, a cancer fighting phytochemical. If you remember your Greek, *phyto* means "plant". That explains why fruits and vegetables contain a varity of phytochemicals, and a cornucopia of new commercial products are heading to the health food stores and eventually to the supermarkets. The idea is to create "functional foods" by transferring phytochemicals from one food to another as an alternative for those who do not eat their five or more servings of fruits and vegetables a day. However, most experts agree that "no supplement can make up for a bad diet." For more information, see the November 1995 issue of Environmental Nutrition.

Dear colleagues: We want to remind you that dues should be paid during the first quarter of the current year. To those who have already paid their annual 1996 dues or have paid for 10-year or lifetime membership, thank you for your generous contribution to the Association. For the ones who have not paid yet, please send your check with the form attached to this Newsletter.