Avoiding Early Cancer Claims

Presentation # 3

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LABORATORY TEST

RED FLAGS

Low Cholesterol

- Low – ***even more so, progressively falling*** – serum TC is a marker for preclinical cancer that is most likely to be apparent in ≤ 2 years
- Does not apply to cases on hypolipidemic Rx
- Strongest correlation when also low serum albumin and/or parallel decreases in HDL-C and triglycerides
- Also correlates with longtime heavy smoking, unexplained weight loss

PSA

- High grade (Gleason 8-10 adenocarcinoma, small cell carcinoma) cancersa often have low PSA levels because anaplastic cells do not manufacture PSA efficiently
- **RED FLAG**: PSA < 2.5 (and no matter how low) that increases at ≥ 1 ng per year
- Often ignored in primary care because it is within “normal” range
- Undetectable PSA = undisclosed radical prostatectomy or poor-prognosis neuroendocrine carcinoma of prostate

Simultaneous elevations of both GGT and alkaline phosphatase (AP) suggest intra- and extrahepatic bile duct lesion.

Must be further evaluated clinically to rule out cholangiocarcinoma, etc.

Pancreatic Carcinoma is one of the main malignant neoplasms accounting for death claims within 2 years.

This is readily explained by 3 factors:

- Rising incidence, now #4
- Nonspecific symptoms
- High mortality rate due to late detection

RED FLAGS in Pancreatic Carcinoma

- Elevated GGT and AP
- Dull epigastric pain, often accompanied by back pain, made worse in supine position and relieved by sitting forward
- Excessive bloating/belching
- Clay-colored (acholic) stool, dark urine
- Generalized pruritus
- Persistent anorexia…

- Worsening fatigue
- Cholecystitis diagnosis within 6 months
- Chronic pancreatitis at any time
- Family history pancreas carcinoma in a ≥ 40 pack-year smoker; doubly so if obese
- Family history of *BRCA*-1, *BRCA*-2 carriers
- **Type T3c diabetes**

Bottom Line:

Our best chance of avoiding pancreatic cancer death claims is to identify recently-diagnosed type 2 diabetics at high risk for actually being type 3c diabetics

Type 3c Diabetes

- At least 5% of new onset DM ≥ 50 = T3cDM
- ≥ 80% of these initially misdiagnosed as Type 2
- 8-10% already have or will develop pancreatic cancer, usually within 1 year
- Over 50% also have chronic pancreatitis, that may be subclinical and undiagnosed
- Type T3c can be easily diagnosed by a meal test that is seldom done in primary care

RED FLAGS for T3c Diabetes

- Sudden and often symptomatic onset
- Underweight/low normal weight, recent weight loss
- No diabetic family history; pancreatic cancer family history
- Low insulin and glucagon levels…

- Episodes of post-diagnosis hypoglycemia
- Comorbid hepatitis C
- Hypoglycemic Rx resistant, requiring insulin early on
- Prior history of acute pancreatitis
- Pancreatic enzyme replacement at any time

In a recent obituary in the *British Medical Journal*

- Female physician diagnosed with “curable” breast cancer at age 31
- Had a recurrence 19 years later
- Died in < 12 months despite treatment

Prior History of Cancer?

Pay attention to every **RED FLAG** for potential recurrence/second tumor… no matter how long ago the original malignancy was diagnosed

RED FLAGS

(unless adequately investigated to r/o cancer recurrence)

- New onset atypical headaches
- New onset localized neurological deficits
- New onset highly localized and otherwise unexplained pain
- Newly-discovered elevations of liver-related tests if with no apparent explanation or prior history of elevated LFTs
- Recent seizure or suspected syncope episode
- Newly discovered lymphadenopathy
- Childhood/adolescence cancer treated with radiation and/or cancer-causing chemotherapy (alkylating agents, etc)

Recommended FREE model drilldown questionnaire for applicants with a history of childhood/adolescent cancer:

Insureintell.com/content/teleinterview-drilldown-questionnaire-childhood-cancer-survivors#attachments

Ductal carcinoma in situ (DCIS) of the breast is a standard risk.

No reason to be concerned about new application 5 years later, right?

Wrong!

University of Toronto oncologists looked at **108,196** carefully selected patients with **DCIS** from **18 database registry studies…**

- Standardized mortality ratio when diagnosed at age 30-34 was 17.0 and at age 35-39 it was 7.3…versus far lower thereafter
- 54% who died did not experience an invasive in-breast recurrence (ipsilateral or contralateral) prior to death, most deaths due to distant metastases
- No significant difference based on type of treatment (mastectomy vs. lumpectomy + radiation)
- Highest risk: poorly differentiated DCIS comedocarcinoma subtype, ≥ 5.0 cm at diagnosis.

What's in your manual?

To make matters worse, one oncologist advocates telling DCIS patients they were treated for *“an indolent lesion of epithelial origin”…*

…pretty well assuring it won’t be mentioned in some cases we see!

In their frenetic obsession with speeding up underwriting, (often without regard to consequences) some companies now lump together *“nonmelanoma skin cancer”* and *“papillary thyroid carcinoma”* as 2 cancers that do not have to even be acknowledged on the Part 2.

Is this wise if you want to avoid early death claims?

NO!

There is a huge difference between

papillary microcarcinoma,

which *almost* always has an excellent prognosis and

micropapillary carcinoma,

an aggressive neoplasm with a poor prognosis

Why do you want a path report on all papillary carcinomas diagnosed within 2 years?

Because you don’t want to see any of these **RED FLAG** pathology report findings

- Tall cell
- Columnar
- Insular
- “Hobnail” (same as micropapillary)
- Poorly-differentiated
- “Solid” foci/areas

HIGH RISK in Thin Melanoma

Level III/IV (vertical growth phase) tumor with *“marked, severe or total **regression**”*

- Average duration of flat extra: 1-3 years since diagnosis
- Average duration from diagnosis to death in high risk thin melanoma: 5-7 years

What’s in your manual?

If the applicant says he had a *"nonmelanoma skin cancer,"* there is no reason to get more information, right?

Wrong!

Merkel cell carcinoma is a highly malignant nonmelanoma skin cancer…

- Painless round and solitary pink/purple to red/brown, dome shaped papule or plaque
- Neither pruritic nor tender
- Often mistaken for BCC, SCC, cyst, pyogenic granuloma, even phlebitis = delayed diagnosis means high % with regional/distant metastases
- Incidence has tripled in last 20 years
- Median age 70
- 34% have with coexisting/later hematological cancer

RED FLAG

Cancer Presenting in Emergency Room

- 23% of all UK cases; mainly < age 24 or ≥ age 70
- 1 year relative survival: all diagnosis *vs.* ER diagnosis only:
  - Melanoma: 97% *vs.* 61%
  - Non-Hodgkin Lymphoma: 74% *vs.* 46%
  - Oral Cavity: 82% *vs.* 56%
  - Bladder 72% *vs.* 35%
  - Prostate 95% *vs.* 54%