1,000 People Drop Dead Every Day in America. This Test Could Have Warned Them. Transcript

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Summit Introduction and Guest Welcome

Hello, everyone. Welcome to the Future of Menopause Medicine Summit. I'm Doctor Ben, your co-host, and I am very excited to be here with you today because we have a very special guest, Doctor Joel Khan.

Welcome, Doctor Khan. Doctor Khan is an incredible integrative cardiologist who has been practicing since 1983. He lectures all over the country and hosts the Heart Doc VIP podcast, where he shares his knowledge of both conventional cardiology and evidence based, natural, holistic approaches that address not only heart health but the whole person.

Welcome to the summit. Doctor Khan, we are thrilled you were able to take some time out of your schedule today to share your wisdom and experience with us.

Thank you. I just want to say you didn't say anything wrong, but actually graduated in med school in 1983. If somebody is doing the math and they think I've been in practice for 53 years, they might say, oh my God, the guy's 90.

I'm not 90, but I can practice is 1990 and it's a lot of time. It's I mean, I'm energetic and going to keep going for quite a while, but I love it. I just want to clarify, I'm not 90. Totally.

That's a little back and forth to kick this off. Sounds good. Sounds good. All right. So I'd like to just jump right into some of the questions I have for you.

I'm very excited to get started. So and I just will say you've not sent them to me. So this is spontaneous. Yes. Oh, yes. Very hard hitting questions coming your way.

So a lot of my patients are concerned with their cardiovascular health. It's the number one killing of the people in the world. As an integrative cardiologist, can you speak to what diagnostics you would recommend for everyone to ask their doctors for as sort of a routine screen of both cardiovascular and heart health?

Probably my favorite question, because I'm so passionate on the topic and it's a great question.

Cardiovascular Screening Basics

And there's such a deficiency, I'll just point out, you know, it's we have this thing called the US Preventive Task Force that dictates the primary care doctors pretty much dictates, because it sets what insurance will pay for and not pay for.

And there's, you know, mammography and colon copy and cervical cancer screening and prostate cancer screening. Although even PSA blood testing has been controversial lately, it's back on the paid schedule.

Crazy. The rise in prostate cancer diagnosis when they did not let primary care doctors get a PSA level on men without paying cash. Crazy crap. There's nothing on the list that really would be called cardiovascular screening.

Even the humble EKG, you know, sticky tabs on your chest test that maybe is a $35 test that got booted as a paid screening test. And it's not a good screening test, nor is it Red mill, a good screening test.

If you want to find people with the worst blockages on the planet, do a stress test and look for 90% blockages. I'm way upstream, you know I want to find you when you have no disease.

So I'll see you 20. You probably have no, you know, atherosclerosis, but certainly by 30 to 40, we should be taking the same aggressive approach we do for education, lifestyle and actually testing.

So I don't need to be too promotional here. I don't want to offend anybody. I wrote a book 15 years ago with a title that execs don't get. Bonuses can be men can be women.

You don't have to be an exact. I give lectures called dead lawyers Don't tell bonuses. Dead dentists don't get the bones. It's just a shock term, like a Howard Stern thing.

But it pretty much it's been updated and it's pretty up to date. It pretty much lays out the answer, the question. But really, to get a bullet point, you want to do one imaging test.

The only way to know I don't care what your lab values are, what your lifestyle is like. There's so much environmental and genetic influence on developing atherosclerosis.

By the time you're in the 2030s, and definitely by age 40, that I see yoga women every day. And they proved to have advanced heart disease. I had one in the office yesterday. Tragic.

I mean, 118 pounds, perfect diet, yoga, fitness, actress, model, I mean unbelievable burden at age 53 of atherosclerosis without symptoms because somebody finally said to her, here's the key.

Get a coronary artery calcium CT scan. This a test that I'm going to show you a picture in a second. But a test that's been around developed in 1990. It's tragic how long ago that is widely available.

Since about 1995. Inexpensive in the last 25 years, like about would you pay $100 to know if you're carrying a burden of the number one killer in all day, $100?

You know, you can't get a urinalysis for $100. Really? And this CT scan, the only regret I have is it is a CT scan. It is equivalent radiation exposure to basically a mammogram.

Although CT scanner are improving and the radiation dose is dropping dropping, dropping. It's painless. There's nothing injected. There's no IV. And in a very five second scan kind of equivalent to a mammogram or call, be almost perfect, not perfect, almost perfect can end up and maybe big book and see this is from that book with a totally normal scan.

No calcified plaque found in the heart arteries. These white spots are a small amount of calcified plaque. And the woman I saw yesterday. I hope she's not watching this, but it's like a 90 year old's calcified.

We call it hardening of the arteries because it's arteries that were once young and supple and now are hard and inflexible and leads to limitations of getting blood flow to the heart rise and blood pressure, and ultimately the risk of events like heart attack, strokes and death.

So this little test is calcium score. You sure would like to be in the Zero Club. And I'll tell you that 67 I am in the Zero club. I'm lucky because there's a good family history of heart disease.

It's a good marketing tool in the cardiology world to be able to say you are a member of the calcium score of zero club, so beg your primary care. Doc, can I get a script?

Because usually you do have to show up at a hospital or a CT center with a prescription. Beg them to get a coronary artery calcium scan cakes. Awesome. 10,000 research articles.

The last thing I'll say is about six weeks ago, the American College of Cardiology, the American Heart Association, updated guidelines. What do you do with your cholesterol and what's the cutting edge?

And this skin has been in the guidelines for about seven years. It got a big upgrade that if you don't want to go on

closed on medicine, get a scan. If you come back a zero, there's almost no justification to use prescription drugs, you know, eat oatmeal and make a little.

I know I have several patients who would be over the moon to hear that. Would you be able would you be able to. Sorry, I take them off. I mean, if they go to the scan and they have a score of zero, I take them off their statin and I'm not, you know, I'm not the guy that hates every statin in the world.

Like a cardiologist in Scottsdale is always on social media saying, I don't hate statins, but I sure don't want to. I don't take one because I've got arteries have been checked.

The second part to answer your question is get better than average blood work like you and your mother. Do you know, get a cholesterol, get the thing primary care doctor does.

Definitely. And a sorry. Again, another commercial moment. Be sure you have this flood test checked. This is a blood test with a horrible name, light bulb protein.

And you got to call it little A or LP little A. I mean, it's a horrible name because nobody can pronounce it. LabCorp doesn't matter who. Everybody runs his test.

There is a billing code. Go as your primary care doctor or your specialist.

Calcium Scans vs CT Angiograms

You know, I just heard that everybody should know if they inherited this is a genetic cholesterol. If they inherited this from mom, dad or both. And about 20% of people inherited it.

This wonderful woman yesterday with this horrible Bernard disease inherited it. And I think it's the major factor since her diet and her labs otherwise were excellent in her early, early advanced heart disease.

Then you want to know your inflammation panel like high sensitivity C reactor protein, your home assisting methylation panel. Awesome. You want to know you know, your insulin resistance.

These are so available whether you just pay cash through my life force or function health or Woohp has a lab panel life extension magazine and vitamin company has had lab panels.

You just pay cash for. They were probably the pioneers in that field. Or I just run these through insurance. And my patients you know insurance I don't ask my patients to pay cash for most labs.

And once you have those two things how old are you are. And a little better snapshot than general, then you really know where you're at. And you then you can say, I'm nearly bulletproof.

It's pretty awesome. So much better than just running, lying on the basic lipid panel that we see most. I'll say conventional doctors running, kind of an offshoot of the first question or your answer.

As far as doing the CT calcium score, can you talk about the importance of running that versus knowing when it's time to run a CT angiogram or a clearly analysis?

Because as I'm sure you're aware, the CT calcium score is only going to show us hard plaques. It's not going to show us the soft plaques that are a little bit more prone to breaking off, traveling down the bloodstream and causing a blockage somewhere.

When would you say you you want to opt more for that more detailed test? Yeah, and I don't have a beautiful picture to show you of a clearly coronary CT Andrew Graham.

But I think as a single practice cardiologist, I'm probably number one in the country for ordering them. I know a lot. I

will tell you, the biggest problem is people don't get any screening and I'm talking now imaging.

So if I were working with Bobby Kennedy and my and the government, I would get insurance coverage for the Coronado calcium scan. I would get the US preventive task force to say at age 45 to 50, and certainly a woman by menopause, whether it's early menopause nerd time or a woman who's had some obstetrical problems like preeclampsia, clamps, a pregnancy, hypertension, pregnancy loss, these are now established risk factors for early heart disease.

Absolutely. Surely early menopause is there. I would get oh yeah buddy to get access to Coronado calcium score inexpensive. Safe. Quick. Recognizing I said it's an almost perfect test.

And the reason it's not perfect is there is something called soft plaque. Non calcified plaque. Under 10% of people that have that wonderful calcium score zero have a significant soft plaque burden.

I'll tell you 30 years in practice and I've been ordering calcium scores since 1995 on everybody. One patient in 37 years had a calcium score is zero, and eight months later got a stent because he developed some burning and went to the emergency room and he was ticked at me.

But there were no clearly studies back then. So if you have to be almost completely certain, you're in good shape. I'm very happy if you come back a zero, but anything other than a zero if you're a 12 or 18, these are numbers or 118.

I'll talk to them about spending. Now we're talking about spending 1500 to $2000 using insurance covered. You do have to be injected with iodine. A few people are allergic.

You have to have a very low heart rate. So you got to take a beta blocker or be very calm. You got to have good kidneys because you're going to give value dying, die, and you don't want to harm kidneys.

So there are nuances to this advanced cardiac testing. But is it a breakthrough? Oh my God, this again I hate to say it, but this woman I saw yesterday by age 53, other cardiologists, she's already had two of them about two years ago.

And recently as an ability to diagnose in detail the disease and then try and evaluate if it's getting worse or better. But it's a little more radiation than a calcium score that is also changing fast.

Better. That's really the only was that CT scanners are getting more and more advanced and lower radiation. But it is, I think, the biggest advance in cardiology really better than any drug.

If you can't make an accurate diagnosis, a accurate, objective diagnosis, who cares what tools you have? You got to make a proper diagnosis, so I agree.

You got a patient who's been a bit resistant to lifestyle change, joining the gym, changing the day. Show all those bumps in their coronary arteries that show up on a clearly CT engineering report.

They become very motivated to get better compliance that way. For sure. It's actually been studied. Even putting a picture of your coronary calcium scan, if abnormal on a refrigerator, has been studied as a motivational step to get people a little more think in 24 over seven about healthy lifestyle.

I try not to scare people, but I don't want them eating, you know, turkey sausage every morning and that's what they tell me they're doing. I gotcha screen.

You mentioned when you showed your book earlier, lipoprotein A is a very important cardiovascular genetically related marker. Could you speak to the importance or you know, I'll say the the more abundance of information you get running a fractionated lipid panel like the cardio IQ, NMR, Lipo profile versus the standard, you know, five item lipid panel that most conventional doctors are going to run as your routine screen.

Advanced Lipid Testing and Risk Markers

Yeah. Well it's interesting. It's a good question. You know, a lot of research out there still relies on total cholesterol, like when you go to something online called the Framingham Risk Calculator.

Why do they put in your total cholesterol? Why not your LDL cholesterol? Because it turns out next time you look at your standard lab panel, it'll say LDL cholesterol and it'll say calc calculated.

It's actually directly measured number. It's a 60 year old formula. It's a little tricky to actually measure LDL, but every cardiology guideline around the world is about LDL cholesterol control.

And we're still approximating it on standard lab panels. Whereas these advanced cholesterol panels, called NMR Lipo profiles been available at least 20 years, maybe 25, three of them for 2025 years, a few extra dollars, maybe $4,045.

So it's not out of range and I run them again. My patients use their insurance if they have an abnormal calcium score. They have corner disease and you know they will directly measure LDL, the directly measure the number of particles.

They may, if check the box, get a test that's 40 years old. But all of a sudden it's hot called apolipoprotein B or a Bobby. You know, really, if you got a calcium score of $100 and then a Bob lab test a ball lipoprotein B lab test, those two tests will tell you 90% of what you know.

Now, they're not going to tell you about homocysteine and C reactive protein. But if you're able lipoproteins be as high. It's either you got a really ugly LDL cholesterol or you got a really ugly lipoprotein, a inherited cluster.

Oh, you got both. Then you got to do, you know, if you really wanted to be cost efficient, those two tests will tell people a dramatic insight into where they're at.

So the actual research, like there's something called the Mesa study, a big research group and Framingham study said the advanced lipid profiles are mainly of value in people with metabolic syndrome overweight, inflamed waistline, visceral fat.

Well, estimates are that's 93% of Americans. So you could argue everybody should get advanced testing because there's something called discordance. The LDL in the family doctor's office isn't bad 110, but they're one of these pre-diabetic metabolic syndrome, visceral fat overloaded people, fatty liver people.

These all go together because of system biology networks. And that's the group where you might find that LDL of 100 or 110 isn't really representing the full abnormality in the LDL particle number it's called can be sky high and lead you to make a more accurate risk assessment.

Gotcha. I love that answer. I know I end up running a fractionated lipid panels on every patient that comes in the practice. I always want to see it. Homocysteine, high sensitivity, crp.

I just always get such good information. I had a patient just yesterday. She ran a basic lipid panel a few months back with one of her other doctors, and I fairly confident she has what we call familial hypercholesterolemia, just genetically predisposed to higher cholesterol.

And I run the fractionated lipid panel with the homocysteine with the CRP. And yes, her cholesterol is higher than, you know, we'd prefer in a vacuum.

But a lot of these other risk factors look perfectly normal. And I told her, hey, let's get a coronary CT calcium score. We'll do a bilateral carotid ultrasound.

Let's see if we really have to worry about this and consider, you know, the end, you know, the last resort, statin

medications. Or if this is just not actually an issue for you.

So that's a great answer I love to hear it. Oatmeal since. Absolutely. So since we are the Future of Menopause Summit here, I'd like to ask you what, in your opinion, is the biggest lie that women have been told by a conventional medicine in regards to their cardiovascular health?

Well, well, I mean, you know, one area is the risk benefit of hormone replacement therapy. In the last years, the biggest lie was that the risks outweighed the benefit.

And if you ever go down that route, get off of it as quick as possible, use low doses. You can. And I don't personally write the scripts for hormone replacement therapy, but I think everybody in my practice who's a female has read the book.

Estrogen matters is just resource. And, you know, and then I got to refer them to somebody like you and your mother and others that can actually do it well.

And so that's that's a lie. I mean, the second one is true of men and women is just I feel good, doc. I played pickleball for two hours, you know, but they've never had, you know, advanced lab and events, vessel imaging.

And you have no idea where you're at. People drop dead a thousand. This is the statistic that should be on every headline in an error times and in the Washington Post and anywhere else.

Is that a thousand people a day in the United States drop dead suddenly. It's called sudden cardiac death. Most of its due to advanced blocked arteries, sometimes with heart attacks that were unknown or silent.

And it's all easily diagnosable. A month, six months, five years before. And it's tragic. There's you know, there's no wonderful family gathering in hospice to say goodbye to grandma and grandpa.

Just 51 year old person drops dead. It's tragic. Yeah. And that includes women. It you hear headlines about men dropping dead a bit more, but women drop dead.

And we need to get really upset, really aggressive about it all. So that's a lie to I feel good. And I've had a routine visit and my doctor said, see you in a year.

That's enough. It's not enough. Gotcha. Kind of continuing along that line, would you be able to speak to the role that estrogen specifically plays with cardiovascular health for women and men?

Yeah. You know, prior to the Women's Health Initiative study published 2002 2003, again topic of their book, Estrogen Matters, which is not the only book, but it's a good resource.

Yeah. Groups actually recommended hormone replacement with estrogen and others as a proven path to improving cardiac health. In addition to talking about future brain health and bone health and sexual health and the rest.

And then it all just blew up for 20 plus years. But we're coming back a little bit to more time. Estrogen tends to be very good. You know, your arteries are are supposed to be making a lot of a wonderful chemical called nitric oxide in the end of the.

And estrogen helps with that. And that helps relax arteries better blood flow throughout the body. You know, if you have better blood flow, you've got a healthier, better body from head to toe.

And then even if you talk about, you know, cholesterol tends to go up at menopause. Lipoprotein this genetic cholesterol.

Menopause, Estrogen, and Heart Health

So we're talking again one out of every four one of every five women. A little bit more common than African-American women. So it's easily can be even a little more than one of every four African-American when it goes up protein and menopause.

And it actually comes down with estrogen not to normal, but it comes down. So, you know, just multiple pathways by which estrogen and other components of heart can be so cardiovascular supportive.

Absolutely. We see that all the time. I always end up having the conversation with my male patients who end up going on testosterone, your testosterone.

Some of it will convert to estrogen via the aromatase pathway. And they always go, well that sounds horrible. I don't want to be all weepy and anything like that.

And I have to explain to them, no, this is very important for your cardiovascular health, the same way I have to have, you know, the women have to have some testosterone in their body.

Males need to have some estrogen in their body. It's very important. We always say hormones are a symphony. It's not just one magic bullet. Correct. That's very nice to hear.

Let's see. Are there any supplements that you like to rely on as a go to for moving the needle? As far as some of the cardiovascular markers that we've been talking about?

You know, in my lab panel, I draw a lab that I think everybody should have, and it's available in omega three index. You know, again, I would probably should write a children's book.

Why do mommy and daddy take fish oil? And I would love to see children taught that. You know, we don't make omega three. We have to eat omega three rich foods.

And let's educate. You know about that. And they'd be on a much better path to life. But boy, these people show up in my office, you know, dramatically deficient in omega three.

People don't like fish. People are vegetarian or vegan like me. Whatever the reason is, people eat tuna, which is not particularly rich in omega three.

Salmon, sardine, mackerel and Jovian herring are rich in omega, so we use a lot of food based support for omega three. Once we check it and find, it is dramatically low.

But we have to use supplements and there are good fish based, high quality, pure supplements that have been third party tested for toxicity. And they're also from algae or even you really want to go deep.

There's a flower called the ahi flower age that provides a vegan source of EPA da. And also that's commonly used because it's such an obvious deficiency, along with vitamin D would be another one.

The two that I mentioned and I, you know, shouting out, these are not companies I own. There's some really interesting research that started in Japan and then moved over to Los Angeles, that an aged garlic extract and used usually the company is called Cheo.

Like colic, there are many, many good companies that make garlic or age. Garlic specifically can lower plus lower blood pressure, lower homocysteine. And they're actually our double blind randomized studies that they can help shrink plaque and arteries.

And you can eat all the garlic on your diet. And you should it's a sulfur rich, glutathione supportive food darkly, along with things like ginger and onions and brassica like broccoli.

But these age garlic tablets, they're a little funny shaped, sometimes hard to swallow. It's a routine in my practice.

They're so inexpensive too, which is pennies a day.

There just was a really interesting you don't see too much new research on age garlic. There are a lot of stuff, human size, but there was a really interesting study that age. Garlic supports healthy muscle function.

This was then within the last couple of weeks and may promote the NAD+ pathway without taking NAD+, you know, direct supplements. And kind of an interesting twist on so many people.

I read an article on mine today. What supplements do the billionaires stake in Men's Health magazine or somewhere? And, you know, it's first on the list is always NAD+ supplements.

I don't think the data is completely perfect. I think more data, but I'll give age garlic to anybody. There's also an interesting supplement. Again, I'm not tied financially from life extension a big company and for luck called Arterial Protect.

And it's two supplements in one capsule called picnic and all maritime pine bark and go to cola bush from India, also called central. But there's data from Italy that in humans with carotid disease, you can see the plaque diminish over time, several years from a very inexpensive, super safe supplement and a good amount of science in terms of how can that happen and why does that happen?

So, you know, those are a couple odd ones. But I never hesitate because the science is actually pretty strong. Oh yeah, I love using go to Cola, one of my absolute favorite herbs for so many different things.

Supplements for Cardiovascular Support

You got scar tissue. It's great for you know you can do fantastic anti fibrotic. Absolutely. Yeah absolutely. All right I did want to ask this is a little bit more for my knowledge because I see this all the time with lipoprotein A since you brought that up specifically the range that I typically see on blood work is 0 to 30.

And what I've noticed with a lot of my patients is, you know, whether you're, you know, eating fast food 4 or 5 times a week or you're like that patient you described earlier, you know, the yoga lady, 118 pounds, you know, outwardly very, very healthy appearing.

And yet it just seems so hard for most people to fall under that 30 range where they're going to flag you as normal on blood work. So I'm just curious if you could speak to if you agree with that range, if you have more of a range that you would consider optimal and you know if it is truly elevated, what are some things we can do to start to go after it and lower it?

I know it's a genetic thing, but we obviously also want to consider epigenetics as well. And I got to say, the very beginning was the questions about lipoprotein little a yeah.

So lipoprotein little a and if you could speak to the range okay. Good. Yeah. So you know lipoprotein literally the molecule was discovered by a Dutch I think it was Dutch researcher in 1963.

Right to that. We didn't know it, but really it didn't hit the discussion until the last 15, 20 years. If you went to advance or integrative lectures.

And really right now is when primary care docs might start to be hearing about it, because the drug companies got drugs in the pipeline. And that's how we funded for doctors.

You know, Doctor Smith, you really should start drawing this lab on your patients to get them ready for the new drugs coming, maybe next year. So good or bad, that's how it's happening.

So one way to measure it. The older way it's called milligram per deciliter. And under the is normal and over 50 is high. Over 75 is really high. Most labs have transition.

And unfortunately I tell my patients it's like stepping on a scale. Is it going to measure you in pounds or kilograms. You're going to get two different numbers. Don't get confused.

You didn't just gain, you know, 80 pounds. You just have a unit. So there's a unit called nano mole per liter. Nemo l most of the advanced labs do it that way.

Now, we say under 75 is considered a low risk. Normal range over to 125 is considered a high risk range. But a very recent analysis last three weeks said really over 175 nano mode per liter for lipoprotein literally that might be 2 or 3% of the population are that high.

And it can go up to 4 or 5 600 at the highest end. That's where the real risk exists. It's a tough one. There's no FDA approved drug. The absolute bottom line is statins, lower cholesterol.

They actually raise they go the wrong direction with label protein. Little I I've seen it not dozens, hundreds of times. I'll take a patient who comes to me.

I like a protein age 200 and animals per liter and they're on 40mg of a stat. I'll take them off for four weeks. Absolutely. You reject the whole lab panel and they're like protein a failed 110.

You know, it can fall that much. Academic lipid doctors tried to downplay that because we don't have much else other than statins. But it is a tricky role that statins have in a person who inherited a high level of lipoprotein.

Little a we have a drug expensive called inject every two weeks. And probably they will lower cholesterol if needed. And lower lipoprotein a modestly that's recently had a big price drop.

It's still patented name brand drug. So it's expensive but the prices dropped by about 6,070%. We have these drugs in development five six of them, but they're going to be very expensive if they get approved and they're going to be limited to people who've had heart attacks and bypass surgery.

So they're going to be patent protected for a while. Unlike you can buy, some of them died at your corner grocery store for some reason, even though it does seem that way these days.

Absolutely. Take a six pack of Diet Coke and Semaglutide on your way home from, you know, your local grocery store now. It's crazy what's happening there that's not going to happen.

So we're going to be limited. I'm old school. I'll just make two comments. There's a theory. I'm sure you're familiar with it. With the double Nobel Prize winner Linus Pauling.

Absolutely. The Roth Pauling protocol. If you take enough, here's my vitamin C, you take enough vitamin C and enough lysine and proline to amino acids.

You may block lipoprotein A and make it basically inactive on your arteries. Absolutely. Very little data to say that's proven.

Lipoprotein(a) Treatment and Closing Remarks

But he's such a powerful figure in the world of what's called ortho molecular medicine or integrative medicine. I will use that because it's cheap and expensive and safe.

Vitamin C plus probably. And the other one is I do. Oh, good. For me, I didn't prepare, I just got some flying around. I still use niacin. This happens to be very inexpensive over the counter brand.

The only brand I use made in Portland, not my company, but niacin was identified to lower cholesterol 70 years ago and identify the lipoprotein a about 20 years ago and a cardiologist have just run away.

They do not use niacin anymore. Now, $0.20 a day, I can show you dozens and dozens. And I have to write that paper up. A major cholesterol drops, major lipoprotein a drops.

I have to watch the liver enzymes. They tend to go up a little bit, watch the insulin sensitivity, make sure it isn't being harmed. But at least on paper, you can get insane advances with niacin.

I don't like using niacin with statins. I use it as monotherapy and I'll do an eight week trial. And if we love what we see, we'll stay on it. Yeah. All right, I love it.

Well, this has been great, Doctor Khan. I really do wish we could keep talking, but unfortunately, we are out of time. I've got a patient to get to. I'd just like to thank you one more time for joining us today and sharing your experience.

Go ahead and share where our listeners can learn more about you and your very excellent approach to cardiovascular health. Well, that's kind of you. And I mean this I'm going to tell you where you can find me.

Don't find me, please. I have so many patients, I am like, I am licensed in 20 states, including Arizona, New York, California. I'm in Michigan and Florida.

I spend the winter in Florida, but I have an office down there. It's a nice situation you can do when you're an integrated doc, and I'm fully licensed, so I do it, you know, totally kosher.

But the best places go to a website. Doctor Joel Kohn, drug K and I'm on Instagram ten times a day, TikTok a couple of times a day, Facebook couple times a day.

I try and be, you know, keep my media time relatively low because I wouldn't call that quality family time. But I'd like to put out the new information as much as there is, and there really is.

I'm kind of a geek about new literature, new data, kind of remember right now what I posted this morning, but it was some new, exciting. Did I know about Alzheimer's disease screening?

And so, you know, I like people let people know what the latest solid sciences and and they can decide where they want to go. I'll say, as a fellow geek, I know that approach will serve you well.

Amazing. Well, everyone go follow him on Instagram Facebook ASAP. Once more. Thank you, Doctor Khan, and thank all of you for being here as well. We are very grateful for you taking the time to learn about and advocate for your own health.

We will see you all for another important conversation next time. But until then, everyone take care and be well. Thank you. Thanks, doc.