

THE SLEEPERS

Diseases That Wait Years to Hit You —
And What to Do Before They Do

SHANE COLLINS

TRUMANI BRILLIANCE

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by Shane Collins

Trumani Brilliance

READ THIS FIRST — THE DISCLAIMER

This book is EDUCATION. It is not medical advice.

I am not a doctor. I don't play one in this book. Nothing in these pages diagnoses you, treats you, or replaces a real doctor who can look you in the eye and run real tests.

Every fact in here comes from public health sources — the CDC, the American Heart Association, the American Cancer Society, MedlinePlus. I translated them into plain language because that's what I do. But translation is not a prescription.

If something in this book sounds like you: go see a doctor. Not next year. Not "when I get around to it." A real one, in a real office, with your name on a chart.

Your body is the only one you get. Treat this book like a friend tapping your shoulder — not like a diagnosis.

Guidelines change — this was written in October 2026. Check current CDC guidance; your doctor has the latest.

Foreword

Everything I do, I do for my children.

And their children.

And the generation after that, and the one after that, and the one after that.

I need you to know where this book comes from. It doesn't come from a doctor's office. It comes from a father who watched people come and go — in clinics, in the streets, in his own family — and decided somebody needed to write it down plain.

I won't be here forever. None of us will. But words outlive us. If my great-grandchildren never meet me, I want them to meet this: a book their grandfather wrote because he wanted them to live longer than the people he watched die too young.

That's what all of this is. One generation tapping the next generation on the shoulder.

Read this. Live longer. Pass it down.

— Shane

And a shout-out to Muñeca Chuleta — Lady Pork Chop. My girl.

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Why I'm Writing This

I'm 53 years old.

I've made mistakes. Plenty of them. I'm not going to list them here — this ain't that kind of book. But I'll tell you where I've been: I worked in an HIV clinic for over seven years. In those same seven years, I worked in a methadone clinic too. A lot of the same faces in both places — yes, several of the methadone clients were HIV positive. I watched several of them come and go. I don't have an exact number — I wasn't counting. But it was several people, not one or two.

I'm a Sagittarius. I recognize patterns — even back then, before I knew that's what I was doing. I'd file things away in my head. Signs. My uncle died of AIDS. He carried that monster for over twenty years.

I know seven people with herpes. On some of them, you can see it took a toll. The others are ignorant — they think it's just a pimple. I've heard them say, "as long as you ain't got nothing there, no bumps, you can't pass it." Curiosity killed the cat — I researched it. That was a lie too. Herpes sheds like a snake sheds its skin. Same kind of science, except you don't see the old skin coming off. It sheds invisible, and it passes invisible.

But I'll tell you this: the mistakes taught me that your body keeps score even when your mind moves on. You can put your past behind you. Your body files it away and waits.

I read an article about shingles. The virus that gives you chickenpox as a kid doesn't die. It goes to sleep in your nerves. It waits. Decades. Then one day your immune system dips — you're older, you're stressed, you're run down — and it wakes up and reminds you it was there the whole time.

That sat with me. Because that's how a lot of things work at our age. Not just viruses. Choices. Habits. Things we ignored because we felt fine.

Here's who this book is for: people like me. People who don't read what they don't understand. I'm not writing this in doctor language and then handing you a dictionary. Every medical thing in here, I'm going to say it plain, right away, in words a 9-year-old and a 99-year-old both get. That's my rule.

This book is about the sleepers — diseases that don't knock. They don't send a warning letter. They sit quiet for years, sometimes decades, and by the time they make noise, they've already done damage. The good news — and there is good news — is that almost every one of them can be caught early, treated, beaten, or prevented. But only if you know they're there.

I'm not here to scare you. Fear makes people freeze, and frozen people don't go to the doctor. I'm here to tap your shoulder. That's it. A friend tapping your shoulder.

Who I wrote this for

I wrote this for the man who hasn't seen a doctor in five years because nothing hurts. For the woman who takes care of everybody else and puts herself last. For the ones who grew up where the doctor was for emergencies, not checkups — where you only went when something was broken, and even then you waited a week to make sure.

I wrote it for people who've been through things. Prison, the streets, bad relationships, bad decisions, hard years. People whose bodies have stories their mouths never told. If that's you, your body might be carrying more than memories. That's not judgment — that's just biology. And biology doesn't care about your past. It only cares about what you do next.

I wrote it for people who don't trust the medical system. I get it. History gives us reasons. But there's a difference between the system and a good doctor. Find the good one. They're out there. Ask around. Somebody you trust knows one.

Fourteen chapters. Fourteen sleepers. Plus the handbook. Let's go.

The Bottom Line (Read This Like It's the Plate)

Before the meat and potatoes, you need the plate. Here's the plate.

Protect yourself. It doesn't matter who somebody's being intimate with. What matters is how they're protecting themselves when they are. That's the only conversation that keeps people safe — parents to children, adults to each other. Have it. Keep having it.

Be intentional about who you join yourself with. The old ways knew something — two bloodlines, kept clean. Every intimacy leaves something behind. Fluids mix, infections are real, and who you share yourself with shapes you. Be intentional about what you're carrying and what you're mixing.

That's the principle. The chapters ahead are the proof of why it matters — what can sleep in a body for decades and wake up swinging. Now let's eat.

How to Read This Book

You don't have to read it front to back. Jump to the chapter that sounds like you. Each one stands alone.

Every chapter has the same four parts:

1. **The hook** — a story. Why this one matters.
2. **What's happening in the body** — the plain-language version.
No dictionary needed.
3. **The warning signs nobody talks about** — what to watch for, honestly.
4. **What to actually do** — the move. Usually a test, a shot, or a visit.

And every chapter has a fifth part I added because people need it: **what people get wrong** — the myths, the excuses, the things we tell ourselves that keep us from acting.

Chapter 15 is the handbook — it plays by its own rules.

You won't find a single sentence in here telling you what you have. That's not my place. What you'll find is everything you need to walk into a doctor's office and ask the right questions. That's the whole job of this book: make you dangerous in a good way — informed, prepared, and done waiting.

Chapter 1: The Virus That Never Left (Shingles)

The hook

Remember chickenpox? If you're my age, you didn't get a vaccine for it. You got the actual thing. You were seven, eight years old, covered in itchy red spots, sitting in an oatmeal bath while your mother told you not to scratch. Everybody got it. It was just what happened.

Here's what nobody told that itchy kid: the virus didn't leave. It never left.

When the spots faded and you went back outside to play, the virus — varicella-zoster, the chickenpox virus — packed a bag and moved into your nerve tissue. Specifically into the nerve roots near your spinal cord. And it went to sleep. Not dead. Asleep. For forty, fifty years.

That's the part that got me. You can carry something inside you for half a century and not know it. Your body made a deal with it: you don't bother me, I don't bother you. And then one day, the deal expires.

What's happening in the body

Plain version: your immune system is the security guard that keeps the sleeping virus in its room. When you're young, the guard is big and awake. As you get older — past 50 especially — the guard gets tired. Stress wears him down. Illness wears him down. Certain medicines wear him down. And when the guard falls asleep on the job, the virus wakes up and walks out.

It doesn't walk out as chickenpox. It comes out as shingles. Same virus, different crime.

It travels down the nerve where it was sleeping and hits the skin. That's why shingles shows up as a stripe or a band — usually on one side of your body, your chest, your back, sometimes your face. It follows the nerve line like a road.

Why does the guard fall asleep? Age is the big one — after 50, the immune system naturally gets weaker at keeping old viruses in check. Doctors call this immunosenescence. Plain version: your immune system gets old just like the rest of you. It doesn't forget how to fight — it just fights slower and weaker.

But age isn't the only thing that tires the guard. Heavy stress does it — the kind that sits on your chest for months. So does being run down from another illness. So do certain medicines, especially ones that suppress the immune system (transplant drugs, some arthritis and cancer treatments, long-term steroids). If any of that sounds like you, your guard is working a double shift with no backup. That's worth knowing.

First comes the pain or the burn or the tingle — sometimes days before you see anything. Then the rash. Then the blisters. The whole thing can run about two to four weeks.

About a million people in the US get shingles every year. The CDC says about one in three of us will get it in our lifetime. Those aren't small numbers. If you're reading this and you're over 50 and you had chickenpox as a kid, you're in the group.

The warning signs nobody talks about

Everybody talks about the rash. Almost nobody talks about what comes before and after.

Before: pain, burning, tingling, or itching on one side of your body — and no rash yet. People think they pulled a muscle. They think it's a pinched nerve. It can go on for days like that. If you feel a weird burning stripe on one side and you can't explain it, that's worth a doctor visit right then. Don't wait for the rash to confirm it.

After: this is the one that scares me. For roughly 10 to 18 out of every 100 people who get shingles, the pain doesn't leave when the rash leaves. It's called postherpetic neuralgia — PHN. Plain version: the nerve got damaged, and it keeps firing pain signals for months. Sometimes years. The skin looks fine. The pain is still there. Burning, stabbing, can't-stand-a-shirt-touching-it pain. The older you are when you get shingles, the more likely this happens.

There's also the face version. If shingles hits near your eye, it can damage your vision. Near the ear, it can mess with your hearing. This is why "wait and see" is a bad plan with shingles.

What to actually do

Get the shot. The CDC recommends Shingrix — that's the shingles vaccine — for adults 50 and older. Two doses, 2 to 6 months apart. It's not the old one (that one's gone). This one is about 97 percent effective for people in their 50s and 60s, about 91 percent for people in their 70s and 80s. It also cuts the risk of that long-term nerve pain way down. Even if you already had shingles, even if you got the old vaccine years ago — ask your doctor about Shingrix.

I know. Shots. I know how people feel about shots. I'm not here to argue with you. I'm telling you what the CDC says, and the numbers are strong. Talk to your doctor and make your own call. That's your right.

If you think you have it, move fast. The antiviral medicine — the pills that fight the virus — works best when you start it within 72 hours of the first symptom — the pain or the rash. Three days from when it starts, not from when you decide it's real. After that, it still might help, but the window is the window. So that burning stripe with no explanation? Don't sit on it for a week. Call your doctor.

Don't try to tough it out. I know our generation. We tough everything out. Shingles is not the thing to tough out. The nerve damage doesn't care how tough you are.

What people get wrong

"It's just a rash." No. The rash is the visible part. The real damage is in the nerve underneath. People who say "it's just a rash" never had the nerve pain that lasts two years.

"The vaccine gives you shingles." Shingrix is not a live vaccine. There is no virus in it that can wake up and give you shingles. What it does is train your immune system to keep the sleeping virus asleep. The shot can make your arm sore for a day or two, maybe give you the chills. That's your immune system doing push-ups, not an infection.

"I'm too young to worry." Risk climbs hard after 50, but stress and illness can wake it earlier. If you're in your late 40s and run down, it's not crazy to ask your doctor about your timing.

"I already had shingles, so I'm immune now." Having it once doesn't protect you forever. You can get it again. The CDC still recommends the vaccine after a shingles episode — just ask your doctor when, usually after the rash is fully gone.

The money question

Here's what stops a lot of people: cost. So let's be plain. Most private insurance covers Shingrix at 50 and up. Medicare Part D covers it. If you're uninsured, ask your doctor or pharmacist about programs — the manufacturer has assistance options, and some health departments carry it. Don't assume you can't afford it before you ask. A phone call costs nothing.

See a doctor. I keep saying it because it keeps being true. This chapter is a tap on the shoulder, not a diagnosis.

Chapter 2: The Quiet One (Hepatitis C)

The hook

This one is personal to our generation. If you were born between 1945 and 1965, the CDC used to say you specifically should get tested for hepatitis C. Not because you did anything wrong. Because the numbers said our age group was carrying it more than anybody else.

Hepatitis C is a virus that attacks your liver. Here's the thing about your liver: it doesn't have pain nerves the way your skin does. It can be getting damaged for twenty, thirty years and you feel nothing. Maybe you're tired. Everybody's tired. Maybe your stomach's a little off. Everybody's stomach is a little off. That's it. That's the whole warning. Nothing.

Then one day it's cirrhosis. Scarring. Or liver cancer. Or your doctor tells you you need a transplant. And you say — how? I felt fine. And the answer is: you had it since the 80s or 90s and never knew.

How do people get it? Blood. Mostly through sharing needles, back in the day. But also through blood transfusions before 1992 — before they started screening the blood supply. Some people got it from a tattoo needle that wasn't clean, or sharing a razor or a toothbrush with somebody who had it. A lot of people in our generation don't know how they got it. They just have it.

I'm not here to judge how anybody got anything. That's not what this book is. This book is: it's in you, you don't know, and now you can do something about it.

What's happening in the body

Plain version: hepatitis C gets into your blood and sets up shop in your liver. Your liver's job is to clean your blood, process what you eat and drink, handle the chemicals. It's the hardest-working organ you never think about.

The virus causes inflammation — swelling and irritation — in the liver. Slow. Quiet. Year after year. About 75 to 85 out of every 100 people who get it don't clear it on their own; it becomes chronic, meaning long-term. Over decades, the constant inflammation turns into fibrosis — that's stiffening — and then cirrhosis, which is heavy scarring. A scarred liver can't do its job. And a liver that can't do its job long enough can develop cancer.

Here's the part that should make you sit up: roughly 4 in 10 people walking around with hepatitis C don't know they have it. The CDC's own numbers say it. Millions of people. Feeling fine. Liver taking damage.

But here's something nobody tells you about the liver: it's the only internal organ that can regrow. Cut away part of a healthy liver and it grows back. That's not true of your kidneys, your heart, your brain — but the liver rebuilds. Which means when you kill the virus, the liver gets a real chance to heal. The damage isn't always permanent. The body wants to fix itself. You just have to give it the opening — kill the virus, ease up on the alcohol, and let the hardest-working organ you own do what it was built to do.

The warning signs nobody talks about

There barely are any, and that's the point of this chapter. But here's what can show up, usually late:

- Tired all the time in a way sleep doesn't fix.
- Belly pain, especially upper right side where the liver sits.
- Skin or eyes looking a little yellow (jaundice).
- Dark urine. Pale stool.
- Joints aching. Brain fog.

But I'm going to be straight with you: waiting for symptoms with hepatitis C is like waiting for smoke to check if there's a fire. By the time you see smoke, the house is burning. The move is the test, not the symptoms.

What to actually do

Get tested. Once. The CDC now says every adult 18 and older should be tested for hepatitis C at least once in their lifetime. One blood test. That's it. If you were born between 1945 and 1965 and never got tested, you're overdue — go handle it.

It's a simple blood test. Your doctor can order it. Some clinics and health departments do it free. No big procedure. Just blood work.

Here's the good news — and it's big: hepatitis C is curable now. Not manageable. Curable. The new medicines — direct-acting antivirals, pills you take by mouth — cure more than 95 out of 100 people in 8 to 12 weeks. That's it — a few months of pills and the virus is gone. A few

decades ago, the treatment was brutal and didn't work half the time. That's over. That's one of the biggest quiet wins in medicine and barely anybody knows it.

There's no vaccine for hepatitis C. Don't let anybody tell you different. The protection is: get tested, get treated if you need it, don't share needles, don't share razors or toothbrushes, make sure any tattoo or piercing place is licensed and clean.

What people get wrong

"I'd know if I had it." Roughly 4 in 10 people with it don't. That's not an opinion, that's the CDC's number. Feeling fine means nothing with this virus. Nothing.

"It's a death sentence." It was, thirty years ago. It's not now. Twelve weeks of pills, virus gone for more than 95 out of 100 people, liver starts healing. The tragedy isn't the disease anymore — it's people not knowing they have a curable thing.

"The treatment is brutal." That was the old treatment — interferon, months of feeling poisoned, coin-flip odds. The new pills are nothing like that. Most people take them and live their normal life. Don't let somebody's 1998 horror story stop you from 2026 medicine.

"That's a junkie disease." No. That's stigma talking, and stigma is why risk-based screening failed — the CDC said so outright. People got it from transfusions before 1992. From a dirty tattoo needle. From sharing a razor. From a medical procedure back when nobody knew. You don't get to look at somebody and know their story. And even if you could — so what? Sick is sick. Get tested.

A word for our generation

A lot of us did things in the 70s, 80s, 90s we don't talk about. I'm not asking you to talk about them. I'm asking you to get a blood test. The test doesn't ask questions. The lab doesn't judge. It's one tube of blood and twelve weeks of pills if you need them. Whatever happened back then stays back then — but the virus doesn't stay back then unless you kill it.

See a doctor. One test. Twelve weeks of pills if you need them. That's the whole deal. Don't let pride or fear or "I feel fine" keep you from a blood test.

Chapter 3: The One Nobody Talks About (HPV and Throat Cancer)

The hook

Nobody wants to talk about this one. That's exactly why it's in this book.

HPV — human papillomavirus — is the most common sexually transmitted infection in the country. Almost everybody who's sexually active gets it at some point. Most of the time your body clears it and you never know it was there.

But sometimes it doesn't clear. Sometimes it sits quiet for decades. And sometimes, twenty or thirty years later, it turns into cancer in the back of the throat — oropharyngeal cancer. The CDC says HPV is now the probable cause of up to 70 percent of these throat cancers in the US.

And here's who's getting it: men. About 19,000 cases a year in men, versus about 4,000 in women. And increasingly men over 50 — our age. Doctors say part of the reason is that the virus was dormant in their bodies for decades, from long before there was a vaccine.

You probably know HPV from the cervical cancer conversation. That's the one everybody heard about. The throat part didn't get the same press. So men walk around not knowing this is even a thing. That's what "slept on" means.

What's happening in the body

Plain version: HPV gets into the cells in the back of your throat — the tonsils, the base of the tongue. Most of the time, nothing happens. Your immune system handles it. But in some people, the virus hangs around and starts messing with the DNA inside those cells. Not fast. Slow. Over years and decades. Eventually some of those cells start growing wrong. That's cancer.

The key word is decades. You could have picked this up in your twenties or thirties and not see a thing until your fifties or sixties. The virus doesn't send announcements.

The warning signs nobody talks about

This is where men get hurt — because the early signs are easy to brush off:

- A sore throat that won't quit. Not a cold. Weeks.
- Trouble swallowing that keeps getting worse.
- Your voice changing — hoarse for no reason, and it stays.
- Ear pain on one side with no infection.
- A lump in the neck you can feel.
- Losing weight without trying.

Any one of these lasting more than a couple of weeks is a doctor visit. Not a "let's see." A visit. Throat cancer caught early is a completely different fight than throat cancer caught late. That's true of almost every cancer, and it's why this chapter exists.

What to actually do

Know the symptoms. That's the whole game for us — there's no routine screening test for throat cancer the way there is for some other cancers. Your eyes and your honesty are the screening. Something's off for weeks? Go.

Don't smoke. Ease up on the drinking. I know, I know. But smoking and heavy alcohol are the classic throat cancer fuel, and they stack with HPV risk. You don't have to be perfect. Less is better than more. That's just math.

The vaccine exists — for the young ones. The HPV vaccine works best before anybody's been exposed, so it goes to kids and young adults. If you've got kids or grandkids, make sure they get it. For men our age who missed it, ask your doctor what's recommended now. Guidelines have shifted over the years.

Dental visits count. Your dentist looks in your mouth and throat. Regular dental visits are an early-warning system most people don't think about. Keep them.

What people get wrong

"Throat cancer is a smoker's disease." That was the old story. The new story is HPV, and it's hitting men who never smoked a day in their lives. If you're waiting for a smoker's cough to warn you, you're watching the wrong door.

"HPV is a women's issue." The cervical cancer conversation was so loud it drowned this one out. Men carry HPV too, and for men the throat is where it does its worst work. This chapter exists because nobody told us.

"If it was serious I'd feel it." Throat cancer doesn't start with agony. It starts with a sore throat that won't quit, a little trouble swallowing, a voice that's slightly off. Small things. Easy to explain away. That's exactly how it gets a head start.

For your kids and grandkids

Here's where you get to be the hero. The HPV vaccine works best before exposure — that's why it goes to kids and young teens. If you've got children or grandchildren in that window, make sure they get it. You can't go back and get it for yourself at 12, but you can make sure they don't miss what you missed. That's how a generation breaks a cycle. One shot, one kid, one less sleeper.

See a doctor. A sore throat that won't leave is not "just a sore throat" until a doctor says so.

Chapter 4: Too Young for This (Colon Cancer Under 50)

The hook

Colon cancer used to be an old person's disease. That's what everybody thought. You hit 50, you got the colonoscopy, you joked about the prep, done.

Not anymore.

Recent American Cancer Society reports say colon and rectal cancer has been rising about 3 percent every year in adults 20 to 49. Three percent a year doesn't sound like much until you stack it over a decade. It's now the number one cause of cancer death in men under 50, and number two in women under 50. Let that sit for a second. Number one.

Nobody knows exactly why. The honest researchers say so — diet, processed food, weight, gut bacteria, stuff in the environment, antibiotics early in life. Probably a mix. The why is still being worked out. The what is not: young people are getting it, and they're getting it late, because nobody — not them, not their doctors — is looking for colon cancer in a 35-year-old.

Three out of four colon cancers in people under 50 are found at an advanced stage. Advanced. Because by the time anybody took the symptoms seriously, it had a head start.

What's happening in the body

Plain version: your colon is the last stretch of your gut — the large intestine. Its job is to take what's left after digestion and turn it into waste. Sometimes a small growth called a polyp forms on the inside wall. Most polyps are harmless. But some, over years, turn into cancer.

Here's the thing: polyps don't hurt. Early cancer doesn't hurt. You can have this growing inside you for years feeling completely normal. That's the sleeper part. The colon doesn't have a fire alarm. By the time there's pain or obvious bleeding, it's been there a while.

The warning signs nobody talks about

Researchers looked at thousands of people diagnosed under 50. The symptoms that kept showing up before diagnosis:

- **Blood in your stool.** Bright red or dark. Not once after spicy food — repeatedly.
- **Bathroom habits changing** and staying changed. Going more, going less, narrower than usual, feeling like you're not done. Weeks, not days.
- **Belly pain or cramping** that won't quit.
- **Losing weight without trying.** Your body burning fuel it shouldn't be burning.

Here's the trap: every one of these gets explained away. Hemorrhoids. Stress. "I ate something." Bad diet. At 35, nobody thinks cancer, so nobody checks. I'm telling you: if these stick around, get checked. Being embarrassed at the doctor's office is better than being late. Pride has killed more people than polyps.

What to actually do

Get screened at 45. The rules changed. It used to be 50. The American Cancer Society moved it to 45 in 2018, and the federal task force followed in 2021 — specifically because of this rise in younger people. If you're 45 or older and haven't been screened, you're behind. Catch up.

Know your options. Colonoscopy is the gold standard — they look directly and they can remove polyps on the spot. But there are stool tests and newer blood-based tests too. A positive on one of those means you still need the colonoscopy to confirm. Ask your doctor which fits you. The best test is the one you'll actually do.

If you're under 45 with symptoms, push. Many under-50 colon cancers happen in people under 45 — below the screening age. So for younger folks, symptoms are the safety net. If something's wrong down there and it won't quit, don't let anybody wave it off because of your age. Ask for the workup.

Family history matters. If a parent or sibling had colon cancer or polyps, tell your doctor. That changes your timeline — you may need to start screening years earlier than 45. Don't sit on that information because you don't want to worry anybody. The people who love you would rather know now than visit you later.

The prep, demystified

Let me take the fear out of this, because fear of the prep keeps more people away than the procedure. The day before, you drink clear liquids and take a laxative drink that cleans you out. Yes, you live in the bathroom for an evening. It's not fun. Nobody's claiming it's fun. But

the procedure itself? You're sedated. You nap. You wake up and it's done. People walk out saying "that was it?" The dread is worse than the day. Don't let dread make your medical decisions.

What people get wrong

"I'm too young." The numbers say otherwise now. Number one cancer killer in men under 50. If you're 45 or up, you're not too young — you're due. If you're under 45 with symptoms, you're not too young to be taken seriously.

"It's embarrassing." The doctor has done thousands of these. You are not the first butt they've seen this week, this day, this hour. And here's the truth about embarrassment: it's a feeling. Cancer is a diagnosis. One passes. The other doesn't have to happen.

"The stool test is enough." The at-home stool tests and blood tests are real options — but they're screening, not the full picture. If one comes back positive, you still need the colonoscopy to see what's actually going on. Think of them as the smoke alarm, not the fire department.

See a doctor. One bad day of prep. That's the price. Pay it.

Chapter 5: The Heart That Skips (Atrial Fibrillation)

The hook

Your heart has a rhythm. You don't think about it — it just does its thing, sixty to a hundred beats a minute, steady, your whole life. You only notice it when something's wrong.

Atrial fibrillation — AFib — is when the top chambers of the heart start quivering instead of beating. Fast, chaotic, out of rhythm. Sometimes you feel it: a flutter, a pounding, like your heart's stumbling. Sometimes you feel absolutely nothing.

Here's the number that stopped me cold: the American Heart Association found that 62 percent of people with AFib had no idea they had it before they were diagnosed. Six out of ten. Walking around, living life, heart misfiring, no clue.

And in about 1 in 4 AFib-related strokes, the stroke itself was the first sign anything was wrong. Read that again. The thing that can kill you or change your life forever is how you find out something was off.

AFib raises your stroke risk up to five times. Five. Because when the heart quivers instead of pumping clean, blood can pool and clot. A clot breaks loose, travels to the brain — that's a stroke.

Over six million Americans have AFib right now, and the number is expected to double by 2030. Our age group is right in the middle of it. Risk climbs as you get older. High blood pressure feeds it. And most of us don't know what it feels like — or that feeling nothing is also an option.

What's happening in the body

Plain version: your heart has four chambers. The top two — the atria — are supposed to squeeze in a steady rhythm, pushing blood down to the bottom chambers, which push it out to your body. In AFib, the electrical signals that control that squeeze go haywire. Instead of a clean squeeze, the top chambers quiver — fast, weak, chaotic. Hundreds of beats a minute in the worst spots.

When blood doesn't move cleanly, it pools. Pooled blood clots. Clots travel. That's the whole danger in one chain. The heart itself might keep going for years like this. It's the clot that gets you.

AFib can come and go — that's called paroxysmal, which just means "it visits." Or it can set up permanently. Either way, the stroke risk is real. The visiting kind doesn't get a pass.

The warning signs nobody talks about

Some people get the classic signs:

- Heart fluttering, pounding, or racing — like it's skipping or doing extra beats.
- Getting winded doing things that used to be easy.
- Chest discomfort. Dizziness. Feeling faint.
- Tired in a way that doesn't match what you did.

And some people get none of that. Nothing. That's the sleeper. You can't feel your way to this diagnosis — which is why "I feel fine" is not an answer for this one either.

What to actually do

Know your pulse. This is free and takes ten seconds. Two fingers on your wrist, count. Is it steady? Is it jumping around? Do it sometimes. Not obsessively — just sometimes. If it's irregular, that's a conversation with your doctor, not a diagnosis from your couch.

Blood pressure matters here. High blood pressure is one of the main things that invites AFib in. If you don't know your numbers, find out. The cuff at the pharmacy counts.

The fix exists. AFib is manageable and treatable. Blood thinners cut the clot risk way down. There are procedures that can reset or fix the rhythm. People live full lives with AFib — the ones who know they have it. The danger isn't the condition. The danger is not knowing.

If your heart ever feels wrong, don't drive yourself — call for help. Chest pounding with dizziness or faintness is not a wait-and-see situation. That's emergency room territory.

What people get wrong

"It's just stress." Maybe. But "just stress" is what people say right up until it isn't. If your heart is racing or skipping and you can't tie it to something obvious, that's worth a check. Stress doesn't get a lifetime pass as an explanation.

"I'm too young for heart problems." AFib risk climbs with age, but it doesn't wait for permission. High blood pressure, sleep apnea, heavy drinking, thyroid issues — these can invite it in earlier. Young doesn't mean immune.

"Blood thinners are worse than the disease." I hear this one a lot. Yes, blood thinners mean you bleed easier and you have to be careful. But compare: a little extra bleeding from a shaving nick versus a stroke that takes your speech, your movement, your independence. That's not a close call. Talk to your doctor about the real trade-offs, not the scary stories.

Your watch might know first

A lot of us wear smartwatches now. Many of them can check your heart rhythm — you sit still, put your finger on the crown, and it takes a reading. If it flags something irregular, that's not a diagnosis. It's a tap on the shoulder telling you to get the real test. Don't ignore it, and don't panic over it. Take the flag to your doctor and let them do the EKG. Let the watch tap your shoulder. Let the doctor make the call.

See a doctor. Especially if you're over 50 with high blood pressure. Ask them to check your rhythm. It takes a minute. An EKG is painless — stickers on your chest, thirty seconds, done.

Chapter 6: The Silent Killer (Chronic Kidney Disease)

The hook

They call this one "the silent killer," and for once the nickname is earned.

More than one in seven American adults has chronic kidney disease. CKD. And the CDC says up to 90 percent of them don't know it. Nine out of ten. Let me say it differently: if ten people in a room have kidney disease, nine of them are walking around thinking their kidneys are fine.

Even in the early stages — stages 1 and 2 — 96 percent don't know. And nearly half the people with severely reduced kidney function, stage 4, still don't know. Stage 4. Almost dead kidneys. Don't know.

Your kidneys filter your blood. All of it, all day, every day. They pull out the waste, balance your fluids, handle your blood pressure, keep your bones right. They're the quietest hard workers in your body. And unlike some organs, they don't grow back. The filters you're born with have to last your whole life.

When they start failing, there's no pain. That's the trap. Diabetes, high blood pressure, heart disease, extra weight — these damage the kidneys slowly, silently, over years. You feel fine. Maybe a little tired. Everybody's tired. Then one day you're not fine, and the damage doesn't reverse.

What's happening in the body

Plain version: each kidney has about a million tiny filters. Blood goes in dirty, comes out clean, waste goes out in urine. When you have diabetes or high blood pressure running wild for years, those filters get damaged — scarred, leaky, clogged. Fewer working filters means the remaining ones work harder, which damages them faster. It's a downhill slide that speeds up.

As the filters fail, waste builds up in your blood. Fluid builds up. Blood pressure climbs higher, which damages the kidneys more. It's a loop, and it runs quiet until it's loud — swelling in the legs, crushing fatigue, nausea, no appetite, trouble thinking straight. By then you're in the late stages, looking at dialysis — a machine doing your kidneys' job three days a week — or a transplant list.

Here's what makes this chapter different from fear: caught early, kidney damage can be slowed way down. Sometimes stopped. The treatments exist — blood pressure control, diabetes control, newer medicines. But early means before symptoms. There is no "wait until you feel it" with kidneys. By the time you feel it, the easy window is closed.

The warning signs nobody talks about

I'm going to be honest: there basically aren't any early ones. That's the whole chapter. But late ones include:

- Swelling in your feet, ankles, or around your eyes.
- Peeing more or less than usual, or foamy urine.
- Tired beyond what your life explains.
- Nausea, no appetite, metallic taste.
- Trouble concentrating. Itchy skin that won't quit.

But if you're waiting for these, you've already lost the early game. The move with kidneys is not symptoms. It's tests.

What to actually do

Get the two tests. That's it. That's the whole play:

1. A blood test that measures how well your kidneys are filtering (doctors call it eGFR — estimated glomerular filtration rate; you can just call it "the kidney filter number").
2. A urine test that checks whether protein is leaking through (healthy filters don't leak protein).

Two tests. Blood and urine. Probably already part of your annual labs — but ask specifically. "Check my kidney numbers" is a complete sentence at the doctor's office.

Control the two big feeders: blood pressure and blood sugar.

Diabetes and high blood pressure are the top causes of kidney failure. Managing them IS kidney protection. This isn't separate advice — it's the same advice, and your kidneys are one of the reasons.

Watch the painkillers. Regular heavy use of certain over-the-counter pain medicines can hurt the kidneys over time. If you take them daily, tell your doctor. Don't just stop prescribed medicine on your own — talk first.

Don't fall for "kidney detox" nonsense. No tea, juice, or cleanse repairs kidney filters. The people selling that are selling to your fear. The real protection is boring: blood pressure, blood sugar, tests, doctor.

What people get wrong

"My pee looks fine, so my kidneys are fine." Your eyes are not lab equipment. Protein leaking into urine is invisible. Declining filtration is invisible. By the time urine looks wrong, you're deep in. The tests see what you can't.

"Kidney disease is rare." One in seven. That's not rare — that's your barbershop, your church pew, your family reunion. It's common and unknown at the same time, which is the worst combination.

"Dialysis is the only ending." Dialysis is the late ending. Caught early, the story is completely different — medicines, blood pressure control, diet changes, and the decline slows to a crawl or stops. The ending depends on when you show up. Show up early.

"I don't have diabetes, so I'm good." Diabetes is the top cause, but high blood pressure is right behind it. Heart disease, obesity, family history, being over 60 — these all count. And some people get kidney disease without any of the big ones. The tests don't care about your reasons. Get them.

Salt, water, and the boring truth

Nobody wants to hear "eat less salt" in a book. But with kidneys, salt isn't about taste — it's about pressure. Too much salt holds water, raises blood pressure, and blood pressure grinds the filters down. You don't need a perfect diet. Less salt, less soda, more water, actual vegetables sometimes. Boring? Yes. Effective? Also yes. Your kidneys don't need you to be a health guru. They need you to be consistent.

See a doctor. Ask for the kidney numbers. If you have diabetes, high blood pressure, heart disease, or kidney disease runs in your family — don't wait for the annual. Go ask now.

Chapter 7: The One I Know Best (HIV)

The hook

Seven years. That's how long I worked in an HIV clinic. In those same seven years, I worked in a methadone clinic too — a lot of the same faces, several of them HIV positive. I watched several of them come and go. I don't have an exact number. I wasn't counting. But it was several people, not one or two.

So when I tell you I know this one, I mean I sat in the room with it. I watched what it did to people. And I watched what fear did to people — and I'm going to be honest with you, the fear was sometimes worse than the virus. People would rather not know than know. People would rather guess than test. And guessing is how it spread.

Here's what I need you to hear first, before anything else in this chapter: the story has changed. Everything you think you know about HIV from the 80s and 90s — the commercials, the fear, the funerals — that was then. I'm going to tell you what it is now. And what it is now would have sounded like science fiction back when I was working in that clinic.

What's happening in the body

Plain version: HIV attacks your immune system — specifically the CD4 cells, the generals of your immune army. The virus gets inside them and uses them to make copies of itself. Slowly, over years, it kills off enough generals that the army can't fight anymore. Then infections your body would normally swat away — a pneumonia, a fungus, certain cancers — walk right in. That end stage is what they call AIDS.

But here's the part that changes everything: today's medicine pushes the virus down so low the tests can't find it. They call that undetectable. And a person with an undetectable viral load cannot pass HIV through sex. Not "very unlikely." Cannot. The scientists have a name for it: U=U. Undetectable equals untransmittable.

Read that again. The medicine doesn't just manage HIV anymore. It disarms it.

And here's why it's in this book: after the first few weeks — sometimes a flu-like illness most people brush off or never notice — HIV goes quiet. For years. Sometimes a decade or more. You feel fine. The virus is working. That's the sleeper. The CDC says about 1.2 million people in the US are living with HIV, and roughly 1 in 8 of them don't know it.

The warning signs nobody talks about

Two to four weeks after exposure, some people get what's called acute infection — fever, rash, sore throat, swollen glands, muscle aches, headache. It feels like a bad flu. Then it passes. Most people never connect it to anything.

Then: nothing. Years of nothing. That's the trap this whole book is about.

Late — and I mean years late, without treatment — the signs are the immune system failing: infections that won't quit, weight dropping off, night sweats, exhaustion sleep doesn't touch, sores that don't heal.

But I'm going to be straight with you: waiting for signs with HIV is the losing play. The test is the sign. That's the whole chapter in one sentence.

What to actually do

Get tested. The CDC says everyone from 13 to 64 should be tested for HIV at least once as part of regular health care. Once. If you're at higher risk — more than one partner, a partner whose history you don't know, shared needles — go yearly. The test is quick. Many places do it free and confidential. Your doctor can order it, or find a site at gettested.cdc.gov, or text your ZIP code to 566948. No excuses left on this one.

Know about PrEP. This is the armor. PrEP is medicine for people who don't have HIV that keeps them from getting it. There used to be just the daily pill. Now there's a shot every two months — and as of June 2025, a shot twice a year. Twice a year. The drug is called lenacapavir — brand name Yeztugo — and in the big trials, more than 99.9% of the people who got it stayed HIV-negative. Two shots a year and you're armored. If that's relevant to your life, ask your doctor. This is the news our generation never got.

Know about PEP. This is the emergency brake. If something happens — a condom breaks, a needle sticks you, the worst night of somebody's life — there is medicine you can start within 72 hours that can stop HIV from taking hold. Seventy-two hours. After that the window closes. So if it ever happens to you or somebody you love: emergency room, immediately. Don't wait the weekend. Don't "see how it goes." Go.

If you test positive: treatment works. One pill a day for most people now — not the handful of brutal drugs from back in the day. Take it, stay on it, get to undetectable, and you live your life. You don't pass it. You don't waste away. The people I watched come and go in that clinic didn't have what you have now. Use it.

What people get wrong

"You can tell by looking." No, you can't. That's the sleeper. Healthy-looking people, years in, no idea.

"It's a death sentence." In 1988, close enough. In 2026, no. Treatment turned it into a manageable condition — a pill a day, undetectable, untransmittable, full lifespan. The death sentence now is not knowing.

"The medicines are poison." The early ones were rough — I'll give you that, I watched it. Today's are nothing like that. One pill. Most people feel normal. Don't let a 1995 horror story make a 2026 decision.

"Undetectable still means risky." U=U. Undetectable equals untransmittable through sex. That's not hope, that's the science — big studies, thousands of couples, zero transmissions. The science is settled on this one.

"PrEP is only for gay men." No. PrEP is for anybody at risk. Anybody. If your life has exposure, the armor doesn't care who you are.

The money

Now let me tell you what I saw from the other side of the desk.

One company — Gilead — reported \$19.6 billion in HIV drug sales in 2024. Billion, with a B. One pill, Biktarvy, did \$13.4 billion in a single year. That's their own earnings report — public numbers, not a rumor.

I'm not mad at medicine that works. A pill that gets you to undetectable and untransmittable is a miracle and I'll say so. But I want you to see the size of the machine. Every person on a daily pill for life is a customer

for life. The twice-a-year shot is great medicine — and it's also a product. Both things are true at the same time. See the medicine. See the money. Then make your decisions with both eyes open.

The question I get asked

In prison I read a book — I can't give you the title, it's gone from me — that said the government spent millions to create this virus. Five, ten million dollars. And I've heard the number tied to something real: in 1969, a Pentagon man named MacArthur went before Congress and asked for \$10 million to develop a synthetic germ — a man-made biological agent that no natural immunity could stop. That testimony is real. It's in the Congressional Record. You can look it up.

Now here's where I'm going to be honest with you the way I'd want somebody to be honest with me.

A real request for bioweapon research money is not the same as proof they built HIV. Those are two different things, and I won't collapse them to make a point.

And here's what the science has actually nailed down about where HIV came from: the oldest HIV samples ever found come from 1959 and 1960, in central Africa — years before that 1969 testimony. And when scientists mapped the virus's family tree, it traced back to a chimpanzee virus that crossed into people in central Africa in the early 1900s. That's genetics, not opinion. The virus is old. Older than the theory.

So here's my line, and I'll stand on it: they didn't have to create it to get rich off it. Nineteen-point-six billion dollars in one year says that plain. My skepticism of the system is earned — I've got my reasons, and history backs me. But I won't build your health decisions on a maybe.

The medicine works whether you trust the maker or not. Take the shot. Take the pill. Get the test. Let the origin stay a question — your health can't wait for the answer.

See a doctor. Especially on this one. Especially if it's been years. The test takes minutes. The knowing changes everything.

Chapter 8: For the Men (Prostate Health)

The hook

Men don't talk about this. We talk about everything else — sports, money, women, cars — but not this. And the silence is killing us.

Prostate cancer is the most common cancer in men, after skin cancer. About 1 in 8 men will hear those words in their lifetime. And here's why it's in this book: early on, it says nothing. No pain. No warning. It grows quiet — sometimes for years — and by the time it speaks, the conversation is harder.

I'm writing this chapter for the men, and for the women who love men too stubborn to read it themselves. Hand it to him.

What's happening in the body

Plain version: the prostate is a small gland — about the size of a walnut — that sits below the bladder. It makes some of the fluid in semen. That's its job.

Sometimes cells in the prostate start growing wrong. Usually slow — so slow that some men will die of old age with prostate cancer they never knew about and never needed to treat. But some of it is aggressive. It spreads — to the bones, the lymph nodes — and then it's a different fight entirely. The cruel part: you can't tell which kind you have by how you feel. Feeling fine tells you nothing.

The warning signs nobody talks about

Early: there aren't any. That's the chapter. That's why it's here.

Later, if it's growing: trouble starting or stopping your stream. Weak flow. Feeling like you didn't finish. Getting up to pee all night. Blood in the urine or semen. A deep ache in the back, hips, or pelvis that won't quit.

But if you're waiting for those, you've skipped the early game — and the early game is where this one is won. Caught while it's still in the prostate, survival is near 100%. Spread far, it drops hard. The difference between those two numbers is timing. Timing is the test.

What to actually do

Have the conversation. Prostate screening starts with a talk, not a test — because the test (PSA, a blood test) isn't perfect. It can run high for reasons that aren't cancer. So the guidelines say: talk to your doctor, know your risk, then decide together.

The American Cancer Society's line: men at average risk, have the talk at 50. Black men, and men with a father or brother who had prostate cancer young — have it at 45. Strong family history, several relatives — 40. Newer urology guidelines say a baseline PSA between 45 and 50 for standard risk, 40 to 45 for higher risk. The exact age matters less than this: have the conversation before there's a symptom. That's the whole move.

Know your risk. Age is the big one — risk climbs after 50. Family history counts double. And race counts: Black men are nearly 70% more likely to develop prostate cancer than white men, and twice as likely to die from it. That's the American Cancer Society's number. It tends to show up younger and run more aggressive in Black men. If that's you, 45 isn't early — it's on time. Don't let anybody tell you you're worrying about nothing.

Don't fear the exam. Let me address it straight, because this is what keeps men home: yes, part of the check can be a rectal exam. A gloved finger, ten seconds, done. I know. Nobody's excited about it. But weigh it honestly: ten seconds of discomfort versus a cancer that could have been caught. Pride has no place in this decision. The doctor has done thousands. You are not special in that room, and that's the point.

What people get wrong

"It grows so slow it doesn't matter." Some of it does grow slow. Some of it doesn't. You don't get to know which kind without looking.

"Probably slow" is not a medical plan.

"No symptoms, no problem." Read this book's title again. The whole point is that the dangerous ones don't announce themselves.

"The PSA test is controversial, so skip it." The controversy is about over-treatment — treating slow cancers that never would have hurt anybody. It's not about knowing. Knowing is power. The conversation exists so you and your doctor can be smart about what to do with the number, not so you can avoid the number.

"That's an old man's disease." Risk climbs with age, but Black men and men with family history get it younger. And "old" starts at 50 in cancer years. If you're reading this book, you're in the conversation.

For the women reading this

You probably know a man who won't read this chapter. Your husband, your brother, your father, your son. Men die of stubbornness as much as disease. So here's your job: put the appointment on his calendar. Drive

him if you have to. "Have you had the talk at 45?" is a complete sentence, and you're allowed to say it every year until he answers. Love is also nagging, when the nagging saves a life.

See a doctor. Men: have the talk at 50 — at 45 if you're Black or it's in your family. Women: make him go.

Chapter 9: The Quiet Sugar (Prediabetes and Type 2 Diabetes)

The hook

Everybody knows somebody with "the sugar." Your uncle. Your neighbor. The lady at church who lost a toe. Diabetes is so common in our community that people treat it like weather — something that just happens to people.

But here's what nobody says: before the sugar, there's the almost-sugar. Prediabetes. And the CDC's numbers on it are staggering — more than 2 in 5 American adults have it. That's 115 million people. And 8 in 10 of them don't know.

Read that again. Eight in ten. Walking around, feeling fine, blood sugar climbing, no idea.

Prediabetes is the quietest chapter in this whole book, because it doesn't even feel like a disease. It's a warning with no alarm attached. And the window it gives you — the years between "almost" and "yes" — is the most valuable window in medicine. The CDC's own research says the right changes in that window can cut your risk of full diabetes by 58%. For people over 60, 71%. But you can't use a window you don't know you're standing in.

What's happening in the body

Plain version: everything you eat breaks down into sugar — glucose — in your blood. Your pancreas, a small organ tucked behind your stomach, makes insulin. Insulin is the key that opens your cells so the sugar can go inside and be used for energy.

Now I need to say something straight, because I know some of y'all heard different: it's the PANCREAS, not the prostate. Easy to mix up — they sound alike, they're both glands, and the word "clogged" gets thrown around a lot. But the prostate is downstairs handling different business entirely. The pancreas is the diabetes organ. It makes the insulin. Different organ, different job.

But here's where the "clogged" instinct is right — and I mean scientifically right. Researchers at Newcastle University in England actually watched it happen with advanced scans: when your body runs out of safe places to store fat — under the skin — the overflow goes into the liver, and then spills over into the pancreas. Researchers call everybody's limit the personal fat threshold — and everybody's is a different size. It clogs the pancreas up — their word, not mine — and switches off the machinery that makes insulin work right. So the buildup idea was never wrong. It was just the wrong organ. Fat clogging the pancreas is a real, documented thing, and it's one of the main drivers of type 2 diabetes.

Back to plain: when your cells stop answering insulin's knock — doctors call that insulin resistance — sugar piles up in the blood. The pancreas works overtime pumping out more insulin until it wears out. That's type 2 diabetes. It accounts for 90 to 95 out of every 100 diabetes cases in adults.

Before that comes prediabetes: blood sugar higher than normal, not yet diabetes. A fasting number between 100 and 125. Most people feel absolutely nothing. And that nothing is the danger — because the damage to your blood vessels starts before the diagnosis does.

The warning signs nobody talks about

Usually there are none. That's the whole point of this chapter. But sometimes:

- Peeing a lot, especially getting up at night to go.
- Real thirsty, all the time.
- Tired in a way sleep doesn't fix.
- Blurry vision that comes and goes.
- Cuts and scrapes taking forever to heal.
- Dark, velvety patches of skin around the neck, armpits, or groin. Doctors call it acanthosis nigricans. Plain version: your skin telling on your insulin.

But I'm going to be straight: waiting for symptoms with blood sugar is like the hepatitis C chapter — by the time you feel it, you've been in it a while. The move is the test.

What to actually do

Get the A1C test. One blood test. It shows your average blood sugar over the last three months — not just that morning, the whole season. The CDC says testing should start at 45 for everybody, and earlier if you're carrying extra weight plus another risk factor: family history, high blood pressure, and the like. Ask for it by name: "I want my A1C." That's a complete sentence.

What actually works — the honest version. People ask me about holistic approaches, natural therapies, all of it. Here's what's real and what isn't. No games.

What works — real evidence behind it:

- **Walk after you eat.** Ten, fifteen minutes. When your muscles move, they soak up sugar straight out of the blood without needing as much insulin. Researchers have measured this — it's not folk wisdom. Cheapest medicine on earth, and you already own the legs.
- **Cut the sugar drinks first.** Soda, sweet tea, juice, energy drinks — liquid sugar spikes blood sugar faster than anything. You don't need a perfect diet on day one. Start with the drinks. That's the biggest lever in the whole house.
- **Eat more fiber.** Beans, greens, vegetables. Fiber slows everything down so sugar enters your blood gradual instead of all at once. Think of it like a speed bump for sugar.
- **Sleep and stress.** Bad sleep and constant stress raise blood sugar. That's measured, that's real. Not the whole story — but part of it. Rest is medicine too.
- **Lose even a little.** The diabetes prevention research is specific: 5 to 7 percent of body weight. For a 200-pound person, that's 10 to 14 pounds. That "little" cut the risk by more than half. You don't need a transformation. You need a start.

What DOESN'T work: no cleanse, no tea, no bottle of pills "unclogs" anything. Anybody selling you a supplement that melts fat out of your pancreas is selling to your fear. Same crowd as the "kidney detox"

people from the kidney chapter — different bottle, same game. The real fix is boring: move, eat different, sleep, repeat. Boring works. Bottles don't.

What people get wrong

"I'm skinny, I can't get it." Yes, you can. Remember the personal fat threshold — everybody's safe storage is a different size. Some people's fills up fast. Skinny people get type 2 diabetes too. The scale doesn't tell the whole story.

"It's just a touch of sugar." There is no "touch." Prediabetes is the on-ramp, and vessel damage starts before the diagnosis. Take it serious at "pre" — that's when you still have the most power.

"The pills handle it, so I can eat what I want." The pills help. They don't erase. Food and medicine are a team, not substitutes. The people who do best do both.

"Diabetes isn't that serious." Go back and read the kidney chapter. The heart chapter. The foot you lose, the eyesight that goes, the dialysis chair. Diabetes feeds every one of them. It's serious the way termites are serious — quiet, and then the house falls.

"They're just trying to sell me drugs." The lifestyle stuff in this chapter — walking, food, sleep — nobody profits off that. The 58% risk reduction came from lifestyle, not a prescription pad. This is the one chapter where the free stuff is the strong stuff.

See a doctor. Ask for the A1C. One test, one number, three months of truth. If it's high, you caught it in the window where it can still be turned around. That's not bad news — that's the best news in this book.



Chapter 10: The Number Nobody Checks (High Blood Pressure)

The hook

There's a blood pressure cuff at every pharmacy in America. You sit down, stick your arm in, and it squeezes. Then it shows you two numbers, and most people look at them the way they look at a check engine light — huh, then keep driving.

About half of American adults have high blood pressure. Half. And a 2026 study in the Journal of the American Medical Association found that nearly 8 in 10 of them don't have it under control. Not 8 in 10 don't know — 8 in 10 aren't controlled. Most of them have insurance. Most of them have a regular doctor. The care is right there. And the number still isn't moving.

High blood pressure is the original sleeper. It doesn't hurt. It doesn't warn. It just quietly beats up your arteries, your heart, your brain, and your kidneys for years — and then one day it's a stroke at the breakfast table, a heart attack in the parking lot, kidneys failing in your fifties. The event gets the attention. The decades of pressure that caused it never do.

What's happening in the body

Plain version: your heart is a pump. Your blood vessels are the pipes. Blood pressure is how hard the blood pushes against the pipe walls.

The top number — systolic — is the push when the heart squeezes. The bottom number — diastolic — is the push when the heart rests between beats. Doctors write it like 120/80 and say it "120 over 80." The American Heart Association and the American College of Cardiology say the goal is to stay under 130 over 80.

When the pressure runs high for years, it's like running too much water pressure through old pipes. The pipe walls get damaged. They stiffen. They narrow. Clots form easier. And everything downstream — brain, heart, kidneys, eyes — takes the beating. High blood pressure is the reason behind a huge share of strokes, heart attacks, heart failure, and kidney disease. It's the quiet engine under half the tragedies in this book.

Why does it run high? Salt holds water, more water means more volume in the pipes. Extra weight means the heart works harder. Alcohol, smoking, stress, bad sleep, getting older — all of it pushes the number up. Sometimes it's just genetics and you did nothing wrong. The pipes are the pipes.

The warning signs nobody talks about

There are none. I mean that. High blood pressure is called the silent killer because silence is its whole strategy. No headache tells you. No dizziness warns you. By the time you feel something — chest pain, shortness of breath, a nosebleed that won't quit, vision going funny — you're not getting a warning. You're getting the event.

That's why the cuff exists. The number IS the symptom. If you're waiting to feel it, you're waiting for the wrong thing.

What to actually do

Know your number. That's the whole move. Get it checked — doctor's office, pharmacy cuff, fire station, health fair, wherever. And don't go by one reading; pressure jumps around. A pattern of high readings is the truth. One high reading after you ran up the stairs is just life.

Get a home cuff. They're cheap. Check it the same way each time — sit down, feet flat, arm supported, rest five minutes first, no coffee right before. Write the numbers down. Bring them to your doctor. A page of real numbers beats "I think it's usually okay" every time.

Take the medicine if it's prescribed — and keep taking it. This is where most people fall off. The pills work, the number drops, they feel fine, they stop. Then the number climbs back up silently. Blood pressure medicine isn't a course you finish — it's a maintenance plan. Stopping because you feel good is like taking the batteries out of the smoke detector because there's no fire.

Eat and move like you mean it. Less salt — and I know, everything good has salt. You don't have to go to zero. Just less. More vegetables, more walking, less alcohol, no smoking. None of this is exotic. It's the same boring stuff from the sugar chapter, because it's the same pipes.

What people get wrong

"I feel fine, so it must be fine." Feeling fine is the disease's best trick. Nearly 8 in 10 people with it aren't controlled, and most of them feel fine too. The number doesn't care about your feelings.

"I'll stop the pills once it comes down." That's the number one mistake. The pills are WHY it came down. Stop the pills, the number goes back up. Ask your doctor before you change anything — don't freelance your dosage.

"It's just the salt." Salt matters, but it's not the whole story. Weight, alcohol, smoking, stress, sleep, age, genes — it's a team effort. Cutting salt while changing nothing else is like locking the front door and leaving the windows open.

"That's an old person thing." Nearly 1 in 4 adults under 40 has it, and most of them don't know. The pipes don't check ID.

"White coat syndrome — it's only high at the doctor." Sometimes true — nerves spike the number. That's exactly why the home cuff matters. A month of morning readings at your kitchen table tells the real story. Don't use one nervous reading as an excuse to ignore twelve calm ones.

See a doctor. Know the number. Under 130 over 80 is the goal. If it's high, that's not a verdict — most people in the study were only about 10 points over, and that's fixable with medicine and habits. Small number, big consequences, easy fix. Don't leave it on the table.

Chapter 11: The Fat Liver (Fatty Liver Disease)

The hook

The hepatitis C chapter was about a virus attacking the liver. This chapter is about something attacking the liver with no virus at all — just fat. And it's sitting in about 1 in 3 American adults right now.

They renamed it in 2023. It used to be called nonalcoholic fatty liver disease — NAFLD. Now it's MASLD: metabolic dysfunction-associated steatotic liver disease. Fancy words. Plain version: fat building up in the liver, tied to the same metabolic mess as diabetes and high blood pressure — the sugar chapter and the pressure chapter you just read. Same story, different organ.

Here's why it's a sleeper: your liver doesn't complain. Remember from the hep C chapter — no pain nerves like your skin. Fat can pack into the liver for years, and you feel nothing. Maybe tired. Everybody's tired. Then the fat causes inflammation, the inflammation causes scarring, the scarring becomes cirrhosis — and cirrhosis from fatty liver is now one of the leading reasons people need liver transplants. From fat. Not alcohol. Fat.

What's happening in the body

Plain version: your liver is the body's processing plant — it handles everything you eat and drink, cleans the blood, manages chemicals. When there's more energy coming in than going out, the body stores the

extra as fat. Usually under the skin. But when that storage fills up — remember the personal fat threshold from the sugar chapter — the overflow goes into the organs. The liver is first in line.

A little fat in the liver is common and not an emergency. The problem is when it stays and grows. The fat irritates the liver — inflammation. Long-term inflammation turns into fibrosis — stiffening. Fibrosis turns into cirrhosis — heavy scarring, the liver can't do its job. And a cirrhotic liver can develop cancer. Same road the hep C chapter described, different vehicle.

Here's the connection to the sugar chapter: it's the same metabolic story. The same insulin resistance, the same overflow of fat, the same fix. These chapters aren't separate diseases as much as they're one condition wearing different masks. Fix the metabolism, you help the liver, the sugar, the pressure, all of it.

And remember the good news from the hep C chapter: the liver is the only internal organ that can regrow. When you take the fat out, the liver gets a real chance to heal. The body wants to fix itself. Give it the opening.

The warning signs nobody talks about

Early: nothing. I keep saying it because it's true for half this book. Maybe tired. Maybe a dull ache in the upper right belly where the liver sits. That's it.

Late — and late is the problem: belly swelling, yellowing skin or eyes, dark urine, confusion, bruising easy. By the time these show up, you're deep in. Don't wait for late.

What to actually do

Ask about your liver numbers. When you get blood work, there's a liver panel in there — enzymes with alphabet names (ALT, AST). If they're high, that's the liver waving a flag. Ask your doctor: "How do my liver numbers look?" Most people never ask. Ask.

Get the ultrasound if it's suggested. If the numbers are off, the next step is usually an ultrasound or a scan that measures liver stiffness. No big procedure. Just pictures.

Lose 7 to 10 percent of your weight. That's the number the liver research points to — for a 200-pound person, 14 to 20 pounds. That range is where the fat actually starts coming out of the liver. Same playbook as the sugar chapter: walk after meals, cut the sugar drinks, more fiber, sleep. One playbook, multiple organs.

Ease up on the alcohol. This isn't an alcohol disease — that's the whole point of the new name. But alcohol and a fatty liver are a bad combination. The liver's already working overtime; don't hand it a second job.

What people get wrong

"I don't drink, so my liver's fine." That's exactly why they renamed it. This isn't about drinking. It's about metabolism. Plenty of people who never touch alcohol have fatty livers. The bottle isn't the only thing that hurts a liver.

"Fatty liver isn't serious." Early fatty liver, caught and reversed — not serious. Ignored for twenty years until it's cirrhosis — very serious. The seriousness isn't in the condition, it's in the ignoring.

"You'd feel it if your liver was in trouble." No, you wouldn't. That's the hep C lesson all over again. The liver suffers in silence. The blood test is its voice.

"It's just a little fat, everybody has it." A third of adults having it doesn't make it harmless — it makes it an epidemic. "Everybody has it" is how a whole country sleepwalks into liver disease.

See a doctor. Ask for the liver numbers on your next blood work. One question: "How's my liver look?" If the numbers are high, you caught it in the window where weight loss can reverse it. The liver forgives. Let it.

Chapter 12: The Night Thief (Sleep Apnea)

The hook

Everybody knows a snorer. The jokes write themselves — the freight train, the chainsaw, the "I thought somebody was dying in there."

Partners move to the couch. Kids imitate it at breakfast. Funny, right?

Here's what's not funny: about 29 million American adults have obstructive sleep apnea, and roughly 8 in 10 of them don't know it. The snoring isn't the joke. The snoring is the alarm. And most people sleep right through their own alarm, every night, for years — while their heart takes the beating.

Sleep apnea means your airway closes, over and over, all night long. Your brain yanks you awake just enough to gasp — dozens, sometimes hundreds of times a night — and you never remember a single one. You think you slept eight hours. Your body went to war eight hours.

What's happening in the body

Plain version: when you fall asleep, the muscles in your throat relax. In some people they relax too much, and the airway narrows or closes completely. Air can't get through. Oxygen in your blood drops. Your brain — which does not negotiate — jerks you awake just enough to tighten everything back up and gasp. Then you fall back asleep. Then it happens again. And again. All night.

Every one of those episodes is a small emergency. Adrenaline spikes. Blood pressure surges. The heart works overtime on no rest. Do that hundreds of times a night, every night, for years — and you've got a

straight road to high blood pressure, heart disease, stroke, and type 2 diabetes. The sleep apnea chapter connects to the pressure chapter, the sugar chapter, the heart chapter. It's all one body.

And the cruelest part: you're unconscious for all of it. The person who knows you have it is the person next to you in bed — the one who hears the silence between snores, the gasp, the choking sound. If your partner has ever told you "you stop breathing in your sleep" — that's not a joke to laugh off. That's a diagnosis trying to introduce itself.

The warning signs nobody talks about

- Loud snoring — especially with pauses, gasps, or choking sounds.
 - Waking up with a headache, dry mouth, or sore throat.
 - Falling asleep during the day — at red lights, in meetings, mid-conversation. That's not "being tired." That's your brain stealing back the sleep it never got.
 - Your partner telling you stop breathing. Believe them.
 - Trouble concentrating, mood going dark, memory slipping.
- People blame age. Sometimes it's just no real sleep for five years.

But here's the thing: the sleeper can't watch themselves sleep. This is the one chapter where somebody else might have to tap your shoulder. If you love somebody who snores like that — tell them. It might save their heart.

What to actually do

Tell your doctor you snore. That's it. That's the move. "I snore loud and I'm tired all day" is a complete medical sentence. Doctors hear it every day and they know exactly what to do next.

Get the sleep study. It used to mean a night in a lab with wires on your head. Now there are home tests — a small device you wear in your own bed, one night, done. If the doctor orders it, do it. One night of awkward sleep to find out about every night after.

If it's CPAP, wear the CPAP. I know. The mask. Nobody wants to look like a fighter pilot in bed. Here's the truth from people who actually stuck with it: after a week, you don't notice it, and for the first time in years you wake up feeling like you actually slept. The machine isn't a muzzle — it's air. It's the easiest treatment in this whole book: you do nothing, it does everything, while you sleep. The people who quit in the first three nights never find out what week two feels like. Give it two weeks.

What people get wrong

"Everybody snores." Everybody doesn't stop breathing. Snoring with pauses, gasps, and choking is not normal snoring — it's the airway closing. Don't let "everybody" talk you out of a test.

"CPAP is for old fat men." Sleep apnea hits women, thin people, young people. The airway doesn't check your demographic. And the "old fat man" who wears his CPAP is going to outlive the young thin man who jokes about his snoring.

"I'm just tired because I work hard." Working hard makes you tired at night. Sleep apnea makes you tired at 10 AM after eight hours in bed. If the math doesn't add up — enough hours, still exhausted — it's not the job. It's the night.

"It'll go away on its own." It won't. Airways don't tighten up with age — they loosen. This one moves in one direction. The only question is whether you meet it with a mask or with a heart attack.

"My partner's the one with the problem — they're the light sleeper." If three different partners over ten years all said you snore like a chainsaw, the common denominator isn't their hearing. Listen to the witnesses.

See a doctor. Say the sentence: "I snore and I'm tired all day." If there's a pause-and-gasp in your night, a home test and a machine can give you back your days. Sleep isn't a luxury. It's when your heart rests. Let it.

Chapter 13: The Quietest Killer (Pancreatic Cancer)

The hook

I'm going to be straight with you before this chapter starts: this is the scariest one in the book. Pancreatic cancer has the worst reputation of any cancer in these pages, and it earned it. I'm not going to soften the numbers. But I'm also not going to leave you frozen — because fear makes people freeze, and frozen people don't go to the doctor. So read this one the way it was written: as a reason to pay attention, not a reason to panic.

The pancreas sits deep in your belly, tucked behind the stomach. You can't feel it. There's no routine screening test for pancreatic cancer the way there's a mammogram or a colonoscopy. It grows quiet, and by the time it makes noise, it's usually advanced. That's the whole terrible story in one paragraph.

Here's the other half of the story, and I need you to hear it: when it's caught early — while it's still local, still contained — the five-year survival is 44%. When it's caught late, after it's spread, it's 3%. Same disease. Completely different fight. The difference between those two numbers is attention. That's what this chapter is: attention.

What's happening in the body

Plain version: the pancreas does two jobs. It makes insulin — that's the sugar chapter's organ, same one. And it makes digestive juices that help break down food. It's about six inches long, sitting deep between your stomach and your spine.

Pancreatic cancer is cells in the pancreas growing out of control. Nine times out of ten, it's the exocrine kind — the digestive-juice part. It doesn't cause pain early because of where it sits — deep, surrounded, no nerves screaming. A tumor can grow there for a long time before anything feels wrong. And there's no blood test or scan that doctors give everybody to catch it early, the way they do for colon or breast cancer. That's why it gets found late. Not because nobody cares — because the tools don't exist yet.

The American Cancer Society's 2025 numbers: about 67,000 Americans diagnosed in a year, about 52,000 die from it. It's the third-leading cause of cancer death in the country, and it's climbing toward second. The overall five-year survival is 13%. I told you I wouldn't soften it. But remember the split that matters: 44% when caught local, 3% when distant. Early is everything.

The warning signs nobody talks about

This is the hard part, because the signs are vague — and vague signs are easy to dismiss. That's exactly why I'm listing them:

- **Belly or back pain that won't quit.** Not a crick. A deep, persistent ache in the upper belly that goes through to the back, doesn't move with position, doesn't go away in a week or two.
- **Losing weight without trying.** Clothes getting loose and you didn't change anything. Unintentional weight loss is the body waving a red flag — for this and for several cancers in this book.
- **New diabetes after 50.** This one's important. If your blood sugar suddenly goes bad in your fifties with no big lifestyle change, tell your doctor — it can be one of the earliest signals of pancreatic trouble. The sugar chapter and this chapter are connected.

- **Yellowing skin or eyes.** Jaundice. If a tumor blocks the bile duct, the yellow shows up. Don't wait on this one — go.
- **Dark urine, pale or oily stools, itchy skin.** The bile duct talking.
- **Losing your appetite, feeling full fast, nausea.** Vague, yes. Persistent, that's the key word. Vague plus persistent is worth a visit.

Any one of these has a dozen innocent explanations. That's true and that's fine. The rule is: persistent and unexplained gets a doctor's eyes. Not panic. Eyes.

What to actually do

Don't dismiss the vague stuff. That's the whole move for this chapter. There's no screening test to order, no shot to get. The tool is you — paying attention and refusing to explain away a persistent change. "It's probably nothing" is the most dangerous sentence in this chapter. Probably nothing is for the doctor to say, after looking. Not you, from the couch.

Know your family history. Pancreatic cancer in the family, especially more than one relative — tell your doctor. There are gene changes (BRCA and others — the same ones you'll read about in the women's chapter) that raise the risk, and high-risk people can get surveillance at specialty centers. If it runs in your family, that's not a curse — it's information. Use it.

Tell your doctor about new diabetes after 50. I'm saying it twice because it matters twice. Sudden blood sugar trouble with no clear cause deserves a look at the pancreas, not just a prescription.

Don't smoke. Smoking roughly doubles the risk. Of all the things in this book you can control, this is near the top for this chapter.

What people get wrong

"If it's that deadly, why bother looking?" Because 44% versus 3%. That's why. The people who get the 44% are the people who didn't dismiss the vague signs. Giving up before you start is the only move with a zero percent survival.

"It's rare, it won't be me." 67,000 diagnoses a year isn't rare — it's a stadium full of people, every year, and climbing. "Rare" is what everybody says until it's them. Don't gamble on rare.

"Back pain is just age." Sometimes. And sometimes it's the thing from three paragraphs up. Age explains a lot — it doesn't explain everything. Persistent is the word. Ache that doesn't quit in a few weeks gets looked at.

"There's no test, so there's nothing I can do." There's no routine test. There IS attention, family history, the diabetes flag, and a doctor who knows what to look for. "Nothing I can do" was never true in this book, and it isn't true here.

See a doctor. Not in a panic — in attention. If something in the warning list has been hanging around and you can't explain it, that's the visit. The people with the 44% are the people who went. Be one of them.

Chapter 14: For the Women (Ovarian Cancer)

The hook

Chapter 8 was for the men. This one's for the women — and for the men who love them, because you're going to need to hear this part too.

Ovarian cancer is called the silent killer of women's cancers, and it's the deadliest of the gynecologic cancers. Not the most common — the deadliest. About 21,000 American women are diagnosed in a year, and about 12,700 die from it. It's the fifth-leading cause of cancer death among women.

Here's the cruelty: the symptoms are vague. Bloating. Belly pain. Feeling full fast. Having to pee all the time. Every one of those sounds like a normal Tuesday — digestion, stress, getting older. So women dismiss them, and doctors dismiss them, and by the time somebody takes it serious, most cases are already at Stage III or later. Only about 15 out of 100 are caught at Stage I — and at Stage I, the five-year survival is over 90%. Read that twice. Over 90% caught early. Most aren't caught early. The gap between those two sentences is the whole chapter.

What's happening in the body

Plain version: the ovaries are two small organs, one on each side of the uterus. They make eggs and hormones. Ovarian cancer is cells there growing out of control — and here's something science learned in the last twenty years: most of the deadliest ovarian cancers actually start in

the fallopian tubes, the little tunnels leading to the ovaries, and then spread. That's why it's so hard to catch — it starts small, in a hidden place, and moves quiet.

There is no reliable early detection test. Let me say that plain: no mammogram equivalent, no colonoscopy equivalent. A Pap smear does NOT detect ovarian cancer — Pap checks the cervix, different organ, different cancer. This is one of the most dangerous misunderstandings in women's health, so I'm putting it in capital letters in your head: THE PAP SMEAR DOES NOT CHECK FOR OVARIAN CANCER.

Risk goes up with age — most diagnoses happen at 63 and older — but it can happen younger. Family history matters: the BRCA gene changes (the same ones from the pancreatic chapter) raise the risk a lot, and so does Lynch syndrome. Never being pregnant, endometriosis, obesity — these raise it too. Birth control pills, pregnancy, breastfeeding — these lower it. None of it is destiny. It's odds. And odds are worth knowing.

The warning signs nobody talks about

The symptoms are real — they're just easy to wave off. The key is persistence: these showing up daily for weeks, not once after a big meal.

- **Bloating that doesn't go away.** Not after-pizza bloating. Belly swollen, tight, persistent — your pants fit different and it's not going back.
- **Pelvic or belly pain.** Ache, pressure, pain low in the belly or pelvis that keeps coming back.
- **Feeling full fast / trouble eating.** Getting full after a few bites. Appetite dropping off for no reason.
- **Urgency or frequency with urination.** Having to go all the time, or suddenly, with no infection.

- **Changes in bowel habits.** Constipation or diarrhea that settles in and stays.
- **Abnormal vaginal bleeding or discharge.** After menopause especially — any bleeding after menopause is a doctor visit, no exceptions.

Any one of these is probably nothing. All of them together, daily, for weeks — that's a pattern, and patterns get a doctor's eyes. You know your body. When the normal-Tuesday explanation stops making sense, stop using it.

What to actually do

Track it. If the symptoms are hanging around, write them down — what, when, how often. Two weeks of notes turns "I don't know, I've been bloated" into "bloated every day for three weeks with pelvic pressure." Doctors act on patterns. Give them one.

Push for evaluation. Here's the hard truth: because there's no screening test, diagnosis depends on somebody taking the symptoms serious — you first, then your doctor. If your doctor waves it off and the symptoms persist, push. Ask about a pelvic exam, an ultrasound, the CA-125 blood test (it's not a screening test for everyone, but it's part of the workup). "I need you to take this serious" is a complete sentence.

Know your family history. Ovarian, breast, pancreatic, colon cancers in the family — especially young — tell your doctor. Genetic testing for BRCA and Lynch exists, and knowing can change the whole plan, including preventive options. If it runs in your family, that's information, not a curse.

For the men reading this: you probably know a woman who puts everybody else first and herself last — your wife, your mother, your sister, your daughter. She's the one who'll dismiss the bloating for six months. Your job: don't let her. "You've said that three weeks in a row — we're going" is love. Say it.

What people get wrong

"My Pap smear was normal, so I'm fine." The Pap does not check for ovarian cancer. Different organ. I said it twice because women die over this misunderstanding. Normal Pap, persistent bloating — still go.

"Bloating is just digestion." Sometimes. For a day or two. Bloating that moves in and stays for weeks is not digestion — it's a symptom with an address. Find the address.

"It only happens to old women." Most cases are 63 and up, true. But younger women get it too, and the dismissing starts young — "you're too young for that" is how months get lost. Symptoms don't check ID.

"There's no test, so there's nothing I can do." No screening test — true. But there's symptom tracking, there's pushing for evaluation, there's genetic testing, there's catching it at Stage I where survival is over 90%. "Nothing" was never true.

"Birth control causes it." Opposite. Birth control pills are associated with LOWER ovarian cancer risk. Talk to your doctor about the trade-offs — every medicine has them — but don't let this myth make the decision.

See a doctor. Women: if the vague symptoms have set up camp for weeks, that's the visit. Bring the notes. Men: make sure she goes. The 90% survival at Stage I is real — but only for the women who get looked at in time.

Chapter 15: The Conversation — How to Ask Without Making It Weird

This is the handbook chapter. Everything in this book points here.

You read fourteen chapters about what can sleep in a body. Now here's the part nobody teaches: how to look a potential partner in the eye and ask the questions that keep both of you safe — without embarrassing yourself, without dropping the ball, and without making them shut down.

Most people don't have this conversation because they don't know how to start it. So they skip it. And skipping it is how people get hurt. This chapter fixes that.

The reframe

First, get this straight in your own head: this is not an interrogation. You're not accusing anybody of anything. You're two adults about to share the most intimate thing two people can share, and you're handling it like adults. That's not weird. That's respect — for them and for yourself.

If you walk in feeling like you're accusing, they'll feel accused. If you walk in like this is just what grown people do, they'll feel that too. How you walk in is how they'll hear it.

When and where

Not in the heat of the moment. Not with clothes coming off and somebody's hand on the doorknob. By then it's too late — nobody thinks straight then, and bringing it up then feels like a brake slam.

Have it earlier. Over food. On a walk. On the phone the night before. Somewhere calm, private, unhurried. Somewhere you can both think.

And never — never — have it as a group chat joke, a text out of nowhere with no context, or in front of other people. Private. Always private.

Lead with yourself

This is the whole trick. You go first.

Nobody opens up to somebody who's grilling them from across the table. But somebody who says "here's me" first? That makes it safe to say "here's me" back.

So you start with your own truth. "I got tested in [month]. Here's where I stand." Then the question isn't an attack — it's an exchange.

Or go together

Here's a move most people never think of: "Why don't we get tested together?"

It's disarming. It takes the whole interrogation feeling off the table, because you're both walking in. You both give the blood or the swab. You both wait. You both walk out knowing. Nobody's the examiner and nobody's the suspect — you're a team handling business.

Some clinics and health departments do couples testing. Or just book back-to-back appointments and get lunch after. Make it a thing you do together, not a test one of you passes and the other fails.

The questions — say this, not that

1. Testing history.

Don't say: "Are you clean?" "Clean" and "dirty" is shame language. It makes somebody feel like a criminal for having a body. Drop those words completely.

Say this: "When was the last time you got tested? I got tested in [month] — I try to go [however often]."

Why it works: you're asking about a *habit*, not a *verdict*. And you answered it first.

2. Current status.

Don't say: "You got anything I should know about?" That sounds like a trap. It puts them on defense.

Say this: "Is there anything going on with you health-wise I should know about? I'll tell you mine — [your honest answer]. I just want us both walking in with eyes open."

Why it works: "health-wise" is neutral. "Both" and "us" make it mutual. "Eyes open" is about care, not fear.

3. Protection.

Don't say: "You're on something, right?" or "We don't need anything, do we?" The first one assumes. The second one is you talking yourself out of safety because the moment feels good. Don't.

Say this: "What do we want to use for protection? I brought [whatever you brought]. I don't do it without — that's just my rule, for both of us."

Why it works: "What do WE want" — it's a joint decision. Stating your rule plainly isn't negotiable-sounding, it's just clear. Clear is kind.

There's also PrEP — medicine that prevents HIV before exposure. Daily pill, a shot every two months, or now a shot twice a year. If that's relevant for your life, it belongs in this conversation too. "Are you on PrEP? I'm thinking about it — want to ask our doctors?" Protection isn't just the moment. It's the plan.

4. Boundaries and expectations.

Don't say: nothing. Most people skip this one entirely and then feel weird after.

Say this: "Before we go there — is there anything you're not comfortable with? Anything off the table? I'll tell you mine."

Why it works: you're giving them explicit permission to have limits. A lot of people — especially younger people, especially women who've been pressured before — have never been asked this straight. Ask it straight.

5. If something comes up later.

Don't say: nothing. Then if something happens, it's a crisis and a blame game.

Say this: "And if either of us ever finds out something after — we tell each other straight, right? No disappearing, no games. Deal?"

Why it works: you're making honesty the agreement *before* it's tested. That's what adults do.

If you already know your status

This is the harder case, and it needs its own script. If you're living with something — HIV, herpes, anything — you tell them before, not after. Before clothes come off. Before the moment. In the calm, private setting we talked about.

Say this: "Before we go further, there's something I need to tell you. I have [X]. Here's what it means, here's how I manage it, here's what it means for us. I wanted you to hear it from me, straight."

Then answer their questions honestly. If they need time, give it. If they walk, let them walk — but know this: most people respect the honesty more than they fear the fact. Being told straight is rare. It's trust, offered up front.

And if it's HIV and you're on treatment and undetectable — tell them what U=U means. Undetectable equals untransmittable. The science is on your side. Say it plain: "My treatment has the virus so low the tests can't find it, and that means I can't pass it through sex. That's not me talking — that's the CDC." Facts, delivered calm, change the temperature of the whole conversation.

Never disclose after. After is betrayal, no matter how good the reason felt in the moment. Before is respect.

If they shut down

Sometimes you'll do everything right and they'll still get uncomfortable, offended, or evasive. Pay attention to that. It's information.

Somebody who gets angry at being asked about health and safety is telling you something about how they handle hard conversations — and hard conversations don't stop at this one. Somebody who says "don't worry about it, trust me" is asking you to gamble with your body on their word alone.

You're allowed to say: "I hear you, and I'm not trying to offend you. But this matters to me. If we can't talk about it, we shouldn't do it." Then mean it.

Walking away from that moment is not losing. It's the win.

If YOU'RE the one who's nervous

Maybe you're reading this thinking "I could never say all that out loud." I get it. Here's the secret: you don't have to perform it. You can literally say, "Look, I'm not good at this conversation, but it's important to me, so I'm going to be clumsy about it." Clumsy and honest beats smooth and silent every time.

You can also write it down first. Read this chapter twice. Practice the lines in your head, in the shower, in the car. By the time you need them, they won't feel foreign.

The close

Here's what I want you to take from this chapter: the conversation IS the protection. Condoms break. Tests have windows. But two people who can talk straight to each other? That's the real safety. Everything else is backup.

Be the person who brings it up. Somebody has to go first. Let it be you.

What to Do Monday Morning

You read the book. Now what? Not "someday." Monday.

Here's the list. It's short on purpose.

1. **Call your doctor and book the visit.** Not the emergency room — your regular doctor. If you don't have one, get one. A primary care doctor is the front door to all of this. No insurance? Community health centers and county clinics see people on sliding scales. The visit matters more than the venue.
2. **At that visit, say these sentences:**
3. "I want the shingles vaccine — am I due?"
4. "Test me for hepatitis C."
5. "Check my kidney numbers — the blood and urine tests."
6. "Check my heart rhythm."
7. "I'm [your age] — am I due for colon cancer screening?"
8. "Anything feel off in my throat that I should have looked at?"
9. "Test me for HIV — when was my last one?"
10. "Talk to me about prostate screening — am I at the age?"
11. "I want my A1C — check my blood sugar."
12. "What's my blood pressure — and what should it be?"
13. "How do my liver numbers look?"
14. "I snore and I'm tired all day — do I need a sleep study?"
15. "Anything in my family history we should be watching — pancreas, ovaries?"

Write them down. Bring the paper. Doctors respect a patient who comes prepared. And if the doctor brushes you off, that's information too — find one who listens.

1. **Know your numbers.** Blood pressure. Blood sugar. Cholesterol. Kidney filter number. Write them down somewhere you'll see them — your phone, the fridge, wherever. If you don't track it, you can't catch it drifting. Next visit, compare. That's how you spot trouble before it becomes damage.
2. **Bring somebody with you if you need to.** There's no rule that says you walk in alone. If having your person next to you makes you actually go, bring them. Pride doesn't get a vote here.
3. **Tell somebody.** Not to scare them — to tap their shoulder the way this book tapped yours. Send this to your brother, your sister, your friend from the block, your kids. The people who don't read what they don't understand — this was written for them too.

That's it. Five moves, one visit, one share. Monday.

If the Test Comes Back Positive

Let me talk about the real reason people don't get tested. It's not laziness. It's not time. It's fear of the answer.

So let's walk through what actually happens — because the unknown is always scarier than the truth.

First: one test is rarely the verdict. A positive screening usually leads to a confirmatory test. The first one says "look closer." The second one says what's actually there. Don't panic at step one.

Second: everything in this book is treatable or manageable when it's caught. That's not a slogan, that's the premise of every chapter: - HIV positive? Treatment gets you to undetectable — and undetectable means untransmittable. You live your life. Full lifespan. That's the medicine we have now. - Hepatitis C positive? Twelve weeks of pills. Cured. More than 95 out of 100. - Shingles? Antivirals, and it passes. The nerve pain is the thing to prevent, and early treatment is how. - Cancer caught early? A completely different fight than cancer caught late. That's why you looked. - Heart rhythm off? Blood thinners, procedures, managed. The people who do fine are the ones who know. - Blood sugar high? Caught at "pre," more than half the risk can be turned around with the boring stuff — walking, food, sleep. Even full diabetes is manageable — people live full lives with it every day. - Blood pressure high? Medicine and habits bring it down. Most people in the studies were only about 10 points over — that's fixable, not fatal. - Kidneys struggling? Caught early, the decline slows to a crawl or stops. - Throat, prostate, liver, ovaries, pancreas — caught early, every one of these is a different fight than caught late. That's why you looked.

Third: nobody in that lab or office is judging you. They've seen it before. You are not the first positive they've delivered this week, and you won't be the last. The shame is in your head — and I say that with love, because I know it's real. But it's not in the room. The room is just medicine.

Fourth: a positive test is information, not a verdict. It's the map, not the territory. It tells you where you are so you can decide where to go. Not knowing doesn't make it not there — it just makes you late.

Here's the truth nobody says out loud: the worst outcome was never the positive test. The worst outcome is the positive you never looked for until there was nothing left to do about it. You looked. That took guts. Now take the next step.

How to Talk to Your Doctor (When You Don't Trust Doctors)

I said I'd be straight, so here it is: a lot of us don't trust doctors. Maybe you got dismissed before. Maybe you watched somebody get dismissed. Maybe the whole system feels like it's not built for people like us. I'm not going to tell you those feelings are wrong.

But here's what I will tell you: don't let distrust of the system keep you from using the parts that work. A test is a test. A vaccine is a vaccine. The machine doesn't know your history and doesn't care. Use the tools, even if you side-eye the toolbox.

Some practical rules:

Write it down before you go. Doctors are busy and visits are short. A written list means you don't forget half of it in the room and remember it in the parking lot. The sentences in the Monday list — bring them on paper.

Say "I need you to explain that plainly." That's a complete sentence and you are allowed to say it as many times as it takes. If they can't explain it plainly, they don't understand it well enough — or they don't respect you enough. Either way, you learn something.

Ask "what happens if I do nothing?" This is the most powerful question in medicine. It forces the real answer out. Sometimes the answer is "probably nothing." Sometimes it's "this gets worse." You deserve to hear which one.

Get the second opinion when it matters. If something feels off about what you're told — especially something big like surgery or a scary diagnosis — another doctor's eyes are worth it. This isn't disrespect. It's diligence.

You can fire your doctor. If they don't listen, if they rush you, if they make you feel small — find another one. You're not stuck. You're the customer. Act like it.

The goal isn't to love the medical system. The goal is to use it before you need the emergency version of it. Checkups are cheaper than crises — in money, in time, in everything.

A Final Word

I'm 53. I've made mistakes. Some of them are probably still in my body, waiting like that chickenpox virus, keeping quiet. I can't go back and unmake them. None of us can.

But here's what I know: the past doesn't get the last word unless you hand it the microphone. Every chapter in this book is proof that knowing beats not knowing. The test beats the guess. The visit beats the worry.

Nobody's coming to save you. There won't be no Publishers Clearing House knocking on your door.

Save yourself. Then help somebody save themselves.

That's TRU health. That's the whole book.

And listen — if you take one thing from these pages, make it this: the body whispers before it screams. Every disease in this book had a quiet phase where it could have been caught, treated, beaten, or prevented. The whisper is the test. The whisper is the shot. The whisper is the visit you keep putting off.

Don't wait for the scream.

— Shane

Sources

Every medical claim in this book traces to one of these. If you want to read deeper, start here — and then talk to your doctor.

- **Shingles:** CDC shingles guidance (1 in 3 lifetime risk; ~1 million US cases/year; Shingrix recommended for adults 50+, 2 doses); Clinical Infectious Diseases / CIDRAP real-world Shingrix data (PHN in 10–18% of shingles patients; ~97% efficacy ages 50–69, ~91% ages 70+); standard clinical guidance — antivirals most effective within 72 hours of first symptom (pain or rash).
- **Hepatitis C:** CDC MMWR 2020 screening recommendations (all adults 18+ at least once; pregnant women each pregnancy; prior 1945–1965 birth-cohort guidance); CDC/peer-reviewed data (75–85% develop chronic infection; ~25% clear spontaneously; no vaccine exists); curative direct-acting antivirals — 95%+ cure rate in 8–12 weeks (CDC, Vermont Dept. of Health clinical resources).
- **HPV and oropharyngeal cancer:** CDC (HPV probable cause of up to 70% of US oropharyngeal cancers; ~19,000 cases/year in men vs ~4,000 in women); University of Cincinnati Cancer Center / AARP reporting (rising rates in men 50+; decades-long dormancy; symptoms: persistent sore throat, difficulty swallowing, hoarseness, ear pain, unexplained weight loss); Cancer Research UK (HPV can go unnoticed for years/decades before cancer develops).
- **Early-onset colorectal cancer:** American Cancer Society, Colorectal Cancer Statistics (recent reports) (incidence rising ~3%/year ages 20–49; leading cancer death cause in men under

50; 3 in 4 under-50 cases found at advanced stage); screening age lowered to 45 (ACS 2018; USPSTF 2021); Journal of the National Cancer Institute early-onset symptom data.

- **Atrial fibrillation:** American Heart Association, Sept 2025 (62% of AFib patients unaware before diagnosis; 5x stroke risk; 25% learn from the stroke itself; 6M+ Americans affected, doubling by 2030); Pfizer/BMS Alliance AFib screening data.
- **Chronic kidney disease:** CDC (more than 1 in 7 US adults have CKD; up to 90% unaware; 96% of early-stage unaware); National Kidney Foundation; American Society of Nephrology (two tests: blood eGFR + urine protein; diabetes and hypertension as leading causes; early detection can slow or stop progression).
- **HIV:** CDC (everyone 13–64 tested at least once; ~1.2M Americans living with HIV, ~1 in 8 unaware; [gettested.cdc.gov](https://www.cdc.gov/gettested)); FDA June 2025 approval of twice-yearly lenacapavir (Yeztugo) — 99.9%+ remained HIV-negative in PURPOSE 1 & 2 trials; U=U (undetectable = untransmittable); PEP within 72 hours of exposure; Gilead Q4/FY2024 earnings (HIV product sales \$19.6B; Biktarvy \$13.4B); Congressional Record, July 1, 1969 — DoD testimony requesting \$10M for synthetic biological agent research; phylogenetic origin evidence (1959/1960 central African samples; SIVcpz zoonotic origin).
- **Prostate health:** American Cancer Society (Black men nearly 70% more likely to develop prostate cancer, twice as likely to die; discuss PSA at 50 average risk, 45 high risk, 40 highest risk; ~1 in 8 men lifetime); AUA/SUO early-detection guideline amendment (baseline PSA 45–50 standard risk, 40–45 high risk).

- **Prediabetes and type 2 diabetes:** CDC Diabetes Report Card (115.2 million US adults with prediabetes — more than 2 in 5; 8 in 10 unaware; 40.1 million with diabetes — 1 in 8; 1 in 4 unaware; type 2 accounts for 90–95% of adult cases); CDC Diabetes Prevention Program (lifestyle intervention cut type 2 risk 58%, 71% for ages 60+); prediabetes fasting glucose 100–125 mg/dL; ADA/CDC testing guidance (start at 45; earlier with overweight plus risk factors); Newcastle University / Roy Taylor, Cell Metabolism (Twin Cycle Hypothesis — ectopic fat overflow from liver to pancreas drives type 2; "clogs up the pancreas").
- **High blood pressure:** Journal of the American Medical Association, Feb 2026 (Hardy et al., NHANES 2021–2023 — 79.1% of US adults with hypertension uncontrolled; 61.3% of those not taking medication); AHA/ACC guideline goal under 130/80 mmHg; AHA (about half of US adults have hypertension).
- **Fatty liver disease (MASLD):** Frontiers in Public Health 2025 / AARP / NIDDK (about 1 in 3 US adults affected; ~31%); renamed from NAFLD to MASLD in 2023 by multi-society liver panel; Clinical Gastroenterology and Hepatology 2026 (1 in 4 MASLD cirrhosis cases under age 50); mainstay treatment is lifestyle/weight loss.
- **Sleep apnea:** American Academy of Sleep Medicine / Frost & Sullivan ("Hidden Health Crisis Costing America Billions" — 29.4 million US adults, 12%, with ~80% undiagnosed); linked to hypertension, heart disease, stroke, diabetes, and accidents; AASM "More than a Snore" campaign.
- **Pancreatic cancer:** American Cancer Society, Cancer Statistics 2025 (~67,440 new US cases, ~51,980 deaths; 5-year relative survival 13% overall, 8% for pancreatic adenocarcinoma; third-

leading cause of cancer death, rising); cancer.org SEER data (localized 44%, regional 17%, distant 3% five-year survival); Pancreatic Cancer Action Network.

- **Ovarian cancer:** American Cancer Society, Cancer Statistics 2025 (~20,890 new US cases, ~12,730 deaths; fifth-leading cause of cancer death among women; lifetime risk ~1 in 91; ~15% diagnosed at Stage I, where five-year survival exceeds 90%); no reliable early detection test — Pap smear does not detect ovarian cancer; ACS/Break Through Cancer "Outsmart Ovarian Cancer" campaign 2025 (most lethal ovarian cancers begin in the fallopian tubes).

General references: CDC.gov, MedlinePlus (U.S. National Library of Medicine), American Heart Association (heart.org), American Cancer Society (cancer.org).
