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Emphysema Foundation For Our Right To Survive

Emphysema Takes Your Breath Away August 2006

ENDOBRONCHIAL VALVES SAFE FOR TREATMENT OF SEVERE EMPHYSEMA

For patients with severe emphysema, placement of one-way endobronchial valves to isolate emphysematous sections of the lung is safe and results in clinical improvement in some, physicians in Brazil report. Dr. Hugo G. de Oliveira and his team at Hospital de Clinicas de Porto Alegre dub the procedure transbronchoscopic pulmonary emphysema treatment (TPET).

"Our study suggests that the treatment of severe heterogeneous emphysema predominantly affecting the upper lobes using TPET and endobronchial valves is a safe, potentially reversible procedure associated with a low complication rate and no mortality, which promoted a transient but significant improvement in quality of life," they report.

Although lung volume reduction surgery and lung transplantation are used for advanced emphysema, many patients do not qualify for these procedures. For these patients, another option may be TPET to reduce gas trapping and improve ventilation.

Initial results of TPET have been favorable, Dr. de Oliveira and his team point out in their report, published in the July issue of Chest. However, follow-up beyond the first 3 months after treatment has not been reported.

.....Source: medscape.com

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HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY TO SPONSOR TWO-YEAR PILOT WITH HACKENSACK UNIVERSITY MEDICAL CENTER

Horizon Blue Cross Blue Shield of New Jersey, the state's oldest and largest health insurer, announced today a two-year collaboration with Hackensack University Medical Center, its physicians, and the VeriChip Corporation (VeriChip) to implant FDA-approved microchips in chronically ill patients enabling emergency room physicians to access those patients' medical record electronically. The microchips provide immediate access to family contact information and information about the patients' medical histories that could mean the difference between life and death in an emergency.

Horizon BCBSNJ will make the new technology, developed by the VeriChip Corporation of Delray Beach, Florida, available to select members with chronic conditions. Those members who participate in the program will agree to have an implantable radio frequency identification device (RFID), the size of a grain of rice, placed under their skin. VeriChip calls the RFID a personal health record module. The information on the module will include medical information from Horizon BCBSNJ's claim records, such as lab test data and pharmacy prescription information. This module emits a 16-digit number that links the patient to their electronic medical record when a special hand-held scanner is waved over it.

The pilot program will give Hackensack Medical Center physicians access to the member's electronic medical records and other vital information in the event the chronically ill member cannot respond during an emergency. The content of the electronic medical records will be approved by each member and include information about their condition, family contact information as well as lab test data and pharmacy information maintained by Horizon BCBSNJ.

.....Source: medicalnewstoday.com

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A PUFF TOO FAR --COPD IN AUSTRALIA

Australia lags in tackling serious lung diseases that kill thousands every year. Portable oxygen availability seems to be really very poor.....

As COPD worsens, patients with more advanced cases often need oxygen to survive. One of the most frustrating sapects of the illness is that it robs people of mobility - but technology such as portable oxygen cylinders allows patients to preserve some of that independence and freedom.

But what you can access for free or at a subsidised cost depends largely on where you happen to live. "Oxygen therapy is highly variable, even within the same states," Frith says. In some states patients have access to more portable oxygen cylinders than they're likely to need: in Victoria, a person can get between four and eight cylinders. But in other states, such as Queensland, patients have no access to subsidised portable oxygen at all - they're given only a big, stationary machine that has to be plugged in to a power point. Meanwhile, those in the southern part of Tasmania can get just one cylinder, while folks in the northern half are eligible for two.

To that end, the Australian Lung Foundation and Frith are urging a national register be established "to account for current resources, ensuring that resources are consistently distributed to those most in need, and identifying any funding gaps which exist". Frith says, Right now, it's a dog's breakfast."

.....Source: www.theaustralian.news.com.

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ANTI-SMOKING DRUG GETS SUPPORT FROM THREE TRIALS

The novel anti-smoking drug Chantix (varenicline) is effective both to stop smoking and to keep off cigarettes,

according to several investigations. Two separate studies -- one from the Oregon Health & Science University here and another from the University of Wisconsin in Madison -- concluded that Chantix is more effective than either placebo or Wellbutrin SR (bupropion) in helping patients stop smoking. A third study, led by researchers from the University of Oslo in Norway, found that Chantix is more effective than placebo in preventing smokers who have quit from relapsing.

All three studies were financially supported by Pfizer, which makes Chantix, and were published in the July 5 issue of the Journal of the American Medical Association. While the findings are promising, they are not a cure-all for smokers, according to an accompanying editorial by Robert Klesges, Ph.D., Karen Johnson, M.D., and Grant Somes, Ph.D., all of the University of Tennessee Health Science Center in Memphis. "Patients currently cannot and probably never will simply be able to "take a pill" that will make them stop smoking," they wrote.

The editorialists noted that Chantix is a novel medication for smoking cessation -- the first to be approved in nearly a decade -- and adds to the armamentarium available to clinicians and patients. But, they added, new drugs in this field tend to be greeted with immoderate enthusiasm that isn't justified by the evidence.

Chantix "definitely is not a panacea for smoking cessation. Many participants in these trials experienced adverse events, stopped taking their study medication before they should have, and discontinued participation in the studies. Importantly, the majority of participants in these three studies did not quit smoking even with (Chantix)," they said.

The first study, led by David Gonzales, Ph.D., of the Oregon Health & Science University, was a randomized double-blind, parallel-group, placebo- and active-treatment-controlled, phase III trial, conducted at 19 U.S. centers from June 19, 2003, to April 22, 2005. The researchers recruited 1,025 smokers, who consumed 10 or more cigarettes a day, and randomized them to one of three arms -- placebo, Chantix titrated to 1 mg twice daily, and Wellbutrin titrated to SR 150 mg twice a day -- for 12 weeks, with 40 weeks of non-drug follow-up. The study found: For the last four weeks of the treatment period, the abstinence rate for Chantix was 44% compared with 17.7% for placebo and 29.5% for Wellbutrin. Both differences were statistically significant at $P<0.001$. Wellbutrin was also significantly better than placebo. During the follow-up period, the abstinence rate for Chantix was 21.9%, compared to 8.4% for placebo and 16.1% for Wellbutrin. The difference between Chantix and placebo was significant at $P<0.001$, but the difference between Chantix and Wellbutrin was not.

The second study had a similar design, but also included brief smoking-cessation counseling. The main outcome measure was complete abstinence for the last four weeks of the 12-week treatment period and throughout the 40-week non-drug follow-up. The study enrolled 1,027 adult smokers. The researchers, led by Douglas Jorenby, Ph.D., of the University of Wisconsin found: For the last four weeks of the treatment period, the abstinence rate for Chantix was 43.9% compared with 17.6% for placebo and 29.8% for Wellbutrin. Both differences were statistically significant at $P<0.001$. During the 40-week follow-up, the abstinence rate for Chantix was 23%, compared to 10.3% for placebo and 14.6% for Wellbutrin. The differences were significant at $P<0.001$ and $P<0.004$ respectively.

The third study, led by Serena Tonstad, M.D., Ph.D., of the University of Oslo, asked whether people who quit during Chantix treatment would do better in avoiding relapse by stopping therapy or continuing the drug for another 12 weeks. The researchers enrolled 1,927 smokers for a 12-week open-label treatment trial; of those, 1,236 did not smoke for the last week and were eligible for the continuation study. In the end, 1, 210 of the eligible participants were randomized to get additional Chantix or placebo, on a double-blind basis. The researchers found that participants randomized to Chantix had higher abstinence rates than those on placebo during the second treatment period (70.5% versus 49.6%; $P<0.001$), as well as over the 40 weeks after the end of the initial 12-week open-label study (43.6% versus 36.9%; $P=0.02$). Nearly 30% of participants reported nausea with Chantix, a rate significantly higher than with either Wellbutrin or placebo. Abnormal dreams were common and much more likely in the Chantix group.

In their editorial, Drs. Klesges, Johnson, and Somes noted that the study design did not include participants who had failed to quit smoking during the last week of the open-label phase, eliminating at a stroke the 35.9% of participants for whom the drug was apparently ineffective. "The relapse prevention results reported are probably more optimistic than what would occur in a real-world situation. Also, because of the numerous exclusion and inclusion criteria for all the studies, their results may not be easily generalizable outside the clinic,"they said. Despite the limitations of the studies, they concluded, the research showed that investigators, clinicians and smokers "now have another product available that appears to help increase the probability of smoking cessation." .....Source: MedPage Today

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DOCTORS UNDERESTIMATE EMOTIONAL IMPACT OF COPD EXACERBATIONS - PATIENTS FEAR BEING HOSPITALISED OR DYING

New data from a multinational, interview-based patient study, published today in the medical journal CHEST, shed light on COPD patients' comprehension, recognition, and experience of exacerbations and the burden associated with these events. Exacerbations are known to impair health-related quality of life (HRQL) in patients with COPD and increase the risk of mortality. Today's paper also brings valuable insight to the burden of exacerbations as experienced by patients. The study shows that physicians often underestimate the psychological impairment experienced by patients during an exacerbation. Exacerbations cause substantial anxiety, patients reported; 12% stated they worry about dying, 10% that they worry about suffocating, 10% that they will experience a permanent worsening of their condition and 8% that they will be hospitalised. A majority of patients reported that besides influencing on their activities in daily live, a worsening

significantly affect their mood causing a variety of negative feelings, such as depression, irritability/bad temper, anxiety, isolation, anger, and guilt. Moreover 42% stated that exacerbations affected their personal relationships.

"The observation that physicians fail to appreciate the considerable changes to the patient's emotional wellbeing demonstrates a communications gap between patients and their doctors and represents a dilemma in the management of COPD. Such underestimation of the burden of exacerbations may contribute to under treatment of COPD by healthcare professionals. This is worrying since the existing evidence shows that early medical intervention improves recovery time, minimises the risk of hospitalisation and improves health-related quality of life. A clear link between increased exacerbation frequency and risk of mortality has also been demonstrated," explained study lead-investigator, Professor Romain Kessler, Department of Pulmonology, Hôpitaux Universitaires de Strasbourg in France.

The study was conducted with 125 patients diagnosed with COPD from France, Germany, Spain, Sweden and the UK. The patients were aged >= 50 and had experienced a minimum of 2 exacerbations during the previous year. 65% of patients were male COPD patients. During the previous 12 months, patients had experienced a mean of 4.6 exacerbations with an average duration of 2 weeks and a mean recovery time of 10 days. Notably, 20% felt that they had not returned to their previous state of health after an exacerbation, demonstrating the importance of reducing these events.

The importance of improving patients' health-related quality of life (HRQL) was further supported by data from a pooled analysis of two multinational randomised controlled clinical trials recently presented at the COPD congress in Birmingham, UK. The analysis showed that HRQL was the strongest predictor of mortality in COPD5 and that the addition of budesonide to formoterol (Symbicort®) and/or a short-acting bronchodilator reduced the risk of mortality compared to bronchodilators alone.

Another interesting finding supporting the observed communications gap between healthcare professionals and patients is that, although a term commonly used by physicians, only 1.6% of patients understood what was meant by the widely used clinical term 'exacerbations' (in the study defined as a worsening of respiratory symptoms such that bronchodilators, and/or oral corticosteroids, and/or antibiotics, and/or oxygen therapy, and/or hospitalisation were required). Instead, patients used simpler, easier to understand terms to describe a worsening of their condition. The single term used most often by patients to describe an exacerbation is 'crisis', underscoring the seriousness with which patients view the worsening of their condition.

Two-thirds of patients stated they are aware of the symptoms associated with their condition getting worse, recognising them as warning signs. Most patients (85%) experience the same symptoms from one exacerbation to another - 'breathlessness' being the most commonly recollected warning sign. At the onset of an exacerbation, 33% of patients reported that they react by self-administering their medication while only a minority contacts their physician.

"The observation that two-thirds of patients are easily able to identify consistent warning signs is new and important. The finding suggests a window of opportunity for intervening and preventing a full-blown deterioration. The fact that patients show a willingness to undertake self-medication moreover suggests a potential role for self-management based on individual action plans," concluded Professor Kessler.

.....Source: medicalnewstoday.com

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CHEMICAL IN MANY AIR FRESHENERS MAY REDUCE LUNG FUNCTION

New research shows that a chemical compound found in many air fresheners, toilet bowl cleaners, mothballs and other deodorizing products, may be harmful to the lungs. Human population studies at the National Institute of Environmental Health Sciences (NIEHS), a part of the National Institutes of Health, found that exposure to a volatile organic compound (VOC), called 1,4 dichlorobenzene (1,4 DCB) may cause modest reductions in lung function.

This particular VOC, 1,4 DCB, is a white solid compound with a distinctive aroma, similar to mothballs. It is typically used primarily as a space deodorant in products such as room deodorizers, urinal and toilet bowl blocks, and as an insecticide fumigant for moth control.

There was approximately a 4 percent decrease in the test which measures forced expiratory volume in 1(FEV1) second between the highest and lowest levels of exposure. FEV1 is a commonly used index for assessing airway function and obstruction. .....Source: www.newswise.com

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UK- IMPROVING CARE FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE

A new National Service Framework (NSF) will be developed to improve standards of care and increase choice for patients with Chronic Obstructive Pulmonary Disease (COPD) announced the Secretary of State for Health Patricia Hewitt today.

The proposed NSF for COPD patients, those suffering from diseases like emphysema and chronic bronchitis, would seek to:

- Provide more choice in treatment for patients
- Reduce inequalities in treatment, which can vary across the country, and
- Improve standards of care for patients.

Speaking about plans for the new NSF, Patricia Hewitt said: "The development of a new National Service Framework is an important step which will support the NHS in managing and delivering COPD services more effectively, in a way that supports patient choice. It will support improvements in standards, tackle the current inequalities in COPD care and ensure that patients are able to access the services they need, where and when they want them."

Launching the plans at a British Thoracic Society event in the House of Commons, Health Services minister Rosie Winterton said: "There are currently around three million people

suffering from COPD in this country and 30,000 people each year die because of this disease. Whilst there are many examples of new and innovative approaches in COPD care in some areas, best practice is not always followed and there is considerable variation in COPD services across the country. It is clear that more needs to be done to ensure that all patients suffering from this debilitating disease are given the standards of care they deserve."

Dame Helena Shovelton, Chief Executive of the British Lung Foundation, welcomed the announcement. She said: "This is a huge step forward for the millions of people with COPD in England. Our hope is that everyone with COPD will benefit from the disease being made a priority for the NHS and from the improvements in diagnosis, treatment and care that should follow. Better management of the disease will also address ways of reducing the significant burden of COPD on the NHS."

To ensure that the NSF meets the needs of COPD patients and their carers an External Reference Group will be established, bringing together health professionals, service users and carers and health service managers, to advise on the development of the framework. It will be jointly chaired by Professor Peter Calverley (President of the British Thoracic Society), and Professor Sue Hill (Chief Scientific Officer at the Department of Health).

Professor Peter Calverley said: "The new COPD NSF gives us a great opportunity to improve the lot of people with this disabling condition and to take a lead internationally in the implementation of effective COPD care."

Professor Sue Hill said of her role in the Group: "Answers to the problems faced by patients with COPD and the healthcare professionals who have a vital role in their care can not be found overnight. It is vital that we take time to seek the views of the whole COPD community on how the NSF should tackle these challenging issues. The announcement of the NSF is very timely, and a chance to ensure COPD services fit with recent reforms to the whole health and social care system."

1) National Service Frameworks were established to improve services through setting national quality requirements (QRs) and markers of good practice to improve services and tackle existing variations in care.

2) Chronic Obstructive Pulmonary Disease (COPD) is an umbrella term covering a range of conditions including chronic bronchitis and emphysema. It is a long term condition that leads to damaged airways, causing them to become narrow, making it harder for air to get in and out of the lungs. There is no cure for COPD, but it can be managed through drug therapy.

3) Professor Calverley is Professor of Respiratory Medicine at the University of Liverpool and an Honorary Consultant Physician at University Hospital Aintree. He is currently the President of the British Thoracic Society. He has published extensively on COPD, sleep and breathing disorders and is a key figure in the international respiratory community.

4) Professor Hill was appointed as the Department of Health Chief Scientific Officer in 2002. She is now also the national clinical lead for physiological measurement within the 18 week delivery programme. She was previously a consultant clinical scientist and clinical lead for respiratory medicine at University Hospital Birmingham and held an honorary position at the University of Birmingham in the Department of Medicine. She has published widely on the pathophysiology of COPD, bringing together basic and applied clinical science.

5) Announcements regarding the full membership of the External Reference Group will be made in due course.

.....Source: Medical News Today

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LUNG AILMENTS NO LONGER STANDING IN WAY OF FLIGHT

Businesswoman Patti Wilson flew more than 3 million miles until she was grounded by a chronic lung ailment. Now, six years later, she's one of a growing number of fliers with lung problems who are returning to the skies or flying more frequently.

"It's wonderful," says the 60-year-old Port Costa, Calif., resident who retired from her management consulting job and now flies for pleasure. "I can travel again."

Travelers with pulmonary disorders are thrilled that they have better access to the skies, making it easier to visit clients or family, even to take faraway vacations. But some medical experts say in-flight respiratory emergencies are common, and some fliers with serious pulmonary problems are not healthy enough to fly. Last year, airlines made about 2,800 calls for emergency assistance for in-flight respiratory problems, says MedAire, a company that assists most airlines. There's also concern that the breathing devices used by passengers with lung ailments could pose some risk to other fliers. The government warns that devices should not be near an open flame and says airlines must ensure that they don't interfere with navigational and other aircraft equipment.

Chronic obstructive pulmonary disease (COPD) — a group of diseases that includes emphysema, chronic bronchitis and in some cases, asthma — afflicts 10 million to 24 million Americans and is a leading cause of death, illness and disability, according to the Centers for Disease Control and Prevention. More than 1 million people with COPD or another respiratory disease require supplemental oxygen for routine activities, the American Lung Association says.

Until recently, most airlines didn't provide or allow supplemental oxygen aboard planes. That made it difficult or impossible for most people with COPD to fly commercial jets. But prodded by the government to give equal access to the medically impaired, airlines began changing their policies in the past year. The Federal Aviation Administration issued a rule last July that says airlines can allow passengers to bring approved oxygen devices aboard. Two months later, the Department of Transportation issued a proposed rule requiring airlines to allow the devices and to supply oxygen for anyone with a medical problem.

Nine of 19 U.S. airlines surveyed by USA TODAY now provide bottled oxygen for a fee, and 11 airlines allow passengers to carry on their own portable oxygen concentrators — a relatively new product that converts cabin air into oxygen. Continental Airlines this month will become the 12th carrier to

allow concentrators aboard, says spokesman Dave Messing. Each device is about 12 inches long, 6 inches wide and 12 inches tall, and, with a battery, weighs 10 pounds. A passenger wheels or uses a shoulder pack to carry the device. The unit can be stowed under a seat in front of the passenger.

Breathing under pressure

Joan Garrett, CEO of MedAire, which provides in-flight medical assistance to about 90 airlines, supports the move to make it easier for pulmonary patients to fly. But she's worried that people with only one lung or serious breathing problems might think that an oxygen device guarantees their well-being in-flight. It doesn't, she says. Many people with pulmonary disorders have multiple problems, such as heart disease, kidney problems and diabetes, and probably should not be on planes, Garrett says. The FAA requires that passengers have a doctor's permission before flying with an oxygen device, but Garrett says some doctors give that clearance without understanding the detrimental effects that altitude can have on an impaired passenger. Air inside an aircraft cabin is pressurized to an altitude of 8,000 feet. "They wouldn't send their patient with a serious pulmonary problem to Denver, and they wouldn't send them on an aircraft if they knew that the oxygen level in the blood decreases at 8,000 feet," Garrett says. "The body may or may not be able to compensate, depending on the severity of the disease."

Claude Thibeault, a doctor and aviation medicine expert, agrees that most doctors aren't well-versed with cabin altitude issues. It's a "legitimate concern" whether a person with a pulmonary disorder should fly, he says. Frederick Tilton, the FAA's federal air surgeon, declined a request for an interview, but provided written responses to questions. He says individuals with medical conditions that require oxygen "should consult with their personal physician to determine fitness to fly before contemplating air travel." Individuals shouldn't fly "if they are medically unstable, and physicians should advise them against doing so," he says. But Paul Billings, vice president at American Lung Association, says he's not aware of any data that show a traveler with lung disease is at any greater risk in-flight than someone with another disease. New technology "holds promise to open the skies" to those with respiratory problems and should be celebrated, he says. Garrett predicts that an increase in oxygen-assisted passengers will lead to more in-flight medical emergencies and more flights diverted for emergency landings.

MedAire's statistics show that it responded worldwide to about 100 in-flight medical emergencies each day last year. More than 2,700 were for respiratory problems, including 182 for COPD. The company consulted on 62 flights last year that made an emergency landing because of a respiratory problem. Airlines aren't equipped to handle many types of in-flight medical emergencies. Flight crews can administer first aid and assist choking victims, Garrett says, but they aren't trained and don't have the equipment to deal with more complex illnesses. The airlines agree that they can provide "only emergency first aid," says David Castelveter, spokesman for the Air Transport Association, which represents most big carriers. Flight crews are given basic emergency medical training, Tilton says, and flight attendants receive instruction in cardiopulmonary resuscitation and use of an automated external defibrillator.

Air of freedom, concern

Though not required to do so, some airlines began allowing oxygen concentrators on planes after the FAA approved two manufacturers' units last year. Among other conditions, the FAA requires those airlines to ensure that the concentrators do not interfere with a plane's electrical, navigation and communications equipment, and that no smoking or open flame is permitted near a passenger with a concentrator.

In comments submitted in January regarding the Department of Transportation's proposed medical oxygen rules, the Air Transport Association said safety experts have expressed concern that oxygen concentrators' batteries couldshort-circuit and cause a fire. The group called on the agency to adopt the FAA's stowage and packaging rules for the batteries. New technology has incorporated safeguards that prevent a fire, says Daryl Risinger, vice president of Inogen, one of the approved manufacturers. Concentrators "use the same battery technology as laptop computers," he says.

Airlines oppose a Department of Transportation proposal that would require them to provide free bottles of oxygen for passengers with lung problems. In comments submitted to the DOT this year, the Air Transport Association said it would cost $103 million annually to provide oxygen, and more to train the flight crew on its use. Providing free bottles of oxygen might also discourage passengers from bringing their own oxygen concentrators aboard, the airlines say. The concentrators store only enough oxygen for a person's next breath, says Risinger, and are safer than bottles of oxygen, which can accelerate a fire and is considered, according to DOT regulations, a hazardous material.

Trouble on board

However, the Air Transport Association also told the DOT that more oxygen concentrators on planes might lead to more medical emergencies. The group said a passenger during the past year failed to bring enough batteries for a concentrator, and an unidentified airline had to give the passenger oxygen from a back-up supply that's available for all passengers if there's a cabin depressurization. The passenger exhausted the back-up supply.

Airlines don't carry extra batteries for the units, and it's a passenger's responsibility to bring extra batteries, says Lana Hilling, lung health services coordinator of John Muir Health, a non-profit hospital and medical services center in California. The Air Transport Association fears airlines could be saddled with extra costs for emergency landings if the DOT rule leads to more widespread use of medical oxygen in-flight. Emergency landings cost $6,000 to $100,000, the group says. The proposed rule — opposed by airlines — would also require airlines to test passengers' oxygen concentrators and make sure they meet safety standards. Inogen and other manufacturers should foot the bill for such testing, airlines say. No problem, says Risinger, who expects the DOT's proposed rule to be revised accordingly. But DOT spokesman Bill Mosley would not comment on what action the agency will take or give a date when a final rule will be issued. The Lung Association's Billings says he understands

safety and cost concerns, but air travel is "very important" to people with pulmonary disorders. It gives them "freedom of mobility," he says. Hilling adds that air travel increases pulmonary patients' quality of life. "It gives them the ability to do what all of us take for granted."

Airlines' medical oxygen policies

Nine airlines provide supplemental oxygen, for a fee, to passengers with breathing problems. Eleven carriers allow travelers to bring approved portable oxygen concentrators aboard.

AIRLINE		
Alaska	America West	American
ATA	Continental **No***	Delta
Frontier	Hawaiian	Midwest
Northwest	Southwest	US Airways

*** — Will begin allowing them later this month.**

.....Source: www.usatoday.com

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MEDICAL TOURISM ADOPTED BY BUSINESSES

Employees sent offshore for cost-saving surgical procedures

As medical costs in the United States continue to rise, more and more employers are sending employees in need of costly surgeries overseas to receive treatment. A number of U.S. employers that fund their own health insurance plans have started sending their employees to countries such as India and Thailand for operations that can costs tens of thousands of dollars more in the United States.

"The hospitals have a monopoly," says North Carolina-based Blue Ridge Paper Products Inc. benefits director Bonnie Blackley. "They don't care, because where else are patients going to go? Well, we are going to go to India." Blue Ridge -- just one of several U.S. companies offering "medical tourism" medical plans -- will send one of its employees to a New Delhi hospital next month for a pair of surgeries that will save the company $10,000 over what the procedures would cost in America.

Tens of thousands of Americans have begun traveling overseas for costly medical procedures in recent years, since the savings can be significant. For example, Arthur Milstein, chief physician at HR consulting giant Mercer Health & Benefits, says a coronary bypass surgery at Apollo Hospitals in India costs about $6,500 -- compared to the same surgery that costs an average of $60,400 in California.

Hospital associations in the United States say medical tourism will only make healthcare price problems worse, as those who travel abroad are often the "best-paying" customers who help keep hospitals afloat in the face of rising costs and expensive government regulations. However, many Americans have no other choice but to travel abroad for surgeries they would otherwise be unable to afford. "America has the best medical treatment," says Rupak Acharya, founder of a Malibu startup insurance company specializing in medical tourism for major surgeries. "Problem is, much of it is inaccessible."

"This accelerating trend of medical tourism," adds Mike Adams, a medical industry watchdog and critic of conventional medicine, "is the free market's way of overcoming the anti-competitive, monopoly practices that have now become accepted as standard in the U.S. medical industry. Despite the industry's best efforts to exploit patients by limiting their options, smart consumers are realizing that U.S. medical costs are, indeed, a sham, and that they can get the same level of care -- plus a free vacation to Asia -- for a fraction of what they'd spend in the U.S." .....Source: www.NewsTarget.com

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STRESS FROM EXERCISE DOES NOT THREATEN THE HEART, HOPKINS STUDY SHOWS

A Johns Hopkins study should ease the concerns held by many older adults with mild high blood pressure about the strain or harm exercise could cause their hearts. Results of the research on 104 men and women age 55 to 75 showed that a moderate program of physical exertion had no ill effects on the heart's ability to pump blood nor does it produce a harmful increase in heart size. In this study, "moderate" translated to sustained exercise for about an hour, three times a week. Researchers say that people's concerns stem from the fact that during each workout, blood pressure can on average rise from 40 millimeters to 60 millimeters of mercury. The Hopkins study is believed to be the first to evaluate the effects of exercise on the heart's ability to function, to pump and to fill up with blood.

"While having high blood pressure at rest is a well-established risk factor for heart problems, older people should not fear the effects of moderate exercise on the heart, despite short-term bump-ups in blood pressure during their workout," says lead study investigator and exercise physiologist Kerry Stewart, Ed.D., a professor of medicine and director of clinical and research exercise physiology at The Johns Hopkins University School of Medicine and its Heart Institute. "Exercise is a highly effective means of increasing the heart's efficiency and reducing body fat, factors that may ward off future health problems, such as heart disease and diabetes."

A report on the Hopkins study, published in the July issue of the journal Heart, showed that after six months of aerobic exercise on a treadmill, bicycle or stepper, plus weightlifting, participants showed no overall ill effects in 11 measures of diastolic heart function, when the organ's main chamber fills with blood between beats. They also found that exercise produced no increase in eight measures of heart size, including left ventricular mass and wall thickness. In contrast, a long-term effect of hypertension, even when the body is relaxed, is hypertrophy, an enlargement of the heart that eventually stiffens and weakens the muscle.

Not only were there no ill effects sustained, despite periodic increases in blood pressure during the workout, Stewart and his team reported, but results also suggest that the exercise producing these effects benefitted the hearts of those who made the most gains in physical fitness and for those who lost the most abdominal fat. Researchers found, for example, that each single point gain in aerobic fitness (of 1 milliliter per kilogram per minute), as measured by peak oxygen uptake by the blood during exercise, translated to a 1.5 percent improvement in one key measure (the E/A ratio), used to measure diastolic heart function. In addition, every 10-point decrease in abdominal fat (of 1 square centimeter) translated to a 1.2 percent gain in a second

key measure (the Em/Am ratio). And, researchers say, unlike the increased heart size that results from high blood pressure, any increase in heart size observed in the active group was similar to what athletes experience when their hearts get bigger and stronger, not stiff. They describe the activity-related form as physiological hypertrophy as opposed to the former kind, which they call pathological hypertrophy.

For a six-month period, the Hopkins team assessed the benefits of a supervised program of exercise training in a group of 104 older men and women, measuring heart function, and body fitness and fat levels at the start and end of the study. All of the participants were in general good health except for untreated, mild hypertension. Half were randomly placed in a widely recommended moderate exercise program while the rest maintained their usual physical routine and diet. The active group participated in a supervised series of exercises for 60 minutes, three times per week. The combination of exercises was designed to work all major muscle groups, including the heart, with substantial improvements observed in active participants' body fat, and muscle and fitness levels.

Aerobic fitness, as measured by peak oxygen uptake on a treadmill, increased by 17 percent (from 24.4 milliliters per kilogram per minute to 28.4 milliliters per kilogram per minute), as did average strength (from an estimated ability to lift a total of 383 kilograms from 328 kilograms, using seven different weight machines). The average weight loss in this group was only four pounds, because much of the loss of fat was offset by increased muscle mass. The fat in the abdominal region, measured by magnetic resonance imaging, was reduced by 20 percent among exercisers. The group that was not exercising had either no or significantly less improvement than the exercising group. Special scans, using an X-ray machine, were used to assess total body fat.

"Making gains in body fitness and losing abdominal fat are truly important to the long-term health of the heart," says study co-author and cardiologist Edward Shapiro, M.D., a professor at Hopkins. "Our results confirm that moderate-intensity exercise can have many health benefits - including gains in heart function that are linked to increased fitness and reduced fatness. Our study also shows that the vast majority of older people with mildly elevated blood pressure can benefit from moderate exercise, and they should talk about it with their physician to determine an appropriate exercise and any other options for treatment."

The Hopkins study's exercise program followed current guidelines from the American College of Sports Medicine. The study was part of a larger, ongoing trial, called the Senior Hypertension and Physical Exercise study (or SHAPE, for short). It is believed to be the first detailed examination of the guidelines' effectiveness and the separate effects of exercise on blood pressure, heart structure and cardiovascular function, with nearly an equal number of men and women enrolled. A study published last year by the Hopkins scientists showed that exercise reduced by more than 20 percent the number of people who develop metabolic syndrome, a clustering of three or more risk factors for developing heart disease, diabetes and stroke. Risk factors include high blood pressure, elevated blood glucose levels, excess abdominal fat and abnormal cholesterol.

.....Source: medicalnewstoday.com

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SURGEON GENERAL RETURNS TO LIFE AS A CIVILIAN

Dr. Richard Carmona's report on secondhand smoke was hallmark of term

Quietly leaving his post as surgeon general, Dr. Richard Carmona said he would judge himself successful if he had persuaded one student to make good health choices or one mother to stop smoking. Carmona's report condemning secondhand smoke was a hallmark of his tenure as the nation's 17th surgeon general. That report, issued just over a month ago, will fuel nationwide efforts to ban smoking in public, predicted Dr. Georges C. Benjamin, executive director of the American Public Health Association. "I think that report is going to turn out to be the nail in the coffin to the tobacco industry," Benjamin said. "I certainly hope so."

Carmona's term expired over the weekend with no announcement from the Department of Health and Human Services. However, a letter Carmona wrote to his fellow officers of the United States Public Health Service began to circulate Monday on Capitol Hill. He cited several accomplishments in the letter, including educating Americans about the importance of preparing for natural and manmade disasters. He also noted his focus on trying to eliminate health disparities among parts of the population on such diseases as AIDS or diabetes. Carmona said in the letter that he was returning to civilian life, but provided no specifics. "I know that in the end, people will ask if my four years as the surgeon general did any good, and, honestly, only time will tell," Carmona wrote. He said it would be all worth it if one student he talked to was dissuaded from making bad health choices, or if one mother quit smoking to improve her child's health.

Carmona had a lower public profile than some of his immediate predecessors, such as C. Everett Koop, who served two terms, Joycelyn Elders, who served about half a term, and most recently, David Satcher. "I think he was in a tough time," Benjamin said. "Here you have a guy who had significant experiences in preparedness and trauma and emergency care, and I wish we had used him more effectively in that role." Christina Pearson, an HHS spokeswoman, said HHS Secretary Mike Leavitt appreciated Carmona's service. "He has helped provide good leadership and counsel to the department on prevention issues," Pearson said. "I would point to the recent smoking report he did, which got unprecedented attention. He also raised the profile of childhood obesity."

Pearson referred to the White House questions about Carmona's potential successor. But Emily Lawrimore, a White House spokeswoman, said it would not comment on personnel matters. .....Source: MSNBC.com

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IT'S NEVER TOO LATE TO START EXERCISING

Just getting off the couch can cut heart disease risk, study shows

It's never too late for couch potatoes to start exercising and cut their risk of heart disease, according to research. Neither does it have to be strenuous activity -- even just walking can make a difference. "You don't have to go to the gym. Just get off the couch," said Dr Dietrich Rothenbacher of the Univ. of Heidelberg in Germany. "It is never too late to start exercising," he told Reuters.

The researchers studied the impact of physical activity on patients with coronary heart disease (CHD) and a group of healthy volunteers of the same age and sex. They found that people who exercised throughout their lives had the lowest risk of the illness, which is one of the biggest killers in industrialized countries. "But we also found that people who changed their physical activity patterns in late adult life also reduced their risk for coronary heart disease," added Rothenbacher, an epidemiologist at the university.

The scientists re-evaluated data they had previously collected on patients and volunteers ranging in age from 40 to 68 who had been questioned about their habits and exercise patterns. Smoking, diabetes and high blood pressure, which are risk factors for heart disease, were more common in the patients with the illness than in the healthy volunteers. People who said they had been active throughout their lives had about a 60 percent lower risk of being diagnosed with coronary heart disease.

Couch potatoes who changed their ways and began exercising after the age of 40 were about 55 percent less likely to be diagnosed with the illness than people who had always been inactive. The British Heart Foundation (BHF) said the heart is a muscle and requires regular physical activity. "The earlier you adopt a more physically active lifestyle, the bigger the rewards will be for your heart, helping to reduce your risk of CHD in later life. So don't wait until you reach 40 to get active," said a spokeswoman. .....Source: MSNBC.com

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YOU'RE NOT GOING TO THE GYM, ARE YOU?

As if there aren't enough exercise obstacles, beware the fitness saboteur

There's no shortage of obstacles preventing us from working out: hellish commutes, long hours at the office, junior's soccer practice, grocery shopping, happy hour, the overwhelming desire to scrub the bathroom floor — any excuse will usually do.

But even when we're ready to hit the gym, sometimes family and friends can sabotage our fitness plans. Family members may contribute to our couch-potato culture more than we might think. A newly released survey by the International Health, Racquet and Sportsclub Association (IHRSA) in Boston and George Washington University Medical Center in Washington, D.C., explored why people don't go to the gym.

Not surprisingly, the nationwide survey of more than 1,700 people, conducted online last fall, found that many Americans say they don't go to health clubs because they don't have time, they find the gym environment intimidating or memberships cost too much. But in addition, when people were asked if their spouse or partner thinks they should go to the gym regularly, 48 percent disagreed. When asked if their kids thought they should go, 51 percent disagreed. Even people who exercise for a living can get pressure to skip a good sweat. Kathy Kaehler, a personal trainer in Los Angeles, says her mother recently told her she should cut back on her workouts, that "doing stairs for cardio is too hard on my system and that I should be careful of my bones."

But who will cook dinner?

Fitness foes within the family may be an underappreciated factor in why so many Americans don't exercise, says Kathleen Rollauer, IHRSA's senior manager of research. "A positive social environment helps," she says. There are a few common reasons why family members or friends may discourage exercise, says Justin Price, a personal trainer in San Diego and spokesperson for the IDEA Health and Fitness Association. And it's not so much about you — it's about them, according to Price. "They worry about the disruption in their own life," he says, noting this is especially true for married women whose trip to the gym may mean someone else has to prepare breakfast or dinner, buy milk or pick up kids from after-school activities. Family members may also fear being compared to the person working out. If only one person in the family is fit, the others may start to feel like a failure, Price says.

His advice for dealing with these issues is to communicate clearly to everyone that the time spent away from them for exercise isn't about getting out of the house or avoiding them; it's about doing something positive for your physical and emotional health.

Schedule it, but be flexible

It also helps to plan your workouts ahead of time and let them know, rather than giving last-minute notice when they may be counting on you to be there for them. And, of course, be considerate and flexible, taking others' priorities into account, too, says Keli Roberts, a personal trainer and group fitness instructor at Equinox in Pasadena, Calif. "Sometimes you have to compromise," she says.

One of her clients was working out intensely — more than two hours a day, six or seven days a week — until her husband told her to cut back. "He just felt it was taking too much time away from the family," Roberts says. The compromise was for the client to go to the gym three days a week for an hour each time, which is still a respectable amount of activity.

Above all, remember that you won't win over your family by nagging about their poor fitness habits. But you might subtly incorporate fitness into your family life by suggesting active outings, Price says. Sunday dinner, for example, could become a picnic with a hike beforehand. And playing sports the kids enjoy is a win for everyone. "Just don't guilt them," he says.

.....Source: MSNBC

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EIGHT STATES CONSIDER PAID LEAVE PROGRAMS FOR EMPLOYEES WHO SERVE AS CAREGIVERS

Eight states have bills under consideration that include some form of paid leave for employees who serve as caregivers for family members, the Wall Street Journal reports. Illinois and Washington might establish health insurance programs; Hawaii

and Minnesota might revise the definition of sick leave; Massachusetts and New Jersey might establish a paid leave benefit; New York might allow employees to defer their paychecks tax-free; and Pennsylvania might offer tax credits to employers that offer paid leave. According to Kathleen Kelley, executive director of the Family Caregiver Alliance, states have begun to consider some form of paid leave for employees who serve as caregivers for family members in response to "a growing awareness that we have all these people in the work force, particularly in their 40s and 50s, who have these multiple responsibilities." Many states and employers have raised concerns about the cost of paid leave for employees who serve as caregivers for family members, but supporters maintain that employers might benefit. According to the supporters, surveys indicate that 94% of employees who take paid leave later return to their employers and that 76% who take unpaid leave do not return.

California Program

In 2004, California established a program that offers paid leave to employees who serve as caregivers for family members. Among the 176,085 California residents who participated in the program in the first year, 12% took paid leave to serve as caregivers for family members, and most took leave to bond with newborns. The average duration of the paid leave among California residents who participated in the program was less than five weeks, according to FCA. California employees pay a small stipend per paycheck -- no more than $63.53 annually in 2005 -- into the State Disability Insurance program to fund the program. California residents who participate in the program can collect 55% of their weekly paychecks or a maximum of $840 weekly for as long as six weeks. .....Source: medicalnewstoday.com

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BUDESONIDE ADDED TO FORMOTEROL AND OR SHORT ACTING BETA 2 AGONIST LOWERS MORTALITY RISK FOR SEVERE COPD PATIENTS

Important new data from the analysis of combined data from the two pivotal Symbicort® studies, announced today at the 5th International Multidisciplinary Conference on Chronic Obstructive Pulmonary Disease (COPD5), reveals that budesonide added to formoterol (Symbicort®) and/or terbutaline significantly reduces mortality in severe COPD over one year, compared to the bronchodilators formoterol and/or terbutaline alone.

Today's results show fewer deaths in the Symbicort / budesonide group compared with the bronchodilator group (p=0.036), with an associated hazard ratio of 0.564 (p=0.039). This represents a 44% reduction in all-cause mortality over one year for patients treated with Symbicort / budesonide .

“Previous findings have shown the beneficial effects of combination budesonide and formoterol, i.e. Symbicort, therapy in significantly reducing COPD exacerbations”, explained Professor Peter Calverley, Aintree Chest Centre, University of Liverpool. “Today's presentation further demonstrates the link between COPD exacerbations and an increased risk of mortality, reinforcing the importance of reducing these events, as indicated by COPD guidelines”.

The re-analysis comprised data from 1834 patients with severe COPD evenly distributed between the two treatment groups, i.e. budesonide added to bronchodilators compared to bronchodilators alone. The survival benefits in this analysis also appear to corroborate the findings in the three year prospective TORCH (TOwards a Revolution in COPD health) study2, presented at the American Thoracic Society Congress in 2006, which has reported a 17% reduction in mortality for fluticasone/salmeterol compared with placebo.

The retrospective pooled analysis also showed that health-related quality of life (HRQL) - as measured by the St. Georges Respiratory Questionnaire (SGRQ), an independently validated tool for measuring quality of life in COPD - was the strongest predictor of mortality in COPD, over and above any other reported predictor (e.g. lung function, breathlessness, Body Mass Index and age), equating to better quality of life leading to lower risk of premature death3. Using the SGRQ, a change of four points is defined as clinically meaningful, equating to a patient being able to walk up a flight of stairs without stopping or to being able to sleep without disruption from coughing. The data presented today suggests that SGRQ scores may have a role in identifying patients at increased risk of mortality over 1 year.

“Previous studies have demonstrated that budesonide/ formoterol is a very effective treatment in preventing COPD exacerbations, leading to clinically important improvements in health-related quality of life”, explained Professor Paul Jones, St George's Hospital Medical School, London “Today's data are important, suggesting as it does that a combination of budesonide and formoterol may provide a tangible survival benefit as well as improving the patients quality of life”.

The pooled-analysis, presented today at COPD5, is based upon the data from two 1-year prospective Symbicort studies in COPD (Calverley et al. 4 and Szafranski et al5), both published in the European Respiratory Journal in 2003. “Randomised, controlled trials are the best way of determining whether therapy is effective in COPD. However, re-analysis of pooled data from comparable clinical trials, as we did in this case, can provide new and potentially important clinical insights”, Professor Calverley concluded. .....Source: Medical News Today

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EDINBURGH RESEARCHERS TO PROBE MEMORY LOSS IN PEOPLE WITH DIABETES

Researchers at the University of Edinburgh are aiming to pinpoint why diabetes can cause memory loss and mental decline. A thousand people will take part in the study, the largest of its kind ever undertaken in the UK.

The research team will ask people with Type 2 diabetes - associated with an increased risk of memory impairment and dementia - aged 60-75 years to complete puzzle-based tests and have their heart function and blood sugar levels measured. Follow up tests four years later will find out if there have been any changes in brain function.

Dr Mark Strachan, an honorary senior lecturer at the University and a consultant in diabetes and endocrinology at the

Western General Hospital, said: "People with type 2 diabetes are at increased risk of developing problems with memory and problem-solving abilities. Although the cause of these abnormalities is not understood, various risk factors associated with diabetes may be important. For example, in some cases, high blood sugar levels can be damaging to small blood vessels in the eyes, nerves and kidneys and there is evidence that the same damage - microvascular disease - can occur in the brains of people with diabetes.

"The main aim of this study is to find out which risk factors, including microvascular disease, inflammation and alterations in hormone levels are linked to altered brain function in people with diabetes. This information is crucial in determining the cause of diabetes-related memory problems and other changes in brain function such as problem-solving abilities and attention span." He added: "Diabetes affects around three per cent of the UK population, and about 170,000 people in Scotland are known to be affected. The prevalence of diabetes is increasing but we are better at treating its complications, such as heart disease. As a result, people with diabetes are likely to live longer and so cognitive problems are likely to become a much bigger issue."

.....Source: medicalnewstoday.com

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EMPHYSEMA SEVERITY SIMILAR AMONG RACES DESPITE AGE DIFFERENCE

A new study reveals that emphysema may have a similar impact on African-Americans and Caucasians, despite African-Americans being younger and smoking less. Researchers from Temple University in Philadelphia, PA, analyzed demographics, cardiopulmonary and pulmonary function, quality of life, and emphysema severity in 1,156 Caucasians and 42 African-Americans enrolled in the National Emphysema Treatment Trial. Although African-Americans were younger and smoked less than Caucasians, they presented with comparable impairment in lung function and exercise. Quality-of-life measures also were similar among the two groups, but African-Americans had lower socioeconomic status, lower education level, and fewer were married. The study appears in the July issue of CHEST, the peer-reviewed journal of the American College of Chest Physicians.

.....Source: medicalnewstoday.com

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LUNG FUNCTION IN PATIENTS WITH HEART FAILURE MAY BE IMPROVED BY CPAP

The use of continuous positive airway pressure (CPAP) for patients suffering from congestive heart failure (CHF) could significantly improve lung function and exercise tolerance, shows a new study. Brazilian researchers performed a blind clinical study on 24 patients with class II or III CHF and dilated cardiomyopathy. Patients were randomly assigned to two groups; 30-minute CPAP therapy and respiratory exercise (CPAP group) or respiratory exercise only (control group), once daily for 14 days. FEV1, FVC, and exercise tolerance were measure on days 4, 9, and 14. Patients in the CPAP group showed progressive increases in FVC, with a maximum of 16 percent on day 9, and FEV1, with a maximum of 14 percent on day 14. The CPAP group also showed a 28 percent increase in exercise tolerance as opposed to the control group, which showed no significant changes in any category. The study appears in the July issue of CHEST, the peer-reviewed journal of the American College of Chest Physicians.

.....Source: medicalnewstoday.com

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THE FOOD THAT FIGHTS FAT

Fiber fills you up then slims you down. Here are 30 ways to make your diet more fiber-friendly

We all know our bodies need calcium for bones, vitamin C to fend off colds, and chocolate to save relationships. But when it comes to losing weight, the nutritional information is a little more confusing. The mighty trilogy of nutrients — protein, carbohydrates, and fat — garners most of the diet industry's attention, but it's becoming much more clear that fiber needs to be the fourth leg of the dietary table. Study after study shows that not only does fiber help lower your risk of cancer, heart attack, and high blood pressure, but it also keeps you full and helps you decrease the total amount of calories you consume every day. Trouble is, most of us think that getting the recommended 30 grams of fiber a day means eating cereal that tastes like the box it comes in. But that's not the case; you can sneak fiber into your diet anywhere. Use these 28 fiber-friendly tactics to eat more — and weigh less.

AT BREAKFAST

Spice up your eggs. One-third of a cup of chopped onion and one clove of garlic will add 1 g of fiber to scrambled eggs. Or fold the eggs omelette-style over ½ cup of cooked broccoli for an additional 2 g.

Drop a whole orange into the blender to flavor your morning smoothie. One peeled orange has nearly 3 g more fiber than even the pulpiest orange juice.

Fill your juice glass with nectar instead of a watery juice from concentrate. Nectar is apricot, peach, pear, or papaya juice, mixed with fiber-rich pulp. It packs more than 1 g of fiber per 8-ounce glass.

Heat up a bowl of oat bran instead of oatmeal; it has nearly 2 g more fiber. Add even more flavor and fiber by stirring in 1/4 cup of raisins or chopped dates before nuking it.

Sprinkle ground flaxseed over your favorite cold cereal, or stir a few spoonfuls into a cup of yogurt. Two tablespoons equals close to an extra 2 g fiber.

Grab an Asian pear. Similar in taste to other pears, the red-colored Asian variety has an apple-like crispness and shape, and it delivers significantly more fiber — 4 g per pear.

Buy spreadable fiber, like almond butter, for your whole-wheat toast. Two tablespoons adds 2 g of fiber, along with a healthy dose of heart-protecting fats and vitamins like E.

Whip up a pack of hot-chocolate mix instead of that second cup of coffee. Most instant-cocoa mixes have as much as 3 g of fiber per cup.

AT LUNCH

Don't like whole wheat? Make your sandwiches with rye bread. One slice has almost 2 g fiber — twice the amount found in white bread.

Opt for burritos instead of tacos. Flour tortillas have more fiber than taco shells. Even better, make the burrito whole wheat for still more fiber per serving. Now, order that burrito with meat and beans instead of meat alone. Half a cup of beans adds 6 g of fiber to your meal.

Stow some microwavable soup in your desk for when you need to work through lunch. Lentil, chili with beans, ham and bean, and black bean each have between 6 and 10 g of fiber per cup.

Shower your pizza with oregano or basil. A teaspoon of either spice adds 1 g of fiber. Order it with mushrooms and you'll get 1 g more.

Build your burger with a sesame-seed bun instead of the plain variety. Sesame seeds add ½ g of fiber per burger.

Order your dog with sauerkraut. Every 1/4 cup you pile on adds close to 1 g of fiber to your frank.

IN THE AFTERNOON

Drink bottled chocolate milk, not white. The combination of the chocolate and the compounds needed to keep it suspended in the milk provides 1.5 g of fiber in every 8 ounces.

Pop a pack of light popcorn instead of popping open a bag of potato chips. There's 8 g of fiber in every bag of popcorn.

Have a low-sodium V8 and its 2 g of fiber. The V8 that comes spiked with salt has half that amount.

Graze on trail mix instead of a granola bar. Most granola bars have only 1 g of fiber, while trail mix with dried fruit has nearly 3 g.

AT DINNER

Toss ½ cup of chickpeas into a pot of your favorite soup. They'll absorb the flavor of the soup and tack 6 g of fiber onto your bottom line.

Swap a sweet potato for your standard spud. Sweet potatoes have 2 g more fiber per tuber than the typical Idaho variety. Not a fan? At least eat the skin of the regular potato — it alone has 1 g of fiber.

Go wild when you make rice. Cup for cup, wild rice has three times the fiber of white.

Add some green to your red sauce. Doctor your favorite jarred pasta sauce with ½ cup of frozen chopped spinach. The spinach will take on the flavor of the sauce and pad your fiber count by more than 2 g.

Prepare whole-wheat or spinach pasta instead of the regular semolina kind. A cup of either has 5 g of fiber.

Cook broccoli, cauliflower, and carrots, and you'll take in 3 to 5 g of fiber per serving, as much as twice what you'll get if you eat them raw. (Heat makes fiber more available.)

Use uncooked oatmeal instead of breadcrumbs in your next meat loaf. Add 3/4 cup of oats per pound of ground meat, and you'll boost the total fiber count to more than 8 g.

AT DESSERT

Say nuts to candy bars. Bars with almonds, like Almond Joy and Alpine white chocolate with almonds, have about 2 g of fiber — almost twice the fiber content of bars without.

Top a bowl of ice cream with sliced fresh berries in lieu of syrup. One-half cup of raspberries provides 4 g of fiber; strawberries and blueberries pack half that amount.

Introduce your pie hole to a slice of apple, cherry, or berry pie, and you'll add an extra 3 to 5 g of fiber. Cake doesn't have nearly as much fiber. .....Source: Women's Health

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FOCUS ON THE BIG 5

It's no surprise that five key health factors that make your RealAge older also steal late-life independence. Which risk factors are they? Not cancer. Not cholesterol. The top five health factors that increase the likelihood you'll need help caring for yourself when you're older are smoking, high blood pressure, diabetes, obesity, and inactivity. Luckily, regular exercise can help take care of four of those risk factors. And if you don't smoke, you'll be able to exercise even more.

RealAge Benefit: Exercising regularly can make your RealAge as much as 9 years younger.

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EASY PASTA SALAD

Prep Time: 20 min
Total Time: 3 hr 20 min
Makes: 4 servings

2 cups rotini pasta, uncooked
2 cups fresh broccoli florets
1 cup halved cherry tomatoes
1/4 cup pitted ripe olive slices
1/3 cup Italian Reduced Fat Dressing
1/4 cup Reduced Fat Parmesan Style Grated Topping

COOK pasta as directed on package, adding broccoli to pasta during last 2 minutes of pasta cooking time; drain. Place in medium bowl.
ADD remaining ingredients; mix lightly. Cover. Refrigerate several hours or until chilled.

NUTRITION INFORMATION
Diet Exchange:
3 Starch,1 Vegetable,1 Fat

Nutrition (per serving)
Calories 310 Total fat 7g Saturated fat 2g Cholesterol 5mg Sodium 470mg Carbohydrate 51g Dietary fiber 3g Sugars 5g Protein 11g Vitamin A 30%DV Vitamin C 50%DV Calcium 15%DV Iron 15%DV

....Source: Kraft Kitchens

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THE EVIL LAUGH, THE HORNS, THE PITCHFORK ... MAYBE IT'S JUST ME, BUT I THINK THERE'S SOMETHING WRONG WITH THAT WEATHERMAN

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