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DRUG COMPANIES TO DISCLOSE SPENDING PRACTICES

Watchdog groups say industry wants to avoid laws over public disclosure

For years, the nation's largest drug and medical device manufacturers have courted doctors with consulting fees, free trips to exotic locales and sponsoring the educational conferences that physicians attend.

Those financial ties in most cases need not be disclosed and can lead to arrangements that some say improperly influence medical care.

Now, under the threat of regulation from Congress, the two industries are promising to be more forthcoming about their spending. A dozen of the nation's leading drug and device makers have told Sen. Charles Grassley, R-Iowa, that they have plans or are working on plans to publicly disclose grants to outside groups. The details will be provided on each company's Web sites.

Watchdog groups say the companies are trying to derail legislation that would require public disclosure of their giving. "If they were doing this out of the goodness of their heart, they would have done so decades ago," said Dr. Peter Lurie of the consumer group Public Citizen.

Of particular interest to Grassley, top Republican on the Senate Finance Committee, is the money companies spend on continuing medical education. Physicians attend such conferences to fulfill their license requirements and to keep up to date with the latest treatment trends. Professional associations and companies frequently ask drug and device makers to help pay for the conferences. Recently, Grassley asked 15 companies whether they planned to follow the lead of Eli Lilly & Co., which now discloses its grants to such programs.

"If your company does not yet have any efforts or plans in place, please explain why not," Grassley wrote.

The responses are in. They are wide-ranging but mostly what the senator wanted to hear. Indeed, many of the companies said they would go beyond disclosing grants for medical education. Some companies said they would also disclose payments to patient advocacy groups such as the American Heart Association or the American Diabetes Association. Boston Scientific said it was developing a system that even discloses certain payments to physicians.

Medtronic Inc. said it will post payments for professional meetings and patient groups on its Web site beginning May 1. AstraZeneca PLC said it would do the same on Aug. 1, providing the amount spent and the purpose of the financing. AstraZeneca gets 4,000 to 5,000 grant applications each year and funds about a third of them.

Merck and Co. was vague about its plans, but committed to the concept. "We are currently in the process of developing an action plan," the company wrote to Grassley.

Amgen Corp. and Abbott Laboratories said they had formed working groups to determine how to compile and display their grants.

Schering-Plough Corp., however, told the senator what he didn't want to hear: "We do not publish or have plans at the moment to publish a list of charitable contributions or educational grants that medical organizations have received from us."

Grassley said, overall, he was happy with the responses. "The way these companies are making information about financial relationships open to scrutiny is the right thing to do," he said.

Two other companies said they already were disclosing third-party payments. The two, Zimmer Inc. and Stryker Orthopedics Inc., avoided criminal prosecution over financial inducements paid to surgeons to use their products, prosecutors announced last year. The companies agreed to new corporate compliance procedures and federal monitoring. Zimmer also had to pay the government \$169.5 million.

The hip-and-knee industry was the subject of a recent Senate Aging Committee hearing titled "Surgeons for Sale." Companies routinely paid doctors \$5,000 every three months for providing information on market trends and operating-room activity. However, the reports typically offered only cursory descriptions and often were duplicated from one quarter to the next. Also, companies sponsored consultant meetings at resort locations. The meetings lasted just a few hours each day. The physicians who presented information at the meetings spoke for as little as 10 minutes.

"Although the remainder of the day was available for recreational activities paid for by the company, the consultants were compensated \$5,000 for a full day of work," said Gregory E. Demske, an assistant inspector general.

Eli Lilly began listing its grants last year. It gave \$18.9

million in the second quarter of 2007, according to the Prescription Project, a Boston-based group that promotes policies to reduce conflicts of interest.

"They support those organizations which they believe will have a positive impact on their drug sales," said David Rothman of Columbia University and associate director of the Prescription Project. "It's self-evident but important."

If all of the companies follow through with their commitments to Grassley, there also would be widespread disclosure of how much money they give patient advocacy groups. The groups rely on industry for much of their financing. For example, the American Heart Association said donations from the pharmaceutical and device industry make up about 6 percent of its annual income, and totaled \$48.3 million in the organization's latest fiscal year.

"Donations from corporations, including the pharmaceutical and device industry, allow us to further enhance our programs and outreach, and to bring objective science and the highest quality of public education and information to more people," said Maggie Francis, the association's communications manager.

Grassley and Sen. Herb Kohl, D-Wis., have introduced legislation that would require drug and device makers to disclose anything of value given to physicians, such as payments, gifts or travel.

The disclosure of medical education grants is an extension of that concept. Last year, the staff for the Senate Finance Committee issued a report that said the drug industry may be using the "medical education industry to deliver favorable messages about off-label uses that the drug companies cannot legally deliver on their own."

The committee report noted that Warner-Lambert, now owned by Pfizer Inc., paid \$430 million to settle claims that medical conferences it sponsored were used to illegally promote off-label uses of the anti-seizure drug Neurontin. Serono-Laboratories paid \$704 million to settle a similar claim concerning the AIDS drug Serostim.

<http://www.msnbc.msn.com/id/24067820/>



SAMPLES: NO SUCH THING AS A FREE LUNCH

At first, they seem like a great deal! But getting free drug samples at the doctor's office may cost you in the long run.

A new study from the University of Chicago Medical Center finds patients who got free drug samples had much higher out-of-pocket prescription costs than those who don't get the samples.

Results show patients who never got samples spent \$178 on prescriptions over six months. Those who did get them spent about \$166 on prescriptions during a six-month period before they got the free medications. But they spent \$244 during the six months in which they got the samples and \$212 during the six-month period after they got the drugs.

"Samples may be particularly valuable in providing patients economic relief when they are used short-term and not followed-up with long-term prescription for the same medicine," study author G. Caleb Alexander, M.D., from the University of Chicago Medical Center, was quoted as saying.

"However, all too often, physicians and patients end up continuing the medicines initially begun as samples, even though older, less expensive alternatives may exist."

The authors say there may be two main reasons sample users have higher prescription costs -- the report found those who received free samples may have been more seriously ill than those who did not. And samples are often the newest and the most expensive drugs. Patients who originally got the samples at no cost may end up paying for future prescriptions for the same medicine.

Authors conclude patients and physicians should consider other ways to cut down on out-of-pocket prescription costs, such as using more generic drugs, stopping non-essential treatments, and using three-month instead of one-month supplies.

Source: Medical Care, 2008;46:394-402



FIVE WAYS TO HELP YOUR DOCTOR HELP YOU

Dr. Adam Dimitrov doesn't play favorites with patients. But he does have a few favorite patients -- ones who make it easy for him to do his job well. Take one of his patients who had a liver transplant. Dimitrov is her internist, and she arrives at every visit with a folder. Inside is a list of the medications she's taking, copies of letters from her other doctors and results of her latest imaging studies and lab tests. This way, Dimitrov isn't searching through her chart for papers that might -- or very well might not -- be there.

"She makes sure that nothing falls through the cracks," he said. This way, he can use their time together to take better care of her.

Now, wait a minute. Shouldn't a doctor have everything -- reports from other physicians, lab test results -- right there? Why is it the patient's responsibility to bring them in?

It's true: In an ideal world, a doctor would have your health history, the medications you're taking and lab results right in front of him. But we live in reality, and the reality is that these things are often lost in a mound of paperwork. So here are five things you can do to help your doctor help you.

1. Bring in a list of medications

Don't waste your precious moments with the doctor saying, "Ummm, I think I take a yellow pill in the morning -- or is it pink? And maybe I take it twice a day?" She's a doctor, not a mind reader. Write a list with the name of the drug, the dosage and how often you take it. "It's surprising and unfortunate how much time is wasted when that list isn't together," said Dimitrov, a family doctor in Baltimore, Maryland.

You can get help making a list from the free Web sites of MedSort and the American Academy of Family Physicians.

2. Come armed with your personal health history

You had your appendix out when? Grandma had Huntington's disease -- or was it Hodgkin's disease? You had a stent for your clogged artery back in '93 ... or was it a balloon? Your doctor wants to know, and you shouldn't rely on your memory (this is particularly important if you have a complicated medical past).

My Personal Health Record and the U.S. Surgeon General's Family History Initiative can help you get it all organized.

3. Bring in your recent test results and doctors' notes

If Dr. Smith the orthopedist ordered an MRI of your bum knee, you should assume that Dr. Jones the rheumatologist has not seen it. You should also assume the two docs haven't spoken to each other. So before your appointment with Jones to nail down the source of your knee pain, get a copy of Smith's notes from your latest visit and a copy of those MRI results.

4. Make a list of your concerns

Dr. Dana Frank, an internist at Johns Hopkins, tells his patients to come in with a written-out list of their top three concerns for each visit. He says it makes the appointment more focused and useful for the patient.

This may sound silly -- after all, you made the appointment, and you know why you're there -- but remember that fuzzy thinking is pretty common when you get to the exam room. Frank said, "What I really want is for patients to be prepared like the Boy Scouts."

Also, if you feel like the doctor is rushing you, ask him to slow down. "There is nothing wrong with saying, 'I feel you are rushing me. I am getting nervous; I can't tell you what I need to tell you,'" Frank said.

5. Don't ask your doctor insurance questions

Don't bother, because he's clueless. "We never know the answer to what is or isn't covered by your insurer," said Dr. Jim Braude, an internist in Atlanta. "Questions about insurance just take away time in the exam room that should be about your health." Insurance questions are, of course, important; a member of your doctor's office staff should know the answer.

<http://tinyurl.com/4Ing4s>



GETTING THE MOST OUT OF DRY POWDER INHALER FOR ASTHMA AND COPD

Johns Hopkins Health After 50 newsletter offers the latest guidelines

Proper technique is the key to benefiting from dry powder inhalers (DPIs) that treat chronic obstructive pulmonary disease (COPD) and asthma. But data presented at the annual meeting of the American College of Chest Physicians suggest that many patients can't or don't know how to use their inhalers properly.

Compared with aerosol metered dose inhalers, DPIs are considered "user-friendly": They don't require coordination between breathing in and squeezing the inhaler to release medication, and DPIs rely on your breath rather than chemical propellants to get the medicine into your lungs.

But using DPIs requires a measured, forceful inhalation to ensure that the powdered medication gets from the inhaler to deep in your lungs.

If you inhale too quickly, the powder ends up at the back of your throat; if you breathe too slowly or too gently, it doesn't go anywhere; and if you accidentally exhale, the powder might get blown away.

Aerosol metered dose inhalers, such as albuterol and ipratropium, give fast relief during acute respiratory attacks, but most DPIs are prescribed to control symptoms. If you are not using your DPI properly, your disease can progress, or you may frequently experience acute episodes that require

hospitalization.

Researchers from Offenburg Hospital in Germany reported that 32% of 224 patients made mistakes using their DPIs that prevented them from getting the right dose of medication. Errors were most common in patients who were over 60 and in people with severe lung obstruction.

Each of the various DPIs works differently. Diskus models contain several weeks' worth of individual doses. Other DPIs look more like traditional tube inhalers and might contain individual doses or need to be loaded with a medication capsule before each use.

If you're prescribed a DPI, ask your doctor both to show you how to use it and then to watch as you use the DPI yourself. Bring your inhaler to each doctor's visit to double-check your technique.

Common DPIs include:

- Advair Diskus (salmeterol and fluticasone)
- Foradil Aerolizer (formoterol)
- Pulmicort Turbuhaler (budesonide)
- Serevent Diskus (salmeterol)
- Flovent Diskhaler/Diskus/Rotodisk (fluticasone)

If you are having trouble, your doctor can prescribe a traditional metered dose inhaler. Combining this type of pressurized inhaler with a spacer--a device that attaches to the inhaler and holds the medication for a few seconds before releasing it into your airways--can reduce problems with hand-breath coordination.

<http://www.prweb.com/printer.php?prid=821744>



HOW DO YOU CHOOSE A HOSPITAL IF YOUR GP REFERS YOU?

Patient choice

Patients in England are being offered more choice about where they want to be treated, but what does this mean in practice?

Most patients in England who are referred by their GP for non-urgent specialist treatment now have the right to choose which hospital they go to. This national system follows pilot projects that offered choice for patients in certain areas and for particular types of treatment, such as hip replacements.

Under the early schemes, people were offered a choice of at least four hospitals or 'secondary care providers' meeting NHS standards and costs.

This has now been extended, so most patients referred for non-urgent treatment can opt for any hospital or treatment centre ('provider') in England that meets government standards.

Your choices

All providers with an NHS contract are listed on the electronic Choose and Book system. This can be used by GPs and patients to arrange hospital appointments and can be done in the surgery, during a consultation, or later by phone or on the internet.

Providers include:

- NHS hospitals
- Foundation trusts (NHS hospitals with greater freedom to manage themselves)

- Private hospitals
- Independent sector treatment centres (ISTCs)

What this means

So, if you need an operation to remove varicose veins and you live in London, you're no longer restricted to your local area. For example, if you want to be treated in Liverpool to be near family, your GP will be able to refer you to your preferred hospital in Liverpool (as long as it has an NHS contract and your GP believes it can meet your clinical needs).

In these circumstances, your primary care trust - the organisation that funds your NHS care with money provided by the government - will not be able to refuse your request.

If you're referred by your GP on the NHS under the patient choice initiative, your treatment will be funded by the NHS even if you choose a private hospital or ISTC.

And if you're eligible for free transport to and from hospital, your journey will be funded by the NHS.

Selecting a hospital

You may be able to decide quickly which hospital you want to use. One hospital may be able to see you more quickly, for example, or a family member or friend may make a recommendation. There may also be practical reasons, such as better transport links, why one hospital or treatment centre suits you better than another.

You can, of course, still choose to be treated at your local NHS hospital.

If you don't immediately know which hospital you'd like to attend, the government has a website, NHS Choices, that can help you to decide.

Type in the treatment you need and it will set out your options. You can also access details of all the hospitals listed and information comparing hospital waiting lists and cleanliness.

Another source of information is Patient Opinion, an independent website that allows people to share their experiences - good and bad - of NHS care.

The Healthcare Commission also provides information about hospitals' performance and Choose and Book has a patient section.

Patient choice leaflets should be available in your GP surgery and local library.

Exceptions

In some circumstances patients won't have this level of choice. Two exceptions are when you need to be seen at a rapid access chest pain clinic or by a cancer specialist within the two-week maximum waiting time.

The extension of patient choice also doesn't currently cover maternity or mental health services. And the location of emergency care or treatment after an accident might not be your choice - for example, an ambulance crew may decide this for you.

Sometimes, even when it isn't an emergency, your GP may choose for you if you need specialist attention quickly.

Scotland, Wales and Northern Ireland

The new arrangements only apply to England. For information about how the health service and referrals work in the other UK countries, visit NHS Wales, NHS Scotland or

Health and Social Care in Northern Ireland.

<http://tinyurl.com/57w8cw>



BIOHEART'S STEM CELL THERAPY FOUND EFFECTIVE IN HEART FAILURE TREATMENT

Bioheart has reported final six-month, follow-up patient data from Seismic trial, which shows that MyoCell myoblast clinical cell therapy is a safe and potentially effective alternative treatment to standard medical therapy alone, for improving heart function among patients with previously implanted cardiac devices who are experiencing congestive heart failure.

On admission to the trial, patients were randomized on a two-to-one ratio into the treatment versus control groups with 26 patients receiving MyoCell therapy and 14 patients in the control group. All patients were experiencing congestive heart failure and were previously fitted with implanted cardiac defibrillators (ICDs) and receiving standard medical therapy.

Final six-month results show that 84% of treated patients experienced improved or unchanged six-minute walking test scores compared to 16% of the control group and 69% of the control group's results worsened, versus only 16% of the treated group. While 94% of treated patients experienced improved or unchanged New York Heart Association (NYHA) classification compared to 58% of the control group, 42% of the control group's results worsened, versus only 6% of the treated group.

Patrick Serruys, principal investigator of the trial, said: "The results from the Seismic trial are encouraging. While the study was specifically designed to show safety, the findings also suggest positive trends in clinical benefits when evaluating the treated group versus the control group at six months."

<http://tinyurl.com/3ou33y>



CAN'T QUIT SMOKING? BLAME YOUR GENES

New studies show 'double whammy' link to addiction and cancer

Scientists say they have pinpointed a genetic link that makes people more likely to get hooked on tobacco, causing them to smoke more cigarettes, making it harder to quit, and leading more often to deadly lung cancer.

The discovery by three separate teams of scientists makes the strongest case so far for the biological underpinnings of the addiction of smoking and sheds light on how genetics and cigarettes join forces to cause cancer, experts said. The findings also lay the groundwork for more tailored quit-smoking treatments.

"This is kind of a double whammy gene," said Christopher Amos, a professor of epidemiology at the M.D. Anderson Cancer Center in Houston and author of one of the studies. "It also makes you more likely to be dependent on smoking and less likely to quit smoking."

Greater cancer risk

A smoker who inherits this genetic variation from both parents has an 80 percent greater chance of lung cancer than a smoker without the variants, the researchers reported. And that same smoker on average lights up two extra cigarettes a day and has a much harder time quitting than smokers who don't have

these genetic differences.

The three studies, funded by governments in the U.S. and Europe, are being published Thursday in the journals *Nature* and *NatureGenetics*.

The scientists surveyed genetic markers in more than 35,000 people in Europe, Canada and the United States, zeroing in on the same set of genetic differences. They aren't quite sure if what they found is a set of variations in one gene or in three closely connected genes. But they said the result is the same: These genetic quirks increase the risk of addiction and lung cancer.

The studies' authors disagreed on whether the set of variants directly increased the risk of lung cancer or did so indirectly by causing more smoking that led to the cancer.

The genetic variations, which encode nicotine receptors on cells, could eventually help explain some of the mysteries of chain smoking, nicotine addiction and lung cancer that can't be chalked up to environmental factors, brain biology and statistics, experts said. These oddities include why there are 100-year-old smokers who don't get cancer and people who light up an occasional cigarette and don't get hooked.

In the last 40 years, the rate of adult Americans smoking has been cut from 42 percent in 1965 to less than 21 percent now.

The new studies point to surprising areas of the genes not associated with pleasure and addiction rewards. That may help explain why people have trouble quitting, said Dr. Nora Volkow, director of the National Institute of Drug Abuse in Bethesda, Md., which funded one of the studies. Eventual testing for the genetic variants could lead to custom treatments for quitting smoking.

"This is really telling us that the vulnerability to smoking and how much you smoke is clearly biologically based," said psychiatry professor Dr. Laura Bierut, of Washington University in St. Louis, and a genetics and smoking expert who did not take part in the studies. She praised the research as "very intriguing."

The studies mostly looked at smokers and ex-smokers — although two of the studies also looked at several hundred nonsmokers. The research only involved white people of European descent. People of Asian and African descent will be studied soon and may yield quite different results, scientists said. Smoking-related diseases worldwide kill about one in 10 adults, according to the World Health Organization.

The studies show on average the consequences of the set of variations in the alphabet of genetic code that people inherit from each parent:

Smokers who get the set of variants from only one parent see a risk of lung cancer that is about one-third higher than people without any variants. They also smoke about one more cigarette a day on average than other smokers. This group makes up about 45 percent of the population studied. Smokers who inherit the variants from both parents have almost a one in four chance of developing lung cancer. Their risk is between 70 and 80 percent higher than the cancer risk of other smokers without the genetic variants. They smoke on average of two extra cigarettes a day, and have a 45 percent higher risk of

peripheral artery disease. This group accounts for about one in nine people of European descent. Smokers who don't have the variants are still more than 10 times more likely to get lung cancer than nonsmokers. Smokers without the variant overall have about a 14 percent risk of getting lung cancer. By comparison, the risk of lung cancer for people who have never smoked is less than 1 percent, said another study author, Paul Brennan of the International Agency for Research on Cancer in Lyon, France.

Brennan and Amos, working on different teams, linked the genetic variation itself — when triggered by smoking — directly to lung cancer. Brennan said the nicotine receptors that the variants act on also can stimulate tumor growth.

Brennan's study also found that lung cancer risk for nonsmokers with the variants was higher than for those without the variants. However, his small sample size of nonsmokers requires further study. Amos' study didn't find increased lung cancer risk for people with the set of variants who have never smoked.

But Kari Stefansson, lead author of the largest of the three studies and chief executive of deCode Genetics of Iceland, said the increased lung cancer risk was indirect, and that the variant caused more addiction and more smoking. It was the extra cigarettes from increased daily smoking and the inability to quit that contributed to the higher cancer risk, Stefansson said.

"It's very likely that in the end there's going to be a test and this is going to be folded into a panel of tests for the risk of cancers," said Stefansson, whose company already does prostate cancer genetic tests. The tests will lead to better treatments, but probably not prevention of smoking, he said.

Stefansson and others emphasize that people without the variants should not take that genetic finding as a green light to smoke. There are other smoking-related diseases and they would still be a high risk of lung cancer.

For Stefansson, the research hits home. His father, a smoker, died of lung cancer. And Stefansson, who doesn't smoke, frequently lectures his 23-year-old daughter "who smokes like a chimney." She acts like she is immortal and smoking can't kill her, Stefansson said. But his own research shows that her genes are probably stacked against her.

<http://www.msnbc.msn.com/id/23919596/>



EMPHYSEMA TO BE THIRD BIGGEST KILLER

Chronic bronchitis and emphysema, now categorised as one disease, will be the third biggest killer of Australians behind heart disease and cancer over the next decade, specialists say. Otherwise known as Chronic Obstructive Pulmonary Disease, or COPD, the disease starts with shortness of breath and coughing and over time can lead to disability and death.

It is a major focus of the Thoracic Society of Australia and New Zealand annual scientific meeting, which began in Melbourne. Conference chairman, associate professor Paul Reynolds said COPD may affect up to 20 per cent of the population but the real extent was still being defined as many cases remained undiagnosed.

The disease is largely caused by cigarette smoking. Mr Reynolds said the symptoms of COPD were often unrecognised,

or simply attributed to "normal ageing". "Patients experiencing shortness of breath are encouraged to see their doctor for assessment," he said in a statement. "Cessation of smoking remains of paramount importance but there have also been genuine improvements in therapy that can improve quality of life and survival for COPD sufferers. Previously held views that smoking-related lung disease is completely irreversible are not valid.

"On a similarly positive note, the reduction in smoking rates that has been achieved in recent years is being reflected in data showing that COPD prevalence in men is starting to drop." But he said smoking rates among young people were a concern.

Medical and scientific representatives from around the world have gathered in Melbourne for the meeting, which will focus on advances in the diagnosis and treatment of respiratory diseases that affect millions of people. <http://tinyurl.com/5t3q7q>



OXYGEN SAFETY AT HOME

Oxygen can be used safely at home.

These are the rules for oxygen safety:

Oxygen therapy

- Oxygen is a drug. Too much or too little oxygen may be harmful.
- Use the amount ordered by your doctor. Do not change the amount of oxygen you are using without first checking with your doctor. If you feel you are not getting enough oxygen, talk to your doctor.

Fire safety

Oxygen itself does not burn. Oxygen can feed a spark and cause it to become a large fire in seconds. Follow these rules to prevent a fire:

- No smoking Do not allow anyone to smoke in the room where oxygen is being used. Your oxygen home care company will provide No Smoking signs to hang in your home.
- Avoid open flames Do not use oxygen within 10 feet of open flames such as fireplaces, wood-burning stoves and gas stoves.
- Using electrical equipment Do not use equipment with frayed cords or electrical shorts. They could cause a spark. Avoid using electric razors and hair dryers while using oxygen. Battery operated (less than 10 volts) razors and hair dryers can be used. Do not use an appliance with a control box such as a heating pad. Control boxes may throw sparks

Avoid static electricity

- Avoid nylon or woolen clothing because it is more likely to cause static electricity. Use a humidifier in winter to add moisture to dry air in your home.

Proper storage and handling of oxygen

- Store liquid and cylinder oxygen away from heat and direct sunlight.
- Secure cylinders with chain as arranged by your home care therapist.
- Place cylinders in a secure holder, in an upright position.

- Never apply any oily substance, such as petroleum based lip products, Vaseline, Blistex or Chapstick, to your nose, lips or the lower part of your face. |

Talk to your doctor or others on your health care team if you have questions. You may request more written information from the Library for Health Information at (614) 293-3707 or email: health-info@osu.edu.



MAYO CLINIC PROCEEDINGS EXAMINES LINK BETWEEN BACTERIA IN THE DIGESTIVE SYSTEM AND OBESITY

Obesity is more than a cosmetic concern because it increases a person's risk for developing high blood pressure, diabetes and many other serious health problems. It's well understood that consuming more calories than you expend through exercise and daily activities causes weight gain. But with about one in every three American adults now considered obese, researchers are attempting to identify additional factors that affect a person's tendency to gain and retain excess weight. In the April issue of Mayo Clinic Proceedings, researchers from Mayo Clinic Arizona and Arizona State University examine the role that bacteria in the human gastrointestinal tract play in regulating weight and the development of obesity.

Known as gut microbiota, the trillions of bacteria that populate the human gastrointestinal tract perform a variety of chores. These "friendly" microbes help extract calories from what we eat, help store these calories for later use, and provide energy and nutrients for the production of new bacteria to continue this work.

According to John DiBaise, M.D., a Mayo Clinic Arizona gastroenterologist and lead author of the Mayo Clinic Proceedings article, several animal studies suggest that gut microbiota are involved in regulating weight and that modifying these bacteria could one day be a treatment option for obesity.

One study cited by the authors observed that young, conventionally-reared mice have a significantly higher body fat content than a laboratory-bred, germ-free strain of mice that lack these bacteria, even though they consumed less food than their germ-free counterparts. When the same research group transplanted gut microbiota from normal mice into germ-free mice, the germ-free mice experienced a 60 percent increase in body fat within two weeks, without any increase in food consumption or obvious differences in energy expenditure.

Another animal study reviewed by the authors focused on the gene content of the gut microbiota in mice. Finding more end products of fermentation and fewer calories in the feces of obese mice led researchers to speculate that the gut microbiota in the obese mice help extract additional calories from ingested food.

"These results suggest that differences exist in the gut microbiota of obese versus lean mice, raising the possibility that the manipulation of gut microbiota could be a useful strategy for regulating energy balance in obese people," says Dr. DiBaise.

Although information on the link between gut microbiota and obesity in human subjects is more limited, the authors present some evidence supporting this connection. One study cited placed 12 obese participants in a weight-loss program for a year, randomly assigning them to either a fat-restricted or

carbohydrate-restricted, low-calorie diet. Researchers noted distinct differences between lean and obese participants when they monitored the type and number of bacteria found in participants' stool samples before and after the diet changes.

Another study cited followed children from birth to age 7 and analyzed stool samples collected at 6 and 12 months. The children who were normal weight at age 7 had distinctly different bacteria in their samples from those collected from overweight-obese children, suggesting that differences in the composition of the gut microbiota precede overweight-obesity.

Dr. DiBaise says that much more research is needed to clarify a number of issues related to the relationship between the gut microbiota and obesity. Future studies need to establish whether the small changes in caloric extraction seen in recent studies can produce measurable weight differences in humans.

Second, researchers need to prove or disprove the possible relationship between the gut microbiota and the regulation of weight. "In particular, it is essential to demonstrate unequivocally whether differences in gut microbiota in obese versus lean people are the cause or the result of obesity," says Dr. DiBaise.

Finally, the authors note that the next wave of research should explore the safety and feasibility of modifying the gut microbiota in clinical trials involving humans. "Although clearly no substitute for proper diet and exercise, manipulation of the gut microbiota may represent a novel approach for treating obesity that has few adverse effects," says Dr.

DiBaise. Source: www.mayoclinic.org/news.



THE INTERNET GIVES PATIENTS CONTROL OVER THEIR DOCTORS

It used to be that no profession carried as much prestige as medicine. White coats conferred instant authority. The doctor-patient interaction was one-way: physicians diagnosed and patients nodded. "Doctor's orders" was sufficient explanation as to why you were assigned this drug or that therapy.

There's been a revolution in how we relate to doctors. Patients are no longer passive subjects but health care consumers. Doctors have been demoted from healers to "providers." I have one friend who didn't like the specialist assigned to a family member, so, as he put it, he "fired" the doctor (by insisting the hospital find another one).

In old TV shows, physicians exuded the aristocratic nonchalance of social elites. But go into any hospital and you'll find an environment about as glamorous as an understaffed restaurant kitchen. The debate over waiting times reinforces the notion that health care is just another service industry.

Surveys show that stressed-out doctors feel that the rewards no longer match the sacrifices. No longer granted automatic deference, doctors today go to dinner parties and get berated by angry strangers who have had bad experiences with the health care system.

(I sympathize. Journalists also get an earful at dinner parties: some nights we're attacked for being puppets of the right-wing corporate establishment and other nights for being liberal muckrakers. You can't win.)

A doctor's status was traditionally a function of having an impressive education. In today's knowledge economy, however, people in many other industries also have eight, 10, 12 years of post-secondary training.

Electrical engineers have law degrees and MBAs; financial executives have doctorates in mathematics and economics. A generation ago, medical doctors were the most educated people in the room. Not any more.

Then there is the democratization of medical knowledge. My favourite analogy is that of the clergy. Back in the days of mass illiteracy, priests were the exclusive custodians of holy texts and hence wielded huge influence. As literacy spread, lay people could access those texts themselves and challenge the clergy's interpretations -- and consequently the clergy lost power and status.

In the Internet age, ordinary people can inform themselves about virtually any health issue. Of course, a bank manager or high school teacher who is diagnosed with colon cancer isn't going to become an expert on the disease overnight, but he or she could learn enough, in short order, to ask the surgeon useful questions.

If I were diagnosed with cancer on a Friday, you can bet that by Monday I'd know what my options were and the risks associated with them; what new surgical procedures were being developed; what drug trials were taking place, and where; what institutions had the best reputations for treating the illness.

In the old days, civilians did not have easy access to such information. The spread of health literacy has eroded the power imbalance in the patient-doctor relationship.

Now it could be that the professions generally are all suffering status anxiety. Just as the Internet allows Joe Sixpack to double check the advice of his doctors, thereby annoying the doctors, it also allows him to set up a website and call himself a pundit, thereby annoying some journalists who do punditry for a living. And don't get lawyers started on how undervalued they believe themselves to be.

Yet lawyers and journalists, with the exception of famous ones like Clarence Darrow or Walter Cronkite, never enjoyed the infallibility that was routinely granted to ordinary doctors.

Even "leading" doctors are far from omnipotent. Patients who understand this are better positioned to advocate for themselves and obtain better outcomes.

Still, older physicians will confess they're sometimes nostalgic for the days when they didn't have pushy patients brandishing articles from online medical journals. Some younger physicians are bitter that they entered the profession after the era when identifying yourself as "doctor" could guarantee a table at top restaurants or buy your way out of a traffic ticket.

The best doctors are those who never wanted the burden of infallibility in the first place. Good doctors try to connect in a human way with every patient, and they know this is hard to do when they are constrained to the isolating and ultimately dangerous role of high priest. Source: The Vancouver Sun 2008



HEPARIN PROBE SHOWS GLOBAL DRUG MARKET**PERILS*****Contaminated blood thinner raises fears about offshore production***

On a dusty lane in east China, a small factory sitting amid strawberry and vegetable fields processes chemicals from pig guts into heparin, a commonly used blood thinner linked to 62 deaths and hundreds of allergic reactions in the U.S. and Germany.

The mysterious problems with heparin from the factory and others like it — China's deadliest product quality scandal since Chinese cough syrup killed 93 people in Central America a year ago — dramatically illustrate the perils of shifting drug production offshore.

With recalls of heparin products now in six countries, it is an issue that regulators are scrambling to address. In the past two weeks, China's drug safety agency ordered tighter controls on heparin production. That followed a U.S. Food and Drug Administration order requiring all heparin imports to be tested. The FDA also announced plans to station eight regulators in China and hire five Chinese to work with them.

"This is just the tip of the iceberg in terms of problems with sensitive drugs," said Dr. Bryan Liang, an adviser to the Partnership for Safe Medicines, an American group working to promote drug safety. "The problem is only going to get worse as more materials come from suspect sources."

Widespread recall

About 40 percent of pharmaceuticals and 80 percent of the chemical ingredients in drugs are imported, according to U.S. government statistics. A growing share comes from developing countries such as China, India and Mexico that are still building their own drug safety systems.

Heparin is derived from mucous wrung and washed from pig intestines and other animal organs. It has been used for decades to prevent clotting from intravenous procedures, dialysis and heart surgery.

The recent problems were traced to heparin made in China and sold overseas by two western companies among the dozens that market the drug.

So far, China has reported no allergic reactions to heparin used locally.

The U.S. FDA announced Tuesday it had found 62 deaths and nearly 800 severe allergic reactions associated with heparin.

The first reports of such deaths were linked to products sold by Deerfield, Illinois-based Baxter International Inc., the biggest heparin seller in the U.S. But the most recent figures also included patients treated with other brands of heparin.

Baxter recalled nearly all its U.S. heparin injections, as have several other companies.

German manufacturer RotexMedica GmbH recalled batches of heparin from China after some 80 reports of allergic reactions, but no deaths.

Danish, French and Italian authorities are recalling batches of potentially contaminated heparin from China as a precaution, the European Medicines Agency said last month.

Three Japanese drug companies and a U.S. manufacturer, B. Braun Medical Inc., also recalled heparin products from Baxter's supplier, Waukegan, Wis.-based Scientific Protein Laboratories, which owns the factory sitting among farm fields outside of Changzhou, a sprawling industrial city west of Shanghai.

The FDA says a contaminant, identified as "oversulfated chondroitin sulfate," accounted for up to half of the active ingredient in some batches of heparin from the factory, known as Changzhou SPL. It has yet to confirm, though, whether the contaminant caused the allergic reactions.

'Globalized supply chain'

Chondroitin sulfate, usually made of animal or shark cartilage, is used as a food supplement for joint pain. It is more than seven times cheaper than heparin, which might tempt suppliers somewhere along the production chain to substitute it. And its chemical similarity to heparin makes it hard to spot, the FDA said.

Heparin was first made in North America and Europe, but production has shifted to lower-cost developing countries over the past 20 years.

The raw chemicals, or active pharmaceutical ingredients, used to make it and many other drugs are now mostly imported from China and India.

"We have an increasingly globalized supply chain," said James Shen, publisher of the industry newsletter Pharma China. "The Chinese are now major suppliers of bulk pharmaceuticals and also supply intermediate chemicals for drugs. It is likely we will continue to see the same problems with other drugs," he added.

The U.S. FDA inspects only about 7 percent of foreign drug makers each year; it failed to inspect Changzhou SPL because of what it says was a language mistake.

The raw chemicals for the drug are usually made in small, unregulated workshops, using pig guts from slaughterhouses and sausage-casing factories, processed by chemical companies and eventually drug makers before being delivered to hospitals.

"The supply chain that was used to make the materials is impossible to follow," said Liang, of the Partnership for Safe Medicines in Virginia. "Add to that, Chinese manufacturers are not averse to cutting corners, as we've seen in toys, toothpaste, food and drugs."

Importers beware

When FDA experts belatedly inspected Changzhou SPL last month, they found scratched tanks with "unidentified material" sticking to their insides. Records were missing for some of its sources of raw heparin, and testing was incomplete.

"We are a company with high standards. We have nothing more to say to you!" shouted a manager at Changzhou SPL who answered the phone but refused to give his name. "We have never had chondroitin sulfate on our production list. Just see the official announcements," he said before slamming the phone down.

A Scientific Protein Laboratories statement emphasized that FDA findings suggest the chondroitin sulfate was in the affected heparin before it reached Changzhou SPL.

"The observations made by the FDA during its inspection do

not indicate any fundamental or underlying problems with the Changzhou SPL facility," the statement said, quoting industry consultant Robert Rhoades speaking on SPL's behalf.

Importers beware is the principle governing all international trade in drugs and pharmaceutical chemicals, said Shen, of Pharma China.

"For exports, (China) doesn't regulate anything at all. There is no export licensing system in place," he said, noting that such chemicals are generally unregulated. "The U.S. FDA doesn't regulate those exports from the U.S. either."

FDA officials say a U.S.-China agreement on improving cooperation in drug safety, signed in December, has helped the heparin investigation, though heparin was not on the original list of drugs covered by the pact.

Even with inspections, heparin is tricky, said Liu Jian, an expert on the chemical at the University of North Carolina.

"In producing heparin, it's very important to control the quality of the raw heparin," Liu said. "Once you have a contaminant that you didn't get rid of in the early stages, it's very hard to tell what you have there."

<http://tinyurl.com/3pbdgs>



SCIENCE WISHY-WASHY ON HEALTH BENEFITS OF WATER

8 glasses a day? Appetite suppressant? The myths that have us guzzling

There is no clear-cut scientific rationale for the average healthy individual to drink eight glasses of water or more a day — and it may be downright harmful for some — according to two kidney experts.

Drinking a lot of water is claimed to be helpful for everything from clearing toxins and keeping organs in tip-top shape to keeping weight off and improving skin tone. At best, however, the evidence to back up these claims is weak, according to a new scientific review published in the Journal of the American Society of Nephrology.

"There is what I call an urban myth that drinking a lot of water is a healthy thing to do and it leads to people toting around plastic water bottles all day drinking water," said Dr. Stanley Goldfarb, of the University of Pennsylvania, Philadelphia.

"The source of this is the complementary and alternative medicine worlds. If you go on the Internet and look up water-drinking and its health implications, that's what you encounter," Goldfarb said.

As a kidney specialist, Goldfarb is interested in how the kidney handles fluids, which prompted him and colleague Dr. Dan Negoianu to review the scientific literature on the benefits of drinking water. In doing so, the researchers debunked four myths.

Myth No. 1:

One is that drinking a lot of water suppresses appetite. "Many people drink water before and during the meal to try to suppress their appetite," Goldfarb explained, yet there is "no consistent evidence" that water suppresses appetite. "Because you absorb water so quickly and it moves through the GI tract

so quickly, it probably doesn't fill you up the way people have proposed, nor does it lead to the release of hormones which suppress appetite as far as we know," the researcher said.

Myth No. 2:

The second myth is that filling up on water flushes toxins from the body. "In fact, that is not how the kidney works," Goldfarb said. "When you drink a lot of water you end up having a larger volume of urine but don't necessarily increase the excretion of various constituents of the urine."

Myth No. 3:

The third myth is that it reduces headaches. It does not, according to the evidence.

Myth No. 4:

The fourth myth is that water drinking improves your skin. "There are no data to suggest that it actually improves the water content of the skin," Goldfarb said.

Goldfarb and Negoianu did find solid evidence that people living in hot, dry climates, as well as some athletes, have an increased need for water, and people with certain diseases like kidney stones may benefit from increased water intake — but no such data exist for average, healthy individuals.

Furthermore, there are a couple of circumstances where drinking a lot of water may be actually unhealthy. "In long-distance runners, for example, more harm is done by long distance runners over-drinking during races than by long distance runners who under-drink," Goldfarb explained.

He also cited the case of a woman who developed swelling of the brain and died when she drank water continuously and very rapidly for several minutes as part of a contest.

Goldfarb also said there is no rational basis for the widespread belief that people need to drink eight glasses of water a day, and it is unclear where this recommendation came from.

<http://www.msnbc.msn.com/id/23921635/>



AVOID ALLERGENS TO REAP THE REWARDS OF GARDENING

The beauty of budding plants and bouquet of aromas are sources of satisfaction for many gardeners. For allergy sufferers, though, gardening can be as much a chore as pursuit of passion.

Pollen from trees, shrub and grasses can cause an onslaught of allergy symptoms, including sneezing, itchy eyes, congestion and in some cases, an asthma attack.

But sensitive people can take a few simple steps to minimize their risk of exposure to bothersome allergens, according to the American Academy of Allergy, Asthma & Immunology (AAAAI).

"Gardening outside during times of high pollen counts puts patients at risk for severe allergic symptoms," said Warren Filley, MD, FAAAAI, an Oklahoma City allergist/immunologist and a long-time horticulturalist who suffers from allergies. "Avoidance measures, as well as the use of medications and allergy immunotherapy, can make the difference between having fun in the garden and being miserable."

An allergist/immunologist can help determine what plant species are causing an allergic reaction and advise on the best times of day or season to work in the garden. For example,

pollen levels are typically lower on rainy, cloudy and windless days. Immunotherapy (allergy shots), medications and other treatments can also help reduce symptoms.

People with allergies can also trim irritation by carefully choosing the plants they include in their landscaping or garden.

Certain flowers, trees and grasses are naturally better suited for the gardens of allergic people. They are less likely to produce bothersome pollen and will still add color and variety to the garden.

These include: - Cacti - Cherry - Dahlia - Daisy - Iris - Magnolia - Rose - Snapdragon - Tulip - Geranium

In general, highly-allergenic plants to avoid include:

Ash - Cedar - Cottonwood - Oak - Maple - Pine - Saltgrass - Timothy

The best way to determine which plants will trigger reactions is through skin testing at an allergist/immunologist's office. An allergist/immunologist can help patients develop strategies to avoid troublesome plants and pollen and can prescribe medication to alleviate symptoms.

Other tips to consider

Whenever working around plants likely to cause an allergic reaction, avoid touching your eyes or face. You may also consider wearing a mask to reduce the amount of pollen spores that you breathe in. Wear gloves and long sleeves and pants to minimize skin contact with allergens. Leave gardening tools and clothing - such as gloves and shoes - outside to avoid bringing allergens indoors. Shower immediately after gardening or doing other yard work.

Consult with an allergist/immunologist

Contact an allergist/immunologist to identify specific causes of allergic reactions or to get information on treatment options and tips to reduce allergen exposure. An allergist/immunologist is the best qualified medical professional to manage the prevention, diagnosis and treatment of allergies and asthma. To find an allergist/immunologist near you, visit the AAAAI Web site at www.aaaai.org.

The AAAAI represents allergists, asthma specialists, clinical immunologists, allied health professionals and others with a special interest in the research and treatment of allergic disease. Allergy/immunology specialists are pediatric or internal medicine physicians who have elected an additional two years of training to become specialized in the treatment of asthma, allergy and immunologic disease. Established in 1943, the AAAAI has more than 6,500 members in the United States, Canada and 60 other countries. <http://tinyurl.com/3w63qq>



NATURAL TRANS FATS HAVE HEALTH BENEFITS, UNIVERSITY OF ALBERTA STUDY SHOWS

Contrary to popular opinion, not all trans fats are bad for you.

University of Alberta researcher Flora Wang found that a diet with enriched levels of trans vaccenic acid (VA) – a natural animal fat found in dairy and beef products – can reduce risk factors associated with heart disease, diabetes and obesity

Results indicated this benefit was due in part to the ability of VA to reduce the production of chylomicrons – particles of fat and cholesterol that form in the small intestine following a meal and are rapidly processed throughout the body. The role of chylomicrons is increasingly viewed as a critical missing link in the understanding of conditions arising from metabolic disorders.

“Our results provide further evidence of the important role of chylomicrons in contributing to risk factors associated with metabolic disorders,” said Wang, a PhD candidate in the University of Alberta Faculty of Agricultural, Life and Environmental Sciences. “They also indicate a strong opportunity for using diets with enhanced VA to help reduce these risk factors.”

The research involved two VA feeding trials – one short-term (three weeks) and one long-term (16 weeks).

The results, presented recently at the International Symposium on Chylomicrons in Disease, included novel findings that VA may have direct effects on the intestine. In addition, they showed key metabolic risk factors were reduced. For example, in the long-term trial, total cholesterol was lowered by approximately 30 per cent, LDL cholesterol was lowered by 25 per cent and triglyceride levels were lowered by more than 50 per cent.

Because VA is the major natural trans fat in dairy and beef products, comprising more than 70 per cent of the proportion of natural trans fat content in those products, the findings support a growing body of evidence that indicates natural animal-based trans fat is different than harmful hydrogenated trans fat. “As the VA results illustrate, some natural trans fats are not harmful and may in fact be very good for you,” she said.

<http://tinyurl.com/3bh9q5>



12 QUICK TIPS FOR A LONGER, HEALTHIER LIFE

Start the day with tea, drink red wine and get the right amount of sleep

1. Tea off in the morning

Hot tea can slash your risk of kidney cancer by 15 percent, according to a review in the International Journal of Cancer. Try pu-erh tea, which is better than green or black tea at preventing DNA damage.

2. Sleep smarter

Too much sleep, or not enough of it, can kill you. A British study found that getting more than 9 hours of sack time a night, or less than 6, doubles your risk of an early death from any cause. Aim for 7 to 8 hours a night.

3. Pop in your lenses post-shower

Soaping up while wearing your contacts can expose your eyes to infection-causing waterborne microbes, say University of Illinois at Chicago researchers.

4. Drink wine, stay lean

Polyphenols, the compounds found in red wine, help your body block fat absorption, an Israeli study found. Red-wine marinades work, too.

5. Lose the lint

Taking 2 seconds to empty the lint trap in your clothes dryer can prevent you from being one of the 315 dryer-fire victims each

year in the United States.

6. Check your neck

An American Journal of Medicine study found that a mildly underactive thyroid can boost your heart-disease risk by 65 percent. A quick blood test can assess your level of thyroid-stimulating hormone (TSH).

7. Lean back

Parking your torso at a 90-degree angle strains your spine, say Scottish and Canadian researchers. Instead, give your chair the La-Z-Boy treatment and recline the seat back slightly. The ideal angle is 45 degrees off vertical.

8. Scent your air safely

Some air fresheners contain phthalates, compounds that may disrupt hormone processes, Natural Resources Defense Council testing reveals. Stick with Febreze Air Effects and Renuzit Subtle Effects.

9. Boost your defenses

An Archives of Internal Medicine review reports that 400 IU of vitamin D a day reduces your risk of an early death by 7 percent.

10. Skip the spray

Using household spray cleaners just once a week increases your risk of an asthma attack by 76 percent, say Spanish researchers. Use wipes instead.

11. Steam your broccoli

Italian researchers recently discovered that steaming broccoli increases its concentration of glucosinolates (compounds found to fight cancer) by 30 percent. Boiling actually lowers the levels.

12. Stretch it out

Genes in your body linked to heart disease, diabetes, and obesity can be "turned on" if you sit for hours on end, reports a study in Diabetes. Hit the "off" button by taking hourly laps during TV, book, and Web sessions.

URL: <http://www.msnbc.msn.com/id/23727899/>



MENOPAUSE -- A CHANGE IN HEART HEALTH

Hot flashes and mood swings get most of the attention, but the health effects of menopause go right to the heart.

Prior to menopause, sex hormones help boost women's cardiovascular system. Estrogen and progesterone are thought to keep arteries healthy, helping lowering the risk of high blood pressure and related. But menopause marks the end of these heart-helpful hormones. And researchers are now asking whether "The jury is still out on this," says Dr. Sandra Davidge, the Canada Research Chair in Women's Cardiovascular Health at the University of Alberta. "This question still requires a lot of investigation, but what we're seeing is that the timing of the hormone replacement is probably critical to any potential cardiovascular benefits."

The benefits of HRT were very publicly called into question in 2002 with the release of the Women's Health Initiative study. The study, which made front-page news, reported that women on HRT actually had an increased rate of heart disease.

The results, says Davidge, pushed researchers to take a

harder look at the timing of HRT. She notes that the heart and blood vessels have specific receptors, or contact sites, for the sex hormone molecules that are lost with menopause. Many of those in the Women's Health Initiative study received HRT years, or even decades, after menopause.

"In many of these cases, the estrogen was probably given too late," Davidge says. "If you give estrogen to aged blood vessels it might not be protective and it might have detrimental effects. But if you give it to women at the onset of menopause it probably has benefits."

That's the conclusion of research, funded by the Canadian Institutes of Health Research, in Davidge's lab on the role of estrogen in maintaining blood vessel health in animal models of menopause.

"We've found in our lab that estrogen acts as a powerful antioxidant and also suppresses some of the proteins that cause inflammation, thereby having a positive effect on the arteries," she says.

This raises the possibility that HRT might be effective in extending cardiovascular health if it's given at the onset of menopause, before the blood vessels have deteriorated.

Dr. Davidge notes that her lab results with aged rats need to be confirmed in menopausal women. That's currently being explored in the United States with a large-scale HRT trial called the Kronos Early Estrogen Prevention Study (KEEPS). (

For now, Dr. Davidge says the best thing for women's long-term heart health is to buffer the drop in sex hormones by improving their overall cardiovascular health as they enter menopause.

If you start menopause with a healthy cardiovascular system through exercise and diet, you're in a much better condition to handle the heart effects of losing ovarian hormones," she says.

<http://tinyurl.com/6zapra>



SPEAK UP!

How to talk to your doctor about absolutely anything & everything

Does your doctor really know you? It's not an idle question. Many people are not comfortable speaking candidly to their health-care providers, often because sharing personal health information or concerns makes them feel vulnerable, embarrassed or intimidated. But this reluctance to speak up creates the potential for health-care disasters. "As physicians, we are here to provide help in any way we can, so we need to know what's on your mind," says Rosemary Browne, M.D., assistant professor of clinical medicine at the University of Arizona, Tucson. "But we can't read your mind. The more forthright and direct you are, the more we can help."

Given the importance of doctor-patient communication, if you're not able to talk to your doctor as freely as you'd like, it may be a sign that it's time to find a new one. But if you simply need help breaking the ice, read on. We offer some practical advice on how to bring up tough-to-talk-about topics at your next appointment.

States of Mind

When it comes to depression, anxiety, and other mood

issues, there's often a **DON'T-ASK-DON'T-TELL** dynamic in the doctor's office. It shouldn't be that way. After all, mood disorders are incredibly common, and your emotional health can have a profound effect on your entire life, including your physical health. To get a discussion rolling, you might say, "I'm so stressed out that it's really interfering with my life" or "I've had a real change in mood recently, and I'm starting to wonder if I'm depressed or anxious." The key points to bring up: how your mood is affecting your life, your ability to function and your eating and sleeping habits; how long you've been experiencing these changes; what helps or worsens your state of mind; and whether you have a family history of mood disorders. It's also important to mention your concerns about treatment. "Some people are worried about the possibility of taking medications for life because they see it as a sign of weakness," says Davis Liu, M.D., a board-certified family physician in Sacramento and the author of *Stay Healthy, Live Longer, Spend Wisely: Making Intelligent Choices in America's Healthcare System*. If you feel this way, tell your doctor so he or she can take it into account when recommending therapy and/or drug treatment.

Salute!

Have you ever fudged the truth when your doctor asked how much you drank? If you're like many people, the answer to that question is yes. Around 30 percent of people in the United States will abuse alcohol or become dependent on it at some point in their lives, and only 24 percent of those people will get treated. A 2004 WebMD survey of 1,500 people found that 24 percent of men and 15 percent of women lie to their physicians about how much they drink, primarily because they don't want to be judged or because the truth is just too embarrassing. "Substance abuse is hard to find out about, because people hide it or are in denial about it," notes Dr. Liu. "They don't see it as a problem until they get into legal trouble or their spouse drags them in." If you're flirting with a drinking or drug problem—or wondering if you might be—it's something you should bring up with a doctor. You may take a direct approach by saying, "I'm having problems with alcohol." Or you could bring it up indirectly by saying, "Alcoholism runs in my family, and I'm worried about this." By bringing it up, you give yourself the chance to get help if you need it or to revisit the issue at a later date if the problem worsens. You also alert your doctor to possible drug and alcohol interactions—for example, regular acetaminophen use combined with heavy alcohol consumption can harm the liver.

Bedroom Business

Your inclination may be to keep the doctor outside your bedroom door. But many sexual problems, from loss of libido to difficulty with arousal to trouble achieving orgasm, can be tied to a medical problem, so it's smart to bring them to a doctor's attention. Sometimes, all it takes to get the conversation started is an opening line like "I'm having difficulty with my sex life" or "Is it normal as we get older to have less of a sex drive?" Be prepared to discuss how long you've had the problem, how often it occurs, what (if anything) has helped and what hasn't, as well as any systemic

illnesses you might have. Diabetes, vascular diseases, sleep apnea, menopause and many other chronic conditions—as well as medications used to treat them—can affect your sex life. "Often things are connected in ways that people might not know," Dr. Browne says. Still reluctant? Focus on the rewards: Having a candid discussion with your doctor can help you take crucial steps toward restoring your sexual health.

Keeping Secrets?

According to a WebMD survey, 38 percent of patients lie about following their doctor's orders. Bad idea, says Sacramento-based Dr. Liu: "If we think someone's taking a medicine and they're not, we may conclude their illness is getting worse, and order unnecessary tests or prescribe a stronger medication, and that increases the risk of complications." But if you explain that you're not taking a med because it's too expensive, you can't stand the side effects, you don't understand how to take it or you keep forgetting to take it, the doctor may find a more agreeable alternative. <http://tinyurl.com/3ohbds>



TOO MUCH SALT? FDA CONSIDERS LIMITS

While the FDA considers limiting sodium, it's up to you to curb your craving

A pinch here, a dash there, could salt really be so bad? Actually, sodium is shaking out to be the next diet villain. The average American consumes 50 percent more sodium — as much as one and a half teaspoons of salt — than the maximum recommendation.

Our diets have become so loaded with salt that, in response to a consumer group's urging, the Food and Drug Administration is considering whether to set limits on the amount that would be permitted in different types of foods, such as breads.

The American Heart Association and other medical experts want stronger labels on foods with high-salt content and are calling for a 50 percent reduction in the amount of salt in packaged and processed foods. Cutting our sodium intake by half would prevent 150,000 deaths from cardiovascular disease each year, according to estimates from the National Heart, Lung, and Blood Institute.

It could be at least a year before the FDA decides whether to restrict salt in foods. In the meantime, a few major food marketers, including Campbell Soup Co., General Mills, and ConAgra, which makes Banquet and Chef Boyardee products have rolled out some low-sodium products.

Still, more needs to be done to cut the amount of salt we consume each day. And that's not as simple as skipping the table salt. More than three-quarters of the salt in our diets comes from packaged, processed and restaurant foods.

We need some, but not so much

Everyone needs some sodium. The mineral works with chloride and potassium to maintain fluid balance in the body. It also helps regulate blood pressure, transmits nerve impulses, and helps muscles, including the heart, contract and relax.

But for some, a high-sodium diet can contribute to the development of high blood pressure. An estimated 30 percent of Americans over the age of 20 have hypertension or take blood pressure lowering medication. Rates are also increasing in

children. Between 1988 and 2002, hypertension in children increased from 7.7 percent to 10 percent.

A variety of studies support lowering salt to reduce blood pressure. A recent long-term, follow-up study found that those with prehypertension, or early-stage high blood pressure, who participated in a lifestyle intervention program that included sodium reduction of 25 percent to 30 percent lowered their risk of several cardiovascular problems by 25 percent. They also reduced their risk of death by 20 percent up to 15 years after the trial.

Deprogram your craving

We learn to crave salt, although studies suggest we can learn to prefer less in just a few months. If you try to cut back on heavily salted items, you'll also likely end up eating a more nutritious diet because sodium often lurks in foods that are high in calories or fat and sugar.

It can be challenge to stick to a lower sodium diet, but you may discover you actually like it.

A recent study in the Journal of the American Dietetic Association showed that people with prehypertension who followed a diet rich in fruits, vegetables, and low-fat dairy foods with three different levels of sodium for 30 days found they liked diets that provided either 2,300 mg or 1,200 mg of sodium as much as or better than the diet with the most sodium — 3,500 mg, an amount similar to what most Americans consume daily. Subjects who followed the lower sodium diets were as likely (if not more likely) to continue with the diets as those who consumed the high-sodium diet.

How to slash the salt in your diet:

Load up on potassium-rich fruits and vegetables. Potassium can lessen the adverse effect of sodium on blood pressure. Sweet potatoes, white potatoes, winter squash, spinach, bananas, cantaloupe, honeydew, lentils, plantains, kidney beans, split peas, soybeans, and lima beans are all good sources. Some foods like breads and cereals may not taste salty, but can be packed with sodium. Look for sodium free (less than 5 mg sodium per serving), very low-sodium (35 milligrams or less per serving), or low-sodium (140 milligrams or less per serving) products. Labels promising "reduced sodium" or "unsalted" foods may still contain more than you need. Salt can be listed by other names, such as baking soda, baking powder, disodium phosphate, or any compound with sodium or Na in its name, so check food labels. An entire meal should contain no more than 600 mg of sodium. Instead of seasoning with salt, try pepper, herbs and spices, lemon, lemon juice, chives, dill, cider vinegar, parsley, garlic, onion, paprika, rosemary, cinnamon and salt-free seasoning blends. When dining out, share entrées, order small portions, and ask for dishes prepared without salt. Ask for no sauce or have it on the side and use sparingly. If you take any prescription or over the counter medications, check if they contain any sodium.

If you must have salt, add it after cooking since the stronger taste of cooked food will help you use less.

<http://www.msnbc.msn.com/id/23694159>



IS YOUR PANTRY SUFFERING FROM STICKER SHOCK?

Prices for food staples such as wheat, eggs, milk and rice have increased substantially in the last year, leaving many to wonder how to affordably plan their next shopping trip. If you or a loved one has diabetes, you know the importance of stocking a well-balanced pantry and eating healthy foods to maintain good diabetes control.

So how do you plan healthy menus for you and your family without breaking the bank? According to the American Diabetes Association (ADA), it is a common misconception that a healthy diabetes meal plan must be costly and consist of high-priced specialty foods.

"Eating well and spending less are not mutually exclusive," commented Ann Albright, PhD, President, Health Care & Education, American Diabetes Association. "In fact, healthier foods can actually save you money by reducing portion sizes and buying fewer high-calorie, high-priced foods."

The ADA offers these tips to save money and help cost-conscious consumers navigate the grocery store shelves:

- Boneless cuts are often better buys, since you are not paying for the weight of the bone. Think of cost per edible serving rather than cost per pound. Turkey has 46% edible meat per pound, while chicken has 41%.
- There is no nutritional difference between brown and white eggs. Choose white eggs since they cost less.
- Vegetables frozen in butter sauce cost twice as much as plain frozen vegetables ? and they have more calories.
- Instead of buying small containers of yogurt, buy a quart and separate it into 1-cup servings yourself.
- Avoid individually packaged snacks. Reap significant savings with a do-it-yourself approach.
- Price fruits with an eye on the cost per edible serving. If you are paying by the pound, you will be paying for the inedible seeds and rinds.
- If fresh fruit is too expensive, buy frozen or canned fruit packed in water. If you buy fruit canned in syrup, rinse it before eating.
- Use nonfat dry milk for drinking, cooking and baking. It is inexpensive and has a long shelf life.
- Make your own cooking spray by putting vegetable oil in a spray bottle.
- Cook your own hot cereal to save money. Regular or quick-cooking oats are much less expensive than instant oats.
- Dry beans triple in volume when they are soaked and cooked. A 1-pound bag will make six 1-cup servings.
- When buying fresh greens by weight, be sure to shake off the excess water before you put them in your cart. It is amazing how much water can be hidden in between the leaves.
- The costs of special "dietetic or diabetic" foods are high and not necessary.

For more tips and recipes, visit the American Diabetes

Association website

www.diabetes.org.



The following recipe can help make the most of precious

resources: health, wealth, and time.

Grilled Asian Pork Kabobs Cost per serving \$0.98

Kabobs can be assembled ahead and refrigerated until cooking time. Serve grilled kabobs with hot brown rice.

Sauce:

2 Tbsp reduced-sodium soy sauce

1/4 cup ketchup

2 Tbsp packed brown sugar

1/4 tsp garlic powder

2 Tbsp cold water

Kabobs:

4 8-inch bamboo skewers, soaked in water for 30 minutes

8 oz raw lean pork, cut into eight 1 1/2 inch cubes

4 pineapple rings canned in juice, each cut into 4 equal-size pieces

1 small red onion (approximately 3 oz), cut into 4 pieces

4 cherry tomatoes (or 1 small tomato cut into 4 pieces)

4 mushrooms

1. Preheat grill to medium heat.
2. In a small bowl, whisk together sauce ingredients. Set aside.
3. Push onto each skewer in the following order: 1 pork cube, 4 sliced pineapple, 1/4 onion, 1 pork cube, 1 tomato, and 1 mushroom.
4. Brush kabobs with half sauce.
5. Grill covered over medium heat for 15-20 minutes, or until pork is cooked through and no longer pink (turn kabobs to allow for even cooking); baste with remaining sauce halfway through.

Preparation time: 20 minutes **Grilling time:** 15-20 minutes

Servings: 4 (1 kabob)

Exchanges/Choices 1-1/2 carbohydrate, 1 lean meat; Calories 147, calories from fat 16; Total fat 2 g, saturated fat <1 g, trans fat 0 g; Cholesterol 30 mg; Sodium 491 mg; Carbohydrate 21 g, dietary fiber 1 g, sugars 16 g; Protein 13 g.



STATEMENT BY THE AMERICAN EGG BOARD AND EGG NUTRITION CENTER ON AJCN STUDY ON EGG CONSUMPTION

A study published in the April 2008 issue of The American Journal of Clinical Nutrition suggests an association between high egg consumption and all-cause mortality, an unusual finding for which the researchers do not provide an explanation. The researchers, Djoussé and Gaziano, analyzed data from the Physicians Health Study I which followed male physicians over a 20 year period.

The fact is, healthy adults can continue to enjoy eggs as part of a balanced diet, and the findings certainly are not strong enough to suggest that anyone change their diet. As an epidemiological study, it does not show cause-and-effect and has other inherent weaknesses. The researchers did not control for a variety of factors including intake of other foods and nutrients including saturated fat. In addition, the high egg consumers exhibited other lifestyle and dietary patterns

associated with increased health risks. In an accompanying editorial, Dr. Robert Eckel, co-chair of the Committee on Cardiovascular and Metabolic Diseases, comments that “The study suffers from the lack of detailed dietary information that may confound the interpretation, such as patterns of dietary intake of saturated fat and trans fats.” This is a significant point, given that some people who eat eggs often consume them with foods high in saturated fat.

In addition, the researchers do not comment on the level of diabetes control of the subjects. Poor diabetic control is associated with an increased risk of a number of chronic diseases that also effect mortality. Moreover, it is difficult to generalize these findings to the general population because the sample was based entirely on male physicians who may behave differently than the general population.

The most credible point in the study is that the researchers demonstrated there is no relationship between egg consumption and cardiovascular disease risk. This is consistent with a comprehensive body of research from the past 30 years which overwhelmingly shows that healthy adults can enjoy eggs without significantly impacting their risk of heart disease. The American Heart Association agrees that eggs can fit within heart-healthy guidelines when cholesterol from other sources is limited. Also, egg consumption does not significantly impact the LDL:HDL ratio – one of the best known and scientifically established indicators of heart disease risk.

Healthy adults should continue to enjoy eggs to increase their intake of a number of beneficial nutrients. One egg, including the yolk, has 13 essential vitamins and minerals, high-quality protein, healthy unsaturated fats and antioxidants, for only 70 calories.

www.incredibleegg.org



HEART-HEALTHY RECIPE

Skillet Ham Hash (To go with those eggs!)

Serves 4; 1 cup per serving

2 teaspoons olive oil

1 large green bell pepper, diced

1 large red bell pepper, diced

1 medium onion, diced

1/2 cup diced lower-sodium, low-fat ham (about 4 ounces), all visible fat discarded

3 cups frozen fat-free southern-style diced hash brown potatoes, thawed

1/2 teaspoon salt-free Cajun or Creole seasoning blend

2 tablespoons snipped fresh parsley

1/4 teaspoon salt

1/4 teaspoon pepper

In a large nonstick skillet, heat the oil over medium heat, swirling to coat the bottom. Cook the bell peppers and onion for 4 to 5 minutes, or until tender, stirring occasionally. Stir in the ham. Cook for 1 to 2 minutes, or until warmed through, stirring occasionally.

Stir in the hash browns and seasoning blend. Cook without stirring for 4 minutes, or until the bottom is golden brown. Stir (the golden-brown pieces will be redistributed). Cook without stirring for 4 minutes, or until the bottom is golden brown and the mixture is warmed through.

Stir in the parsley, salt, and pepper. Spoon onto plates.

Cook's Tip: If you can't find salt-free Cajun or Creole seasoning blend or just prefer to make your own, stir together 1 teaspoon each chile powder, onion powder, garlic powder, dried thyme, paprika, and ground cumin in a small bowl. Makes 2 tablespoons. Store in an airtight container for up to 6 months.

Nutrition Analysis (per serving)

Calories 207; Total Fat 3.5 g; Saturated, 0.5 g;
Polyunsaturated, 0.5 g; Monounsaturated, 2.0 g
Cholesterol 12 mg; Sodium 420 mg; Carbohydrates, 37 g
Fiber 5 g; Sugars 6 g; Protein 9 g

Dietary Exchange

2 starch
1 1/2 vegetable
1/2 lean meat

Healthy Soul Food Recipes, © 2007 American Heart Assoc.



Chocolate Bread (Low Sodium)

The quantities fit in a bread machine and it is sweet and tasty, almost better as a dessert than for breakfast.

1 c plus 2 T Water
3 c Bread Flour
1/2 c Sugar
1/4 c Cocoa
2/3 c Semisweet Chocolate
1 3/4 t Yeast

Place ingredients in bread machine in order specified by manufacturer. Process on white bread cycle.

Yield: 12 Servings

Recipe from Dick Logue - "Low Salt Cooking"



On the lighter side - for those of us who are laundry challenged!

SELF-CLEANING UNDERWEAR GOES WEEKS WITHOUT WASHING

Self-cleaning fabrics could revolutionize the sport apparel

industry. The technology, created by scientists working for the U.S. Air Force, has already been used to create t-shirts and underwear that can be worn hygienically for weeks without washing.

The new technology attaches nanoparticles to clothing fibers using microwaves. Then, chemicals that can repel water, oil and bacteria are directly bound to the nanoparticles. These two elements combine to create a protective coating on the fibers of the material.

This coating both kills bacteria, and forces liquids to bead and run off.

The U.S. military spent more than \$20 million to develop the fabric, deriving from research originally intended to protect soldiers from biological weapons.

Jeff Owens, one of the scientists who worked to develop the process, said, "During Desert Storm, most casualties were from bacterial infections—not accidents or friendly fire. We treated underwear for soldiers who tested them for several weeks and found they remained hygienic. They also helped clear up some skin complaints."

Science fiction writer Neal Stephenson wrote specifically about nanotech fabrics that stayed clean; he referred to "fabricules" in his 1995 novel *The Diamond Age*:

...with a quick brush, John and Gwendolyn were able to transfer most of the dirt onto their white gloves. From there it went straight into the air. Most gentlemen's and ladies' gloves nowadays were constructed of infinitesimal fabricules that knew how to eject dirt...

British news organizations pointed out that an earlier reference to the general idea of clothes that never got dirty can be found in the 1951 film "The Man in the White Suit." Sci-fi fans can console themselves with the fact that the lead role was played by Alec Guinness, who of course played Obiwan Kenobi in the original Star Wars films.

http://www.livescience.com/technology/070105_nanofabric.html



Information in this newsletter is for educational purposes only. Always consult with your doctor first about your specific condition, treatment options and other health concerns you may have.





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