COMPLIMENTARY ISSUE

Something More *for you*

THE OSTEOPATHIC PATIENT

VOL. 6, ISSUE 1, 2004

Are you a Hypochondriac?

Hormone therapy: the great debate

Colon Cancer: early detection, aggressive treatment

Get back on track with answers to your back pain problems

Arthritis in children: diagnosis and treatment

Kimberly Carlson, DO, is a family practice physician with Carondelet Medical Group, P.C.

Tucson Osteopathic Medical Foundation

The Tucson Osteopathic Medical Foundation's mission in serving the seven counties of southern Arizona is to advance osteopathic medical education, to improve the public's understanding of osteopathic medicine, and to elevate through education the health and well-being of the community. In so doing, the Foundation has established itself as an innovative contributor to the development of a wide range of community projects, which impact the lives of many.

Lew Riggs, Ed.D.
Executive Director,
Tucson Osteopathic
Medical Foundation

HealthWise *with* Dr. Lew Riggs

Sundays at noon on 790 KNST

When it comes to you and your family's health, you make sure they get the best treatment even if it's just a common cold. Sometimes making decisions with regard to you and your family's health can be really confusing.

Sunday afternoons at noon on 790 KNST is dedicated to your health with HealthWise, brought to you by the Tucson Osteopathic Medical Foundation, a non-profit organization.

Local doctors join your host Executive Director of the Foundation, Lew Riggs, to discuss health topics, like the effects of osteoarthritis, valley fever, women's health issues and many more to help you and your family live healthier lives.

If you have any questions about any show you have heard or are interested in a new topic, call Lew Riggs at the Foundation, 299-4545.

Dr. Lew Riggs interviews Edmund Krasinski, Jr., DO for HealthWise, heard every Sunday at noon on 790 KNST.

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This publication presents general information and is not intended as medical advice. Medical advice should be obtained from your own personal physician.

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Back on Track:

Getting to Know Your Back—Causes and Treatment of Lower Back Pain

An aching lower back is no laughing matter. It affects most of us at some time or another, and the pain can be debilitating. Simple activities such as dressing or just reading the paper can become ordeals.

By Mark Flint

Approximately eight out of 10 people will experience back pain at some point in their lifetime. In the United States, back pain is the leading cause of disability in men over 45 years old. It is also the second most common reason for a visit to a primary care doctor, the third most frequent reason for surgical procedures and the fifth most frequent cause of hospitalization.

The good news is that most back pain goes away, and invasive procedures are not usually needed.

"Most back pain can be taken care of in a couple of weeks by doing stretching and simple exercises," notes Rex D. Cooley, Jr., DO, a Tucson orthopedic surgeon. "I tell my patients that 90 percent of people who hurt their back can take care of it within a month, and 90 percent of the rest within another month."

"Most back pain can be taken care of in a couple of weeks by doing stretching and simple exercises."

The most common cause of back pain is muscle spasm. An awkward movement of the back can lead to a severe muscle spasm, causing the back to "lock up," often with severe pain. A simple sneeze or cough may be enough to trigger a muscle spasm. It can also occur after an awkward bending or twisting motion, such as bending to pick up a scrap of paper and twisting to face in a different direction. Muscle spasms can also occur when a heavy object is lifted incorrectly.

Other causes of lower back pain can include degenerative disk disease, or wear and tear on the disks that lie between and cushion the vertebrae, or back bones. The vertebrae allow the spine to bend and flex.

"Another area I look at for back pain is the joints in the back part of vertebrae, the facet joints, which can get arthritis," Cooley says. The facet joints play a role in keeping the spine aligned and allowing the spine to move in different directions. Each vertebra has four facet joints, two holding the vertebra to the above vertebra, and the other two holding the vertebra to the one below.

Cooley adds that back pain also can be associated with muscle imbalance in the quadriceps, hamstring, hip flexor muscles, which can irritate the muscles in the lower

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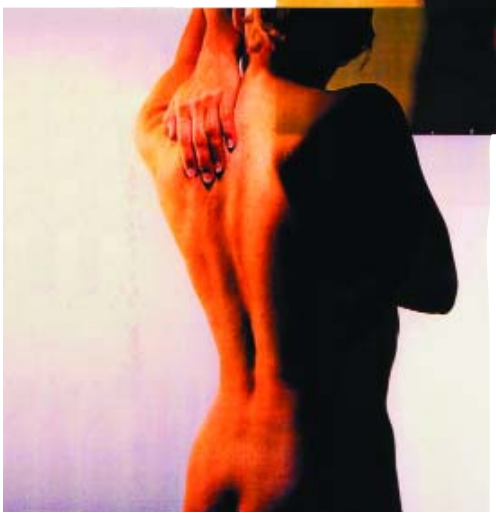


back. "This is more common among young athletes who don't stretch properly," he notes.

Much less common is back pain that is the result of more serious medical conditions, such as infections and tumors. (See related article.)

An ounce of prevention is priceless

Many low back injuries are preventable. Understanding and using proper body mechanics, especially when lifting, is probably the most important step you can take to avoid a low back injury. Most doctors' offices have informational brochures that describe and illustrate proper lifting techniques. You can also find this information on the Internet at sites such as www.spine-health.com.

Another important step in avoiding back injuries is to do stretching and strengthening exercises for your stomach and low back muscles. "People often forget about their abdominals and back muscles when they exercise," Cooley says.

Treating low back pain

"Most muscle strains are best treated with anti-inflammatories and ice or heat," says Cooley. If you experience a lower back injury, take an anti-inflammatory, apply ice (in the

…(an) important step in avoiding back injuries is to do stretching and strengthening exercises for your stomach and low back muscles. "People often forget about their abdominals and back muscles when they exercise."

first 48 hours) and heat and try to relax the muscles. Light stretching — but not if it's painful — also may help.

Manipulation has been proven very effective in treating lower back pain, Cooley notes.

"I will refer my patients to a physical therapist, a chiropractor or to other osteopathic physicians who do manipulation," he says. "Most people get relief from manipulation."

Manipulation can take several forms. High velocity/low amplitude (back cracking) causes a reflex relaxation of the muscles, and can block the nerve signals that cause spasms. Muscle energy manipulation techniques alternate contraction of muscles with stretching. Another form of manipulation simply stretches the muscles.

"Strain/Counterstrain is the osteopathic term for the technique of trying to shorten a muscle as much as possible and allowing it to be in a short position until it unwinds, or relaxes." he adds.

"Strain/Counterstrain is the osteopathic term for the technique of trying to shorten a muscle as much as possible and allowing it to be in a short position until it unwinds, or relaxes."

Massage is another treatment than can help reduce back pain, Cooley says. "Massage helps improve blood flow, encourages muscles to relax and gets the person to relax — and that inevitably helps the tissue itself."

Cooley advocates conservative approaches initially. A patient in pain from a low back strain or injury may want more aggressive treatment, but that usually isn't necessary. In most cases he won't order an x-ray or MRI unless the pain hasn't subsided in a month.

"An x-ray or MRI for lower back pain early in the treatment process is likely to be a waste of money," he says.

If conservative treatments don't bring relief, the pain could be disk related, in which case treatment gets more complicated, and more invasive.

Cooley urges people with back problems to take a measured approach to their treatment.

"When it comes to the back I'm very conservative," he says. "The buyer needs to beware when dealing with back problems, and should not be rushed into surgery when it may become better over time. A lot of things are being done that haven't been proven effective." ❖

Sources in addition to Dr. Cooley: Mayo clinic Website, spine-health.com, University of Washington Orthopaedics and Sports Medicine Website

Serious Back Conditions

While most low back pain is easily treated and not a significant health threat, less common, and sometimes more serious conditions may be involved. These include:

Spinal stenosis. This is a condition in which the openings in the vertebrae are too small and the delicate tissues in your spinal cord and its nerve roots get pinched. Some people are born with this problem, while others develop it over time. Signs and symptoms can include an ache in the buttock, thigh and calf, pain radiating from the lower back to the calf, progressive numbness or weakness in a leg, and problems controlling the bladder and bowel. Symptoms often worsen when standing or walking, particularly downhill, but subside after sitting for a few minutes or bending forward from the waist.

Ankylosing spondylitis. This is a form of arthritis that causes the joints and ligaments in the spine to become inflamed. Eventually, the vertebrae can actually fuse. Signs and symptoms include chronic pain and lack of motion in the lower back, typically starting where the spine is joined to the pelvis. The disease primarily affects young men.

Infections and tumors. Infections can develop in the spine in rare cases. Cancer also may spread to the spine from a tumor in another part of the body. Tumors rarely originate in the spine, and most that do are benign.

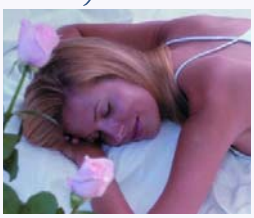
Referred pain. Pain signals from other organs may feel as if they originate in your back. Bladder infections and kidney stones can cause back pain, as can endometriosis, ovarian cysts and ovarian cancer.

If your back pain is accompanied by any of the following, you should see a doctor immediately:

- weakness or numbness in one or both legs
- pain going down one leg below the knee
- back pain from a fall or injury
- back pain accompanied by fever without flu-like aches
- pain that continues to interrupt sleep after three nights
- back pain that remains after six weeks of home treatment

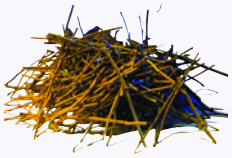
Health News

Sleep on It



A good night's sleep improves our memory of tasks that might otherwise be forgotten, according to a study published in Nature.

Ephedra Dangers



The Food and Drug Administration plans to ban products containing ephedra, which has been linked to heart ailments, strokes, high blood pressure, and irregular heartbeats. Ephedra is a common ingredient in many weight loss supplements.

Balancing Act

Losing your balance? One day a change of footwear might help you find it again. Subtly vibrating insoles reduced swaying in elderly volunteers, according to a study in *Lancet* Journal.

- *Start hormone therapy at the onset of menopause to protect against heart disease and osteoporosis.*
- *Take hormones at the lowest effective level for the shortest amount of time.*
- *Unless she has severe menopausal symptoms, no woman should be on hormones.*

Hormone therapy

the great debate

Welcome to the great hormone therapy controversy. If you are in the menopause zone, these are the kinds of statements you can expect to encounter.

Hormone replacement therapy has polarized the medical community in a Democrat/Republican, pro-life/pro-choice sort of way. Do much reading and you are likely to feel like a ping pong ball. *Hormones double your risk of dementia*—whap—*estrogen is the best therapy for hot flashes*—whap—*"bioidentical" hormones are better*—whap—*traditional hormones (such as Prempro and Premarin) are proven.*

Read on for a short course in what doctors in Tucson are saying and what some women are doing about hormone therapy.

A look back at menopause

Menopause wasn't really a part of women's life until the early 1900s. Why not? Women didn't live long enough to go through it. At that time, the average life span was 47. Some people theorize that women weren't designed to live longer than their childbearing years. (If continued, this tends to veer off into a debate along the lines of 'taking hormones is natural' or 'ramping down from high levels of hormones is natural.') But as medical science advanced life expectancy, "the change" became part of women's lives.

However, it wasn't until the 1940s that hormone therapy became available. As women began to move into the business world, hormones were a welcome relief from the hot flashes, night sweats, mood swings, insomnia, and other unpleasant physical changes related to menopause.

"I share data with my patients—I tell them what we know, what we know that we don't know and what we think we know."
—Tammie Bassford

But studies over the years seemed to indicate that taking hormones provided a broader benefit than relief of traditional menopausal symptoms, most of which last a few months to a few years. Some 30 studies on the effects of hormones had been done over the decades, most indicating a protective effect on heart disease and osteoporosis.

Based on the results of these studies, by the 1970s women were taking hormones for the long haul. Although it was known that estrogen increased the risk of breast cancer, and in some cases, uterine cancer, those risks were thought to be outweighed by protection against heart disease. "There's definitely some fountain of youth effect with estrogen," says obstetrician/gynecologist Edward Miller, DO. Women, he notes, live longer than men in most societies (even after adjusting for wartime deaths). Women don't start getting heart disease until 15 years after men do. "Estrogen raises good cholesterol, lowers bad cholesterol, and maintains the health of the lining of the blood vessels."

The 30 studies, however, were observational studies, meaning that they "observed" the health outcomes of women who chose to take hormones. Observational studies are considered less reliable than the highest echelon of medical research—randomized

"There's definitely some fountain of youth effect with estrogen. Estrogen raises good cholesterol, lowers bad cholesterol, and maintains the health of the lining of the blood vessels."

clinical trials. In these studies, one group takes a specific drug and another group takes a placebo. The trials are double-blinded, meaning that neither the patient nor the doctors know who is taking the drug and who is taking the placebo.

So, in 1991, the Women's Health Initiative (WHI) set out to apply the most rigorous standards to the long-term effects of hormone therapy on heart disease and hip fractures. The WHI was widely expected to confirm that taking hormones conferred benefits to the heart.

However, in 2002, three years before it was due to end, the arm of the WHI which involved an estrogen/progestin combination (Prempro) was stopped because of concerns about breast cancer. Not only was the incidence of breast cancer increased, but the cancers found were more advanced. The study also showed increases in heart disease and dementia. Researchers decided that risks of using hormones outweighed the benefits. The estrogen-only arm of the study continues.

Gospel or grain of salt

This is where it gets thorny. Doctors differ strongly on how to interpret the same set of data. Admittedly, the issue is complicated: estrogen's effects on the body are broad and complex. The hormone has different effects at different sites in the body. Women, however, read the headlines, thought *breast cancer*! and jumped ship. Studies show that women are more afraid of breast cancer than heart disease and accordingly, tend to overestimate their chances of getting it. Not at all true: heart disease is the biggest killer of women, outweighing breast cancer by a factor of 12. But since the WHI showed a small increase

"Basically, timing is everything," says Miller. "Estrogen prevents atherosclerosis, but it does not treat it once it's there."

Edward Miller, DO, OB/Gyn (pictured at right)

DAVID SANDERS

in heart-related problems, there seemed to be no reason to take hormones and several reasons (breast cancer, Alzheimer's disease) not to take it.

Critics of the study, however, assert that it was flawed in design in a number of respects. The short list: most of the participants were well past menopause, more of them may have had existing heart disease than expected, only one type of hormone was tried and only in oral form. "It really is a study you have to take with a grain of salt," says family practitioner Kimberly Carlson, DO.

A primary criticism asserts that hormone therapy is only useful against heart disease if taken within five years of menopause. "Basically, timing is everything," says Miller. "Estrogen prevents atherosclerosis, but it does not treat it once it's there." Of the 16,000 women enrolled in WHI, the average age was 63—only 1,700 were between the ages of 50-54. Because of their age, it is likely, say critics, that the majority of women already had some degree of atherosclerosis. That hypothesis also explains why the earlier Heart and Estrogen-Progestin Replacement Study (HERS) trial also did not show a protective effect of estrogen: its subjects were women with existing heart disease.

A primary criticism asserts that hormone therapy is only useful against heart disease if taken within five years of menopause.

Although she wishes it were true, Tammie Bassford, M.D., principal investigator for the Arizona WHI site and head of the UA School of Medicine's Department of Family and Community Medicine, says that the WHI data simply doesn't support a heart-protective benefit for hormone therapy. Looking at different age groups didn't result in a different conclusion. "What we found is that you couldn't define a subgroup for whom it was safe to prescribe estrogen." And prescribing hormone therapy on purely a preventive basis is irresponsible, given the study's findings. "There's no way," says Bassford "that a clinician can look at a woman and say, 'This is going to have a protective effect on you,' just based on the fact that she's within five years of menopause."

Other things to think about if you are considering stopping or not taking hormones:

- most of the women in the study were older than the typical woman seeking relief for menopausal symptoms
- researchers assume that those with the most severe menopausal symptoms, for example, were less likely to enroll in the study and take a risk of receiving a placebo
- the study used one kind of hormone (a mixture of 10 or so different types of equine estrogen): "bioidentical" or synthetic hormones may have different results
- hormones were given in pill form: a skin patch or vaginal ring may produce less risk of blood clots

When the change is unbearable

However, if you need relief from menopausal symptoms, there are a couple important things to remember: the Women's Health Initiative was not designed to look at the effects of hormone therapy on hot flashes or night sweats. It is generally accepted that estrogen is the gold standard when it comes to hot flashes. Nothing else works as well,

although certain types of antidepressants—the SSRIs such as Paxil—show some results. The second and perhaps most important thing to remember—the increased risk to an individual is still small. "Gaining 10 pounds is more of a risk for breast cancer than taking estrogen," says Miller.

Many doctors agree that women suffering from symptoms that rob them of sleep, drench them in perspiration many times a day, eliminate their sex life, or make them crabby enough to consider divorce court may want to consider taking hormones. The current thinking is "the lowest effective dose for the shortest amount of time." It's an individual decision, say doctors, one that can be made only by weighing symptoms against medical history. "Certainly, women have the right to take a small risk in order to control their symptoms," says Bassford. "It comes down to a well-informed choice by a woman about her own health situation and quality of life." Carlson agrees. "In my own practice, it's a matter of choosing the right patient. I don't think it's right for everyone, but it is right for certain people."

Miller believes that stopping hormone therapy will imperil millions of women, who may die prematurely of heart disease.

Which kind is best: the other debate

So if you decide to take estrogen—whether for a year or 10 years or the rest of your life—which kind do you take? Do you take something made from horse urine (possible animal cruelty issues), or something made from soy plants or Mexican yams? Do you opt for a patch, a pill, a vaginal ring, a cream? Do you need estrogen only or an estrogen/progesterone combination? There is a dizzying choice of options available and the debate is just as heated on this issue.

In terms of hormone replacement therapy, there is no such thing as a natural hormone, says pharmacist Dana Reed-Kane. All hormones undergo synthetic processing to arrive at a formulation the body can use. The term "bioidentical" means that the hormone has the same molecular structure as hormones made by the body. Bioidentical hormones can be made from soybeans, yams, or animal products. Some women prefer bioidentical "compounded" hormones which are customized by a special pharmacy to varying dosage strengths and combinations. Because a woman's body makes principally three kinds of estrogen—estradiol, estrone, and estriol—the compounding pharmacy can vary the type of estrogen depending upon a woman's symptoms and medical history.

Many physicians are not familiar with bioidentical hormones, so if you're interested in that route, find a doctor who is. Because existing studies have been done with animal-based estrogens, some doctors feel uncomfortable prescribing something for which there is little scientific verification.

Sorting it out: Make up your own mind

Knowledge is evolving, so do your own research. And, of course, talk to your doctor. Sometimes that doesn't work—"It's premature to talk about it, said one gynecologist. "I won't even discuss it until next October." Others outline the controversy, even detailing the difference between clinical trials and

observational studies. “Women are smart,” Bassford says. “They all understand the difference.”

Finding a doctor who takes the time to discuss the benefits and risks with you is of paramount importance. One woman, for example, felt strongly about the animal rights issues associated with conjugated equine estrogen and knew that she wanted to take a plant-based hormone. When, in her late 40s, she found that her bone density was dangerously close to the osteoporosis stage, she kicked her research into high gear, concentrating on that angle. She consulted an endocrinologist, had extensive testing done, and decided on a “bi-est” (two types of estrogen) and progesterone made by a compounding pharmacy. She hired a personal trainer, who prescribed an aggressive weight-lifting regimen. Over the months, she moved from 5 lb. weights to 20 lb. weights and has reversed the bone loss in her spine.

Another woman, who had suffered from fibroid tumors, multiple surgeries, and years of excessive bleeding, decided to take a bioidentical hormone in patch form and a testosterone cream. “My past was almost unbelievable when I think about it,” she says. “Lying in bed for days, bleeding through onto my school chairs, passing out on the toilet; in my mind, it was not even a choice. I had been miserable for so many years.” Hormone therapy has given her life back. “It’s a great thing,” she says. “It works for me.”

Others have found relief with herbal remedies. “Black cohosh is wonderful,” says one. “I used to have hot flashes several times a day and I don’t have them anymore.” Others had health issues which precluded taking hormones or simply didn’t feel the need for them. “I figured this was a natural part of what happened with women’s bodies and so I just accepted it and didn’t get too strung out about it,” said one woman.

In terms of prescribing HRT to her own patients Kimberly Carlson, DO, says, "I don't think its right for everyone, but it is right for certain people."

DAVID SANDERS

What the future holds

If there is anything that physicians agree on, it is that more study is needed. Bassford feels that the main benefit of the WHI was to demonstrate that doctors should not base clinical therapy on hypotheses, no matter how logical they seem.

On the other side of the coin, Miller believes that stopping hormone therapy will imperil millions of women, who may die prematurely of heart disease. Fortunately, there is another study in the wings to research the effects of hormone therapy on cardiovascular disease. The Kronos Longevity Research Institute, a not-for-profit organization based in Phoenix, is coordinating a study set to begin in the summer of 2004.

In the meantime, there are the designer estrogens. Although too new to have much data on them, these estrogens, called SERMS, try to combine the helpful effects of estrogen, while minimizing the disadvantages. Some are useful in preventing bone loss while protecting against breast and uterine cancer. They may, however, cause hot flashes.

For the sake of their daughters

Uncertainty marks those on both sides of the hormone therapy quandary. “I hope I don’t regret this when I’m 72,” says a woman who opted not to take hormones. “Is this the right answer long-term?” wonders a woman who is taking them. “I don’t know. What works at 52 and what works at 62 may be totally different.”

Even though the Women’s Health Initiative sparked a wildfire of controversy, the fact that it increased the body of knowledge about hormone therapy is what is important, says Bassford. “Every participant coming into the study cited that as the reason they were entering this long-term, arduous study. They wanted more information to be available to their daughters and grand-daughters than was available to them. And I think they succeeded in that.” ❖

Osteoporosis	Heart disease	Hot flashes	Insomnia	Vaginal dryness	Mood swings
Try specific osteoporosis drugs such as Fosamax or Actonel	Healthy lifestyle-healthy diet, not smoking, limited alcohol consumption	Take herbals such as black cohosh, and dong quai; try antidepressants such as Paxil, Prozac, or Effexor	Hot shower or bath before bed; drinking milk before bed	Over-the-counter vaginal lubricants	Try anti-depressants or anti-anxiety drugs
Exercise, including weight-lifting and weight-bearing exercise such as walking or running	Controlling high blood pressure and cholesterol, managing diabetes	Avoid spicy food, caffeine. Eat more soy products.	Over-the-counter sleep remedies	Vaginal rings or creams which deliver estrogen locally	Exercise and get adequate sleep
Calcium supplements	Taking appropriate high blood pressure medicine	Try stress reduction techniques such as deep breathing and meditation	Do not exercise late in the afternoon or at night which may increase wakefulness	If irritation is not too severe, keep making love—it actually increases lubrication	Practice relaxation techniques

Health News

BOLD BENEFITS

Taking a few chances may be good for you. Risk-averse rats age faster and die younger than their more adventurous counterparts, according to a University of Chicago study.

Mediterranean Eating

Many people already consider a Mediterranean diet--one rich in olive oil, fruits, and vegetables--to be heart-healthy. Here's more evidence: Greek researchers report that those on such a diet have lower blood concentrations of inflammatory proteins linked to heart disease.

Chicken Arsenic Estimates Revised

U.S. chickens contain three to four times as much arsenic as other kinds of meat and poultry, according to Environmental Health Perspectives; this means an average U.S. adult consumes from 3.6 to 5.2 micrograms daily from chicken alone. That figure still represents a small portion of the currently accepted safe limits, however: the United Nations recommends consuming no more than 15 micrograms of arsenic per kilogram (33 micrograms per pound) of body weight per week from all sources.

For Jenna Johnson, being diagnosed with juvenile rheumatoid arthritis (JRA) came almost as a relief. Her doctors originally thought she had scleroderma, a disease that can cause hardening of internal organs. “But they took away that diagnosis when I was 11, and since then I’ve just had JRA,” Johnson says.

“JRA is usually a diagnosis of exclusion,” says rheumatologist Jane Power, DO. Like all arthritis, the disease is defined by joint inflammation—in this case, joint inflammation that lasts more than six weeks and affects those 16 years old or younger. Other diseases have similar symptoms, however; the pediatrician and rheumatologist must often rule out

Treating Juvenile Arthritis

by Janni Lee Simner

everything from viruses and fibromyalgia to leukemia and lupus. Typically JRA patients undergo some combination of physical exams, blood tests, X-rays, and bone marrow biopsies.

Once diagnosed, though, JRA is often highly treatable—if dealt with early and aggressively.

Not like adult arthritis

JRA can be divided into three distinct types. Pauciarticular disease affects four or fewer joints, usually large ones such as knees, ankles, or elbows. Polyarticular disease affects five or more joints, often smaller ones. Systemic disease affects the entire body; it can involve inflammation of internal organs. "Systemic kids are usually the sickest at onset," Power says, but adds that the lines between the types of JRA are not as clear as one might expect. Often a child diagnosed with systemic disease over the short term will go on to develop polyarticular disease over the long term, for instance.

The types of JRA have subtypes in turn:

> Once diagnosed, JRA is often highly treatable—if dealt with early and aggressively.

pauciarticular patients can be positive or negative for antinuclear antibodies (ANA); polyarticular patients can be positive or negative for rheumatoid factor (RF). Other antibodies may be involved with various forms of the disease as well. Polyarticular, RF positive JRA is similar to adult rheumatoid arthritis—but it affects only 20 percent of all JRA patients.

"The other kids have a disease that doesn't resemble anything an adult gets," Power says.

Sooner is better

Whatever the form of JRA, aggressive treatment is key. "Sooner is better," Power says. Without treatment, the disease can limit motion and affect growth for life; until relatively recently, such crippling effects were common. Now, while long-term impairment is still possible, with treatment 70 to 90 percent of all patients can enter adulthood without serious disability.

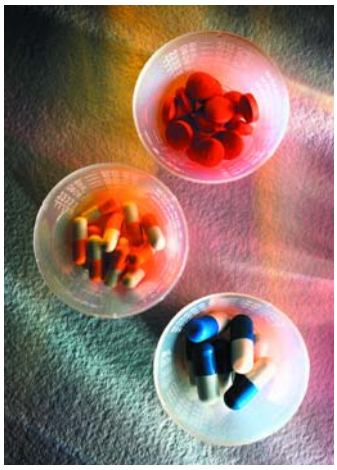
Treatment typically involves a mix of medication and physical therapy aimed at

> Teenagers will stop taking their medications sometimes. They don't want to be different from anyone else."

> I tell them that with aggressive care, by their early twenties there's a chance they can get to a place that's better.

reducing inflammation, relieving pain, increasing range of motion, and preventing long-term damage to bone, cartilage, muscles, tendons, and joints.

To this end, nearly all patients take non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen, aspirin, or naproxen, to control pain and inflammation. Most also take disease modifying anti-rheumatic drugs (DMARDs) such as methotrexate and sulfasalazine to help hinder JRA's long-term progression. Sometimes glucocorticoids such as prednisone are prescribed when JRA doesn't respond well to other medications, but these are used sparingly on account of their side effects, which include slowing of growth rates.



Power admits that parents sometimes hesitate to give their children high doses of medication. "But these medications give the kids a chance to grow and develop normally," she says. "And children metabolize drugs well. They have far fewer side effects than adults." She adds that anti-inflammatory herbs, while not harmful, act too slowly to be used on their own. "We don't have that kind of time. When inflammatory cells are active in a joint, they call in other cells that break down bone and cartilage. It's a destructive process that we need to stop."

Johnson says medication made a difference for her. At age 12 she was in a wheelchair, had trouble using a pen, and couldn't attend school. Now, at 14, one can't always tell she has JRA at all.

Never stop moving

Physical activity is crucial to treatment, and JRA patients often work with a physical therapist to increase their range of motion. "You never want to stop moving," says Power, who encourages her patients to take part in regular PE classes as well. She recommends JRA children stay as active as they can, adding that until the teen years most children set appropriate limits on their own.

Johnson made a habit of swimming regularly. "That really helped me get my joints moving again," she says.

Taking responsibility

Eye disease is a sometimes-overlooked potential JRA complication. "Any kid with arthritis needs to have an eye exam," Power says. Pauciarticular, ANA positive patients are at particular risk and should have eye exams every three months.

For adolescents, maintaining medication schedules and physical activity routines can also be a challenge. "Teenagers will stop taking their medications sometimes," Power says. "They don't want to be different from anyone else." Drinking or smoking can also interfere with medications and complicate JRA.

Ultimately, Power says, JRA patients need to take responsibility for their disease, whatever their age. "I always talk directly to the kids," she says, adding that her training as a DO has made doing so instinctive. "I explain to them, I hand them the prescriptions—I try to give

them the idea that this is about them, not about their parents."

"And I tell them that with aggressive care, by their early twenties there's a chance they can get to a place that's better. There's a chance this won't be as big an issue for them." ❖

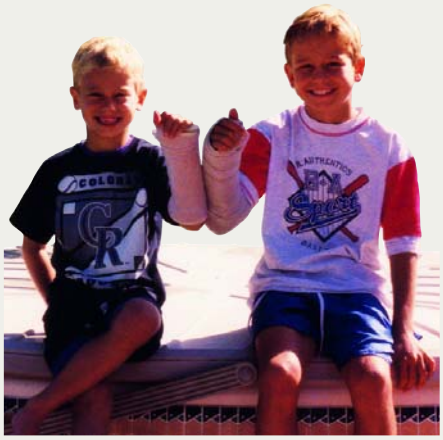
Health News

Mood and Memory

Events occurring at emotional times tend to be remembered more often than other events, according to a study in the Proceedings of the National Academy of Sciences. Events taking place just before such times, however, tend to be forgotten.

Not from Sticks and Stones

Adolescent arm fractures have risen more than 40 percent over the past 30 years. Mayo Clinic researchers say sports injuries account for much of the increase, and that decreased calcium consumption may also play a role.



Painless Injections

Microscopic needles may one day take the pain from injections. These microneedles, being developed by researchers at the Georgia Institute of Technology, are narrow enough to avoid sensitive nerves, yet wide enough to handle molecules too large for patches to deliver.

Hypochondria:

how destructive is it?

by Mark Flint

Concern about our health is a good thing. Observing symptoms and discussing them with our doctor is how we catch diseases early, when they are more treatable.

But what happens when this concern becomes an obsession, and we don't trust our doctor's reassurances? This is known as hypochondria, which is defined as "a belief that real or imagined physical symptoms are signs of a serious illness, despite medical reassurance and other evidence to the contrary."

Hypochondria has widespread effects that ripple far beyond the patient.

Writing in the Aug. 11 issue of *New Yorker Magazine*, Jerome Groopman, MD, referred to studies showing "that at least a quarter of all patients report symptoms that appear to have no physical basis, and that one in ten continues to believe that he has a terminal disease even after the doctor has found him to be healthy."

Groopman further stated that as many as six percent of patients seen by primary care physicians have hypochondria. "The number is likely growing, thanks to increased medical reporting in the media, which devotes particular attention to scary new diseases like SARS, and to the Internet, which provides a wealth of clinical information (and misinformation) that can help turn a concerned patient into a neurotic one."

> ...Osteopathic medicine's emphasis on treating the whole person better helps physicians deal with the non-clinical aspects of health.

People suffering from hypochondria stress an already overburdened health care system, monopolizing a doctor's time, insisting on costly tests and, when they don't get the diagnosis they believe they should get, switching doctors and repeating the process. Doctors treating hypochondriacs can't be blasé, though. A hypochondriac may have valid complaints, or a different condition entirely.

A quandary for primary care physicians

As the front line doctors, primary care physicians face the brunt of the impacts of hypochondria. It's not a simple task, notes Christopher Marsh, DO, who has a family practice in Tucson. Marsh says there are telltale

hypochondria:

"a belief that real or imagined physical symptoms are signs of a serious illness, despite medical reassurance and other evidence to the **contrary**."

signs that alert him to the possibility that a patient has hypochondria. They may bring in multiple typewritten pages detailing their symptoms; they may change doctors frequently; and they often have multiple complaints related to multiple organ systems.

"When talking about symptoms I ask open-ended questions — 'How does it affect your life? Can you describe your day to me?' Or I will ask what they think is wrong," he says. "You can discover a lot about them from a psychological standpoint, learn more than medical issues. But it's extremely difficult to do. They can literally overwhelm you."

Family practitioner John Wadleigh, DO, of the Midvale Family Medical Clinic in Tucson, notes that primary care physicians have to deal with a number of conditions that require them to be skilled communicators and counselors.

"Counseling is a part of being in primary care," he says. "When a patient becomes a diabetic, you have to help them adjust. When a loved one becomes ill, you help them cope."

Whole person approach is effective

Primary care requires looking at the whole person, Wadleigh says, "and you look at a hypochondriac in the same way as you would a first-time diabetic, or a patient who had had a heart attack or stroke. You get to understand the problem, put it in perspective and work with it on a day-to-day basis.

"Hypochondria is one in the spectrum of conditions we treat," he continues. "In primary care you see almost everything sooner or later. We're not psychiatrists but we deal with psychological problems all the time; we're not cardiologists but we deal with cardiac care all the time."

Marsh describes consulting with a hypochondriac as a delicate balance. "If you don't talk about their symptoms, they get angry," he says. "Talk too much and they begin to somaticize and worry and develop the symptoms of that disease. You are always walking a tightrope of what you should say.

"The best way to approach this — and the studies back this up," he continues, "is to tell them that they are most likely going to have symptoms and problems, rather than tell them they are fine and nothing is wrong with them. You can develop more of a rapport."

Wadleigh believes osteopathic medicine's

"A researcher said to pay more attention to the symptoms they complain the least about. The ones they complain about repeatedly have been checked."

emphasis on treating the whole person better helps physicians deal with the non-clinical aspects of health.

"I went to the College of Osteopathic Medicine of the Pacific, now the Western University of Medical Sciences," he says. "In addition to the standard medical school classes they also had sociology classes. People would come in from different cultures and religions, and talk about how they interact with medical care."

Sorting out the shades of gray

Like most other conditions, hypochondria runs the gamut from mild to severe. Most of us have had the occasional fear that we have a serious illness, perhaps brought on by learning a close friend or relative has that illness.

"Like anything else there's a continuum," says Wadleigh. "What some people might call hypochondria, a lot of us might not look at it that way."

Wadleigh recalls one patient who had been labeled a hypochondriac, and not without reason. He was convinced he had bowel cancer, and other doctors had run out of patience with him.

"I spoke to a gastroenterologist and he said not to send him back," Wadleigh says. He listened to the patient, and learned that he had many family members who had had bowel cancer.

"He was afraid he was going to die of this disease sooner or later," he says. "I told him be on the lookout, but every cramp or stomach pain is not cancer, and that cancer usually is pain-free at first." He told the patient to take hemocult tests every six months, and to have routine examinations for a person with his risk factors.

"He is very satisfied and now can deal with the concern," Wadleigh said.

"By knowing that every six months he's going to check it, he has no fear. He was labeled a

"Consulting with a hypochondriac is a delicate balance. If you don't talk about their symptoms, they get angry. Talk too much and they begin to somaticize and worry and develop the symptoms of that disease. "

...listening is important

hypochondriac but it was just that he had a fear of a certain disease that ran in his family. We helped him address it, and set up a reasonable program to assure him that if anything came along we'd catch it early and take care of it."

Marsh agrees that listening is important, even with a patient known to have hypochondria.

"That's the other side of the coin: you have a patient you know is a hypochondriac and you set boundaries. When people live long enough they are likely to develop some type of disease. Knowing when they are not crying wolf is the problem," he says. "A researcher, Dr. Edward Elger, said to pay more attention to the symptoms they complain the least about. The ones they complain about repeatedly have been checked."

Sorting the irrational from the real is a challenge in dealing with patients who have hypochondria, says Marsh, but that's part of being a physician.

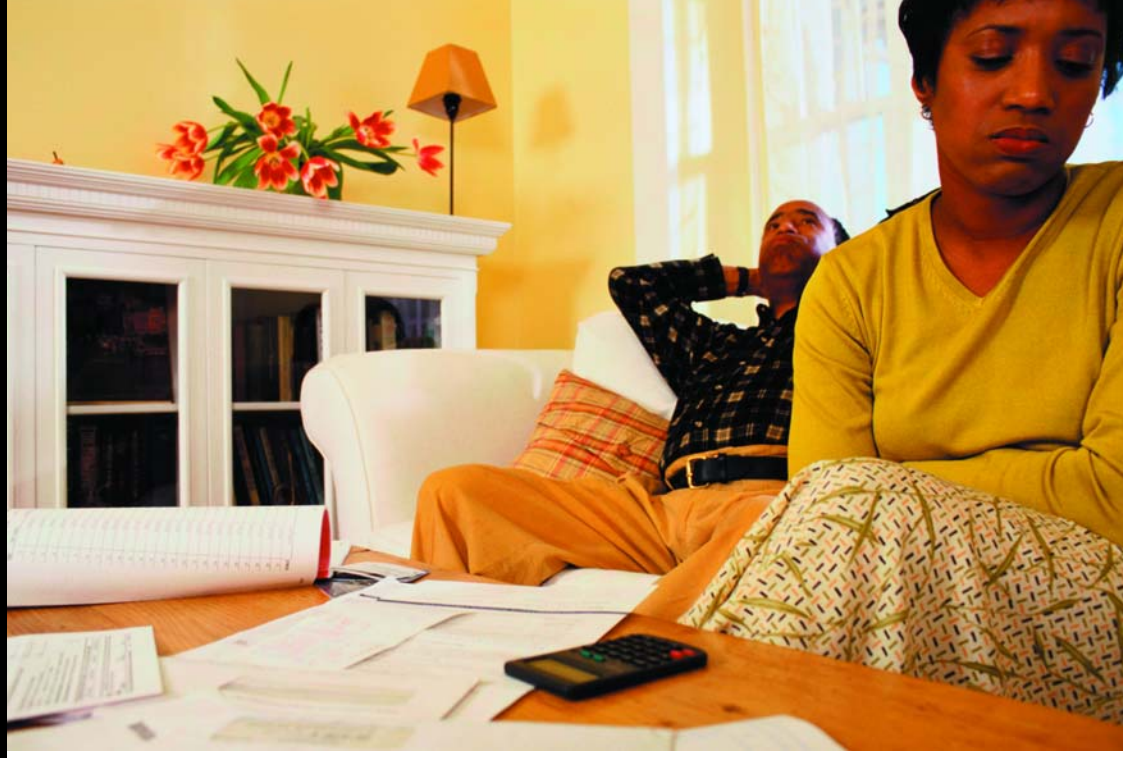
"You have to be on your toes, and listen carefully, which drains you," he says. "Then to say, 'this is different,' and actually work them up for it."

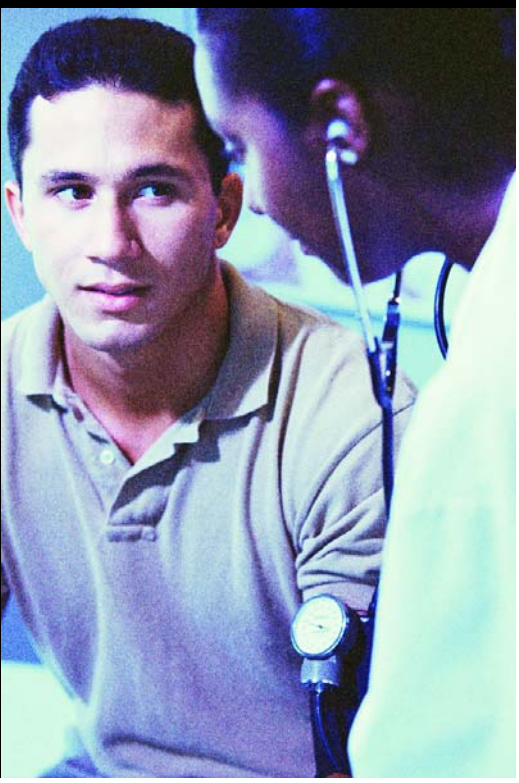
Just as some people with diabetes may need to be sent to an endocrinologist for specialized care, some hypochondriacs may require psychiatric care, Wadleigh says. Research has shown some promising results from cognitive-behavioral therapy and some anti-obsession medications.

For those who are less severely afflicted, the primary care doctor often can find a solution.

"They are intelligent human beings," notes Wadleigh. "Often you can get them to work with you about dealing with the fear in a reasonable fashion. People with hypochondria are human beings, too, with families and fears, and you need to deal with them just as you would someone with another disease." ❖

"...at least a quarter of all patients report symptoms that appear to have no physical basis, and that one in ten continues to believe that he has a terminal disease even after the doctor has found him to be healthy."





How do you know?

How do we know if we are being reasonable in seeking answers to questions about symptoms? Could some of us be burdening the system with our fears?

Christopher Marsh, DO, has a checklist. If you:

- Consistently have the same symptoms over and over
- Have gotten two to three medical opinions, and doctors are consistent with what they tell you
- Have had a physical and blood work done

You are probably safe in being reassured.

"If people still find themselves worrying, they should consider getting a consultation with a psychologist to see if there's something in their history that may cause them to be preoccupied with their health or to have a fear of developing specific diseases," he says.

Colon Cancer Early

Janni Lee Simner

"Colon cancer is different from most other cancers," says oncologist Steven Ketchel, M.D. That's because the likelihood of developing colon cancer can often be detected—and treated—before it even occurs.

The disease begins with pre-cancerous growths, or polyps, on the colon's inner wall. Given time the polyps become cancerous; given enough time, the cancer spreads. But if the polyps are discovered early, they can be removed while still benign.

Because of this fact, regular screening for colon cancer is crucial.

Screening options

When it comes to screening, "colonoscopy is the gold standard," says gastroenterologist Edmund Krasinski, Jr., DO. This procedure uses a thin plastic tube with a video camera on the end to examine the inside of the colon.

The American Cancer Society (ACS) recommends a colonoscopy every 10 years for men and women alike, starting at age 50. Alternately, the ACS says, patients can have a double contrast barium enema every five years, or they can have a yearly stool blood test and a flexible sigmoidoscopy every five years. A sigmoidoscopy is much like a colonoscopy, only the tube is shorter and examines only the lower third of the colon.

Colon cancer is already the third most common cancer in the United States, but some people face a particularly high risk: those with a history of ulcerative colitis or Crohn's disease; those with a history of breast, uterine, or ovarian cancer; and anyone with a family history of colon cancer. Such individuals should consult their physicians; they likely need to start screening sooner.

A recent study from the National Naval Medical Center suggests that a computed tomography (CT) scan might provide a less invasive—yet still effective—colon cancer screening option. Krasinski says it's too soon to schedule a "virtual colonoscopy" just yet, though. "CT scans might be in our future," he says, "But right now [the technique] is still too young."

The basics of treatment

When colon cancer screening reveals polyps, they're removed as soon as possible, often by the gastroenterologist during a colonoscopy. If signs of colon cancer are also found, the next step is for a surgeon to remove the cancerous areas and reconnect the remaining portions of the colon. Ketchel says that, in general, patients tolerate this surgery well. "Most people are able to move their bowels normally afterwards, although

…Colon cancer is already the third most common cancer in the United States

Detection, Aggressive Treatment

occasionally they will have problems with diarrhea or cramping," he says.

Colon cancer surgery generally doesn't require a colostomy, but rectal cancer surgery sometimes does. A colostomy involves rerouting waste materials through a hole in the abdomen and into an attached bag; it is performed when not enough healthy tissue remains to reconnect rectum and anus.

After either colon or rectal cancer surgery, an oncologist is usually brought in and chemotherapy called for. "There's a statistical risk that cancer cells have been left behind," Ketchel explains; chemotherapy reduces that risk. "In general chemotherapy for colon cancer is also well tolerated," he adds. "Patients have few side effects from it."

The American Cancer Society (ACS) recommends a colonoscopy every 10 years for men and women alike, starting at age 50.

Being aggressive

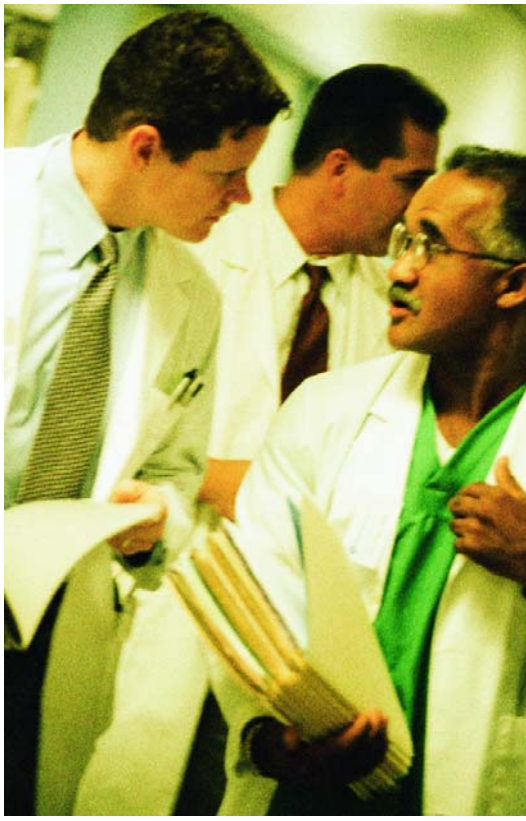
The stage at which colon cancer is detected directly effects the prognosis. According to the ACS, if colon cancer is found before it spreads, the five-year survival rate is 90 percent. Once the cancer reaches nearby organs and lymph nodes, that rate drops to 65 percent. If it reaches distant organs such as the liver or lungs as well, survival drops to just eight percent.

The link between survival and the stage of the cancer makes regular screenings all the more crucial. It also means patients need to consult a physician immediately whenever they notice any changes in their bowel function, even if they feel hesitant about doing so. "People don't like to talk about their bowels, and that makes them less likely to bring problems to their physician," Ketchel says.

Symptoms to watch for include—but are not limited to—rectal bleeding, blood in the stools, stools that are narrower than usual, abdominal discomfort, and the feeling that the bowels are not emptying completely. While colon cancer is more often associated with those over 50, it can strike at any time, and Krasinski cautions that younger individuals shouldn't dismiss symptoms on account of their age.

Krasinski and Ketchel both say the jury is still out on whether lifestyle changes such as high fiber diets or daily doses of aspirin can help prevent colon cancer. There's little question left, though, about the benefits of regular screening and increased awareness. According to the ACR, death rates from colon cancer have been declining for the past 15 years. When in doubt, Krasinski says the best bet is to go ahead and consult a physician.

"It's always better to err on the side of being aggressive," he says. "It's always better to check it out." ❖



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Information obtained from:
AOA Yearbook and Directory of Osteopathic Physicians and the Arizona Board of Osteopathic Examiners in Medicine and Surgery—Directory of Licensed Osteopathic Physicians

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