

HEALTH AND WELLNESS NEWS ITEMS – August 2012

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If any of these abstracts seem relevant to your care, be sure to consult with your personal physician before changing your treatment.

1. WHERE DO AMERICANS GET SO MUCH SALT?

A recent report from the national Centers for Disease Control and Prevention listed the top 10 sources of salt (i.e., sodium) in the American diet. Surprisingly, breads and rolls topped the list, not because they are saltier but because people eat more of them. The usual suspects — chips, pretzels and popcorn — came in at No. 10. Other sources of sodium that made the list were cold cuts and cured meats, pizza, fresh and processed poultry, soups, fast-food hamburgers and other sandwiches, and cheese. The following suggestions are offered to reduce your sodium intake, along with your craving for salt.

Retrain Taste Buds

Gradually retrain your taste buds so that you will not need additional salt on your food. Use herbs and spices to kick up the flavor. Aim for more whole foods and fewer processed foods in your diet.

Read Labels

Reading labels is key to reducing salt intake. Watch for sodium-containing ingredients such as baking powder, baking soda, monosodium glutamate (MSG), sodium nitrate, sodium nitrite, soy sauce, and condiments. High-salt foods to watch out for include boxed cereals, deli meats, canned vegetables, snack foods, and vegetable juices.

Understand Your Options

Sea salt is not a good option. Table salt and sea salt contain the same amount of sodium chloride and sea salt does not contain iodine, which is essential for thyroid health. Salt substitutes can be an option, but they do not lessen the craving for salt. Also, some substitutes contain a small amount of sodium, so be sure to read the label. Further, many salt substitutes contain high amounts of potassium, which may be problematic for anyone with kidney disease or individuals on medication for heart failure.

(Editorial Note: The Food Service, Nutrition Committee, and individual residents of Kendal are acknowledged for their contributions in seeing that entrees and soups are labeled with nutritional values and that lower sodium soup and entrée options are often available.)

Source: *Cleveland Clinic Catalyst enews*, June 21, 2012

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2. MIND YOUR MEDS

Each year, medication errors injure more than 1.5 million patients in the U.S. and add \$3.5 billion in extra medical costs. Older people are disproportionately hospitalized because of such errors. Nearly half of medical-related injuries that result in death occur in those over 60 years of age. Errors are common both in pharmacies and in hospitals.

A study from Auburn University of 100 community pharmacies showed that one out

of every five prescriptions contained a significant error. Among the common errors were forgetting to put “take before dinner” on a diabetic drug, labeling with the wrong drug name or the wrong dosage, and giving a drug to the wrong patient. One study revealed that 89% of the errors are discovered during counseling at the drug counter and were corrected before patients left the store. You are advised to always review your prescription with a pharmacist and, in the case of refills, to open the container before you leave the store to make sure that the pills are the same as those you have taken in the past.

One fourth of medication errors occur in hospitals. Such errors commonly occur upon admission or discharge. At Northwestern Memorial Hospital in Chicago, 85% of the errors originate when patients provide histories at admission. You are advised to carry with you at all times a list of names and doses for prescription and over-the-counter drugs, including vitamins, minerals, and herbal supplements. A study at Duke University Medical Center demonstrated that nearly all patients had a change of medications at discharge. You are advised to ask how your drug regimen has changed as you leave the hospital and to provide that information to your medical care staff.

Sources: *AARP, The Magazine*, June/July 2012, Pgs. 20-22

3. CAN TOO MANY DOCTORS SPOIL YOUR CARE?

A recent article in *Consumer Reports on Health* offers the argument that “many patients are suffering from too much care.” Of U.S. primary care physicians surveyed, 42% believe that their patients are receiving excessive care and only 6% believe that these patients receive too little care. Both physicians and patients might be contributing to this problem. Some physicians may see patients too frequently and order unnecessary tests for financial reward or for fear of malpractice. Patients, on the other hand, may at times mistakenly believe that more visits and more tests will keep them healthier.

The author points to a finding reported in *The Journal of the American Medical Association* that increasing the number of practitioners and health-care systems involved in a patient’s care results in less coordination of care and more unnecessary prescriptions, excessive treatment, and invasive testing. Consequently, large amounts of time, money, and emotional stress are expended by patients and by society. The bottom line is that analysis shows that increasing the number of medical participants increases the incidence of medical problems.

Source: *Consumer Reports on Health*, August 2012, Pg. 11

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4. DON’T UNDERESTIMATE YOUR PERSONAL BACTERIA

(Editorial Comment: The content of this abstract may be hard to believe because it forces us to view our bodies in a completely different way and because the findings and their implications have been given little coverage in the press.)

You may be surprised to learn that **hundreds of trillions of bacteria** are harbored in and on your body. They comprise 90% of the body’s cells, the other 10% being human cells. However, bacterial cells are much smaller than mammalian cells and account for only approximately two pounds of weight.

In humans, bacteria live in the entire GI tract, in the body’s orifices and crevices, and on the skin. Although dispersed, the bacteria collectively may be considered an organ and this is called the “microbiome.” Of the 100 types of bacteria classified as phyla, the human microbiome is dominated by only four of these phyla—the Actinobacteria, Bacteroidetes, Firmicutes, and Proteobacteria. Some bacteria are transferred from mother to child at or shortly after birth. The ratio of the four types of bacteria varies markedly among geographic

locations and between fat and lean individuals. The ratio of types is also affected by malnutrition, type of diet, antibiotics, and disease.

Although these single cell organisms use us as their home and source of food, they are not “free loaders.” They contribute to our normal physiology and thus deserve the positive attribution of “bacterial flora.” For example, intestinal bacteria provide enzymes that digest dietary compounds that mammalian digestive enzymes are unable to degrade. More than 10% of the energy derived from carbohydrate ingestion is attributed to such bacterial action. Thus, humans and their beneficial bacteria are symbiotic and together represent an “ecosystem.”

The impact of the human microbiome on **chronic diseases** has only recently been appreciated. Preliminary studies suggest that not only does the microbiome assist in the human well-being, but it “may misbehave in ways which cause disease.” Studies strongly suggest that specific bacteria play a crucial role in the prevention and treatment of obesity, malnutrition, irritable bowel syndrome, *C. diff* infection, diabetes, hypertension, heart disease, neurological conditions such as autism, and auto-immune diseases including asthma, eczema, and multiple sclerosis. Changing the ratio of the various bacteria of the microbiome impacts the above pathological states by a host of mechanisms, including changing fat and carbohydrate metabolism, synthesizing vitamins, and regulating salt excretion.

It appears that the human microbiome will play an important role in medical prevention and treatment in the future, but only after medical science better understands our resident microbes.

Source: *The Economist*, 18 August 2012, Pgs. 69-72, citing research from Imperial College, London; Washington University in St. Louis School of Medicine; Cleveland Clinic; and Baptist Medical Center, Oklahoma City.

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5. **TREMORS NOT ALWAYS A SIGN OF PARKINSON’S DISEASE**

Hand tremors can arise from a number of problems—some more serious than others. The most common and least understood type is **Essential Tremor**, which is inherited and can affect the hands, head, legs, and voice. It occurs when holding a posture or when moving, but less so at rest. This tremor can be treated with beta blockers, anti-convulsants, Neurontin, and Topamax. Similar tremors can arise as a result of anxiety, stress, low blood pressure, thyroid problems, caffeine or other stimulants, drugs, or withdrawal of drugs or alcohol. Such **Physiologic Tremor** can be managed by addressing the underlying cause. Tremors are also a symptom of Parkinson’s Disease. This tremor mimics rolling a pill between the thumb and forefinger. Later, the chin, lips, and legs are affected, but not the head or voice. **Parkinsonian tremor** accompanies the other classic symptoms. It occurs at rest and diminishes with movement. Parkinsonism is treated with a combination of drugs, including the “levo” stereoisomer of dopa. Tremors may also arise from multiple sclerosis, stroke, brain tumor, or brain trauma. Drugs are not successful in treating such tremors.

Source: www.HL.MayoClinic.com. July 2012

6. **SHOULD A DIET BE LOW-FAT?**

A study from the University of Illinois College of Applied Health Sciences compared the

cardiovascular benefits of a low-fat diet with that of a weight reduction diet alone. Two groups of obese women were assigned to a six week weight loss study, with one group on a low-fat diet and one on a higher-fat diet. While both groups lost weight, only the low-fat group experienced a decrease in fat mass and waist circumference as well as increased blood flow, measured in the major artery of the arm. These results suggest that weight loss alone may not improve cardiovascular health and that a low-fat diet is key to reducing one's risk.

Sources: *Illinois Health*, Spring 2012

7. **UPDATE ON ATRIAL FIBRILLATION**

The main concerns with atrial fibrillation (AF) are the risk of stroke and the symptoms of heart failure and fatigue (often with exercise intolerance). The main argument for restoring normal sinus rhythm in patients with mild to moderate symptoms is that it improves exercise capacity. Several antiarrhythmic drugs are available to control symptomatic AF.

The CHADS score (**C**ongestive heart failure, **H**ypertension, **A**ge > 75, **D**iabetes, and prior **S**troke or transient ischemic attack) provides an amazingly simple way to identify patients with AF who are at highest risk of stroke. Stroke prevention becomes one of the main priorities in managing AF, and this requires long term anticoagulation. Newly available anticoagulants are promising with some advantages over Coumadin, but have the disadvantages that their levels cannot be monitored and their effect cannot be reversed rapidly if bleeding develops. Patients who are doing well on warfarin need not change.

Radio frequency ablation is usually effective (65-75%) in controlling AF, but recurrence is common. Early recurrence usually subsides, but late recurrence often requires a repeat procedure. The need for anticoagulation persists when patients are converted to sinus rhythm because the risk of recurrent AF remains high.

Source: *Cleveland Clinic Journal of Medicine*, 79, August 2012, Pg. 522