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"Getting To Know You"

featuring Karen & John Dulany



What is your name and at what age did you contract polio?

My name is Karen Dulany and I got polio in 1949 after just having recuperated from rheumatic fever. I was in bed for a whole year until the fever left and then our old country doctor said I would be able to get out of bed and do things again. When I got up to walk my left leg kept collapsing. My mom called the doctor and he said I was probably just weak from having been in bed for a year. When this went on for several days, the doctor came to the house and said I had polio. I was 8 years old at the time. We lived in a small town, Pierce, NE but I was sent to Children's Hospital in Omaha. I was there for two months and then in Hattie B. Munroe Home for two more months for rehab.

How did you having polio affect the way you were treated?

I was not really treated any different from other children and never had any problems in grade school, except for one boy. He would steal my crutches and hide them somewhere outside. The teacher always made him go get them for me again. During the months I was in the hospital I attended school there. It was

interesting as many of us came on stretchers or in wheelchairs.

I was treated just like everyone else. I went to a small country school and everyone knew me and the situation. My grade school friends even wrote me letters while I was in the hospital. After I finished the exercises from the polio, I then had muscle transplants in my left leg and foot to stop the foot drop. Two years after my muscle transplant I went to the Orthopedic hospital in Lincoln and had two hip surgeries from a bone disease called Perthes Disease. I was about 12 at that time. After that I went to high school and could do everything that other people could do for the most part.

I was able to participate in marching band and school plays in high school. Our school had three floors and going up and down the steps then didn't bother me at all. I never felt tired or weakness and could do almost anything the other people did, except dance. Since I couldn't stand on my toes on the left foot or stand on my left leg, it made dancing pretty much impossible.

How did you having polio affect your self-esteem?

I had to attend crippled children's clinics until I was 17. I remember one very traumatic time when I was about 13 years old. Since I had many different illnesses besides the polio, I had to attend a huge doctors' conference. So in front of an auditorium of doctors, I had to walk out on stage naked so they could all see how my gait was and how the surgeries had helped. I was just mortified and have never forgotten that time.

Are you married, and if so, how did you meet your mate?

I met John on a blind date while he was stationed in Omaha with the Air Force and we got married in 1963 and we have three children, all of which are married. Two children live in Omaha and our other one lives in Colorado. We have 7 grandchildren. We lived in Germany for two years and our first son was born there. Then John got sent to California and our second child was born there. When he was discharged we moved to Omaha and our third child was born here. John was from Louisiana but I didn't want to move there. We have also been able to take some wonderful vacations in spite of my health issues.

When did PPS enter your life?

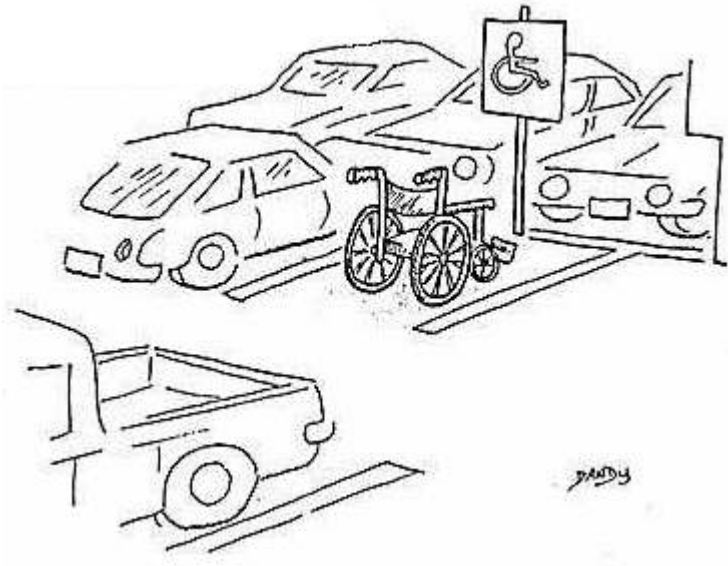
I had a brain aneurysm in 1997 and the surgery resulted in a light stroke. The stroke was on the left polio side and after that my leg got weaker and I had to start using a cane. My right leg then had to work harder for me to walk so that is when my hip, that I had the two surgeries on and my good knee started to have pain again. When I overdo my leg muscles twitch and cause some pain and more weakness.

How is PPS affecting your life style?

I finished college by going at night while I worked. I have worked at Eppley Institute for Cancer Research for nearly 39 years as manager of the histology lab. I may just go part time sometime instead of retiring all at once. I don't think I would be happy just sitting around at home, as I love being around people.

Comments to or from your spouse/supporter?

I feel very fortunate for the life I have been able to lead. When we take vacation, John doesn't mind pushing me around in the wheelchair and says it gives him good exercise. He doesn't want anything to stop us from enjoying our lives and still wants to travel with me even if he does have to do more things for me now. He is retired now so keeps busy by doing the vacuuming and laundry and helping me in any way he can. I feel very blessed to have John. I also feel blessed to have the friends I have. They do a lot for me too.



Polio Survivors' Painful Body Parts: The Big Four

by Dr. Richard Bruno

(Note: This column is for information purposes only and is not intended as a substitute for professional medical advice.)

Polio Shoulder: Because polio survivors usually have more leg than arm muscle weakness, they use their relatively stronger uppers to compensate for weaker lowers. So, when getting up out of a chair, climbing out of the bath or walking using crutches, the arms take the freight. The joint that complains most is usually the shoulder, the pain typically caused by bursitis or tendonitis. Sometimes, shoulder pain and an inability to lift your arm directly upward in front of you may be signs of a rotator cuff tear that could require physical therapy or, possibly, surgery.

Polio Neck: “Polio shoulder” can also be a part of “polio neck,” when the muscles that move the head and those that “shrug” the shoulders upward, go into spasm due to overuse weakness and poor posture. Polio neck is also the number one cause of headaches in polio survivors.

Polio Wrist: “Polio wrist” is usually caused by carpal tunnel syndrome, the squishing of the nerves that pass across the wrist. Polio survivors have much more carpal tunnel syndrome than the general population because pain in the wrists develops in the same way as polio shoulder — from overuse of joints — and in the case of the wrist, with repeated hyperextension (bending backward) as you push yourself upward from sitting to standing or walk using crutches.

Polio Hip: Pain in the hips also is often the result of bursitis or tendonitis caused by weak hip muscles trying to keep you from wobbling back and forth. Polio survivors and many doctors immediately assume that all hip pain is due to arthritis. Polio survivors can have arthritis, but hip pain is almost never caused by arthritis. Again, it is irritated tendons and ligaments that are making you hurt. What’s more, what you call hip pain may actually be caused by low back or butt muscles going into spasm as they try to compensate for weak leg muscles.

What do you do about the big four? Since pain is triggered by overuse, you need to take the load off of angry joints, their weakened muscles and nerves and their abused ligaments and tendons. Raising the height of chairs, using a toilet booster seat with arm/hand grips to help you stand and using a wide tub bench instead of standing in the shower or hauling yours elf in and out of the tub will take the load off your upper body.

Once you are up, using light-weight Lofstrand crutches is better than using nothing or even a cane. If you have “polio wrist” crutches that have foam covered hand grips or grips that are ergonomically designed could be a big help (see www.walkeasy.com). Crutches are also helpful for polio hip since they balance you from front to back and side to side, taking the load off of strained tendons and ligaments and weak hip, back and butt muscles. Of course, rolling in a power wheelchair is better than walking to ease all post-polio pains.

If taking the load off isn't helping enough, bursitis, tendonitis and muscle spasm can be treated by a physical or occupational therapist with ultrasound, heat (and sometimes, ice) and deep tissue massage. Your doctor may want to try a non-steroidal anti-inflammatory drug, like Ibuprofen or Celebrex. However, oral steroids should almost never be used to treat bursitis and tendonitis since their side effects are very unhelpful for most polio survivors. However, a few injections of cortisone and a local anesthetic into a joint or a muscle, followed by the above therapies, can knock down inflammation and prevent spasm. Local injections of cortisone in the wrist can also help reduce inflammation and swelling in those with carpal tunnel syndrome.

Sometimes, surgery may be required to treat CTS when the nerves are being pinched and damaged – and to repair a rotator cuff. For some rotator cuff tears, therapy is recommended to increase muscle strength. Strengthening should be done without causing fatigue, muscle weakness or pain and only after pain is gone. Asking a polio survivor to strengthen an overworked joint or muscle is like trying to put out a fire with gasoline.

Richard L. Bruno is Director of The Post-Polio Institute at New Jersey's Englewood Hospital and Medical Center, and Chairperson of the International Post-Polio Task Force. Nancy M. Frick is Executive Director of Harvest Center in Hackensack, N.J. Articles describing the research mentioned above can be found in the online PPS Library: <http://members.aol.com/harvestctr/pps/polio.html>.

“My mind not only wanders... sometimes it leaves completely!”

What Polio Survivors Had to Say – What Families Had to Say

These are the results of a workshop session, which followed a talk by Dr. Susan and Dr. David O'Grady on the Psychological Issues and Family Relations in Polio Survivors

(Reprinted from the Mt. Diablo Post Polio Network Newsletter, Vol. 6.)

The group was divided into polio survivors and family members. Each group was asked one question, with discussion lasting 45 minutes. They then reconvened to summarize and discuss what the two groups said. The question posed to each group was:

“What part of the experience of post-polio syndrome is most difficult to communicate to your spouse or family?”

The Polio Survivors: By all accounts, this turned out to be an intense discussion. Strong feelings were stirred up. Many were moved, some cried. It was clear that the process of confronting the emotions

surrounding the experience of post-polio is difficult and painful. Similarly, communicating about these feelings to family and even to other polio survivors can sometimes feel overwhelming.

Paraphrased, here are some of the areas of concern:

- ☛ We are afraid of what the future holds. In fact, sometimes the future seems so scary we can't allow ourselves to think about it.
- ☛ We are afraid that our physical needs will place such demands on our families that they will grow weary and resentful and withdraw support. We wish we had reassurance that we will not become so burdensome that others will leave us.
- ☛ We want families and friends to not judge us by our appearance. Appearances can be deceiving. More often than not, we look much better than we are. Weakness, fatigue and pain are less visible than braces and wheelchairs, but no less real.
- ☛ When we are tired, we mean it. In fact, it usually means we are exhausted and a short rest may not remedy it. Don't overestimate how much we can do. We struggle enough as it is, to figure out our own limitations.
- ☛ Sometimes we need to put ourselves first, which is difficult for most of us to do – this is a major shift for us. We would like you to help us do this by cooperating when we say we need something. We know the difference between a need and a whim. It is hard for us to ask for help; it doesn't come easily.

Conflict within the group emerged when some participants expressed fear and frustration while others reacted with anger. It seemed that both fear and anger were central and universal experiences, but that people cope differently. The anger expressed seemed to grow out of a need to fight feelings of vulnerability and helplessness and instead, maintain a sense of control and a positive attitude. Worried that their fears and sorrow will pull them down, some people use anger to protect against feeling fear. Other people are afraid of how intense their anger can become, so they suppress it.

Partners and Families: All expressed a deep commitment to their partner and a readiness to be a part of their lives, regardless of changes in physical status. This commitment was not naïve or superficial, but seemed founded on genuine love and respect for the challenges their partners have faced and will continue to face.

They acknowledged that coping with PPS involves a series of compromises, but they adapt by remaining flexible and tolerant. Within this group there was much commonality, but when differences of experience emerged this group was quite respectful and compassionate.

Partner and family expressed the following concerns:

- ☛ It is difficult to see our partners in pain. We feel helpless to ease physical suffering. Therefore, we would like our partners to listen to their bodies, slow down and not be such perfectionists.
- ☛ It is hard to see our partners reject changes that would help them cope (e.g. – using a wheelchair or a scooter). We do not view use of adaptive devices as failure, but as an increase in functionality and freedom to enjoy life together.
- ☛ Sometimes our partner's anger is hard to deal with. When they are feeling tired and frustrated they get irritable. If we say the wrong thing, they get upset. We sometimes have to ignore what they are saying, so we don't take it too personally.
- ☛ The lack of predictability of the illness is frustrating and frightening. We don't know what our partners will be able to do in the future. Therefore, we feel it imperative to live for today and not postpone doing things that give us pleasure.

- ☛ Over time, our role in household responsibilities is getting larger. We accept this. Still, your comment of appreciation is very welcomed.
- ☛ Some of us feel concern about our own physical ability to provide care for our partners as we, ourselves, age and contend with our own aches and pains. We worry about the possibility of not being able to give necessary help.
- ☛ It is difficult to know when to be the cheerleader, when to be comforting and soothing and when to confront anger or passivity. We'd like to feel we have permission from our partners to express our feelings about this.

In conclusion, there was a broad agreement that life is all about challenge and response; that amidst the hardship, post-polio represents an opportunity for personal growth for both survivors and family, if the challenge can be faced with flexibility, acceptance and openness.

(BGG Editor's Note: Understand please..., these results are from the Mt. Diablo Post-Polio Network and not from our group. The survivors' and supporters' meetings we conduct annually at our reunion are kept confidential. This article was reprinted for the sole purpose of allowing us all to understand some concerns from polios and their supporters.)

The early worm gets eaten by the bird... so sleep late.

Polio Literature

by Henry Holland

As an infectious disease, historical evidence would indicate that polio has been in existence for over five thousand years. However, over these many centuries, the literature on polio has been limited. In this century there has been more in the medical literature about polio as a result of the epidemics that began in the early part of this century. With the development of the Salk and Sabin vaccines, the medical literature regarding polio quickly vanished. Now, with the reality of Post-Polio Syndrome (PPS), the literature, both medical non-fiction and fiction, has increased in the last decade. In my opinion, this literature has resulted for two reasons. One is due to PPS and the other is due to books that have been written by polio survivors and family members of polio survivors. In our support group's library, we have many of the medical books on PPS, but we do not have many of the non-medical books. Listed elsewhere in this newsletter (The Deja View, not here in the BransonGoers Gazette) are some of the books with a polio or PPS connection. This is by no means a complete list. I have read some of these books, but certainly not all of them.

As complete as this list seems to be, a connection to polio still occurs in literature or the arts when I least expect it. Last fall, I audited a course on Job at a local seminary. The course dealt with "Job in the Bible and Beyond" and how the story of Job has influenced the arts down through the centuries. On one evening, the professor was showing slides of art that best depicted the suffering of Job. One of the slides was a painting by Piero della Francesca in Arezzo Italy. The painting revealed a recently resurrected Jesus, half in and half out of the grave. There was still some of the look of death on Jesus' body. At this point, the professor read a passage from a novel, *Crossing to Safety* by Wallace Stegner.

"But I noticed that Sally stood a long time on her crutches in front of that painting propped temporarily against a frame of raw two-by-fours. She studied it soberly, with something like recognition or

acknowledgement in her eyes, as if those who have been dead understand things that will never be understood by those who have only lived."

In the novel, Sally is a polio survivor who wears leg braces and uses crutches. She and her husband Larry become life long friends with Sid and Charity when both husbands are young college professors at the University of Wisconsin in the late 1930's. Both wives get pregnant at the same time. While vacationing in Vermont, Sally is stricken by polio. Years later, the two couples travel to Italy and the scene described above occurs. One interpretation offered by this scene is that many polio victims can identify with Job or the suffering of the crucified Jesus. Many polio survivors have risen to full lives despite the damage of polio. However, many can recall the fear and even horror of a near death experience. We may tend to forget that thousands of children died from acute polio, especially before the development of the iron lung. This disease has shaken thousands of families. Many of us do "understand things that will never be understood by those who have only lived."

I can identify with many interesting passages in this novel. Larry, Sally's husband, writes this novel in the first person. Larry comments on the uncertainty of life with these words: "You can plan all you want to. You can lie in your morning bed and fill whole notebooks with schemes and intentions. But within a single afternoon, within hours or minutes, everything you plan and everything you have fought to make yourself can be undone as a slug is undone when salt is poured on him. And right up to the moment when you find yourself dissolving into foam you can still believe you are doing fine." This sounds a bit like the process of PPS. Many of us have "fought" to be contributors and not burdens to our individual worlds, only now to feel undone by the "salt" of PPS.

Again Larry speaks of the friendship that has developed over the years between his wife Sally and Charity. "The cant word these days is 'bonding.' I suppose some people see in a relationship like that signs of an unacknowledged lesbianism---the same people who probably speculate about the sex life of somebody like me, a perfectly healthy man with a crippled wife. I don't care how they speculate, or what their answers are. We live as we can, we do what we must, and not everything goes by either Freudian or Victorian patterns. What I am sure of is that friendship---not love, friendship---is as possible between women as between men, and that in either case it is often stronger for not having to cross sexual picket lines. Sexuality and mistrust often go together, and both are incompatible with *amicitia*."

Near the end of the novel, Larry writes of his observations upon living his adult life with his polio disabled wife.

"One of the peculiarities of polio is that its victims, once they have recovered from the virus and settled down to whatever muscular control it has left them, live a sort of charmed life. Crippled as they are, they are rarely ill, they are surprisingly tough and durable, they astonish their sound companions with their capacity to endure. But that is not forever. There comes a time in the life of every such patient when the whole system---muscles, organs, bones, joints---begins to fall apart all at once, like the wonderful one-hoss-shay. Every polio patient is warned to expect that time, every polio family lives with the foretold doom waiting for it at some unknown but expected time in the future. One learns to live with it by turning away from it, by not looking. And yet on occasion one is aware of an intense, furtive watchfulness, and the victim, the doomed one, must surely have just as often the vulnerable sense of being watched."

In my mind, the above paragraph is describing PPS. The author of this novel, Wallace Stegner, lived from 1909 to 1993. *Crossing to Safety* was published in 1987, around the time PPS was being identified as an entity. Stegner has written many novels and wrote this one after fifty years of writing. I wonder how he knew so much about the character of polio. Perhaps, he had some personal experience with polio. If any of you know, please let me know. In his career, Stegner won the Pulitzer Prize, the National Book Award, and O. Henry prizes.

Originally published in the Central V A PPS Support Group (PPSG)'s newsletter, The Deja View, in 1999.
Reprinted here with permission of the author, Henry Holland.

Putting both feet in your mouth at the same time leaves you with no leg to stand on .

Heart Health: What You Need to Know

(Reprinted from Elder Update, May/June 2006, Health and Wellness)

Although heart disease is sometimes thought of as a “man’s disease, it is the leading cause of death for both women and men in the United States, with women comprising 51 percent of the total heart disease deaths.

While heart disease is the number one killer of women, only 13 percent of women in a 2003 survey by the Centers for Disease Control were aware that this is their greatest health problem. Here, the term “heart disease” refers to the broadest category of “diseases of the heart,” which includes acute rheumatic fever, chronic rheumatic heart disease, hypertensive heart disease, coronary heart disease, pulmonary heart disease, congestive heart failure, and any other heart condition or disease.

Studies among people with heart disease have shown that lowering high blood cholesterol and high blood pressure can reduce the risk of dying of heart disease, having a nonfatal heart attack, and needing bypass surgery or angioplasty. Studies among people without heart disease have shown that lowering high blood cholesterol and high blood pressure can reduce the risk of developing heart disease.

Facts about Women and Heart Disease

Heart disease is often perceived as an “older woman’s disease,” and it is the leading cause of death among women age 65 and older. However, heart disease is the third leading cause of death among women age 25-44 years of age and the second leading cause of death among women aged 45 -64 years. Additionally, in 2002, death rates for heart disease were higher among black women than among white women.

There is a range of risk for heart disease depending on family and personal health history and the treatment recommendations from a physician will depend on a woman’s level of risk. Regardless of the risk level, these life style modifications are recommended for all women:

- Cigarette smoking cessation
- 30 minutes physical activity most days
- Heart healthy diet with weight maintenance / reduction.
- Evaluation and treatment of depression

Facts about Heart Failure

- Heart failure is a condition where the heart cannot pump enough blood and oxygen to meet the needs of other body organs. Heart failure does not mean that the heart has stopped, but that it cannot pump blood the way that it should.

- Heart failure is a serious condition. There is no cure for heart failure at this time. Once diagnosed, medicines are needed for the rest of the person's life.
- The risk of death within five years of being diagnosed with heart failure is more than 50 percent. About 80 percent of men and 70 percent of women with heart failure under the age of 65 die within eight years.
- People with heart failure are at increased risk for sudden cardiac death.

Source: Center for Disease Control

Women Experience Different Symptoms from Men

Heart attack symptoms in women are often more subtle than those experienced by men. Women are more likely to experience the following symptoms during heart attacks:

- Fatigue
- Anxiety
- Sleep disturbance
- Stomach complaints

Unfortunately, these symptoms are not generally associated with an AMI (acute myocardial infarction). Even members of the medical profession sometimes fail to link these symptoms with heart problems. It is not unusual for a woman's heart attack to be dismissed as anxiety.

Although considered a classic heart attack symptom, chest pain is not commonly experienced by women. Results from a survey of 515 women published in the American Heart Association's journal *Circulation*, revealed some interesting statistics: more than 70 percent of women experienced no chest pain prior to the attack, and as many as 43 percent of women reported no chest pain symptoms during the attack.

Further, women who do experience chest pain may describe the pain as "sharp," rather than "crushing." This description does not match the popular (and traditional medical) perception of heart attack symptoms, and may be misdiagnosed.

Additionally, in the days before the attack, 95 percent of women surveyed reported unusual symptoms; the most common being fatigue, anxiety, and sleep disturbances. This list presents some of the common symptoms experienced by women both prior to and during a heart attack. These symptoms are important to consider in addition to chest pain, since in some women they may be the only symptoms present.

Symptoms Before an Attack

Fatigue (71 percent)
 Sleep disturbances (48 percent)
 Shortness of breath (42 percent)
 Indigestion (39 percent)
 Anxiety (35 percent)

Symptoms During an Attack

Shortness of breath (58 percent)
 Weakness (55 percent)
 Fatigue (43 percent)
 "Cold sweat" (39 percent)
 Dizziness (39 percent)

Source: NCERx



Statins: Good for Heart, Bad for Joints?

(Reprinted from Arthritis Today, September-October 2005)

If you are taking a cholesterol-lowering drug, chances are your heart may be protected, but your hip joint may not be. A recent study shows that the statin drugs, a class that includes Lipitor, Pravachol and Zocor, may nearly double the risk of developing hip osteoarthritis (OA) in women older than 65.

In the study of 5,674 women by researchers at the University of California in San Francisco, 745 women showed X-ray evidence of OA. After eight years, the researchers found a 92% increase in the risk of developing hip OA in the women who had been taking statin drugs. Of women already had OA, however, the statin drugs were not associated with making the disease worse.

If lifestyle modifications, such as eating right and getting regular exercise, didn't succeed in lowering lipid levels, statin medications are the first-line drug of choice for this purpose, but they are not the only choice, says John H. Stone, MD, associate professor medicine, division of rheumatology and director of the Johns Hopkins Vasculitis Center at Johns Hopkins University School of Medicine in Baltimore.

"Fibrate drugs, such as gemfibrozil (Lopid), can boost "good" high-density lipoprotein (HDL) cholesterol and improve the overall cholesterol ratio. The drug ezetimibe (Zetia) keeps the body from absorbing cholesterol, and the prescription forms of niacin, a B vitamin, can decrease "bad" low-density lipoprotein (LDL) cholesterol, increase HDL and decrease triglycerides," says Dr. Stone.

Don't cry because it's over; smile because it happened.

HealthSmart: Expired Drugs: Toss 'Em?

by Dr. Tedd Mitchell

(Reprinted from USA Weekend, July 8-10, 2005)

Dear Dr. Tedd,

Must I throw out any medication that's past its expiration date? If a drug expires on one day, does that really mean it's no good the next day?

Back in 1979, a law was passed requiring drug manufacturers to print an expiration date on the bottle or package. That date is generally two to three years from the date the drug was made. The manufacturer guarantees that the medication (over-the-counter as well as prescription) will have its full potency and safety through that date – if left in the original, unopened package.

Does that mean it starts to degrade, or break down, soon after that date? Probably not. It's important not to confuse a drug's expiration date with its shelf life. As long as you don't unseal the manufacturer's container, a drug may be good far beyond its expiration date.

We know this because back in 1985 the Air Force wound up with a stockpile of medications that were just about to expire. Not wanting to throw away medicine (and money) unnecessarily, the Air Force asked the Food and Drug Administration to check the drugs for safety and effectiveness. The FDA estimated that 80% of the medications would remain safe for nearly three years past their expiration date.

Some people suspect that expiration dates have as much to do with marketing as science. By dumping expired drugs and restocking, pharmacies and families keep the economic machinery of the manufacturers running. Of course, folks in the pharmaceutical industry have a different view. They say replacing medicines promotes public safety. Indications for medications change, and labels need to be updated. New drugs are developed that sometimes are more effective than the older ones.

The American Medical Association wants more testing to see whether expiration dates can be lengthened. The AMA also points out that the downside of expired drugs is lost effectiveness, not toxicity. Many people believe that taking an old medication can be harmful, but the data just doesn't support that.

PLAY IT SAFE: SOME MEDICINES DON'T LAST

Even though testing has been limited, I think it's safe to say that using most medications for three years after their expiration date is all right, with a few caveats:

- ⇒ **Liquid or suspension medications.** These don't retain their potency nearly as well as solid medications, so stick to the expiration date on the package.
- ⇒ **"Lifesaving" medications.** Someone taking a medication for a severe cardiac arrhythmia probably shouldn't rely on an older drug to do the trick.
- ⇒ **Medications bottled by the pharmacist.** Remember that expiration date guarantees come from the manufacturer and are based on unopened packages. After a pharmacist breaks the seal, counts out pills and puts them in a pharmacy bottle, he places a new expiration date on that bottle. It's generally limited to about a year from the time the prescription is filled. This is called the "beyond use" date. So drugs you pick up from a pharmacy that are in one of the pharmacy's bottles may not last quite as long, although the three year rule might still apply. Ask your pharmacist.

A TIP: To improve the efficacy of your medications in your home, store them in a cool, dry spot; the refrigerator is probably best. That will help ensure their long-term effectiveness.

Foods that Fight Disease

Here are top five foods to help fight diabetes, cardiovascular disease, migraine headaches, and arthritis.

Diabetes

1. Soybeans (combo of protein, high-quality carbs, and soluble fiber helps stabilize blood sugar levels)
2. Wild salmon (provides protein, omega-3 fats, and vitamin D)
3. Swiss chard (great low-glycemic carbohydrate, plus provides magnesium)
4. Beans (slow-release carbohydrate with soluble fiber and magnesium)
5. Almonds (great low-carb snack; also provides unsaturated fat, protein, and fiber)

Cardiovascular disease

1. Wild salmon (thins the blood and lowers triglycerides)
2. Bananas (rich in magnesium and potassium; helps manage blood pressure)
3. Brussels sprouts (rich in soluble fiber, which lowers cholesterol)
4. Oatmeal (rich in soluble fiber, which lowers cholesterol)
5. Sunflower seeds (3 heart-healthy ingredients: soluble fiber, plant sterols, and folic acid)

Migraines

1. Omega 3 fortified eggs (provides omega-3 fats)
2. Beans (provides magnesium)
3. Skim milk (provides riboflavin)
4. Ground flaxseeds (provides omega-3 fats and soluble fiber)
5. Spinach (provides magnesium)

Arthritis

1. Red bell pepper (rich in vitamin C and beta cryptoxanthin)
2. Carrots (provides ample beta carotene)
3. Berries (contains potent antioxidants called anthocyanins)
4. Oranges (provides vitamin C and beta cryptoxanthin)
5. Pumpkin (provides beta cryptoxanthin and beta carotene)

Gird for GERD

by Tedd Mitchell

(Tedd Mitchell, M.D. is president and medical director of the Wellness Program at Dallas' Cooper Clinic.)

Change habits to beat the burn.

I grew up in a household where you could find Roloids in every room. My brothers and I referred to it as Dad's "candy." I didn't realize he suffered from gastro esophageal reflux disease, a condition in which the acid contents of the stomach slosh up into the food pipe. Those who are afflicted develop a burning in the chest, and some experience the stomach acid regurgitating into their mouths. For those who have symptoms a few times a month, it's generally a nuisance. But for many, the symptoms occur daily, disrupting their lives.

To control GERD, keep in mind the three "T's":

Meal Timing. Gastro esophageal reflux tends to be worse when you lie down, so eat your evening meal as early as possible. Giving your stomach three to four hours to work on it and pass it downstream into the small intestine makes reflux less likely.

Type of food. Although foods don't cause GERD, they can aggravate the symptoms. Some common triggers are caffeine, alcohol, fatty or spicy foods and citrus fruits. After episodes of reflux, think back on what you ate to see if there is a pattern.

“Tonnage.” Large meals make the upper intestinal tract work overtime to handle the load, so you're more likely to have acid reflux. Eating less reduces this tendency.

Whether your reflux is a nuisance or a nightmare, changing a few habits can improve your situation. Get started today and you'll feel better before you know it.

Hand Washing:

An Important Preventive Health Habit

by Joe Thomas

Although the washing of hands seems like a little thing, it can have a powerful impact on managing the spread of infectious disease. According to the [Centers of Disease Control and Prevention \(CDC\)](#), hand washing is considered the single most important means of preventing the spread of infection.

Everyday we come into contact with germs from a variety of sources -direct contact with people, contaminated surfaces, food, animals, and animal waste. When we don't wash our hands or wash them properly, we greatly increase the risk of spreading germs to other people, as well as to ourselves by touching our eyes, mouth, and nose. One of the most common ways to catch a cold or the flu is by rubbing the nose and eyes with hands that have been contaminated. Beyond these common illnesses, poor hand hygiene can be a contributor to potentially serious illnesses such as hepatitis, meningitis, infectious diarrhea, and severe acute respiratory syndrome (SARS).

Inadequate hand hygiene also contributes to food-related illnesses such as salmonella and Escherichia coli (E. coli.). According to the [U.S. Food and Drug Administration](#) and the CDC, transmission of pathogenic bacteria, viruses, and parasites from raw food or from ill people to food by way of improperly washed hands, continues to be one of several major factors in the spread of food-borne illnesses. Reportedly, 76 million Americans contract a food-borne illness each year, and of these, about 5,000 die as a result of their illness. Others experience nausea, vomiting, and diarrhea.

It is important to wash your hands often, particularly anytime you think you have exposed them to bacteria or viruses. The CDC recommends washing of hands:

- ❖ Before preparing or eating food.
- ❖ After going to the bathroom.
- ❖ After changing diapers or cleaning up a child who has gone to the bathroom.
- ❖ Before and after tending to someone who is sick.
- ❖ After blowing your nose, coughing, or sneezing.
- ❖ After handling an animal or animal waste.
- ❖ After handling garbage.

- ❖ Before and after treating a cut or wound.

Equally important as when to wash your hands, is how to wash your hands. The CDC offers these guidelines for washing with soap and water:

- ❖ Wet your hands with clean running water and apply soap. Use warm water if it is available.
- ❖ Rub hands together to make lather and scrub all surfaces.
- ❖ Continue rubbing hands for 20 seconds.
- ❖ Rinse hands well under running water.
- ❖ Dry your hands using a paper towel or air dryer. If possible, use your paper towel to turn off the faucet.

For those times soap and water is not easily accessible, keep an alcohol -based hand sanitizer handy-car, purse, briefcase, desk, especially if you spend a great deal of time in public areas, e.g. trains, buses, subways.

- ❖ Apply product to the palm of one hand.
- ❖ Rub hands together.
- ❖ Rub the product over all surfaces of hands and fingers until hands are dry.

If you take a moment to think about all the things you touch each day and how many people may have touched them before you, you might want to consider heading straight to the sink to wash your hands! Hand washing is a simple act that doesn't take much time or effort and it is one of the most important steps we can take in keeping ourselves -and others- healthy.

August Celebrations

Birthdates:

2nd Dave Davison
 Phil Vrana
 Phyllis Bischof
 5th Jim Sutton
 6th John Booth
 9th Dick Bischof
 12th Harley "Van" Vanlandingham
 13th Jaan Lill
 20th Dale Ryals
 Paul Price
 22nd Everett Jensen
 29th Virginia Wood

Anniversaries:

7th Deanna & Ron Block
 Sandy & John Knisely
 17th Judy & Don Eades
 24th Judith & Paul Price