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Health News

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Living With GERD

Are you plagued by heartburn more than twice a week? If the fire is more than the occasional antacid can quell, then you may have gastroesophageal reflux disease (GERD). This condition occurs when the esophagus is exposed to an abnormal amount of acid caused by relaxations of the muscle connecting the esophagus and the stomach.

In addition to the most common symptom, heartburn, GERD may also manifest as tightness in the chest, an unexplained hoarseness, or a constriction in the airways, similar to asthma. Others may experience frequent hiccoughs or abdominal pain. Sometimes people will not exhibit any symptoms until they present with complications.

Once GERD strikes, the condition may remain for a lifetime. The good news is that lifestyle changes combined with effective over-the-counter and prescription medications can help people manage GERD successfully.

In the past several years new medicines have emerged to combat GERD symptoms. Groups of acid reducers can lessen the amount of acid in the stomach dramatically. Most of the therapeutic efforts for GERD are medicinal rather than surgical.

"Diet and lifestyle are at least as important as medication," says gastroenterologist **Brian R. Landzberg, M.D.,** NewYork-Presbyterian Hospital/Weill Cornell Medical Center. "If many of my GERD patients lose 15 or 20 pounds, their condition would vanish. It's not entirely clear why weight loss has such a big effect—but it does!" Dr. Landzberg also suggests eating smaller, more frequent low-fat meals, avoiding chocolate, mint, caffeine and alcohol, and not eating at least two hours before bedtime.

As for medication, Dr. Landzberg recommends first trying an over-the-counter antacid. "If patients find they have to reach for an antacid more than once or twice a week, then it may be time to consider another class of medicines called proton pump inhibitors, such as Prilosec, Prevacid, Nexium, Protonix, or Aciplex," says Dr. Landzberg. "These medicines directly block the acid pump in the stomach cells."

To be sure symptoms are related to GERD, some physicians may use a 24-hour pH probe connected to a thin catheter that runs through the nose and down the esophagus to chart whether heartburn and chest pain correspond to an acid reflux event and if an abnormal amount of acid reflux is present. A certain degree of acid reflux is normal and occurs in everyone.

Chronic acid reflux can also lead to Barrett's esophagus, a condition of the esophageal lining that can lead to esophageal cancer. This condition is more frequently seen in patients with longstanding symptoms, people over 50, and, in particular, in Caucasian men for unclear reasons. We recommend that patients in these categories undergo an endoscopic evaluation. Although GERD is common and esophageal cancer far less frequent, we know that patients with the former are at increased risk for the latter.

"Although GERD often presents as typical heartburn," continues Dr. Landzberg, "it is important to realize that the disease has many faces and may be entirely asymptomatic. It is also important to remember that symptoms which seem like simple GERD may reflect a more serious process, or a non-esophageal cause, such as angina pectoris, and merit evaluation by a physician."

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What's Inside

On the Watch for Whiplash Injuries

The term "whiplash"—that most common of injuries often resulting from a rear-end auto accident—has been used for many years to describe a soft tissue injury to the neck. In the United States last year, there were some one million reported cases of whiplash injuries. Also called neck sprain and strain, it is characterized by a collection of symptoms that occur following damage to the neck, usually because of sudden hyperextension (backward movement of the neck) and flexion (forward movement).

"A whole range of symptoms associated with this type of injury falls under Whiplash-Associated Disorders," says **Gary I. Polykoff, M.D.,** Anesthesia Pain Management, Massachusetts General Hospital. "They include pain in the neck, upper back and lower back, shoulders, headache, blurred vision and dizziness, which could indicate a concussion, as well as abnormal symptoms, such as burning or a prickling sensation, and a loss of taste, smell or hearing."

In many instances, symptoms will not occur immediately, and may take 24 to 72 hours to manifest themselves. According to Dr. Polykoff, the amount of time that elapses between injury and the onset of neck symptoms can be a predictor of the severity of injury and prognosis. "A shorter time to onset of symptoms signifies a potentially severe injury with more frequent long-term complications," notes Dr. Polykoff.

Treatment protocol is based on a case-by-case basis, but general recommendations may include:

- rest, not exceeding three days
- a short course of pain medications, such as analgesics and non-steroidal anti-inflammatory medications
- short applications of ice and heat therapy to relieve muscle tension and pain, and
- muscle relaxants

If there is soft tissue injury, the patient would be referred for range-of-motion exercises and anti-inflammatory modalities, and the application of cold, heat and electrical stimulation for a short period of time. X-rays of the neck would be ordered if the physician suspects ligamental instability, bone fractures, or if there are persisting neurological symptoms.

For most patients, the symptoms of whiplash usually subside in two to four weeks. If symptoms continue or worsen after six to eight weeks, further X-rays and other diagnostic testing, sometimes including an MRI, could be required. Severe whiplash can damage the intervertebral discs, requiring surgical repair.

Whiplash injuries often bring damage to the muscles, ligaments and joints supporting the neck, and an injection with a small amount of lidocaine and cortisone may be used to relieve persisting pain.

Pain and symptoms that last over three months are considered chronic, notes Dr. Polykoff. Research shows that women are more likely to suffer for a longer period of time and more likely to develop chronic problems and/or permanent impairment. Some theorize that the female neck is less muscular, has a smaller circumference, and in some cases, is longer than those of males, all leading to greater forces involved in the creation of injuries.

"Chronic symptoms are also related to a patient's age—older patients are predisposed to chronic symptoms because of anatomic changes, such as arthritis, that were present at the time of injury," adds Dr. Polykoff.

Speeds as low as 15 miles per hour can produce enough energy to cause whiplash. The position of the patient at the time of impact and whether he or she was wearing a seatbelt can also contribute to the severity of the injury.

Safety experts say that a properly adjusted car headrest and the angle of the seat back can reduce the force of whiplash and reduce the risk of whiplash-related injuries. The generally accepted measurement for the proper height of the headrest is the ear. Headrests have been rated good if they are above the ear, poor if below the ear, and very poor if the headrest is not visible at all. The acceptable to good rating for how far back the headrest should be from the head is two to four inches. If the distance is more than half the width of the head, restraints are rated poor.

Taking the extra time to properly adjust your headrest and seat back may mean the difference between walking away unhurt from an accident, or living with the pain of a whiplash-related injury.

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Cholesterol Guidelines: A Moving Target

What's in a number? Plenty, according to the National Cholesterol Education Program (NCEP), which this past July updated elements of its 2001 cholesterol guidelines. According to **Mason W. Freeman, M.D.,** Chief of the Lipid Metabolism Unit of Massachusetts General Hospital, the revised guidelines recommend lowering the LDL (low-density lipoprotein) cholesterol target down from 100 mg/dL (milligrams per deciliter) to potentially as low as 70 in the people who are at highest risk for a coronary event.

The update, endorsed by the National Heart, Lung, and Blood Institute, the American Heart Association, and the American College of Cardiology, is based on a review of five clinical trials of cholesterol-lowering statin treatments. It offers options for more intensive cholesterol-lowering treatment for people at high risk and moderately high risk for a heart attack.

High-risk patients are regarded as those individuals who have coronary heart disease; disease of the blood vessels to the brain or extremities; diabetes; or multiple (two or more) risk factors that give them a greater than 20 percent chance of having a heart attack within 10 years. Other risk factors include being male; being postmenopausal; having hypertension; obesity; having a family history of early coronary disease; and having an HDL cholesterol level of less than 40.

Dr. Freeman emphasizes that the new reduction to 70 is an optional target for physicians and patients, not an explicit direction. Dr. Freeman also stresses that one's risk of a heart attack is not simply determined by cholesterol levels, but from a compilation of factors that combine to block arteries. "There are many people who have cholesterol levels that we think are quite high who never have coronary disease," says Dr. Freeman. "The NCEP guidelines are designed to examine all that we know about lifestyle, inherited risks, and factors that make one more likely to have heart disease and make recommendations about cholesterol, based on whether a person has lots of risks or very few."

Reducing the Number

Changing one's lifestyle—for example, losing weight, improving diet and exercising—can produce positive and dramatic results in some patients. "Before a person is put on a drug therapy or before they develop heart disease, he or she ought to be encouraged to take these steps," says Dr. Freeman.

The new guidelines recommend consideration of drug treatment in addition to lifestyle therapy for LDL levels of 100 or higher in high-risk patients, and suggest drug treatment as optional for an LDL less than 100. The most widely prescribed drugs used in lowering LDL are called statins, a class of medications that block a cholesterol-synthesizing enzyme. "The least powerful of these can lower LDL cholesterol by about 35 percent, and the most powerful, by 60 percent," says Dr. Freeman. "However, the statin drugs—though spectacularly effective cholesterol-lowering agents—do have measurable side effects."

What's Ahead?

Dr. Freeman and other researchers have identified a pathway that uses a specific protein to move cholesterol out of cells and away from the artery wall before it can do damage. "We want to find a drug target to make that happen more efficiently," he says.

According to Dr. Freeman, two human studies have been published in the last year that provide insight into methods that could be used to improve performance of this "reverse cholesterol transport pathway." In the first, an HDL or good cholesterol-like material was directly infused into patients and the impact on the size of arterial lesions was measured. This resulted in a measurable decline in plaque size, which could reduce heart attack rate. Further studies will be needed to prove that benefit, but this initial report generated a lot of excitement.

The second study used an experimental drug to raise the HDL level 60 to 100 percent. Both of these studies focus on the role of HDL in preventing heart disease and represent a novel approach to prevention. Dr. Freeman points out that the current cholesterol guidelines primarily direct physicians to lower LDL levels to prevent cholesterol from being deposited in the artery wall. These new approaches could be combined with LDL lowering to enhance cholesterol removal as well, leading to even greater reductions in coronary heart disease.

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Combination Therapies Advance Treatment for Rheumatoid Arthritis

According to experts at Georgetown University Hospital, new medication combinations are helping to slow or stop the progression of rheumatoid arthritis, a chronic autoimmune disease that can cause deformity and permanent disability in children and adults.

Current treatment often combines biologic response modifiers, a new class of disease-modifying anti-rheumatic drugs (DMARDs), with other DMARDs to inhibit the disease's destructive processes. According to Georgetown rheumatologist **Sean Whelton, M.D.,** these potent drugs can be prescribed successfully in combination with symptom-relieving non-steroidal anti-inflammatory drugs, COX-2 inhibitors, and corticosteroids.

"The goal of treatment is to stop the person's immune system from destroying his or her body," says Dr. Whelton. "If untreated, this disease will very predictably lead to deformity and disability in a few years time. We use DMARDs to block some of the destructive activity of the immune system."

More than two million people in the United States have rheumatoid arthritis. Three out of four of them are women, and the peak onset is between 20 and 45 years of age, according to the American College of Rheumatology. The disease affects the joints, most commonly in the hands and wrists, but also can cause inflammation in other body systems.

DMARDs were introduced 25 to 30 years ago and have greatly improved rheumatoid arthritis drug therapy, Dr. Whelton explains. However, no additional drugs for rheumatoid arthritis were approved until about five years ago, when there was "a flurry of new medications." Since then, treatment science took another leap forward with the introduction of biologic response modifiers, which target specific body chemicals that cause inflammation, joint damage, and tissue damage.

"In many patients, these breakthrough drugs have a dramatic influence on the disease, significantly slowing its progress and, in some cases, halting any destruction that's taking place," Dr. Whelton reports. "People feel a lot better, they're able to do much more, and they're able at times to go back to essentially normal function."

Biologic Response Modifiers

Biologic response modifiers differ from other DMARDs in that they are proteins rather than the usual chemical compounds. They are modeled on natural substances found within the body's immune system. Two of the drugs, infliximab (Remicade®) and adalimumab (Humira®), mimic immune globulins. Etanerecept (Enbrel®) is a fusion reception molecule that binds to cytokines, rendering them ineffective. Anakinra (Kineret®) blocks a receptor so that a chemical signal cannot be communicated.

Biologic response modifiers can benefit both adult and pediatric patients, as well as persons with other rheumatic diseases, including psoriatic arthritis and ankylosing spondylitis. Infliximab is given by intravenous infusion in the physician's office once every six to eight weeks. Adalimumab and etanerecept are self-administered by injection, the former twice a month and the latter twice a week. Anakinra is given as a daily injection. The drugs frequently are prescribed in combination with oral DMARDs, including methotrexate, hydroxychloroquine, sulfasalazine, and leflunomide, as well as with pain and inflammation relievers.

"Using multiple modalities is associated with better control of the disease," says Dr. Whelton. "Using a combination of methotrexate and one of the biologic response modifiers is the current state-of-the-art treatment."

Despite their remarkable benefits, the new drugs are not for everyone with rheumatoid arthritis. For example, they are contraindicated for patients with immune diseases such as multiple sclerosis and for patients with infections such as tuberculosis, pneumonia, and severe sinusitis.

"In the case of very active rheumatoid arthritis, the immune system is dysfunctional, and people are more prone to infections at baseline," Dr. Whelton explains. "These drugs can play a role with that, sometimes worsening the situation."

Dr. Whelton observes that the introduction of biologic response modifiers has been a major step forward and that other promising drugs are in the research pipeline.

"Even though these medications represent a significant advance in our ability to treat this disease, we all have to keep our eye on the goal of curing the disease," he says.

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Focusing on Glaucoma

Like a thief in the night, glaucoma—the leading cause of preventable blindness—can gradually steal your sight without warning and often without symptoms. It affects an estimated 3 million Americans, half of whom do not even realize they have it.

Open-angle glaucoma is the most common form of glaucoma. It occurs when the intraocular pressure (IOP) increases to dangerous levels. An increased IOP reading indicates a problem with the amount of aqueous humor (fluid) in the eye. Usually, it is not draining properly. This can result in damage to the optic nerve leading to decreased peripheral vision and, eventually, blindness.

Closed-angle glaucoma (acute glaucoma) results from a sudden, complete blocking of the fluid flowing out of the eye. Symptoms may include severe pain, nausea, vomiting and blurred vision. Closed-angle is a medical emergency and must be treated immediately.

Another form of glaucoma—normal tension glaucoma—can also cause visual field loss due to optic nerve damage, but the eye's IOP remains normal. "The most rapidly evolving, cutting-edge research involves normal tension glaucoma," says **Gregory K. Harmon, M.D.,** Director of the Glaucoma Service at NewYork-Presbyterian Hospital/ Weill Cornell Medical Center. "We don't know what causes the glaucoma, but it's not related to intraocular pressure. We believe it has something to do with blood flow to the eye, and often people with normal tension glaucoma have low blood pressure."

Notes Dr. Harmon, many people in their 40s and 50s, who are otherwise healthy, go to an optician or optometrist just to update their prescriptions for glasses. "These checkups might include an eye pressure check," says Dr. Harmon, but that is no substitute for a complete eye exam by an ophthalmologist, since an estimated half of people who have glaucoma register normal eye pressure.

"Elevated pressure is a very significant risk factor," he continues, "but it is not the definition of glaucoma. In addition to checking pressure, the physician also examines the optic nerve, and performs a visual field test."

Knowing the risk factors for glaucoma helps define who should be checked every year. These include:

Age. It's been estimated that less than one percent of people age 60 to 64 have chronic open-angle glaucoma. Among people 10 years older, the prevalence more than doubles, and among those 80 to 84, it more than doubles again.

Ethnic Background. Chronic glaucoma is four times more common in African-Americans than Caucasians, and develops earlier.

Certain Medical Conditions. Diabetes, extreme nearsightedness and previous eye injury, as well as the use of oral or inhaled steroids—particularly high doses over a long period—can also increase risk.

Family History. Having family members with glaucoma increases one's risk four to nine times more than those with no family history of the disease.

Treatment Options

There is no cure for glaucoma; the key is to control it through early diagnosis and treatment, which begins most often in the form of eye drops. "In the last few years, a number of eye drops have been developed that have virtually no side effects," says Dr. Harmon. "The drops, which must be taken every day, either help the eye to drain fluid more effectively or cause it to produce less fluid."

According to Dr. Harmon, if someone does not tolerate eye drops, laser surgery has proven very effective for most forms of open-angle glaucoma. Incisional surgery to create a new opening for fluid to drain is usually performed after the other treatment options have failed.

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