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HEALTH SCENES®

JOURNAL OF WELLNESS AND GOOD HEALTH CARE • FALL 2007

Health Link



HEARTS AND BRAINS AT RISK Slightly more than one out of every 10 women and men in the U.S. have cardiovascular disease. This includes coronary heart disease, congestive heart failure, heart attack and stroke.

U.S. Agency for Healthcare Research and Quality



PILL PRESERVATION

Be sure to keep prescription medications in their original containers. The containers are specifically designed to reduce the amount of light that can get inside, which can help protect some medications.

American Medical Association



KEEP KIDS SAFE ONLINE

Remind your child to never give out identifying information on the Internet, such as a name, address or telephone number.

American Academy of Pediatrics



Tests to measure your bone mineral density can tell your doctor how strong your bones are.

OSTEOPOROSIS

TESTING FOR BONES AT RISK

You may not realize that you have the bone disease osteoporosis until something dramatic calls attention to it—something like a broken bone, for instance, or realizing you're now looking eye to eye with a friend who had always been shorter than you. But you don't have to wait to find out if you have osteoporosis—or to do something about it.

A CLOSER LOOK Tests to measure bone mineral density (BMD) can tell you and your doctor how strong your bones are and whether you are at risk for fractures.

If you are being treated for osteoporosis, the same tests can also help doctors see how well the treatment is working.

The most accurate test is the DEXA (dual energy x-ray absorptiometry), notes the U.S. Agency for Healthcare Research and Quality. DEXA measures bone density at the hip and spine.

Similar tests that measure bone density but at other sites, such as the wrist or heel, are available. These tests are usually less expensive and can be useful but may not be as precise as the DEXA, says the

American Academy of Orthopaedic Surgeons (AAOS).

WHAT'S THE SCORE? The results of a BMD test are usually given as a T score. The T score is a comparison of your BMD to that of a healthy young adult. A T score of zero is considered normal. Scores below normal are given in negative numbers.

A score between -1 and -2.5 means you have low bone mass and are at increased risk of osteoporosis. If your score is -2.5 or lower, you have osteoporosis.

In general, the further below zero your T score is, the higher your risk of having a fracture, says the AAOS.

For example, a T score of -1 indicates twice the risk of fracture.

TIME TO CHECK The vast majority of people who develop osteoporosis are older women. Therefore, most women should start regular osteoporosis screening at age 65.

Women at high risk for the disease should start earlier, at age 60, recommends the U.S. Preventive Services Task Force.

If you have osteoporosis, effective drugs are available that can help prevent further bone loss or even help rebuild bone.

Are you at risk for osteoporosis?

There are many risk factors for osteoporosis. Some of them are beyond your control; others you can take steps to change or prevent. Risks include:

- **Gender.** Eighty percent of the 10 million people with osteoporosis in the United States are women, notes the National Institutes of Health. Thin women, in particular, are at increased risk, as are Caucasian and Asian women.
- **Age.** Your risk increases as you grow older.
- **Diet and health habits.** A lack of calcium and vitamin D can increase your risk. Drinking alcohol and smoking are also bad for your bones, as is a sedentary lifestyle.
- **Certain health problems,** such as hyperthyroidism, chronic kidney disease or rheumatoid arthritis.
- **Some medications,** including thyroid medicine and oral steroids.

InSide

3 KNEES ACI PROCEDURE RELIEVES PAIN

6 BREAST CANCER FAMILY HISTORY

4 OVERWEIGHT? CHOOSE TO LOSE

8 PATIENT NAVIGATOR THE CARE YOU NEED

Calendar OF EVENTS

CLEVELAND REGIONAL MEDICAL CENTER

PREPARING FOR CHILDBIRTH

Breastfeeding Support Group

Sept. 5, Oct. 3, Nov. 2
10 a.m. to noon

Women's Life Center
Conference Room

Open to all breastfeeding mothers (nursing babies welcome too) and expectant moms who are interested in breastfeeding. To learn more, call **704-487-3887**. To register, call **704-487-3983**.

Daddy Boot Camp

Sept. 15
10 a.m. to 1 p.m.

Women's Life Center
Conference Room

\$10
Dad-led training for expectant fathers. To register, please call **704-487-3983**.

Early Bird Pregnancy Class

Nov. 14
7 to 9 p.m.

Women's Life Center
Conference Room

Registration required. Call **704-487-3983**.

Expectant Grandparents Class

Oct. 22
6 to 8 p.m.

Women's Life Center
Conference Room

Registration required. Call **704-487-3983**.

Kangaroo Kapers

Sept. 17, Oct. 15, Nov. 19
6 to 7 p.m.

Women's Life Center
Conference Room

Helps brothers- or sisters-to-be gain a positive outlook on the changes that come with welcoming a new sibling. Registration required. Call **704-487-3983**.

Mom-to-Mom Support Group

Oct. 3, Dec. 5
10 to 11 a.m.

Women's Life Center
Conference Room

This session will meet as part of the Breastfeeding Support Group. Mothers are welcome to join us to discuss "Travel With Baby." Call **704-487-3983**.

Special Delivery OB Tour

■ Sept. 12
7 to 9 p.m.

■ Oct. 14, Nov. 11
2 to 4 p.m.

Women's Life Center
Conference Room

Take a tour of the OB department, and learn more about pregnancy. Registration required. Call **704-487-3983**.

SAFETY

Car Seat Safety Class

Sept. 6, Nov. 1
5:15 to 6:30 p.m.

Women's Life Center
Conference Room

Receive helpful instructions about securing your baby's car seat in your vehicle. To register, call **704-487-3983**.

Infant and Child CPR Class

Oct. 1, Nov. 5
6 to 8 p.m.

Women's Life Center
Conference Room

\$10 per person or \$15 per couple
For parents and other infant/child caregivers. Registration required. Call **704-487-3983**.

SUPPORT GROUPS

Bridges

Sessions offered Sept. 10 or 24,
Oct. 8 or 22, Nov. 12 or 26
2 to 3 p.m.

CRMC Cancer Center

An educational program for recovery during the postoperative period of a mastectomy or lumpectomy. One session. We recommend registering two weeks after a mastectomy or lumpectomy. Call **704-487-3757**.

Diabetes Support Group

■ Sept. 11: "Grilling Out For Your Health"

■ Oct. 9

■ Nov. 13
5:30 p.m.

CRMC Auditorium

For more information, call the Diabetes Center at **704-487-3953**.



Healthy Hearts Support Group

Sept. 10, Nov. 12
6 to 7 p.m.

CRMC

For more information, call Johnny Stamey at **704-487-3697**.

Look Good...Feel Better

Sept. 10
3 p.m.

CRMC Cancer Center

This class is designed to help cancer patients learn beauty techniques to help boost their self-esteem. For more information or to register, call Rita Wortman at **704-487-3757**.

Parkinson's Support Group

Nov. 27
6:30 p.m.

Life Enrichment Center

For more information or to register, call Judy Hawkins at **704-487-3782**.

Prostate Cancer Survivor Support Group

Oct. 2, Nov. 6
7 p.m.

CRMC Educational Resources
Grover Building

For more information, call **704-487-3182**.

WINGS Cancer Support Group

Oct. 1, Nov. 5
6 p.m.

CRMC Cancer Center

For more information, call **704-487-3025**.

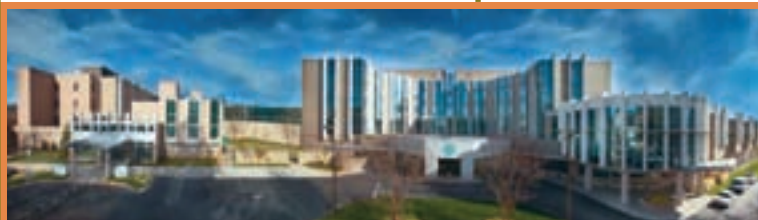
WELLNESS

Blood Pressure Screening

Sept. 25, Oct. 23, Nov. 27
11:30 a.m. to 2 p.m.

CRMC Main Lobby

Check your blood pressure. For more information, call Judy Hawkins at **704-487-3182**.



Our focus at Cleveland Regional Medical Center is your family's health. Check out the many opportunities you have to improve and preserve your health and the health of those you love.

VISIT US ONLINE AT www.clevelandregional.org.



KNEE PAIN

NEW PROCEDURE REPLACES DAMAGED CARTILAGE

EACH YEAR APPROXIMATELY 2 million people experience knee injuries. Knee pain is one of the most common types of chronic joint pain. Depending on severity, knee pain can limit a person's ability to enjoy recreational activities and perform duties at work or other daily tasks.

Many knee injuries involve cartilage and may be caused by trauma, such as a sports injury, or by repetitive everyday movements. Regardless of the cause, damaged cartilage in the knee does not have the ability to heal itself.

This new procedure may help you return to your favorite activities and daily tasks without pain.

NEW HOPE FOR HEALING The treatment generally used for damaged cartilage in the knee works only on small lesions. During the past few years, a relatively new procedure called autologous chondrocyte implantation

(ACI) has been shown to effectively treat larger lesions, or damaged cartilage, in the knee.

Kevin James, M.D., an orthopedist at OrthoCarolina in Shelby, is trained and certified to perform ACI. "I think there is a need to offer new technology to patients in Cleveland County," Dr. James says. With all of the athletes and active adults in this area, he thinks this procedure could benefit the community.

Dr. James' research indicates that he is the only surgeon performing ACI in the region between Charlotte and Asheville, and perhaps beyond. "It is a very tedious surgery, so many surgeons may elect not to perform it," he says.

HOW IT WORKS ACI takes the patient's own cells, reproduces them and reintroduces the new cells into the damaged area of the knee.

When Dr. James performs this procedure, he begins by taking a biopsy of a patient's healthy cartilage cells. He sends the harvested cells to a lab, where more healthy cartilage cells, called chondrocytes, are grown.

After about six weeks, the patient's newly grown

cells are returned to Dr. James. After that, he opens the patient's knee, takes material from the tibia and sews it over the damaged area to form a protective cover. Then, using a syringe, he injects the patient's new cells underneath the protective cover and adds a few more stitches to completely seal the area. The entire surgery takes about an hour; most of that time is spent sewing the protective cover in place.

The new cells grow, and over time the healthy cartilage completely fills the damaged area.

RIGHT INTO REHAB Meanwhile, the patient's rehabilitation begins almost immediately after surgery. Dr. James says that patients need to start motion right away because movement helps stimulate the growth of new cells.

ACI patients go through extensive rehabilitation. Although every patient is different, rehabilitation usually begins with two weeks of non-weight-bearing movement. Dr. James says that most patients are placed on crutches about two weeks after surgery and begin to practice touch-down exercises. They must continue to use crutches for approximately six weeks, depending upon the patient. The entire process, from biopsy to completion of rehab, takes approximately eight months.

IS IT FOR YOU? For most patients, the completion of the process means they can return to their favorite activities and daily tasks without pain. However, not every patient is a candidate for ACI. It is primarily recommended for teenagers and adults younger than 55. There are limited applications for people with arthritis.

 For more information about ACI, call OrthoCarolina at 704-484-0606.

*Tuesday, September 11
5:30 p.m.*



Local Chef will Demonstrate Healthy Grilling Tips
Blood Pressure Screening
Heart Health Information



Cleveland Regional Medical Center
Carolinas HealthCare System
Front Parking Area

co-sponsored by 




The Wonderful Journey
PREGNANCY FAIR
Saturday, September 8 • 10 a.m. - 2 p.m.
Cleveland Mall

 Cleveland Regional Medical Center
Carolinas HealthCare System
Women's Life Center
Health and Education

Spirit of Women



ARE YOU READY TO LOSE WEIGHT AND KEEP IT OFF? HERE'S HOW

Take steps to control your health by getting a free blood pressure screening. See page 2 for details.

Kay Barker went on her first diet when she was a teenager. More than five decades and many diets later, she finally got it right. ♦ “I lost 91 pounds. It took me 15 months, but I did it,” says Barker. ♦ What tipped the balance for Barker was visiting her mom in a nursing home. ♦ “I realized that if I wanted to stay as healthy as possible for as long as possible, I had to start now,” she says. ♦ Barker’s story proves that it’s never too late to start healthy eating habits—and to shed unwanted pounds. That’s a good thing, because across the United States, people of all ages are in need of such a change.

SERIOUS CONSEQUENCES It’s no secret that our nation has a weight problem. Two out of three American adults are overweight or obese, says the U.S. Centers for Disease Control and Prevention (CDC).

Carrying around extra pounds is far more than just a cosmetic issue—it’s a major health risk. People who are overweight or obese are at higher risk than those of normal weight for a long list of medical problems, including:

- Sleep apnea.
- Osteoarthritis.
- Gout.
- Heart disease and stroke.
- High blood pressure.

- Certain types of cancer—including cancer of the colon, kidney or uterus—and some breast cancers.
- Diabetes.
- Gallbladder disease.

According to the CDC, about 400,000 deaths each year are associated with overweight and obesity—making too many pounds second only to cigarette smoking as the leading cause of preventable death among Americans.

BALANCING CALORIES The reasons behind all these extra pounds boil down to one simple equation, says Christine Gerbstadt, M.D., R.D., spokeswoman for the American Dietetic Association (ADA): If you take in more calories than you expend, your body will save the excess in fat.

That’s all too easy with today’s lifestyles, according to Dr. Gerbstadt.

“We eat too much and exercise too little,” she says. “And the easiest food is usually the least nutritious choice—high in calories, high in fat, and low in nutrients and fiber.”

Think fast food, such as burgers and fries. And think soft drinks, which are packed with sugar. Combine these foods with too much time in front of a TV or computer instead of being active, and the result is weight gain.

A GOOD FIT We’re all at the mercy of the calorie equation. The key is to turn it around and use it to your advantage—take in fewer calories and expend more.

A good place to start is to know your body mass index, or BMI, a measure of body fat based on height and weight.

You can calculate your BMI this way: Multiply your weight by 703. Divide

that number by your height in inches, squared.

You can also use this link from the National Heart, Lung, and Blood Institute: www.nhlbisupport.com/bmi/bmicalc.htm.

A BMI of 25 to 29 usually signals overweight, and one of 30 or above means obesity.

The next step is to be sure you’re ready to lose weight. That isn’t as easy as it sounds, but according to Dr. Gerbstadt, it’s essential.

“You have to make a conscious decision to change the way you eat,” she says.

If you’re not ready to make the commitment, you may be setting yourself up for failure.

Another way to invite failure is to set unreasonable goals, according to Gary

Bariatric surgery: How to know if it's the right choice for you

For some people who are severely obese, weight-loss surgery—also called bariatric surgery—may be an option for losing weight.

This surgery restricts the amount of food you can comfortably eat, and some types of weight-loss surgery also limit how much food is absorbed in the small intestine.

Most people who have bariatric surgery lose weight right away and continue losing for up to two years, reports the American Obesity Association (AOA). That can mean better health and improved quality of life.

But this is major surgery, and you should be cautious about choosing it.

According to the AOA, people who qualify for this surgery should:

- Have a BMI of 40 or more. Or have a BMI of at least 35 and

a serious medical condition, such as high blood pressure or diabetes.

- Have been unable to lose weight using other methods.

- Be unable to perform routine daily activities because of their weight.

You should also understand the risks of this surgery. It can lead to problems such as abdominal hernias or gallstones and, less commonly, to even more serious complications.

If you have bariatric surgery, you'll have to make lifelong changes in the way you eat, such as chewing each bite of food well and eating small meals.

You'll also need to take vitamin and mineral supplements, maintain a healthy diet, and get regular exercise.

Your doctor can tell you more about bariatric surgery, and the two of you can discuss if it is right for you.

Foster, Ph.D., the 2007-2008 president of NAASO, The Obesity Society.

"Instead of making dramatic changes that won't last, make small changes that will," he says. That way your weight loss will be gradual and easier to maintain.

And have a plan for when your willpower slips—having a cookie should trigger an adjustment in your eating that day, not a diet meltdown.

With that advice in mind, follow these tips from the ADA and other medical experts:

Keep a food diary. It makes you conscious of what you eat and points out problem areas.

Get in the habit of reading food labels to know how many calories you eat. Keep in mind that *low-fat* doesn't necessarily mean *low-calorie*.

Limit your consumption of high-calorie foods, such as chips, fried foods, full-fat dairy products, oils, and sugar-sweetened beverages (including regular soda and fruit juice).

Eat more vegetables and whole grains at each meal. They contain vitamins and minerals, and they fill you up faster.

Don't deprive yourself. Instead of ruling out treats for life, limit them to special occasions and enjoy them without guilt.

Eat slowly so you'll know when you are full.

Watch your portion sizes. Share large restaurant meals with a friend, or take half of your meal home. In fact, it's a good idea to eat a little less of everything all the time, Dr. Foster says.

Eat breakfast, and don't put it off. The sooner you eat after waking, the more calories you'll burn that day, says Dr. Gerbstadt.

Get plenty of sleep. People who sleep less than seven hours a night gain weight more easily.

Be active. You should try to exercise at least 30 minutes on most days of the week. But check with your doctor first if you haven't exercised in a while or if you have a chronic medical condition.

You don't have to join a gym to get fit—walking, jogging and riding a bicycle are good ways to burn calories. The important thing is to keep it up. People who exercise are more likely to maintain their weight loss than people who are sedentary, says Dr. Foster.

PRESCRIPTION DRUGS: YES OR NO?

Several prescription weight-loss drugs are approved for people with a BMI of 30 and above. But you should be cautious about using them, says the ADA.

Some are dangerous for people with certain conditions, such as high blood pressure. Most of these drugs also have troublesome side effects, and the resulting weight loss probably will be only short-term.

For a lasting change, you'll need to do the work yourself, Dr. Gerbstadt says.

GETTING STUCK It's best to lose weight slowly. In fact, losing just one-half to 1 pound a week is about right, advises the ADA.

But as you watch your weight drop, be prepared for the inevitable—you will reach a plateau.

"It happens to everyone," says Dr. Gerbstadt. "Expect it, and don't get discouraged."

A plateau is when you temporarily stop losing weight or even gain a small amount.

It happens because even if you maintain exactly the same calorie intake, your energy expenditure is bound to change.

For example, you may be eating breakfast at a different time, which can change your metabolism that day. Or you may be walking a little less. When it happens, don't worry.

"You can jump-start your weight loss by just eliminating 20 calories and adding 10 minutes of activity each day," says Dr. Gerbstadt. "Skip the cream in your coffee or the sugar in your tea for a week. You'll break through the plateau."



HEALTHY FOR LIFE In fact, you should expect your weight to fluctuate over the long run as well. And that's where having a plan comes in.

"You have to expect that you will regain some pounds," says Dr. Foster.

When that happens, respond quickly. Cut back on calories right away—success means reversing a 3- to 5-pound weight gain before it becomes a 30- to 50-pound gain.

Kay Barker will tell you that keeping the weight off is a lifelong challenge. But it's well worth it, she says.

"I have much more energy now, and I just feel better," she says. "I still have to work at it, but in the end you have to take care of yourself."

Too many children face health risks

Not long ago, chubby toddlers were considered the healthy ideal.

But no longer.

With more and more children gaining too much weight, the risks are clear: According to the National Institutes of Health (NIH), kids who are too heavy are at higher risk for health problems, both now and as adults.

Growing up overweight

One-third of American children and youth are either obese or at risk of becoming obese, reports the U.S. Institute of Medicine.

The extra pounds are making kids sick. Some are getting type 2 diabetes, which was once considered a disease of adults only. Others develop bone and joint problems, sleep apnea or asthma.

Many obese children even have high cholesterol and high blood pressure—risk factors for heart disease.

To make matters worse, overweight kids don't leave their pounds behind as they get older.

A child who is overweight just once during elementary school is 25 times more likely to be overweight at age 12 than a child who was never overweight during elementary school, reports the NIH. And overweight adolescents are likely to grow into overweight adults.

Changing course

If you're concerned that your child might be too heavy, talk to your child's doctor. You can also try these tips from the American Academy of Family Physicians:

- Focus on teaching your child how to make healthy food choices—not on losing weight to look better.
- Eat together as a family as often as possible. It can help minimize the number of fast-food meals consumed, and it encourages kids to eat slowly and enjoy their food.
- Serve more fruits and vegetables and less fatty food.
- Keep lots of healthy snacks around, such as fresh fruit and whole-grain crackers.
- Limit TV and computer time; encourage active games and sports instead.

BREAST CANCER

THE ROLE OF FAMILY HISTORY

WILL IT HAPPEN to me too?

If you have a family history of breast cancer, that question may haunt you. And like so many women with such a history, you may imagine the worst.

You may also be unnecessarily alarmed.

“Often women with breast cancer in their families exaggerate their own risk of getting the disease,” says Debbie Saslow, Ph.D., director of breast and gynecologic cancers for the American Cancer Society (ACS). “Many are convinced that if they have a close relative with the disease, they then have a high risk of breast cancer.”

But a family history of breast cancer is frequently not as powerful a risk factor as women may fear. Consider:

- Roughly 80 percent of all women with breast cancer have no known family history of the disease, says Dr. Saslow.
- Age—not family history—is the most significant risk factor for breast cancer. Only one out of every 233 women in their 30s develops breast cancer, according to the National Cancer Institute (NCI). But one out of 27 women in their 60s develops the disease.

And while it is true that breast cancer in your family increases your chance of having the disease, that extra risk may be a modest one.

For example, assume that you have one close relative, such as a mother or aunt, who was diagnosed with breast cancer at age 70.

Because your relative very likely developed cancer simply as a result of growing older, your breast cancer risk is only barely above that of a woman without a family history of the disease, says Dr. Saslow.

INHERITED RISK Some women, of course, do have family histories that are worrisome. In fact, some histories are so strong that they suggest a woman may



Join us for the Pink Ribbon Tea on Saturday, Oct. 13. Call 704-487-3066 for details.

have inherited a genetic susceptibility to breast cancer.

Two genes—named BRCA1 and BRCA2—are most often linked to breast cancer. Normally, these genes make proteins that help keep breast cells from becoming cancerous.

However, if you inherit a defect in either of these genes:

- You have up to an 80 percent chance of developing breast cancer, the ACS reports.
- You are at increased risk of developing breast cancer before menopause.
- You also face an increased risk of ovarian cancer.

The good news: Studies show that only a small fraction of breast cancers—about 5 to 10 percent—are inherited.

Still, the risk is real. Thus, it's vital to be aware of any red flags in your family history that suggest you may have

inherited an abnormal BRCA gene.

Among them, says Dr. Saslow:

- Breast cancer in multiple people on one side of your family, including your father's side. This history is of particular concern if a woman in your family was diagnosed with breast cancer before age 50 or had cancer in both breasts.
- Both breast and ovarian cancers in your family, especially in one person.
- Breast cancer in a male relative.

GETTING TESTED If your family history suggests a strong risk for breast cancer, a genetics counselor can help you determine if being tested for BRCA1 or BRCA2 abnormalities is in your best interest.

The test, which requires a blood sample, does have limits.

“It doesn't give you a simple yes or no answer about whether you'll get cancer,” says Sheila Prindiville, M.D., M.P.H., speaking for the NCI.

Even if an abnormal gene is found, the test reveals only that your risk of breast or ovarian cancer is high. But you may never develop either cancer.

Conversely, if an abnormality isn't found in either you or any of your family members, you may still be at risk for cancer. You might, for example, have inherited a genetic abnormality that has not been identified yet.

REDUCING RISK If you do test positive for an abnormal BRCA gene, it may help to remember that knowledge is power.

Because you are aware of your vulnerability, you can take steps to both reduce your risk of getting breast cancer and find it early. These may include:

- Stepped-up screening. To find any potential cancer in its beginning stages (when it's most treatable), you can be closely monitored with mammograms, ultrasounds of the breast and ovaries, breast MRIs, and other screening tests.
- Drug therapy. Certain prescription medications may help keep breast cancer from developing.
- Surgery. Surgically removing healthy ovaries or breasts, or both, significantly reduces cancer risk.

For more information on genetic testing for breast cancer, go to the ACS Web site at www.cancer.org or the NCI Web site at www.cancer.gov.

Some drugs can help prevent breast cancer

If you have an above-average risk of breast cancer, you have options other than simply worrying whether you're going to get the disease.

One such option is drug therapy.

Several studies show that two drugs—tamoxifen and raloxifene—can help keep breast cancer from developing in women who have an increased risk of the disease.

These drugs aren't for every woman at increased risk, however. Because the drugs have side effects, your risk of breast cancer has to be high enough to justify their use.

Here's some more information to consider about the drugs:

Tamoxifen. This drug has been used for more than 25 years to prevent recurrence of breast cancer. Doctors now know it can also keep breast tumors from forming in the first place, reducing the risk of invasive breast cancer in high-risk women by about 50 percent. It also protects against osteoporosis in postmenopausal women.

Still, tamoxifen has side effects. It increases the chances of rare but serious health problems, including endometrial cancer and blood clots. It can also trig-

ger vaginal discharge and hot flashes.

Raloxifene. This widely used osteoporosis drug appears to be as effective as tamoxifen in preventing invasive breast cancer in postmenopausal women.

However, it may not decrease the risk as well as tamoxifen does of a very early form of breast cancer known as ductal carcinoma in situ. And it is only prescribed to women past menopause.

On the plus side: It may be less likely to cause blood clots than tamoxifen.

Is it right for me?

Your doctor can assess your risk of breast cancer, and the two of you can decide if drug therapy to prevent the

disease is appropriate.

You may be a candidate if you:

- Are 60 or older. Older women are especially prone to breast cancer.
- Have a mutation in one of the breast cancer (BRCA) genes.
- Have a strong family history of breast cancer.
- Had a breast biopsy that revealed atypical hyperplasia (a condition that increases breast cancer risk).
- Had a breast biopsy that revealed lobular carcinoma in situ (a condition that increases breast cancer risk).

Sources: American Cancer Society; Sheila Prindiville, M.D., M.P.H., director of coordinating center of clinical trials, National Cancer Institute; Debbie Saslow, Ph.D., director of breast and gynecologic cancers, American Cancer Society



PSA TESTING: QUESTIONS AND ANSWERS

UNLESS YOU'VE BEEN playing Rip van Winkle for the past decade, you've at least heard of the PSA test, a screening tool for prostate cancer. But how much do you really know about it?

What follows are some common questions about the test, with answers from the American Cancer Society (ACS), the National Cancer Institute (NCI) and other medical organizations.

Q What is the PSA test and why is it done?

A It's a blood test that checks for increased levels of prostate-specific antigen, or PSA, a protein made by the prostate. To do the test, a blood sample is drawn from the arm. Because a high level of PSA may be a sign of prostate cancer, the test can be used to screen men for the disease before symptoms appear.

Q What are some limitations of the test?

A Although PSA testing can help find prostate cancer early, it isn't perfect.

For one thing, PSA levels can rise for reasons other than cancer, such as an enlarged prostate or an infection. So some men may wind up having a biopsy—and dealing with the anxiety of possibly being sick—even though they don't have cancer.

Also, research is still trying to determine if the discovery of small prostate tumors actually helps men live longer. And since many prostate cancers are slow-growing, treatment—which can have side effects—may not be necessary.

Q For whom is the PSA test recommended?

A Not all experts agree when it comes to prostate cancer screening.

For example, the ACS says men 50 and older should be offered annual testing if they have at least a 10-year life expectancy. African Americans and men with a father or brother diagnosed with prostate cancer before age 65 should start testing at age 45; men at even higher risk could start screening at 40.

On the other hand, some experts, including the NCI, don't recommend regular screening for prostate cancer. They say men and their doctors should discuss this option.

Q What do the numbers mean?

A PSA levels are reported in nanograms per milliliter (ng/mL) of blood, and in general, the higher the number, the greater the chance of cancer.

Usually, though not always, PSA levels exceed 4 ng/mL in men who have prostate cancer.

According to the ACS, men with PSA levels between 4 ng/mL and 10 ng/mL have about a 25 percent chance of having cancer. But that risk climbs above 50 percent with levels greater than 10 ng/mL.

Another potential indicator of cancer is how rapidly a PSA level rises over time, called its velocity. Even when a PSA level is low, a high PSA velocity suggests that cancer might be present, reports the ACS.

AN ENLARGED PROSTATE YOUR OPTIONS FOR RELIEF

IT'S A MIDLIFE choice that many men face: what to do about an enlarged prostate, a condition doctors call benign prostatic hyperplasia (BPH).

If your BPH symptoms aren't causing you too much trouble, you and your doctor may decide to wait and see if they worsen before starting treatment.

On the other hand, if BPH is more than just a minor matter in your life, perhaps you're thinking about more options.

Fortunately, effective treatments are available for BPH. With your doctor's help, you can find the best approach.

DRUG CHOICES Today's prescription drugs are a popular choice for many men with mild to moderate BPH symptoms, according to the National Institutes of Health. Two main types are used:

- Alpha-blockers relax muscles of the prostate and part of the bladder, which can improve urine flow and relieve symptoms quickly. Side effects can include dizziness, headache and fatigue.

- 5-alpha reductase inhibitors lower hormone levels to help shrink the prostate and relieve symptoms. But you may need to take them for up to a year to find out if they help. Sexual side effects are possible.

Your doctor might also suggest taking both types of drugs, which may work best at keeping symptoms from worsening.

SURGICAL OPTIONS If medicines don't help enough or if your symptoms are severe, surgery might be an option.

Various types of surgery to ease BPH symptoms are available. Most involve going through the urethra—the tubelike structure that carries urine from the bladder out through the penis—to reach the prostate. Some of the surgeries require a hospital stay; others may not.

Choices include:

- Transurethral resection of the prostate. In this most common BPH surgery, the doctor removes pieces of the prostate with a wire loop.

- Transurethral incision of the prostate. No tissue is

removed; instead, small cuts are made in the prostate to take pressure off the urinary tract.

- Transurethral radiofrequency needle ablation. Radio waves heat the prostate tissue, causing it to shrink.

- Transurethral microwave thermotherapy. Microwave heat is used to destroy excess prostate tissue.

Effective treatments are available for BPH. With your doctor's help, you can find the best approach.

- Open surgery. The prostate is sometimes removed through an incision in the lower abdomen. This traditional form of surgery might be done, for example, if the prostate is very large.

MORE INFORMATION The most important thing to keep in mind about BPH is that when it is properly diagnosed and treated, most symptoms can be improved, reports the American Urological Association (AUA).

So see your doctor if symptoms are bothering you. You can also learn more about BPH at the AUA Web site, www.urologyhealth.org.

Is it BPH? Know the signs

When nature calls too often, the trouble might be your prostate.

As men get older, trouble urinating or urinating often—especially at night—can be caused by an enlarged prostate, called benign prostatic hyperplasia (BPH).

According to the American Urological Association Foundation, other BPH symptoms can include:

- A feeling that your bladder doesn't completely empty.

- Being unable to postpone urination once the urge starts.

- Dribbling or having a weak stream or a urine stream that stops and starts.

- Trouble starting to urinate.

PATIENT NAVIGATORS

THE HEALTH CARE JOURNEY MADE EASIER

HEARING A PHYSICIAN say that you have cancer is frightening. After a diagnosis, the journey through the health care system begins. For some families, that journey may be just as frightening as the diagnosis. Suddenly they must face the challenges of understanding what the physician is saying and scheduling and getting to treatment appointments—not to mention dealing with financial strain.

For these and other reasons, LaTonia Hopper, R.N., B.S.N., M.S.W., oncology services department, became our first patient navigator on May 1. Hopper's role as the patient navigator is to guide patients and their families through the care process. Her assistance could be the difference between patients receiving lifesaving treatment promptly or having it delayed because they have no transportation.

Have you been diagnosed with cancer? Our "Look Good...Feel Better" class can help. See page 2 for details.

PRACTICAL HELP Hopper's focus is to help patients, caregivers and families deal with all the logistics of coping with an illness so that families can concentrate on caring for loved ones.

Although not yet a part of a widespread program, patient navigators are helping patients and families maneuver through the health care system at hospitals across the country.

A patient navigator is a trained professional, usually a nurse or social worker, who coordinates services and helps patients overcome barriers to receiving quality care.

The navigator provides advice, support and direction throughout the entire treatment process. Navigation begins when an abnormality is found and continues through cancer diagnostic tests and the completion of cancer treatment.

With the assistance of Velma Thompson, clinical research analyst, and Rita Wortman, R.N., B.S.N., M.S.N.,



oncology services educator, Hopper works with the following staff to coordinate the initial interview with patients and families: Lisa Laughlin, patient registration clerk; Patty MacArthur, patient family advocate, escort and greeter; Tracy Parker, outpatient surgery unit secretary; and Denise Hogan, operating room scheduling specialist.

EXCELLENT CARE We all want to find a cure for cancer, as we saw from the passion of our Relay for Life participants. But until that day arrives, we continue to care for our cancer patients as if they are our loved ones. Patient navigators are simply one more example of how we provide excellent care.

HOW TO

REACH US

- Business Services 704-476-7436
- Care Solutions 704-487-0968
- Cleveland Regional Heart Center 704-487-3877
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