



Fending Off Frailty

The signs of frailty are as obvious as they are ominous. A slowed step. Weight loss. A lack of strength and stamina. Maybe you've seen these signs in an elderly friend or a relative. Perhaps you've noticed them in yourself.

Being frail can have severe consequences. People who are frail are more likely to fall, fracture a bone, develop cognitive impairment or dementia, be incontinent, become depressed or lonely, have limited mobility, be hospitalized, have a poor quality of life, end up in a nursing home, and die prematurely. The flu vaccine also tends to be less effective in frail older adults than in their nonfrail counterparts, which is especially troubling as flu season is fast approaching while we're still in the midst of the Covid-19 pandemic.

Yet, many people are reluctant to discuss frailty with their doctors. The condition is often a difficult topic for patients because few people want to think of themselves as being feeble or dependent on others. According to a review in the March 2020 issue of *Patient Education and Counseling*, the word "frailty" has such a negative connotation that it can bring a quick end to a conversation:

Frailty warning signs

Talk with your doctor if you notice signs like these in yourself or a loved one:

- Weakness
- Slowed walking speed
- Unplanned weight loss
- Difficulty exercising
- Frequent falls

Patients often shut down as soon as their doctor mentions the word "frail."

But, though you're more likely to become frail as you age, it's not an inevitable outcome of aging. You may be able to prevent frailty with the help of healthy habits like exercise and good nutrition. And, if you recognize frailty's warning signs (see box below) now, you may be able to slow its progression or potentially reverse its course.

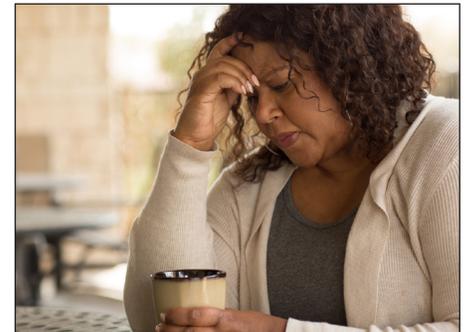
Defining frailty

Although the signs of frailty are clear to doctors, the clinical definition of frailty varies. Some experts describe frailty as a syndrome—a constellation of signs and symptoms that characterize a certain condition—and not a disease in the classic sense.

The most common screening tool used to identify frailty is called the frailty phenotype, which is based on five criteria. If you have three or more of these symptoms or signs, you're considered frail. If you meet one or two, you're in a precursor state known as pre-frail:

1. Weakness (measured by your grip strength)
2. Slow walking speed (more than 6 to 7 seconds to walk 15 feet)
3. Decreased levels of activity (such as low levels of exercise, household chores, and recreational activities)
4. Exhaustion (the feeling that everything you do is an effort or you feel that you can't "get going")
5. Unintentional weight loss (5 percent or more of your body weight within the past year)

Other potential markers, when com-



Don't let frailty sneak up on you. If you recognize its early warning signs—like chronic exhaustion—you may be able to keep it at bay.

bined with additional factors, can point to frailty, including:

- Difficulty climbing stairs
- Difficulty walking more than a block
- An inability to rise from a chair five times without using your arms

Doctors don't routinely screen patients for frailty, at least partly because research hasn't proven that identifying it will lead to better outcomes. But if you are frail or pre-frail, you may benefit from interventions that address the factors that put you in either category. For example, if you're inactive, almost any level of physical activity and muscle strengthening that you can safely tolerate can be beneficial. Occupational therapy to help you perform activities of daily living that you're having difficulty with can also be helpful. If you're losing too much weight, your doctor might recommend oral nutritional supplements, such as high-calorie drinks or puddings, to help you boost your calorie and protein intake.

Who's at risk?

About one in six older adults who don't live in a nursing home or an assisted-living facility are frail, according to a review of

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studies published in August 2019 in *JAMA Network Open*. And though the risk of frailty increases with age, many people live well into their 90s without losing vitality. Women are more likely than men to become frail, possibly because of their biology, differing economic factors, or a lifespan that typically extends longer than a man's. Yet women are also more resilient and less likely than men to have frailty associated with their death.

Other factors that can increase frailty risk include:

- A poor diet
- A sedentary lifestyle
- Obesity
- Smoking
- Increased alcohol intake
- Depression
- Age-related hormonal changes
- A lower educational or income level
- Multiple illnesses or medical conditions, especially high blood pressure, diabetes, cancer (other than a minor skin cancer), lung disease, heart attack, congestive heart failure, angina, asthma, arthritis, stroke, and kidney disease

What you can do

The earlier you address factors that can lead to frailty later in life, the better. Even if you've neglected your health up to now, it's not too late to start making the types of positive changes that might help you avoid frailty and disability later. The following strategies are good ways to help shore up

your strength and reduce your frailty risk:

■ **Exercise.** Staying active strengthens all the systems that can fall into decline—including your heart, muscles, bones, and brain. A combination of aerobic exercise, resistance training, and balance and coordination exercises improves all measures of frailty—walking speed, muscle mass and strength, and physical performance, research finds.

Even people who are older and very frail can take part in an exercise program, provided that it's tailored to their abilities. Although it's not clear from the research how often or intensely you need to work out to see improvement, your doctor can give you personalized recommendations based on your health and abilities.

■ **Consume a healthy diet.** Eating well is another tool to strengthen your reserves and prevent many diseases that contribute to frailty. Follow a low-fat, high-fiber diet. Limit polyunsaturated and monounsaturated fats to 20 grams a day and avoid saturated fats. Healthy oils include oily fish (such as tuna, salmon, mackerel, and herring); flaxseed, canola, and soybean oils; and walnuts. Fill up on nutrient-dense foods, such as fruits, vegetables, and whole grains. As you get older, it's important to increase your intake of heart-healthy protein-rich foods—more fish, beans, and peas—to maintain your muscle mass. Keep your daily salt intake to 2.3 grams or less and get at least 1,200 milligrams of calcium a day. Getting an adequate intake of vitamins and minerals

Frailty vs. sarcopenia

Sarcopenia is a term that's often used along with frailty. It refers to the loss of muscle mass and strength. Muscle mass naturally peaks at around age 30 and then slowly declines. Diseases like cancer can accelerate the muscle-wasting process.

Both frailty and sarcopenia become more common as you get older. Although each is a distinct condition, they have much in common. Some of the same factors cause both, including disease and a poor diet. Both manifest with symptoms like a slow walk and a weak grip. Sarcopenia and frailty mutually contribute to falls, disability, and an increased risk of hospitalization or death.

may be helpful, especially vitamin D to improve strength and balance.

As you get older, you can inadvertently lose weight simply from eating less. Often that's because of one or more reasons: You don't have much of an appetite, it's harder for you to chew or swallow, food isn't as appealing as it once was, or some drugs you take make your food taste unpleasant. Tell your doctor about any such difficulties so underlying issues can be treated. Your dentist can help if your inability to eat stems from oral health ailments or poorly fitting dentures.

If you simply need to increase your daily calorie intake, try to eat more healthy snacks throughout the day. Vegetables with hummus, cheese on whole-grain crackers, and yogurt with granola are all nutrient-dense choices.

■ **Treat underlying medical conditions.** People who are frail often have more than one chronic medical condition, like heart failure, depression, or diabetes. Treating these disorders can help support your body's defenses.

■ **Routinely review your medications with your doctor.** Some drugs may have side effects that contribute to frailty symptoms. Your doctor may be able to discontinue use of any drug you potentially no longer need, reduce drug doses, substitute a drug for a safer alternative, or replace a medication with a nondrug therapy.

Surgery risks in people who are frail

Frailty can become a major issue if you're planning to have surgery. Undergoing a procedure when you're frail can tax your already limited reserves, increasing your risk for complications, an extended hospital stay, and an inferior quality of life afterward. People who are frail are also more likely to die after surgery than those who aren't frail.

Even minor surgery can be risky for anyone who isn't hardy enough to handle it. In a study of more than 430,000 patients in Veterans Affairs hospitals that was published by *JAMA Surgery* last November, frail patients were more likely to have complications and to die from any type of procedure—even typically low-stress surgeries like laparoscopic hernia repair or knee arthroscopy. Within six months after low to moderately stressful surgeries, more than 16 percent of those who were frail and 43 percent of those who were very frail had died.

If you or a loved one is living with frailty and planning to have surgery, have a discussion with your doctor and surgeon to determine whether the risks of the procedure are worth the benefits.

How Vaccines Are Made

“Why does it take so long to make a vaccine?” That’s a question many of us have been anxiously asking as the novel coronavirus continues to take its hold. As you might expect, there’s no simple answer: Developing a vaccine is a complex process that can take years and years of methodical research and robust testing until one is ready to be used on the general population.

In the beginning

Vaccines have come a long way since physician Edward Jenner used substances derived from cowpox (a relatively minor infection once common among people who milked cows) to create a makeshift smallpox vaccine in 1796. Fast forward to today, as scientists race against time to develop a coronavirus vaccine. As of July, researchers around the world were investigating more than 145 Covid-19 vaccines, hoping to have one approved for use sometime early next year—an unprecedented—and, some experts say, unrealistic—time frame.

Below is an overview of what goes into the making and testing of a vaccine in the United States—and why it takes so long.

The first phase

Vaccines typically take 10 to 15 years to develop and bring to market, with some exceptions like the seasonal flu vaccine. The process starts with exploratory research by scientists in government, universities, or pharmaceutical companies. The scientists, usually funded by grants from the government or private foundations, can spend two to four years working to identify the best way to immunize people against a disease.

Certain cells in the immune system recognize and eliminate potentially harmful microbes (germs). They zero in on chemicals on the microbe, called antigens. This activity gives rise to “memory” cells that retain the ability to recognize the invading microbes, triggering an immune response if the germs enter the body again.

Scientists generally create vaccines using

weakened microbes, microbes that have been killed, small microbe fragments, or the toxins that microbes produce. Vaccines work by tricking the immune system: When a vaccine is introduced into the body, it triggers the production of memory cells that protect against future infection.

Next steps

After identifying the target antigen, scientists move on to the preclinical phase, usually undertaken by researchers in private industry. For the next year or two, they test, often in animals, the potential vaccine’s safety, how much it stimulates the immune system, and the best starting dose.

If the vaccine is shown to be safe and capable of eliciting an immune response, the vaccine’s sponsor (typically a pharmaceutical company that plans to manufacture the vaccine) submits an investigational new drug (IND) application to the U.S. Food and Drug Administration (FDA). The FDA has 30 days to review the application. If approved, the sponsor can begin testing the vaccine on humans in clinical trials.

Clinical trials for vaccines involve at least three phases to monitor the vaccine’s safety and how well the immune system responds to it. These trials can take several years to complete, and they can move to the next phase only if the previous phase is successful. In phase 1, fewer than 100 people are enrolled. In phase 2, hundreds of people are given either the vaccine or a placebo. Phase 3 trials, which can involve tens of thousands of people, must show that the vaccine is safe and effective and that its benefits outweigh any potential risks.

Regulatory review and approval

After successfully completing phase 3, the vaccine manufacturer submits a biologics license application to the FDA. The licensure process can take another few years as the FDA and CDC review the application and clinical trial data and inspect the manufacturing facilities. If a license is granted,

manufacturing can begin.

The full effects of vaccines don’t always become clear until the product is made available to the masses. For this reason, the manufacturer continues monitoring the vaccine in phase 4 trials.

Searching for a Covid-19 vaccine

Development of a Covid-19 vaccine has gotten a head start since the disease is caused by two similar coronaviruses, SARS and MERS. Scientists have been studying both for several years, so much of that research has been applied to the novel coronavirus. By July, 10 vaccine candidates were in clinical trials. Scientists are also testing new technologies that can be developed faster, such as using virus DNA or RNA.

In addition, the FDA has said it would consider expediting some steps in its regulatory processes. The agency requires that this vaccine be only 50 percent effective in preventing disease or decreasing its severity.

Some experts are concerned that, in the rush to produce a vaccine, rigorous safety reviews might be fast-tracked to a fault, despite the FDA’s assurance that it will only approve or make available a Covid-19 vaccine without “sacrificing our standards for quality, safety, and efficacy.”

Once a vaccine is approved, production must be rapidly scaled up, but it will be some time before vaccines are available for everyone. The first vaccines will likely be administered to healthcare providers, essential workers, and others at high risk, such as older adults and the chronically ill. But we still won’t know how long immunity will last.

Fast-tracking flu vaccines

Unlike other vaccines, annual seasonal influenza vaccines are developed within about six months. That’s because the only vaccine ingredient that changes each year is the antigen. All other ingredients can remain intact, eliminating the need for additional research and lengthy clinical trials. This also allows for speedy production, since the manufacturing process doesn’t need to be updated each year.

The Psychological Toll of Chronic Pelvic Pain

Sharp pains, a dull ache, heavy pressure inside the pelvic area, painful sex. Those are just some of the words women have used to describe their persistent pelvic pain symptoms. Not too long ago, women's chronic pelvic pain—defined as pain in the pelvic area that lasts more than six months—was sometimes deemed to be psychosomatic if no direct cause could be found. But doctors now know that the pain is real, not “all in the head,” and that it can be debilitating.

What's more, many women report that their sex life is on the skids as a result, and their social relationships may deteriorate since the pain can interfere with normal activities. Chronic pelvic pain can also lead to anxiety, depression, and social isolation, which can, in turn, increase pain sensitivity. Over time, a vicious cycle ensues.

The conundrum for doctors and their patients: What to treat first—the physical issues or the psychological concerns? Recently updated guidance from the American College of Obstetricians and Gynecologists (ACOG) advises doctors to treat both with equal urgency.

Conditions associated with pelvic pain

A number of gynecologic, gastrointestinal, urologic, and neuromuscular conditions are associated with chronic pelvic pain, and they frequently overlap in patients. They include:

- Irritable bowel syndrome
- Interstitial cystitis (painful bladder syndrome)
- Chronic pelvic inflammatory disease
- Endometriosis
- Inflammatory bowel disease
- Psychological factors, such as depression and chronic stress

Be sure to see your doctor if you experience any new or sudden pelvic pain to rule out conditions such as bladder or colon cancer or cancers of the reproductive tract.

The face of chronic pelvic pain

Current estimates indicate that 10 to 20 percent of women in the United States have experienced chronic pelvic pain. The condition primarily affects women of reproductive age (18 to 50 years), but peri- and postmenopausal women can develop chronic pelvic pain as well.

Anxiety and depression are common among women with pelvic pain, as well as with any pain syndrome. It's estimated that 39 to 73 percent of women with chronic pelvic pain suffer from anxiety compared with 12 percent in the general population. Depression affects about 26 to 52 percent of women living with pelvic pain compared with 5 to 10 percent in the general population. And depression and anxiety often coexist in patients with chronic pelvic pain.

The pairing of chronic pelvic pain and psychological distress isn't a trivial concern. According to a review in *Clinical Obstetrics and Gynecology* published in March 2019, patients with chronic pain plus psychological distress report more disability, face higher healthcare costs, and report a lower quality of life than women without pelvic pain. Additional evidence suggests that risk factors for developing chronic pelvic pain could include a history of sexual or physical abuse, mental illness, a lack of support, social stressors, and relationship problems.

Pinpointing pain

Chronic pelvic pain can be a challenge for doctors to diagnose since any number of underlying medical conditions—not all gynecological—can cause it. (See box, “Conditions Associated with Pelvic Pain.”) Frequently more than one cause is at play. But for many women with chronic pelvic pain, the reason behind it isn't clear cut, and a cause may never be identified. As a result, a straightforward treatment plan may be elusive—a situation that can potentially contribute to a patient's distress.

One often underrecognized reason for

chronic pelvic pain may be the presence of hypersensitive areas on the pelvic floor that induce pain and discomfort, called trigger points. Trigger points are small, hard knots within taut bands of muscle and surrounding tissue. The muscular irritation that trigger points cause is called myofascial pain. Trigger points can have several causes, such as trauma, exercise, an adaptation to other types of pain, or constipation.

Regardless of its source, chronic pelvic pain and its varying degrees of intensity might be partly explained by malfunctioning mechanisms that affect how the brain perceives pain. In a person with chronic pain, something can go awry in the brain's normal pain processing system. Recent evidence suggests that certain nerve fibers involved in pain signal transmission may become more sensitive to pain in both men and women with chronic pain, resulting in a lower pain threshold. Other research indicates that pain signals, which would normally stop after an injury, may remain activated. These central nervous system changes can affect your perception of pain.

Therapies for mind and body

The updated ACOG guidelines, published in the March 2020 issue of *Obstetrics and Gynecology*, recommend the following therapies, alone or in combination, for women with chronic pelvic pain and associated painful intercourse, especially when it stems from myofascial and psychosocial causes or when the underlying cause is nonspecific:

■ **Cognitive behavioral therapy.** Initially used as a treatment for depression, cognitive behavioral therapy is based on the concept that negative thoughts and behavior patterns can affect the perception of pain, making it feel worse. Cognitive behavioral therapy teaches patients to recognize and replace negative thoughts with more positive ones by reframing their reaction to pain. The therapy also helps patients develop skills to better cope with pain.

Combining cognitive behavioral therapy with medical and physical therapies may be particularly helpful in improving relationships and other aspects of well-being once depression and pain are addressed.

Research on cognitive behavioral therapy for chronic pelvic pain is limited. However, several studies show that this type of therapy is mildly to moderately beneficial for many other chronic pain conditions. Support for the use of cognitive behavioral therapy in women with chronic pelvic pain comes primarily from studies in which the therapy is used as a part of a treatment plan that addresses a woman's physical and psychological concerns.

■ **Pelvic floor physical therapy.** The pelvic floor is a group of muscles that support the pelvic organs, including the uterus, bladder, and bowel. Physical therapy should be the first-line treatment for muscular pain. It targets the pelvic floor muscles and fascia (the connective tissue that covers the muscles and other organs in the body) in areas that may be contributing to the problem, including the pelvic floor, abdominal wall, back, and hips.

Other treatments are sometimes used in conjunction with physical therapy, such as transcutaneous electrical nerve stimulation, which delivers electrical impulses to nerve pathways, and biofeedback to help identify and release areas with muscle tightness.

Pelvic floor physical therapy should be performed only by a physical therapist or another healthcare practitioner who has had specific training in managing patients with pelvic pain.

■ **Sex therapy.** Chronic pelvic pain can adversely affect a woman's sexuality and relationships. Sex therapy is a specialized type of counseling intended to help address those issues. According to ACOG, sex therapy, as well as individual counseling or couples therapy, can help partners engage in pain-free intercourse, especially when used with physical therapy. Your doctor should refer you to a certified sex therapist who has experience treating pelvic pain.

■ **Trigger point injections.** Injections of

saline, anesthetics, steroids, or a combination of these, directly into pelvic floor trigger points can inactivate them. Injections are sometimes recommended as a next step to manage pain or muscle spasms if physical therapy and other treatments don't help. The way in which the injections work isn't understood, but it's thought that the needle stimulus itself might act as a counterirritant, and depending on the substance injected, the injections might block certain neurotransmitters or metabolic processes involved with pain. Though data is limited as to the therapy's effectiveness, many women report experiencing a benefit, especially if the pain involves the muscles.

■ **Antidepressants.** Antidepressants are a treatment option often used for women whose chronic pelvic pain is mainly neuropathic. However, the drugs haven't specifically been studied in people with chronic pelvic pain who don't have depression. But they have been studied and shown to be effective in nondepressed individuals with other types of chronic pain syndromes. Based on those findings, ACOG recommends a type of antidepressant known as serotonin-norepinephrine reuptake inhibitors (SNRIs) for women with underlying depression and neuropathic pain

syndromes, such as fibromyalgia. In addition to treating depression and anxiety, SNRIs appear to decrease pain sensitivity.

Speak up

Clearly, doctors have made progress in their understanding of the link between chronic pain and psychological distress. Nevertheless, some women hesitate to tell their doctors they're feeling depressed or anxious or share how the pain is affecting their sex lives. One reason for the reluctance is the long history of pain complaints in women being minimized or even dismissed as being all in their head. Calling attention to any psychosocial symptoms, some women fear, might cause the doctor to focus primarily or solely on those areas instead of identifying and treating physical issues.

Nevertheless, experts say the best way to get the help you need is to communicate openly and honestly with your doctor about all your symptoms. If your doctor doesn't ask, don't hesitate to bring up your concerns. Research shows that a multipronged treatment strategy that addresses both your physical and psychological symptoms results in better outcomes. Your doctor may also suggest adding a pain management specialist to your multidisciplinary team.

What about complementary therapies?

Tai chi, massage, yoga, acupuncture, osteopathic manipulation, and cannabinoids have all been studied to determine whether they're beneficial in women with nongynecologic chronic pain. Limited evidence suggests that two—acupuncture and yoga—may help women with chronic pelvic pain when the pain's origin involves the muscles, ligaments and tendons, or bones.

Acupuncture. This technique in which practitioners stimulate specific points on the body—most often by inserting hair-thin needles into the skin—has been a traditional Chinese medicine practice for more than 3,000 years. The ACOG recommendation for acupuncture is based on a review of 32 studies of complementary treatments for chronic pain that included six randomized trials of acupuncture. However, none of the studies looked at chronic pelvic pain specifically. The 2017 review, published in *Anesthesia and Analgesia*, showed strong evidence that acupuncture reduced pain and opioid use in patients with chronic musculoskeletal pain.

Yoga. Evidence for the ACOG recommendation for yoga comes primarily from a small 2017 study by researchers at the University of California, San Francisco. Investigators there evaluated a group-based therapeutic yoga program in 16 women with chronic pelvic pain who were between ages 31 and 64. The program included 12 yoga poses designed to help reduce pelvic floor dysfunction and improve underlying stress and anxiety. The findings, reported in *Pain Medicine*, showed significant improvements in the women's pain, emotional well-being, and sexual function after six weeks of practice.

Fecal Impaction: When Stool Gets Stuck

It's not a popular topic, but fecal impaction is a subject that needs to be discussed, especially if you're prone to constipation. It's a gastrointestinal disorder that primarily affects older adults—and it can cause serious complications or even death.

Fecal impaction occurs when a mass of hard, dry stool gets stuck in your rectum or lower colon, usually in the narrow part above the rectum. The stuck stool blocks other waste from moving through your system. Without treatment, the blocked stool, or impaction, might cause your intestine to tear, or rupture, which is the most common complication. A ruptured intestine, also known as a perforated bowel, can allow bacteria from your colon to spread throughout your abdominal cavity. This complication, called peritonitis, is an extremely dangerous infection. Fecal impaction can also damage tissue in your rectum, sometimes leading to an ulcer that can cause pain and bleeding. It can also contribute to fecal incontinence in the future.

Prompt treatment can clear up impaction and help prevent serious complications.

Why it happens

Fecal impaction is most likely to occur in people with constipation, usually chronic in nature. When you're constipated, stool stays

in your intestine longer than it should. During that time, your body pulls water from the stool, causing it to become harder, drier, and less moveable. If it gets stuck, it can cause pressure and inflammation that can damage the walls of your colon or rectum.

A review published in 2016 in *BMC Geriatrics* analyzed the cases of 280 people with fecal impaction and found that half of the patients suffered from chronic constipation. It also found that 43.5 percent of patients were over age 65.

Spending most of your time sitting or lying down can also raise your risk for fecal impaction; it's common in elderly people who are hospitalized or bedridden or who live in long-term care facilities. It's also more likely to occur in people with certain health conditions, such as kidney failure, scleroderma (an autoimmune disorder), neurological diseases (such as dementia and Parkinson's disease), nerve damage that affects the muscles of the intestines, and a history of intestinal surgery or rectal abnormalities. Certain medications can underlie the constipation that leads to an impaction.

Fecal impaction is also associated with long-term laxative use, which can lead to dependency, causing your intestines to lose their ability to move stool without the help of laxatives.

How to prevent constipation

Chronic constipation, especially in older adults, is a major risk factor for fecal impaction.

■ **Be active.** Exercise such as walking helps strengthen the muscles that propel stool through your gastrointestinal system. Aim for at least 30 minutes a day, five days a week, but any amount of activity is better than none.

■ **Eat a high-fiber diet.** Fiber softens stool and allows it to pass through your intestines more easily. Good sources of dietary fiber include high-fiber cereals, beans, lentils, whole grains, vegetables and fruits with their peels, nuts, and seeds. If you have trouble getting enough fiber from foods, ask your doctor about taking a fiber supplement.

■ **Stay well hydrated.** Hydration helps soften stool so it can move through your body easily.

■ **Check your meds.** Some prescription and over-the-counter medicines can contribute to constipation, including narcotic pain relievers, some anticholinergics (such as antihistamines and antiparkinson agents), certain psychiatric drugs, and nonsteroidal anti-inflammatory medications. People who are bedridden and are constipated may benefit from the regular use of a stool softener.

■ **Respect the urge.** Give yourself time in the bathroom when you feel the need to go.

When to get medical help

Because of the potential for fecal impaction to lead to serious complications, you shouldn't wait to seek medical care if you're experiencing symptoms accompanied by constipation. Common symptoms include:

- Abdominal pain or distension (bloating)
- The inability to pass stool or gas
- Liquid stool that leaks around the impaction and might be mistaken for diarrhea
- Nausea and vomiting

Less frequent symptoms include:

- Urinary incontinence or bladder pressure
- Blood in the stool
- Pencil-thin stools
- Lower back pain
- Light-headedness or a rapid heartbeat that occurs as a result of straining to defecate

To diagnose fecal impaction, your doctor performs a digital rectal examination. You may also need abdominal X-rays and possibly a computed tomography (CT) scan.

Removing the impaction

Depending on where the blockage is located, you may receive one or more of the following treatments:

■ **Manual removal.** Your doctor inserts a gloved, lubricated finger into your rectum to break up and remove impacted stool.

■ **A mineral oil enema.** An enema can help soften the stool so it can be passed or removed more easily.

■ **Laxatives.** Taking an oral laxative such as polyethylene glycol over a period of hours may unblock stuck stool. However, if you suspect you have fecal impaction, don't take laxatives unless instructed by your doctor since they can lead to serious complications.

■ **Surgery.** In rare cases when your doctor can't get the impacted stool to move, or when you have a high risk of intestinal rupture, you may need surgery.

After your impaction clears, your doctor will recommend steps you can take in the future to manage chronic constipation and prevent future stool blockages, including important lifestyle changes.

HouseCalls : Expert Advice

Q. My headaches seem to return with a vengeance after my pain reliever wears off. What's going on?

A. You may be experiencing what are known as medication overuse headaches (MOHs), sometimes called rebound headaches. You can get them after frequently taking pain relievers for headaches, typically for an underlying headache disorder like migraine or tension headache. That begins a vicious cycle: If another headache begins once the drug wears off, you take more medication, and once that wears off you take more drugs, and so on. Headaches thus tend to recur even more frequently.

Clinically, MOH is defined as a headache that appears on 15 days or more each month in people who have overused either over-the-counter or prescription pain medication for at least three months.

The exact mechanisms that cause MOH are unknown, but it's thought that a combination of genetics, changes in the sensory pathways that produce feelings of head pain, and behavioral factors that drive drug taking are responsible. Anxiety and depression may also heighten the risk of experiencing this condition.

How do you know if you're overusing

pain meds? Experts recommend the following limits to avoid MOHs:

- Acetaminophen, such as Tylenol—no more than twice a week
- Nonsteroidal anti-inflammatory drugs (NSAIDs), such as aspirin and ibuprofen (Advil, Motrin, others)—no more than 15 days a month
- Aspirin-acetaminophen-caffeine combination drugs, such as Excedrin—no more than nine days a month
- Triptans, such as Imitrex—no more than nine days a month
- Butalbital combinations, such as Fiorinal, Fioricet, and Esgic, or any narcotics—if possible, try to avoid

To overcome MOHs, you may need to be evaluated by a headache specialist who can help you find the best strategy to wean you from pain relievers. For example, preventive medicine may lessen the frequency of your headaches, making them less of a problem.

Q. Is coconut oil a healthy alternative to vegetable oils?

A. Coconut oil has been marketed as a heart-healthy oil and has grown in popularity in recent years. However, two large analyses published earlier this year provided evidence that coconut oil raises LDL (“bad”) cholesterol, which in turn increases the risk of heart disease.

In the first, published in *Circulation* in January, coconut oil raised LDL cholesterol significantly when compared to nontropical vegetable oils, such as olive, soybean, safflower, or canola. Even compared to palm oil, another tropical oil high in saturated fat, coconut oil raised LDL markedly.

The second paper, in *Nutrition Reviews* in March, found that coconut oil was better than animal oils (butter, lard) but worse than nontropical vegetable oils in terms of its LDL-raising effects.

The meta-analyses, combined with a 2017 American Heart Association advisory that recommends avoiding coconut oil because it increases LDL, provide good reason to be cautious about consuming coconut oil regularly, especially if you have risk factors for cardiovascular disease. It's fine to use sparingly if you like it, especially as a replacement for butter or lard—with unrefined coconut oil (sometimes labeled “virgin,” “extra virgin,” or “cold pressed”) being a possibly healthier choice than refined versions.

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September Newswire

Keeping you up to date with the latest research and medical news



► **THE RECOMMENDATIONS:** If you want to decrease your risk of cancer, try becoming a teetotaler, eliminating red and processed meats from your diet, and moving above and beyond what national guidelines recommend.

In June, the American Cancer Society (ACS) updated its 2012 guideline for diet and physical activity for cancer prevention. The updated guideline is similar to the 2012 version but takes a stronger stance on activity, diet, and alcohol than it had in the past. While the 2020 ACS recommendation for physical activity is generally consistent with those of the current government guideline—175 to 300 minutes of moderate aerobic activity a week—the ACS calls for exceeding the upper limit of 300 minutes whenever possible for optimal cancer prevention. The ACS also strongly encourages people to avoid red and processed meats, along with sugar-sweetened beverages, and highly processed foods and refined grain products—all of which are associated with cancer—instead of merely calling for just limiting them, as the ACS suggested in the past. In 2012, the ACS recommended that people should limit alcohol consumption; now it suggests avoiding all alcohol. That's because all forms of alcohol—wine, beer, liquor—contain ethanol, a known cancer-causing substance. And the ACS continues to urge people to maintain a healthy weight—being overweight or obese is a known risk factor for cancer. Losing just a few pounds can lower cancer risk.

WHAT ELSE YOU SHOULD KNOW: At least 18 percent of cancer cases and 15 percent of cancer deaths are associated with a combination of inactivity, an unhealthy diet, overweight or obesity, and alcohol consumption. Only cigarette smoking accounts for more cancer deaths, at 30 percent.

WHAT YOU SHOULD DO: To reduce your risk of cancer, follow the 2020 ACS guidance:

- Try to engage in more than 300 minutes of moderate physical activity (like walking), or 150 minutes of vigorous-intensity activity (jogging), each week for optimal cancer prevention. That boils down to 45 minutes of moderate, or 20 minutes of vigorous, activity a day. If that seems daunting, aim for at least 150 minutes of moderate, or 75 minutes of vigorous, activity a week.
- Focus on an overall healthy eating pattern instead of on specific foods and nutrients. A well-rounded diet should include a colorful variety of vegetables and fruits and plenty of whole

grains, brown rice, and legumes (lentils, beans, peas).

- Avoid red meat and processed meats (beef, pork, lamb, sausage, bacon, deli meats, hot dogs), sugar-sweetened beverages (soda, fruit drinks, energy drinks), highly processed foods (ready-to-eat or heat foods, snack foods, cake, candy), and refined grain products (white bread, white rice).
- Don't drink or drink only in moderation (no more than two alcoholic beverages a day if you're a man and one a day if you're a woman).

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Why Masks Are Now a Must



In the May issue of *Health After 50*, we reported facemask-wearing should be reserved for people who exhibit symptoms of respiratory illnesses like the flu and the novel coronavirus. This advice was based on Centers for Disease Control and Prevention (CDC) advisories, which was meant to protect people around individuals with symptoms from becoming infected. Since then, things have changed—drastically.

Evidence now shows that many people with the highly contagious coronavirus are asymptomatic, so experts are urging everyone to wear a mask whenever they leave their homes or have visitors in their homes so as not to spread the virus to others. Specifically, the CDC recommends that people “wear cloth face coverings in public settings and when around people who don't live in your household, especially when other social distancing measures are difficult to maintain.”

The only people who shouldn't wear a mask, according to the CDC, are children under age 2 or anyone who has trouble breathing or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. It's also worth noting that a simple facemask will do. The CDC does not want you buying N95 respirator masks, which have been low in global supply and are critical to protecting healthcare workers on the front lines.

Covering your mouth and nose with a facemask protects people around you by reducing the number of potentially infectious respiratory droplets you spread when you talk, cough, or sneeze. Wearing a mask does not eliminate the need for social distancing: Stay at least six feet away from people in public settings.

The spread of Covid-19 can be minimized when you combine wearing a facemask and practicing social distancing with frequent and thorough handwashing (for at least 20 seconds), using an alcohol-based hand sanitizer (with at least 62 percent alcohol—ethanol, isopropanol, or both) if soap and water aren't available, and cleaning and disinfecting frequently touched surfaces.