HARVARD

Women's Health Watch™

INFORMATION FOR ENLIGHTENED CHOICES FROM HARVARD MEDICAL SCHOOL

Beta-Carotene Reconsidered

Recent studies seem to be telling us that it isn't smart to second-guess Mother Nature. Although it once seemed as though beta-carotene supplements might lower the risk of lung cancer and heart disease, controlled trials have determined that these pills have no benefit and may even be harmful. Many experts are suggesting that the antioxidant wrapped in its natural packaging — a fruit or vegetable — is a better alternative.

On January 18 the National Cancer Institute (NCI) announced that it had halted the Beta-Carotene and Retinol Efficacy Trial (CARET) ahead of schedule because the beta-carotene supplements might be doing more harm than good; there were 28% more cases of lung cancer and 19% more lung-cancer deaths among those who took 30 mg of beta carotene and 25,000 IU of vitamin A daily than among the placebo group. The same day, the directors of the Physicians' Health Study announced that their project had ended and had shown that beta-carotene supplements neither increased nor decreased the risk of cancer or heart disease.

The results of the CARET study, which included 18,314 men and women at high risk for lung cancer, were more dramatic than those reported two years ago from a Finnish study of 29,133 male smokers. In the Finnish study, the men on beta-carotene supplementation had 18% more lung cancers and 8% more lung-cancer deaths than those on placebo.

Although there were only 6,289 women — all present or former smokers — in the CARET study, their response to beta-carotene was similar to that of men. Thus, many scientists believe that the findings in the Finnish study and the Physicians' Health Study — another all-male investigation — can reasonably be extended to women. As a result, the leaders of the Women's Health Study — a project designed to assess the influence of beta-carotene, vitamin E, and aspirin on the risk of heart disease and cancer — discontinued the beta-carotene part of that project. The researchers concluded that the supplement — which was the same dose and formulation as that in the Physicians' Health Study — was unlikely to benefit any of the women.

All four randomized trials had been undertaken after observational studies consistently indicated that people who ate lots of fruits and vegetables and had high blood levels of beta-carotene also had relatively low risks of lung cancer and heart disease. The studies were designed to determine whether beta-carotene supplementation conferred similar benefits.

In both the CARET and Finnish studies, the men and women who entered the trials with the highest blood levels of beta-carotene emerged with the lowest risks of cancer. Blood levels of beta-carotene are directly related to the consumption of foods containing carotenoids, such as carrots, squash, yams, peaches, apricots, spinach, broccoli, collard and mustard greens and other orange, deep yellow, or dark green vegetables and fruits.

Many of the same vegetables also contain hefty amounts of other carotenoids, such as lutein and zeaxanthin — which may help to preserve vision as we age — as well as additional micronutrients. Researchers speculate that the health benefits are likely to be derived from a mix of micronutrients rather than from beta-carotene alone. Some scientists have hypothesized that heavy doses of supplemental beta-carotene may prevent other carotenoids from being absorbed or may interfere with their bioavailability, thus negating the benefits conferred by a diverse diet.

At present, the best advice is probably the NCI's recommendation to eat at least five servings of fruits and/or vegetables daily. In other words, skip the market's supplement shelves and head for the produce counter.❖

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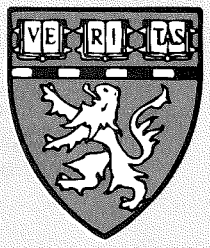

HARVARD WOMEN'S HEALTH WATCH™

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Colorectal Cancer

Although it may not rank at the top of most of our lists of health concerns, colon cancer is the third leading cause of cancer deaths in women, exceeded only by cancers of the lung and breast. This year, about 66,000 women will be diagnosed with the disease, and more than 27,000 are expected to die of it.

Yet the death rate from colon cancer has been steadily declining since the 1940s, when it claimed 27 women in 100,000 — a figure equal to that for breast cancer at the time. In 1992, the last year for which statistics are available, the rate had dropped to 15 in 100,000.

The story in these numbers is that colon cancer, when detected in the early stages, is a highly treatable and often curable disease. Moreover, as observational studies indicate, it may also be preventable.

The genesis of colon cancer

Colon cancer often arises in adenomatous polyps, benign tumors that are most often found in people over age 50. These polyps may protrude from the bowel wall like small mushrooms (tubular polyps) or appear as flat, spreading growths along its surface (villous adenomas). Villous adenomas are more likely than tubular polyps to transform to cancer. The likelihood that an adenomatous polyp contains a cancer becomes substantial when the polyp is wider than one inch.

Only a small percentage of polyps or adenomas become cancerous, and those that do aren't transformed overnight. By comparing the DNA of cells taken from typical colon epithelium to that from benign polyps and malignant colon tumors, scientists have determined that it takes a series of genetic changes for tumors to form and to progress to malignancy.

These alterations appear to occur in one of three types of genes — DNA-repair genes, which prevent mutations from occurring; tumor suppressor genes, which keep cells dividing normally; and oncogenes, which stimulate tumor growth. If, over the years, these genes are damaged, lost, turned off, or, in the case of oncogenes, activated inappropriately, the cells will proliferate recklessly. As genetic damage accumulates, tumors become more resistant to treatment.

Symptoms

Colon cancer usually develops silently. When symptoms do occur, they vary according to the location and the severity of the tumor. The following are among the most common:

- *Bleeding.* Colon cancers — as well as benign polyps — can ooze blood steadily or intermittently, often producing black or bloody bowel movements.
- *Anemia* may result from continued blood loss.
- *Constipation.* Gradually worsening constipation without apparent cause is reason for concern.
- *Pain* in the lower abdomen can be due to an obstruction caused by the tumor.
- *Weight loss* and loss of appetite that seem to occur for no reason are signs of advanced cancer.

Screening

The declining death rate is primarily due to aggressive screening measures aimed at identifying colon cancer, or even a precancerous condition, in the early stages. The following schedule is recommended by the American Cancer Society:

- *Digital rectal exam.* This procedure, in which the doctor inserts a lubricated gloved finger in the rectum to feel for abnormalities, should be part of the annual physical for everyone over 40.
- *Fecal occult blood test.* This test detects blood — usually from the higher regions of the colon — that has become incorporated in stools. It entails applying hydrogen peroxide to stool samples smeared on cards. (Blood in the stool will produce a blue color when the peroxide is added.) Although kits are available at drug stores, most cards are issued by and returned to the doctor. Occasionally, the physician might use stool acquired during a rectal exam. The most accurate results are acquired after abstaining from meat and certain other foods for a few days. A test is recommended annually for people over 50.
- *Sigmoidoscopy.* This is a procedure in which the doctor examines the rectum and lower colon through a lighted flexible tube. Although it is recommended every 3-5 years for people over age 50, health insurance may not cover this test for people without symptoms.

Risk Factors

Family History — Having colon cancer in the family increases risk somewhat, but familial adenomatous polyposis (FAP), which confers an almost certain chance of developing colorectal cancer by one's 40s, or hereditary nonpolyposis colon cancer (HNPCC) indicates high risk. Genetic tests are available for both FAP and HNPCC, and people found to have the mutations that are responsible should have frequent colonoscopies beginning in adolescence.

Adenomatous Polyps

Inflammatory Bowel Disease — Severe ulcerative colitis, Crohn's disease

Age — Although age isn't as important a factor as those listed above, the risk of colon cancer increases after age 50.

Diagnosis

The following diagnostic tests may be used when symptoms suggest colon cancer. The procedure employed depends on the type of symptom.

- *Flexible sigmoidoscopy* is often the first approach when the symptom is bright red blood, which could be emanating from several sources, including hemorrhoids, proctitis, benign polyps or malignant tumors.
- *Colonoscopy*, an exam with a longer lighted tube, affords a view of the entire colon. It is used when an occult blood test is positive or to check for additional polyps if the doctor discovers an adenomatous polyp with the sigmoidoscope. Regular colonoscopies are recommended for individuals at high risk for colon cancer (see box.) The polyps that are seen are removed and examined for cancer cells.
- *Barium enema.* An x-ray taken after the administration of a barium enema produces an image of the colon. If polyps are found, colonoscopy is necessary.

Treatment

When malignancy is established, colon cancer is classified by stages, depending on the spread of the primary tumor and the degree of metastasis — the presence of cancer cells in nearby lymph nodes or in other regions of the body. Surgery, sometimes followed by radiation or chemotherapy, is the standard approach to colon cancer. However, as with other types of cancer, the treatment varies with the stage of the disease as explained in the chart at right. Colostomy— in which the surgeon creates an opening called a stoma in the abdomen and sutures the remaining colon to it — is rarely necessary.

Stages of Colon Cancer

	Treatment	5-Year Survival
Stage I: Tumor confined to colon wall	Bowel resection	94.3%
Stage II Tumor through colon wall	Bowel resection; occasionally radiation	84.4%
Stage III Colon tumor and malignant lymph nodes	Bowel resection; radiation; chemotherapy with 5-fluorouracil (5-FU) and levamisole.; experimental immune system boosters	56.6%
Stage IV Colon tumor and metastases to other regions of the body	Bowel resection; radiation, occasionally surgery to remove liver metastases; 5-FU; other drugs and immune boosters used experimentally	2.4%

Prevention

Because colon cancer is far more common in the industrialized nations than in less developed regions of the world, living habits seem at least partially responsible. The following appear to reduce risk.

- *Diet.* Low-fat, high-fiber regimens with several daily servings of fruits, vegetables, and cereals are associated with reduced risk. A diet rich in calcium and folate — a micronutrient in leafy green and yellow vegetables — may reduce risk.
- *Nonsteroidal anti-inflammatory drugs.* Although no one seems to be certain why these over-the-counter drugs work, people who take them for several years appear to have lower rates of colon cancer.
- *Smoking cessation.* As with lung and cervical cancers, cigarette smoking increases risk.
- *Postmenopausal estrogen.* More than half of the epidemiologic studies reported to date have indicated a 30-40% reduction in the risk of colon cancer among women who have used estrogen after menopause. An observational study of more than 400,000 women has indicated that those who have used estrogen have a 29% lower risk of fatal colon cancer than do nonusers. There is some speculation that estrogen reduces concentrations of bile acids, which may promote tumor growth in the colon. However, these observations need to be tested in randomized, controlled studies.
- *Polyp removal.* Removing polyps and adenomas eliminates a potential site of malignancy.❖

DIAGNOSIS & THERAPY

Face Lifts

The record of time's passage is most noticeably transcribed on our faces. Some women accept these lines as a trade-off for the privileges and freedoms of age. Others find that the face in the mirror no longer represents the youthful spirit inside. Many of the latter occasionally seek a surgical solution — a face lift.

In the last 20 years this procedure, once the exclusive province of the privileged, has become commonplace. According to the American Society of Plastic and Reconstructive Surgeons, 32,283 face-lift operations were performed by board-certified plastic surgeons in 1994.

How the face ages

The face is composed of several different types of tissue, layered in curved sheets something like an onion. Most of the visible signs of age are the result of two forces: changes within the layers of facial tissue and gravity. With age, cell death begins to outpace cell growth and, as cells are lost, the tissues become progressively thinner, drier, and less elastic. Under gravity's relentless pull, they stretch and sag, forming folds, creases, and pouches.

These alterations occur at slightly different rates for each of us. The progression of age-related change is influenced by heredity as well as exposure to cigarette smoke and sunlight, both of which accelerate cell loss.

In the epidermis, or outermost layer, the number of pigmented cells called melanocytes decreases at a rate of up to 20% per decade after age 30; in the dermis, the second layer, blood vessels and sweat glands diminish and collagen and elastin — substances that provide elasticity — atrophy; and in the third layer of skin, called the hypodermis or subcutis, fat shifts. The superficial facial fascia — a fibrous layer that supports the skin and overlies the muscles, ligaments, nerves, and larger blood vessels — loses elasticity.

The procedure

One medical name for face lift, *rhytidectomy*, stems from the Greek word for wrinkle. Yet "wrinklectomy" is a somewhat simplistic term for a major surgical procedure to remove the excess skin and fat from the face and neck, tighten the underlying muscle and connective tissue, and redrape the skin.

If you're considering a facelift, it is important to find a good surgeon. Although any licensed doctor can legally perform plastic surgery, those certified by the American Board of Plastic Surgery or members of the American Society for Aesthetic Plastic Surgery have had appropriate training in cosmetic surgical techniques. There are also training programs in cosmetic surgery for dermatologists, otorhinolaryngologists, and ophthalmologists. You may want to ask your primary-care doctor for a recommendation or talk to a friend who has had a facelift and is pleased with the results.

At your first visit, the surgeon will want to know your reasons for seeking a face lift and what aspects of your face you would like to change. He or she will analyze your facial structure and will tell you whether your goals are realistic; most surgeons try to be very clear about what can or cannot be changed by the procedure. Plastic surgeons may use computer-assisted drawings of potential patients to create a projection of the expected result and often have before-and-after pictures of women who have undergone similar operations. Your surgeon should also take a medical history, including health conditions or medications, past surgeries, allergies, and habits such as smoking or alcohol use.

The surgeon should then provide a step-by-step description of what he or she plans to do. You should understand the procedure thoroughly, including the type of anesthesia, lines of incision, possible discomfort, time required for surgery, types of medications used and what to anticipate postoperatively. Surgeons should always discuss the possible risks and complications; beware of a surgeon who minimizes or will not discuss the risks involved in surgery. You should read and sign a consent form.

You should also discuss fees, which vary widely among surgeons and communities. As cosmetic procedures, most facelifts are not covered by insurance.

The procedure may be performed in a free-standing outpatient surgical unit or in a hospital operating room. The majority of facelifts are performed under intravenous sedation and local anesthesia. The surgeon or nurse will insert an intravenous line into your arm, and you will be given a sedative. Once you are quite relaxed or completely asleep, your face and neck will be "painted" with a sterile iodine solution. A local anesthetic will be injected into your face at several places.

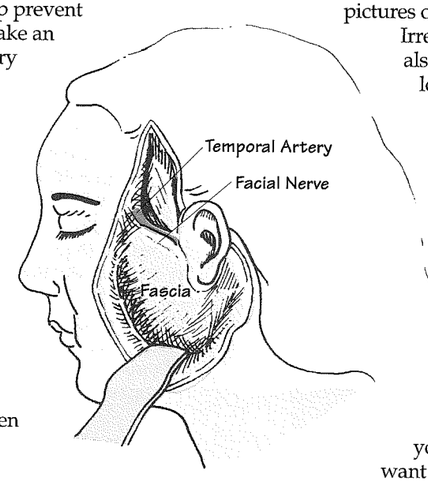
The skin is usually cut free at both sides of the face. The surgeon customarily begins by making an incision inside or along the hairline at one temple. The scalpel traces a path that passes inside and out of the contours in front of the ear, around the earlobe, and then in back of the ear up into the lower scalp, following natural skin creases. The surgeon will repeat the procedure on the other side of the face.

These incisions create two large flaps of skin, which are then lifted away from the underlying fat and muscle. Often a small incision under the chin is also made. The surgeon then removes excess fat from the neck and jawline. Loose neck muscle (the platysma) is then tightened, and any excess skin is then either redraped or removed. Finally, the incisions are closed.

In women who have excess fat, but little or no excess skin to remove, the surgeon may recommend a less invasive approach. The fat can be removed with scissors or suctioned through a narrow tube through a small incision under the chin.

Once the operation has been completed, the surgeon may place a few small drains in the incision to eliminate excess fluid. Your face will be loosely bandaged. You will probably remain in bed for several hours with your head elevated to reduce facial swelling. Most drains and dressings will be removed 24 to 48 hours after surgery and stitches taken out three to seven days later. To help prevent infection, you will be asked to take an antibiotic 24 hours before surgery and for several days afterward.

Facial bruising, which occurs as a result of blood oozing from blood vessels disrupted during surgery, can be reduced by discontinuing aspirin, other non-steroidal anti-inflammatory drugs, and vitamin E for at least two weeks prior to surgery. Nonetheless, bruising is usually quite extensive, and most women don't feel comfortable going out in public for a week or two after the procedure. Many women camouflage the bruises with makeup for as long as a month.



You can expect to have a temporary loss of sensation in the cheeks and neck where the surgeon has worked under the skin. Sensation begins to return within a few weeks and is usually almost normal within 3 to 4 months.

During the first postoperative week, you will probably be encouraged to be up and about but advised not to bend over or engage in strenuous activities such as tennis or golf for 4 to 6 weeks.

Complications

While complications are rare, when they occur they can be dramatic. In about 1% of cases, a large pool of blood called a hematoma will develop rapidly under the skin, putting tension on the skin flaps. If hematomas are not recognized and drained early, the newly-draped facial tissue can be severely injured and may even die and slough off.

Damage to nerves of the face and neck is another rare but feared complication. The great auricular nerve is the one most commonly injured, resulting in a loss of sensation in and around the ear. Injury to this nerve may also stimulate the development of a neuroma — an overgrowth of nerve cells that can be painful. Facial-nerve damage, which occurs in less than 1% of cases, can result in the inability to move some of the muscles of the affected side of the face. It may take 3 to 6 months for the nerve to heal, and in rare instances it may be permanently damaged.

Scarring can also present problems. Dark-skinned women are at increased risk for the formation of the thick, raised scars called keloids. If you are African-American you might want to be certain that your surgeon has performed the procedure on several other black women, and should ask to see pictures of the results.

Irregularities in facial contour may also result. Occasionally, certain localized areas of swelling may persist for months.

Because compounds in cigarette smoke constrict blood vessels, smokers are more likely than nonsmokers to have complications such as delayed healing or sloughing of skin flaps. Diabetes, hypertension, heart disease, or vascular disorders also increase the risk of complications. If you have any of these conditions, you should discuss them with your plastic surgeon, who may want to confer with your primary-care clinician.

What to expect

A face lift will make a subtle or dramatic alteration in your appearance, depending on what is done, your age, and the state of your skin. It will not make you look 20-25 years younger. It will not erase multiple small wrinkles, uneven pigmentation, or acne scars, all of which are treated more effectively with retinoic acid (Retin-A), chemical peels, dermabrasion or laser resurfacing.

Nor will it solve personal problems, ensure a job promotion, or necessarily help you find a mate. If you expect a personal transformation or are considering a facelift because someone wants you to, you might think about discussing your motives with a psychotherapist. While a face lift may make you feel better about your appearance, it may not be enough to elevate your self-image. ❖

DHEA: The Next HRT?

The most recent addition to the list of candidates for hormone-replacement therapy is dehydroepiandrosterone (DHEA), the most abundant steroid produced by the adrenal glands. These days, DHEA is often touted as a universal antidote to aging. Yet until recently medical scientists hardly gave it a second thought.

DHEA and DHEAS — a DHEA molecule that has passed through the liver and emerged with a sulfate molecule attached — were once considered to be unimportant and were dismissed as "weak androgens" — principally because they appeared to do little more than contribute to adolescent acne. However, in the last decade researchers studying the aging process have recognized that the rise and fall of the hormones seems to mirror that of the body itself. Blood levels of DHEA increase steadily until we're in our 20s. They then decline gradually until, at age 60, DHEA concentrations in the blood are only about two-thirds of peak levels.

Moreover, scientists have found that DHEA levels fall during such illnesses as lupus, rheumatoid arthritis, and major depressive disorder. A few studies have linked low levels of DHEA to such age-related conditions as cardiovascular disease, non-insulin dependent diabetes, abdominal obesity, and certain cancers. Thus, there is speculation that the hormone's depletion might be partially responsible for age-related degenerative diseases, and a few researchers postulate that DHEA-replacement therapy might reduce the risk of such disorders.

Physiologic Evidence

Some animal studies seem to support such a theory. In mice, DHEA has been shown to improve immune function, prevent breast and skin cancer, reduce body weight, improve memory, and increase longevity.

While many studies have failed to show an effect for DHEA, a few have suggested that it may help to regulate the immune system. Researchers have identified DHEA receptors on T-lymphocytes — the white blood cells considered the masterminds of the immune response — and interpret this discovery as evidence that DHEA acts directly on these cells. Early physiological data seem to lend credence to this observation. In one study of postmenopausal women, a 50-mg daily dose of DHEA — an amount that boosted blood levels of that hormone to those of early adulthood — was associated with a significant increase in the activity of natural-killer cells, a type of T-lymphocyte that is instrumental in preventing the development of tumors.

Research in postmenopausal women has yielded preliminary evidence that DHEA may also protect against obesity and adult-onset diabetes. In one investigation, the 50-mg dose appeared to reduce insulin resistance and lower serum triglyceride levels — two risk factors for non-insulin dependent diabetes. In another, the same dose appeared to increase the production of insulin growth factor 1, a hormone that protects against obesity and diabetes.

Clinical Research

However, the most dramatic clinical results have been in studies of patients with lupus. In a recent Stanford study of 28 women, those who took 200-mg daily doses for three months had significantly fewer flares of the condition and required lower doses of prednisone to control symptoms than did those taking placebo.

Nonetheless, the most important questions remain unanswered. No one has yet tracked a large group of people over time to determine whether individual changes in DHEA concentrations can be used to predict subsequent disease. There have been no large clinical trials to determine whether taking DHEA is effective in staving off degenerative diseases or whether it is safe for long-term use.

Reports of side effects are limited. Eight of the 14 women who took 200-mg doses of DHEA in the Stanford study developed mild to moderate acne, and some women taking 100-mg doses have reported increased facial hair.

Synthetic forms of DHEA — the versions used in most of the physiologic studies — are marketed in Europe, but they have not been approved by the United States Food and Drug Administration (FDA). However, natural DHEA, which is extracted from *dioscorea*, a Mexican yam, is available from a few pharmacies, which will make up custom compounds of DHEA for physicians.

Preparations of ground *dioscorea* are sold as DHEA or DHEA "precursor" in some health-food stores and are also widely advertised in newspapers, magazines, and on the Internet. There are no manufacturing standards for these products, nor are there requirements for quality or purity. Classified as food supplements rather than drugs, they fall under the regulatory control of the National Institutes of Health's Office of Dietary Supplements Research. If that office determines that a product is harmful, the FDA will pull it from the shelves.

As with postmenopausal estrogen therapy, it will take years of scientific study to determine the benefits and risks of DHEA supplementation. In the meantime, any DHEA use should be considered experimental.❖

Premarin and Animal Rights

Over the last year, we've received a number of letters from readers calling attention to a campaign by PETA (People for the Ethical Treatment of Animals) against Wyeth-Ayerst, the manufacturer of Premarin, a mix of conjugated estrogens extracted from the urine of pregnant mares. PETA contends that the mares kept to supply the urine are treated inhumanely and that their foals are routinely sent to slaughter.

We looked into the Premarin-manufacturing process, and our findings are detailed below.

Wyeth contracts with horse ranchers in North Dakota, Saskatchewan, Alberta, and Manitoba to provide urine. The ranchers establish a reproductive calendar in which mating season begins in June, when stallions are released into pasture with mares, and runs through August, when the stallions are removed.

When a mare is 120 days pregnant, usually in October or November, the estrogen content of her urine is high. She is brought into a barn. There she is housed in a stall where she straddles a funnel-like rubber collecting device that is suspended from the ceiling by pulleys, allowing her to move a few feet in any direction and to lie down in her stall. The device is connected by a hose to a urine-collecting vessel. Most of the horses used are draft horses, who withstand confinement better than do race horses.

In March, the mares are put out to pasture. They give birth in May or June, and remain with their foals until weaning, usually by mid-September. The foals have varied futures — some go to breeders, many are sold to riding stables, and an estimated 10% are consigned to Asian or European meat markets.

Wyeth states that the ranchers agree to follow stringent guidelines, which have been endorsed by agricultural ministries of the three Canadian provinces and by the North Dakota Board of Animal Health. In June 1995, the Equine Welfare Committee of the American Association of Equine Practitioners, a horse veterinary group, inspected 32 Canadian farms that produce urine for Wyeth. The committee's report stated that although most horses got enough to drink, water was available only at specific times of the day; it advised that the horses be given free access to water. It also advised providing regular exercise during the five months of confinement. However, the report determined that there was no evidence of inhumane treatment. In the United States, the Department of Agriculture, Animal and Plant Health Inspection Service issued a report with similar findings.

Of course, whether the horses are being treated humanely and whether they should be used at all are two different questions. The ethics of using animals to improve human well-being — not only to supply estrogen, but for food, clothing materials, scientific research, recreation, or companionship — remains a topic of public debate and personal deliberation.❖

Menstruation and the Mouth

The late luteal phase — the days immediately preceding the menstrual period — have been associated with bloating, abdominal discomfort, and mood swings. According to "Women's Oral Health Issues," a report by the American Dental Association, certain dental conditions are also more likely to flare during that time. Like PMS, these dental woes have been attributed to the effects of progesterone, which reaches peak levels a few days before our periods begin. They include:

- *Gingivitis.* Women who suffer from gingivitis — an inflammation of gum tissue — often find that bleeding increases and that teeth become slightly loose. Progesterone dilates the capillaries feeding the gingiva — or gum tissue — making them more permeable, which contributes to swelling. It also inhibits the repair of gingival collagen, which helps to support teeth.
- *Cold sores and canker sores* often erupt during the luteal phase. This may be due to progesterone's suppressive effects on the immune system.
- *Hemorrhage following oral surgery.* Post-surgical hemorrhages are more likely to occur during menstruation than at any other time of the cycle. The phenomenon may be due to a slight reduction in platelet count and the prolongation of clotting time.
- *Swollen salivary glands.* Several researchers have observed that salivary glands swell and become painful during menstruation, although the cause is unclear. Not even progesterone appears to be responsible.❖

By the Way, Doctor

Q I've been seeing quite a few ads for ulcer medications that are now available over the counter for treating heartburn. Are they safe to take without a prescription?

A There are now over-the-counter versions of three drugs: Tagamet 100 (cimetidine), Pepcid AC (famotidine), and Zantac 75 (ranitidine). They block the production of acids that break down food, and which, when overproduced, can erode the protective mucous layer, resulting in inflammation and perhaps an ulcer. Acid-blockers in high doses given for four to six weeks have been very successful in treating ulcers.

These drugs are now marketed in substantially lower doses as a treatment for heartburn, which is caused by a reflux or backflow of stomach acid into the esophagus. Studies show that in low doses the drugs are safe and effective in reducing the symptoms without a doctor's supervision. These acid-blockers have longer-lasting effects than acid-neutralizers such as Tums, Mylanta, or Maalox and are less likely to cause diarrhea.

If you take an acid-blocker for heartburn and find that it doesn't relieve the symptoms, don't increase the dosage. It is also possible that you may have an ulcer, and you should consult your clinician.❖

Q I prepare for each visit with my doctor by jotting down the questions I want to ask. However, each session is limited to 15 minutes. How can I get my questions answered in such a short period of time?

A Unfortunately, your experience isn't unique. Under managed care, office visits have been shortened dramatically, and we doctors and our patients are under pressure to make the best possible use of our time together. You can help if, at the beginning of the visit, you tell your doctor that you have questions so he or she can set aside time to answer them. If your questions are extensive, you can request a longer visit in advance, make another appointment, or schedule a follow-up phone call. Always ask the questions that are most important to you first.

In some offices, nurses may be able to answer many of your questions or provide patient-education materials with the information you need.

Plan to arrive a little early to register or to handle other administrative details. Doing so will keep you from wasting time that may be used on the office visit.

The bottom line is that 15 minutes is inadequate for most office visits. We are in a time of transition in healthcare delivery, and you can participate in the change by voicing your concern to your doctor, insurer, and elected representatives.❖

Q I am 58 and have been taking cyclic estrogen and progestin for about five years. For the first two years I had regular bleeding, much like my menstrual periods. However, I haven't had a "period" for two years, even though I'm continuing to take cyclic hormone-replacement therapy. Should I be concerned about a problem?

A You needn't be concerned. It's true that a cyclic HRT regimen — estrogen taken for 25-30 days and progestin for 10-14 days — simulates the menstrual cycle. Estrogen stimulates the growth of the endometrium, or uterine lining; the addition, and then withdrawal, of a progestin causes the lining to slough off. However, after menopause the endometrium gradually atrophies, occasionally becoming resistant to the effects of both hormones, and bleeding ceases.❖

Celeste Robb-Nicholson, M.D.

The goal of the Harvard Women's Health Watch is to interpret medical information for the general reader in a timely and accurate fashion. Its contents are not intended to provide personal medical advice, which should be obtained directly from a physician.

We regret that we cannot respond to inquiries regarding personal health matters.

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Bold type indicates a major article on a given subject. Month of issue and page numbers follow each topic.