

Heart & Health Reports™

Your one source for prevention, treatment, fitness and nutrition

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Risk factors common to both conditions

Heart Disease & Sexual Health

ERECTILE dysfunction (ED) has been a topic of great interest since the beginning of recorded history. References to erectile dysfunction appear in the Bible, characteristically in the form of punishments for transgressions against the Lord. In medieval times, erectile dysfunction was thought to be caused by the spell of witches. Throughout history cultures have sought remedies for ED. The ancient Egyptians and Greeks concocted a variety of potions hoping to cure the malady. Lacking modern science, all were doomed to failure. It was not until the past few decades when enhanced understanding of the physiology of male sexual function allowed development of breakthrough medicines to treat ED.

An all too common problem

Erectile dysfunction is very common, affecting to some degree more than half of all men age 40 years or older. The prevalence increases with age, with 70% of men older than 70 years experiencing



ED drugs can restore sexual function for many, but proper evaluation is necessary.

ED. This condition is particularly important to our readers because ED is common in men with circulatory disorders and in those who take cardiovascular medications.

Risk factors the same for heart disease

Erectile dysfunction and cardiovascular disease share many of the same risk factors. Two key studies analyzing this topic include the Massachusetts Male Aging Study (MMAS) and the National Health and Nutrition Examination Survey (NHANES).

- **Diabetes.** This represents the most common risk factor, as more than half of all men with diabetes have ED. The onset of ED in patients with diabetes is associated with other complications of this disease involving the eye (retinopathy) and nervous system (sensory and autonomic neuropathy).

- **Hypertension.** This is a controversial and complex association. Not all studies agree, but many support hypertension, particularly

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Real people

A Hole in the Heart

DANA, age 38, was enjoying reading the Sunday newspaper on a beautiful October morning. After two hours of pouring through her favorite articles, she decided to tackle the Sunday crossword. But after a few minutes, she found it difficult to see the right side of the page. She closed her eyes for a few seconds to rest. But when she opened her eyes again, the trouble seeing objects on the right remained. Something drastic had happened to her vision.

Her husband took her immediately to the emergency room. A neurologist was called in consultation who admitted her to the hospital and ordered a battery of tests. An MRI of the brain confirmed that Dana had suffered a small stroke in the back of the brain, an area that controlled vision. But all her other tests were normal. The doctor was puzzled about the source of the stroke and more investigation was necessary.

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Heart & Health Reports™

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NY Trans-fat ban successful!

Earlier this year, the New York City Board of Health issued a mandate that most foods prepared in the city's 22,000 restaurants contain no more than half a gram per serving of artificial trans-fat. This unhealthy, partially saturated vegetable oil is used for baking and frying and has a number of undesirable effects on the lipid profile. Trans-fat raises the total and LDL (bad) cholesterol and lowers HDL (good) cholesterol. Estimates are that this unfavorable effect alone is responsible for about 6% of coronary events in the United States. A recent survey by the NYC Health Department of more than 3,300 restaurants found that about 94% had switched to spreads and oils containing zero grams of trans-fat. Those found out of compliance were issued fines.

New Yorkers, like many Americans, tend to eat out frequently and hopefully, this elimination of trans-fat will translate into fewer cardiovascular complications. You should also be aware of the trans-fat in the foods you purchase. Since 2006, trans-fat has been listed on the nutritional labeling of packaged foods. Trans-fats are not essential and have no known benefit. Eliminating trans-fats from the diet should be your goal.

Franklin H. Zimmerman, MD

Chest compression only CPR preferred

Cardiopulmonary resuscitation (CPR) is the first line of defense in sudden cardiac arrest. The ability of a bystander to perform it effectively can be life saving. But what is the best way to do it?

Any form of CPR will only provide a fraction of the body's normal cardiovascular function. The goal is to maintain a life-sustaining delivery of oxygen to the vital organs until a more definitive treatment such as defibrillation can be administered. Traditional methods of CPR called for chest compressions combined with assisted respirations usually in the form of mouth-to-mouth breathing. However, the need for mouth-to-mouth resuscitation discouraged many bystanders from participating due to the fear of contagious diseases. A new study from the Kanto region of Japan eval-

uated the use of a new form of CPR using only chest compressions (cardiac-only) compared to conventional methods of CPR.

Over 4,000 witnessed out-of-hospital cardiac arrests were surveyed. Eleven percent received cardiac-only CPR, 18% received conventional CPR, and 72% received no bystander CPR. Cardiac-only resuscitation was found to result in a higher percentage of patients with a favorable neurologic outcome compared to conventional CPR (6.2% vs. 3.1%). Any form of CPR was better than no CPR for good neurologic outcome (5% vs. 2.2%). There was no evidence of a benefit from the addition of mouth-to-mouth breathing. The authors concluded that the cardiac-only resuscitation should be considered the method of choice for CPR.

Analysis: The findings of this study come as a surprise for those trained in conventional CPR. We had previously thought that air

exchange in the lungs was critical for preservation of neurologic function. However, some air exchange may occur due to gasping respirations. Uninterrupted chest compressions appear to be the key to success until defibrillation or spontaneous recovery is obtained.

It should be noted that neurologic recovery rates remain low even when CPR is instituted promptly, underscoring the importance of availability of automatic external defibrillators. Hopefully, the use of simplified CPR, without the need for mouth-to-mouth resuscitation, will encourage more bystanders to participate in this potentially life-saving treatment.

— Arthur E. Fass, MD

SOS-KANTO Study Group. Cardiopulmonary Resuscitation by Bystanders with Chest Compression Only (SOS-KANTO): An Observational Study. Lancet 2007;369:920-26.

Pedometer use improves activity

Most adults in the U.S. do not perform adequate physical activity for cardiovascular health. We all agree that exercise is beneficial, and many of us claim to walk regularly. But how much walking are we really doing? Would it be helpful to know exactly how many steps we take in an average day by using a pedometer? And, would this knowledge motivate us to be more active?

These questions were addressed in a recently published meta-analysis of 2,767 patients that evaluated the effect of pedometer use and actual exercise obtained. The studies evaluated the difference in walking activity between individuals with pedometers versus control patients. Over an average follow-up of 18 weeks, patients fitted with pedome-

ters increased their average walking activity by about 2,000 steps per day (26.9%), nearly a mile per day increase over baseline. The increased activity translated to a significant decrease in body weight and lowered systolic blood pressure by an average of 3.8 mm Hg.

Analysis: Psychological factors play an important role in our motivation to exercise. Some individuals require the structure of a supervised exercise program. Others need to "see and be seen" in a health club environment, often paying a high premium to use exercise equipment that they already have at home. One aspect of human nature is the need for positive reinforcement and "credit" for our efforts. This is the first study to confirm the usefulness of pedometers in increasing physical activity.

The pedometer is a simple, inex-

pensive device that can be worn on the hip and measures the number of steps taken. It seems to answer our desire for immediate feedback on what we've accomplished and challenges us to do more. Apparently, without this incentive, many of us lose our motivation.

The benefits of exercise cannot be overstated. If you need a pedometer to measure your progress and push you to do more, we heartily encourage you to make the investment!

— Arthur E. Fass, MD

Bravata DM, et. al. Using Pedometers to Increase Physical Activity and Improve Health. A Systematic Review. JAMA. 2007;298:2296-2304.

Erectile dysfunction . . . continued from page 1

severe hypertension as a risk factor for ED. Complicating the analysis is that treatment with some blood pressure lowering agents clearly increases the likelihood of ED.

- Smoking. The MMAS found that smoking nearly doubled the risk of moderate or complete ED compared with nonsmokers. It also markedly increases the risk of ED in men with heart disease and other cardiac risk factors.

- Obesity and physical inactivity. Overweight men are more likely to have ED. The NHANES found that sedentary behavior was strongly correlated with ED. In the MMAS, men who were initially sedentary had lower rates of ED if they increased their level of activity.

ED and heart disease linked

Men who have coronary heart disease often have ED. One study of

300 men with angina and documented coronary disease found that 49% had ED. Conversely, men with ED have a high likelihood of coronary disease. A study analyzing nearly 13,000 men found that after adjustment for other risk factors, men with ED had double the risk of myocardial infarction compared with men without ED.

Sexual dysfunction may precede the onset of coronary symptoms. One analysis found that ED developed nearly three years prior to the onset of angina.

Why erections fail

When a man becomes sexually excited, nerve signals trigger release of a chemical that dilates the arteries supplying the penis. Blood flows into the penis, causing an erection. At the same time, veins draining the penis compress, maintaining the

erection by preventing the outflow of blood. Disorders that either interfere with the nervous system or blood supply of the penis can cause ED.

Drugs to the rescue

Treatment of ED was revolutionized in 1998 with the release of sildenafil (*Viagra*). This drug was followed by vardenafil (*Levitra*) and tadalafil (*Cialis*). All work by inhibiting an enzyme (PDE5) that breaks down a chemical that dilates blood vessels (cGMP). With more cGMP, penile blood flow is enhanced and the erection is improved. These medications will not produce an erection in the absence of sexual arousal.

Viagra and Levitra are relatively short-acting drugs, beginning to work within 30-60 minutes with an effect lasting four hours. Cialis

Hole . . . continued from page 1

The next day Dana underwent a procedure called a transesophageal echocardiogram. A small ultrasound probe was positioned down her esophagus to take close-up ultrasound pictures of the heart. It didn't take long to find a potential cause of Dana's stroke. "You have a small hole between the upper chambers of your heart called a patent foramen ovale," the cardiologist said. "This could have allowed a clot to pass from the right to the left side of your heart, which then flowed to the brain and caused a stroke."

Next came a search for the source of the blood clot. Further tests showed that Dana had a genetic predisposition to forming blood clots. She was prescribed the "blood thinning" anticoagulant, *Coumadin* (warfarin). Thankfully, Dana's vision eventually returned to normal and she can look forward to her lazy Sunday afternoons reading the paper.

Cardiologist's comment:

Stroke is most often seen in people older than 65 who have risk factors for atherosclerosis. When a younger person, especially one without conventional risk factors has a stroke, an extensive workup is usually warranted. When no cause is found, the stroke is called *cryptogenic*. The most common cause of cryptogenic stroke in a young person is a patent foramen ovale.

A patent foramen ovale (PFO) is a remnant of the fetal circulation. It usually closes at birth, but if it remains open, it can act as a "doorway" for a clot to pass from one side of the heart to the other. If a blood clot develops in the legs or pelvic veins, it can break free and flow to the lungs, causing a pulmonary embolus. In patients who have a PFO, the clot can cross from the right (venous) side of the heart, through the opening into the left atrium. From there it can travel through the left ventricle, flowing

to the brain causing a stroke.

The yearly risk of cryptogenic stroke in an otherwise healthy person with a patent foramen ovale is as low as 0.1%. Additional factors may increase this risk. These include use of oral contraceptive drugs, recent surgery, trauma, and blood clotting disorders that produce a hypercoagulable state.

There are three potential treatments for a young person with a PFO who has suffered a stroke. These include medications such as aspirin or warfarin, catheter-based devices to close the opening, and cardiac surgery. At the present time there are no firm guidelines to determine which is the best treatment for each individual, but research is ongoing. ♥

— Dina R. Katz, MD

The stories reviewed in this section represent actual patients. Details have been modified to preserve anonymity.

— Editor

begins to work within 30 minutes, but has a much longer duration of action of 24-36 hours.

Is sex dangerous?

After proper medical evaluation, most stable cardiac patients can maintain their usual sex lives. This includes both men and women with chronic angina, after suffering a heart attack, or following cardiac surgery.

Many spouses worry about having sex with a partner who has a heart condition. This fear is largely unfounded. Sex is very unlikely to cause a heart attack and death during intercourse is extremely rare. Anger or emotional upset occurring as part of daily living is likely to pose a greater risk than sexual activity.

Sex is a relatively modest form of exercise. Healthy men having intercourse with their usual partners average a heart rate of 110-127 beats per minute. A traditional recommendation is that sexual activity requires about the same effort as walking up two flights of stairs.

The risk of coronary insufficiency during sex can be predicted by exercise testing. A 1995 study published in the *American Journal of Cardiology* found that all patients who had coronary insufficiency during sex also had abnormal stress tests. Conversely, a normal exercise test predicted adequate coronary blood flow during intercourse.

Guidelines exist to separate men into high, low and intermediate risk for sexual activity.

High risk. This includes men with a recent heart attack (< 2 weeks), decompensated congestive heart failure, uncontrolled angina, or severe valve disease such as aortic stenosis.

Low risk. Men with mild, stable angina, heart failure, or valve disease are considered low risk. Also included are those with successful angioplasty or bypass surgery, past heart attack (> 6-8 weeks), and other common conditions such as atrial fibrillation or controlled hyperten-

sion.

Intermediate risk. This includes all other men who require further evaluation to determine their risk. Exercise testing is usually needed to place them into another category.

Are ED drugs safe?

The safety of drugs for sexual dysfunction is an important question for cardiac patients because so many are affected with ED. After the launch of Viagra in 1998, reports of deaths associated with its use caused concern. Since then, research involving thousands of patients using all three currently available drugs of this class indicate that they are well-tolerated and safe for men with stable cardiovascular disease.

Side effects do occur with use of these drugs. The most common adverse reactions with all three are headache (7-22%), flushing (5-13%), and dyspepsia (1-11%). Vision disturbances, particularly changes in certain colors have been reported in some patients taking both Viagra and Levitra. The effect relates to the fact that these drugs also inhibit an enzyme in the eye. Cialis does not affect this enzyme. There have been sporadic reports of vision loss with these agents called nonarteritic anterior ischemic optic neuropathy (NAION). Whether the cause is truly due to use of ED drugs is not confirmed, but patients are now advised to stop the drug and contact their doctor for any sudden vision loss.

Some precautions necessary

All PDE5 inhibitors can modestly lower blood pressure. This effect is amplified by use of nitrates in any form with a potentially severe drop in blood pressure. Accordingly, short or long-acting nitrates (e.g., nitroglycerin, isosorbide) must not be combined with these drugs.

Many men with ED also have benign enlargement of the prostate gland or high blood pressure. Treatment can include alpha blockers such as doxazosin (*Cardura*) and terazosin (*Hytrin*), medications that

can also potentiate the blood pressure lowering effect of ED drugs. This effect is not as pronounced as nitrates, but caution is advised when combining alpha blockers with PDE5 inhibitors.

More discussion wanted

Physicians lag behind patients in their inclination to discuss sexual activity and sexual function. One survey of coronary patients found that 81% of men and 64% of women desired a discussion of sexual function with their cardiologist. Only 3% of men and 18% of women indicated they received adequate information.

Cardiologist's comment:

Medical options like Viagra, Levitra and Cialis have revolutionized treatment for erectile dysfunction. Patients are deluged with media exposure about treatments for sexual dysfunction, a topic once considered taboo. ED is frequently present in patients with cardiovascular disease and we routinely inquire about sexual function.

If you have ED, a medical evaluation is necessary. It is important to look for evidence of underlying cardiac disease and to treat risk factors. In some cases, a stress test is necessary to determine whether sexual activity is safe and before prescribing ED medications.

Never feel embarrassed to discuss erectile dysfunction with your doctor. Always tell your doctor whether you are taking ED medications and never obtain these medications over the Internet and without your doctor's prescription. Some individuals have mistakenly obtained ineffective, counterfeit drugs online. Remember that erectile dysfunction is just another medical condition that can now be treated with modern science. Perhaps the 18th century German dramatist, Goethe said it best, "Gladly I think of the days when all my members were limber – all except one. Those days are certainly gone, now all my members are stiff – all except one."♥

— Franklin H. Zimmerman, MD

Cordarone/Pacerone

(amiodarone hydrochloride)

What kind of medicine is Amiodarone?

Amiodarone is a class III antiarrhythmic drug. It is indicated for the treatment of serious ventricular arrhythmias. These rhythm disturbances originate from the lower chamber of the heart (ventricle). Many doctors also use it to treat supraventricular tachyarrhythmias such as atrial fibrillation and atrial flutter, originating from the upper chambers of the heart (atria).

How does Amiodarone work?

Amiodarone changes the properties of the heart's electrical conduction system by altering the chemical transfer of sodium, potassium and calcium. The result is a slowing of the arrhythmia or conversion to a normal rhythm.

How will Amiodarone help me?

Ventricular arrhythmias are serious and potentially fatal. Atrial fibrillation can lead to stroke. Amiodarone can suppress these abnormal rhythms. This drug is especially useful in people who have congestive heart failure, because it does not worsen cardiac function like some other antiarrhythmic drugs. Amiodarone can be used in the perioperative period to prevent atrial fibrillation. It is also used in people with an implantable defibrillator to prevent shocks.

How is Amiodarone prescribed?

For ventricular arrhythmias: 800-1600 total mg in 1-2 daily doses for 1-3 weeks, followed by 600-800 total mg in 1-2 daily doses for 1 month. The maintenance dose is 400 mg daily.

For recurrent atrial fibrillation (off label use): 10 mg/kg daily in 1-2 daily doses for two weeks (e.g. for an 80 kg individual, 400 mg twice a day). Follow the initial dose with 300 mg for 4 weeks. The maintenance dose is 200 mg. For low weight patients, the dosage may be decreased to 100 mg daily.

What dosage sizes are available?

Amiodarone is available in 200, and 400 mg tablets. It should be taken with food and may be split or crushed.

How long will it take to work?

Amiodarone takes a very long time to work. The effect begins at 2-3 days; however, it may not reach its full effect until six months later.

What if I miss a dose?

Take the missed dose as soon as possible. Do not take an additional dosage.

Do food or other drugs affect this medicine?

Grapefruit juice can affect the metabolism of this drug. Avoid grapefruit products.

Amiodarone may affect many other medications.

- Amiodarone increases the levels of digoxin, warfarin, clonazepam, cyclosporine, flecainide, theophylline.
- Amiodarone levels may be increased with use of cimetidine or protease inhibitors (HIV drugs).
- Amiodarone levels may be decreased with use of cholestyramine, rifampin, and St. John's wort.
- Beta blockers, diltiazem and verapamil, used with amiodarone may cause a very slow heart rate.

Who should use caution or not take this medicine?

- Pregnant women — amiodarone crosses the placenta and may harm the developing fetus.
- Nursing mothers — amiodarone enters breast milk.
- Patients with liver disease.
- Patients with severe lung disease.
- Patients who have a slow heart rate.

How will I feel while taking Amiodarone?

Amiodarone is usually well-tolerated. GI side effects are common during the initial higher, loading doses.

Are there serious side effects to watch for?

- Serious lung complications can occur. These characteristically resolve when the drug is stopped.
- The most common side effect is a slow heart rhythm.
- Thyroid abnormalities including both hyperthyroidism and hypothyroidism.
- Corneal micro-deposits are seen in almost all patients, but are rarely of clinical significance.
- A gray-bluish skin discoloration may be seen in patients who take large doses for long periods.
- Neurologic side effects such as tremor, insomnia and memory impairment may occur.
- Hepatitis is a rare complication.
- Hair loss is an infrequent side effect.

How does the doctor monitor my progress?

The doctor will periodically perform an EKG and routine labs, including complete blood chemistries and thyroid function. An eye exam, dermatologic exam, pulmonary function test and chest x-ray are often performed prior to initiating therapy and periodically during long-term treatment.

Do you have any special tips for me?

- Immediately report any feelings of dizziness, lightheadedness, or palpitations to your physician.
- Amiodarone is a complicated drug that requires close follow up with a specialist.
- Always inform your doctor when new medications are prescribed with amiodarone.

— Dina R. Katz, MD

Problems with portions

This is the season where we look forward to enjoying a plethora of holiday food and cheer. But a frequent consequence of this celebration is plenty of unwanted pounds. Studies indicate that the weight people gain during the holiday season is rarely shed during the rest of the year. This contributes to that gasp frequently heard around the country as Americans step on the scale.

“Portion distortion” is often a factor that contributes to our need for elastic waistbands as we visit each family gathering, office bash, and neighborhood party. Most of the time, we place much more on our plate than a recommended serving. But you can still be sociable without piling on the calories. Learning how to eyeball a standard portion size is an effective strategy in the battle against the holiday bulge.

One technique to help “guestimate” what a proper amount of food looks like is to use familiar objects. For example, a tennis ball is about the same size as 1 cup of pasta and a pair of dice is about a 1 oz serving of cheese. Your hand can also help gauge proper portion size. For instance, the palm of your hand is about the equivalent of 3 oz of meat and your fist is comparable

to a serving of cereal.

There are a number of strategies you can use to triumph over those extra holiday calories. Filling half the plate with vegetables and leaving a quarter each for lean meat and starch can help control the portions of high calorie foods. Eating more healthy vegetables and fruits will help you get the nutrients you need and facilitate a feeling of fullness. Also, try to avoid feeling famished before your next social soirée. Have a light, healthy food such as a low-fat yogurt with walnuts before you leave for the party. This will help you avoid overloading on those enticing high-fat, high-calorie foods.

Try not to lose sight of what your body actually needs versus indulging in every temptation during this season. And if you find yourself unable to avoid that large portion of delectable, mouth-watering apple pie, try cutting the calories in half by finding someone to share in the enjoyment. After all, sharing is part of what the holidays are all about!

— Emily Kratz, MS, RD

Ms. Kratz is an outpatient nutrition coordinator at Phelps Memorial Hospital, Sleepy Hollow, NY.

Supermarket Savvy

Portion Control Buying Guide

Portion size	Common item
1 cup of Pasta	Tennis ball
1 oz Cheese	Pair of dice
1 Small potato	Computer mouse
3 oz Meat	Palm of hand
1/2 cup of Ice cream	Lightbulb
1/4 cup of Nuts	Large egg
1 teaspoon Butter	Thumb tip
2 tablespoons of Salad dressing	Ping-pong ball
1 Pancake	Compact Disc
3 oz Fish	Checkbook
1 cup Green salad	Baseball
1/2 cup Rice	Cupcake wrapper full
1 cup Cereal	Fist

Q: “Is there a role for using CoQ10 to reduce muscle aches from statins?”
—Irvington, NY

A: Coenzyme Q10 (CoQ10) has been a popular supplement used for a variety of purported benefits. For the most part however, it has not been embraced by the medical establishment as being a particularly useful agent.

With the widespread prescription of statins (e.g. *Lipitor*, *Zocor*, *Crestor*, and others) for the management of elevated cholesterol levels, CoQ10 is getting a closer look. A common side effect of statins, often requiring their discontinuation, is nagging muscle pain, known as myalgia. It is thought that Coenzyme Q10 may have a role in the prevention or treatment of this type of myalgia. A more severe type of muscle injury from statins called rhabdomyolysis, an actual breakdown of muscle tissue, is fortunately very rare.

Statins work by inhibiting a major enzyme in cholesterol synthesis. They can also block production of CoQ10, a factor involved in

energy production in the mitochondria of muscle cells. Blood levels of CoQ10 are reduced in patients receiving statins. Whether levels of CoQ10 are also reduced in muscle cells is unknown.

Several animal studies designed to assess the effect of statins on mitochondrial function yielded contradictory results. A small study of human muscle biopsies in four patients with statin-induced myopathy revealed evidence of mitochondrial injury, which reversed when the drug was discontinued.

A number of studies suggest that CoQ10 supplements can increase circulating CoQ10 blood levels in patients on statins. There is preliminary data suggesting possible improvement in pain symptoms of myalgia patients given CoQ10. Another study however, revealed no apparent benefit.

Where does this leave us with CoQ10? Although the data are conflicting, and the cause of statin-induced myopathy has not been proven, there are no known risks to

CoQ10 supplementation. While we do not recommend CoQ10 tablets for all patients on statins, it is reasonable to try this supplement in patients with mild muscle pain during statin therapy.

Many patients with muscle pain from statins can tolerate the drug in a lower dose. Some patients with myalgia from one statin will be able to tolerate another drug in this class without ill effect. Another option to try is to administer the statin on alternate days. We have successfully used this approach on a number of patients who were unable to tolerate a usual daily dose. There are also anecdotal reports of a beneficial effect of ezetimibe (*Zetia*) in alleviating statin-related myopathy. This effect has not been confirmed.

The optimal dosage of CoQ10 is unknown, but a dose of 200 mg. daily is a good place to start. All patients with statin-related myopathy require very close clinical follow-up to assure that they don't progress to serious muscle injury.

— Arthur E. Fass, MD

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