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When Worry Becomes Worrisome

Excessive worry may signify generalized anxiety disorder—but treatment can help you take back your life

Are you constantly worried, distressed, and on edge? If so, you may be among the 4 million people a year who suffer from *generalized anxiety disorder (GAD)*. While some anxiety is a normal part of life, GAD is different. "Normal anxiety is healthy. Without it you might not get to places on time or prepare properly for a speech," says Jerilyn Ross, MA, LICSW, president and CEO of the Anxiety Disorders Association of America (ADAA) and director of the Ross Center for Anxiety and Related Disorders. "Abnormal anxiety is irrational, intense, and persistent. It's out of proportion to any real threat and generally interferes with day-to-day living."

But many people aren't aware of GAD, and the condition often goes unrecognized. Twice as many women as men develop GAD. Among older people, anxiety may be overlooked as a part of normal worries about aging. But excessive worry is not normal at any age, and safe and effective treatments are available.

Trouble in mind

People with GAD continually ruminate, imagining worst-case scenarios. "The hallmark of the disorder is excessive or uncontrollable worry," notes Michael Liebowitz, MD, professor of clinical psychiatry at the Columbia University College of Physicians and

Surgeons. "Patients worry not just about one thing, but a whole variety of things, minor as well as major. Their minds never stop."

GAD is associated with feelings of restlessness, extreme fatigue, difficulty concentrating, irritability, and muscle tension. Sleep disturbances are common. Sufferers may experience clammy hands, dry mouth, sweating, nausea, difficulty swallowing, or diarrhea.

According to a survey conducted by the ADAA, the majority of people with GAD say their illness has a major impact on relationships with family, friends, and co-workers. Nearly two-thirds of sufferers report that GAD interferes with their ability to perform everyday activities.

Age and anxiety

There's some evidence that anxiety disorders are twice as frequent as mood disorders later in life. Of course, there are normal worries that accompany aging, such as those about health, finances, loss of friends and family. Many older people

worry about illnesses, such as Alzheimer's disease, or becoming dependent on others.

According to the ADAA, most older adults with the excessive worry of GAD probably had an anxiety disorder when they were younger. GAD can emerge due to the stresses and vulnerabilities of aging (chronic physical problems, cognitive impairment, or losses).

Continued on page 6

HOW CAN YOU TELL IF IT'S GAD?

Yes or No? Are you troubled by:

- Excessive worry, occurring more days than not, for at least six months?
- Unreasonable worry about a number of events or activities, such as work or health?
- The inability to control the worry?

Are you bothered by at least three of the following?

- Restlessness, feeling keyed-up or on edge
- Being easily tired
- Problems concentrating
- Irritability
- Muscle tension
- Trouble falling asleep or staying asleep, or restless and unsatisfying sleep
- Anxiety that interferes with your daily life

If you answered "yes" to two of the three questions, and have three or more of the associated symptoms, talk to your health care professional.

Sources: ADAA; Diagnostic and Statistical Manual of Mental Disorders IV





Women's Health Advisor®

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FRONTLINE



Newer breast cancer drug better at preventing recurrence

The breast cancer drug *anastrozole* (*Arimidex*) prevents more cancer recurrences and improves disease-free survival by 26 percent compared to *tamoxifen*, according to results of a new clinical trial. Researchers from the M.D. Anderson Cancer Center say

Arimidex might be able to prevent 70-80 percent of recurrences of estrogen-positive breast cancers after menopause, compared to a 50 percent reduction in recurrences reported for *tamoxifen*. *Arimidex*, one of three new drugs called *aromatase inhibitors*, prevents estrogen from being made by the body. Estrogen fuels the growth of breast tumors that have receptors for the hormone. *Tamoxifen* blocks estrogen from entering cells. The clinical trial, involving more than 7,000 women from the U.S. and 20 other countries, found those who took *Arimidex* for five years after being treated for early-stage breast cancer were less likely than those who took *tamoxifen* to have either a recurrence, a tumor develop in the other breast, or a spread of their cancer. The researchers told the annual San Antonio Breast Cancer Symposium in December 2004 that *Arimidex* should become the first-line treatment for most women with the disease. Another study presented at the meeting found women who switched to *Arimidex* or another aromatase inhibitor (*Aromasin*) after taking *tamoxifen* for 2-3 years had around a 40 percent lower risk of recurrence, compared to those who remained on *tamoxifen* for the standard five years. Neither study challenged *tamoxifen* as the first-choice drug for premenopausal women with breast cancer, since aromatase inhibitors do not seem to be effective in younger women.



Botox may help incontinence

A small study suggests that treatment with *Botox* can help women with urge incontinence. In urge incontinence, abnormal contractions of muscles in the bladder wall cause severe urgency to urinate and also urine leakage. *Botox*, tiny doses of *botulinum toxin-A*, paralyzes small areas of muscle, and is used to relieve muscle spasms, among other things. In a pilot study at Duke University School of Medicine in Durham, North Carolina, seven women underwent *Botox* treatment, which used a fiberoptic device, called a *cystoscope*, inserted through the urethra into the bladder, to help inject the drug directly into the hyperactive muscle. The women's incontinence improved substantially for up to six months but recurred after that, according to the study reported in the December 2004 issue of the *Journal of Urology*. The only side effects were mild urinary tract infections in three women. Further studies in larger groups of women are needed to confirm the effectiveness of the treatment, and establish the dosage and frequency of *Botox* as a short-term treatment. 🍷

Rx ALERT



Cardiac concerns raised about Celebrex and Aleve

The FDA has issued a public health advisory recommending limited use of the prescription drugs known as *COX-2 inhibitors*, after new health concerns emerged in December 2004 about the prescription arthritis drugs *Celebrex* and *Bextra*, and the over-the-counter drug *naproxen* (*Aleve*). The National Cancer Institute stopped a long-term clinical trial designed to see whether *Celebrex* could prevent certain colon tumors (*adenomas*) after a safety analysis found patients taking 400 mg a day of the drug had a 2.5-fold risk of heart attacks (and 3.5-fold risk with 800 mg) compared to those taking a placebo. A safety analysis of data from a second long-term trial, testing whether 400 mg of *Celebrex* daily could prevent colon polyps, did not show any cardiac risks for the drug. (The usual dose of *Celebrex* for osteoarthritis pain is 100-200 mg a day.) A third clinical trial, the Alzheimer's Disease Anti-Inflammatory Prevention Trial (ADAPT), was also stopped. ADAPT was designed to compare the potential benefits of long-term use of *Celebrex* and the over-the-counter nonsteroidal antiinflammatory drug *naproxen* (*Aleve*) among people over age 70 at high risk for Alzheimer's. While a preliminary analysis of data from ADAPT did not find any risks for *Celebrex*, it did show a slight increase in heart attacks and strokes among people taking *Aleve*. In addition, warnings about serious skin reactions and cardiac risks for people undergoing bypass surgery were issued by the FDA for *Bextra*, another prescription *COX-2* inhibitor. The FDA is currently reevaluating data from all prevention studies involving *nonsteroidal antiinflammatory drug* (*NSAID*) products, including *COX-2* inhibitors. 🍷

Whole Body CT—Looking for Trouble?

Should you go for a body-wide scan if you have no apparent health problems?

You've probably seen advertisements for whole body CT or MRI scans, which are being promoted directly to healthy consumers as a way to identify hidden early medical problems, such as heart disease or cancer. The message often plays on fear: "I had a time bomb in my body...you need to know," says one ad. Another ad promises: "30 minutes can save a life—your own."

But a new study by Stanford University of more than two dozen advertisements for high-tech body imaging in major U.S. newspapers and 20 brochures for clinics offering the scans concluded they can mislead consumers about the benefits and the risks. The study, published in the December 13/27, 2004 *Archives of Internal Medicine*, called for professional guidelines and stricter government oversight of these direct-to-consumer ads and the imaging clinics they promote. The study comes on the heels of a seminar sponsored by the National Academy of Sciences (NAS) in November in Washington, D.C. on the pros and cons of whole body scans. Our Washington correspondent reports on the meeting.

Help or hype?

Whole body scanning is done with *computed tomography (CT)*, a diagnostic technique which combines X-rays with a computer to offer fast, three-dimensional, cross-sectional images of the human body (or, less commonly with *magnetic resonance imaging, MRI*). In recent years, clinics offering whole body scans have sprung up around the country, and healthy people with no symptoms willing to pay \$400-1,200 out of pocket can obtain a scan without a doctor's referral.

While CT and MRI are approved by the FDA as diagnostic tools for patients with symptoms, clinical trials have not proven their effectiveness for screening healthy people. One-quarter of the newspaper ads surveyed by Stanford noted that the technology is

FDA-approved, but glossed over the fact that it has not been approved for general screening.

The study notes that the ads and brochures urged people to take action to protect their own health, while "virtually none" advised first consulting their doctors or mentioned the risks. CT scans expose patients to a level of radiation far higher than that of traditional X-rays (a fact not mentioned by the ads), and the increased radiation exposure (which can cause cancer) may outweigh the benefits of possibly detecting hidden disease. In addition, the scans could result in a false-positive or a "suspicious" finding that would never have presented a significant health risk, both of which could lead to unnecessary medical testing and needless worry, says lead author Judy Illes, PhD, of the Stanford Center for Biomedical Ethics.

Promise and peril

A spokesman for the American College of Radiology (ACR) told the NAS conference that there's no scientific basis to recommend the scans for asymptomatic people, noting "to date, there is no evidence that total body CT screening is cost efficient or effective in prolonging life." The ACR does support ongoing studies of targeted screening for specific diseases, such as CT scans for lung cancer in current and former smokers and CT virtual colonoscopy for colon cancer in people with recurrent precancerous polyps.

The Conference of Radiation Control Program Directors, Inc., a nonprofit, professional organization of state and local regulators of radiation, has passed a resolution stating that its members should "actively discourage" people from self-referral to whole body scanning centers. The resolution



also says the group's members should require that all CT scans be specifically ordered and authorized by a doctor.

The case for scans

Whole body CT scanning moves medicine from a reactive profession that treats disease when it arises to a proactive profession that catches disease before symptoms are evident, says Harvey Eisenberg, MD, founder and CEO of HealthView in Newport Beach, Calif., and MultiDimensional Imaging, which introduced the CT Screening BodyScan. "Usually we are asymptomatic for years. Cancer may start five to seven years before a symptom," says Dr. Eisenberg, who has served as a professor of radiologic sciences at the University of California, Los Angeles and Harvard Medical schools.

Furthermore, he told the NAS conference, a complete annual physical is now generally considered to be "pretty ineffective" and a "crude examination" because its tools, such as the stethoscope, are out of date. CT scanning, on the other hand, can pick up small plaques in artery walls that could cause a future heart attack if they rupture, as well as small cancerous tumors in the lungs, liver, pancreas, or colon. People whose cancer is detected and treated early have a better chance of survival. "We don't have a screening test for most cancers," says Dr. Eisenberg, whose wife's breast cancer was missed on a mammogram but detected on a whole body CT scan. "Virtually every cancer is seen on whole body CT," he notes, even when a person has no symptoms. Waiting for symptoms is a "deadly game" where cancer is concerned, he adds.

According to Dr. Eisenberg, one of the benefits of whole body scanning is that it helps people to become more health-conscious, prompting them to exercise more and eat more sensibly. However, the scans need to be combined with health counseling and comprehensive care. When it is, he says, "the preventive imaging concept is a very powerful one. People need this kind of educational process."

Continued on page 4

CT SCANS *Continued from page 3***The case against scans**

“Nontargeted full body scans are unethical; we’re reassuring the worried well,” counters Robert K. Zeman, MD, chairman of the Department of Radiology at George Washington University in Washington, D.C. Whole body scanning for those who feel fine is an “exploitation of fear and hope,” he told the NAS conference.

Physicians should not be salesmen, he says. While flyers that make people aware of the existence of medical centers that offer CT scans are fine, Dr. Zeman is opposed to imaging centers that hype claims that whole body scans can save lives when there’s no science to back up those claims.

One of his major concerns about whole body CT scans is that it finds “incidental lesions” which might not be harmful at all. “One test begets another,” comments Dr. Zeman. An initial CT scan can lead to more tests, additional exposure to radiation, and extra costs. “Pseudolesions often require follow-up,” even if they turn out to be nothing, such as noncancerous lung nodules. “Many of us in the radiology community are concerned about cumulative doses (of radiation). Even if the initial screening scan was done at the typical dose of a diagnostic exam, it’s the follow-up scans that really rack up the dose.”

Right now, whole body scans should be reserved for those with signs and symptoms, says Elaine Ron, PhD, a senior scientist in the Radiation Epidemiology Branch of the National Cancer Institute. CT scans are “an invaluable tool, but radiation is a carcinogen, so one has to balance it,” she told the NAS conference. Dr. Ron notes that studies of atom bomb survivors show that even when radiation exposure was low, there was an increased risk of cancer. “New screening procedures need to be tested for benefits and harms. Every exam should be justified,” she concludes. If you want to go for a whole body scan, first talk with your doctor about the potential benefits...and the possible risks. 🍷

Can You Really Help Aging Skin?

There’s a lot you can do to improve the appearance of your skin—just don’t expect miracles

It’s an undeniable fact of life that the appearance of your skin changes with age. While some of us are born with genes that prevent deep wrinkles, we all have to take steps to protect skin from the major cause of damage—ultraviolet radiation from the sun. Beyond sunscreens, there are hundreds of products, from drugstore face creams to pricey prescription formulas that can help (to varying degrees) to improve the appearance of aging skin, minimizing fine lines and discoloration.

New products recently approved by the FDA go a step further: Actually filling in lines and furrows, lifting sagging tissues, and temporarily relaxing wrinkles. None of these products or procedures are as invasive or costly as a face lift, and do not produce as dramatic or lasting results. Nothing can reverse the aging process. But depending on how much you want to spend and how far you want to go, you can make a difference in how your skin looks.

Only skin deep

If your skin has just begun to show signs of aging, or you only have fine lines and mild wrinkling, prescription creams containing the vitamin-A derivative *retinoic acid* (*tretinoin*) can make a difference, says Diane S. Berson, MD, assistant professor of dermatology at the Weill Medical College of Cornell University. “These preparations help slough off the top layer of dead skin and act in the skin’s deeper cellular layer to increase collagen. They can improve the appearance of fine lines and mild wrinkles, and fade some brown

spots,” says Dr. Berson. Prescription retinoids include *Retin-A*, *Renova*, *Avage* (*tazarotene*) and *Differin gel*. Over-the-counter creams contain weaker *retinols*.

In addition to retinoids, agents that can help aging skin include *alpha hydroxy acids*, (*AHAs*, which act similarly to retinoids), vitamins C and E, and *green tea extract*, says Scott B. Wells, MD, a New York City plastic surgeon who has created skin care products for his patients. “With aging, the skin is less able to rebound from oxidation by free radicals. Oxidation robs the skin of its structural proteins, including collagen. With topical antioxidants we try to diminish this process and increase formation of new collagen,” Dr. Wells explains. “For example, vitamins C and E help neutralize free radicals as they are formed in the skin. *Polyphenols*, green tea extract, reduce inflammation in the skin, which also has oxidative effects.”

Uncovering new skin

Quicker ways to remove the damaged top layer of skin are chemical peels

WHAT’S HAPPENING TO MY FACE?

A combination of factors alters the appearance of the face with aging. As we age, three components in skin—collagen, elastin and hyaluronic acid—start to break down. This is partly due to the effects of harmful oxygen molecules called free radicals. Skin cells normally produce these molecules, but they are usually removed by naturally occurring antioxidants in skin cells. Fewer antioxidants are produced as skin ages, so free radicals produce more damage. The breakdown of collagen and elastin is also accelerated by excess sun exposure, resulting in discoloration, sagging skin, and wrinkles, explains Cornell dermatologist Diane S. Berson, MD. The fat pads that round out the cheeks and fat beneath the forehead and other structures of the face thins (lipatrophy), resulting in a sunken appearance. So you see deepening of forehead wrinkles and frown lines (nasolabial folds), between the nose and the lips, says Dr. Berson. The effects of gravity also cause a downward shifting of the fat pads in the cheeks; there is also some loss of bone.



and microdermabrasion.

Chemical peels use varying strengths of *lactic* or *glycolic acid* to remove the superficial layer of skin, making skin appear fresher. These “lunchtime peels” require virtually no downtime (the after effect may be a slight redness), and can improve early signs of aging. For deeper wrinkles or damage, a stronger solution of an agent such as *trichloroacetic acid* may be used. Deeper chemical peels produce more dramatic results, but they can be painful and require 2-3 weeks to heal. *Microdermabrasion* uses tiny crystals or a diamond wand for a mild “sandblasting” effect to remove the top layer of skin.

While many day spas offer superficial chemical peels, stronger facial peels should be performed by a dermatologist. A series of treatments (costing \$250-500) may be needed. Less expensive, at-home chemical peels or microdermabrasion kits produce lesser effects.

Filling in furrows

Soft tissue fillers can fill in areas where sagging skin produces deep folds, such as the frown lines that run from the nose to the mouth (*nasolabial folds*). There is now a variety of fillers, from human collagen (*Cosmoderm*, *Cosmoplast*) to a newly approved, larger-volume synthetic filler, *poly-L-lactic acid*, *PLLA* (or *Sculptra*).

The soft tissue fillers *Restylane*, *Perlane*, and *Hylaform* contain *hyaluronic acid*, identical to the naturally occurring component of skin that provides volume and shape. When injected into the skin, they bind to water and create volume, plumping out furrows. The effects are usually immediate and last up to 6 months. Collagen is absorbed by the body, so its effects only last 3-4 months. It can be layered with hyaluronic acid gel fillers for more lasting effects. A larger particle filler for deeper furrows, *Hylaform Plus*, was approved last fall.

Cosmoderm and *Cosmoplast* contain *lidocaine* to numb the area during the injections; hyaluronic acid fillers require numbing creams. Fillers cost \$400-1,000 per treatment, depending on how much material is injected. “The most common side effects are redness, swelling, and some bruising at the

injection sites. But generally downtime is minimal,” says Dr. Berson.

Sculptra, initially approved for facial wasting in AIDS patients, will eventually be used more widely for facial *lipotrophy* associated with aging, says Florida dermatologist Susan H. Weinkle, MD. Injecting *Sculptra* is much more involved than collagen or *Restylane*. It requires a larger needle and uses a criss-cross tunneling technique to place *Sculptra* deep into the dermis. “*PLLA* gets broken down by the body and new collagen is formed at the site” to fill sunken areas, Dr. Weinkle told an industry-sponsored symposium on the aging face at the American Academy of Dermatology’s summer meeting in New York City last July. Several treatments, 4-6 weeks apart, may be needed.

Benign Botox?

Botox injections are the most popular cosmetic nonsurgical procedure for aging skin, with almost two million people opting for the treatment in 2002. However, you need to be careful. In November 2004, four people were hospitalized in Florida for botulism poisoning after they received injections of raw botulism toxin instead of the cosmetic Botox.

Botox Cosmetic (*botulinum toxin-A*) or *Myobloc* (*botulinum toxin B*) are injected in tiny doses to relax small areas of muscle and smooth wrinkles on the forehead or between the eyes (*glabella*). You may not see the full effects of Botox for 48-96 hours, and it lasts only 3-4 months. So regular treatments, costing \$400-1,000, are needed if you want a furrow-free brow.

It’s critical to get Botox injections only from a board-certified dermatologist or cosmetic surgeon who has been trained to use the drug.

A little lift

The FDA recently approved a self-anchoring, barbed suture for elevating midface tissues in a nonsurgical approach to face lifts. The product, *Contour Thread*, has small cuts in the

WHAT YOU CAN DO

To improve aging skin:

- Use sunscreen every day of the year, rain or shine, to prevent further UV damage from the sun.
- If you opt for wrinkle fillers or Botox, make sure your doctor has been specially trained to use them.
- Before committing to any treatment, find out how many are needed, side effects, costs, and how often you’ll need touch-ups.
- For more information, see these web sites: The American Academy of Dermatology, www.aad.org or The American Society for Aesthetic Plastic Surgery, www.surgery.org



side of the polypropylene suture that allow its barbs to catch in the subdermal tissue of the cheek. It is passed through the skin through a tiny incision, and is pulled to raise the deeper tissue to lift and smooth sagging areas. There are no long-term studies of the use of this technique, however.

Other “lifting” techniques include *ThermaCool*, which uses pulses of radiofrequency energy applied to the deeper layers of skin to tighten the forehead, midface, and nasolabial folds. Results are not apparent for at least a month, as the underlying layers of skin regenerate. The procedure costs \$1,000-2000, depending on how many areas are treated. It can be uncomfortable, and the side effects include temporary redness. Up to three treatments may be needed.

Preventive maintenance

Whatever you choose to do, drink plenty of water and use moisturizers that contain *humectants*, which hold water in the skin. Don’t cleanse with harsh scrubs. Always use a broad-spectrum sunscreen with an SPF of 15-30 every day of the year, rain or shine. Says Dr. Berson: “By using sunscreen you are actually giving your skin a chance to repair itself, and preventing further damage that ages skin.” ☺

Chronic anxiety in the elderly is grossly underestimated, underdiagnosed, and undertreated. It is *not* a normal part of aging, says Ross.

Added problems

People with GAD are vulnerable to other conditions, such as depression, panic disorder, or social anxiety. “If you’re highly stressed, tense, and hypervigilant, and then something bad happens, you have no reserves left to cope,” explains Dr. Liebowitz. “By the time patients seek help, GAD has usually become complicated with another disorder.”

Depression and anxiety often occur together. Half the people with major depression also meet the criteria for anxiety, and one-quarter of those with anxiety are also depressed.

Depression is one of the consequences when GAD is not diagnosed or treated, notes Ross. “Patients with GAD often don’t eat, exercise, or sleep properly. They are really tired, have no energy, and can’t function well. This can lead to depression,” she says. “Also, the worries start to bear down and, in a vicious cycle, the patient becomes depressed about worrying so much.”

Diagnosis difficulties

Participants in the ADAA survey report suffering for about three years before being diagnosed with GAD. “Patients typically visit their primary care physician because they have muscle aches or can’t sleep. After test results rule out a physical illness, they feel ‘it’s all in their head,’” says Ross. “Then they worry that their worry is irrational. They don’t know where to turn and run from doctor to doctor in an attempt to get a diagnosis.”

With 83 percent of GAD patients seeing their physicians for a physical complaint, rather than for anxiety, misdiagnosis is a significant problem. Diagnosis can be especially difficult in older people whose medical conditions often produce symptoms that mimic those of anxiety. What’s more, older people are more likely to emphasize physical complaints that

could be a symptom of either GAD or a medical problem.

Many people with chronic excessive worry don’t see their problem as an illness, and some ignore GAD symptoms, thinking they’ll go away. Others just explain away their anxiety as an inherited trait.

If your symptoms are not due to a physical problem or side effects of medication, your physician should ask about anxiety-related symptoms, the nature of your worries, how these worries may be affecting your life, and how you are coping with symptoms. He or she should also inquire about any family history of anxiety or mood disorders. Vague somatic complaints, such as muscle tension and nervousness, should raise a red flag.

The roots of anxiety

While the exact cause of GAD is unknown, experts think biology and environment are both factors. “There’s an interplay between genetic propensity and stress of the environment. Environmental stress can bring out GAD in a genetically prone individual,” says Shelley Fox Aarons, MD, a psychiatrist affiliated with the Weill Cornell Medical Center. “Anxiety disorders, including panic disorder, obsessive-compulsive disorder, and GAD, tend to run in families. The risk of GAD increases if a family member has any of these disorders.”

An imbalance between the neurotransmitter *serotonin* (a chemical in the brain linked to anxiety) and its receptor, seems to play a role. Successful treatment with medications that affect neurotransmitters, such as serotonin, seems to bear out this theory.

Anxiety can have roots in your childhood, stemming from messages you unconsciously absorbed that the world is unsafe. “Overprotective parents who worry too much tend to engender a pattern of worry in their children. These children grow up



frightened by many things,” says Dr. Liebowitz. “Children reared in over-protective homes, never learning to adapt to novelty and stresses, may be at high risk for GAD later in life.” Such inability to adapt and to worry excessively does not dissipate with maturity and may even intensify.

Calming worry

GAD patients usually respond to psychotherapy, most often, *cognitive-behavioral therapy (CBT)*, medication, or a combination of both.

By changing distorted ideas and challenging negative thoughts, cognitive therapy helps people with GAD view the world in a more realistic way, putting fears into perspective. Behavioral therapy helps patients relax by reversing their agitated physical state with techniques, such as deep breathing, progressive relaxation, visualization, meditation, and biofeedback. CBT involves about 8-12 weeks of sessions. For people with specific issues, such as relationship problems, *psychodynamic therapy* can help examine the roots of their anxiety. Phobias that accompany GAD, can be combated by new therapies, including the use of virtual reality.

Treatment with medication generally begins with a *selective serotonin reuptake inhibitor (SSRI)*, such as *citalopram (Celexa)* or *escitalopram (Lexapro)*, which have fewer side effects than some other drugs in this class. SSRIs affect the concentration of the neuro-

Correction:

Due to a printing error, the last line of “Sleep Strategies” was omitted from page 5 in the December 2004 issue. The last line should read: “However, the secrets to better sleep lie within all of us...if we’re patient enough to make the needed lifestyle changes and stick to them.” We regret the error. *The Editors.*

A Woman's Heart

transmitter *serotonin*.

Serotonin norepinephrine reuptake inhibitors (SNRIs), such as *venlafaxine (Effexor)* and *duloxetine (Cymbalta)*, affect two brain chemicals, *serotonin* and *norepinephrine*. All these medications are taken on a long-term basis. (However, recent concerns about increased suicidal behavior among people taking SSRIs has led to the FDA putting a “black box” warning on some of these medications.)

Benzodiazepines like *lorazepam (Ativan)* or *alprazolam (Xanax)* work fast and are useful on an as-needed basis, but they can affect cognitive functioning and be habit-forming. They are not recommended for people over age 65.

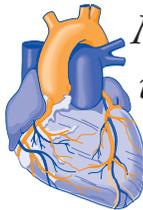
“Medicine works faster than therapy, but some patients don’t want to be dependent on a pill,” comments the ADAA’s Ross. “However, when patients have severe anxiety and are also depressed, medication can calm down their system so they can begin therapy.”

Patients have strong preferences, adds Dr. Liebowitz. “Some opt for psychotherapy, which requires more commitment of time and money, but can produce more definitive results,” he says. “Medications can be very effective and fairly cost-effective over time but, very often, they are treatments rather than cures.”

Diagnosis and treatment can start by talking to your primary care physician about the things that worry you. Don’t be afraid to discuss the anxieties that may be keeping you awake nights. Says Dr. Aarons: “If you are at the point where fears and worries are interfering with the enjoyment of the good parts of your life, you should seek help.” 🧠

RESOURCES

For more information on generalized anxiety and other anxiety disorders, contact the Anxiety Disorders Association of America: (240) 485-1001
or, on the web:
www.adaa.org/AnxietyDisorder/Inf/Index.cfm



Many women at high risk for heart disease are under-recognized and undertreated

Cardiovascular disease continues to be the leading cause of death for American women, with around 500,000 deaths every year. But many of those deaths might have been prevented if at-risk women were treated according to guidelines set by the American Heart Association (AHA) and federal health experts.

Yet research presented at the annual AHA Scientific Sessions in November 2004 found too many women are not recognized as being at high risk for *coronary heart disease (CHD)*, and too few are being adequately treated.

Managing cholesterol

A study of more than 1 million people in a managed care database (including 8,353 high-risk women, whose average age was 66) found that 61 percent had *atherosclerotic cardiovascular disease (ASCVD)* and total cholesterol above 210 mg/dL at the start of the study between October 1999. (In ASCVD, arteries are narrowed by fatty plaques that can rupture and form blood clots to cause heart attacks or strokes.) Eight months after their initial cholesterol test, a third of the women were put on cholesterol-lowering drugs. But over a three-year period only a small percentage of the women were sufficiently treated to meet AHA guidelines: an LDL cholesterol of less than 100 mg/dL, HDL greater than 50, total cholesterol of less than 130, and triglycerides less than 150.

“What was really striking was that only 12 percent of women had achieved the optimal levels for all the lipid goals,” reported Lori Mosca, MD, PhD, director of preventive cardiology at New York-Presbyterian Hospital. “So it’s clear there are substantial opportunities for us to improve the quality of cardiovascular care in women.”

HDL helps remove cholesterol from the blood. An HDL below 50 mg/dL (<0.9 mmol/L) is a particular risk factor for women.

“Low risk” only part of the picture

The Framingham Risk Assessment Estimation (FRE), a scoring system adopted by federal health officials, can help identify women at high risk who need treatment. But a low score, under 10 percent risk for a cardiac event within the next 10 years, only tells part of the story. For example, the FRE does not take into account family history.

Researchers at Johns Hopkins studied 102 women (average age 50) who had no symptoms but had a sibling under age 60 with CHD. While almost all had low risk scores (less than a 10 percent 10-year risk, with a mean score of 2 percent), 40 percent had evidence of calcium deposits in their coronary arteries—a sign of *subclinical atherosclerosis (SA)*. Almost a third had significant SA. “Yet, these women would have been erroneously classified as low risk, resulting in missed opportunities for preventative pharmacological therapy,” says lead researcher Erin D. Michos, MD, of the Ciccarone Preventive Cardiology Center.

Dr. Michos notes previous studies show 25 percent of people who have a non-fatal heart attack or suffer sudden cardiac death have no prior symptoms or warning signs, and women often have atypical symptoms. While she doesn’t recommend calcium scans for general screening, the test may benefit women with a family history to find those with significant SA. “Women with a family history of premature CHD are actually at an intermediate, not low risk, and should be treated.”

Knowledge is power

Educating women about heart risk is key in helping them take the first steps toward prevention, says Dr. Mosca. She conducted a study that showed giving women information about heart disease (in a manner geared to age and ethnicity) helped them understand and correctly assess their own risk. “Many women are unaware or underestimate their risk. We have to do a better job of education.” 🧠

I am in my late 70s, I'm healthy, and no one in my family has had breast cancer. Do I still need to get a mammogram every year? What about my daughter, who is going to be 50 soon? She had one breast biopsy that turned out to be benign.

There are no official guidelines on mammography for older women, but a recent study found that for women aged 50 and up, there did not seem to be an increased risk of a diagnosis of late-stage breast cancer when screening mammograms were done every two years. However, this same study (of 8,000 women diagnosed with breast cancer after screening mammography at intervals of one or two years), found that among women under age 50, screening every two years increased the risk of being diagnosed with later-stage disease by around 35 percent. While the incidence of breast cancer rises with age, cancers found in younger women are often more aggressive, and the dense breast tissue of premenopausal women can make tumors harder to spot on an X-ray, researchers wrote in the December 15, 2004 issue of the *Journal of the National Cancer Institute*. In addition to a family history of breast cancer, the risk assessment scale most physicians use also lists later age for menarche, older age at menopause, having a child after age 35, and having a previous breast biopsy. Most experts would agree that your daughter needs annual screening. As for yourself, you should ask your physician whether screening every two years would be appropriate.



Following my bone density test, my doctor told me I had osteopenia and prescribed Evista. In the November 2004 issue of the Women's Health Advisor, you list Fosamax and Actonel as drugs approved to treat osteoporosis. Are they more effective than Evista?

Raloxifene (Evista) is a *selective estrogen receptor modulator (SERM)*. It acts like estrogen to prevent the excess resorption of bone without causing abnormal growth of cells in the breast or the uterus. *Alendronate (Fosamax)* and *risedronate (Actonel)* are *bisphosphonates*, which act differently to prevent excess bone resorption. Recent head-to-head clinical trials comparing Evista and Fosamax found Fosamax was more effective than Evista in increasing bone mineral density among women with osteoporosis. Fosamax also reduced the level of urinary markers of bone turnover to a greater degree than Evista. However, the decision to prescribe raloxifene is sometimes based on a patient's age and whether they have an increased risk of breast cancer; Evista has been shown to reduce the risk of breast cancer in younger women. Some studies also show Evista lowers cholesterol. Its main drawback is that it can cause hot flashes. Women with acid reflux or esophageal problems are generally not given bisphosphonates, because they can irritate the esophagus if not taken as instructed (with a full glass of water, sitting upright, at least 30 minutes before breakfast). You didn't mention your age or any other health factors, so we would advise discussing the options for treating your osteopenia with your doctor.

COMING SOON

- The exercise prescription for bones
- What you can do about urinary tract infections
- Genetic testing: Are you a candidate?

FYI: NEWS FROM THE SOCIETY FOR WOMEN'S HEALTH RESEARCH

The use of "off-label" prescriptions is on the rise, and concern is increasing about the practice. Doctors frequently prescribe medications for purposes other than what they were approved for because there's some evidence the drug may help a particular condition, says the Society for Women's Health Research (SWHR). For example, antidepressants are being used to treat restless leg syndrome and chronic pain syndromes. Off-label use may also benefit cancer patients, such as when a drug approved for one cancer can help fight another. But physicians often get information from industry-sponsored continuing medical education and may take advantage of free samples from a drug company representative, says Sherry Marts, PhD, vice president of scientific affairs for the SWHR. "The temptation to treat beyond one's specialty, in addition to economic pressure by insurance companies, can put doctors in a tough situation," comments Marts. When published research shows a new treatment produces better outcomes, many doctors incorporate the findings into their practice ahead of formal drug approval, which can take years. While this can sometimes be beneficial, women need to protect themselves. Ask the name of every drug being prescribed for you, what that drug is being prescribed for, its potential side effects and interactions, the physician's experience in prescribing it, and what to do if symptoms return, advises Marts. Above all, she stresses, make sure you're taking a prescription drug for the right reasons.

For more on how disease and medications affect women, log onto: www.womenshealthresearch.org

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