

Heart & Health Reports™

Your one source for prevention, treatment, fitness and nutrition

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What To Do When Prevention Fails

Understanding Heart Attack

THE last decades have ushered in a new era in the treatment of heart attacks. Gone are the days of passive convalescence. No longer are doctors relegated to the role of concerned observers, powerless to alter the natural course of the illness. Today, heart attack victims are given a range of the most modern and aggressive treatments available in cardiology. Heart attack patients arriving in the hospital now have a greater than 90% chance of surviving the event. Most will go on to lead fully productive and active lives.

What causes a heart attack?

The crucial breakthrough in improving treatment was a superior understanding of the cause of heart attacks. Utilizing anatomic and angiographic studies, it is now known that heart attacks are usually caused by blood clots that block the flow of blood in a coronary artery. The clotting occurs when an underlying atherosclerotic plaque tears or erodes, exposing cholesterol and other clot-promoting substances to



Doctors need to make rapid decisions when heart attack symptoms strike.

the bloodstream.

We do not know what specifically causes a coronary plaque to rupture and trigger a heart attack. Many plaques remain stable for

years and never lead to a major clinical event. A great deal of research effort is now directed at attempting to identify “vulnerable” plaque and preventing it from causing trouble.

The role of risk factors

While a specific inciting cause in plaque rupture is often unknown, there is general agreement that certain risk factors predispose to coronary events. These include hypertension, cholesterol abnormalities, cigarette smoking, diabetes, obesity, and sedentary lifestyle. High levels of mental stress or anger may play a contributory role.

Rarely do risk factors occur in isolation. They are interrelated and tend to bunch together. For example, a sedentary life style is often associated with obesity and diabetes. One aspect common to all risk factors may be the inflamma-

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Real People

A Twiddler’s Tale

FLORENCE, age 79, looked forward to meeting her neighborhood friends every Tuesday afternoon for a friendly game of gin rummy. She turned her car into her friend’s driveway and suddenly felt lightheaded. The next thing she remembered were the voices of her concerned friends calling her name, as she lay slumped over her steering wheel, her air bag slowly deflating.

A few minutes later emergency services arrived at the scene. Her friends related they heard a crash and were shocked to see that Flo-

rence had driven her car into the side of her friend’s garage. Florence then realized she must have fainted. The emergency personnel told her she was lucky to have suffered only a small cut on her forehead.

Florence was rushed to the local hospital and admitted to a cardiac telemetry unit. She was resting in her room when the nurses suddenly came running in. “How do you feel?” a nurse inquired. She said she was a little lightheaded for a few

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Heart & Health Reports™

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Yes, you need a flu shot!

This time of year is not just about celebrating the holidays, because the flu season is now also upon us. From 1990 to 1999 there were an average 36,000 deaths each year in the U.S. from influenza. Immunization in past years was hindered from scarce supplies of vaccine, but this season, adequate supplies are predicted. The vaccine is safe and effective.

Current recommendations call for vaccination in the following groups:

- People age 50 and older (especially those 65 years and older).
- Individuals with chronic health conditions, such as diabetes, lung, heart, or kidney disease, sickle cell anemia, a weakened immune system (e.g. HIV, cancer treatment), seizures, and children age 18 years and younger on long-term aspirin therapy.
- Children age 6 months to under 5 years old.
- Pregnant women and those who may become pregnant during the flu season.
- Close contacts, household members and caregivers of high-risk persons, as well as those of infants and children younger than 5 years.
- All healthcare workers.

Franklin H. Zimmerman, MD

Stunning setback for HDL-raising drug

Numerous studies demonstrate that lowering elevated LDL (“bad”) cholesterol with statins can prevent cardiovascular complications. Patients with low HDL (“good”) cholesterol, also a risk factor for atherosclerosis, have not been as fortunate. Medications that raise HDL are few and often limited by side effects. Niacin can raise HDL by as much as 25%, but produces intolerable flushing in many patients. Fibrates such as gemfibrozil (*Lopid*) and fenofibrate (*Tricor*, *Triglide*) are particularly effective in raising HDL in patients with elevated triglycerides, but have limited use in those with isolated low HDL.

A new, highly-touted class of drugs that raise HDL was hoped to provide physicians with a new weapon to fight heart disease. Two recent studies describe the use of torcetrapib, a drug that raises HDL by a unique mechanism. Torcetrapib works by inhibiting cholesteryl ester transfer protein (CETP), an enzyme that unfavorably alters the distribu-

tion of lipids. By inhibiting this enzyme, torcetrapib raises HDL. It also reduces LDL particle size, an effect that makes LDL less likely to enter the blood vessel wall and develop coronary plaque.

Torcetrapib was given to 162 patients with low HDL levels in dosages ranging from 10 to 90 mg. The average HDL level was <44 mg/dl in men and <54 mg/dl in women. After eight weeks of therapy, treatment with torcetrapib significantly raised HDL by an average 27.5% with the 30 mg dose and 54.5% with the 90 mg dose.

A second study analyzed whether torcetrapib could raise low HDL levels in patients who were also treated with a statin. Torcetrapib, 10-90 mg, was given to patients already treated with 20 mg of atorvastatin (*Lipitor*). Doses of torcetrapib, 30-90 mg, increased HDL from 23.8% to 40.2%.

In the two studies, torcetrapib was generally well-tolerated. One concern, however, was that the drug appeared to raise blood pressure in a small percentage of patients (2%). This effect might offset the benefit of HDL increase.

These small studies prompted a much larger trial of 15,000 patients. The study was halted when independent monitors noted a much higher death rate and other complications in patients who were taking torcetrapib.

Analysis: This is yet another example of the importance of clinical research. Torcetrapib does raise low HDL levels, a known risk factor for coronary disease. But the drug appears to have hidden risks that offset any potential benefit.

— Franklin H. Zimmerman, MD

Davidson MH, et al. *Efficacy and Safety of Torcetrapib, a Novel Cholesteryl Ester Transfer Protein Inhibitor, in Individuals With Below-Average High-Density Lipoprotein Cholesterol Levels.* *J Am Coll Cardiol* 2006;48:1774-81.

McKenney JM, et al. *Efficacy and Safety of Torcetrapib, a Novel Cholesteryl Ester Transfer Protein Inhibitor, in Individuals With Below-Average High-Density Lipoprotein Cholesterol Levels on a Background of Atorvastatin.* *J Am Coll Cardiol* 2006;48:1782-90.

Converting atrial fibrillation may improve quality of life

More than two million Americans have atrial fibrillation. Many individuals with atrial fibrillation have symptoms of palpitation, lightheadedness, or shortness of breath. Others will be completely unaware of the arrhythmia. This recent study investigated whether converting patients with atrial fibrillation back to a normal rhythm improved their quality of life.

Investigators analyzed more than 600 patients with a history of atrial fibrillation who were treated with medications to convert them to a normal cardiac rhythm. Those who

successfully converted were compared with those who remained in atrial fibrillation with regard to general health, vitality, physical limitations and mental health. Exercise tests were performed to objectively measure fitness level.

The analysis demonstrated that patients who converted to a normal rhythm had better measures of quality of life and well-being than those with persistent atrial fibrillation. Ability to exercise was also much better in those with a normal rhythm. The improvement in fitness level and lifestyle was most pronounced in patients with symptomatic atrial fibrillation. Patients with “silent” atrial fibrillation at baseline were less likely to feel

better after the arrhythmia resolved.

Analysis: The optimal treatment of atrial fibrillation remains highly controversial. Not all studies agree with this report and therapy must be individualized. Some patients clearly feel better with conversion to normal sinus rhythm. For others, control of the heart rate and treatment with anticoagulants or aspirin to reduce the risk of stroke is an appropriate and reasonable plan.

— Franklin H. Zimmerman, MD

Singh SN, et al. *Quality of Life and Exercise Performance in Patients in Sinus Rhythm Versus Persistent Atrial Fibrillation.* *J Am Coll Cardiol* 2006;48:721-30.

Heart Attack . . . continued from page 1

tory response. Inflammation is a complicated series of biochemical reactions mounted by the body in response to a variety of insults such as injury and infection. In a sense, the known coronary risk factors represent forms of physical or biochemical injury to blood vessels resulting in an inflammatory response. Inflammation, in turn, renders atherosclerotic plaques more vulnerable to rupture. It follows that by avoiding or minimizing these risk factors, one will lower the risk of heart attacks. It is tempting to think that by improving the biologic conditions in the coronary circulation that coronary plaques can be stabilized and not cause clinical problems.

An ounce of prevention

There is now overwhelming evidence that control of blood pressure, smoking cessation, and aggressive lowering of lipids will have major preventive benefits. Perhaps the most compelling evidence has accumulated in the area of lipid lowering. Treatment with statins has dramatically changed the cardiology landscape. These agents dramatically lower LDL (bad) cholesterol. They also have a variety of other beneficial actions including an anti-inflammatory effect.

Preventive measures, especially risk factor modification, have had a significant impact on the rate of heart attacks. Coronary mortality has declined about 20% during the past two decades. Contributing to

this decline is a greater awareness of healthy diet and lifestyles.

When a heart attack strikes

It is the patient's job to seek medical attention as soon as possible after symptoms occur. Classic symptoms of discomfort, pressure, or heaviness over the upper chest may be absent. Instead, shortness of breath, sweating, weakness or lightheadedness may be the only signs.

On presentation to a medical facility, symptoms are reviewed, vital signs are taken, and a focused examination is performed. An intravenous line is inserted, blood tests are drawn, and oxygen is administered. An electrocardiogram (EKG) is quickly obtained. The next phase of treatment depends on the EKG

Twiddler . . . continued from page 1

seconds, but that the feeling had passed. The nurses placed a temporary pacemaker device on her chest and said they were calling her doctor.

Shortly thereafter, her cardiologist arrived to explain the situation. He told her she would need a permanent pacemaker. During her periods of lightheadedness Florence's heart rate was dropping as low as twenty beats per minute. The problem was intermittent and unpredictable, but he was confident a pacemaker would solve her fainting spells.

Later that day, a surgeon implanted a pacemaker using a small incision under her clavicle (collar bone). She was released from the hospital in the morning, and other than a little soreness over the incision site, she felt back to normal.

Two weeks later, her problems returned. For a few seconds, she felt as though she would have another fainting spell. She called her cardiologist who advised her husband to take her immediately to the emergency room. "Your pace-

maker has failed for some reason," the cardiologist said with a puzzled look. The problem was revealed when a chest x-ray showed the pacemaker leads twisted into a bunch. She needed to go back to the operating room.

The surgeon was surprised to find that the pacemaker leads he had so carefully placed only two weeks before were twisted twenty-five times! The wires were unraveled and replaced with new leads and connected to the pacemaker.

After the operation, the surgeon asked Florence whether she had been "playing" with her pacemaker. When Florence protested her innocence, her husband interrupted stating that she habitually touched and "fiddled" with her pacemaker. The surgeon said he attached her leads "extra tight" this time and told her to keep her hands away from her pacemaker.

Cardiologist's comment:

A pacemaker system consists of two main components. The first is a pulse generator that contains an energy source (battery) as well as a

sophisticated minicomputer to analyze the heart rhythm. The pulse generator is attached to one or two electrical leads (wires) that are inserted into a vein and passed into the heart muscle to carry the electrical stimulus. Both an adequate energy source and functioning electrodes are required for normal pacemaker performance. This case illustrates the "twiddler's syndrome," an unusual cause of pacemaker failure.

The twiddler's syndrome is where a patient twists the pacemaker, displacing the attached leads from their proper location inside the right ventricle. Normally, a pacemaker is held secure with only a few sutures. On rare occasions, a determined twiddler like Florence can twist the pacemaker in its pocket, dislodge the leads and interfere with normal pacemaker function.♥

— Dina R. Katz, MD

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

— Editor

findings. If the typical EKG changes of an acute myocardial infarction (heart attack) are present, the medical team will swing into action.

Opening the artery

The overriding aim is to restore blood flow in the blocked artery as soon as possible. This will limit damage to the heart muscle and avoid complications. Other treatments are designed to decrease the workload of the heart to minimize its oxygen demand. After protecting the heart with a beta-blocker (to lower pulse and blood pressure), a concerted effort is focused on dealing with the offending clot.

All available weapons are brought into the therapeutic arena. Aspirin will be given without delay. This old remedy has potent inhibitory effects on platelet clumping. Even by itself, aspirin can decrease heart attack mortality by 20%. Another platelet inhibitor, clopidogrel (*Plavix*) is also routinely administered.

The assault on the clotting mechanism will be expanded with heparin or one of its low-molecular weight derivatives. These agents interfere with the synthesis of fibrin, the reinforcing protein in clot formation.

With a simultaneous attack on platelet aggregation, and clotting proteins, coronary blood flow will sometimes be restored. Often, however, additional measures will be necessary. It is at this point that subsequent treatment will be determined by the available facilities.

Clot-busters in the community

Heart attack patients in community hospitals without angioplasty laboratories who have not responded to the above treatments, will now receive intravenous therapy with powerful clot-busters known as thrombolytic agents. Numerous studies have documented the effectiveness of these agents in opening arteries clogged with a blood clot. The majority of patients will obtain prompt restora-

tion of coronary blood flow with alleviation of symptoms and reversal of EKG changes.

Thrombolytic agents, originally introduced in the mid-1980's dramatically improved the prognosis of heart attack victims. Mortality was reduced by about 40%. For the first time, doctors had the ability to actively alter the course of the disease. Several drawbacks, however, became evident with the thrombolytic approach. Some patients did not achieve clot resolution. Also, a small percentage of patients experience significant bleeding. The most serious is cerebral hemorrhage, a complication occurring in fewer than 1% of patients. Other patients are not candidates for this treatment because of bleeding problems, recent surgery, or history of stroke.

Mechanical options with angioplasty and stents

With the development of coronary angioplasty and stenting, another approach to treating heart attack victims emerged. Instead of thrombolytic therapy, the patient is taken directly to a catheterization laboratory to undergo coronary angiography. The blocked artery is then opened with a balloon angioplasty, usually followed by stenting (implantation of a metal scaffold to maintain artery patency). When performed promptly (i.e. within 90 minutes of arrival at the hospital) this technique has a certain advantage over thrombolysis.

There is a greater likelihood of opening the blocked artery and a slightly lower mortality rate. In addition, the entire coronary anatomy can be evaluated. There is a lower risk of significant bleeding and virtually no risk of intracranial hemorrhage. Because of these advantages, immediate coronary angioplasty has become the preferred treatment of heart attacks in hospitals having facilities to perform the procedure.

Should all patients presenting to a community hospital be transferred to another hospital for urgent angio-

plasty? The answer depends on the time required to transfer to the catheterization facility. If the transfer cannot be accomplished within 90 minutes, thrombolytic therapy should be given at the community hospital to restore coronary flow as quickly as possible. In practice it is usually not possible to transfer a patient to a receiving catheterization lab in the prescribed period of time.

Cardiologist's comment:

Great strides have been made since the introduction of thrombolysis and primary coronary angioplasty. The strengths and limitations of each of these modalities are becoming better defined.

Thrombolysis offers an immediate treatment that can be delivered at any hospital or even in the field by emergency medical personnel. It provides an opportunity for the most rapid relief of coronary obstruction and is non-invasive.

Primary angioplasty can open virtually all acutely blocked coronary arteries, but usually with a longer delay to treatment. As with any invasive procedure, complications can occur at arterial puncture sites. The angiographic dye can have a toxic effect on the kidneys, and considerable radiation exposure is required for the procedure. In addition, coronary stents require careful long-term management. Anti-platelet treatment with aspirin and Plavix must be continued for many months, and possibly indefinitely, to prevent sudden thrombosis (clotting) of the stent.

Research continues on the use of combined therapy — thrombolysis for immediate clot dissolving followed by angioplasty for more definitive treatment. Our improved understanding of coronary disease has opened exciting new opportunities in prevention and treatment. Hopefully, options will continue to expand as research is translated into further clinical progress.♥

— Arthur E. Fass, MD

Zaroxolyn

(metolazone)

What kind of medicine is Zaroxolyn?

Zaroxolyn is a member of a class of medications called diuretics. Also called “water pills,” diuretics are used to treat high blood pressure and other conditions that require removal of excess fluid from the body. Zaroxolyn is one of the more powerful examples of thiazide-type diuretics, which are effective at eliminating fluid.

How does Zaroxolyn work?

Zaroxolyn works by stimulating the kidneys to excrete more sodium (salt) and water. This reduces the amount of fluid in the body and lowers the blood pressure.

How will Zaroxolyn help me?

Zaroxolyn helps to decrease leg edema (swelling) caused by congestive heart failure, kidney or liver disease. It helps to remove excess fluid in the lungs, relieving shortness of breath in patients with congestive heart failure.

Hypertension is a serious condition that damages the blood vessels and increases your risk of heart attack, stroke, heart failure, and kidney disease. Zaroxolyn lowers high blood pressure, reducing the risk of complications.

How is Zaroxolyn prescribed?

For treating mild-to-moderate hypertension, the dosage is 2.5 mg to 5 mg, once daily. For treating leg edema from kidney or heart failure, the dosage ranges from 5 mg to 20 mg daily.

What dosage sizes are available?

Zaroxolyn is available in 2.5 mg, 5 mg, and 10 mg tablets. They may be taken with food or milk. They may be split or crushed.

How long will it take to work?

Zaroxolyn increases urine flow usually in about one hour with peak effect by the second hour. The diuretic effect will last 12 to 24 hours.

What if I miss a dose?

Never try to “catch up” by taking an extra tablet. If you are late by a few hours, take your normal dose. For a longer delay, take your usual dose the next day.

Do food or other drugs affect this medicine?

Ingesting alcohol with Zaroxolyn may cause excessive lowering of blood pressure.

Zaroxolyn may interact with some medications:

- ACE inhibitors may lower blood pressure too much and harm the kidneys.
- Bile acid sequestrants (e.g. Questran) may decrease the absorption of Zaroxolyn.

- Lithium blood levels may be increased by Zaroxolyn.

Who should use caution or not take this medicine?

- Pregnant women — Zaroxolyn crosses the placenta. Adequate safety studies are not available.
- Nursing mothers — Zaroxolyn enters breast milk.
- Patients with gout. The condition can be precipitated.
- Patients with allergies to sulfa. Some people will be allergic to Zaroxolyn.
- Patients who are dehydrated.

How will I feel while taking Zaroxolyn?

Zaroxolyn is a powerful diuretic and you are likely to urinate more frequently.

Other side effects may include.

- Attacks of gout in people with this condition.
- If you have diabetes, Zaroxolyn may increase sugar levels.
- Your skin may become more sun-sensitive. Use protective clothing and sunscreen.

Are there serious side effects to watch for?

Call your doctor immediately for more serious side effects including:

- Fainting, lightheadedness, or dizziness, which may represent dehydration and a low blood pressure.
- Leg cramps or general weakness, a sign of low potassium.

How does the doctor monitor my progress?

The doctor will monitor your blood pressure and periodically take blood tests to follow your kidney function, blood chemistries (e.g. sodium, potassium, glucose, magnesium, uric acid), and blood count. If you have heart failure, your doctor will examine your lungs and ankles to look for weight loss and reduction in fluid retention.

Do you have any special tips for me?

- Zaroxolyn is frequently given to potentiate the diuretic effect of Lasix (furosemide). It is usually given 30 minutes prior to the Lasix dosage.
- Ask your doctor whether you should be taking a potassium supplement or eating high-potassium foods such as orange juice, bananas, or tomato juice.
- Discuss with your doctor whether you should restrict your intake of sodium.
- Weigh yourself each morning before taking Zaroxolyn.

— Dina R. Katz, MD

Holiday Cheers

THIS is the time of year when winter “spirits” may induce you to imbibe some alcohol-based cheer. But be extra careful this season, because alcohol-based drinks can add plenty of calories to the already pound-adding meals routinely served during the holidays. Many people who do not normally drink much alcohol do partake of some special cocktails during holiday festivities.

We often do not think of counting alcohol calories as part of a daily diet. But with holiday parties sometimes scheduled two or more times a week, these “hidden” calories can really add up. For example, a single, 1.5-ounce cocktail of distilled spirits (90 proof vodka, gin, rum, or whiskey) contains 110 calories. A 5-ounce glass of wine has 124 calories, 6 mg of sodium and 4 grams of total carbohydrate. Even a mundane 12-ounce can of beer will cost you 153 calories, 14 mg of sodium and 13 grams of carbohydrate. Consider what “having just a few” can do to your waistline!

Holiday drinks also tend to include flavored mixes and punches, ingredients that really increase the calorie, sugar, and carbohydrate content. When you add everything up, one modest specialty holiday cocktail

can contain hundreds of calories. And, if eggnog is your favorite holiday cheer, you add approximately 9 grams of fat per 4 ounces.

If you are watching your weight, there is a way to have your “spirits” and eat your cake too! Here are a few suggestions. Make your first drink a glass of sparkling water with lime or lemon. Wait at least thirty minutes before having your first alcoholic beverage. This also dilutes the effect of the cocktail and keeps your blood alcohol level a little lower. Alternate a cocktail with a glass of sparkling water or nonalcoholic drink. Above all, remember that sweet holiday drinks go down a little easier, so be careful not to become impaired, especially if you will be driving. Use our chart below to have an idea what festive drinks can do to your diet. Enjoy in moderation and have a happy and safe holiday season.

— Stefanie Schwartz, RD

Ms. Schwartz is a nutrition consultant for “Nutritionally Yours” in Chappaqua, NY.

Supermarket Savvy

Holiday Mixers Buying Guide

Variety (serving size)	Calories	Carbohydrates (g)	Sugar (g)
Master of Mixers Cosmo Mix (3 oz)	87	18	21
Daily's Sweet & Sour Mix (3 oz)	130	33	31
Daily's Daiquiri/Margarita Mix (4 oz)	180	47	44
Daily's Mocha Mud Slide Mix (2.3 oz)	110	23	22
Jose Cuervo Margarita Mix (4 oz)	100	24	24
Margaritaville Margarita Mix (4 oz)	110	27	26
Holland House Pina Colada (4 oz)	170	44	42
Rose's Grenadine (2 Tblsp.)	90	22	21
Rose's Sour Apple Mix (1.5 oz)	60	16	14
Shop Rite Tom Collins Mixer (8 oz)	100	23	23
Tabasco Bloody Mary Mix (8 oz)	70	15	2
Martinelli's Sparkling Cider (8 oz)	140	35	31
Farmland Eggnog (4 oz)	180	20	18

Q: "Please explain how a heart murmur can cause congestive heart failure?"
—Georgetown, KY

A: A heart murmur, by itself, does not lead to congestive heart failure (CHF). However, a heart murmur heard on a physical examination in someone with CHF often points to the underlying cause.

A variety of heart sounds are routinely heard with the stethoscope during a doctor's examination. A murmur is a "swishing" sound that occurs either during systole, when the heart contracts, or during dias-

tole, when the heart relaxes. Sometimes a heart murmur is completely normal, especially when detected in a young, healthy individual. But in adult patients with cardiovascular disease, a murmur usually indicates a disturbance of blood flow.

Two common situations cause a heart murmur. If the blood is pumped past a scarred or obstructed valve, the turbulent flow may be heard as a murmur. Alternatively, a murmur may reflect blood leaking backward through an incompetent valve. Rarely, a murmur reflects blood flowing from one chamber to another through a defect or "hole" in the heart.

A small or moderate disturbance of blood flow usually does not cause heart failure. But if the valve obstruction is severe, such as with aortic stenosis, the heart cannot pump adequate blood through the narrowing. Over time, pressure builds up and causes heart failure. Similarly, if a valve is severely incompetent and the heart cannot compensate for the loss of forward blood flow, CHF will develop.

It is important to remember that not all murmurs are serious or cause CHF. In addition, patients with a murmur can have CHF unrelated to the abnormal heart sound.

— Franklin H. Zimmerman, MD

Q: "Can you tell me about nighttime leg cramps?"
—Hernando, MS

A: Nocturnal leg cramps are painful contractions of the leg muscles that characteristically occur just as you are going to sleep or when waking up. Usually they affect the muscles of the calf, but they can also involve the soles of the feet.

The exact cause of nocturnal leg cramps is unknown, but they are sometimes related to overexertion and standing for long periods on hard floors. Low levels of potassium can also produce leg cramps.

You can help prevent leg cramps by stretching your calf muscles before bedtime and avoiding dehydration by drinking plenty of fluids. Keep your blankets loose to avoid pointing your toes downward when

you sleep. If your potassium level is low, your doctor can prescribe supplements. Never take these on your own without your doctor's advice, because excess potassium can be dangerous. Persistent leg cramps can be treated with quinine sulfate.

Leg cramping when you walk is a different condition usually caused by poor leg circulation.

— Franklin H. Zimmerman, MD

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Have a question? Please write to The Editor, Heart & Health Reports, 465 North State Road, Briarcliff Manor, NY, 10510. We regret that we cannot respond personally and questions may be edited for clarity and space.

In Future Issues

- **More about arthritis and anti-inflammatory medications.**
- **Options for carotid artery disease.**
- **Prehypertension: A new form of high blood pressure?**