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What to do if your medication is recalled

Drug recalls don't necessarily affect every batch of a pill or potion. You'll need to do a little homework before you stop taking your medication.

We take prescription and over-the-counter medications to get better or avoid getting sick. We know drug side effects can make us feel ill. But we don't imagine that medications can contain toxic impurities. Yet, it happens. Recently, for example, dozens of prescription blood pressure pills (angiotensin-receptor blockers, or ARBs) containing trace amounts of potentially cancer-causing compounds were recalled.

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Verify that your medication is affected by checking the expiration date, lot number, and manufacturer.

Recalls happen frequently. Sometimes, the FDA finds the manufacturing process to be defective. Other times, a dangerous side effect that was initially not apparent becomes clear later. "Some medication recalls are for problems that are not very serious, but the products have to be recalled nonetheless," says Joanne Doyle Petrongolo, a pharmacist with Harvard-affiliated Massachusetts General Hospital.

What should you do if one of your medications is recalled?

Issuing a recall

Recalls are issued by a drug maker (the FDA does not have the authority to mandate drug recalls). However, the FDA can ask the drug maker to recall a drug, and that request usually is honored.

The company recalling the medication is then responsible for notifying its customers, such as pharmacies. When the recall involves a product that has been widely distributed or poses a serious health hazard, drug makers may also issue press releases to the media.

The FDA posts all recalls weekly in the FDA Enforcement Report (www.accessdata.fda.gov/scripts/ires). Sometimes the FDA also alerts the news media to help spread the word about potential dangers. The FDA also oversees the recall, monitoring whether the product has been removed, destroyed, or corrected.

What happens next?

A recall triggers an investigation process at pharmacies. "When medications are recalled, the manufacturer, lot number, and expiration date are reported in the recall. The pharmacies can see if that particular medication was actually dispensed from the pharmacy. If it was, the pharmacy would then contact patients, either by letter or phone call," Doyle Petrongolo says.

Your own sleuthing

You may hear about a drug recall before your pharmacy is able to contact you. In that case, you can take several steps to find out more information, such as

- calling your pharmacy
- visiting the FDA drug recall website
- visiting the drug manufacturer's website
- reading or watching the news.

Keep in mind that the recall might not affect the pills that you have. Just because one batch of drugs has been recalled, it doesn't mean all other batches of the medication are affected. Your pills may be from a batch or brand that was not recalled.

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ASK THE DOCTOR

by **ANTHONY L. KOMAROFF, M.D.,** *Editor in Chief*

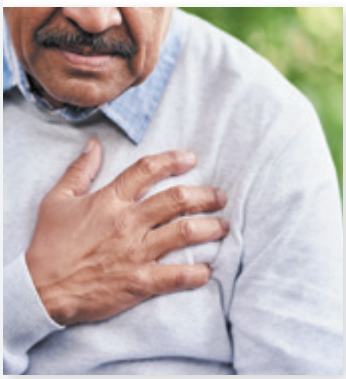
What does heartburn feel like?

Q *I think I have heartburn, but I hear that what feels like heartburn is sometimes a more serious condition. How do I know if I have heartburn?*

A You've asked an important question. "Heartburn" describes symptoms caused by the reflux of stomach acid up into the esophagus (the tube that carries food from the mouth down to the stomach). It is a burning sensation. You can feel it high in the abdomen, just below the bottom of the breastbone, or underneath the middle of the breastbone in the chest. In other words, despite the word "heart" in the word "heartburn," real heartburn comes not from the heart, but from the stomach and esophagus.

Heartburn often starts following a meal (when there's lots of acid in the stomach) or when you're bending over or lying down (allowing gravity to pull acid from the stomach into the esophagus). It can awaken you from sleep. The burning sensation can last minutes or longer and usually is relieved by swallowing antacids.

Heartburn often is accompanied by other symptoms. Acid-tasting stuff (sometimes containing small particles of chewed, partially digested food) can regurgitate up to and irritate your throat, producing a sour or salty taste, or causing you to make so much saliva that it sometimes drips out of your mouth. People who have had heartburn for a long time sometimes have trouble swallowing food because stomach acid has irritated and narrowed the esophagus, so that food sticks going down or swallowing becomes painful. Reflux of stomach acid up to the vocal cords in the throat can cause hoarseness, a chronic cough, or wheezing.



Sometimes it's hard to tell if you're experiencing heartburn or pain from a heart condition.

When you have what seems like "just" heartburn, what serious conditions should you worry about? If you've had heartburn for a long time, acid can irritate the bottom part of your esophagus and raise the risk of cancer forming there. Heartburn may be caused by an ulcer in the stomach or small intestine, which can cause serious bleeding or an abdominal infection. If you've had heartburn for many years and done little or nothing about it, your doctor should check it out.

Finally, what seems like "just" heartburn can actually be a condition called angina—a symptom caused by the buildup of fatty deposits in the arteries of the heart, which can cause a heart attack and even sudden death. If, along with your heartburn pain, you feel lightheaded or faint; if you break out in a sweat; or if the pain goes into your jaw, your shoulders, your back, or down your arms, contact your doctor. While it still might really be just heartburn, the chance that it's heart trouble is great enough that you need to get it checked out.

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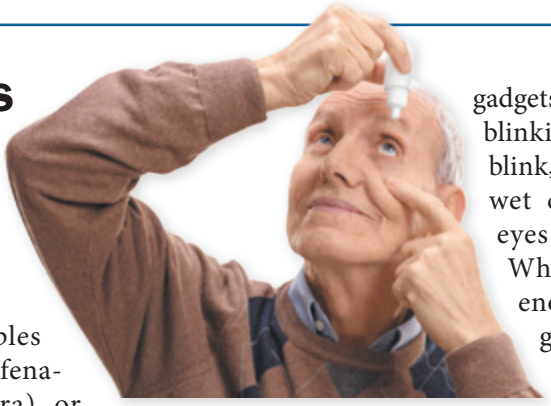
Common eye problems and how to fix them

In most cases, the solution to relieving symptoms is simple.



Apply eyedrops by tilting your head back, pulling your lower eyelid down, and letting the eyedrop fall into your eye.

Your eyes are tearing all day long, or they're dry and burning or crusty. What seems like a minor symptom suddenly has a major effect on your vision and your day. But take heart: in most cases there's a fix for the discomfort. "Ninety percent of the complaints are common and temporary," says Dr. Matthew Gardiner, an ophthalmologist with Harvard-affiliated Massachusetts Eye and Ear Infirmary.

Here are some common eye problems and the typical fix for each one.

Red eyes

Any time the eye is irritated—whether it's from dust, allergies, or dryness—the eye's response is to get red. "The tiny blood vessels in the eye swell up because they contain more blood, and that makes your eyes look red," Dr. Gardiner explains.

The fix: For rare occasions, the "get the red out" over-the-counter medication tetrahydrozoline (Visine, Opti-Clear) may be safe. But don't make using it a habit. "The medication makes the red go away, but your eyes can become dependent on it. When you stop using it, there's a rebound effect and your eyes get redder than ever," Dr. Gardiner says. Treating an underlying condition or waiting out redness is a better plan. Artificial tears (without tetrahydrozoline) are a safe way to make your eyes feel better and may decrease redness too.

Itchy eyes

When your eyes are so itchy you wish you could scratch them, the cause is often an allergy. It could be a seasonal allergy, or it could be a reaction to a lotion or cosmetic.

The fix: Treating underlying allergies with oral antihistamines will help. Examples include fexofenadine (Allegra) or loratadine (Claritin), available over the counter. Need something stronger for your eyes? Dr. Gardiner recommends nonprescription topical antihistamine eye drops such as ketotifen (Zaditor) or prescription-only eye drops such as olopatadine (Patanol).

Crusting or gooey eyes

Eye debris has a few different causes. "If your eyes tear, the tears can dry into a crystalline, sandy material on your lids. If there's something goopier or thicker, then it's either pus from an infection like conjunctivitis or mucus from severe allergies," explains Dr. Gardiner.

The fix: Treating an underlying condition (like allergies) will reduce eye debris. For a bacterial infection that's causing goopy eyes, your doctor can prescribe antibiotic drops or ointment. If the infection is caused by a virus, you'll have to wait until it goes away on its own, usually in just a few days.

Dry or burning eyes

Dry, burning, or gritty sensations are the result of a change in either tear quality or quantity. Tear quality changes when there's a blockage in the glands around the eye that produce natural oils to keep the eye slick and help it retain water. Tear quantity changes when the tear glands aren't making enough fluid, which is common as we age. Some inflammatory conditions (such as Sjögren's syndrome) can cause dry eyes as well.

And here's something that can make dry eyes worse: looking at electronic gadgets too long without blinking. Each time you blink, you reapply a new wet coating on your eyes (the tear film). When you don't blink enough, you aren't giving your eyes a chance to replenish the tear film.

The fix: To improve tear quality, Dr. Gardiner recommends applying warm compresses on the eyes for five minutes, twice per day, to help unclog oil glands. To improve tear quantity, you can use artificial tears (they don't have to be preservative-free unless you use them more than six times per day) or your doctor can prescribe ophthalmic cyclosporine (Restasis) to stimulate the tear glands to make more tears. Another solution: plugs for the tear ducts. "We take silicone plugs and place them in the openings of the tear drainage ducts, so your tears last longer. The plugs usually last about six months," Dr. Gardiner says.

Watery eyes

When the tear drainage ducts become blocked, you experience watery eyes. Wateriness may also occur when your eyes react to dust or allergens, and your eyes pump out tears to flush irritants.

The fix: "We treat the underlying cause of irritation, such as allergies. You have to figure out what's causing the problem and eliminate that. Or we may check for blockages in the tear drainage system," Dr. Gardiner says.

When should you see a doctor?

It's okay to relieve symptoms on your own, unless there's something persistent that's been going on for many days or something severe. "Then it's time to visit a doctor—especially if your eye is very swollen, if your vision has changed, or if you have pain," Dr. Gardiner says.

Battling the big toe joint blues

Arthritis, bunions, and gout can be disabling. Here are common fixes to stay mobile.

Aching hips, knees, and shoulders are common, and over time can lead to immobility. But so can an aching big toe. The joint at the base of the big toe—called the metatarsophalangeal or MTP joint—is the part of the toe that is affected.

What's the MTP joint?

The MTP joint connects the first long bone (metatarsal) in the forefoot to the first bone of the big toe (phalanx). The joint bends with every step you take, so that you can push off and let the other leg move forward. But the MTP joint takes a beating during that process: for a brief moment as you push off, the MTP joint supports half of your body weight.

An aching MTP joint affects your ability to walk and exercise. Numerous conditions can strike the MTP joint. Following is information on three that are common.

Osteoarthritis

Osteoarthritis, the wearing away of cartilage at the end of the bones, is a common MTP joint problem, often starting in middle age. Without cartilage, the space between bones decreases and the bones rub against each other. This can cause pain and lead to painful growths called osteophytes or bone spurs. Osteoarthritis can also cause a loss of flexibility in the MTP joint, a condition known as hallux rigidus.

But MTP arthritis isn't always painful. "Often, big toe arthritis doesn't cause symptoms. We commonly see people come in for other problems and then we see arthritis on an x-ray," says Dr. Christopher Chiodo, chief of foot and ankle surgery at Harvard-affiliated Brigham and Women's Hospital.

If MTP arthritis doesn't hurt, your doctor may recommend that you simply avoid wearing high heels and instead wear stiff-soled shoes to reduce the motion of the MTP joint. "We only offer medical treatments if we need to," Dr. Chiodo says.

When you have a bunion, the first long bone in the forefoot juts outward, causing the big toe bone to point toward your other toes.

Treatment comes in if there's pain. In that case, Dr. Chiodo often prescribes a carbon-fiber base plate to insert inside the shoe and decrease joint motion. "And some patients have relief with a rocker-bottom shoe," he adds.

Surgery to remove bone spurs, clean out the arthritic MTP joint, or fuse the bones is a last resort. Dr. Chiodo says it may be necessary if there's daily pain that's lasted for more than three months, if the pain interferes with your daily activities, and if you haven't responded to nonsurgical options.

Bunions

Family history and tight shoes with narrow toe boxes may play a role in creating a bunion, a condition in which the first metatarsal bone juts outward at the joint, causing the phalanx bone to point toward the other toes of the foot. "Compressing the toes together over years weakens the ligaments that hold the toe in a straight position," Dr. Chiodo explains.

If bunions don't hurt, avoid surgery, Dr. Chiodo recommends. "You can wear shoes with a wide toe box or stretch your shoes to make room for the bulging MTP joint," he says. You'll also want to avoid wearing heels, which continue compressing the toes together.

If your bunion hurts, surgery aims to realign the bones of the foot so the big toe is in a straight position. "Sometimes we have to cut the bone and reset it, and sometimes we have to fuse it," Dr. Chiodo explains. Afterward, you may have to wear a special shoe or boot and avoid putting weight on your foot for six weeks. However: "Bunions can recur. It's one of the most common complications. Wearing shoes with a narrow toe box will increase the chance that this happens," Dr. Chiodo warns.

Gout

Gout is a type of inflammatory arthritis that commonly affects the MTP joint. It strikes men more than women and results from high uric acid levels.

We normally flush out uric acid—a waste product from the breakdown of chemicals called purines—in the urine. But if your body makes too much uric acid or doesn't flush it out adequately, it can form sharp crystals that often settle in the MTP joint.

Symptoms show up suddenly: excruciating pain, warmth, redness, and swelling. Other joints besides the MTP joint can be affected, as well—typically the ankles, feet, hands, wrists, or knees.

The fix: go to your doctor for relief and to avoid another attack, which is likely. Your doctor might recommend a nonsteroidal anti-inflammatory drug (NSAID) such as ibuprofen (Advil, Motrin), naproxen (Aleve), or a prescription NSAID like indomethacin (Indocin) to relieve the pain and swelling of an attack in process. Another option is a corticosteroid, taken orally or injected at the joint.

To prevent new attacks, several prescription medications, such as allopurinol (Zyloprim, Aloprim), are used to lower uric acid in the body. Cutting out purine-rich foods and drinks (shellfish, red meat, alcohol, and soda) will go a long way toward preventing flare-ups in the future.

Keeping your weight stable in older age

How to gain weight safely when you're down a few pounds.

You've spent your whole life trying to keep extra pounds off. Now your doctor says you actually need to gain a few pounds to stay healthy. But healthy weight gain isn't so simple. "Some people find it difficult to add enough calories to their usual diet. It takes a lot of effort," says registered dietitian Kathy McManus, director of the Department of Nutrition at Harvard-affiliated Brigham and Women's Hospital.

Where to begin

A dietitian can help you come up with an eating plan based on your specific calorie needs. It starts with understanding how quickly you've lost weight and why (see "Why are you underweight?"). Your age, size, activity, amount of weight lost, and overall health will be key to designing a diet that's right for you.

Meal structure is also important. McManus says eating mini-meals throughout the day is better than relying on large feasts. "If you've lost weight, you're used to eating a lower volume of food, and you get fuller faster. It's better to spread several 300-calorie meals throughout the day than dump 900 calories at dinner," she explains.

What if you're not up to eating a mini-meal at some point during the day? "Have a protein drink. It could be something you make at home or something ready-made that you buy," McManus says.

If it's ready-made, you'll want a drink with about 10 to 20 grams of protein per 8-ounce serving, and as little added sugar as possible. (If sugar is the first or second ingredient, there's probably a healthier option.)

The best foods to eat

McManus steers people toward nutrient-dense foods with the most nutrition bang for the buck: they have lots of vitamins, minerals, fiber, lean protein, or unsaturated fat.

For example, a slice of white bread has about 70 calories, but very few vitamins and minerals. However, one slice of whole-wheat bread has about 70 calories, plus four times the amount of potassium and magnesium and three times the zinc.

Other examples of nutrient-dense foods: green, leafy vegetables (kale, spinach); fruits (berries, apples); whole grains (oatmeal, quinoa); beans and lentils; lean protein (fish, poultry, lean meat); dairy foods (low-fat milk, cheese, or yogurt); and unsaturated fats (nuts, seeds, avocado).

Making it work

Don't worry about counting grams of nutrients. "Just aim for a balance of healthy carbohydrates, unsaturated fats, and protein," McManus says. She advises power-packing each mini-meal with as many nutrient-dense foods as possible. Examples include oatmeal with berries and walnuts; a salad with spinach, tomatoes, cheese, black beans, shelled sunflower seeds, and avocado dressing; or brown rice with raisins, almonds, chicken chunks, and asparagus pieces. For something simple, try scrambled eggs with cheese or whole-wheat crackers with peanut butter.

Eating this way throughout the day will help you regain the weight you've lost. "I look to see 2 to 3 pounds per month if they're going in the right direction. It won't be faster than that," McManus says. "You have to hang in there and be consistent over time. Slow and steady wins the race."

Why are you underweight?

You're considered underweight if your BMI score is less than 18.5.

There are many reasons for weight loss in our older years. "Unless it's because someone is dieting, weight loss is a cause for concern, especially if the person has lost 10% of their prior body weight," says Dr. Suzanne Salamon, associate chief of gerontology at Harvard-affiliated Beth Israel Deaconess Medical Center.

Sometimes weight loss results from a lifestyle change, like the loss of a loved one or a loss of independence. You may be depressed and lose interest in eating. Or you may have to cut back on food because of a tight budget. "Usually weight loss suggests an underlying health condition, such as an overactive thyroid, depression, cancer, or dementia that causes people to forget to eat or shop for food," Salamon points out.

Other possible causes of weight loss:

- a recent hospitalization
- a loss of taste or smell due to Parkinson's disease or another condition
- medication side effects such as nausea, diarrhea, or decreased appetite
- dental problems that cause difficulty chewing
- infections such as pneumonia or skin infections
- disability or pain that makes it hard to prepare food for yourself.

Whatever the reason, weight loss increases the risk for malnutrition: insufficient calories, protein, vitamins, and minerals you need to function properly.

Tips for better bowel control

Try simple measures first, like using a fiber supplement and treating underlying conditions.

Nobody wants to talk about or even imagine it. But loss of bowel control—known as fecal incontinence—is a problem for millions of adults in the United States, especially women.

"It becomes more common with age. It's socially isolating and takes away your dignity. You live in fear that you have stool in your pants and people can smell it. Some people won't even tell their doctors about it," says Dr. Kyle Staller, a gastroenterologist at Harvard-affiliated Massachusetts General Hospital.

Symptoms and causes

Feces can leak out of the rectum accidentally—in liquid form or as solid stool—for a number of reasons. One is that age tends to weaken muscles, including the anal sphincter (the muscle that holds in feces until you're ready for a bowel movement).

Damage to nerves or muscles can also lead to fecal incontinence. You may experience damage from rectal surgery, inflammatory bowel disease, multiple sclerosis, stroke, childbirth, or diabetes, for example.

Fecal incontinence can be an effect of chronic diarrhea from conditions such as irritable bowel disease. Impacted stool due to constipation can also cause fecal incontinence.

And sometimes, fecal incontinence is the result of an attempt to thwart constipation. "Older people frequently take laxatives and stool softeners because they're worried about constipation. That creates loose stool. If age has weakened the muscles of the anal sphincter, fecal incontinence can occur," says explains Dr. Jennifer Irani, a gastrointestinal surgeon with Harvard-affiliated Brigham and Women's Hospital.

Try this at home

Both experts suggest trying simple fixes for fecal incontinence before seeking treatment from a doctor.

You can cut back on stool softeners and laxatives, if those are causing the problem. Or you can bulk up your stool (so it's easier to hold on to) with an over-the-counter fiber capsule or a powder that you can add to a drink or food. Examples include Metamucil, Citrucel, FiberCon or Benefiber.

© GregorBister | Getty Images

Taking an antidiarrheal drug can help stop leaks of loose stool and give you back your freedom.

"Fiber won't constipate you," Dr. Irani says. "The rectum is smart and can sense bulkiness. When you have more sensation, you have more time to get to the bathroom," she says.

You can also try bulking your stool with dietary fiber. Legumes such as beans and lentils are a go-to source. For example, a cup of canned low-sodium black beans has about 17 grams of fiber. A cup of cooked lentils has about 16 grams of fiber.

Taking a nonprescription antidiarrheal medication such as loperamide (Imodium) can work if you have incontinence with diarrhea. "It's okay to take it every day under supervision, but it won't work if you have a weakened sphincter," Dr. Staller points out.

Pelvic floor exercises (Kegel exercises) may also help reduce fecal incontinence. These involve contracting (squeezing) the anal sphincter several times per day or whenever you feel fullness in the rectum. "Pelvic floor physical therapy will help, but it won't always solve the problem. Also, you have to do the exercises every day or it doesn't work," Dr. Irani notes.

Pads that you tuck into your underwear or adult diapers can offer security when you have fecal incontinence. But pads and diapers can irritate the skin, as can a bowel movement that's been near your skin for too long. Using a barrier cream such as zinc oxide can help protect the skin.

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Dietary fiber linked to a lower risk for fecal incontinence

When fecal incontinence strikes, increasing your dietary fiber with foods like legumes can help get you back to normal. And a Harvard-led study published last September in *Gastroenterology* suggests that eating a high-fiber diet over the long term is associated with a lower risk for developing fecal incontinence in older women.

Researchers looked at questionnaire responses from more than 58,000 women who were followed for more than 20 years. Women in the study who ate the most fiber (25 grams per day) had an 18% lower risk for fecal incontinence, compared with women who ate the least amount of fiber (13.5 grams per day). The study is observational and doesn't prove that eating fiber prevents fecal incontinence. But it's reasonable that it should.

"There are so many reasons why fiber can be helpful. It may help ward off heart disease and diabetes. A reduced risk for fecal incontinence adds another potential benefit," says Dr. Kyle Staller, the lead author of the study and a gastroenterologist at Harvard-affiliated Massachusetts General Hospital.

Formal diagnosis

When simple fixes aren't making a difference, it may be time to see your primary care physician or a specialist. You can expect a specialist to take a full medical history and conduct a digital rectal exam (feeling the inside of the anus with a gloved finger to assess how tight the anal sphincter is).

Further testing to look for damage to the anal canal, sphincter, or lower colon may include

- anoscopy (insertion of a small, short scope into the anal canal)
- sigmoidoscopy (insertion of a flexible viewing tube to examine the sigmoid or lower colon)
- anal ultrasound (using sound waves to look at the sphincter structure)
- anal manometry (insertion of a catheter and balloon to measure anal sphincter strength).

Treatment

Often, treatment of an underlying bowel condition, such as impacted stool or chronic diarrhea, solves the problem. "It's much easier to fix a bowel disturbance than it is to tighten up the sphincter," Dr. Staller says.

Beyond that, there are only a few treatment options for older adults whose fecal incontinence does not respond to simple measures.

One option is called sacral nerve stimulation. "It's like a pacemaker for your anus," Dr. Irani explains. "We implant wires into the sacral nerve in the spine to stimulate the sphincter muscle to contract. What's key is that it will only work if incontinence involves solid stool, not liquid stool. Also, you have to be able to operate an external device and participate in your care."

The other option is surgery to create a colostomy, bringing the end of the large intestine through a special opening in the abdomen so that it drains into an attached bag. "People rarely choose this option. They'd rather wear an adult diaper. But people who choose surgery seem to get their freedom back. They just empty the bag when it gets full," Dr. Irani says. "Colostomy is especially helpful for people who are in a wheelchair and can't get to the bathroom frequently," Dr. Staller adds.

A ray of hope

You'll find dietary fiber supplements in capsules or powders.

Most people don't have to resort to drastic measures like surgery. Bulking stool through diet or with fiber powders usually solves or greatly reduces the problem. But if that's not working for you, don't suffer in silence. Your doctor may be able to help.

"Just talking about it with someone who knows what you're going through is a real benefit," Dr. Staller says. "You may not be able to get rid of fecal incontinence, but you may be able to eliminate 50% of the episodes and many of the accidents you have. And we know that even one accident feels like it's too many."

Drug recalls ... *from p. 1*

Verify whether your medication has been affected by looking at the manufacturer, lot number, and expiration date. This information is listed on the packaging of nonprescription medications; however, the information isn't typically listed on prescription medication packaging. You will likely have to call your pharmacy for that.

When your medication is recalled

It might be okay to stop taking a recalled medication if it's an over-the-counter drug such as an allergy, headache, cold, or sleep remedy that's meant only to relieve occasional symptoms. However, it's important not to stop taking medications you take daily until you have discussed it with someone in your doctor's office or your pharmacy.

In some cases, stopping a medication abruptly can actually cause a rebound effect—the return of symptoms that are sometimes worse than the ones you experienced prior to taking a medication.

Talk to your pharmacist or doctor before you stop taking a recalled medication.

For example, you can suffer a rebound effect if you suddenly quit taking a proton-pump inhibitor, such as lansoprazole (Prevacid) or omeprazole (Prilosec), used to reduce acid reflux and heartburn.

In other cases, stopping a medication abruptly can be life-threatening. For example, it is generally unwise to stop taking medications to treat high blood pressure or other heart problems without first consulting your doctor.

Calling your pharmacist is a good first step, advises Doyle Petrongolo. "The pharmacy may be able to get the same medication from a different drug company. If there are no other manufacturers available, either the patient or pharmacy can contact the doctor to switch to another medication," she says.

If you change to a different drug

"It may take a couple of tries to find the right substitute medication," says Dr. Suzanne Salamon, associate chief of gerontology at Harvard-affiliated Beth Israel Deaconess Medical Center. "Make sure you keep track of when you switch medications, and note and report any symptoms that develop, like a rash, so we'll know if the new drug caused it."

Beer-before-wine strategy doesn't hold water

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Ever hear the saying that drinking beer before wine can reduce hangover symptoms? It's just a myth, according to a small randomized study published Feb. 1, 2019, in *The American Journal of Clinical Nutrition*. Researchers found out by dividing 90 men and women (ages 19 to 40) into four groups. One group drank beer first, and then wine; another group drank wine first, and then beer; and the last two groups drank only beer or only wine. All of the participants drank until they were intoxicated (measured by a breath test), and then rated their hangover symptoms (like headache and nausea) on the day after drinking. The process was repeated a week later, but this time the beer-first group drank wine first; the wine-first group drank beer first; the wine-only group drank only beer; and the beer-only group drank only wine. The results: everyone experienced hangovers, no matter what they drank or the order in which they drank it. The strongest predictors for hangover intensity were perceived drunkenness and vomiting. The bottom line: Drinking too much is unhealthy for anyone. If you drink at all, drink in moderation. That means no more than one drink per day for women, no more than two drinks per day for men.

Using mind over matter to help treat chronic pain

Many people use psychological techniques to help them cope with chronic pain. But which approach is best? A study published Jan. 31, 2019, in the journal *Evidence-Based Mental Health* offers insight. Researchers analyzed 21 randomized studies focusing on the effect of either cognitive behavioral therapy (CBT), to redirect pain-related thoughts and behaviors, or mindfulness-based stress reduction (MBSR), combining yoga and meditation to build awareness and acceptance of moment-to-moment experiences (including pain). The result: There was no clear winner. Both approaches reduced pain and depression and improved physical functioning compared with usual care or no care. The authors say the findings are important, since CBT is considered the go-to psychological technique for chronic pain. But MBSR should be considered as an additional tool, they suggest. Want to try it? Many hospitals, universities, and meditation centers offer MBSR programs. You can also search for MBSR videos and classes online.

Interrupt your sitting time to ward off heart disease

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There's a silver lining in a recent study that found older women who were sedentary for long chunks of time had a much higher risk for developing cardiovascular disease than women who sat less. The observational study, published Feb. 22, 2019, in *Circulation*, analyzed activity patterns of more than 5,000 older women (ages 63 to 97) for a week, and then followed them for another five years. Both the total time spent sitting each day and the duration of each period of inactivity was measured with fitness trackers. The key finding: an additional hour of total sedentary time was associated with a 12% higher risk for cardiovascular disease during the follow-up period, and when that sitting time was made up of long uninterrupted sedentary sessions, the risk was far higher (as much as 54%) than when it was accumulated in short, regularly interrupted bouts of sedentary time. The silver lining: reducing sedentary time by an hour per day was linked to a 12% lower risk for cardiovascular disease and a 26% lower risk for developing heart disease during the study period. Even better: researchers say the one-hour reduction each day doesn't have to be accumulated at one time. The moments spent jumping up to get a glass of water, running out to your mailbox, or darting across the house to get the phone can all add up. The key is to interrupt your sitting time with activity that will get your heart and lungs pumping.

What's coming up:

- Food and drink fads you can skip
- What's causing your muscle weakness?
- Top reasons you're not sleeping through the night
- Should you get an active workstation?