Herniated disk

Conservative care often effective

There’s no doubt reaching and twisting to get that overpacked luggage in and out of the car trunk yesterday was a mistake. Now, instead of comfortably settling into your winter vacation escape, you’re lying down, flat on your back because of pain.

A herniated disk can make you feel like staying flat on your back for days, but that’s generally not the best course of action. Conservative care may start with short periods of rest, but prolonged inactivity can actually delay herniated disk recovery. For most people, a better formula for recovery and symptom relief is planned exercises and pain relief medications. Usually, surgery for herniated disk isn’t necessary.

Tough cushions

Between each of the bones (vertebrae) in your spinal column is a pad of tissue called a disk. Each disk consists of a thick outer portion with multiple rings of cartilage (annulus) and an inner gel-like core (nucleus). It’s the disks between your vertebrae that
make it possible for your back to flex or bend. They also act as shock absorbers. The hollow space in the middle of the spinal column is the spinal canal. It houses your spinal cord and nerve roots.

As you age, the disks in your spine naturally lose water and protein, becoming thinner, more rigid and less flexible. As a result, the disks are more vulnerable to injury.

A herniated disk — some refer to it as a ruptured, torn or slipped disk — occurs when a small portion of the disk’s nucleus pushes out through a tear in the annulus, which causes back pain. If it pushes farther into the spinal canal and puts pressure on the nerves in the canal, it may cause leg pain and sometimes nerve damage (radiculopathy).

**Painful change**

Rupture may occur anywhere along the spine, but is most often seen in the lower back (lumbar spine). It also may occur in the lower neck (cervical spine).

The most common signs and symptoms caused by a herniated disk include:
- Pain, numbness or weakness in your lower back and one leg, or in your neck, shoulder, chest or arm.
- Deep aching pain, possibly with tingling and numbness, that starts in the buttock and radiates down the back or side of the leg (sciatica). Less often it may cause radiating pain into the front of the thigh.
- Pain in the low back or leg that gets worse when you sit, cough or sneeze.

In addition to natural changes with aging, factors that increase your risk of a herniated disk include a family history of disk problems, obesity, lack of exercise resulting in loss of core muscle strength, smoking, lifting large objects using your back instead of your leg muscles, twisting and turning while lifting, or previous back injury or herniated disk.

**Conservative care**

There are instances when immediate medical care is warranted, but in general, moderate or severe back or leg pain that persists for more than a week signals a need for medical evaluation.

Unless your doctor advises otherwise, stay as active as you can tolerate until your appointment. Long periods of inactivity are best avoided — muscle strength and bone mass, which are important for recovery, are diminished with bed rest. It’s probably best to avoid high-impact activities — such as running and jogging — and focus instead on gentle activities, such as walking or swimming. If you encounter severe pain, stop the activity.

Usually, your doctor can diagnose a herniated disk by doing a physical exam. If recommended, imaging — such as X-ray, magnetic resonance imaging (MRI), computerized tomography (CT) scan or CT myelogram — also may be done.

In general, healing often takes at least a month or two — and sometimes many months — as the inflammation decreases. Think of the protruding inner disk material as being like a juicy grape. It typically dries out over time — like a raisin — and is resorbed.

During that time, your doctor may recommend modified activities. Generally, this means an activity level that doesn’t cause pain, and if needed, pain medication.

An anti-inflammatory corticosteroid drug may be injected into specific areas along the spine to help reduce back pain. Leg pain may be helped by injecting corticosteroid medication around the affected nerve that’s being compressed.

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**When to seek emergency care**

A herniated disk isn’t typically a medical emergency, but if the herniation is large or severely compresses a nerve root, emergency surgery may be required.

If you experience any of the following signs and symptoms, seek emergency care without delay:
- Significant or increasing pain, numbness or weakness spreading to one or both legs
- Loss of bladder or bowel control
- Progressive loss of sensation affecting the inner thighs, back of your legs and the area around the genitals or rectum
Surgical treatment

Studies have shown that about 90 percent of the time, symptoms of herniated disk are relieved without surgery. Research suggests that nonsurgical treatment outcomes for herniated disk are about the same two to four years after the start of pain as they would be had surgery been done. However, a recent trial suggests there may be some advantage when surgery is performed.

There are certain circumstances in which immediate surgical treatment is warranted, including if you’re having trouble standing or walking due to leg pain or weakness, if back pain remains severe and unrelenting, or if you lose bowel or bladder control. Otherwise, surgery typically isn’t considered unless conservative measures fail to improve leg pain caused by a herniated disk after six weeks. In that case, surgery will result in quicker relief of leg pain.

Standard (open) diskectomy involves making an incision to remove a small portion of the spinal bone (vertebra) in order to get at the herniated disk pressing on a nerve root in the spinal canal. This same procedure is being done at many specialized spine centers with smaller incisions and a specially designed surgical microscope or magnifying lens. This procedure — called microdiskectomy — may result in less postoperative pain and shorter recovery. Most people can return to work within two to six weeks, although full recovery takes longer.

A minimally invasive procedure called microendoscopic diskectomy is commonly done for herniated disks. Rather than cutting into muscles along the spine to access the disk area, this procedure relies on the use of tiny, progressively dilated tubes to reach the disk area. These tubes act to displace — spread apart — muscle without cutting into it, and create a small tunnel to the herniated disk through which the surgery can be done.

Another relatively new procedure for chronic back pain is disk replacement surgery, which involves replacing the damaged disk with a metal and plastic disk. Its use in treating chronic lower back (lumbar spine) pain remains controversial among spine specialists.

In addition, those considered best suited for possible lumbar disk replacement are people who don’t have coexisting arthritic changes in their vertebrae, which is something most people have by middle age.

Although there’s growing evidence to support the use of disk replacement in the neck (cervical spine), Mayo Clinic doctors say that more study is needed to determine the long-term safety and the effectiveness of disk replacement surgery in general.

Core strength a plus

Core-strengthening exercises can help condition your trunk muscles and stabilize your spine. Once your pain is improved, conditioning the core muscles can help.

The bridge position is commonly recommended to promote core strength:

- Lie on your back, knees bent, keeping your back in a neutral position so that it’s not overly arched or pressed hard into the floor.
- Identify core muscles by coughing, then holding that contraction in your abdominal muscles as you raise your hips off the floor.
- Align your raised hips with your knees and shoulders and hold the position for five to eight seconds.
- Slowly return to the starting position and repeat.

Health tips

Skin care tips

Some skin changes with age are inevitable, but proper skin care can help optimize skin function and appearance. Be sure to:

- **Protect your skin from the sun** — Even if your skin is already wrinkly or spotted, sun exposure will cause further damage. In addition, it can increase your risk of developing skin cancer. Apply sunscreen with a sun protection factor (SPF) of 30 or higher at least once a day to areas that are likely to get sunlight — even in the winter. Wear clothing to block sunlight and a broad-brimmed hat when feasible. Try to avoid being in the sun from about 10 a.m. to 3 p.m., and seek shade when you are outside.

- **Wash gently** — Take warm, not hot, baths and showers, because hot water can deplete natural oils from your skin. Use a mild superfatted or glycerin soap and generally use soap only on your face, underarms, genital area, hands and feet.

- **Moisturize after bath** — Gently pat your skin dry after bathing, then immediately apply a moisturizing lotion to trap moisture in your skin. For extra-dry skin, a product in which petrolatum is one of the top three ingredients is likely to be best. Products containing glycerin, lactic acid or urea may provide an extra boost.

- **Drink water** — Being well hydrated moisturizes your skin from the inside out.
A revolution in joint replacement

New ways to manage pain

Getting a knee or hip joint replaced is a major procedure. It hardly seems possible that it could be done without general anesthesia.

Yet, that's now the case for many who have major joint replacement surgery. In the past few years, new combinations of targeted pain-blocking injections have been introduced so that you may not need to have general anesthesia to have a hip or knee joint replaced.

In addition, you can often avoid having intravenous narcotic drugs — and their side effects — for pain relief after surgery. That's because some of the anesthesia techniques used in surgery can be continued several days afterward to relieve pain and speed rehabilitation.

The old and the new

A decade ago, hip or knee joint replacement was almost exclusively done using general anesthesia, in which you lost consciousness, and your breathing was assisted. This commonly resulted in nausea, vomiting, grogginess, a sore throat and decreased bowel function.

The new technique involves infusing the bladder with a drug — hexaminolevulinate (Hexvix) — that's absorbed by cancer tissue. When illuminated with blue light, the absorbed drug glows bright red, allowing tumor tissue to be easily identified and removed.

The study, presented by Mayo Clinic doctors at the April 2009 meeting of the American Urological Association, involved over 700 people with bladder cancer. All participants were initially evaluated with standard techniques. Then, a random group of 278 people were examined with the new technique. In 17 percent of the re-examined people, at least one additional tumor was detected.

When the cancer was removed using the blue-light technique, the rate of recurrence was 36 percent, compared with a 46 percent recurrence rate in those who had their cancer removed the standard way.

Mayo Clinic experts say they can do a much better job of removing the entire tumor the first time when using the technique. It's one of the few major improvements to come along in recent years in the detection of bladder cancer and the prevention of recurrences.

This new technique is receiving a fast-track review by the Food and Drug Administration, which means that approval for use in the U.S. may occur as early as this spring.

Whole-grain consumption tied to lower blood pressure

Men who eat greater amounts of whole grains on a regular basis reduce their likelihood of developing high blood pressure (hypertension). That's according to a study of more than 31,000 men published in the September 2009 issue of the American Journal of Clinical Nutrition.

Researchers found that men who consumed the most whole grains — about 52 grams (g) daily — were 19 percent less likely to develop hypertension than were men who consumed the least whole grains. Earlier studies have linked whole-grain consumption with reduced risk of mortality, heart disease, weight gain and diabetes.

Mayo Clinic doctors say that many Americans consume far too little in the way of whole grains. The most recent Dietary Guidelines for Americans, released in 2005, recommends consuming at least 85 g of whole-grain products daily — that's about 3 ounces or the equivalent of three slices of whole-wheat bread.

News and our views

New bladder cancer removal technique reduces recurrence

What you can't see can hurt you. At least this was the conclusion of a large, multinational study testing a new way to visualize — and more thoroughly remove — bladder cancer tumors.

Treating bladder cancer often involves surgical removal of tumors from the wall of the bladder. This is often done with thin, flexible instruments inserted through the urethra. The instruments provide standard white light, allowing the surgeon to see the tumor and cut it away. However, distinguishing small tumors from normal tissue is very difficult. As a result, these tumors can be overlooked, and edges of tumors that have seemingly been removed may be left behind.

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anesthesiologists began developing new anesthesia protocols for joint replacement surgery. These protocols used anesthetic and pain relief techniques that had been around for decades, but in new combinations.

The goal was to eliminate the need for general anesthesia and intravenous narcotics. The new protocols may vary from place to place, but they typically involve:

- **A choice** — Even with the new protocols, you can still choose general anesthesia over having the lower half of your body numbed using regional anesthesia.

- **Oral pain medications early on** — Whether you choose general or regional anesthesia, a combination of oral pain medications often are given before proceeding to the operating room. These may include the oral narcotic oxycodone, the COX-2 inhibitor celecoxib (Celebrex) and the nerve drug gabapentin (Neurontin, others). Narcotics given by mouth cause fewer side effects than do those given intravenously.

- **Sedation** — If you choose to have regional anesthesia, you may be given sedative drugs before proceeding to the operating room. Sedatives help you nap throughout the procedure, but they don’t make you unconscious.

- **Nerve blocks** — These are performed in conjunction with either general or regional anesthesia. For knee joint replacement, a tiny tube (catheter) is placed alongside the nerve that gives sensation to the front of the knee. A continuous infusion of numbing medicine is given for 48 hours.

- **Oral pain medications after surgery** — For more than 95 percent of people, pain that occurs after the nerve blocks are removed can be managed with oral pain medications such as acetaminophen (Tylenol, others), tramadol (Ultram, others) or oxycodone. Intravenous narcotic medications are used as a last resort.

### The advantages

Avoiding the side effects of general anesthesia and intravenous narcotics is a key benefit of regional anesthesia. With the new protocols, you may still experience nausea, vomiting and itching, but these occur much less often than with the older methods. Retention of urine — another potential side effect that requires a urinary catheter to be placed — occurs much less often when regional anesthesia is used.

Confusion after surgery is a concern for older adults. Intravenous narcotics can be big contributors to confusion. When they can be eliminated from pain control after surgery, older adults do much better during recovery. Mayo Clinic anesthesiologists have also found that regional anesthesia protocols allow surgery to be performed on older adults with more complicated conditions. A decade ago, older adults often were refused surgery because they would have fared so poorly with older anesthesia techniques.

Those receiving regional anesthesia report significantly less pain after surgery than do those who receive general anesthesia and intravenous narcotics. This allows those who receive regional anesthesia to get out of bed sooner, start physical therapy sooner and participate more aggressively in physical therapy. The result is often a hospital stay that’s one to two days shorter than when general anesthesia and intravenous narcotics are used. Despite the shorter stay, those who receive regional anesthesia may also have greater range of motion in the knee.

### Few downsides

Nerve injury where there was no prior nerve problem is a rare potential complication of the new anesthesia protocols. About 1 person in every 3,000 to 4,000 may have a nerve bumped, bruised or injured when nerve catheters are placed. This may cause numbness and weakness that persists after initial recovery. In most people, the numbness disappears within eight to 12 weeks. A small number may experience ongoing numbness and weakness.

For most people, the regional anesthesia protocols represent a major change for the better, allowing for less pain, fewer complications and a quicker recovery.
Treating diarrhea

If basics aren’t enough
An episode of diarrhea is never pleasant. Usually, though, it settles down in a day or two and clears up on its own.

Quick passage
Diarrhea occurs when the foods and fluids you ingest move through your colon too quickly or in too large an amount — or both. Normally, your colon absorbs most of the fluids as food residue is passed along. However, if that process is short-circuited by some sort of infection or the bowel lining is inflamed or diseased, then fluids aren’t sufficiently absorbed, and the result is a watery bowel movement.

Diarrhea may be either acute or chronic. Acute diarrhea is generally of short duration — lasting just a few days — with infection as the major cause. Some infections that may cause acute diarrhea include:
- Viruses such as rotavirus and noroviruses, including Norwalk virus
- Bacteria, such as campylobacter, salmonella, shigella, Clostridium difficile and E. coli
- Parasites, such as Giardia lamblia, cryptosporidium and cyclospora

Chronic diarrhea generally persists for four weeks or longer. Ongoing diarrhea may be indicative of a number of underlying conditions, among them gluten intolerance (celiac disease), irritable bowel syndrome, inflammatory bowel disorders — such as Crohn’s disease and ulcerative colitis — overactive thyroid (hyperthyroidism) or microscopic colitis.

Dehydration is a critical concern with diarrhea. Loss of fluids can disrupt the important balance of salts and electrolytes, such as sodium and potassium that are needed to maintain the electric currents that prompt your heart to beat.

If you have diarrhea, a doctor’s care is warranted if you:
- Become dehydrated or remain dehydrated despite drinking lots of liquids
- Pass six or more unformed stools in a 24-hour period or diarrhea persists beyond several days
- Experience severe abdominal or rectal pain
- Pass stool that’s bloody or black
- Have a temperature higher than 102 F
- Have recently taken antibiotics or been hospitalized
- Are elderly or have a compromised immune system

Time, diet changes
Acute diarrhea is typically caused by a virus and clears on its own within one week. Usually, you can help things along by avoiding caffeine and alcohol and drinking plenty of clear liquids — with the exception of apple and pear juices, which can actually contribute to diarrhea.

As stool becomes more normal, add semisolid, bland, low-fiber foods such as soda crackers, toast, eggs and rice. The general rule is to not challenge your digestive system with dairy products or fatty or high-fiber foods for several days.

In the absence of fever, bloody stools or pain other than cramps, nonprescription anti-diarrheal drugs are generally safe. Anti-diarrheals, such as loperamide (Imodium) and bismuth subsalicylate (Kaopectate, Pepto-Bismol), won’t speed recovery, but they may help you feel better. Loperamide helps slow the speed of fluids moving through your bowels. Bismuth subsalicylate helps balance the way fluid moves through your bowels, but it can also make stool color very dark.

Be aware that there’s a potential for anti-diarrhea medications to interact with other medications you may be taking, such as blood thinners. Ask your doctor about using anti-diarrheals if you take other medications.

Sometimes a puzzle
Drugs are a common cause of chronic diarrhea. The list includes certain antibiotics, chemotherapy drugs, laxatives, magnesium-based antacids and some blood pressure drugs. Also on the list are proton pump inhibitors (PPI) such as lansoprazole (Prevacid) and omeprazole (Prilosec), used to manage gastroesophageal reflux disease (GERD). If the cause of diarrhea is thought to be drug related, work with your doctor to modify your medication plan.

If you’re an older adult, antibiotic-associated diarrhea can be a particular concern, especially if you’re taking antibiotics and become infected with the bacterium C. difficile during a stay in a hospital or nursing home. Under these circumstances, C. difficile can grow out of control, leading to severe diarrhea and potentially life-threatening complications.

For some, chronic diarrhea may be associated with a problem absorbing lactose, a type of natural sugar found in dairy products. Your doctor may recommend trying a lactose-free diet — no dairy products whatsoever — for at least two weeks to see if lactose malabsorption may have a role in ongoing diarrhea.

Blood and stool tests may be done to check for infection. If the cause is parasite or bacteria, antibiotics may be prescribed. If initial tests don’t determine a cause, then more tests — such as endoscopy, urine analysis, additional blood tests and possibly more specialized tests — may be needed to identify whether a possible underlying condition might be responsible.
Aging of your skin

Many changes are normal

Wear and tear over a lifetime — particularly from sun exposure and for some, cigarette smoking — can take a toll on your skin. Many skin changes with age are normal and harmless, but you can still take steps to minimize their effect on your appearance and to keep your skin as healthy as possible.

The breakdown

Of the skin’s three main layers, the middle layer — called the dermis — is the thickest and most important in terms of aging. The dermis makes up 90 percent of the bulk of your skin. It contains fibrous connective tissues called collagen and elastin that give skin its strength and elasticity. Thinning and breakdown of collagen and elastin is the primary mechanism that causes skin to appear aged. It makes skin less full and taut and more wrinkly, saggy and loose. In addition, it leaves tiny blood vessels in the skin more susceptible to damage from bumps or injury. Easier bruising is the result. Bruising may look bad, but it isn’t harmful to your health.

Areas of skin that typically show the most signs of aging are the areas that see the most sunlight, such as the face and the top of the hands and forearms. With extensive sun exposure, skin may actually thicken, and have a yellowish, waxy, wrinkled appearance.

Protecting your skin from the sun is the main way to prevent breakdown of collagen and elastin. In addition, prescription retinoid skin creams such as tretinoin (Renova, others) can help rebuild collagen. This may reduce fine wrinkles and improve the texture of your skin.

Other methods of augmenting facial skin include injections of botulinum toxin A (Botox) or various fillers to temporarily smooth deeper wrinkles of the face. Chemical or laser peels can initiate the growth of a smoother, less splotchy outer layer of skin. Face-lift surgery involves removing excess skin and fat in your lower face and tightening facial muscles.

Mayo Clinic dermatologists recommend having a skilled, experienced and certified medical doctor advise you on the pros and cons of these procedures. Side effects and complications can occur, and the costs of cosmetic procedures generally aren’t covered by insurance.

Spots and growths

Most of the spots and growths that occur with age are harmless. Some common examples include:

- **Age or liver spots** — These flat, brown areas, also called solar lentigos, typically occur on the hands, back and face. Using a topical retinoid — often in conjunction with bleaching cream and a mild topical steroid — may gradually fade an age spot.

- **Skin tags** — These are flesh-colored growths that protrude from the skin, often on a narrow stalk. They’re often found on your neck or in your armpits. Your doctor can remove them with a surgical scissors, an electrical device or liquid nitrogen.

- **Cherry angiomas** — These small, smooth, cherry red spots are commonly found on the torso. They range from pinhead size to 1/4 inch across. They can be removed with a laser, liquid nitrogen or an electrical device.

- **Seborrheic keratoses** — These brown, black or pale growths look waxy, as if they were dripped on the skin by a candle. They also may have a “stuck-on” appearance. They usually appear on the face, chest, shoulders and back, often in multiples, and can be 1/4 inch to 1 inch across. They can be removed with a simple surgical procedure or with liquid nitrogen.

Be aware that most insurance companies won’t cover removal of these types of lesions, since the procedures are considered cosmetic and not medically necessary.

Remember, skin cancer can look a lot like a harmless spot or growth. A yearly skin check by your doctor is an important way to differentiate suspicious skin spots from harmless spots.

In addition, have any skin spot or growth examined if it’s bleeding and won’t heal or if it’s changing, whether by becoming itchy or painful, by growing or becoming irregular in its outline or appearance, or by changing color.

Not all cosmetic

Natural aging and thinning of skin isn’t only a cosmetic concern. It can also lead to:

- **Dry, itchy skin** — Aging skin is less able to retain moisture, leading to dry, itchy skin. Basic skin moisturizing goes a long way toward prevention. If itching doesn’t subside with home care or seems to involve your whole body, talk to your doctor. It can sometimes be a symptom of an underlying problem.

- **Slower healing** — Wound healing may be up to four times slower in older adults than it is in younger people. Talk to your doctor if a sore isn’t healing or if you experience signs of infection, such as tenderness, redness, swelling or pus drainage around the area, or fever.
Second opinion

Questions and our answers

Q: Do diet pills that claim to boost metabolism really work?

A: When people talk about boosting their metabolism, they’re usually referring to increasing their basal metabolism, or the amount of energy (calories) the body burns while at rest. Claims by diet pill manufacturers emphasize the goal of boosting metabolism and would have you believe that you can melt away excess weight without putting any effort into changing your exercise or dietary habits.

However, the number of calories you burn at rest for basic needs — such as for organ function, blood circulation, and growing and repairing cells — stays fairly consistent and isn’t easily changed. Diet pills won’t rev up your basal metabolism, as your body has a limited ability to burn more calories while at rest.

Physical activity is a form of energy expenditure that’s separate from basal metabolism. If you want to burn more calories, physical activity is by far the best means of doing so. You may be able to increase your ability to burn calories after exercise by:

■ Building muscle with weight-lifting or resistance training — At rest, muscle tissue burns more calories than does fat. Building muscle can slightly raise your basal metabolism, possibly allowing you to burn a few more calories when at rest.

■ Exercising more intensely — This boosts the number of calories you burn while exercising, and for a while after the activity is over. With low-intensity exercise, such as walking, the afterburn trails off fairly quickly. The afterburn is longer with higher intensity activities, such as ordinary walking interspersed with intervals of fast walking.

Q: Is blood pressure ever too low?

A: Yes, for some people it can be too low. In fact, some people who are otherwise healthy can have quite low blood pressure. The medical term for this is hypotension.

Hypotension may result from serious heart disease — such as after a heart attack, coronary artery disease or heart valve disorders — in which the heart’s ability to pump blood is damaged or defective (cardiomyopathy). Low blood volume due to dehydration or blood loss from internal bleeding or major injury also can result in hypotension.

Although blood pressure can vary from person to person, a blood pressure reading of 90 millimeters of mercury (mm Hg) or less systolic — the top number in a blood pressure reading — or 60 mm Hg or less diastolic blood pressure — the bottom number — is considered low blood pressure.

Low blood pressure that occurs upon standing up is called postural or orthostatic hypotension. This type is fairly common in older adults and may cause lightheadedness or fainting. Disorders affecting the brain, spinal cord or nerves, or the body’s internal reflexes that control blood pressure can cause this condition. Examples include diabetic neuropathy, loss of movement in the legs and lower body (paraplegia), problems with thyroid and adrenal glands, and certain medications.

Some older adults, particularly those on high blood pressure drugs, may be at risk of fainting or falling due to a drop in blood pressure after a meal (postprandial hypotension). Persistent lightheadedness, dizziness or fainting warrants a visit with your doctor to determine the cause.

If it’s related to postural or postprandial hypotension, making accommodations in things like how quickly you stand up, or eating smaller portions of food can help.

Drinking more fluids and — under a doctor’s guidance — increasing sodium intake can help. Special elastic garments may be worn to reduce pooling of blood in your legs. For the most serious cases, there are drugs that may help.