Low sexual desire

Finding a new rhythm

In your younger years, the thought of older adults having a satisfying sex life may never have crossed your mind.

Of course, you know better today. Sexuality and intimacy are important aspects in life no matter what your age. But with age, sexuality also can be challenging. Health issues may interfere with a variety of things you never gave a second thought to in your 30s and 40s. For adults in the second half of life, one such issue may be a drop in sexual drive (libido). However, reinvigorating or cultivating sexual desire — a longing for intimacy — is often possible once the contributing factors are understood and addressed.

Steps in the dance of intimacy

Libido results from a combination of biology, emotion, thoughts, meaning and motivation. Libido strongly correlates with satisfaction in a couples’ emotional as well as physical relationship. It also includes an understanding of you and your partner’s wants and needs. Sexual drive is the normal urge to be sexual.

A study published in the British medical journal BMJ looked at sexuality and health among a large group of adults ranging in age from 65 to 85. Overall, the study found that many older adults are sexually active and
consider sexuality an important part of their lives. However, the need or desire for sexual intimacy can be quite variable over a lifetime due to priorities related to family, career or social commitments. Being sexually available to your partner can be especially challenging during times of illness or after developing a serious medical condition. The physical and emotional changes that come along with aging also may contribute to how you feel about sex.

For instance, if you’re with someone new in your life, you may feel as anxious and uncertain about sex as you did during your first sexual experiences. Alternatively, attraction to a new partner may result in an increased libido.

Ladies in this corner
Throughout a woman’s life, bodily changes including those related to the ups and downs of estrogen and progesterone and the gradual decline of testosterone, which women produce in small amounts, can play a significant role in libido.

Changes leading up to menopause and after — both physical and emotional — can make a difference in how you experience your sexuality, including various sexual activities. These changes may include:

■ Naturally occurring changes in body shape and size — These factors may affect how desirable you feel. Changes with age also may mean a loss of support in your pelvic floor muscles, which normally hold your uterus, bladder, rectum and vagina in place (see our June 2009 article “Pelvic floor weakness”).

■ Decreased estrogen production — This typically results in thinning of vaginal tissues and less natural vaginal lubrication. These changes may lead to lower levels of desire due to pain or discomfort during sexual stimulation.

■ Urinary or genital tract changes — Problems such as urinary inconti- nence, overactive bladder, or vaginal itching or dryness may hinder your participation and enjoyment in relaxed foreplay and intercourse.

■ Changes in sexual arousal — With age, orgasms typically become more muted.

Men over here
For men, aging means a natural change in testosterone levels. Unlike the rapid drop-off in estrogen that women experience with menopause, testosterone levels peak in a man’s late teens and then gradually decline throughout life.

Normally, as men get older, that gradual decline in testosterone may show up as a normal change in sexual response, specifically:

■ Erections may take longer to achieve and may not be as firm.

■ Penile sensitivity may be decreased.

■ Full arousal may take longer and ejaculation may be less intense.

The problem of erectile dysfunction (impotence) becomes more common as men age. Erectile dysfunction may be due to treatment or surgery related to prostate cancer and conditions affecting the cardiovascular system or the nervous system.

Among aging men, the desire to be sexual is often based less on hormonal drive and more on emotional attachment to their partner. Desire for emotional intimacy decreases age, so the focus on a physical relationship can shift increasingly to an emotional one. This change tends to bring older adults together for satisfying sexual intimacy even if arousal and orgasm aren’t the same as they once were.

Issues beyond gender
For both men and women, medical conditions that affect general health and well-being can interfere with their sexual life. If medical concerns or illness impairs your partner’s sexual function, you’re also likely to encounter a dampening effect on your own sexual enjoyment.

Multiple chronic conditions of aging can lead to impaired arousal and reduced sexual enjoyment or comfort. Some of these may include:

■ Diseases affecting the cardiovascular system — Adequate blood circulation figures strongly in arousal for women and men during sexual activity. Conditions such as diabetes, high blood pressure and high cholesterol can contribute to problems of impaired or diminished blood flow. Cardiovascular damage is also related to smoking.

■ Joint health — Conditions affecting joints, such as osteoarthritis and rheumatoid arthritis, may impair movement or cause pain. Special considerations and adapting new positions during sexual intercourse may be necessary after joint replacement surgery.

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Hormone therapy may be used to enjoy, comfort and desire. These drugs can have a powerful negative impact on sexual relationships. Among prescription drugs that reduce or block estrogen action in treating prostate cancer, the antiandrogens flutamide, bicalutamide and nilutamide, used to treat prostate cancer, don’t alter libido, only function.

Hormone therapy related to cancer treatment also can have an impact on sexual relationships. Some women who have had breast cancer are prescribed medications that reduce or block estrogen action. These drugs can have a powerful negative impact on sexual enjoyment, comfort and desire.

Hormone therapy may be used in treating prostate cancer to lower a man’s testosterone level. Commonly, this causes a loss of libido, but not always. Some men maintain their sexual desire, but have difficulty getting an erection or are unable to reach orgasm.

What can be done
Communication is key to addressing sexual-function changes, including loss of libido. Talk openly with your partner about any physical difficulties you may be encountering and changes you’re experiencing in your sexual function or sexual enjoyment. Try to explore different ways to enhance your enjoyment of intimacy as a couple. Sharing in this manner can enhance your relationship.

Vaginal dryness related to menopause may be helped by using a nonprescription, water-based product such as a moisturizer (Replens), or non-glycerin lubricants, such as System Jo H2O or Slippery Stuff.

Another consideration may be to talk with your doctor about using a vaginal estrogen. If you suspect or wonder if the problem is medical in nature, see your doctor. Underlying medical conditions can be troubling obstacles to sexual enjoyment for men and women of all ages.

If you’re taking medications, ask your doctor whether any might be limiting factors for sexual activity. In that case, a different medication or another form of treatment may be an option for you.

But remember, drugs such as sildenafil (Viagra), tadalafil (Cialis) and vardenafil (Levitra), used to treat erectile dysfunction, don’t alter libido, only function.

Regular exercise can help improve your energy levels as well as help you feel more attractive. Exercise also helps stimulate genital blood flow.

Many individuals and couples benefit from brief counseling by a trained therapist who can provide education, specific suggestions and tailored interventions for sexual concerns. Often, counseling is done as well as medical evaluations and related treatments for the specific sexual concerns.

The one thing you can’t do is go back in time. So, rather than wishing things to be as they were in your youth, consider instead who you are now and how you and your partner might enjoy or respond to sexual experiences now.

Health tips
Outwitting your taste buds

Taste is a powerful force. Eating great food with friends and loved ones is one of the great pleasures of life. But at the same time, you’re not a slave to your taste buds.

You may be able to take control of your diet when your taste buds seem to be getting you into trouble.

Even if you don’t like the taste of vegetables and fruits, you may be able to incorporate these healthy foods into your diet by:

■ Looking for ripe, in-season strawberries, grapes or dark cherries, as these are often quite sweet.

■ Adding vegetables to favorite foods, such as a soup, casserole or pizza. Slice up fresh fruit and put it in your morning cereal or yogurt.

■ Making a fruit smoothie or use a vegetable juicer.

■ Choosing milder offerings, such as carrots, bananas and pears, if bitter or sour flavors are what turn you off.

■ Not keeping unhealthy food that you can’t resist in your home. If you do, keep it in very small amounts.

■ Eating healthy foods first, so when it comes time to enjoy a favorite treat, you’re less hungry.

■ Determining in advance how much of a treat you’ll eat and sticking with the plan.

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■ Nervous system damage — Many conditions, such as diabetes and stroke, may impact normal nerve function that contributes to the process of sexual response. Nerve sensation is required for sexual arousal and is as important for women as it is for men.

■ Psychological issues — Depression or anxiety can distort and flatten normal enjoyments in life, including libido. Relationship issues — such as performance anxiety or the guilt some experience when moving into a new relationship after the death of a partner — can impair sexual desire or enjoyment.

In addition, older adults tend to take more medications, which can inhibit sexuality — including desire for sex, ability to become aroused and orgasmic function. Among prescription drugs that may affect sexual function are antidepressants, opiate-type drugs for pain relief and high blood pressure medications. Excess alcohol consumption can have a similar effect.

Hormone therapy related to cancer treatment also can have an impact on sexual relationships. Some women who have had breast cancer are prescribed medications that reduce or block estrogen action. These drugs can have a powerfully negative impact on sexual enjoyment, comfort and desire.

Hormone therapy may be used in treating prostate cancer to lower a man’s testosterone level. Commonly, this causes a loss of libido, but not always. Some men maintain their sexual desire, but have difficulty getting an erection or are unable to reach orgasm.
After a heart stent, cardiac rehabilitation extends life

Widening a clogged heart artery and propping it open with a stent (coronary angioplasty) can help prevent heart attacks and save lives. But new research from Mayo Clinic indicates that your therapy shouldn’t end there. Beginning a cardiac-rehabilitation program — one that improves heart health with exercise, promotes healthy changes in diet and optimal use of medications, and provides important psychological support — can cut your risk of death nearly in half over the following six years.

The research, presented at the 2010 meeting of the American College of Cardiology, examined the records of 2,341 Mayo Clinic patients who received coronary angioplasty between 1994 and 2008. About 40 percent of these people took part in a cardiac-rehabilitation program. Those who did reduced their risk of dying of any cause by 45 to 47 percent in the years after coronary angioplasty. Risk of death due to a heart-related cause also was significantly lowered.

Although cardiac rehabilitation is the gold standard of care after a heart attack, its impact when done after angioplasty has been less clear. Unfortunately, cardiac-rehabilitation services are used by fewer than one-third of eligible patients nationwide.

Mayo Clinic heart specialists hope that evidence from this study will help promote more widespread use of this important lifesaving therapy. Cardiac rehabilitation after coronary angioplasty — and after heart attack and most other heart-related procedures — is usually covered by health insurance, including Medicare.

If you undergo a coronary angioplasty procedure, it’s important to remember that cardiac rehabilitation can provide additional lifesaving benefits. Ask your doctor to refer you to a cardiac-rehabilitation program near your home. Your life may depend on it.

Vitamin K intake linked to reduced lymphatic cancer risk

Here’s another reason to eat your spinach: A recent Mayo Clinic study found that people who ate more food with plenty of vitamin K were less likely to develop non-Hodgkin’s lymphoma.

Researchers compared questionnaires about what foods were eaten from 603 people who were newly diagnosed with non-Hodgkin’s lymphoma, with those from 1,007 cancer-free people who didn’t have lymphoma. Those who ate more than 108 micrograms (mcg) a day of vitamin K were only about half as likely to develop non-Hodgkin’s lymphoma as were those who took in less than 39 mcg a day.

Although the study’s results point to a fairly strong protective effect from higher dietary intakes of vitamin K, Mayo Clinic researchers say it’s too soon to say it’s all due to vitamin K. Other nutrients or compounds in vegetable-rich diets that include vitamin K also may play a role.

The study was reported during the April 2010 annual meeting of the American Association for Cancer Research.

Persistent constipation

Sorting myths from facts

Lately, you’ve had a tough time dealing with constipation. When you mentioned it to a few friends, they suggested everything from laxatives to herbal supplements and enemas.

What should you believe?

Virtually everyone has dealt with an occasional bout of constipation. Sometimes, short-term use of a laxative such as milk of magnesia may be needed to get things moving. A few simple tips — such as eating adequate fiber, avoiding dehydration and heeding the call of nature — may be enough to help keep you on track after your constipation passes.

However, it’s not always so simple. For many older adults, constipation is a complex and persistent (chronic) problem requiring individualized treatment from a doctor. Here, we tackle some of the common myths about chronic constipation.

Get the facts

Myth: If you don’t have a bowel movement every day, you’re constipated.

The facts: Constipation is a symptom that’s generally defined as the infrequent or difficult passage of stool. Normal frequency of bowel movements in healthy adults can range from three bowel movements a day to three a week. That’s why frequency alone isn’t the most reliable indicator of constipation.

Typically, signs and symptoms of constipation also include straining, passing lumpy or hard stools, a sensation of incomplete evacuation, or a sensation of blockage. To overcome this, you may have to assume certain positions or manually assist in the removal of stool.
Seek prompt medical care if your constipation involves new symptoms, or if they’re associated with bleeding, significant abdominal pain or nausea. Talk to your doctor if your constipation isn’t responding to self-care within several weeks.

Myth: My body absorbs toxins from stool if I’m constipated for too long.

The facts: Simply put, this is false. Still, some people unnecessarily take laxatives because they think they need to have a daily bowel movement. Others try colon cleansing to remove supposed toxins. These habits aren’t helpful and may actually be harmful.

Myth: Constipation only occurs when you don’t eat a healthy diet.

The facts: A low-fiber diet may contribute to constipation, but chronic constipation often involves one or more additional causes.

Sometimes, constipation occurs as a complication of another disease or condition, or as a side effect of a drug or supplement. This is called secondary constipation.

In addition to these secondary causes of constipation, there are several primary causes of constipation. One common primary cause — especially in women — is pelvic floor dysfunction. This is a lack of coordination of the complex muscular actions that allow you to have a bowel movement. This can occur in conjunction with problems of urinary or sexual function. In addition, it’s more common in those who have had surgery of the rectum or anus, or who have given birth vaginally.

Myth: Diagnosis of constipation doesn’t require much more than a description of bowel habits.

The facts: That’s likely to be part of the diagnostic process, but it may be only the beginning. Your doctor may also perform a physical exam, discuss medication or supplement use, take X-rays, and do blood, urine or stool tests. Depending on the results of initial testing or treatment, you may be referred to a gastroenterologist for more-specialized tests.

Myth: Your doctor shouldn’t prescribe a laxative for long-term use.

The facts: It was once thought that long-term use of certain laxative drugs would cause the bowel to become “lazy,” or unable to properly function without the aid of the drug.

However, careful review of published studies now indicates that this isn’t the case. Long-term use of laxative drugs as prescribed by your doctor can be safe and effective treatment for some forms of chronic constipation. Side effects with long-term use of laxatives may still occur, which is why it should only be done under the supervision of your doctor.

If laxatives are necessary, Mayo Clinic experts generally first recommend osmotic laxatives, such as milk of magnesia, polyethylene glycol (Miralax) or sorbitol.

Stimulant laxatives — such as senna (Agoral, Ex-Lax, others) or bisacodyl (Dulcolax, Correctol) — may be needed if osmotic laxatives aren’t effective. Stool softeners such as docusate sodium (Colace) can be another effective alternative.

Myth: Laxatives and surgery are the only two ways to treat chronic constipation.

The facts: There are many treatment options, which vary depending on your circumstances and the cause of your constipation. After careful diagnosis of primary or secondary causes, therapy may include such approaches as using laxative drugs, treating an underlying disease or adjusting medications. Surgery is used rarely as a last resort.

In recent years, pelvic floor rehabilitation (biofeedback therapy) has become the treatment of choice for many with pelvic floor dysfunction. The results can be very impressive. Biofeedback often involves an intensive training program where various sensors are used to detect contraction and relaxation of muscles critical to a successful bowel movement. The sensors display results on a computer screen. By viewing this and working with a therapist, you relearn how to control and coordinate the necessary muscles for a bowel movement.
The science of taste

Putting flavor in your favor

Do you know anyone who doesn’t like pizza? Do you know any children who don’t like candy?

There’s a pretty good chance that you don’t.

In fact, there are scientific reasons for the love of certain foods, and at least part of it has to do with how humans perceive flavor.

A better understanding of your tastes helps you understand why you probably like pizza. It also can help guide the decisions you make to avoid overeating those satisfying, but fattening foods — and to derive more enjoyment out of healthier food choices.

How taste works

At the most basic level, taste is one of the main ways you determine whether a potential food item is accepted and eaten, or rejected and spit out. You are born with a taste reflex that accepts sweet tastes — signaling a source of energy — and rejects bitter tastes, which may signal toxins.

Beyond that, taste is extremely complex. Taste occurs when chemicals from food reach taste receptors that are packed into onion-shaped bulbs called taste buds.

Taste buds are located on many of the smooth surfaces throughout your mouth, and many are located within the tiny folds of your tongue. While taste receptors send information to the brain about flavor, other nerve cells surrounding taste buds send additional information about the food, such as its texture, temperature, spiciness or weight.

Your sense of smell is also closely integrated with how you perceive taste. In fact, much of what you perceive as taste is due to smell. Smell experts have shown that a large part of flavor actually comes from smell.

There appears to be a genetic component of taste. For example, research has shown that up to about 25 percent of the population doesn’t taste certain bitter chemicals that other people can taste. Among those who do taste these bitter chemicals, some are extra sensitive and are considered to be “supertasters.”

Your current state of health and the medications you’re taking also may dramatically alter your sense of taste.

Additional factors related to your likes and dislikes include appearance, familiarity and cultural acceptance of a food item. Also important is the context in which you eat or have eaten a particular food. Another crucial factor is how the food item made you feel during and after you ate it.

What you taste

It’s generally accepted that there are five primary tastes:

- **Sweet** — You’re hard-wired to enjoy sweetness, whether from a strawberry or piece of candy.
- **Salty** — Some salt flavor is delicious, but too much is repulsive. Where does your body draw the line? It appears that you adjust your tastes to the amount of salt in your food. If you cut back on your sodium intake, your food may taste bland for a few weeks until your sense of taste adjusts to a new normal. After that, you may taste the saltiness in foods with lower amounts of salt in them.
- **Bitter** — A natural aversion to bitterness may save you from eating something toxic. However, it causes some people to avoid somewhat bitter foods that are healthy, including many types of vegetables.
- **Sour** — Caused by acids in foods, this provides the tanginess of many fruits. Sour flavor can also be a sign of fermentation, both good — as with yogurt or wine — and bad, as with spoilage.
- **Umami** — This Japanese word is often translated as “savory.” The main compound that causes the subtle umami taste is a protein called l-glutamate. This amino acid is found in the commonly used food additive monosodium glutamate (MSG).

Umami taste is found in a wide variety of foods, including corn and tomatoes, aged cheese, meat, carrots, fish and shellfish, and dark-colored mushrooms. Anchovies are particularly well-known for their umami-enhancing ability. No wonder so many people love pizza — the ingredients typically used on pizza tap into the sweet, salty and umami flavors along with the fat flavors that humans have evolved to crave.

There’s debate about whether “fat” is a sixth primary flavor. It’s not known if the human inclination toward consuming fats includes specific fat taste receptors.

Otherwise, fat flavor — and many other flavors such as spicy-hot, tartness, metallic, water, tingling and pungent — are believed to result from the coactivation of the five primary taste receptors in addition to activation of your sense of smell and other nerve endings in the mouth.

Taste and age

With age, your sense of taste may naturally diminish some. Your sense of smell may diminish even more dramatically and thereby further reduce your sense of taste.

However, a decline in taste or smell may be worth mentioning to your doctor, as these changes can also be caused by an illness, many common medications or oral problems that can be addressed.
Irritable bowel syndrome

Often manageable

After weeks of dealing with cramping, abdominal pain, bloating, gas, diarrhea and constipation, you finally broke down and visited your doctor.

It’s a good thing you did. Talking about bowel problems with your doctor may be uncomfortable, but any persistent change in bowel habits warrants a visit. Still, although as many as 1 in 5 American adults has similar signs and symptoms to those described above, fewer than half seek medical help.

The signs and symptoms you experienced are commonly caused by irritable bowel syndrome (IBS). A visit to your doctor is a good first step toward learning how you may be able to control your symptoms with diet and lifestyle changes, and by better managing stress.

It’s also possible that symptoms such as these may indicate a more serious condition, such as ulcerative colitis or Crohn’s disease — which are forms of inflammatory bowel disease — or colon cancer. And it’s important to rule out these problems.

What’s the deal?

The signs and symptoms of IBS can vary widely and often resemble those of other diseases. Among the most common are:

- Abdominal pain or cramping
- A bloated feeling
- Gas (flatulence)
- Diarrhea or constipation — sometimes alternating bouts of diarrhea and constipation
- Mucus in the stool

Many people have only mild signs and symptoms of IBS. However, sometimes these problems can be disabling. In some cases, you may have difficulties that don’t respond well to medical treatment.

Because symptoms of irritable bowel syndrome can occur with other diseases, it’s best to discuss these symptoms with your doctor.

For most people, IBS is a chronic condition, although there will likely be times when the signs and symptoms are worse and times when they improve or even disappear completely.

How did this happen?

It’s not known exactly what causes IBS. The walls of the intestines are lined with layers of muscle that contract and relax in a coordinated rhythm as they move food from your stomach through your intestinal tract to your rectum.

If you have IBS, the contractions may be stronger and last longer than normal. Food is forced through your intestines more quickly, causing bloating and diarrhea.

In some cases, the opposite occurs. Food passage slows, and stools become hard and dry. Abnormalities in your nervous system or colon also may play a role, causing you to experience greater than normal discomfort when your abdomen stretches from gas.

If you have IBS, you probably react strongly to stimuli that don’t bother other people. Triggers for IBS can range from gas or pressure on your intestines to certain foods, medications or emotions. For example:

- **Foods** — Many people find that their problems may worsen after they eat certain foods. For instance, chocolate, milk and alcohol might cause constipation or diarrhea. Carbonated beverages and some fruits and vegetables may lead to bloating and discomfort in some people who have IBS.

  If you experience cramping and bloating mainly after eating dairy products, food with caffeine, or sugar-free gum or candies, the problem may not be IBS. Instead, your body may not be able to tolerate the sugar (lactose) in dairy products, caffeine or the artificial sweetener sorbitol.

- **Stress** — Most people with IBS find that their signs and symptoms are worse or more frequent during stressful events. But while stress may aggravate symptoms, it doesn’t cause them.

- **Hormones** — Because women are twice as likely to have IBS, researchers believe that hormonal changes play a role in this condition.

- **Other illnesses** — Sometimes another illness, such as an acute episode of infectious diarrhea (gastroenteritis), can trigger IBS.

Because there are usually no physical signs to definitively diagnose IBS, diagnosis is often a process of elimination.

Your doctor also may recommend several tests, including stool studies to check for infection or malabsorption problems.

Treatment options

Because it’s not clear exactly what causes IBS, treatment typically focuses on the relief of symptoms. In most cases, you can successfully control mild signs and symptoms of IBS by learning to manage stress and by making changes in your diet and lifestyle.

However, if your problems are moderate or severe, you may need more than lifestyle changes. Your doctor may suggest that you try using fiber supplements or anti-diarrheal medications. Eliminating high-gas foods may help with bloating and gas.

Some people may benefit from taking anticholinergic medications to relieve painful bowel spasms. These may be helpful for people who have bouts of diarrhea, but can worsen constipation.

Low dose antidepressant medications may be appropriate as they inhibit the activity of neurons that control the intestinal muscles, whether or not you have underlying depression.
Second opinion

Questions and our answers

Q: I had my cataracts removed about a year ago, and now my vision seems to be clouding up again. Are my cataracts returning?

A: No. Even though what you’re likely experiencing is commonly referred to as a second cataract or aftercataract, it’s something different called posterior or capsular opacification (PCO).

A cataract occurs when the normally clear lens in your eye becomes cloudy, causing blurred vision. Surgery to remove a cataract typically involves removing the clouded, outer and middle parts of the lens and inserting an artificial lens. However, the clear back surface of the lens — part of what’s called the lens capsule — is left in place to help support the artificial lens.

In about 20 to 40 percent of those who have cataracts removed, cell growth on the lens capsule causes it to become cloudy months or years after cataract removal.

Fortunately, treating PCO involves a quick and painless outpatient procedure in which a laser beam is used to make a small opening in the clouded lens capsule. Complications are uncommon. However, the laser procedure can raise eye pressure, particularly those who have glaucoma or are extremely near sighted.

Advances over the years have reduced the rate of PCO development. Researchers continue to test ways to decrease it further — including by improving the surgical technique for cataract removal, improving artificial lens design, using different lens materials and by using various preventive drugs.

Q: On reviewing results from a recent brain scan, my doctor said it showed only some normal brain shrinkage and that there wasn’t anything to worry about. Why wouldn’t I be worried about my brain shrinking?

A: As you age, the number of neurons in your brain decreases and the number of connections between nerve cells (neurons) is reduced. As a result, your brain actually shrinks (atrophy) slightly.

That sounds bad, but with billions of neurons and trillions of connections between them, the brain has a much greater capacity than is required for normal needs in a lifetime. In addition, living cells continually make new connections that replace at least some of those that are lost.

Still, starting at about age 50, you may begin to notice normal cognitive changes that directly affect memory and other brain functions. For example, it may take a little longer for you to learn new things, you may have occasional memory lapses. You may also find that you need to focus on only one task at a time.

Have a question or comment?

We appreciate every letter sent to Second Opinion but cannot publish an answer to each question or respond to requests for consultation on individual medical conditions. Editorial comments can be directed to:

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