Peptic ulcers

Stopping them for good

Here you are again, up in the middle of the night with a gnawing stomach pain. You’re not hungry, but eating a quick snack and taking an antacid seems to quiet the problem so that you can get back to sleep.

Still, you’ll probably want to talk to your doctor. It’s possible that you may have an ulcer in your stomach, (gastric ulcer), or in the uppermost part of your small intestine (duodenum).

Not long ago ulcers were considered a chronic condition that you had to live with. Today, most peptic ulcers can be cured within a matter of weeks. But an ulcer doesn’t go away at the snap of a finger. Careful diagnosis and follow-through with an appropriate treatment plan are crucial — and you may need to work with your doctor to develop a plan for avoiding another.

Sore spot

As recently as 1980, it was thought that peptic ulcers were caused primarily by lifestyle factors such as too much stress or spicy food. It’s now known that an infection in the lining of the stomach caused by the bacteria Helicobacter pylori (H. pylori) is a common cause.

H. pylori causes peptic ulcers by damaging the acid-tolerant lining of the inner stomach or duodenum. This
allows stomach acid to reach more-sensitive tissues underneath, leading to further damage and irritation. Infection is common among older adults in the United States, but most people infected with H. pylori never develop an ulcer. It’s not entirely known why some develop ulcers and some don’t.

Another leading cause of peptic ulcers is regular use of anti-inflammatory pain medications. Five to 20 percent of people who do so may eventually develop an ulcer. Those at highest risk appear to be adults older than 60, women and people who’ve had a past peptic ulcer.

Anti-inflammatory medications can irritate and inflame the lining of the stomach, potentially leading to ulcer development. They may include common pain relievers such as celecoxib (Celebrex), diclofenac (Voltaren), ibuprofen (Advil, Motrin, others), naproxen (Aleve, Naprosyn) and ketoprofen. Aspirin — even low-dose aspirin taken to prevent heart attack — and related medications also raise the risk of peptic ulcer.

Rare causes of ulcers include bisphosphonates used to treat osteoporosis — such as alendronate (Fosamax) and risedronate (Actonel) — cancer, extreme stress such as from a severe illness, a major surgery, or rare diseases affecting stomach acid production.

Although lifestyle factors aren’t primary causes of peptic ulcers, smoking, excessive alcohol consumption and stress can contribute to worsening symptoms, interfere with healing or increase the risk of recurrence.

The symptoms

Symptoms of peptic ulcer vary widely and can be tricky to distinguish from other problems, such as heartburn. Still, a burning, gnawing pain anywhere from your navel to your breastbone is the predominant symptom. The pain often:

■ Lasts from a few minutes to several hours.
■ Is worse when your stomach is empty.
■ Flares up at night.
■ Can be temporarily relieved by eating food or taking a medication that reduces stomach acid. However, in some cases, pain may be brought on by eating.
■ May disappear and then return for a few days or weeks.

Not all pain falls into this pattern, though. Some people may experience a more vague abdominal pain or cramping, and it’s not uncommon for older adults to have a peptic ulcer that causes no pain. Additional signs and symptoms may include:

■ Weight loss, because the pain and indigestion make it hard to eat or you feel full quickly.
■ Weight gain, because eating helps relieve the pain.
■ Bloating and belching.
■ Nausea and occasional vomiting.
■ Anemia.

Ulcers that fail to heal

Your doctor may suggest a repeat upper endoscopy to make sure the ulcer is healed. Common causes of an ulcer that has failed to heal include:

■ Not taking medications according to instructions.
■ Having a type of H. pylori that’s resistant to the antibiotics you were given.
■ Continuing to take anti-inflammatory drugs.

Treatment of nonhealing ulcers generally involves eliminating factors that may interfere with healing, along with taking stronger doses of ulcer medications. Sometimes, additional drugs may be included. Surgery to help heal an ulcer is necessary only when the ulcer doesn’t respond to aggressive drug treatment.

The bottom line is that if you feel abdominal discomfort — or if you’re controlling what you think is heartburn on your own with nonprescription medications for more than a few days — talk to your doctor.

Untreated, peptic ulcers can cause life-threatening problems such as internal bleeding or a perforation that creates a hole in the wall of your stomach or small intestine. Seek emergency care if you experience:

■ A sudden, sharp abdominal pain that may feel like it’s radiating toward your back and won’t go away.
■ Black or bloody stool.
■ Bloody vomit or vomit that looks like coffee grounds.

The goal of diagnosis is determining if a peptic ulcer is causing your symptoms and, if so, determining what caused it to develop.

A description of symptoms and your medical history — such as...
whether you take anti-inflammatory drugs — can provide important clues. A test that may be done involves taking an X-ray of your abdomen after you’ve swallowed a liquid that makes your digestive tract more visible on X-ray.

However, a definitive diagnosis of peptic ulcer requires an upper endoscopy. With upper endoscopy, a long, thin flexible tube with a camera attached to the tip is threaded down your throat to your stomach and duodenum. The procedure is done under light (conscious) sedation. If an ulcer is found, a small tissue sample (biopsy) may be removed and examined under a microscope to rule out cancer or detect the presence of H. pylori.

If an upper endoscopy isn’t performed, H. pylori can also be identified by blood tests, a breath test or with a stool sample. Breath testing and stool testing for H. pylori also are effective ways to monitor whether a course of treatment is working.

Whether the cause of your ulcer is an H. pylori infection, anti-inflammatory drugs or both, a key treatment is protecting the lining of your stomach or duodenum from stomach acid. You’ll likely begin taking one or more acid-reducing drugs. These may include drugs in the proton pump inhibitor class such as esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec, Prilosec OTC), pantoprazole (Protonix) or rabeprazole (Aciphex) — or drugs in the histamine (H-2) blocker class such as famotidine (Pepcid) or ranitidine (Zantac). Other, less commonly used medications include bismuth subsalicylate (Pepto-Bismol), misoprostol (Cytotec) and sucralflate (Carafate).

If you’re infected with H. pylori, you’ll likely be prescribed a combination of two antibiotics, along with an acid-reducing drug. This typically results in an H. pylori eradication rate of 80 to 90 percent.

With a peptic ulcer of any cause, the ideal is to stop taking all anti-inflammatory medications. This is especially true if anti-inflammatory drugs are a root cause. Acetaminophen (Tylenol, others) is a commonly recommended alternative to anti-inflammatory drugs for pain relief since it doesn’t affect the gastrointestinal tract.

The decision to stop taking low-dose aspirin to reduce heart attack and stroke risk may involve discussing with your doctor risks versus benefits.

**Help things along**

With an appropriate treatment plan, peptic ulcers usually heal within a few weeks. You can encourage the healing process and reduce your risk of delayed healing by addressing lifestyle factors that can irritate your stomach or increase acid levels. This may include managing stress, stopping smoking and avoiding alcohol.

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**Anti-inflammatory drugs after an ulcer**

If a certain anti-inflammatory medication controlled your arthritis pain — or you take low-dose aspirin for your heart — can you take the medication again after your ulcer heals? The answer is generally one of weighing the risks.

Deciding will likely involve talking to your doctor about your health history, the benefits and risks of anti-inflammatory use, and possible alternatives. If you and your doctor decide that the benefits of taking aspirin or an anti-inflammatory pain reliever outweigh the risk of another peptic ulcer, use these tips to minimize risk:

- Take an acid-reducing medication such as a proton pump inhibitor.
- Use the lowest effective dose of anti-inflammatory pain medication.

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**Health tips**

**Fingernail care**

Proper care of your fingernails can help keep them healthy and in good shape. Practical nail care steps include:

- **Protecting your nails** — Like your skin, nails need regular moisturizing. Make a point to rub lotion into your nails when moisturizing your hands. If your hands are going to be in soapy water for a long time, wear dishwashing gloves. Never use your fingernails as tools to pry things. Don’t bite your nails or pick at the cuticles. This can damage the nail bed and may even lead to infection.

- **Performing routine nail maintenance** — Trim your fingernails regularly with a sharp manicure scissors or clippers. Smooth and bevel the nail edges with an emery board, rounding them slightly at the tips for a manicure. Never use your fingernails as tools to pry things. Wearing gloves. Never use your fingernails as tools to pry things. Don’t bite your nails or pick at the cuticles. This can damage the nail bed and may even lead to infection.

- **Strengthening weak nails** — To avoid ragged nail breaks, keep brittle nails trimmed short. Trim after a bath or a hand soak in bath oil. Apply a nail hardener, but avoid products containing toluene sulfonamide or formaldehyde, as these chemicals may irritate skin or cause redness.

Thinly applied nail polish may help keep moisture in the nail. However, don’t use nail polish remover more often than once a week. When you do need a remover, avoid those that contain acetone, which dries nails.
Multiple myeloma

Progress is being made

Over the years, your blood test results have for the most part been normal. But this year, a finding of anemia and other blood abnormalities prompted additional tests. You generally feel fine, so you were surprised when your doctor said you might have the early beginnings of multiple myeloma — a cancer of the plasma cells in your bone marrow.

Although multiple myeloma generally isn’t curable, considerable progress has been made in managing it, and new treatment options are available. Depending on your health and the disease stage, treatment can relieve symptoms, potentially put the disease in remission and prolong life.

Makings of a cancer

Normally, plasma cells make antibodies that help fight infections. By doing so, they play an important role in the immune system. However, if abnormal plasma cells — myeloma cells — multiply out of control, they can accumulate in bone marrow as a plasma cell tumor and crowd out healthy blood-forming cells. This may cause a number of problems, including anemia due to a shortage of red blood cells, increased bleeding and bruising due to low platelet levels, and difficulty fighting infections due to a lack of white blood cells. Myeloma cells can damage bones in multiple locations, hence the name multiple myeloma.

Magnetic resonance elastography (MRE) is used here to detect liver stiffness. The MRE at left shows normal liver stiffness. The image on the right shows markedly elevated liver stiffness, indicating the presence of advanced liver fibrosis.

Magnetic resonance elastography (MRE) may improve how doctors diagnose diseases

The age-old diagnostic practice of doctors feeling for bodily abnormalities using touch — known as palpation — has just entered the digital age. A new diagnostic imaging tool invented at Mayo Clinic has taken the art of palpation and merged it with high-tech magnetic resonance imaging (MRI).

The result? Magnetic resonance elastography (MRE). MRE uses sound waves to vibrate soft tissues within the body, and then captures and analyzes the characteristics of how the tissues vibrate to create an image depicting the relative stiffness of the examined tissues. Elastography can also be done with ultrasound imaging, but it may not always provide the sensitivity of MRE.

A healthy liver, for example, is a soft and supple organ. However, the early effects of liver disease cause a stiffening of liver tissues from fibrosis. Early stages of fibrosis of the liver often can be halted or reversed with appropriate treatment. However, fibrosis also may advance to cirrhosis and liver failure, which is treatable only with a liver transplant.

MRE is capable of detecting fibrosis within the liver — even the subtle changes in tissue stiffness that would indicate the earliest stages of fibrosis development. This offers hope of early detection of fibrosis, which then may be reversed before advancing to cirrhosis. Before the development of elastography, the only way to detect fibrosis was by taking tissue samples (biopsy) from the liver using a biopsy needle. Biopsy has the potential to cause complications such as pain and bleeding. In addition, biopsy doesn’t always accurately detect fibrosis because biopsy samples may come from areas of the liver unaffected by fibrosis. In contrast, MRE is a quick, painless procedure that images the entire liver. Researchers estimate that MRE can diagnose the presence of fibrosis 98 percent of the time.

MRE technology is already in use at Mayo Clinic and at select major medical centers for diagnosing liver fibrosis. MRE use is likely to become more widespread within the next year or two. Mayo Clinic researchers also are studying MRE for use in better diagnosing other diseases, such as breast cancer, brain injury, Alzheimer’s disease and musculoskeletal disease.
Myeloma cells can disrupt normal bone remodeling. A substance made by myeloma cells speeds up bone breakdown and short circuits signals to make new bone. As a result, bones weaken and are more easily broken. In addition, excess calcium from dissolving bone enters the bloodstream. This causes complications such as dehydration and even kidney failure.

Who’s at risk?

Multiple myeloma is relatively uncommon and tends to occur more often among older adults.

Another factor that may increase the risk of multiple myeloma is having a condition called monoclonal gammopathy of undetermined significance (MGUS). It’s often considered a pre-myeloma condition.

Like multiple myeloma, MGUS is marked by the presence of monoclonal proteins. The difference is that in MGUS there’s no damage to the body. MGUS is thought to be a relatively benign condition, but those who have it have a very small chance each year of developing myeloma.

What causes multiple myeloma is unknown. Possible factors may include exposure to radiation or chemicals such as benzene, herbicides and insecticides, or working in certain petroleum-related industries. Genetic factors may play a role, as well.

Tell-tale signs and symptoms

Signs and symptoms of multiple myeloma can vary considerably from one person to the next. As the disease progresses, one or more of the following may occur:

- **Bone pain** — This pain, especially in the back or ribs and sometimes in the arms, hips and legs, may be triggered by movement.
- **Bone loss** — Overall bone loss and bone erosion in specific areas may lead to a decrease in bone mass and fractures, including vertebral fractures.
- **Presence of monoclonal proteins** — These abnormal proteins may be found in blood or urine.
- **High blood-calcium levels (hypercalcemia)** — Calcium from affected bones dissolves into your blood. Hypercalcemia may result in loss of appetite, nausea, excessive thirst and urination, constipation, weakness, or mental confusion.
- **Fatigue** — Paleness and weakness may occur. Anemia is possible due to a reduction in oxygen-carrying red blood cells, as the bone marrow is replaced by myeloma cells.
- **Diminished kidney function** — This may result from demand placed on kidneys to filter excess proteins and calcium from the blood.

Another sign is weight loss. Multiple myeloma may also result in repeated infections, such as pneumonia, sinusitis, skin infections, and bladder or kidney infections.

**Treatment considerations**

Treatment is based on factors including how advanced the cancer is, your age and overall health. Increasingly, doctors also use special tests to determine the genetic nature of the myeloma cell and then tailor treatment accordingly.

If the disease progresses, treatment may become necessary to help prevent symptoms. The main treatment options for multiple myeloma, which may be used alone or in combination, include:

- **Immunomodulatory drugs** — These medications include lenalidomide (Revlimid) and thalidomide (Thalomid). How these work is unclear, but it’s thought they help the immune system fight myeloma. They may also block blood vessels that support myeloma cell growth.
- **Proteasome inhibitors** — Bortezomib (Velcade) is the first in a new class of medications called proteasome inhibitors. It causes cancer cells to die by blocking the breakdown of proteins necessary to control cell division.
- **Chemotherapy drugs** — These partially control the disease by killing myeloma cells. Some commonly used include melphalan (Alkeran), cyclophosphamide (Cytoxan) and liposomal doxorubicin (Doxil).
- **Corticosteroid drugs** — These drugs — notably prednisone and dexamethasone — can help kill tumor cells and decrease the nausea and vomiting associated with some chemotherapy drugs.
- **Stem cell transplantation** — This treatment requires using high doses of chemotherapy — usually melphalan — to destroy as many myeloma cells as possible, then transplanting healthy stem cells into your body. Due to serious side effects, this treatment generally isn’t recommended for adults older than 70 — although it may be an option for some older adults who are otherwise healthy.

Along with treatments for multiple myeloma, you may need to be treated for one or more of the complications related to the disease. Antibiotics may be needed to treat or reduce risk of infections. Dialysis may be necessary if kidneys are severely damaged. Medications may be used to help prevent bone loss. Anemia may be managed with injections of erythropoietin-type medications, which can stimulate production of red blood cells.

**Consider clinical trials**

Myeloma treatments are constantly evolving. Mayo Clinic doctors note that in the last decade, tremendous progress has been made in treating multiple myeloma thanks to new drugs. Many other drugs are being actively studied and tested in clinical trials.

Before starting therapy for multiple myeloma or changing your treatment plan, talk with your doctor about available clinical trials. Many important new drugs are available only through clinical trials.
Psoriasis

Managing this chronic skin disorder

Psoriasis can be like a moving target. Just as the thick, red, itchy areas of skin on your elbow start to subside, another flare-up occurs.

Psoriasis is a chronic skin disorder affecting millions of people. For some, it’s a relatively minor nuisance. For others, it’s a far more distressing and prevalent part of life. Although there’s no cure for this noncontagious skin disease, lifestyle measures and treatments for psoriasis may offer significant relief.

Beyond skin deep

Normally, skin cells take about a month to mature and slough off. With psoriasis, new skin cells move to the outermost layer of skin too quickly — in days rather than weeks. The result is a rough, dry buildup of the skin’s outer layer. This is driven by the immune system — specifically by a type of white blood cell called a T lymphocyte (T cell).

T cells normally protect against disease and infection. However, if you have psoriasis, T cells are overactive and trigger other immune responses — which lead to inflammation and rapid turnover of skin cells.

Flare-ups lasting a few weeks or even months may be triggered by cold weather, stress or infections such as strep throat. Injury to the skin — such as constant friction or rubbing, a cut, a scrape, or possibly a sunburn — can provoke psoriasis. Certain drugs, such as beta blockers to treat high blood pressure, lithium for bipolar disorder, and some antimarial drugs, also can be triggers.

Although psoriasis may begin at any age, it typically develops either in early adulthood or between the ages of 50 and 60. Psoriasis patches can vary from just a few spots of dandruff-like scaling to major eruptions that cover large areas. More-severe cases can be painful, disfiguring and disabling. Sometimes, psoriasis is associated with a form of arthritis (psoriatic arthritis), which occasionally can be severe and disabling.

Most commonly, psoriasis produces patches of raised, reddish skin (plaques) covered with silvery scales. Plaque psoriasis may occur anywhere on the skin, but it’s most common on elbows, knees and the scalp. Psoriasis can also affect nails, resulting in abnormal appearance.

Tailoring treatment

Treatment is generally tailored to the severity and extent of the disease. Often a combination of therapies is used. Options include:

- **Self-care measures** — Keeping skin soft and moist may reduce itching and tenderness. Talk with your doctor about skin creams or ointments that may be best suited for your skin’s condition. Consider using bath oils or applying moisturizer after daily bathing. If your scalp is affected, medicated nonprescription shampoos with coal tar may be helpful. Topical tar creams, lotions, ointments and oils also are available. Used as directed, nonprescription hydrocortisone or salicylic creams or ointments may help reduce itching and scaling.

- **Topical therapies** — For more severe psoriasis, prescription corticosteroids of varying strengths may be applied to active skin outbreaks. Other prescription creams — calcipotriene (Dovonex) and calcitriol (Vitacal) — may be of help. The topical retinoid tazarotene (Tazorac, Avage) also may help. The calcineurin inhibitor pimecrolimus (Elidel) may be another option, though it’s not for long-term or continuous use due to potential increased risk of skin cancer or lymphoma. Older topical therapies that may be used include anthralin (Dritho-Scalp).

- **Ultraviolet light therapy (phototherapy)** — Light therapy using ultraviolet A (UVA) or B (UVB) light may be useful for treating large areas of psoriasis. Using a narrow range of UVB wavelengths may be more effective than using broadband UVB. Some phototherapy may combine light-sensitizing medications such as tar treatments or the oral medication psoralen plus ultraviolet A (PUVA), which carries a higher risk of skin cancer. Excimer laser is another option that uses a controlled UVB light beam to treat only the psoriasis plaques, leaving healthy skin unaffected.

- **Oral or injected drugs** — If your psoriasis is severe or resistant to topical or phototherapy treatments, systemic medications may be recommended. Some may be used only for brief periods due to severe side effects, including the anti-cancer medicationmethotrexate (Rheumatrex, Trexall), vitamin A-related retinoids such as acitretin (Soriatane CK) and the anti-rejection drug cyclosporine. Several immune-modulating drugs (biologics) have recently become available. They may be considered for moderate to severe psoriasis that hasn’t responded to other drugs.
Telomeres and health

Keeping your DNA happy

When it comes to your chances of developing a certain disease, risk factors are usually in one of two categories — those you can control, and those you can’t. DNA contained in your genetic code is usually considered a potential risk factor over which you have no control.

However, new research into the protective end caps (telomeres) of your DNA-filled chromosomes is revealing that you may have some control over your genetics after all. Telomeres are the protective end caps on the ends of every chromosome. They’re often likened to the plastic ends on a shoelace that help keep the shoelace from unraveling. In the same way, telomeres keep the DNA within a chromosome from unraveling or becoming damaged — or from accidentally linking end to end with another chromosome.

While you can’t change your DNA sequence, you may be able to influence your telomeres — and therefore the vitality of chromosomes and the DNA contained within them.

Telomere health appears to be most enhanced by a healthy diet, exercise and stress management. This suggests that a healthy lifestyle may be protective down to the very essence of your being.

The great divide

When a cell divides, the DNA-containing chromosome within the nucleus of the cell copies itself. Then, one strand of the chromosome goes to each of the two new cells. That way, each cell within your body has a copy of your full genetic code. When your chromosomes are healthy, cells can divide when needed to facilitate the healing and renewal of tissues, such as organs and muscle, body fluids such as blood — and nearly every other aspect of your body.

However, every time a cell divides, the telomere at the end of each chromosome gets slightly shorter. If a telomere gets shortened to a certain point, a signal is sent to the cell to stop dividing. In a controlled laboratory setting, a cultured human cell will divide about 50 times before the telomere becomes short enough to stop further division.

Cells with shortened telomeres may also lead to damaged chromosomes and genetic instability. This may spark tumor growth. Early research has linked shorter telomere length in humans with conditions such as high blood pressure, less healthy cholesterol levels, cancer, heart disease and early death.

Gradual telomere shortening with cell division sounds like a tidy, if fatalistic, process. But it’s not. You can’t just look at people’s telomere length and calculate their age. However, telomere length is emerging as a marker for how advanced you, or specific tissues within your body, are in the process of aging. This may partly help explain why some people seem to age quicker or develop certain diseases sooner than do others.

Related research indicates that telomere shortening can be accelerated. Conversely, shortening can be slowed, stopped or even reversed.

Stress appears to play an important role in accelerated telomere shortening — particularly stresses of:

- Inflammation, which appears to inhibit an enzyme (telomerase) that can maintain or lengthen telomeres
- Oxidative damage, which increases the amount of shortening that occurs when a cell divides

The most common causes of inflammation and oxidative damage are an unhealthy diet, lack of exercise, obesity, diabetes, smoking, sunlight exposure and unmanaged emotional stress.

When it comes to telomere maintenance and lengthening, telomerase is key. Researchers have theorized that fully functioning telomerase may be as important a factor as telomere length when it comes to aging and disease risk.

Preliminary research shows that a healthy lifestyle can increase telomerase activity. In one study, a three-month program that involved a plant-based diet, 30 minutes of brisk walking six days a week, and stress management therapy, yielded a 29 to 84 percent increase in telomerase activity.

A fountain of youth?

It’s hoped that telomere length can one day be a helpful predictor of disease, but questions remain. For example, research at Mayo Clinic has found that among adults younger than 50, those with very short — and unusually long — telomeres were at significantly higher risk of developing colon and rectal cancers. Additionally, it’s hoped that manipulation of telomeres may one day be a way to prevent or even treat disease.

Still, cause-and-effect relationships between telomeres and disease have yet to be proved. In addition, a telomerase “supplement” — if one were to be developed — may not be a fountain of youth. Telomerase may help repair, maintain and lengthen telomeres of healthy DNA, but it may also help protect the damaged DNA of a cancerous cell.

Until more is understood, it can be comforting to know that far out on the frontiers of science, new discoveries appear to be pointing toward the importance of a healthy lifestyle.
Q: A while back, my doctor prescribed several new drugs for me. A week later, I broke out in a rash. I stopped taking the drugs, and the rash went away. Since then, my doctor seems to be having a hard time figuring out which drug caused the problem. Isn’t there a better way?

A: Maybe not. Finding out which drug is responsible for a drug rash can be challenging, especially if you are taking multiple drugs.

Any medication can produce a drug rash, which is an allergic reaction to a medication. Some of the most common culprits include antibiotics, anti-seizure medications and nonsteroidal anti-inflammatory pain relievers, such as ibuprofen. The rash usually starts within the first days to weeks of taking a new medication and begins as discrete red dots that spread, often covering large areas of the body.

The solution to a drug rash often is to stop taking the drug that caused it. When you do, the rash usually goes away over the course of one to three weeks, but can take up to six weeks. Still, this may not be as simple as it sounds.

Clues to identifying the offending drug may include the characteristics of your rash, the known and common reactions to certain drugs, your medical history, and possibly the results of skin allergy testing. You and your doctor will probably need to review every drug you’ve taken recently, including nonprescription medications or supplements, eyedrops, nose drops, or suppositories. Any of these substances could have caused the rash.

Additionally, your doctor may ask you to stop taking noncritical medications, especially if you’ve recently started taking them. In some cases, your doctor may be able to substitute the offending drug for another that does the same thing, but with different chemical components.

The rash may subside after these steps. If your doctor feels that it’s important to get you back on the drugs you’ve stopped taking, you’ll likely need to try adding the discontinued drugs one at a time — possibly starting at a low dose and if needed, increasing to a full dose — to see if the rash returns.

Q: I’ve heard that skin cancer is slow to develop. I’m 78 years old. At my age, do I really need to wear sunscreen and otherwise protect myself from the sun?

A: Yes. Ultraviolet (UV) radiation from the sun can damage skin cell DNA, leading to a mutation of cell genes that can turn a normal cell into a cancerous one. This DNA damage can happen at any age. Your immune system can usually repair damaged DNA, but overexposure to UV radiation can suppress your immune system. This makes it harder for your skin to protect itself from cancer development.

As you suggest, skin damage may be slow to develop. Damage that occurred when you were young may not become apparent until midlife or later. In addition, the most common forms of skin cancer are typically slow growing and highly treatable.

But don’t let this lull you into a false sense of security. One in five Americans will develop skin cancer at some point in life, and not all forms of skin cancer are slow-growing and easy to treat. In addition, your risk of developing skin cancer increases with age because of the accumulating effects of sun damage over time. It may take several episodes of damage to your DNA to cause a cancer. You can’t go back in time to prevent previous damage, but you may be able to prevent the last critical piece of damage that could tip a cell to becoming cancerous.

Simply put, you never know when a certain instance of UV exposure will cause DNA damage that goes on to become cancer.

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