Polymyalgia rheumatica

Treatment produces dramatic pain relief

The sudden and deep ache in the muscles of your shoulders defies explanation. It hurts to comb your hair or put on a jacket. On top of that, getting out of bed has become increasingly difficult the last few days as pain and stiffness have now settled into your hips and upper legs. Maybe this is some new form of flu — you feel as if you’ve aged 20 years in just a matter of days.

Actually, your doctor suspects the problem may be a treatable inflammatory disorder called polymyalgia rheumatica (pol-ee-my-AL-juh rheo-MA-tih-kah). As debilitating as the pain can be, proper treatment can often improve the symptoms in a matter of days or even overnight. Keeping the disorder in check as it subsides usually involves careful medication management over one to two years, and sometimes longer.

Behind the inflammation

Inflammation is your body’s usual response to injury or disease. But in some disorders — known collectively as rheumatic diseases — inflammatory activity erupts where there’s

Signs and symptoms of polymyalgia rheumatica

- Aches or pain in your shoulders
- Aches or pain in your neck, lower back, buttocks, hips or thighs
- Stiffness, especially in the morning
- Limited range of motion in affected joints
- Upper arm tenderness
- Less commonly, pain or stiffness in your wrists or knees
- Possible low-grade fever early on, as well as fatigue, appetite loss, weight loss, depression

Voices of Mayo Clinic

Health Letter
Recognizing giant cell arteritis

Giant cell arteritis is an inflammatory disorder that occurs in the same people who are at risk of polymyalgia rheumatica. As many as 60 percent of people who have giant cell arteritis may have polymyalgia rheumatica symptoms at the same time. In giant cell arteritis, the inflammation affects the lining of large- and medium-sized arteries. Typically, arteries of the scalp and head are involved, especially those located over your temples (temporal arteries). Large vessel involvement of the aorta or vessels off the aorta also are a concern.

Signs and symptoms of giant cell arteritis vary. Most commonly, you may experience new and marked headaches. Among other indicators of the disorder are scalp tenderness and jaw-muscle pain when chewing. If you have polymyalgia rheumatica and have any of these symptoms, it’s critically important to let your doctor know right away. Visual changes are possible if blood vessels that supply the eye become affected. If you experience changes such as blurring, double vision and even sudden blindness, seek a prompt emergency evaluation.

When giant cell arteritis is suspected, a diagnosis is made by taking a small tissue sample (biopsy) from the temporal artery and checking for signs of inflammation. Occasionally, more than one biopsy is done because there may be areas where the artery isn’t inflamed. Blood tests also may be done to confirm the diagnosis.

Due to the risk of vision loss and possible stroke, treatment of giant cell arteritis is started as soon as possible. To begin, high daily doses of prescription corticosteroids — typically 40 to 60 milligrams of prednisone — are taken for about a month before being slowly decreased. Symptoms quickly subside. As improvements in your symptoms and blood tests occur, corticosteroid doses are tapered accordingly. Often, corticosteroids can be discontinued after a year or two.

As with polymyalgia rheumatica, you can expect to work closely with your doctor to manage side effects related to long-term corticosteroid use. Preventing osteoporosis and decreasing the risk of fractures are particular concerns with long-term corticosteroid use.
Most people who develop polymyalgia rheumatica are older than 65 — rarely does it affect people younger than 50. The disorder is more common in women.

Research suggests that a combination of inherited and environmental factors may contribute to the development of polymyalgia rheumatica. It’s most common in people of Northern European heritage — in particular, those of Scandinavian descent — and may run in families. Patterns where new cases of polymyalgia rheumatica appear in cycles suggest there may be some connection with the normal cycle of contagious viral diseases.

Quick relief

If polymyalgia rheumatica is suspected, certain blood tests can be helpful in making a diagnosis and beginning a treatment plan. An erythrocyte sedimentation rate (ESR) — commonly referred to as a sed rate — reflects changes in red blood cells (erythrocytes) related to inflammation. An elevated sed rate indicates the inflammatory response of your immune system is heightened. Another blood test measures the concentration of C-reactive protein, which increases when there’s inflammatory activity.

The primary treatment for polymyalgia rheumatica is a low dose of an oral corticosteroid, such as prednisone. Treatment typically begins with a daily dose of 15 to 20 milligrams of prednisone. A corticosteroid regimen usually produces relief from pain and stiffness within the first two or three days. Then, about two to four weeks into treatment, the corticosteroid dose is gradually decreased based on improvements in your symptoms and follow-up blood test results. However, if symptoms of polymyalgia rheumatica return, it may be necessary to temporarily increase the corticosteroid dose.

Side effect concerns

The goal in managing treatment of polymyalgia rheumatica is to keep your corticosteroid dose as low as possible. Most people with the disorder need to continue corticosteroid treatment for one to two years, and sometimes longer. Because long-term use of these drugs can result in a number of serious side effects, you can expect frequent follow-up visits with your doctor to monitor treatment effects and watch closely for any potential problems. Your doctor may adjust your corticosteroid dosage and prescribe treatments to help manage associated problems.

Among possible side effects related to corticosteroid treatment are a loss of bone density and weakening of bones (osteoporosis). To help reduce the risk of bone fractures, your doctor may prescribe calcium and vitamin D supplements.

Other side effects of long-term corticosteroid use that may require treatment include:

- High blood pressure, which increases the risk of cardiovascular and kidney disease
- Diabetes, which can cause tissue damage in a number of body systems due to chronic high levels of blood sugar
- Cataracts, which can significantly impair your vision
- Depression or other emotional disturbances

Resolution

With proper diagnosis and treatment, the life expectancy of someone treated for polymyalgia rheumatica is generally the same as for anyone else of the same age. Although corticosteroid therapy is an effective treatment, it can cause serious side effects. Newer medications that target specific aspects of the immune system are being studied as possible treatment options for the disorder.

Health tips

When heart failure worsens

If you have heart failure, diet, medications and a healthy lifestyle can prevent or slow progression and improve symptoms such as fatigue, breathlessness and leg swelling. But if symptoms worsen, talk to your doctor. Treatable problems can contribute to worsening heart failure, including:

- **Uncontrolled high blood pressure** — Carefully selected medications to lower high blood pressure often can improve heart failure symptoms.
- **Drug side effects** — Pain medications as well as some drugs used for high blood pressure and heart rhythm disorders can worsen heart failure.
- **Sleep apnea** — Treating nighttime breathing problems can improve symptoms.
- **Heart rhythm problems** — The most common is atrial fibrillation. Drugs or various procedures may help.
- **Thyroid problems** — These include overactive and underactive thyroid glands.
- **Coronary artery disease** — This can reduce blood flow to heart muscle, limiting your ability to exercise or be active. Medications, heart stents or coronary artery bypass surgery may help.
- **Worsening kidney function** — This can cause increases in body fluid volume and contribute to progression in congestive symptoms. Medications may need to be adjusted if this occurs.
Non-Hodgkin’s lymphoma

Keeping it in check

Lymphomas are types of cancer that develop when abnormal infection-fighting white blood cells (lymphocytes) begin to multiply out of control and become abnormal. Although the disease often starts in the lymph nodes, it can spread to other parts of your lymphatic system — including lymph vessels that branch out into tissues throughout your body, or the tonsils, adenoids, liver, spleen and bone marrow — and occasionally to organs outside the lymphatic system.

There are two general types of lymphoma — Hodgkin’s and non-Hodgkin’s lymphoma. Non-Hodgkin’s is more common and involves a different type of lymphocyte than does Hodgkin’s. It occurs most frequently among older adults.

Thanks to treatment advances, some forms of non-Hodgkin’s lymphoma can sometimes be cured or sent into remission. Therapy for low-grade (indolent) forms of the disease usually won’t lead to a cure, but the disease often can be kept in check for many years.

Narrowing to diagnosis

Signs and symptoms of non-Hodgkin’s lymphoma vary and sometimes are the same as those caused by a less serious condition, such as a cold or flu virus. A painless swelling of neck, underarm or groin lymph nodes is the most common sign of indolent forms of non-Hodgkin’s lymphoma.

Swollen lymph nodes that can’t be explained by an infection or illness may prompt additional testing for the disease. If you have lymphoma, your lymph nodes may feel rubbery and may be getting larger.

Diet high in potassium may deter stroke

Diets that are high in potassium are associated with lower stroke rates, according to a study published in the March 8, 2011, issue of the Journal of the American College of Cardiology.

Researchers compared findings from 11 different studies. The studies included data related to regularly eating potassium-rich foods and the association this might have with cardiovascular events. Their analysis showed that an additional 1.64 grams of daily potassium — or about three pieces of fruit high in potassium — was associated with a 21 percent lower risk of stroke. Those eating the additional dietary potassium also had a lower risk of coronary artery disease and overall cardiovascular disease.

The authors of the analysis suggest the results might be connected to potassium’s known effect of lowering blood pressure. That effect is especially notable in people who have high blood pressure and in people whose diets are high in sodium. Potassium blunts the negative effects of sodium on blood pressure.

Mayo Clinic doctors say the best approach is to eat more fruits and vegetables in general. Unless you have a condition — such as kidney disease — in which potassium consumption should be restricted, aim for at least five or six servings of fruits and vegetables a day. Focus on those that are particularly high in potassium, such as bananas, tomatoes, oranges, and many legumes and beans.

Biological leukemia treatment shows breakthrough potential

Although treatment of chronic lymphocytic leukemia (CLL) has advanced rapidly in recent years, for some people the disease isn’t responsive to therapy and options for treatment may be limited.

But researchers may have found a new way to destroy CLL that’s resistant to other therapies. In a case report published in the Aug. 25, 2011, issue of The New England Journal of Medicine, killer T cells were biologically altered to seek and destroy cancerous immune B cells.

After being treated with chemotherapy and antibodies to decrease the number of CLL cells in the patient’s body, a low dose of the biologically altered T cells were infused. The altered T cells began multiplying, to more than 1,000 times the level infused.

At two weeks, the patient developed flu-like symptoms, suggesting an immune response. It was determined that the illness was the result of killer T cells destroying cancerous B cells. Soon, swollen lymph nodes returned to normal and bone marrow tested free of CLL. Remission of CLL was ongoing 10 months after therapy started.

Mayo Clinic experts feel that this is an important step in developing immune therapy for people with CLL and other cancers. The study shows that genetically modified immune cells from people with cancers such as CLL could mount an effective immune response resulting in long-term disease control. However, this therapy will have to be tested further to ensure that it’s effective and safe.

News and our views
Aggressive forms of non-Hodgkin’s lymphoma are more likely to cause fever, excessive night sweating, fatigue, loss of appetite and weight loss. A physical exam and blood and urine tests can help rule out other causes or point to non-Hodgkin’s lymphoma.

Definitive diagnosis of non-Hodgkin’s lymphoma is typically made from a lymph node biopsy, which involves surgically removing all or part of a lymph node. The lymphocyte cells in the sample are examined in the laboratory for evidence of lymphoma, and whether it’s Hodgkin’s or non-Hodgkin’s type. Further, cells in the sample can be classified into one of the more than 30 subtypes of non-Hodgkin’s lymphoma. This may include studying factors such as:

- Which types of lymphocyte — B cells or T cells — are affected
- Genetic profiles or abnormalities of the lymphoma cells
- What types of markers are present on the surface of the cells

Tests also are done to stage the disease, which means finding where lymphoma cells are located in your body, such as in the lymph nodes in your chest, abdomen and pelvis. This may involve looking throughout the body for evidence of disease using imaging tests, such as X-rays, computerized tomography (CT) scans, magnetic resonance imaging (MRI) and positron emission tomography (PET) scans. A bone marrow biopsy is often done to check for spread of lymphocytes to bone marrow, and other tests may look for evidence of disease in other organs or tissues.

The process may seem overwhelming, but accurate results guide treatment, which can vary dramatically depending on your lymphoma subtype, the stage of your disease and your health. The goal of most non-Hodgkin’s lymphoma therapy is to kill as many lymphoma cells as possible, and send the disease into partial or full remission.

In those with small amounts of slow-growing indolent lymphoma with no symptoms, a watch-and-wait approach may be best. This approach may also be appropriate for those with widespread but stable lymphoma when treatment options aren’t likely to lead to a cure.

Watch and wait involves frequent checkups to monitor disease progression. You may be able to forgo potentially arduous treatment for months to years, with little impact on your long-term survival.

The treatment choice

Treatment for non-Hodgkin’s lymphoma can be intricate and individualized to the characteristics of your disease. Sometimes, initial treatments may cure the disease. At other times, particularly with indolent disease, lymphoma may come back after remission, and new drugs or treatments may be needed. The range of treatments for non-Hodgkin’s lymphoma includes:

- **Chemotherapy** — This is often a combination of drugs — given orally or by injection — that kills cancer cells. Chemotherapy often is combined with other treatments.
- **External radiation therapy** — With this, radiation is directed at precise points to kill cancerous cells and shrink tumors. Radiation can be used alone or in combination with other cancer treatments.
- **Biological drugs** — Rituximab (Rituxan) is a common therapy for the treatment of B-cell lymphoma. Rituximab is a type of monoclonal antibody that attaches to B cells and makes them more visible to the immune system so that it can attack them. Rituximab lowers the number of B cells, including your healthy B cells, but your body produces new healthy B cells to replace these. The cancerous B cells are less likely to recur.

Radioimmunotherapy drugs are also made of monoclonal antibodies that carry radioactive isotopes. This allows the antibody to attach to cancer cells and deliver radiation directly to the cells. Two radioimmunotherapy drugs — ibritumomab (Zevalin) and tositumomab (Bexxar) — are approved for use in people with recurrent lymphoma.

- **Stem cell transplant** — With this, chemotherapy is used to destroy or weaken cancer cells and your immune system. Then, healthy blood stem cells — from yourself or someone else — are infused into your body. The stem cells migrate to your bone marrow and begin creating new bone marrow, blood cells — including lymphocytes — and platelets.

Health support

Non-Hodgkin’s lymphoma and treatment for it can take a toll. Part of caring for this disease involves attention to side effects or complications of the disease or treatment.

This includes being on guard against infections by preventing them and getting treatment if one occurs. Fatigue from diminished red blood cells is common. Drugs or blood transfusions can help.

A healthy diet and engaging in some form of exercise may help you feel better during treatment. □
Costochondritis

Chest wall pain

Spending time at the emergency room wasn’t in your plans. Fortunately, the doctors determined that the sharp pain in your chest has nothing to do with your heart. Instead, the pain is in your chest wall, and it’s due to inflammation in the rubbery cartilage that connects one of your ribs to your breastbone (sternum).

This type of chest wall pain is called costochondritis (kos-toe-kon-DRY-tis). Treatment focuses on easing the pain while the tenderness improves over time.

Rib connections

Ribs consist of cartilage and bone. The cartilage serves as an elastic bridge between the bony portions of your ribs and your sternum. As a result, your rib cage can expand and contract, such as when you breathe in and out.

Costochondritis is a common cause of chest pain that may come on suddenly or gradually. It occurs most often in women and in people older than 40. However, it can affect anyone, including children. Signs and symptoms may include:

- A specific area of pain and tenderness, usually on one side of your breastbone, in one or more of the places where your ribs attach to your breastbone (costosternal joints)
- Pain that’s usually sharp, although it may be a dull or gnawing pain in your breastbone that doesn’t improve with time
- Pain with deep breaths
- Pain when coughing
- Pain that intensifies when you raise your arm

In most instances, there’s no apparent cause for the pain and tenderness that originates in one or more costosternal joints. If the pain and tenderness occur with swelling, it’s called Tietze’s syndrome. Tietze’s syndrome is rarer than costochondritis, and most of the time it affects just one rib. There’s some controversy over whether the two are distinct disorders.

The pain of costochondritis can be very similar to the pain associated with heart disease, lung disease, gastrointestinal problems and osteoarthritis. Your description of the pain and what makes it feel worse or better helps your doctor narrow down a cause. During the physical exam, your doctor may feel along your breastbone for any specific areas of tenderness or swelling.

Although costochondritis generally can’t be seen on chest X-rays or other imaging tests, these tests and others may be done to rule out other possible causes.

Pain relief while biding time

Costochondritis usually goes away on its own and is short-lived, although in some cases it may last several months or longer. As for the swelling associated with Tietze’s, it may persist even after the pain and tenderness have let up.

In the meantime, if your symptoms are mild and there’s no swelling, nonprescription painkillers may help. If pain isn’t controlled with any of these, your doctor may prescribe similar pain relievers at stronger doses depending on your health. Another option may be topical prescription medications, available in different forms.

If you’re experiencing ongoing chronic pain, other medications that may be prescribed include:

- **Tricyclic antidepressants** — Low-dose tricyclics such as amitriptyline, nortriptyline (Pamelor) or imipramine (Tofranil) taken at bedtime may be of help.

- **Tramadol (Ultram)** — This drug can help relieve pain, but should be taken only on an as-needed basis. Among side effects, tramadol can be associated with nausea, extreme tiredness, constipation and seizures.

- **Selective serotonin and norepinephrine reuptake inhibitor (SSNRI)** — This type of antidepressant may be an alternative if other health conditions, such as heart rhythm problems, preclude the use of tricyclics.

In instances of severe pain, a mixture of corticosteroids and a local anesthetic may be injected into the pain site. X-ray or ultrasound may be used to help guide placement of the needle. This must be done with caution and requires a physician experienced in performing the procedure.

Chest pain conundrum

There’s every reason to seek emergency medical help if you experience new or unexplained chest pain or pressure that lasts for more than a few moments. Don’t waste any time for fear of embarrassment if it’s not a heart attack. Even if your chest pain turns out to be something other than your heart, you need to be seen right away.

For pain that’s less alarming, or tenderness in your breastbone that isn’t improving, it’s reasonable to make an appointment with your doctor to determine cause.
Chronic cough

First, find the cause

Coughing is a normal reaction to irritants in your respiratory system. Coughing forcefully expels foreign bodies, mucus and other irritants, such as pollution, from your throat and clears them from your airway.

However, when a cough lasts too long, it may be a sign of an underlying problem or disease. Moreover, coughing itself becomes a problem. The forces exerted on your body by persistent coughing can result in direct physical problems — such as damage to your vocal cords, rupture of small blood vessels in your airway, fainting spells, hernias or even broken ribs. It can harm the quality of your life, sleep and social life, contribute to embarrassing urinary or fecal incontinence, as well as cause anger and embarrassment over a problem that won’t go away.

When a cough lasts longer than six to eight weeks, it’s considered a chronic cough. Diagnosing the cause can be time-consuming, but is usually a critical first step.

Common causes

Finding the cause of a chronic cough involves systematically eliminating probable causes through history taking, testing and trying different treatments. Common causes of chronic cough include:

- **Postnasal drip** — This is a sensation of mucus trickling from the back of your nose down into your throat. It may be due to hay fever, allergies or irritants. How postnasal drip causes a cough is still not clearly understood. In some cases, this sensation may not even be noticed. In chronic cough, postnasal drip may be due to inflammation of your nasal passages including your sinuses.

- **Asthma** — While unusual, this may occur only as a cough. This is known as cough variant asthma. It doesn’t necessarily mean that you will develop chronic asthma with wheezing.

- **Gastroesophageal reflux disease (GERD)** — In this, stomach acid and digestive enzymes and bile back up (reflux) into your esophagus. It may reach up to the voice box. In severe cases, reflux material may get into the lungs. These substances are irritating to your respiratory tract and may trigger a cough.

Coughing itself may cause acid reflux, turning it into a vicious cycle. While heartburn is common in reflux, not everyone with reflux experiences it. Hoarseness, throat clearing, the sensation of a tickle in the throat and cough — usually when in an upright position — may be associated with GERD affecting the throat. This is called laryngopharyngeal reflux (LPR).

- **Pertussis** — Chronic cough may be due to an unrecognized case of whooping cough (pertussis).

- **Angiotensin-converting enzyme (ACE) inhibitors** — Taken to lower blood pressure, drugs in this class include enalapril (Vasotec), lisinopril (Zestril) and others. Chronic cough can occur long after these drugs have been started. And, it may take two to three weeks for a cough to improve after stopping these medications.

- **Lung disorders** — Chronic cough can be caused by airway damage called bronchiectasis, and by a condition that causes asthma-like symptoms, but with normal lung function (eosinophilic bronchiolitis).

In smokers, persistent cough and phlegm production (chronic bronchitis) is common. Throat or lung cancer also may be suspected in a smoker or former smoker who has a chronic cough that changes abruptly or lasts for more than one month following smoking cessation, coughs up blood or has voice changes.

Treating the cause

Usually, chronic cough can be stopped by treating an underlying cause. In about 90 percent of cases, the underlying cause is postnasal drip, asthma or GERD. If sinus disease or reflux is thought to be the cause, treating them may help determine if they really are. Sometimes, there can be more than one cause that needs to be addressed at the same time to control the cough. Depending on your diagnosis, treatment may include:

- **Antihistamine allergy medications and decongestants** — These are standard treatments for postnasal drip. If you can identify a trigger of allergies that causes nasal symptoms, avoiding that trigger may be helpful. Nasal corticosteroid sprays also may be of value.

- **Inhaled asthma medications** — These reduce inflammation and spasms and widen your airways.

- **Drugs to suppress stomach acid** — These help manage acid reflux. Additional measures for reducing acid reflux include losing weight if you’re overweight, eating meals three to four hours before lying down for bed or elevating the head of your bed a few inches. They don’t stop the reflux, but they do suppress the acid part of the reflux.

- **Antibiotics** — If your coughing is suspected of being caused by a bacterial infection, such as a persistent sinus infection or a lung infection, antibiotics may help.

- **Not smoking and avoiding secondhand smoke** — In addition to causing chronic bronchitis, smoking irritates your lungs and can worsen coughs from other causes.

If no cause for your cough is found, or if the cause can’t be effectively treated, drugs may be prescribed to suppress the cough, loosen mucus or relax airways.
Second opinion

Q: I throw out leftovers that have been in the refrigerator for a week or so, even if they don’t smell bad. My husband says I’m wasting. When should leftovers be tossed?

A: Begin by handling leftovers properly. After meals, promptly refrigerate or freeze leftovers in shallow containers. Avoid having perishable foods at room temperature for more than two hours — or above 90 F for more than one hour. By refrigerating or freezing promptly, you minimize the time food is in the “danger zone” of 40 to 140 F, in which bacteria can quickly multiply.

The Department of Agriculture recommends refrigerated, properly stored leftovers be eaten within four days to minimize risk of food poisoning. If you want to save food longer, freeze it right after the initial meal. Potentially harmful bacteria typically won’t change the taste, smell or appearance of food — at least early on. Therefore, you can’t determine if food is safe to eat by smelling or tasting it.

Reheat leftovers so that the internal temperature reaches 165 F to kill any bacteria. When using a microwave, stir or rotate food halfway through reheating to eliminate cold spots. Reheat sauces, soups and gravies to boiling. Thoroughly heating leftovers won’t necessarily make up for ignoring safe-storage tips, because some types of bacteria produce toxins that aren’t destroyed by cooking.

Q: I’ve read that too much vitamin A can weaken bones. How much is too much?

A: You’re correct — studies indicate that excess vitamin A stored in the body may increase the risk of reduced bone mineral density and lead to osteoporosis. For women, 700 micrograms (mcg), or 2,330 international units (IU), of vitamin A are recommended a day. For men, the daily recommendation is 900 mcg, or 3,000 IU. Most Americans easily reach this goal without any supplementation.

Virtually all evidence of increased risk of bone weakening from vitamin A is due to a form of vitamin A called preformed vitamin A, which comes from:

- Foods derived from animals, such as liver, eggs and milk
- Dietary supplements or foods fortified with vitamin A acetate or vitamin A palmitate

A large study of postmenopausal women found that long-term intake of at least 2,000 mcg, or 6,660 IU, of preformed vitamin A from these sources may increase risk of hip fracture.

In contrast, carotenoids such as beta carotene are another form of vitamin A — called provitamin A — because your body converts it into active vitamin A. Beta carotene hasn’t been linked to bone weakening. Sources of beta carotene include plant foods such as sweet potatoes, carrots and kale. Beta carotene may also be used in certain vitamin supplements or in fortified foods.

Avoid excessive amounts of vitamin A by eating little if any animal liver. If you take a daily multivitamin, check the label for one that contains vitamin A from beta carotene and contains no more than the Recommended Dietary Allowance. You may also want to reduce your intake of fortified food sources of vitamin A acetate or palmitate.

Notably, 1 cup of skim milk is typically fortified with 500 IU, or 152 mcg, of vitamin A palmitate. Drinking 2 or 3 cups of milk daily to help meet your calcium requirements would leave you well below the amount of vitamin A that may increase hip fracture. By consuming a few other foods that contain preformed vitamin A and generous amounts of plant foods high in provitamin A carotenoids, you can easily meet your needs.

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