Aortic aneurysm

Safer surgery for bulging abdominal artery

Doctors have been monitoring the bulge (aneurysm) in your aorta — the main artery in your abdomen — for several years. Although it's been growing slowly, it's now large enough that surgical repair is recommended. Since the aneurysm is in your abdominal area, you imagine repairing it will require a large incision in your belly and a long recovery time.

However, you’re surprised when your surgeon recommends a procedure that won’t require an abdominal incision. In fact, it may not require an incision at all. And you’ll likely be out of the hospital the day after the procedure.

Not long ago, open surgery to repair aortic aneurysms was the go-to procedure for most people. Now, for about 60 percent of those requiring aortic aneurysm repair, the repairs are made using instruments and devices that are fed into the aorta through a small incision in the groin area — or through a small puncture hole in the lower abdomen that’s closed with a simple adhesive bandage and no stitches.

These surgical improvements — in addition to improving management of aortic aneurysms — have led to a 36 percent reduction in deaths from the condition in the past decade.

An aneurysm occurs when one or more areas along the wall of the aorta become weak or damaged. They most commonly occur in the abdomen (abdominal aortic aneurysms). With minimally invasive endovascular surgical repair, a collapsed synthetic graft (endograft) is inserted into the aorta and expanded and secured into place.
A weakened artery

Your aorta exits the top of your heart and curves downward through the chest and abdomen. It’s the largest artery in the body, with other major arteries branching off it to supply blood to the brain, arms, internal organs and legs.

An aneurysm occurs when one or more areas along the wall of the aorta become weak or damaged. They most commonly occur in the abdomen (abdominal aortic aneurysms). Less commonly, they can develop in the chest (thoracic aortic aneurysms).

Over time, the constant pressure of blood flowing through the weakened area can cause a section of the artery to enlarge. Most aneurysms are small and slow growing, and they only rarely cause symptoms such as a pulsing sensation near the navel or tenderness or pain in the abdomen or back. They’re often discovered when an X-ray, ultrasound or computerized tomography (CT) scan of the chest or abdominal area is done for another reason.

The main danger of an aortic aneurysm is that it may burst or tear and cause life-threatening internal bleeding. This may feel like a sudden ripping sensation between your shoulder blades or down your back to your groin. The pain can be intense but can also feel dull and may be accompanied by a clammy, lightheaded feeling.

A bursting aortic aneurysm is fatal 80 to 90 percent of the time and requires emergency care. Small aneurysms have a very low risk of rupture. As the size of the aneurysm increases to more than 5 centimeters (cm) for women and 5.5 cm for men, the risk of rupture climbs rapidly.

Upon discovery

If you have an abdominal aortic aneurysm that’s discovered inadvertently during a test for something else, further evaluation of the aneurysm is usually needed to determine its size and growth rate. Although aneurysms never heal and return to normal aorta tissue — and many will grow large enough over time to require surgical repair — it’s not always necessary to perform surgery as soon as they are discovered.

Aortic aneurysms that are less than 4.5 cm and growing at a rate of less than half a centimeter a year are typically managed with a “watch and wait” approach. Once or twice a year, imaging tests will be done to assess aneurysm size and growth rate. The frequency may vary, depending on your situation.

You may be able to minimize aneurysm growth and the already-small risk of rupture — and maximize your overall artery and heart health — by:

■ Stopping smoking and avoiding secondhand smoke.
■ Addressing hypertension and cholesterol levels, which may require a combination of improving your diet, exercise and certain medications.
■ Getting regular, moderate exercise, such as 30 minutes of brisk walking five days a week. Avoid long periods of strenuous activity that could cause prolonged elevation of your blood pressure.

Considering surgery

Often, surgical repair is recommended when an aneurysm reaches a size of 5 cm in women and 5.5 cm in men, or if it’s growing quickly or causing symptoms. Aneurysms between 4.5 and 5.5 cm fall into a gray area where careful consideration of your circumstances is necessary to make a recommendation of surgery or further waiting and waiting.

Surgical options may include:

■ Open surgery — This is done through an abdominal incision. The aorta is clamped off, and the damaged section of aorta is replaced with a synthetic tube (graft), which is sewn into place.

Open repair results in a very durable fix requiring minimal follow-up. Because of this, it’s often still preferred for younger people. Open surgery may

Risks and screening

Two of the most important factors that put you at risk of developing an aortic aneurysm are smoking — which weakens and damages artery linings — and having a family history of aortic aneurysm.

Aging also is a risk factor — most aortic aneurysms occur in adults older than 60 — as are high blood pressure (hypertension) and artery clogging and hardening (atherosclerosis). Generally, people with abdominal aortic aneurysms are found to have more than one risk factor.

Aortic aneurysms are too rare to warrant widespread screening. However, a one-time ultrasound screening test is recommended for men age 60 and older who smoke or who have a history of smoking.

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be necessary if you have unusual artery anatomy that doesn’t match available endovascular graft options. Other situations, such as an infected aneurysm or a failed endovascular graft, are additional indications for open repair.

The main downsides of open repair include higher risk of complications and the fact that it’s very hard on the body. Recovery from open repair often involves five or more days in the hospital, and several weeks of gradual recovery after that.

- **Endovascular repair** — With this approach, a small incision or just a puncture through the skin is made in the groin area. A small tube (catheter) — through which the repair will be performed — is guided along the femoral artery into the aorta. Using X-ray guidance, a collapsed synthetic graft (endograft) is inserted into the aorta and expanded and secured into place.

Endovascular surgery is much easier on the body than is open surgery. You may leave the hospital the day after surgery, and full recovery may take only a couple of weeks. Complications from surgery also are much less likely.

The main downside of endovascular repair is the need for lifelong follow-up to make sure the graft is functioning properly. This typically involves two computerized tomography (CT) scans in the first year after surgery. After that, annual CT or ultrasound scans may be appropriate. Ultrasound scans — which cost less and don’t involve exposure to X-ray radiation — are increasingly being used in place of CT scans.

Compared with open repair, endovascular repair has a small increased risk of graft or aneurysm rupture. However, the risk is less than 1 percent with appropriate follow-up. In addition, blood vessel leaks into the aneurysm can occur. These can be plugged using an endovascular procedure or with an injection, but many are low-pressure leaks that can safely be left alone.

Endovascular repair is now the preferred option over open repair for the majority of people. New graft technology designed to fit people with unusual aorta anatomy is expanding the pool of qualified candidates.

Some new grafts have holes where kidney or bowel arteries connect to the aorta. Once the holes are positioned over the exiting artery, a small graft can be pushed through the hole to assure proper blood flow to organs.

Continued progress in the area of graft technology may some day open up the possibility of complete endovascular repair of complex abdominal aortic aneurysms.

- **Through the skin (percutaneous) repair** — This shares most of the characteristics of endovascular repair, except the small incision isn’t required, resulting in even quicker recovery time, reduced infection risk and easier mobility after surgery.

Instead, using ultrasound guidance, a hollow needle is inserted directly into the aorta below the aneurysm. This needle is used to place the repair graft and the surgical devices used to position and secure it into place.

This technique may be a possibility for about 20 to 25 percent of endovascular aortic aneurysm repairs. One limitation is that it can’t be done if the artery is diseased or calcified.

- **Hybrid repair** — In cases of unusual anatomy, surgeons know ahead of time that artificial grafts used in endovascular repair would end up blocking off arteries leading to organs such as the kidneys. The hybrid repair is an open surgical procedure that solves this problem with a smaller incision than would be required with full open repair of an aortic aneurysm.

The open part of the hybrid procedure involves placing bypass arteries that create a new route of blood flow to any organ that will have its blood supply blocked by the artificial graft.

With blood flowing through the bypass, the abdominal aortic aneurysm can be surgically repaired using an endovascular procedure, blocking off the old route of blood flow without causing harm to organs.

### Health tips

**Finding balance in Alzheimer’s caregiving**

Caring for a loved one with Alzheimer’s disease or another form of dementia can be rewarding, but also frustrating and exhausting. Sustainable caregiving often depends on finding balance between taking care of your loved one and taking care of yourself. Finding the balance may involve:

- **Acknowledging your emotions** — Caregiving can seem difficult and lonely, and you may feel anger, frustration, sadness and guilt. Accept whatever your feelings are, and seek healthy outlets for them. This might include talking with an understanding friend, meeting with a support group, journaling, meditation or going for a walk.

- **Setting limits** — Try to come to terms with the fact that you simply can’t do everything — no caregiver can. Set reasonable limits for what you can comfortably achieve in a day. If you can accept imperfection and lighten your expectations, you’ll be better able to cope.

- **Taking regular breaks** — Short breaks throughout the day are good, but arrange for a couple of longer breaks each week. During those times, do something you enjoy that’s unrelated to caregiving. Visiting with friends can help you avoid isolation.

- **Getting help** — Come up with a list of tasks that friends or loved ones can help with. Having specific requests makes it easier for others to help. In addition, visit www.communityresourcefinder.org — or call the Alzheimer’s Association at 800-272-3900 — to learn about resources in your community.
News and our views

Mindful meditation may cut risk, severity of common cold

New research suggests meditation may significantly reduce susceptibility to the common cold, and may minimize symptoms for those who do get sick.

The research, published in *Annals of Family Medicine*, involved 149 adults 50 or older who were mostly inactive and didn’t practice meditation. They were divided into three groups. One group performed a structured, moderately intense exercise program, another performed a structured program of mindful meditation, and the final group carried on as normal.

The meditation instruction was based on a program called mindfulness-based stress reduction (MBSR). Over eight weeks, students were taught a variety of meditation techniques to reduce stress, such as gentle stretching, mindful yoga and discussions aimed at enhancing awareness.

Study participants were monitored over the winter cold and flu season. Those in the meditation group had 33 percent fewer colds, and those in the exercise group had 29 percent fewer colds than did those in the group that didn’t do meditation or exercise. The duration of the colds in the meditation and exercise groups were 43 percent shorter, and significantly less severe.

Mayo Clinic doctors see this research as part of growing evidence of the benefits of mindfulness meditation. Past research has shown that it may enhance memory and learning, decrease feelings of stress and anxiety, improve sleep quality, help control blood pressure, decrease anger, and improve overall well-being. Although further research is needed to verify these results — and to learn if combining exercise and meditation might have an additive benefit — it’s possible that having a relaxed mind and a well-rested, physically fit body leaves your immune system at full strength to tackle viral infections. ☰

Zeroing in on a biomarker that may influence muscle mass

Mayo Clinic researchers have found a new link between levels of a particular protein biomarker in circulating blood and its possible relationship to age-related changes in muscle mass. The biomarker is insulin-like growth factor binding protein-2 — otherwise known as IGFBP-2.

The study was published in the October 2012 issue of *Journal of Bone and Mineral Research*. Participants included 589 men and women ages 20 to 97. Several high-resolution imaging technologies were used to measure muscle mass in participants’ arms and legs and to evaluate bone components.

The newer imaging tools used in the study offered researchers a closer look at bones’ innermost microstructures and the interplay of bone and muscle across a broad age span. These detailed measures also added to the evidence that better muscle mass is significantly associated with coinciding favorable bone structure, even at non-weight-bearing sites such as the wrist. Of particular interest was data showing that higher blood levels of IGFBP-2 were associated with lower levels of muscle mass.

Mayo Clinic researchers say the new insights concerning IGFBP-2 indicate it may be a useful biomarker for looking at the health of the musculoskeletal system. For instance, IGFBP-2 could potentially be used to identify people who are at particular risk of falls and associated fractures. For now, more study is needed to understand how this protein biomarker contributes to the upkeep or tear down of bones and muscles. ☰

Immune suppression and infections

Keeping a balance

Everyone has encountered infections. For most people, fighting off infection is routinely done with the assistance of the body’s immune system.

But if your immune system isn’t working properly — whatever the reason — then you may face a greater risk of infections. In the setting of a suppressed immune system, infection may take a dangerous turn for the worse. In some instances, unexpected (opportunistic) infections may develop and potentially become life-threatening.

Natural forces challenged

A healthy immune system consists of cells, tissues and organs that distinguish between your own cells and those that are foreign. Normally, the immune system works to ward off attacks by foreign invaders. Among the primary targets that draw an immune response are bacteria, viruses, fungi and protozoa.

Sometimes, though, the immune system can’t do its job properly — the medical term is immunocompromised. This deficiency may occur for a number of reasons, some of which include:

- Corticosteroid therapy — These anti-inflammatory drugs play an important role in treating a variety of conditions, including rheumatoid arthritis, lupus, asthma and allergies. They may be applied to the skin, injected, taken orally, or delivered by an inhaler or an intranasal spray. Normal immune function is particularly vulnerable to suppression from oral or injected corticosteroids — which act systemically throughout the body — but effects are rarely noted with inhaled corticosteroids or creams.

- Cancer treatment — Some cancers can damage the immune and blood systems. More commonly, cancer treat-
ment — chemotherapy, radiation therapy and bone marrow transplants — can suppress or weaken the immune system.

- **Autoimmune disease treatments** — In a case of mistaken identity, the immune system launches an attack on the body’s own cells or tissues. Treatments for autoimmune disease typically involve suppressing or interfering with immune system function. Autoimmune disease includes many conditions, such as rheumatoid arthritis, lupus, psoriasis and inflammatory bowel disease.

- **Organ transplant treatment** — In order to prevent rejection, transplant recipients must take drugs to suppress the immune system (immunosuppressants). These drugs reduce the immune system’s ability to fight infections and to destroy certain cancer cells, including some skin cancers, lymphoma, cervical cancer and Kaposi’s sarcoma.

In addition, certain diseases themselves — such as HIV infection, common variable immunodeficiency (CVID) and immune deficiency disorders that may be present at birth (congenital) — result in immune system compromise.

**A closer look**

Commonly used corticosteroids can have broad impact on the immune system. Systemic corticosteroids are associated with increased risk of viral, bacterial and fungal infection risk. Generally, the higher the dose, the greater the risk.

In some cases, your doctor may advise taking an antibiotic to prevent infection if high-dose corticosteroids or other immunosuppressant medications are being used. For instance, if more than 20 milligrams of prednisone is prescribed for daily use, the risk of pneumocystis pneumonia is high enough that a preventive medication is prescribed to guard against this dangerous form of pneumonia.

Infection risk may be greater when corticosteroids are used along with other immunosuppressant drugs. Some of these other drugs include:

- **Biologic therapies for autoimmune diseases, such as tumor necrosis factor (TNF) inhibitors** — TNF inhibitors are used to treat moderate to severe rheumatoid arthritis and other autoimmune disorders. People on these medications are at higher risk of infections caused by mycobacteria — which includes tuberculosis (TB) — and inhalation of fungal spores that cause histoplasmosis and blastomycosis.

If previously exposed, people on these medications are at risk of these infections being reactivated, when they otherwise would have remained dormant. Screening for some of these types of infections may be recommended prior to starting TNF inhibitor treatment. Many other biologic therapies also are associated with an increased risk of infection.

- **Immunomodulating medications for autoimmune diseases** — These cancer drugs are commonly used in much lower doses for rheumatoid arthritis and other autoimmune disorders. Use of methotrexate along with corticosteroids may play a role in the occurrence of mild to moderate respiratory tract infections and reactivation of the shingles virus (herpes zoster).

- **Anti-rejection drugs** — These are critical after organ transplant. However, their use also comes with some risk, including increased risk of viral infections — especially cytomegalovirus (CMV) infection — bacterial infections and fungal infections, such as histoplasmosis.

Opportunistic infections may develop when the immune system is significantly weakened. Examples of opportunistic infections include:

- **Pneumocystis pneumonia, a life-threatening fungal lung disease**
- **Invasive aspergillosis, a fungal infection that affects sinuses and lungs but can spread throughout the body through the bloodstream**
- **Candida esophagitis, a fungal yeast infection affecting the esophagus**
- **Cytomegalovirus, a type of herpes virus that may resemble infectious mononucleosis but which can spread to various organs including the eyes and brain**
- **Epstein-Barr virus, a widespread herpes virus that normally causes mononucleosis, but in someone with a weakened immune system it can cause lymphocyte cancers**
- **Cryptococcosis infection, caused by fungi found in soil throughout the world that may result in meningitis and other serious infections**

**Careful management**

When possible, dormant infections — such as TB and hepatitis — are identified and treated prior to use of immunosuppressant drugs. Depending on your overall health and what condition needs treatment, other drug management options may be considered to help reduce infection risks.

### Immunosuppressant drugs that may elevate infection risk

<table>
<thead>
<tr>
<th>Class</th>
<th>Drugs</th>
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<tbody>
<tr>
<td><strong>Corticosteroids</strong></td>
<td>Oral (systemic) prednisone; methylprednisolone (Medrol).</td>
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<tr>
<td><strong>Anti-rejection drugs</strong></td>
<td>Cyclosporine; mycophenolate mofetil (CellCept); sirolimus (Rapamune); tacrolimus (Prograf).</td>
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<tr>
<td><strong>Immunomodulator</strong></td>
<td>Methotrexate; azathioprine (Imuran); mycophenolate mofetil (CellCept).</td>
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<tr>
<td><strong>Biologic therapies</strong></td>
<td>Etanercept (Enbrel); infliximab (Remicade); adalimumab (Humira); golimumab (Simponi); certolizumab (Cimzia); rituximab (Rituxan); abatacept (Ocrelizumab); tocilizumab (Actemra); anakinra (Kineret).</td>
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Urinary tract infections in women

A common concern

You haven’t had a urinary tract infection (UTI) in decades. But suddenly, you can’t get to the ladies’ room fast enough. That old familiar urge to go to the bathroom followed by the painful burning sensation while urinating reminds you of past UTI symptoms.

Generally, a UTI is a bacterial infection that can affect any part of the urinary tract. It’s a common problem, especially among women. Up to 50 percent of women encounter UTIs during their lifetimes.

When treated promptly, a UTI is generally curable. Antibiotics typically play a key role in treatment, although half of UTIs resolve on their own just by drinking lots of fluids. Rarely do UTIs progress to something more serious, such as an infection of the kidney or infection of the bloodstream.

Connections

UTIs are typically caused by bacteria that live in the colon. The most common bacterium causing a UTI is a type of Escherichia coli (E. coli). The female anatomy increases risk of UTIs. Bacteria can more easily migrate from the nearby rectum or vagina to the urethra and into the bladder.

Other factors also may contribute. Sexually active women are more prone to UTIs — sexual activity is also the leading cause of UTIs. Changes associated with menopause may increase susceptibility to recurrent UTIs. The loss of estrogen results in thinning of the urethral tissue. Loss of estrogen also disrupts the vagina’s acidity level. When this happens, there can be a shift in the vagina’s balance of “good” bacteria that normally disrupt the growth of unwanted bacteria, especially E. coli.

In addition, impaired bladder emptying, urinary incontinence, obstructed urine flow due to kidney stones in the urinary tract, diabetes or immunosuppression can increase risk of UTIs. Hospitalization requiring an indwelling urethral catheter is another factor that contributes to UTI occurrence.

Bacteria may be present in urine (bacteriuria) without any symptoms of infection. This is fairly common, especially in older women who have a urinary catheter or are chronically incontinent and live in a care facility. Generally, unless there are symptoms of infection, bacteriuria isn’t treated.

Need to know

Most UTIs affect the bladder and urethra (lower urinary tract). UTIs are generally referred to as cystitis or a bladder infection. Classic signs and symptoms of urinary tract infections vary and may include:

- Frequent urge to urinate, even if passing only small amounts
- Burning sensation or pain when urinating
- Abdominal pain or pressure
- Cloudy, dark or bloody urine
- Foul-smelling urine

Most UTIs aren’t serious. But if infection moves upstream and affects the kidneys, additional symptoms can occur. You may feel tired, shaky, weak or even faint. Some people experience difficulty walking and may experience difficulty thinking clearly. Other signs and symptoms of a kidney infection include:

- Fever of 101 F or greater
- Shaking and chills
- Upper back and side (flank) pain
- Nausea or vomiting

A suspected kidney infection (pyelonephritis) warrants immediate medical care. Failure to do so can allow bacteria to enter the bloodstream (septicemia). Treatment may involve several weeks of antibiotics. If the infection is severe, hospitalization and intravenous antibiotics may be needed. Rarely, recurrent kidney infections can cause kidney scarring, leading to high blood pressure and poor kidney function. Septicemia, though even more rare, is life-threatening.

Timely care

Treatment for simple uncomplicated UTI — which means you have UTI symptoms but are otherwise in good health and nothing is blocking the urinary tract — typically includes a course of antibiotics. Which one is prescribed is based on the nature of the UTI or the strain of bacteria that’s caused the infection. Another consideration is whether the UTI is an isolated new infection or if it’s one in a series of recurrent UTIs.

If your doctor needs to confirm that you have a UTI, a urine sample may be taken to check for white blood cells, red blood cells or bacteria. A urine culture — which involves growing bacteria from your urine sample — is done less frequently. A urine culture can help identify which bacterium is causing the infection and what medication best targets that organism. If you’ve had a new sexual partner in the last few months, let your doctor know. In that case, your doctor may also check for sexually transmitted infections.

In most cases, a short-course antibiotic regimen is prescribed for simple uncomplicated UTIs. Drugs commonly recommended include:

- Trimethoprim sulfamethoxazole (Bactrim, Septra)
- Nitrofurantoin (Macrobid, others)
- Trimethoprim
- Fosfomycin (Monurol)
- Amoxicillin clavulanate (Augmentin)
- Ciprofloxacin

A topical vaginal estrogen cream may be considered for recurrent UTIs in postmenopausal women. Topical estrogen is associated with improved balance in “good” bacteria and a decrease in vaginal E. coli. Taking an antibiotic after intercourse is another option that may help some women avoid recurrent infections. If your doctor suspects an abnormality in your urinary tract, imaging studies, such as ultrasound or computerized tomography, may be done.
Happy, healthy feet

Exercises for stability

Try standing on one foot — with something sturdy close by to grab onto if you start to lose your balance.

What do you feel?

Chances are, you’ll feel just about every one of the many muscles in the foot, ankle and lower leg firing back and forth, flexing and relaxing in a coordinated way that allows you to maintain your balance.

The foot is both a durable and delicate part of your body. It plays an obvious role in how you move about — as anyone who has ever struggled to get around with an injured foot can attest. But the feet also play a less appreciated role in how you maintain your balance.

If your activity level has declined with age, the muscles of your foot and lower leg may become smaller and less strong, and tendons become weaker from underuse. This may affect your stability and may contribute to your risk of falling — or increase your risk of injuring your foot.

By merely staying as active as possible, you’re taking great strides toward keeping your feet strong and healthy. In addition, simple foot exercises you can do at home can help you maintain foot strength and flexibility.

Even happier feet

In addition to strengthening and stretching exercises, try these tips for healthy, happy feet:

■ Protect your feet with comfortable, well-fitting shoes that have a stable sole and adequate arch support.

■ Make sure there’s adequate padding in your shoes, as your body’s protective, cushioning fat pads on the bottom of your feet can diminish with age.

■ Consider wearing socks with a light amount of elastic compression to help prevent blood from pooling in the feet and lower legs. Wear socks that don’t have an extremely tight band at the top. Being active and doing foot exercises also can help get the blood pumping.

■ Try an occasional warm foot soak to ease aches and pains such as those from arthritis.

Strengthening exercises for your feet can include picking up a towel using your toes (at left) or performing heel and toe raises (below) while hanging on to something to steady yourself.
Second opinion

Q My doctor wants me to use an inhaled steroid for asthma. Why can’t I just use my quick-relief inhaler?

A Inhaled corticosteroids and quick-relief inhalers each have a different role in asthma control.

When asthma is mild, a quick-relief inhaler can help reverse airway spasms (bronchospasms), which occur when muscles around your airways become constricted. Quick-relief inhalers relax these muscles.

If a quick-relief inhaler is needed twice a week or less, asthma is typically considered to be mild and intermittent, and this type of inhaler alone may be adequate for treatment. Quick-relief inhalers are also useful for asthma that occurs only with exercise.

More-frequent asthma flares indicate two additional asthma components—airway inflammation with swelling and increased mucous secretions. Neither responds to quick-relief inhalers. Instead, what’s needed is an anti-inflammatory medicine like a corticosteroid that can stabilize the airways and make them less reactive to asthma triggers, such as cold air, viral infections and allergies.

Inhaled corticosteroids are important medications that keep more-persistent asthma under long-term control by reducing airway inflammation. An inhaled corticosteroid is delivered in small doses directly to your airways. When used as directed, this kind of medication helps keep asthma from damaging your lungs.

Inhaled corticosteroids shouldn’t be confused with systemic steroids, which are taken internally for certain conditions. Taken in high doses, systemic steroids can have multiple side effects, including weight gain, cataracts, osteoporosis and diabetes.

By preventing asthma attacks, inhaled corticosteroids can actually reduce the need for corticosteroid pills such as prednisone to treat asthma attacks. Inhaled corticosteroids aren’t habit-forming and are generally very well tolerated with minimal side effects.

Some may experience hoarseness or a yeast infection (thrush) in the mouth, which can usually be avoided by gargling and rinsing the mouth immediately after using an inhaler.

Q I understand why someone with an underactive thyroid would be fatigued, but I was diagnosed with an overactive thyroid and fatigue was my main symptom. How could I be fatigued if I have too much thyroid hormone in my system?

A When most people think of an overactive thyroid (hyperthyroidism), they correctly associate the disease with the body systems being “revved up.”

Indeed, hyperthyroidism often has signs and symptoms of that activation, including accelerated heart rate or palpitations, increased metabolism and weight loss, frequent bowel movements, and a jittery nervousness. However, being revved up can only last for so long before fatigue sets in.

People with hyperthyroidism often have poor sleep quality. On top of that, their bodily functions such as heart rate, breathing and metabolism are always racing, even when at rest. Eventually, muscles weaken and the capacity for exercise declines, further accelerating the downward spiral of fatigue. Some older adults may have heart failure related to hyperthyroidism, which may sometimes contribute to fatigue.

In extreme cases, the only apparent symptom of even severe overactivity of the thyroid gland can be profound and debilitating fatigue. This is most often seen in older adults.

Fatigue related to hyperthyroidism usually develops fairly rapidly, whereas fatigue from an underactive thyroid (hypothyroidism) usually develops so slowly that it’s sometimes hard to notice. Fatigue related to the thyroid is usually a symptom of a significant thyroid problem.

Have a question or comment?
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