HARVARD MEDICAL SCHOOL

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Nine tips for patients

Few of us like being patients, but there are ways to take charge of the situation and make the best of it.

It's no fun being a patient. You're sick or worried about being so. There's the loss of control to contend with as your illness (and the health care system) seems to take over. Even normally assertive and intelligent people find themselves "shutting down," so they can't understand new information or think clearly about important decisions. Others become irritable or downright hostile — not a great mind-set for making medical decisions, either.

On the bright side, patients now have more rights than ever before. Most doctors today neither want nor expect patients to passively follow orders. And the Internet provides vast resources to help you understand your condition and make choices.

Earlier this year, Harvard Medical School sponsored a forum titled "Taking Charge: Patient Advocacy for Yourself or a Loved One." Dr. Nancy Keating, an internist at Brigham and Women's Hospital, and Dr. George Demetri, director of the Center for Sarcoma and Bone Oncology at the Dana-Farber Cancer Institute, led the discussion. Here are nine suggestions that emerged from the forum:

1 ***Bring along a family member or close friend.*** This is perhaps the single most important piece of advice anyone can give. Patients need a second pair of eyes to look out for them and a second set of ears both to hear their concerns and to listen to the doctors and nurses. If you don't have anybody close by who can accompany you in person, ask the doctor to list someone in the medical record who should be called before crucial decisions are made or after something important has happened.

Incidentally, many doctors like patients bringing a family member or friend along. It's helpful to them to have friends or family members of the patient who can listen carefully and perhaps help the person make important decisions. Many people become calmer patients that way. And doctors often pick up some insights into the people they're taking care of by meeting family and friends.

2 ***Talk to a nurse.*** Even if we know better, some of us are a little too eager to be good patients, so we don't complain or admit to having a problem. Others may feel embarrassed at repeatedly asking, "What does that mean?" Some find themselves clamming up around authority figures. If you don't feel comfortable talking to a doctor, seek out one of the doctor's nurses or some other staff member. It's no secret that patients confide in nurses and other staff. Many doctors have found out more about their patients from nurses than they'd ever find out on their own.

3 ***Know your options.*** Most medical journeys have several crucial forks in the road. If a doctor presents only one choice, chances are you're not getting the full story. Of course doctors often do — and should — make recommendations. If you make a choice not favored by a doctor, then you must decide whether that doctor can still provide you with the care you need.

4 ***Set the terms of the relationship.*** A study published several years ago showed that most patients want a collaborative relationship with their doctor. But people's preferences vary. The researchers found that roughly 1 in 4 people prefer an active, take-charge role, ▸▸

INSIDE

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while 1 in 10 prefer a more passive one and would rather defer to the doctor's expertise. But when researchers asked people how well their preferences matched their actual experience, only half said it was what they wanted. About a quarter said they were relegated to a more passive role than they desired, and a similar percentage felt thrust into one that was too active.

There's a limit to how much any patient can influence the dynamics of his or her relationship with a doctor. But if you find your doctor too bossy or too deferential, make that known. If it continues to bother you, think about switching doctors (see #9).

5 ***Think through your priorities.*** Treatments often involve tradeoffs that only you can sort out. Are you willing to go for a potential cure even if it means harsh side effects? Or are you more comfortable with a conservative approach that has drawbacks but also a well-established track record? As best you can, express your thoughts to your doctors. If they know about your values and preferences, it can mean more fruitful and focused discussions of treatment choices.

6 ***Use the Internet.*** Sure, the Internet is full of half-baked hokum and untested snake oil. But today there's also plenty of credible health information, so much so that it's really a missed opportunity *not* to get online and tap into it. Harvard Medical School provides editorial oversight of the Aetna InteliHealth site at www.intelihealth.com. The Web site for the National Institutes of Health is a treasure trove with a great deal written for the public. The federal government's National Library of Medicine offers PubMed, a free, searchable database of all the medical journals.

7 ***Get your medical records.*** Under the federal Health Insurance Portability and Accountability Act (HIPAA), you have a right to see and get copies of your medical records. You'll probably be charged for the copies, so it can get expensive. HIPAA also gives you the right to ask for changes to your medical record, although doctors have the final say-so over whether they'll be made. We're not suggesting that everyone run out and get copies of their medical records. But getting acquainted with your official medical biography can help you become a fully informed patient.

8 ***Bring a tape recorder to your office visit.*** This may seem intrusive, but — especially if you have a serious medical condition like cancer or heart disease that involves complicated treatment choices — listening to an audiotape after your visit may help you understand things you didn't grasp the first time around. Just refreshing your memory can be helpful. Canadian researchers published a study of audiotaping visits last year in the *Journal of Clinical Oncology.* They found that breast cancer patients who listened to an audiotape of their first appointment about chemotherapy had significantly better recall of having discussed the side effects than did patients who didn't listen to a tape.

9 ***Find a doctor you like and respect…*** This can be hard. Your health insurer may limit your choices. For routine care, many people want someone whose office is nearby. Good doctors are often popular, so they may not be accepting new patients. But especially if you have some health problems, the value of compatibility with your doctor is hard to overrate.
…and don't feel obligated to stick with one you don't. It's important to make a good-faith effort to work with your doctor — and it can be work. But don't settle for someone who you don't like or trust. It may not feel like a good match from the doctor's perspective, either. You'd both be better off going your separate ways.

All-in-one pills for heart disease

A polypill may make sense, but drug companies are coming up with their own combinations.

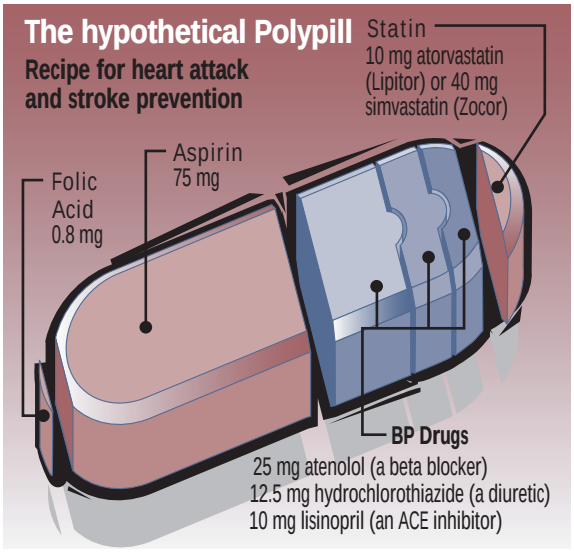
Taking your medicine these days often means taking not just one or even two pills but a whole assortment. Particularly for cardiovascular conditions (heart attack, stroke, unstable angina), some researchers say we'd be better off combining many of the common drugs — statins, blood pressure medications, aspirin — into a single pill. It would reduce the number of pills a person has to take, increase the likelihood that people will take their medicine (the more complex a medical regimen, the less likely people are to follow it), and save on co-payments. There's also evidence that some of these drugs are more effective when they're taken together.

Poly wants a pill

Combination pills aren't new. For years, drug makers have sold blood pressure medications that combine one of the dirt-cheap diuretics with an ACE inhibitor, beta blocker, or calcium-channel blocker. Advair is a popular asthma medication that combines fluticasone (Flovent) with salmeterol (Serevent). Pravigard is pravastatin (Pravachol), a statin, plus buffered aspirin.

But last year, British researchers Nicholas Wald and Malcolm Law took this familiar approach a step further. In an article in the *British Medical Journal*, they proposed a Polypill (they've applied for a trademark on the name) that would include five drugs and one vitamin. Moreover, they proposed that *everyone* age 55 and over should take the hypothetical pill as a preventive measure against heart attack, stroke, and other cardiovascular conditions. The Polypill would contain a cholesterol-lowering statin, half doses of three blood pressure–lowering drugs (an ACE inhibitor, a beta blocker, and a diuretic), aspirin, and the vitamin folic acid. Extrapolating from existing research results, they estimated that their Polypill would prevent 88% of all heart attacks and 80% of all strokes.

The biggest problem, they said, might be an increase in the likelihood of a bleeding (hemorrhagic) stroke from the aspirin component. That risk would be offset, though, by the lower risk for ischemic strokes, because aspirin works to prevent blood clots that cause those strokes.



In any event, Wald and Law's pill is only a theory, based on studies of the effects of each component taken individually. Dr. Debabrata Mukherjee and his colleagues at the University of Michigan are putting the theory to the test. They are investigating how different combinations of drugs have affected about 1,200 people admitted to the university's hospital after a heart attack or a bout of unstable angina. In a study published earlier this year in *Circulation*, Mukherjee reported that, compared with patients taking no medications, those who took four drugs — a statin, an ACE inhibitor, a beta blocker, and aspirin (or some other drug with an antiplatelet effect) — were 90% less likely to die during the six months after their hospitalization.

What's next?

Some critics say that a Polypill is a bad idea because, while the combination may make sense for the "average" person, one or more of the medicines within it may not be healthy for a given person — aspirin for people with aspirin allergies, for example. Mukherjee says that all-in-one needn't mean one for all. There could be several versions, so, for example, some might take a version without aspirin, while others might take one with more statin. Pill size shouldn't be a problem, he says, because the volume of the active ingredients is really quite small.

Ideally, the all-in-one pills would be made from inexpensive generic drugs. But selling individual brand-name drugs is very profitable, so it's not clear who would have the financial incentive to make a Polypill or something like it. Mukherjee says he is contacting charitable foundations, but the goal will be to make a pill for research purposes. Drug makers in India are a possibility. Heart disease rates in the developing world are skyrocketing, so the need for inexpensive prevention and treatment is great.

Meanwhile, American pharmaceutical companies continue to bundle their brand-name products into new combinations. Pfizer, for example, is now selling Caduet, a combination of Lipitor, its best-selling statin, and Norvasc, a calcium-channel blocker. Some people might benefit from Caduet. But skeptics see it mainly as a marketing maneuver to entice people into buying brand-name drugs. It also gives Pfizer fresh patent protection on a new pill made of two older drugs with patents that will expire much sooner. The Polypill may be a great idea. But there's a danger that it will languish as wishful thinking while pharmaceutical companies push more profitable, but less worthy, combinations.

Fainting

Simple maneuvers could keep you from losing consciousness if you're feeling faint.

The most common causes of fainting are conditions that temporarily deprive the brain of the blood it needs. No organ "likes" not having enough blood. The brain, though, is particularly sensitive to any shortages, and your cardiovascular system has to fight gravity to keep them from happening. The simple act of standing up causes a quarter of your blood supply to plummet toward your legs and the lower part of your body. To compensate, your heartbeat speeds up by 10–15 beats per minute. The autonomic part of your nervous system pitches in by narrowing your smallest arteries, like someone squeezing a hose. Blood pressure increases, so more blood is pushed into the brain. One reason older people faint more is that the various sensors and reflexes responsible for all of this fine-tuning become less sensitive and a bit slower with age.

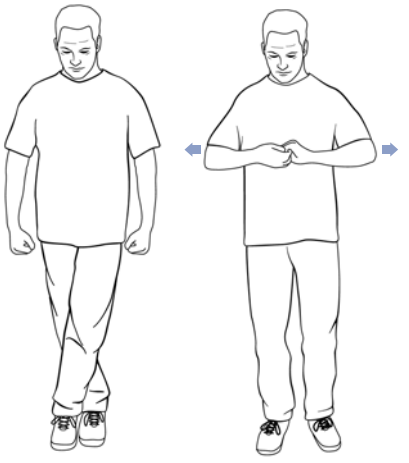
Going to the bathroom and eating (more precisely, digestion right afterward) can be a trigger because, as with standing up, blood is pulled into lower parts of the body. Anything that lowers blood volume can set the stage for a swoon: bleeding, dehydration from hot weather or not getting enough fluids, or kidney problems. Medications, particularly the diuretics used to control high blood pressure, can also decrease blood volume.

Fear factor

Psychological events like fear, strong sensations such as pain, and everyday occurrences like coughing or even laughing sometimes make someone faint. No one is sure why. The "wires" of the nervous system may get crossed and send the wrong signal to the cardiovascular system.

The conditions that cause these temporary drops in blood pressure go by several medical terms. Neurally mediated hypotension and vasovagal syncope (SIN-co-pee) are the most common. They're the most frequent causes of fainting in young adults and people with a lifetime tendency to faint easily.

Starting at about age 50, the chances that fainting might be a sign of a potentially dangerous heart problem increase. Ventricular tachycardia, when the main pumping chambers of the heart (the ventricles) beat rapidly but not effectively, and heart block, which causes the heart to beat so slowly that blood pressure drops, are two of the most serious.



Crossing your legs and tensing your abdomen pushes blood back up into the brain.

Isometric arm counter-pressure might also quickly boost blood pressure and possibly keep you from passing out.

Seizures, which are the result of abnormal electrical activity in the brain, are another potential cause of fainting. Certain inner ear disorders can also make you faint.

Be sure to talk to your doctor

You should always inform your doctor of any fainting spells. While it may turn out to be a small problem, you want to be certain. If doctors suspect a heart problem, they'll usually start by ordering an EKG. Sometimes tweaking medications helps. Drugs that lower blood pressure can make people vulnerable to fainting because they slow the heartbeat (beta blockers, nitrates) or relax arteries (ACE inhibitors, calcium-channel blockers).

Some recent research suggests that antidepressants might help people who faint frequently. Researchers have also had some success "retraining" the nervous and cardiovascular systems of frequent fainters. In one study, the successful therapy was just a matter of standing up against a wall twice a day for 40 minutes.

Cross your legs to stay on your feet

If you feel a fainting spell coming on, a couple of simple maneuvers may head off a full loss of consciousness — provided the cause is a temporary drop in blood pressure. Crossing your legs and tensing your abdominal muscles increases blood pressure by squeezing the veins in your legs (which moves more blood up from the legs to the heart) and by stimulating your nervous system to tighten up arteries (which raises blood pressure). Another technique is to grab one hand with the other and pull out with your arms.

It doesn't help right away, but drinking a couple of glasses of water may keep some people from fainting over the next 30–60 minutes, presumably by increasing blood volume. And that familiar advice to sit down and put your head between your legs actually makes pretty good sense. By sitting down you're avoiding a fall and by putting your head between your legs you're getting blood into the brain.

If someone does faint, the best thing you can do is to keep them flat on the ground. That way the cardiovascular system doesn't have to fight gravity. You should turn the person on his or her side to prevent choking. It's a mistake to sit people up after they faint because then the blood has to flow uphill to the brain.

The end of glasses?

First came LASIK. Now there's a procedure for baby boomers who don't want to wear reading glasses. But does it work?

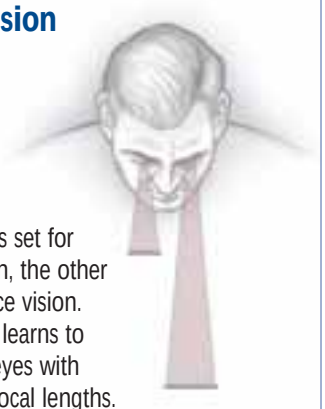
Behind your pupil and iris is a tiny, disc-shaped lens that adjusts so you can shift your focus easily back and forth between seeing objects in the distance and those right in front of you. Beginning in your 40s, the lens stiffens up and becomes less adaptable, like an autofocus camera getting stuck in a certain position. Ophthalmologists refer to this phenomenon as a "loss of [lens] accommodation." The condition is called presbyopia, which comes from the Greek for *old sight*.

At first, many people manage by holding things farther away from their eyes. Those who've worn glasses for seeing in the distance (they're nearsighted from myopia) often take them off to see some things up close.

Eventually, though, many people who have never worn glasses find that they now need a pair that magnifies for reading and other tasks that require near vision. You can buy them without prescription for $25.

For those who are nearsighted and wear glasses, the next step is often bifocals or progressive lenses. Wearing them does take some getting used to. Even when you've adjusted to them, they're not ideal because they narrow your field of vision and affect your depth perception. An Australian study found that, compared with older people who wore regular lenses, those wearing multifocal lenses were more than twice as likely to suffer falls.

Monovision



One eye is set for near vision, the other for distance vision. The brain learns to adapt to eyes with different focal lengths.

Eyes that see things differently

Having one eye for distance vision and the other for near vision is another way of coping with presbyopia. This approach is called monovision, a bad name because it suggests that you see with just one eye. Purposely having eyes with mismatched sight may seem odd, but the brain is capable of integrating the inputs into a single, clear field of vision.

Some eye doctors believe that more people should try monovision because it's a good answer to the hassle of reading glasses and the problems with bifocals. But others say most of their patients don't really like monovision and certain people never get used to it. Common drawbacks include loss of depth of field, poorer night vision, and less "contrast sensitivity" — the ability to distinguish between light and dark.

One way to achieve monovision is with contact lenses. A nearsighted person wears one lens to provide clear vision in the distance, while the other eye is either uncorrected (because it already sees well up close) or has a contact lens that boosts that near vision. LASIK is another option — although anyone considering it for monovision should use contact lenses on a trial basis first. LASIK, which has proved to be so popular among nearsighted people who don't want to wear glasses or contact lenses, involves using a laser to reshape the cornea, the clear, dome-shaped tissue in front of the pupil and iris. Often, both eyes are operated on if the goal is monovision.

New kid on the block

A third choice is conductive keratoplasty (CK). Instead of using a laser, the ophthalmologist directs tiny bursts of radio waves in a circular pattern around the center of the cornea. That cinches up the cornea like a purse string or belt, so the curve of the center portion is steeper. As a result, the eye is focused for near vision. The procedure takes minutes and is simpler than LASIK.

Conductive keratoplasty

Radio waves are used to reshape the cornea so the eye can see things up close.

The FDA approved CK for monovision in March. The procedure isn't for nearsighted people. It's only performed on people who don't need glasses for distance vision and who want to reduce their dependence on reading glasses.

CK is safe and easy for a competent eye doctor to perform. But there are two big question marks. How many people are going to be happy with monovision? And how long before the treatment wears off? Data submitted to the FDA showed that perhaps 4 out of 10 patients will need reading glasses again six months after the procedure and over half will need them after a year, according to Dr. Andrew Huang, a University of Minnesota professor who was on the FDA advisory panel on the CK application. You can get repeat treatments, however.

Initially, CK is cheaper than LASIK. The procedure is performed on just one eye, and the cost per eye is about $1,000 less. But over the long run — if you need to go back for additional treatments — the savings may fade from view.

What is a healthy bowel movement?

The characteristics of feces can offer clues to health problems, digestive and otherwise.

Australian colorectal surgeon Dr. Michael Levitt wrote in his witty but plainly titled *The Bowel Book: A Self-Help Guide for Sufferers* that the "human gastrointestinal system was designed to operate best where stool resembles the shape and consistency (although not the color!) of an unripe banana." Other sources say as much, although not quite so vividly.

The quantity and quality of stool can say something about a person's health — digestive and otherwise. Here are a few categories covered by Levitt and other sources.

Frequency. In Western societies, people generally defecate two or three times a day, but it's an individual matter. All the advice about the importance of regular bowel movements notwithstanding, some people defecate just once a week and are perfectly healthy. Constipation isn't defined by the frequency of bowel movements, but by whether someone has difficulty when they have one.

The urge to defecate is often strongest in the morning: Just getting up triggers the movement of the large intestine. The stomach also sends a signal when it expands after a meal. This gastrocolic reflex is the reason many people, and especially children, need to go to the bathroom soon after eating. The reflex gets weaker with age, which is one source of constipation problems.

Levitt says in his book that it's a good idea to delay defecation a little whenever possible because a more intense urge makes it easier to start a bowel movement. He also advises against forcing a bowel movement.

Color. Feces are normally brown because of pigments formed by bacteria acting on the bile that comes into the digestive system from the liver. Bleeding from the esophagus, stomach, or small intestine produces black, tarry stool called melena that has a very bad odor. Large bleeds from the large intestine cause the red color you'd expect from blood; small ones from anywhere in the gut are invisible. Liver problems, such as jaundice or a blockage of the bile duct that connects the liver to the small intestine, may result in acholic (which means without bile) stool that is white or pale.

In many cases, however, changes in the color of feces are completely harmless. Darkly pigmented foods like blueberries and beets can change the color. Iron pills and the bismuth in Pepto-Bismol darken stool. The contrast agents in imaging studies lighten it.

Fat content. Normal stool is about 1% fat. Passing stool that is 7% fat is called steatorrhea. The feces are soft, unusually smelly, and stick to the side of the toilet bowl. Steatorrhea is a sign that the digestive system isn't breaking down or absorbing fat as well as it should. There might be a problem with your pancreas, which produces enzymes that break down fat, or the small intestine, which absorbs fat. High-fat meals may also cause brief bouts of steatorrhea.

Consistency. Feces are normally about 75% water. If they contain too much water, they're soft; if they contain too little, they're hard. Soft feces can lead to incontinence and passive soiling. Hard feces can cause constipation.

Removing water is one of the major functions of the large intestine. A healthy large intestine takes 1 1/2 quarts of mushy material from the small intestine and turns it into a cup or so of semisolid feces. But if that material goes through the large intestine too fast, it stays watery and the stool is soft. If the so-called colonic transit time is slow, the material dries out and the stool is hard. One reason older people are often troubled by constipation is that movements of the large intestine tend to slow down with age, so colonic transit times get longer. Many medications and less physical activity cause intestinal sluggishness, too.

Fiber intake also influences stool consistency because it tends to hold on to water as it passes through the large intestine. Diets high in fiber from fruit, vegetables, and whole grains have a multitude of health benefits. But if you're bothered by soft-stool problems you might consider cutting back a little.

Fiber does add bulk to feces, but it's soft bulk (because of the water) and that's why it can help people with mild constipation. Dr. Levitt cautions that fiber is really a very mild laxative. For someone with a serious problem with constipation, he says "the large intestine will laugh at these puny efforts [of fiber] to make it contract while all the time permitting gas to build up inside."

Conditions that cause water and salt to flow into, rather than out of, the intestines are another cause of soft stool and diarrhea. Any number of infections can cause this wrong-way flow of fluid into the intestines.

Odor. The normal unpleasant scent of feces comes primarily from sulfur compounds produced by certain types of bacteria in the colon. Foods that are naturally high in sulfur — such as cabbage, broccoli, and other cruciferous vegetables and some types of protein — can lead to high-sulfur, and therefore, strong-smelling, feces. Sulfur compounds are also added to foods like beer and bread as preservatives. Even without a major dietary source, some people produce sulfur-rich stool because their large intestines are heavily colonized by bacteria that generate sulfur compounds.

Almonds, oh joy! But peanuts better?

They're good for us, but which nut is the best?

Health-conscious people are mad about nuts these days. The enthusiasm comes from a steady drumbeat of studies over the past decade showing that they're genuine health food. Their most salient effect seems to be heart attack prevention. Some studies suggest they give you some protection against diabetes, too.

True, nuts are high in calories: Just an ounce of most varieties has more than the 140 or so calories contained in 12 ounces of many brands of soda. Ideally, you should incorporate them into regular meals as a protein source. About 80% of the calories come from fat. Much of the fat, though, is "good" monounsaturated and polyunsaturated fat, not the "bad" saturated variety in meat and dairy products — or worse yet, dreaded trans fat. In research studies, cholesterol-lowering diets that contain nuts reduce "bad" LDL cholesterol by 9%–20%, regardless of the amount of fat or nuts.

Other healthful ingredients in nuts include copper, fiber, folate, and vitamin E. They have lots of arginine, an amino acid that the body uses to make nitric oxide. Nitric oxide relaxes blood vessels so blood flows easily. An ounce of most varieties of nuts has about 10%–20% of the recommended daily intake of magnesium. Studies have shown that many Americans don't get enough of the mineral, with average intake falling about 100 milligrams (mg) shy of daily recommendations (420 mg for men, 320 mg for women). Magnesium is important to maintaining the proper proportion of calcium to potassium. The evidence is iffy, but low levels of magnesium in the diet may contribute to heart attacks and hypertension.

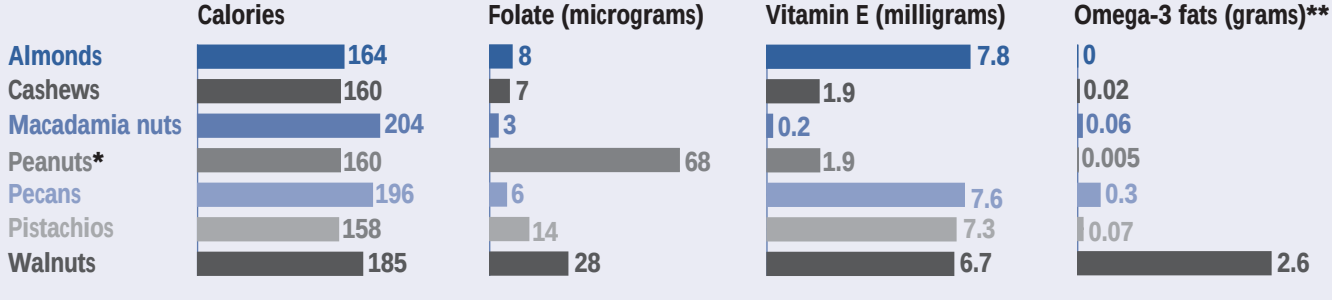
Competition

If it's clear that nuts are nutritionally virtuous, we should expect a welcome and all-too-rare concord on a nutritional subject, right? Guess again. Almonds, peanuts, walnuts — each has its own association or board, primarily composed of growers and related companies. Of course health claims are a major selling point. So the associations sponsor studies of their particular nut's boon effects on cholesterol levels, blood vessels, and other cardiovascular factors.

Which nut comes out on top? The competing studies are difficult to compare. But the United States Department of Agriculture has a database of the nutrient content of individual foods that sheds a little light on the subject. Almonds have slightly more vitamin E than walnuts, and much more magnesium. Walnuts, on the other hand, stand out as the only nut with an appreciable amount of alpha-linolenic acid, the only type of omega-3 fat you'll find in a plant-based food. Peanuts (which technically are legumes rather than nuts) lead in the folate category. Cashews have even more magnesium than almonds (83 milligrams per ounce vs. 73) but they lag behind in vitamin E. If it's selenium you're after — as many men are, because the mineral might protect against prostate cancer — then look to Brazil nuts: One ounce has almost 10 times the Recommended Dietary Allowance (RDA) of 55 micrograms. When it comes to taste, macadamia nuts are hard to beat: They're almost buttery. But they're also high in saturated fat (3.4 grams per ounce) compared with other nuts.

Nobody has done a comprehensive side-by-side comparison of the cholesterol-lowering effect of nuts. But citing individual studies, the authors of an almond study published in *Circulation* a couple of years ago said that, ounce for ounce, walnuts, peanuts, and pistachios are equally effective. Almonds are a close second, they said. Pecans and macadamia nuts, which are a bit higher in calories, lagged far behind.

So far, though, no nut is the clear hands-down winner in the health sweepstakes. And there is always the noncompetitive approach: mixed nuts. Unsalted, of course.



Values based on 1 ounce.

* Values are for the Virginia peanut, the variety used most often for roasted and in-the-shell peanuts.

** Amounts may include a small amount of omega-6 fats.

Source: United States Department of Agriculture National Nutrient Database

Should I get an Lp(a) test?

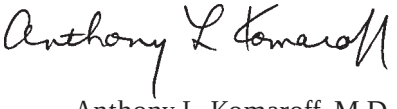
Q I'm 70 and recently heard about a new blood test for something called lipoprotein(a) that might help determine if I'll get heart disease. Should I get this blood test?

A Lipoprotein(a), which is often abbreviated as Lp(a), is a molecule of "bad" LDL cholesterol with an extra protein attached. High levels may be harmful because Lp(a) interferes with the blood's natural clot busters. Over the past several years, some studies have shown that people with high Lp(a) levels are more likely to have a stroke or suffer a heart attack. The risk seems to be more pronounced in men.

But that doesn't mean you should get an Lp(a) test. Conventional risk factors like high blood pressure, high cholesterol, and smoking are far more reliable predictors of future cardiovascular risk. And we know that lowering high blood pressure and cholesterol levels — and, of course, quitting smoking — pays off by lowering cardiovascular risk. There is medicine that reduces elevated Lp(a) levels, but we still don't know whether that reduction actually translates into a lower risk for having a heart attack or stroke.

Testing for Lp(a) might be warranted if you have diseased arteries (atherosclerosis) and none of the conventional risk factors. I might also consider ordering this test for a patient whose high cholesterol level isn't responding to a statin (Lipitor, Mevacor, other brands) or to one of the bile-acid binders (LoCholest, Colestid, other brands).

Talk to your doctor about the value of Lp(a) testing for you. Don't be disappointed if he or she says, "I'm not sure." I'm afraid this is an area where doctors need to know more before they can give you definitive advice.



Anthony L. Komaroff, M.D.
Harvard Health Letter Editor in Chief

Do stents do any good?

Q I read in the newspaper that angioplasty and stents don't do any good because narrowed arteries aren't the cause of most heart attacks. Is that true?

A Before patients get angioplasty or stents, they (and their doctors) need to be clear about their goals. Are they trying to relieve symptoms or extend life?

Patients who feel fine and have no symptoms of coronary disease will not feel any better after an angioplasty. If, on the other hand, their lives are being limited by angina from relatively mild activity, then opening up a coronary artery could really help because angina is caused by low blood flow to the heart. Angioplasty and stents restore blood flow.

But let's turn to people who have some evidence of coronary disease — say, a positive stress test — but no symptoms. For them, the question is not relief from angina but whether angioplasty will help them live longer. The answer for most people in this situation is no. Why? Because crushing a big, scary-looking atherosclerotic plaque won't do anything about all the smaller, less obvious plaques in the artery. Yes, people with significant coronary narrowing are at higher risk of dying from a heart attack than others are, but it's not so much because of obvious plaque — it's the many smaller ones that go along with it. When these small plaques rupture, they can cause just as much trouble as the larger ones, and there are plenty of them left after an angioplasty has squashed the big ones.

The good news is that the small plaques can be stabilized with cholesterol-lowering therapy, good blood pressure control, and other risk factor interventions. And those treatments can help you live longer.

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