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walking/6OTC  
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# yale health care

NEWS FROM THE YALE HEALTH PLAN

VOL. X NO. 2

MARCH–APRIL 2007

## Confronting sexual assault

Carole T. Goldberg, Psy.D.  
Mental Health and Counseling Center  
Director: S.H.A.R.E. (Sexual Harassment & Assault Resources & Education) Center  
Rhea Hirshman, editor



**R**ape victims and rapists come in all shapes, sizes, colors, nationalities, sexual orientations, ages, backgrounds, and social classes, as well as both genders. Estimates are that one in four women will be the victim of a sexual assault or attempted assault before the age of 30. For men the figure is one in seven. While men rape men, women rape men, and women rape women, the majority of perpetrators are male and the victims female, accounting for about 95 percent of sexual assault incidents.

### It's not just strangers

The scenario where a stranger jumps out of the bushes and drags his victim into an alley and rapes her happens in

less than 20 percent of cases, meaning that 80-85 percent of sexual assaults are committed by someone the victim knows—"acquaintance rape" or assault by "someone known to the victim." According to John Faubert at the College of William & Mary, victims have usually known perpetrators for at least one year.

Research with convicted rapists conducted by David Lisak from the University of Massachusetts has led him to observe that men who fall into the category of "undetected rapist" are responsible for the majority of sexual assaults. These are men (boyfriends, husbands, "players") who pursue women as a means of conquest or a "score." They target women who seem less credible; appear insecure; or have a strong need to be liked or to belong, (hesitant about saying "no") and manipulate them with alcohol, drugs, or the fear of rejection.

These attitudes are present also in men who rape or force sex on wives or partners, or use coercive behaviors to manipulate, dominate, and degrade them to get what they want.

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## Diagnosis is science and art

David Smith, MD  
Internal Medicine

**W**hen we experience symptoms—sensations that indicate something may be amiss in our bodies—we want our clinicians to come up with diagnoses. With the tools of patient history, clinical observation, laboratory tests and imaging, clinicians use their medical knowledge and their experience to solve the puzzle of "what's wrong."

Diagnosis—the explanation for symptoms—begins with the story of your illness, the "history" taken during a clinical encounter; the history will focus on the current problem and may also require asking questions about habits, lifestyle and family medical issues. Studies have shown that nearly 80% of diagnoses are made via the history alone.

Symptoms are an ancient language the body uses to express itself when something is wrong. Clinicians are trained to translate this language. In the taking of a history, clinicians will first identify a "chief complaint," a pivotal finding such as back pain, which helps organize further inquiry and narrows the "differential diagnosis," the short list of potential causes.

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## DIAGNOSIS

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We then ask questions to clarify the dimensions of the symptoms—such as severity, frequency and circumstances under which the symptoms are experienced. Answers to these questions provide clues about the organ systems involved and the factors that alter the strength of the symptoms.

Next we turn to the physical examination, used to test diagnostic hypotheses as well as to uncover new findings. Clinicians are trained to apply four methods to physical diagnosis: inspection (using vision to detect surface manifestations of diseases); palpation (using touch and pressure to detect clues about deep structures); percussion (tapping on the surface to infer the underlying structural density); and auscultation (listening with a stethoscope). Although many of these techniques are centuries-old (for example, the stethoscope was introduced in 1816), they have been modernized with the advent of precise imaging techniques, so that we now know the underlying processes that the findings represent, and their relative accuracy in diagnosis.

*Symptoms are an ancient language the body uses to express itself when something is wrong.*

History and physical examination are then combined to point toward a diagnosis. Research has discovered that clinical expertise is based on “illness scripts” of prototypical patients, containing rich detail about the physiological processes associated with disease or injury and contexts. Even subtle clues may be important. For instance: I recently saw a patient with cough, fever and body aches. Because the symptoms came on abruptly rather than gradually, I considered influenza rather than a common viral respiratory infection. Our first case of the season of influenza A was confirmed with a rapid influenza test, and the patient was treated with antivirals.



Finally, we may apply laboratory and imaging tests. These are best used to verify a diagnosis. If diagnostic tests are used as “fishing expeditions,” false positive results can lead us down the wrong path. Judgment, of course, also comes into play: “When you hear hoof beats, expect horses rather than zebras” is an expression of probability that encourages us to consider first the common causes of an illness. At the same time, we must remain aware of the possibility of serious conditions that may masquerade as common illnesses. Accurately making this distinction requires clinical experience. Even as we have numerous advanced technological diagnostic techniques, we still rely on the history and physical examination to tell us which test to order and how to interpret the results.

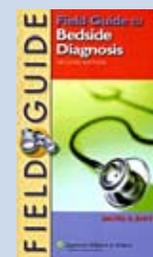
Here is an example of how history, clinical observation, and the results of diagnostic testing might combine to provide a diagnosis: A patient comes in with sudden-onset back pain when lifting his young child. Upon questioning, he notes that he feels pain radiating down his right leg, and has a “pins and needles” sensation (paresthesia) in the sole of his right foot. Paresthesia is a nerve symptom, so the radiating pain is interpreted as being caused by pressure on a nerve, due in turn to a herniated disc. He is then examined for weakness in standing on his toes and asymmetry of the ankle reflexes, which confirm sensory, motor and reflex abnormalities of the first sacral (S1) nerve. An MRI confirms the diagnosis of an L5/S1 herniated disc.

# in touch

## IMPORTANT TELEPHONE NUMBERS

<b>Urgent Care</b>	203-432-0123
<i>Open 24 hrs/day, seven days per week</i>	
<b>Toll free out of area</b>	1-877-YHP-CARE
<b>General information</b>	203-432-0246
<b>Pharmacy</b>	203-432-0033
Monday, Tuesday,	
Wednesday, Friday	8:00 AM–6:30 PM
Thursday	8:30 AM–6:30 PM
Saturday	8:30 AM–3:30 PM
<b>Patient Representative</b>	203-432-0109
<b>Medicare/Retiree Coordinator</b>	203-432-8134
<b>Outpatient referrals</b>	203-432-7397
<b>Claims</b>	203-432-0250
<b>Inpatient Care Facility</b>	203-432-0001

“Precise and intelligent recognition and appreciation of minor differences is the real essential factor in a successful diagnosis” wrote Sir Joseph Bell, Arthur Conan Doyle’s medical professor at Edinburgh (and model for Sherlock Holmes). “Eyes and ears which can see and hear, memory to record at once and to recall at pleasure the impressions of the senses, and an imagination capable of weaving a theory or piecing together a broken chain or unravelling a tangled clue, such are the implements of his trade to a successful diagnostician. To masters of [the] art there are myriad signs eloquent and instructive, but which need the educated eye to detect.”



David Smith, MD is an internist who joined Yale Health Plan in 1993. In addition to his clinical practice, he also teaches Yale medical students and residents. He recently published a 2nd edition of *Field Guide to Bedside Diagnosis*, an illustrated handbook of history and physical diagnosis for medical trainees.



# from the desk of

**PAUL GENECCIN, MD**

DIRECTOR, YALE UNIVERSITY HEALTH SERVICES

*Most importantly, the new YUHS will have the flexibility to accommodate change.*

The new YUHS facility has reached another major milestone with the start of “design development,” in which all of our space needs and all the basic concepts of layout are transformed into architectural plans. We will break ground in this calendar year and plan to occupy our new home in early 2010, in a building that will be functional, flexible, convenient and beautiful. In coming months, we will provide more information, but in the meantime I want to give you some highlights.

“Clinic flow” is the term we use to describe the ease with which patients find their way to appointments, get taken into the clinic, and are guided through; finally leaving the clinic with everything they need to take the next steps. We look forward to more than twice the number of examination rooms than we have now—with vastly improved ability to provide appointments and take care of members’ clinical needs quickly and efficiently.

Clinical staff will also benefit from these designs, which create confidential, professional spaces in which to provide care.

We look forward to greater efficiency in our Pharmacy, which fills a daily prescription volume that is more than three times the average of a typical store in the major national chains. The queue that often traverses our lobby will be gone, as we will provide prescription drop-off and pick-up in a more effective working space. Other major developments include entirely new and contemporary designs to support the highest standard of care in Physical Therapy, the Surgical and Ob/Gyn departments, Urgent Care and all of our primary care and specialty departments.

The new YUHS facility will be able to accommodate nearly all routine gastrointestinal endoscopy procedures in private, comfortable surroundings. Many minor procedures requiring conscious sedation will be performed in-house.

Our inpatient unit (ICF) will include isolation rooms, which are so often needed for students with chicken pox and other contagious infections that make staying in the dormitory impossible. We will have vastly enhanced diagnostic imaging capability, with MRI, CT scan, breast screening mammography, more ultrasound capability and other modalities.

Most importantly, the new YUHS will have the flexibility to accommodate change. Health care transforms so rapidly that even ten years ago we would not have been able to envision some of the diagnostic and therapeutic procedures that are standard today. Our new facility will have the flexibility to permit growth in our populations and to address the evolving needs of the dynamic and increasingly international Yale community. Watch upcoming issues of *yale health care* for illustrations of the new facility—and you will soon be able to see pictures on our web site and throughout 17 Hillhouse. As always, I welcome your feedback.

## Does your neck turn green?

Have you ever wondered why certain pieces of jewelry cause the skin they come into contact with to turn green? Or whether obtaining adequate dietary calcium is possible without using dairy products? Or what the numbers in a blood pressure reading refer to? Or why a medication has been taken off the market?

Beginning in the next issue, we'll be running a new column. Readers are encouraged to send in health-related questions of general interest.

The newsletter editorial board will choose one or two to be answered in each issue, with responses provided by a member of the YHP clinical staff.

Send your questions to [yalehealthcare@yale.edu](mailto:yalehealthcare@yale.edu).

Note: This email address can also be used to make general comments about anything in the newsletter.

Please remember: Questions should be of a general nature; we cannot respond to questions related to individual medical needs.



## SEXUAL ASSAULT

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### Sexual assault on college campuses

Although campuses are generally safer than other settings with young people of comparable ages, the picture is different with sexual assault. John Faubert's research shows that females are most vulnerable during high school and college. The first few months of freshman year is the most critical time. Friendships and support structures are not yet established and young women may be preyed on by upperclassmen. Also, this may be the first time away from parental scrutiny, as well as a time when they may experiment with alcohol and other behaviors. Another major concern is "date rape" drugs. Many are aware of drugs like "roofies" (rohypnol) and "GHB" (gamma hydroxyl butyrate—liquid ecstasy) but the number one drug in date or acquaintance rapes is alcohol, which is involved in as many as 80 percent of these assaults.

### Rape myths

Rape myths are beliefs and attitudes that perpetuate sexual violence by objectifying victims and by perpetuating and justifying demeaning and degrading behaviors—including rape.

Familiar rape myths include: "She wanted it." "No means yes!" "She's lying!" "He couldn't help it!" "Real men don't take no for an answer!" "Acquaintance rapes are less traumatic than stranger rapes."

Rape myths give perpetrators "justification" for objectifying victims and disregarding their protests. Women are portrayed as helpless, mindless, deceitful, and confused, and "real men" as being less than masculine if they don't overpower or take what they want. Rape myths inhibit change and fuel attitudes that support what has been termed a "rape culture."

### Rape culture

The Cleveland Rape Crisis Center defines rape culture as "a complex belief system that encourages male sexual aggression and supports violence against women. It endorses a society where violence is seen as sexy and sexuality is violent. In this setting, women perceive a continuum of threatened violence that ranges from sexual remarks, to sexual touching, to rape....A rape culture condones physical and emotional terrorism against women as a norm and both men and women assume that sexual violence is a fact of life, inevitable as death or taxes...."

### The most underreported crime

A consequence of a "rape culture" is underreporting of sexual assaults. According to the Justice Department's 2003 Report on Sexual Violence, rapes and sexual assaults are the most underreported crimes. While about two-thirds of victims tell *someone*—often a friend—approximately 65% of rapes and sexual assaults in 2005 were not reported to officials.



[Note: official rape statistics are based on incidents initially reported to police and other authorities. More realistic statistics incorporate information from Rape Crisis services, which may or may not provide data to authorities]. Historically, fewer than 5 percent of college women and only 16 percent of the general population who are victims of rape or attempted rape report to the police. Reasons given by victims for not reporting include:

- Fear of publicity and/or that families will find out
- Feeling responsible—for instance, self-blame for being alone with the assailant
- Tendency to minimize the incident
- Feelings of embarrassment, guilt or shame
- Fear that there is insufficient evidence or that the case won't be prosecuted
- Drunk or high when it happened
- Fear they would not be believed or that they would be blamed

### Resources at Yale



At Yale, groups such as **NO MORE** (National Organization for Men's Outreach & Rape Education), **RSVP** (Rape & Sexual Violence Prevention) **RALY**

(Reproductive Rights Action League) and the peer health educators do presentations and promote awareness and change. Yale also recently opened the **Sexual Harassment and Assault Resource & Education (S.H.A.R.E.) Center**, which provides crisis support to assault victims as well as offering programs designed to promote awareness of sexual violence on college campuses. More information about the S.H.A.R.E. Center and about options and procedures to follow in the event of a sexual assault is available on the Yale website ([www.yale.edu/yhp](http://www.yale.edu/yhp)). Click on "SHARE Center."

### Transforming rape culture

Some suggestions, adapted from Cleveland Rape Crisis Center materials:

- **Speak up!** Don't listen quietly to sexist jokes or comments. Say something when you see a T-shirt, sign, movie—anything you find offensive to women.
- **Model for children** that each sex has value and that neither is better, more powerful or smarter, than the other.
- **Encourage men** you know to explore what it means to be an anti-rapist.
- **Learn to say "no,"** knowing that you can be courteous while exerting your rights and expressing your feelings.
- **Teach others** that the best women to look up to are those who are making a difference, not those who are the most famous, or focused on appearance or wealth.
- **Dare to expect** a culture free of sexual violence.

### Minimizing the risk

- **Don't allow yourself to be alone** with someone you do not know or trust.
- **If you feel you are in danger,** don't be afraid to attract help in any way you can. Scream or run away to safety.
- **Avoid being alone in public,** particularly at night and avoid isolated places such as deserted parking lots or stairwells.
- **Keep personal information** (name, address, phone number) on your person and not on key chains.
- **Keep your vehicle, home, and room locked.**
- **If a motorist asks for assistance,** keep a distance from the vehicle.
- **Never sleep in public—including buses, cabs, trains and benches.** Have car, house, and room keys ready before you reach your door.
- **Walk facing traffic.**

- Assailant may be part of daily routine (classmate, co-worker, neighbor)
- Fear of reprisal
- Fear of bias of police/officials
- Desire to protect offender

Also, the closer the relationship between victim and offender, the less likely that police will be notified. For instance, when the offender is a friend, 61 percent of completed rapes are not reported; this figure rises to 77 percent when the offender is a current or ex-boyfriend.

Other barriers to reporting have to do with confusion about whether the incident was a “crime” or whether the offender had “criminal intent”—many victims cannot imagine or admit that an acquaintance could be a rapist or that they could be victims of sexual assault.

### Crying rape?

The myth that “Women ‘cry rape’ to cover up what they wanted or to get back at someone” has been in the news lately, but the number of false and/or unfounded reports is very small. In 2003 according to the FBI, 5.5 percent of sexual assault reports were determined to be “unfounded.” The FBI tracks only the total number of “unfounded reports.” These include not only cases in which allegations were found to be false, but also cases with insufficient evidence; cases where the victim decided not to prosecute, or changes the account, recants or cannot be located. Some officials further confuse this issue by

considering cases “unfounded” if the victim had a prior relationship with the offender; the victim used alcohol or drugs at the time of the assault; there is no visible evidence or injury; the victim delays disclosure to officials and does not undergo a rape medical exam; or the victim fails to label immediately the assault as rape and/or blames herself/himself.

### Men can stop rape

Allen Johnson, professor, author, and researcher on sexual violence observes, “The fact that sexual violence is not defined as primarily a man’s problem is startling when we consider that men account for almost all the sexual violence...in the U.S. If we were to discover that a type of crime was committed almost entirely by a particular category of people—such as an ethnic group—criminologists, journalists, politicians, and others would have a field day trying to explain what it is about the category that generates such a distinct pattern of behavior there, but not elsewhere. Sexual violence should be regarded first and foremost as a man’s problem.”

Current research shows (Lisak, Faubert, Berkowitz et. al.) that activities such as men educating other men and men speaking out when other men brag about sexual conquests do have an impact. Parents and other caring adults also can teach the men and boys in our lives to support and respect women and to take stands against sexual aggression.

- **Trust your instincts.** If you feel you are being followed, if you have suspicions about a minor auto accident, or being stopped by a police official, keep driving to a well-lit, populated area before stopping.
- If you carry any item for self-protection, consider your ability and willingness to use it. Remember that it could be grabbed and used against you.
- “No means no.” Someone who is intoxicated, asleep or passed out cannot give or be perceived as giving legal consent—and having sexual contact with someone who cannot give consent is a crime.
- Avoid intoxication and be alert to the danger of “date rape” drugs. Remember that 55% of female students and 75% of male students involved in acquaintance rape admit to having been drinking or using drugs when the incident occurred. Alcohol lowers inhibitions and interferes with decision-making.

At best, deciding to have sex with someone while under the influence can cause embarrassment the next morning. At worst, you can become the victim of sexual assault or be infected with HIV or other sexually transmitted illnesses (STIs).

- **Protect yourself against “date rape” drugs**

**Don’t put down your drink.** If your drink is out of sight, even for a moment, don’t finish it. Get yourself a new one.

**Don’t accept an open drink from anyone.** If you order a drink, make sure you watch the bartender open the bottle or mix your drink.

**Avoid punch bowls.** With “roofies” and GHB in circulation, you can’t be sure what’s in the punch—or what someone added to it after it was made.

**Make a pact with your friends to watch out for each other, and spread warnings about “date rape” drugs.**

# YHP staff



ASHFORD



SCHRIER

### New Manager for Population Health

The department of Population Health Management will be headed by Darlene Ashford, MPH. Ashford came to YHP in January 2007 from Anthem Blue Cross and Blue Shield, where she worked since 1988, most recently serving as a regional manager for population health. In that position she was accountable for clinical strategies and preventive health and disease management programs for 2.4 million plan members throughout Connecticut, Maine and New Hampshire. Ashford received her Master’s in public health from Southern Connecticut State University, where she also earned a B.A. in journalism. She is a recent graduate of the Leadership Greater New Haven program, volunteers with the Susan G. Komen Breast Cancer Foundation, and is a member of the United Way of Greater New Haven Health Action Team.

### Health Educator Joins Staff

Rebecca Schrier, MPH, MSW, joined the Department of Health Promotion and Education as a student health educator in November. Schrier received her Master’s in public health and her Master’s in social work from Tulane University and her B.A. in psychology from the College of William & Mary. Her areas of research interest include the mental health outcomes of exposure to community violence, maternal and child health promotion, and social policy development and advocacy.





# information

## HITCH A RIDE

*My Ride* has loosened its eligibility rules. Adults may now enroll in and use *My Ride* once they reach age 60—whether or not they have any disability. Greater New Haven Transit provides public transportation in South Central Connecticut. Call 203-288-6282 for more information or to request an application. Applications are also available in the YHP Member Services Department.

## yale health care

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## WORK TOGETHER, WALK TOGETHER 2007

Time to get outside during your lunch hour! The annual spring walking program, co-sponsored by the YUHS Office of Health Promotion and Education and the Department of Athletics, is now in its 17th year.



These progressive distance walks will be held on Tuesdays and Thursdays

from Tuesday, March 27 through Thursday, April 26. We leave from the front of YUHS, 17 Hillhouse Avenue, at 12:10 pm. The sessions, led by Larry Matthews, Associate Director of Sports and Recreation, Payne Whitney Gymnasium, meet rain or shine and are free and open to the Yale community. No registration is required.

The *Work Together, Walk Together* program encourages members of the Yale community to join with friends and colleagues. Bring your whole department and get yourself moving. Participants are encouraged to walk at their own pace. Wear comfortable walking shoes and non-restrictive clothing. For more information call 203-432-1892.

## Colorectal cancer screening at YHP

If you're 50 or older, contact your YHP clinician about getting a CRC screening test.

The endoscopy program at YUHS provides colonoscopies and is in a comfortable, private area on the 5th floor with staff who are trained to make your experience as pleasant as possible. Starting in February, we began performing upper endoscopies as well as colonoscopies.

See back page for additional information and to learn more about colonoscopy and colon cancer screening, visit the *Healthwise*® section of the YUHS website: [www.yale.edu/yhp](http://www.yale.edu/yhp) and click *Healthwise*.

## OVER 65 AND STILL WORKING?

YHP members who are over 65 but still working and not currently Medicare participants (Medicare primary) may enroll in Medicare A through March 31.

Because the age of eligibility for full Social Security benefits is gradually increasing from 65 to 67, an increasing number of people will need to enroll in Medicare at age 65 without also registering for Social Security benefits. Here's how to do it:

- Call 1-800-772-1213, choose prompt 1 for English, 3 for other additional services or to speak with a representative, and finally 0 to speak with a claims representative.
- Once you are talking to a claims representative, explain that you want to enroll in Medicare but not Social Security. They will fill out an application for you and instruct you how to submit your birth certificate.
- Your application will then be submitted by the claims representative.
- Four to six weeks after receipt of your documentation, you will receive your Medicare card and handbook in the mail.

Please provide Yale Health Plan with a copy of your card when you receive it. Mail it to:

YUHS COB Office  
55 Whitney Ave., 2nd Floor  
P.O. Box 208217  
New Haven, CT 06520-8217

YHP can better coordinate your care if we have all current insurance information on record. Always provide YHP with information regarding any changes to insurance for yourself and for all dependents who are on your YHP contract.



## From the Pharmacy

### Pain relief over-the-counter

A number of pain relievers can be purchased over-the-counter (OTC)—without a prescription. Below is some information about which ones are best suited for which individuals and which circumstances. The information applies to adults only.

#### ACETAMINOPHEN

*(Tylenol and other brands)*

**Use.** Relief of fever as well as aches and pains associated with headache, back-ache, mild arthritis (with no underlying inflammation), toothache, and aches from cold or flu.

**How it works.** Analgesic (pain reliever) and antipyretic (fever reducer). Works with pain threshold for its analgesic effect and tells the heat regulating center in the brain to lower body temperature for its antipyretic effect.

**Dosage.** Adult dosage is 325mg to 650mg every 4 to 6 hours to a maximum of 4000mg per day.

**Drug Interactions.** Metabolized by the liver so drugs that increase liver enzymes may decrease the action of acetaminophen (e.g. Isoniazid, Rifampin, Carbamazepine).

**Pregnancy and nursing.** Safe to take during pregnancy and nursing (small amounts are excreted in breast milk) but always consult a health professional.

**Side effects.** Can include rash and hypothermia. Liver or kidney damage may result from long-term high doses.

**Other notes.** If combined with alcohol, potential for liver damage increases. Should not be taken with alcohol or given to those who have three or more alcoholic drinks a day. Always check ingredients in combination products (e.g. Nyquil) to make sure you don't get too much!

#### IBUPROFEN

*(Advil, Motrin, Nuprin and other brands)*

**Use.** Relief of mild to moderate pain, inflammation and fever. Good choice for menstrual cramps, arthritis, headache, muscle sprains, fever.

**How it works.** Belongs to drug class called non-steroidal anti-inflammatory drugs (NSAIDs). Another member of this class is naproxen sodium (Aleve and other brands). Used for the management of mild to moderate pain, fever and inflammation.

Prostaglandins are chemicals that are made by the body and that cause pain, fever, inflammation; this drug blocks the enzyme that makes prostaglandins.

**Dosage.** Adult dosage is 200mg to 400mg every 4 to 6 hours to maximum of 1200mg per day. Also available in prescription strength.

**Drug interactions.** Ibuprofen may reduce the effectiveness of drugs used to lower blood pressure. Problems may occur if taken with certain antibiotics. Persons taking oral blood thinners or anticoagulants (Warfarin, Coumadin) should avoid ibuprofen because it also thins the blood and excessive blood thinning may lead to bleeding. Ibuprofen may increase blood levels of lithium (esklalith) by reducing the excretion of lithium by the kidneys, leading to lithium toxicity.

**Pregnancy and nursing.** Not recommended for use during pregnancy or nursing.

**Side effects.** The most common are abdominal pain, constipation, dizziness, drowsiness, heartburn, and rash. Ibuprofen may cause ulceration of the stomach or intestine. Sometimes, ulceration and bleeding can occur without abdominal pain, and black tarry stools, weakness and dizziness when standing (also called orthostatic hypotension) may be the only signs of a problem. NSAIDs reduce blood flow to the kidneys and should be avoided in patients with impairment of kidney function and congestive heart failure. Persons allergic to aspirin or other NSAIDs should not use ibuprofen.

**Other notes.** Take with meals.

#### ASPIRIN

*(Bayer, Ecotrin and many others)*

**Use.** Aspirin although relatively inexpensive and common is not recommended to purchase for mild to moderate pain and fever. It is a potent medicine and should be only used when recommended by your clinician.

**How it works.** Aspirin blocks the release of chemicals (prostaglandins) that cause pain and inflammation. Also works in the brain to help "adjust" body temperature (similar to acetaminophen above).

**Dosage.** Aspirin in doses from 81mg to 325mg daily may be prescribed to reduce the risk of recurrent stroke and near stroke (transient ischemic attack) and is used similarly to prevent heart attacks. Adult dose for other purposes is 325-650mg every 4 hours as needed.

**Pregnancy and nursing.** Should not be used.

**Other notes.** Should not be used in children because of associated risk of Reye's syndrome, a serious disease of the liver and nervous system that can lead to coma. Note that ointments that are sold in the stores under the names Ben-Gay and Icy Hot provide relief by creating the sensation of warmth or cold, taking our minds off the pain beneath. The no-odor products contain triethanolamine salicylate that is absorbed into the skin. This is an aspirin derivative and should not be used with aspirin allergy or sensitivity. As always use cautiously, follow labeled directions and consult your clinician or pharmacist if you need more information.

The YHP Pharmacy stocks adult formulations of acetaminophen, ibuprofen, naproxen and aspirin. Be careful of multi-drug combinations; read the ingredients to make sure you are not taking extra acetaminophen or ibuprofen, two of the commonly used drugs in multi-ingredient preparations. Consult your pharmacist (203-432-0033) if you have any questions on the choice of OTC pain relievers.

*Information supplied by Martha Asarisi, RPh, YHP pharmacist*



# healthy ideas

## Colorectal cancer screening saves lives

Nearly 30,000 American lives could be saved each year if everyone age 50 and older were tested for colorectal cancer, according to the American Cancer Society. While younger adults can develop colorectal cancer, more than 90% of those diagnosed are over 50. Colorectal cancer (CRC) is the second leading cause of cancer deaths among men and women in the U.S. However, if detected early, it can be cured. The best way to prevent colorectal cancer is through regular screening, which means testing a person with no symptoms of disease. Screening can find growths before they become cancer and prevent the disease entirely.

### What types of tests are available?

The American Cancer Society and the US Preventive Services Task Force (USPTF) recommend that adults begin screening at age 50 with one of the following tests:

- **Colonoscopy** every 10 years
- **Fecal occult blood test** or **stool test** annually
- **Flexible sigmoidoscopy with or without stool testing** every 5 years
- **Double contrast barium enema** every 5 years

**Colonoscopy** allows the examination of the inner lining of your large intestine using a thin, flexible tube. It is the preferred screening test by YHP physicians because it can view the entire colon and can remove polyps or tissue samples for testing. In most cases, a colonoscopy can be performed here at YHP.

**Fecal occult blood test** checks for blood that may not be visible to the naked eye. If there is evidence of blood in the stool, a colonoscopy is recommended.

**Sigmoidoscopy** looks inside the rectum and lower colon using a sigmoidoscope (a thin, tube-like instrument). It may also have a tool to remove polyps or tissue samples, which are checked for signs of cancer. Often done in conjunction with fecal occult blood testing.

**Barium enema** is an x-ray of the large intestine. To make the intestine visible on an x-ray, the colon is filled with a contrast material containing barium. It is usually reserved for patients unable to complete a colonoscopy or sigmoidoscopy.

### How else can I reduce my risk?

- Eat five or more servings of fruits and vegetables a day
- Substitute poultry and fish for red meat
- Exercise at least 30 minutes daily
- Maintain a healthy weight
- Avoid smoking and limit alcohol



### A little olive oil does a body good

If you're watching your weight, eating a small amount of whole-grain bread dipped in olive oil, or a few nuts, can help you eat less overall. Consuming some healthy unsaturated fat, such as olive oil, before a meal slows the rate at which the stomach empties.

This means:

- You'll digest food more slowly, so you'll eat less but feel full.
- Your blood sugar won't hit a high peak after you eat, but will remain at a lower, stable level.
- Your body will more easily absorb fat-soluble vitamins such as A, D, E, and K, as well as fat-soluble nutrients such as lycopene and lutein.

Remember not to overdo it! Just 70 calories' worth will do the trick: half a tbsp of olive oil; 6 walnuts; 12 almonds; or 20 peanuts.

## yale health care

Yale Health Plan  
Member Services  
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New Haven, CT 06520-8237



Please remember that free parking for YHP members is available both in the lot right next to 17 Hillhouse Avenue and in parking lot 37, just across Trumbull Street.

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