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**Big News**

We have such good news to share:

First, Positive Women's Network is the newest Prime Contractor for the Washington Breast and Cervical Health Program (WBCHP) responsible for Island, San Juan, Skagit, Snohomish and Whatcom Counties. PWN has worked for years to connect uninsured and underinsured women to this program, so we are delighted to expand our program.



Secondly, we have signed a letter of intent, drawn-up plans, and are assertively moving forward with our plans for a Wellness Center. In February, we will be the newest tenants of the Betty Spooner's School of the Dance building. We are delighted to be joining the resurgence of enthusiasm in downtown Everett, and especially pleased to reside in a building that has had such a positive impact on so many Everett residents over the years.

Lastly, PWN is the new home for breast awareness key chains and necklaces.

Kim Schaaf, the creator of Beads for Life has worked

hard over the last 8 years to distribute the key chains across the nation. Since moving the business into PWN as a program, we have changed the name to BeadPositive. October is Breast Awareness Month, and a perfect time to give this thoughtful gift to people in your life. Not only can you order them at [www.beadpositive.org](http://www.beadpositive.org), but you can feel good knowing that all proceeds support programs at Positive Women Network.

Positive Women's Network is dedicated to connecting women and their families to health care, support services and disease prevention programs.

Send comments, articles, poetry or event information to:

Kerri Mallams, Editor  
3701 Broadway,  
Everett, WA 98201

Please Note:

Information and resources included in this newsletter are for informational purposes only and do not constitute an endorsement or recommendation of any medical treatment or commercial product by Positive Women's Network.

Call 425.259.9899 to be added to our mailing list.



Member Agency,  
Women's Funding Alliance

PWN invites you to an Open House for Breast Cancer Awareness Month  
On October 10th from 10 a.m. - 4 p.m. at 3701 Broadway, Everett WA

Stop in for breast health information, gifts and to see the floor plan for our new space.

Hope to see you there.



Kristine Smith, PWN Board Member is in the News ...

## Gift of Life

— Andrew Sirocchi, Herald Staff Writer  
*Published Friday, August 25th, 2006*

Kristine Smith can thank Sara Casey for every breath she takes — literally. For two weeks, Smith attended each day of the vehicular homicide trial of the man found guilty Thursday of crashing into Casey and killing her as she rode her bicycle along Clearwater Avenue.

Smith is not related to Casey. They never met.

But Smith does have the 19-year-old's lungs, and a burning desire to help the Casey family get through the challenges the trial presented.

"Nothing can ever make up for the lungs," she said. "These people are the most generous, non-judgmental people I have ever met. I needed to thank them personally."

Diagnosed with a rare form of hereditary emphysema, Smith in 2003 was living with 24-hour oxygen treatments when Sara Casey died. She was given only months to live. Then, Casey died in a Spokane hospital and the lung transplant was approved.

After the successful surgery was performed and Smith's health improved, the Seattle woman began corresponding with the Casey family through an organ donor organization. When the former federal public defender found out about the trial the past spring, Smith decided she might help the Casey family through the daunting experience of watching the trial of someone accused of killing a loved one.

"Lori Casey gave birth to my lungs," she said. "I'm really here to support her."

Lori Casey said that help has been invaluable.

Six days after the Sept. 17, 2003, accident that took their daughter's life, Lori and Terrance Casey had to make the difficult decision to release Sara Casey's organs. With their strong Catholic faith, the family had to consult a minister before making the decision that ultimately saved Smith's life.

"Kristine was very open from the beginning with letters and correspondence," Lori Casey said. "She's so generous. She's offered to help any way she can."

The women found themselves leaning on each other as the case against Randall Foos moved slowly through the court system the past two weeks. Smith said she hopes the two have developed a lifelong friendship thanks to Sara Casey.

Sara Casey's death gave life to Smith and it gave life to a push by the Casey family to establish legislation requiring doctors to notify the Department of Licensing when they inform a patient that a medical condition will prevent them from driving.


Colette Casey, Lori Casey's sister-in-law, said the family hopes a similar Oregon law can be used as a model in Washington.

"This is about ability, not age," she said. "This is a significant public health risk."

Lori Casey said privacy laws make it challenging to receive medical information and history about patients. Sara Casey's death can highlight that struggle.

Criminal charges against Foos were filed in the case only after the Casey family pursued a civil trial against the 57-year-old pastor and uncovered evidence that he knew of his failing eyesight but drove nonetheless.

"I think we're in new territory, with the privacy laws being as new as they are," she said. "We haven't quite crossed that area of where individuals' right to privacy and patients' privacy privilege intersects with the public's right to know."

In this case, if a doctor says you're not legal to drive, we believe the public should know." 



## Hey J

Hey J -

In my circle, people (guy-friends and gal-friends) see the 'risk' of pregnancy, not disease as the main consequence of unsafe sex. So, most of my friends use the pill or other methods of birth control, but not the dreaded condom. So how can I protect myself from HIV and other sexually transmitted diseases, even if my partner doesn't want to wear a condom?

Sincerely,  
Impossible.

Dear Impossible,

Mission impossible... '85 choose a different mission! We all know, more or less, about the male condom - certainly tried and true, and used properly and consistently is 95% effective (85% effective with "real world" use), against pregnancy and most sexually transmitted diseases.

But, let's focus on the lesser known FC Female Condom, also 95% effective against pregnancy and highly effective to viruses and bacteria that cause sexually transmitted disease, including HIV/AIDS.

What is the Female Condom?

The female condom has been available in Europe since 1992 and it was approved in 1993 by the US Food and Drug Administration (FDA). The female condom carries various brand names in different countries. In the United States it is known as the FC Female Condom previously referred to as Reality Female Condom.

The female condom is a polyurethane sheath or pouch about 6.5 inches in length. It is worn by a woman during sex. It lines the entire vagina and it helps to prevent pregnancy and sexually transmitted diseases (STDs) including HIV.

At each end of the condom there is a flexible ring. At the closed end of the sheath, the flexible ring is inserted into the vagina to hold the female condom in place. At the other open end of the sheath, the ring stays outside the vulva at the entrance to the vagina. This ring acts as a guide during penetration and it also stops the sheath from bunching up inside the vagina.

There is silicone-based lubricant on the inside of the condom, but additional lubrication can be used. The condom does not contain spermicide.



PRO's

- shared responsibility for condoms,
- the female condom can be used if her partner refuses to use the male condom,
- poly-urethane is less likely to cause an allergic reaction than a male latex condom,
- The female condom will protect against most STDs and pregnancy,
- It can be inserted up to 8 hours before intercourse so it does not interfere with the moment,
- polyurethane is thin and conducts heat well so sensation is preserved,
- No special storage requirements are needed because polyurethane is not affected by changes in temperature and dampness. The expiration date for female condoms is 5 years from the date of manufacture.

CON's

- The outer ring is visible outside the vagina, which can make some women feel self-conscious,
- The female condom can make noises during intercourse. Adding more lubricant can help this problem,
- Some women find the female condom hard to insert and to remove,
- It has a higher failure rate in preventing pregnancy than non-barrier methods such as the pill,
- It is relatively expensive and relatively limited in availability in some countries.

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Let's take a final look at how the male vs. female condom stacks up:

Male Condom	FC Female Condom
Rolled on the man's penis	Inserted into the woman's vagina
Made of latex, fits the penis snugly	Made of polyurethane, is a looser fit
Lubricant: <ul style="list-style-type: none"> <li>• Can include spermicide</li> <li>• Can be water-based only; <b>cannot be oil-based</b></li> <li>• Located mostly on the outside of condom</li> </ul>	Lubricant: <ul style="list-style-type: none"> <li>• Can include spermicide</li> <li>• Can be water-based or oil-based</li> <li>• Located on the inside and outside of condom</li> </ul>
Can use for vaginal/anal/oral sex	Can use for vaginal/anal/oral sex
Condom must be put on an erect penis	Can be inserted prior to sexual intercourse, not dependent on erect penis
Must be removed immediately after ejaculation	Does not need to be removed immediately after ejaculation
Covers most of the penis and protects the woman's internal genitalia.	Covers both the woman's internal and external genitalia and the base of the penis - <b>which provides broader protection, especially against skin to skin infections like Herpes and HPV.</b>
Latex condoms can decay if not stored properly	Is not susceptible to deterioration from temperature or humidity.
Recommended as one time use product.	Recommended as one time use product. Re-use research has been done on the original FC female condom, and WHO issued an Information Update in July 2002 (available at <a href="http://www.who.int/reproductivehealth/rtis/reuse.en.html">www.who.int/reproductivehealth/rtis/reuse.en.html</a> )



A female condom and a male condom should not be used together as friction between the two can result in either product failing.

#### Support for the Female Condom

WHO and UNAIDS are encouraging the introduction of the female condom as a new method of preventing both pregnancy and infection and as an additional tool in efforts to respond to the needs of women and men in sexual and reproductive health. The female condom is also an effective part of the solution in prevention of HIV/AIDS/STD in high prevalence areas. Most users preferred the FC Female Condom to the male condom and would use it again. Eighty-five percent of men indicated the FC Female Condom was pleasurable.

Mission Accomplished!

Questions to Hey J are answered by Jessica Burt, MPH, and Health Educator with Snohomish Health District. You can submit questions related to sexual health including HIV/AIDS and sexually transmitted diseases (STD's), addressed to 'Hey J' at [info@pwnetwork.org](mailto:info@pwnetwork.org). Or mail to Hey J, c/o Positive Women's Network 3701 Broadway, Everett, WA 98201.

#### Sources:

- WHO (2002) The safety and feasibility of female condom reuse: Report of a WHO consultation', Geneva, January 28-29
- Female condom re-use issues explored, Network 2003. Vol 22, No 4
- Re-use of the female condom: Now for the practical realities, Philpott, A., Reproductive Health Matters 2003, 11(22): 185-186
- [www.femalehealth.com](http://www.femalehealth.com)
- [www.fwhc.com](http://www.fwhc.com) (Feminist Women's Health Center)



## Kegels Hold Up as Urinary Continence Treatment

— Harvard Women's Health Watch  
*Volume 13 - # 9 - May 2006*

A review of studies confirms that women with urinary incontinence can benefit from pelvic floor muscle training, better known as Kegel exercises. The review appeared in *The Cochrane Library* (2006, issue 1), published by The Cochrane Collaboration, an international organization that evaluates medical research. The authors examined randomized trials comparing pelvic floor exercises with no treatment, a placebo, a sham treatment, or some other type of control treatment. Women who did the exercises were more likely to report being cured or improved compared with the women who did not. The Cochrane review also suggests that receiving training in how to identify and exercise the right muscles boosts the effectiveness of a Kegel regimen.

Urinary incontinence — the involuntary loss of urine — is a problem for as many as 30% of women in the United States. The most common type is stress incontinence, which can occur with coughing, sneezing, laughing, and physical activities such as jumping. Another form, urge incontinence, is the inability to hold back urine after feeling the urge to urinate. Some women have both types. Kegel exercises (named for Arnold Kegel, the physician who first described them) are usually recommended for stress incontinence but only sometimes for urge and mixed incontinence. The Cochrane review found that they helped with all three types of incontinence. Trials of women with stress urinary incontinence suggested greater benefit for those in their 40s and 50s who were in a supervised program lasting at least three months. But further study is needed to explore these factors.


Pelvic floor muscles run from the pubic bone to the tailbone, with openings for the urethra, vagina, and anus. They're the muscles you use to hold back urination and thus are important in maintaining continence. They may weaken due to age and, possibly, the loss of estrogen at menopause. Many experts believe that damage during vaginal childbirth also places a woman at risk for urinary incontinence. But not all studies support this idea. For example, in a study of pairs of postmenopausal sisters — in each pair, one sister had given birth vaginally and the other had never given birth — researchers found no difference in the incidence, type, or severity of incontinence (*Obstetrics and Gynecology*, December 2005).

### How to Kegel

To perform Kegel exercises, you first need to find your pelvic floor muscles. Pretend you're trying to avoid passing gas while simultaneously tightening your vagina around a tampon. You should feel the contraction more in the anal area than the front. Avoid contracting the muscles of your stomach, legs, or buttocks.

Once you've located the pelvic floor muscles, practice contracting and relaxing them repeatedly, alternating short contractions and releases (called flicks) with longer ones. Mastering long contractions may take more practice. Start by holding each one for 3–5 seconds, resting the same number of seconds between contractions. Build up to 10-second contractions, with 10 seconds of rest between contractions.

Try to do 30–40 Kegels every day, divided into groups of 10 each. You can start by lying on your back until you get the feel of contracting the pelvic floor muscles. Later, practice in different positions. For example, you might do 10 Kegels before getting out of bed in the morning, 10 standing after lunch, 10 in the evening while sitting, and another 10 before going to sleep.

You can also use Kegels to control symptoms. If you have stress incontinence, tighten your pelvic floor muscles just before lifting, coughing, or whatever usually causes urine leakage. Do the same several times when you have the urge to urinate and doubt you can to make it to the bathroom in time. 

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## Is There a Downside to Low-Sodium Diets?

— Harvard Health Letter  
*Volume 31 - # 8 - June 2006*

We're supposed to limit our daily sodium intake to less than 2,400 milligrams, which is about the amount in a teaspoon of table salt. In return, we cut our high blood pressure risk.

But a Canadian researcher says all the low-sodium admonitions may be having the unintended consequence of lowering iodine consumption.

We need iodine in our diets because the body needs it to make thyroid hormones. In adults, those hormones regulate metabolism and in children, they're critical to


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mental and physical development. The Recommended Dietary Allowance (RDA) for adults is 150 micrograms a day. Thyroid disease from iodine deficiency used to be a big problem in the United States and many other countries. But the addition of iodine to salt has greatly reduced the problem and is one of the most successful public health interventions ever. In the United States, only table salt is iodized, not the salt used in processed food.

Stephen A. Hopton Cann, a researcher at the University of British Columbia in Vancouver, lays out his hypothesis in the *Journal of the American College of Nutrition*. He starts by noting that iodine deficiency is becoming more common. In the 1970s, the health surveys indicated that 1 in every 40 Americans had a moderate-to-severe iodine deficiency. Twenty years later, it had grown to 1 in every 9.

Then he cites research showing table salt intake has declined. By avoiding the salt shaker in the name of sodium reduction we may be inadvertently reducing our iodine intake, Hopton Cann says. He goes on to weave together various study results into an argument that low iodine intake might increase the risk for cardiovascular disease.

It's all pretty tenuous. But we've got another reason to eat saltwater fish. And people who love sushi, with its iodine-rich seafood and seaweed, can hope they've fallen for a health food. 

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## Women at Greatest Risk for HIV Feel Powerless to Protect Themselves from Infection

— National Women's Health Report

### New NWHRC Report Highlights Societal and Physiological Inequalities for Women Facing HIV/AIDS

June 2006. Red Bank, NJ - A new report by the not-for-profit National Women's Health Resource Center (NWHRC) finds that although women account for nearly half of all AIDS cases worldwide, those at greatest risk still do not feel empowered to protect themselves against the deadly virus. According to "Women & HIV," the latest issue of the National Women's Health Report, U.S. women often are powerless to protect themselves. Some don't insist

that their partners wear condoms during intercourse, while others don't take the antiviral medication known to dramatically increase survival rates.

Minority women bear the greatest burdens imposed by this disease. African-American women account for nearly 60 percent of all AIDS cases in women in the U.S., with a diagnosis rate 25 times that of white women and about four times that of Hispanic women. HIV/AIDS experts in the latest NWHRC Health Report blame "centuries of unequal treatment of women" within minority communities resulting in dangerously submissive behaviors as well as sexual abuse that leads to HIV infection.


Unfortunately, once infected, most women continue to put their health last, rarely making time to take care of themselves before taking care of others. As cited in the Health Report, just one in four women eligible for the antiretroviral therapy known as HAART—highly active antiretroviral therapy—are on the regimen.

"We've always known that from a health care perspective, women consistently put themselves last on the list, putting the needs of their families first," stated Elizabeth Battaglino Cahill, RN, executive director for the NWHRC. "When you combine this behavior with the continued stigma women with HIV must confront, the results can be deadly."

The Health Report also identifies how the disease physically affects women differently and with more intensity than men. For example, the virus is two to four times more transmissible to women. Other physiological differences include:

- Adolescent girls are particularly vulnerable to HIV infection due to their unwillingness to negotiate condom use and an increased chance of vaginal tearing during intercourse.
- The risk of HIV infection doubles during and immediately after pregnancy.
- Having another sexually transmitted infection (STI) increases the risk of HIV infection up to tenfold, and women are more likely to have an STI than men.

The report also discusses the latest advances in HIV/AIDS research, takes a special look at HIV and pregnancy, and includes a Lifestyle Corner column by NWHRC medical advisor Pamela Peeke, MD, MPH, that offers tips for living with HIV.

For a complimentary copy of the National Women's Health Report, "Women & HIV," please visit [www.healthywomen.org](http://www.healthywomen.org) or call 877-986-9472. 



## Enthusiasm: Fuel for Life

—Shobhna Hendry, M.S., CMHC

It appears to me that there are a lot of books and talks by people on how we need to think positive and be optimistic in life. In fact, there is more and more research being conducted to examine the healing power of being optimistic. Scientists are studying the effects of hope and optimism on the healing process.

It is not surprising that as humans we want some research to validate and quantify something that offers us comfort and inspiration in time of need. Can an optimistic attitude heal us in the face of illness, disease, an emotional crisis? If so, how do we scientifically define and measure the results of healing?

Jerome Groopman, M.D. examined the lives of his patients with cancer and HIV to determine whether hope changes the course of their illness. He further distinguished between optimism and hope. Groopman states that optimism blooms from an outlook that life always turns out for the better. Hope on the other hand he states is an elevated feeling which is rooted in reality. He says hope offers us courage to confront our circumstances and the capacity to overcome them. The dictionary defines optimism as “an inclination to anticipate the best possible outcome”

I tend to think of hope as being more resilient and enduring. In a serious illness for example there may be setbacks and optimism may wear down, but hope encourages us to move forward and be open to possibilities as they unfold, with no attachment to the perfect outcome.

Hope seems to be a powerful motivator. C.R. Snyder, a University of Kansas psychologist, posed the following hypothetical situation to college students: “Although you set your goal of getting a B in a class, after your first exam, which accounts for 30% of your grade, you find you only scored a D. It is now one week later. What do you do?” Snyder found that hope made all the difference. Students with high levels of hope said they would work harder and thought of a wider range of things they could do to improve their final grade. Students with moderate levels of hope thought of several ways to improve their grade, but had far less determination to pursue them. Students with low levels of hope gave up attempting to improve their grade, completely demoralized (Goleman, 1995).

Results from some studies have concluded that prayers from afar can have beneficial effects on health. Telling the patient they are being prayed for increases hope and speeds their recovery. This specific issue has actually drawn

a lot of attention. The federal government has spent \$2.2 million in the past five years on studies of distant healing, which have also drawn support from private foundations. There are of course just as many studies which suggest no significant link to prayer and healing.

Physicians already acknowledge the power of the placebo. The placebo effect, as it is commonly referred to, is the belief that a medication will have benefits and creates positive results. In 1955, researcher H.K. Beecher published his groundbreaking paper “The Powerful Placebo,” in which he concluded that, across the 26 studies he analyzed, an average of 32 percent of patients responded to a placebo. Michael Jospe, a professor at the California School of Professional Psychology who has studied the placebo effect for more than 20 years stated “The placebo effect is part of the human potential to react positively to a healer. You can reduce a patient's distress by doing something which might not be medically effective but just provide hope.”

The research continues. In the meantime, you and I can decide as to the power of optimism and hope as healing tools. I already know that no amount of further research will change my mind. Based on personal experience I believe in the power of hope. I believe in the global state of optimism. Moreover, I believe that in order to be optimistic and remain hopeful one must enjoy a certain degree of enthusiasm.

Enthusiasm is the fuel which keeps the feeling of hope and state of optimism alive. With enthusiasm, either in a fractioned portion of our life or encompassing our whole life, we move forward with momentum towards our purpose and goals. Setbacks do not indicate failures, but opportunities to learn. In my opinion the questions we need to focus on are of a more personal note. What brings you joy? What fuels your life and brings you the energy you need? What do you get enthusiastic about? Use your answers as your guiding light to keep hope and optimism alive. Allow your hope and optimism to carry you through illness, disease, an emotional crisis. As far as scientifically defining and measuring the results of healing~ do we have to quantify an experience that so many people find solace in?

“Years may wrinkle the skin, but to give up enthusiasm wrinkles the soul.” ~Samuel Beckett.

Resources used:

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- Groopman, Jerome M.D. (2003) The Anatomy of Hope: How people Prevail in the Face of Illness.
- Researchers Look at Prayer and Healing: Conclusions and Premises Debated as Big Study's Release Nears, by Rob Stein, Washington Post Staff Writer Friday, March 24, 2006.
- The Healing Power of Placebos by Tamar Nordenburg. FDA Consumer Magazine, VOL. 34 #1 January/February.

## Posture and Arthritis

— Dr. Todd Luther D.C.

We've all been told to sit up straight and not to slouch. Those who told you that were wise because, to some degree, they understood that poor posture affects health.

Poor posture damages your spine, it can be painful and it causes arthritis.

However, if you start early, it is preventable, and if you already have poor posture, the chiropractors can even correct it. Lets take a look at how this works.

Take two people of the same age, one with good upright standing posture and the other with a rounded mid-back, rolled forward shoulders and a forward head. Which person would typically be healthier? The answer is the former, and it's been proven.

Last year, in the top orthopedic journal Spine, a study was published where 752 adult patients had their posture precisely measured using x-ray, and they also filled out three health status questionnaires.

The researchers found a linear relationship between poor posture and a decline in all measures of health status. This means that rolled forward shoulders a rounded mid back and forward head posture are harmful to your health. Importantly, they found that even minor imbalances in posture are harmful to health. This means that we all need to work on our posture.

Posture affects your health because the condition of your spine directly affects the health of your central nervous system, which is your brain and spinal cord. The central nervous system directly or indirectly controls every cell tissue and function in your entire body.

Researchers have demonstrated that deformities in the posture of your neck (a.k.a. "forward head posture") actually compresses and flattens your spinal cord which chokes off vital blood supply to the nerve tissue.

Frighteningly, this also leads to demyelination, which is when the protective layer around your nerve tissue breaks down. Demyelination is also a cause of the disease multiple sclerosis.

Poor posture also causes arthritis (a.k.a.: DDD, DJD and osteoarthritis) in your spine. Arthritis is when your joints wear out causing pain, inflammation and spinal deformity.

At Hanson Chiropractic we often use the "alignment in your car" analogy to explain how spinal misalignment or poor posture causes arthritis. If the wheels in your car are

out of alignment, then the tires wear down quicker. This also applies to your spine. If your spine is out of alignment (poor posture), then the discs and joints will wear out faster. In fact, its been shown they wear about 10 times faster! So having good posture is essential to preventing arthritis in your spine.

Spinal misalignment / poor posture can also be extremely painful; however, many times it is not. What most people don't realize though, is that whether or not they have pain at the time, the nervous system is suffering and the joints are wearing out at a high rate of speed.

Then, one of two scenarios takes place: pain and stiffness develop slowly over time becoming more and more severe, or a crisis takes place when your "back goes out" from something simple like picking up a coin or even doing nothing at all.

Taking a preventative approach to correcting poor posture is the wisest decision because once the damage is done it cannot be reversed.

Ask your chiropractor if they have the ability to do this: to fix your posture, or to get it to as near normal as possible, so that your spine will last a lifetime and not wear out.

Remember that poor posture affects every aspect of your health and that there is a normal position for your spine.

Dr. Luther practices at Hanson Chiropractic in Everett, WA.



# WHO QUALIFIES FOR THE BASIC FOOD PROGRAM? YOU MIGHT IF:

Your monthly gross income  
is at or below:  
(Values updated every October)

One Person	\$1,037
Two People	\$1,390
Three People	\$1,744
Four People	\$2,097
Five People	\$2,450
Six People	\$2,803

Qualifying for Food Assistance will  
not hurt an immigrant's chances of  
becoming a citizen.

You may receive deductions for:

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This material was funded in part by the USDA Food Stamp program.  
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handicap, religion or political belief.



## Wash Your Hands

—Harvard Men's Health Watch,  
*Volume 10 - #12 - July 2006*

Harvard Medical School can claim many important discoveries in its more than 220 years of research and education. One of its most important contributions, though, is often overlooked amid the glitter of today's dramatic advances in science and technology. In 1843 Dr. Oliver Wendell Holmes, the school's eighth dean, discovered that childbirth fever was spread by contamination on the hands of doctors and nurses. It took decades for scientists to discover that the bacteria transmitted by health care personnel were streptococci. Even then, the profession was slow to adopt handwashing to prevent infection. In fact, the struggle to ensure proper handwashing in hospitals is still in progress. But you should combine Dr. Holmes's sentinel observation with the insights of 21st-century microbiology to protect yourself from infection.

### Skin and Bacteria

Human skin — even in the most healthy and fastidious of us — is teeming with bacteria. Most of those bacteria are rather wimpy critters that cause disease only under special circumstances. But everyone also carries potentially dangerous germs from time to time, such as staph, strep, and the intestinal bacteria that cause food poisoning and diarrhea. Sad to say, health care personnel — including your doctors and nurses — are particularly likely to carry the most troublesome bacteria, especially on their hands. In fact, health care workers carry up to five million bacteria on each hand. And although viruses don't set up shop on the skin the way bacteria do, the viruses that cause diarrhea and respiratory infections — from the sniffles to the flu — can hang around on the hands long enough to spread from person to person.

If your skin is covered with so many bacteria, why don't they make you sick more often? Although the skin

is a hospitable resting place for bacteria, it is also a tough barrier that prevents hostile bugs from reaching the body's vulnerable internal tissues. Ironically, perhaps, some of the traditional methods of removing bacteria from the skin can disrupt the skin's own defenses. Scrubbing, for example, can produce minute abrasions that allow bacteria to sneak into your tissues. Detergents can remove the skin's oils, which have important antibacterial properties. Even plain water can remove oil, leaving the skin dry and vulnerable.

Good handwashing, then, involves two potentially conflicting goals: removing microbes while still keeping your skin healthy.

### Preached But Not Practiced

Cleanliness may not actually be next to godliness, but handwashing is an important part of many religious rituals. Handwashing is also preached by civic authorities, ranging from your mother ("Wash your hands before you eat, dear") to the local board of health ("Employees must wash their hands before returning to work"). It's good advice — but do Americans follow it?

Often, we don't. When intrepid investigators from the American Society for Microbiology surveyed public restrooms around the country, they found that only 83% of people washed up after using the toilet. Do posted reminders to "Please Wash Your Hands" help? When researchers from Pennsylvania State University tested this simple strategy, they found that handwashing improved in women but not in men.

The gender gap applies to hospitals, too. In one study, female physicians washed their hands after 88% of patient contacts, but male doctors washed after just 54%. Without specifically comparing men and women, another study added confirmation when it reported that nurses washed after 50% of encounters, while the rate for doctors was a rather pathetic 15%. And in another gender-blind hospital study, the overall rate of handwashing was just 48%. Even in Switzerland, a land famous for cleanliness, doctors adhered to hand hygiene guidelines only 57% of the time.



### Does It Work?

Yes.

Just 30 seconds of simple handwashing with soap and water reduces the bacterial count on health care workers' hands by 58%. And there is an even better way: Alcohol-based handrubs (discussed below) reduce counts by 83%. Reducing the number of germs is one thing, actually preventing infection another. But a two-year study of Navy recruits shows that handwashing pays big dividends. A simple soap and water handwashing campaign reduced clinic visits for respiratory infections by 45%, and the sailors who washed most often enjoyed the greatest protection.

### What's Best?

Soap and water is the time-honored technique, and it does work. In fact, it's still the best way to remove visible soilage and particulate material. But as the public has become concerned about the risk of infection, soaps with antibacterial additives have gradually taken over 45% of the market. It's understandable, but it's not helpful; antibacterial soap is no better than ordinary soap, and the additives actually increase the risk of allergic reactions and other side effects. The only exception is that the spores of the anthrax bacillus are more susceptible to antimicrobial soap than ordinary soap. Unless the bioterrorism of 2001 resurfaces, however, that's not a worry for ordinary folks.

Plain soap will do the job — and so will plain water. Tap water is excellent, and cool or lukewarm temperatures serve as well as hot water. In fact, excessively warm water may do more harm than good by damaging skin.

If soap and water are not available, antibacterial wipes can help. Although they are not as effective, they will reduce bacterial counts. Antibacterial towelettes are particularly convenient for travel and picnics.

Washing with soap and water is the best way to remove dirt, but waterless, alcohol-based handrubs are even better at killing germs. Handrubbing is faster and more convenient than handwashing, and it's also easier on the skin. Hospitals are switching to handrubs because they kill more bacteria and viruses and they are used more regularly. Alcohol-based rubs and gels are also available for use at home. The best products contain 60%–95% isopropanol or ethanol.

### When and How

Without succumbing to the corruption of machine politics, you should apply the legendary method of rigged voting to handwashing: Do it early and often.

Wash your hands before each trip to the dining room and after each trip to the bathroom. Wash after handling diapers and animals. Wash before and after you handle food. Wash after you take out the trash, work in the yard, clean the house, repair the car, or do other messy chores. Wash before and after sex. Wash after you come in contact with anyone who is sick, particularly if they have a respiratory infection or diarrhea. Wash your hands whenever they look or feel dirty, but use common sense. If you follow reasonable guidelines you'll be washing often, but you won't become obsessive or compulsive. Be careful, not fearful.

How should you wash? Liquid, bar, powdered, and lather forms of plain soap are all acceptable. Wet your hands with water, then apply the soap to your palms. Rub your hands together briskly for at least 15 seconds before rinsing. In most cases, removing jewelry is not necessary. If your nails are dirty, scrub under them with a nailbrush, but unless you are a surgeon preparing to operate, don't scrub your skin. Whenever possible, use a disposable towel to dry your hands thoroughly, and use the towel to turn off the faucet.

Alcohol-based handrubs are preferred for health care workers, and you should consider using them at home when dirt is not an issue but infection is a particular worry. Apply the recommended amount of the gel or rub to the palm of one hand, then rub your hands and fingers until your hands are dry. If your hands dry in less than 15 seconds you have not used enough rub; if it takes 30 seconds or longer, you've applied more than you need.

Skin care is also important. Alcohol-based rubs are easy on the skin, but if you use a lot of soap and water, your skin may get dry, itchy, or cracked. Soaps that contain bath oil may help, but the best protection is to apply a moisturizer after each wash.

### Protect Yourself

In today's world, infections are more worrisome than ever. Fortunately, simple precautions can go a long way toward protecting you. Do your best to minimize close contact with anyone who has an infection, and protect others by coughing or sneezing into a tissue. Keep up with your immunization; for most American adults, that means a tetanus-diphtheria-pertussis booster every 10 years, a flu shot each fall, and a pneumococcal pneumonia vaccine at age 65. Check with your doctor about immunizations and medications for travel. Always practice safer sex. Avoid exotic pets and unnecessary animal contact. Be alert for infectious agents and travel advisories. Consider wearing a high-quality respirator mask (N95) if

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there is a realistic worry about exposure to a virulent respiratory agent such as bird flu or tuberculosis. And above all, wash your hands. It's the most common and obvious precaution — but for all its simplicity, it's the most important.

What about gloves?

Your physicians wear them when they give you shots, draw blood, or operate. Your dentists wear them whenever they probe in your mouth. And many of your food preparers wear them when they make your sandwich. Do gloves help? And should you wear them?



Gloves do help protect health care workers from germs you may be harboring, and they are required whenever there is contact with blood or body fluids. Gloves (and gowns) have been quite effective in reducing patient-to-patient

transmission of infections in hospitals. And it's a two-way street: Gloves will also protect you from infection whenever you undergo an operation or other invasive procedure or test. But it's not clear if gloves will help reduce the transmission of foodborne infections. Medical personnel change their gloves after each patient contact, but food handlers don't change after each use, and gloves can get dirty, too.

The gloves worn by medical personnel are usually made of natural latex rubber or various synthetic vinyl and plastic polymers. Latex gloves are a bit more reliable, but they cannot be used if the provider or patient is allergic to latex, an increasingly common problem. Powder-free gloves are the most convenient.

Gloves are very important for health care workers and hospitals. Except in very unusual circumstances, though, you won't need them at home. Even in hospitals, in fact, personnel are instructed to use an alcohol-based handrub after they take off their gloves.

At home, you can skip the gloves and go straight to washing your hands.



## Message from Kim Schaff

Inflammatory Breast Cancer has been in the news a lot lately. Positive Women's Network has received several phone calls from concerned women. We are thankful for the increased awareness of inflammatory breast cancer that Komo4-TV has brought to our community ([www.komotv.com/ibv/](http://www.komotv.com/ibv/)).

The key to remember is that the majority of breast cancers are not inflammatory breast cancer. In fact, inflammatory breast cancer only accounts for 1 - 6% of all invasive breast cancers; however, it is a very aggressive cancer and is not usually detected until it has spread. The term "Know Thyself" has never been more appropriate.

According to Cancer.org, in the United States in 2005, 269,730 new cases of breast cancer were diagnosed among women, 211,240 were invasive breast cancer, and out of that number 12,674 were inflammatory breast cancer. In Washington State it is estimated 4000 women will be diagnosed in 2006 with breast cancer, early stage and invasive. Of the invasive (advanced) breast cancers, 6% will be inflammatory.

It is critically important that women pay attention to their bodies. Notice when your breasts look different or change in any way. Remember to do a visual exam as part of your monthly breast self-examination. Listen to your body and trust your intuition. If you feel there is something wrong, pursue that feeling until you know that everything is okay. Nothing takes the place of personal awareness. The advantage to all our modern technology is that women are being diagnosed with breast cancer at earlier stages than ever before. But the best technology we have still isn't perfect; it doesn't detect all cancers, including inflammatory breast cancer.

Most women want to do their breast exams and want to know what to look for, but feel uncertain. A new local non-profit organization called Check Your Boobies will send a health educator along with a breast cancer survivor to your home, work or community group free of charge to educate you and your friends on how to perform a monthly breast self-examination. You can contact them at [www.checkyourboobies.com](http://www.checkyourboobies.com).



## Alcohol Over Time: Still Under Control?

—Harvard Women's Health Watch  
Volume 13 - #11 - July 2006

For women, there's not much leeway between healthful and harmful drinking, especially as we get older.

Currently, the word is that moderate drinking can be good for you. Various studies suggest that it promotes longevity, helps prevent cardiovascular disease, and lowers the risk for dementia and other ills. What hasn't made as many headlines are the downsides for women, especially drinking that starts at a moderate level but eventually becomes a problem. Why this happens and to whom isn't fully understood. Most people who drink in moderation do so with little or no risk. But 1 in 13 adults in the United States has developed a serious alcohol problem, and at least six million of them are women. According to the National Center on Addiction and Substance Abuse (CASA) at Columbia University ([www.casacolumbia.org](http://www.casacolumbia.org)), published figures are probably an underestimate of alcohol problems in women, in part because they don't take into account drinking patterns that are not serious enough to be called abuse or addiction but still have damaging physical and psychosocial consequences.

At every age, women develop drinking problems at lower levels of alcohol consumption and over shorter periods of time than men do. Women are also less likely to get medical attention for the problem, often because physicians don't recognize the signs in women. Older women are especially susceptible to alcohol's harmful effects and may be at particular risk. According to CASA's analysis of substance abuse in women, *Women Under the Influence* (Johns Hopkins University Press, 2006), about half the cases of alcoholism in older women begin after age 59.

You don't need to be addicted to alcohol to have a problem. For women, there's a fine line between healthful and harmful drinking. Moderate drinking means no more than seven drinks per week and no more than three in a single day. But even these levels don't guarantee safety. What constitutes moderation varies with many factors, including age, genetic makeup, and health. What's okay in your 30s or 40s can be risky after age 60. And if you have liver problems or a history of alcohol addiction, no amount of alcohol is moderate or safe.

No one should feel obliged to start drinking for the health benefits. There are plenty of other ways to safeguard your health, including exercise, a nutritious diet, weight control, and not smoking. But if you enjoy alcoholic beverages, it's important to know when and where to draw the line — and to be prepared to redraw it as you get older. Fortunately, there are ways to determine how much is too much and limit your intake.

### A Special Concern for Women

Women are more sensitive to alcohol than men are. That's because our bodies contain proportionately less water and more fatty tissue than men's bodies. Water dilutes alcohol in the bloodstream; fat retains it. So our brains and other organs are exposed to higher concentrations of alcohol for longer periods of time. At any given dose, even after accounting for differences in body weight, our blood levels will be higher, and we'll be more intoxicated (and more likely to suffer a hangover). Moreover, men's stomachs secrete more alcohol dehydrogenase, a digestive enzyme that breaks down alcohol before it reaches the bloodstream. As a result, one drink for a woman, on average, is the equivalent of two for a man.

### Age and Alcohol Use

Our bodies contain even less water and more fatty tissue as we age, so blood alcohol concentration rises faster. We also metabolize and eliminate alcohol more slowly and less effectively. And older women are more likely to take multiple medications that may interact with alcohol, further raising the risk of accidents and health problems. Women often turn to alcohol when faced with later-life changes, such as the loss of a spouse or friends, health problems, financial insecurity, or empty-nest syndrome. After retirement, some women engage more in social activities that involve alcohol, or drink more in order to relieve boredom. A woman may conceal her drinking problem or seek help for its symptoms — insomnia, depression, or anxiety — without mentioning the underlying reason. Moreover, physicians may fail to recognize the problem because of cultural bias. "A woman just can't be an alcoholic," elaborates Nancy Waite-O'Brien, a psychologist at the Betty Ford Center in Rancho Mirage, Calif., and a speaker at a recent CASA conference on substance abuse in women. "She doesn't look like it. She comes from a nice family. Or she has an education. So she just can't be."

If the symptoms of alcohol abuse are mistaken for depression or anxiety, a woman may be given a psychoactive drug that raises the risk of multiple addictions or drug-alcohol interactions.

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### Weighing the Benefits

There's solid evidence for benefits from moderate drinking. For example, the Nurses' Health Study (NHS), a large-scale, 30-year study of women's health, found that one drink per day, compared to no drinking at all, reduced women's risk for heart disease and stroke by 50%; beer, wine, or spirits provided the same benefit. A Swedish study of women with heart disease found that wine (but not beer or spirits) improved a measure of heart risk called heart rate variability.

Not everyone is swayed by such findings. An international team of researchers, analyzing 54 studies on the relationship between alcohol consumption and mortality, reported in the May 2006 issue of *Addiction Research and Theory* that most of the studies were flawed — because they included among the “abstainers” former drinkers who quit for health reasons. Thus, the higher death rate in this group (compared to the alcohol-imbibing group) may have had little to do with lack of alcohol consumption. When moderate drinkers were compared with long-term nondrinkers, there was no difference in mortality.

Some studies suggest that older women who drink moderately have improved cognitive skills, compared with women who don't drink at all, but it's not clear whether other factors might be at work, such as education or overall health habits. The NHS found that women who consumed an average of one drink per day had higher bone density than nondrinking women, but this benefit was outweighed by the increased risk of falling and resultant hip fractures.

### The Risks

Alcohol — as little as one-half drink per day — is an established risk factor for breast cancer. One explanation: It raises estrogen levels in the blood, which can promote the growth of breast tumors. It may also stimulate a particular type of breast cancer. A study of women ages 65–79 found that those who consumed about two drinks per day were more likely than nondrinkers to develop hormone-sensitive breast cancer (especially lobular cancer). Taking folate may lower this risk. Among women in the NHS who had one drink or more per day, the risk of breast cancer was higher in those with low folate intake. Some studies suggest that low folate also plays a role in the slight increase in colon cancer risk that's been linked to moderate alcohol consumption.

Moderate drinking for men — two drinks per day — is the threshold of heavy drinking for women. Women are quicker to become alcohol-dependent and to suffer the consequences, which include brain damage; psychiatric problems; damage to the cardiovascular, musculoskeletal,

and gastrointestinal systems; anemia; and fatal accidents. Even if you drink fewer than seven drinks per week, you're at risk if you occasionally have four or more on a given day.

Thus far, few studies have focused exclusively on women or included enough older women to provide conclusive evidence on the particular health risks that drinking has for them. But in the absence of more information — and given their increased susceptibility to alcohol-related problems — women 65 and over should be especially careful to limit themselves to one standard drink per day. ... They may want to consider drinking even less, especially if they're taking medications that could interact with alcohol.

### Do I Have a Problem?

There are many ways to tell, including several simple questionnaires:

**CAGE Test.** This test asks: Have you ever felt you should Cut down on your drinking? Have people Annoyed you by criticizing your drinking? Have you ever felt Guilty or bad about your drinking? Have you ever taken an Eye-opener (a drink first thing in the morning)? One “yes” suggests that you might have a drinking problem. Two or more mean you probably do. But you could have a problem even if you answer “no” to every question.

**AUDIT.** Another screening tool is the 10-question AUDIT (Alcohol Use Disorders Identification Test) developed by the World Health Organization. An online version is available at [www.alcoholscreening.org](http://www.alcoholscreening.org).

**Number of Drinks.** Some research suggests that it's possible to screen for risky alcohol use with a single question: “On a typical day when you're drinking, how many drinks do you have?” If you answer “three or more,” you probably have an alcohol problem.

**Drinking Patterns.** Binge drinking (four or more drinks on a given day or occasion) is a sign of an alcohol problem, even if you rarely drink that much and even if you abstain most days. For a woman, taking more than one drink every day also indicates an alcohol problem.

### What To Do

If you think you might have a problem with alcohol — especially if you feel depressed or irritable — speak with a trusted clinician or pastoral counselor, or make an appointment with a mental health professional. Having an alcohol problem doesn't mean that you're an alcoholic or that abstinence is the only solution — assuming you tackle the problem early enough, can learn to drink in moderation, and don't have a genetic vulnerability to alcoholism.



One strategy for people who aren't alcohol-dependent but are drinking too much is the "brief intervention." This typically involves one to four visits with a health professional such as a physician, nurse, or social worker who evaluates an individual's drinking pattern, discusses the possible health risks, and offers nonjudgmental advice on cutting back. You can find out more on the Web site of the National Institute on Alcohol Abuse and Alcoholism (NIAAA): [www.niaaa.nih.gov](http://www.niaaa.nih.gov).

Here are some other suggestions for cutting back — or stopping altogether:

**Set a Goal.** Decide on a drinking limit. Write it down. Tell a friend. Track your progress in a drinking diary — a sample diary can be found on the NIAAA Web site.


**Change Your Pattern.** Decide not to drink for several days each week. Or try abstaining for two or three weeks to see how you feel. Taking a break can be a good way to start drinking less. You may be pleasantly surprised by

how much more productive you are with less alcohol in your life. If you're used to a drink before dinner, pour yourself a glass of water, seltzer, or diet soda instead. You may find that your desire for a drink fades.

**Drink Carefully.** Sip your drink slowly. Savor it. Set it down often. Make it last for more than an hour. After one drink, have a glass of water.

**Find Other Ways to Relax.** Fatigue, loneliness, and stress sometimes trigger the desire for a drink. Instead, take a walk, put on a record and dance, or go out to a movie.

**Take a Class.** Pick up a new hobby, or revisit an old one. Plan games or other activities after a meal to reduce the temptation to stay at the table and drink.

**Take a Measure.** Know what a standard drink looks like. Measure out 5 ounces of water, for example, and pour it into various wine glasses. When you're dining out or socializing, you'll have a better sense of what you're getting — and when to draw the line. 

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## Middle-Income Americans Without Health Insurance

—Victoria Colliver, Chronicle Staff Writer

The number of moderate-to-middle-income Americans of working age who lack health insurance has risen dramatically in recent years, according to a study released in April 2006.

Forty-one percent of adults with incomes between \$20,000 and \$40,000 a year did not have health insurance for at least part of 2005, up from 28 percent without coverage in 2001, according to the report by the Commonwealth Fund, a New York-based health care policy foundation. The report illustrates how employers are dropping health coverage or are offering insurance plans that are too expensive for many workers to afford, according to the authors.

The Commonwealth study found that the percentage of individuals earning less than \$20,000 a year without insurance rose to 53 percent, up from 49 percent in 2001. Overall, the percentage of people without insurance rose to 28 percent in 2005 from 24 percent in 2001. About 45.8 million Americans did not have health insurance in 2004, according to the U.S. Census Bureau.


The percentage of businesses offering health benefits to their workers dropped to 60 percent in 2005 from 69 percent in 2000, according to the latest annual report on employer-sponsored health insurance by the Kaiser Family Foundation and Health Research and Educational Trust. That report found the \$10,880 average annual premium

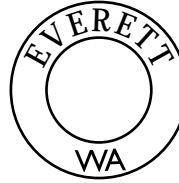
for a family of four in 2005 surpassed the yearly gross earnings of \$10,712 for a full-time minimum-wage worker. While employers pay most of that premium, workers are covering about 25 percent.

More than half of 4,350 people surveyed in the Commonwealth study said they had medical debt or bill problems.

Medical debt has become a growing problem among people with insurance. A Harvard University study released last year found that almost half of those who filed for bankruptcy in five states, including California, cited illness and medical bills as a major reason. More than 75 percent had insurance at the onset of illness. The Commonwealth report also found that 59 percent of uninsured people with chronic conditions such as asthma or diabetes either skipped a dose of their medicine or went without it because it was too expensive.

"Between employers dropping coverage and health care costs going up, the uninsurance crisis is reaching more broadly across the population," said Anthony Wright, executive director of Health Access, a coalition of California community and labor groups. "That's especially true in California, which already has one of the highest costs of living."

The Associated Press contributed to this report. 



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