To celebrate men’s and women’s health months in May and June, Valerie Mazziotti, PA-C joined us for a webinar to address some frequently asked questions in a mock primary care appointment.

Patient: Before we get started, I have a question. Why did I have to come in for this visit? Why couldn't I just send a MyChart message?

Valerie: Great question. We started doing more telemedicine appointments with the pandemic because people were afraid of coming into healthcare facilities and potentially being exposed. However, MyChart is not a good replacement for face-to-face, ongoing care. It's a great place to ask a quick question. For instance, “Can I change my pharmacy?” or “Do you want me to come in for labs?” You can also send your most recent blood pressure or blood sugar readings, but we can’t diagnose and treat you safely without seeing you. Statistics show that 40% of people stopped coming into their primary care clinics during COVID. Unfortunately, as a result, we’re seeing a lot more diabetes, heart disease, obesity, depression, and anxiety. We've also seen adults and children not getting their immunizations; some delayed cancer screenings; some delayed surgeries. People are more complicated than they've been in the past due to these conditions, and we really want to make sure that we're listening to you and we're doing what you need to keep your health optimal, which means we need to see you.

Patient: Okay, that makes sense… but I see a lot of specialists for my health issues regularly, so why do I need to come in periodically to see my primary care provider also?

Valerie: You see your specialists for a very important reason, but as your primary care providers, we can help you with a lot of other things. We provide continuity of care and make sure that everything you're doing is safe. For instance, as your primary care provider, we make sure you're getting your screening, like your mammogram, or having your cholesterol checked. Especially if you are seeing a specialist who is not within Valley, and we can't see your medical notes on the computer. In that case, it's really good to have you come in so we can make sure we know what medicines you're taking. This makes sure we don't ever prescribe something that's going to be a problem with medications that we didn't know about. Sometimes I have patients who come in after getting a report from their specialist and they don’t understand what some of it means, so we can sit down and go through it together to help them understand. We also get to know you; a lot of times we see the whole family and that helps us know how to treat you better.

Patient: That is helpful, thank you for explaining that. I've got kind of a couple things going on, but one of the biggest things that I'm dealing with is that I don't sleep very well. I feel tired all the time. What can I do to help improve my sleep?

Valerie: That's a great question. Who doesn't want to sleep more? Sleep is an interesting topic. We spend a third of our life sleeping. One big thing affecting people’s sleep is lighting. Being exposed to dark is one of the things that tells our bodies it’s time to sleep, but with TVs, cell phones and computers, our brains are constantly getting light, so they never get the message. So, one of the best things you can do for your sleep is have a routine that includes turning off all electronics one hour before bedtime. I also recommend not eating right before bedtime, because it increases your metabolism and makes it hard for your body to focus on sleep.

One of the things we don't want you to do is lay in bed and look at the clock and think about how tired you're going to be the next day, or how little sleep you've had. So, if you're not asleep in 20 minutes, we recommend you get out of bed and go into a different room. You can listen to some music, read a book, do some stretching, have a decaf beverage (no food), and when you start to feel tired, go back to bed. I know it sounds horrible to think about getting out of bed, but it will train your body to understand that getting in bed means sleep. Another little trick I like is when you go back to bed, instead of looking at the clock and thinking, "Oh my gosh, I have to get up in two hours and I'm going to be so tired all day," look at the clock and say, "Awesome, I get to sleep for two more hours." It makes everything change. It's all about how we talk to our bodies.

Also, specialists do not recommend sleep medicine if we can avoid it because most of the time the problem comes down to habits and patterns that we can help change, and we can start to sleep better. This includes limiting Melatonin. It can be helpful for some people, but our bodies naturally decrease melatonin production as we age. If you do take Melatonin, I have a couple of recommendations. The first is to take it at least two hours before bedtime because it doesn't have an immediate effect. If you take it right before bedtime, you may fall asleep, but then it starts to work in the middle of the night and it's still working when you're trying to wake up in the morning. The other thing that you want to do is keep your dose really low. Ideally, never more than three milligrams. You'll see it sold at much higher doses in the store, but those high doses can cause your body to stop making its own melatonin, which causes ongoing sleep problems. I would recommend starting with half a milligram to one milligram.

Patient: Great to know, thank you for that. I think a part of my difficulty sleeping is also because I've been feeling a little bit down lately. I've been dealing with some anxiety. Are you the right person to talk to about that or should I see a therapist?

Valerie: Well, I think the answer to that is both. You should really see both of us. I think we don't have enough emphasis on mental health. We certainly don't have enough insurance coverage for mental health, which has been a huge problem. We have fewer providers to work with since COVID, but I would say probably the majority of things that we see medically have something to do with your mental health. If you're not happy, you may be overeating, you may not have the energy or the motivation to exercise. Overall, it's going to affect your medical health as well. We can also help give you some ideas for how to find a therapist, which can be really hard to do right now, and some people do need medication. So, how do you know if you need medication? Well, working with a therapist is great because your therapist will know if you're not really progressing in therapy or they see signs and symptoms of more major depression that could benefit from medication. So, some of those symptoms might be, not having interest or pleasure in doing things, you could have problems with sleep, changes in your appetite, you might cry all the time or feel really irritable, you stop thinking about your future and maybe even think about maybe not being here; those are things that medication can probably help you with. We have a lot of safe options so never hesitate to come in, we're here for you. And sometimes we're just here to listen if that's what you need.

Patient: Great, thank you! I know at least a portion of what I've been feeling lately relates to my weight. I know being overweight isn't the best for my health, but can you talk a little bit about what my risks are specifically?

Valerie: We do have a lot of data that shows that being above your ideal body weight does cause health problems, and two of the major things that we see are heart disease and diabetes. Heart disease is

actually the number one cause of death in women – a lot of women don't realize that. In fact, in the United States, they say a person dies every 33 seconds from heart disease. In 2021, almost 700,000 people died of heart disease, 1 out of every 5 deaths. 1 in 20 people over the age of 20 have heart disease. One of the highest risk population is the African American population, which often get underserved as far as health care, which is a problem that we're trying to work on. Alcohol is a big part of heart disease as well, and we've really seen alcohol increase since COVID, especially in women. We deal with alcoholism in our primary care all the time. Heart risk increases with age, so the earlier that we can intervene and get your cholesterol down, and get your weight down and get you moving again, the less your risk of heart disease and that being your cause of death.

Diabetes is another thing we've seen a huge increase in. We see prediabetes, which is a person trending towards diabetes, all the time. People who've had diabetes when they were pregnant also have a higher risk. If someone in your family has diabetes, you have a 5 to 10 times more likelihood that you'll get diabetes. How do I know if I have diabetes? You might have increased thirst, increased urination, blurred vision and you might be feeling tired. If you don't treat diabetes, what happens? It affects your entire body. You can get eye disease and blindness, kidney disease, neuropathy (a painful nerve condition), or hypertension. One of the things people don't realize is diabetes is a major risk factor for dementia. The good thing is we have many, many new medications for diabetes, which are great. We have the new monitors, like the Freestyle and the Dexcom, which are helping to educate our patients and it's making a huge difference.

I know everybody has been hearing about the weight loss medicines, right? The Ozempic, the Wegovy; about a year ago, when these first came out on the market, we were able to prescribe these for patients who had risk for being overweight and maybe having pre-diabetes and insulin resistance. The problem lately is that these medications are very expensive. Ozempic out of pocket is about twelve hundred dollars a month. Insurance companies have figured that out and they don't want to pay for it, and they're not probably going to pay for it unless you're really a diabetic, and even then they may not pay for it. They may want you to try five other medicines first. And I know a lot of people are going online and using different programs where they can get the Semaglutide or Ozempic cheaper. If you're doing that, make sure you're getting labs done. Get your liver and kidney checked, make sure you've had an eye exam, because Ozempic can cause eye disease, and just make sure you know where this product is coming from. Patients are starting to use compounded products - what's in them? They're not FDA approved, they haven't had the safety rating –just be careful and we're here to help you. We're also more than happy to refer you to one of Valley's dietitians.

Patient: You mentioned diabetes. I've heard this term before, but I don't really understand what it is - what is pre-diabetes?

Valerie: Pre-diabetes means your blood sugar is not quite into the diabetic range. A normal blood sugar is 70 to 99 fasting, meaning you've had nothing to eat for 12 hours. Pre-diabetes is from 100 to 125. Diabetes is 126 and higher, or we use an A1C, which is a test that can tell us what your blood sugar's been over the last 90 days. An A1C less than 5.6 is normal, up to 6.4 is pre-diabetes, and above that is diabetes. But when you're in that pre-diabetic range, it means you don't have to go in that diabetic range. We have a lot of programs. The YMCA has a diabetes prevention program, which is amazing; we have our dietitians; we have nurses who can help you. There's tons of support out there for you, and we're here to help you, without judgment.

Patient: I heard someone say that menopause causes obesity. Is that true?

Valerie: That's a great question. Studies have shown that menopause itself does not cause weight gain, but menopause coincides with, around the age of 50, when all of us have a metabolic decline. It makes it very hard to lose weight, and many women gain weight, especially in the abdominal area. I can tell you pretty much every woman around 50 comes in and says, "What happened? What happened to my abdomen?" It's not specifically due to menopause, but due to a series of changes in your body that are occurring about the same time.

Patient: Can weight gain or obesity increase my risk of cancers?

Valerie: It can. One big one is uterine cancer. Obesity is one of the number one causes of uterine cancer and that's because fat tissue holds more estrogen, which stimulates the lining of your uterus, causing it to overdevelop the lining, and that's the risk factor for uterine cancer. The symptoms of that is abnormal vaginal bleeding. It can be treated, so if you have any abnormal vaginal bleeding, especially if you're over the age of 40, that does need to be evaluated.

Patient: Since we're talking about health risks, I also know that smoking causes lung cancer, but can it cause other diseases also?

Valerie: Absolutely. Some of the biggest effects are on your heart and on your lungs. It can lead to emphysema or COPD, where the airways are destroyed by smoking, and they don't work well, and people develop a chronic cough and shortness of breath. Tobacco smoke accelerates the formation of plaque in our arteries, which can eventually lead to a heart attack. Smoking can contribute to almost every cancer in the body. Smoking is also linked to cataracts, because when you're smoking, the smoke is coming up, and that's actually damaging to the lenses of your eyes. It also contributes to cervical cancer, so if you're having abnormal pap smears, you want to definitely make sure you're not smoking.

Patient: I've heard of a medication, Chantix? Can you tell me about that?

Valerie: Chantix was a medication that we prescribed to help patients stop smoking. Unfortunately, it was taken off the market. We have one option, called Wellbutrin or Bupropion, that can be helpful for patients. What a lot of people don't know is that Washington state has a lot of amazing resources for you to quit smoking. If you go to "Washington Quitline," they have free smoking cessation counseling for you, they have a lot of patient information on how to prepare to stop smoking, and it's all free! If you quit smoking, in about five years, your risk of disease starts going down. After 15 years, your risk of dying from having smoked, decreases by about 50%.

Patient: What about marijuana? It's legal now; does that mean it's safe to use?

Valerie: We're starting to see some studies now rolling in about chronic marijuana use, people who are using it every day, many times a day. The marijuana we have now can be stronger, more potent than it has been in the past. What we're seeing is people using it heavily are having some of the same heart disease issues that patients do who smoke cigarettes. If you're inhaling, anything going into your lungs, things aren't supposed to be going into your lungs other than your fresh air. In teenagers, there is more effect on the brain, on ADHD. For men, it can cause sperm problems, and it can cause an increased risk of testicular cancer if you're using it heavily. So, I think it's like everything else: a little bit is probably okay, but a lot is too much.

Patient: Can we talk about screenings? Like, for women, when do I need a mammogram?

Valerie: Usually we start at age 40, although the guidelines are always changing and there's many different organizations, and they all have different guidelines. I would suggest that you talk with your primary care provider about your personal health and your risk, and then you can decide when you are going to start mammography and how often you will get a mammogram. If you have some risk factors, you will want to do it more. Risk factors include a family history of a mother or a sister with breast cancer, especially if they had any of the breast cancer genes that made them at higher risk. Mammography these days is very safe, it's digital, with a very low level of radiation.

Patient: When do people stop getting mammograms?

Valerie: Most of the guidelines say 75, but women can live much longer than that and may live another 10 - 20 years. If you want to continue to do a mammogram, we can definitely continue to do mammograms.

Patient: Sticking to screenings for women while we're here. What about ovarian cancer?

Valerie: Despite urban legend, there is no screening for ovarian cancer. Fortunately, even though you hear about it, and it's a really horrible disease, it's actually pretty rare. It's about 22,000 cases in the United States per year. It's kind of a sneaky one, but people who have had ovarian cancer have reported some symptoms that led to the diagnosis. Sometimes they'll have an increase in urination, or even the development of incontinence of urine that they never had before; persistent abdominal; and pain, often in the pelvis or the back. If there's a distinct change in how you've been feeling, that's what we want to know about.

You may have seen people on social media recommending a “CA 125.” We do not recommend that. A CA 125 is a blood test and it is designed to be a tumor marker. If you had ovarian cancer, this may be ordered periodically if your care team thinks you may have a risk of the cancer coming back, but it's not a screening method. A CA 125 can be high because you're perimenopausal or for other reasons. Unfortunately, with ovarian cancer, you cannot see it on an ultrasound, you can miss it on a CAT scan, and the only way that you can say, “you don't have ovarian cancer,” is to have surgery and to have those ovaries removed. So, we really don't recommend that test and we will work it up if you have those symptoms, and obviously refer you to Gynecology Oncology if we have concerns.

Patient: Are there things I can do to reduce my risk?

Valerie: Yes! Number one is use of birth control pills. Even for a small period in your lifetime, it substantially decreases your risk of ovarian cancer.

By the way, the majority of the studies show there's no increased risk of breast cancer. Unless you have a super strong family history of a specific estrogen receptor-type of cancer, in most cases even daughters of mothers with breast cancer may be able to use the birth control pill.

Patient: I don't know if this will be the same for men and women, but when should people start colon cancer screening?

Valerie: Colon cancer screening is the same for men and women, because it doesn't pick one over the other. Just like breast cancer, you don't have to have a family history to develop colon cancer, and we're

seeing more and more colon cancer in younger people. That may be due to our diet, it may be due to the environment. As a result, this screening has recently been dropped from age 50 to 45. You have three tests to pick from for colon cancer screening, and the one that I always recommend over everything else, is the colonoscopy. The colonoscopy prevents cancer. When you have your colonoscopy done, what they're looking for are little growths called polyps, and polyps are the precursors to cancer. When they do your tests, they can remove those little polyps and they've removed cancer. And then then they know that you are a person who makes polyps, and they will probably screen you more frequently to make sure you don't get cancer.

The symptoms of cancer are rectal bleeding, unexplained weight loss, abdominal pain. By the time the symptoms have showed up, you may have a pretty advanced cancer. There's two other tests you may have heard of. One is called a Cologuard. Cologuard is a test that's sent to your house. You do a stool, you put the whole thing in the box, and you mail it back. What that looks for is the DNA of cancer. It's pretty specific for finding that cancer DNA. It can have a 14% false positive rate, so if you have a false positive test, you're going to have to have a colonoscopy to rule out cancer. I've had a few patients who have that happen, and it was very stressful waiting for that colonoscopy. If you won't do a colonoscopy, go ahead and do the Cologuard; however, the Cologuard will find cancer, not prevent it.

The third one is called a fit test. It's a little test we send you home with from the office. You get a little sample of stool, put in this little tube, and you mail it back. What that looks for is blood, microscopic blood that you won't see but could be from a cancer. It's simple and cheap and easy to do. Just know that with the colonoscopy, you're preventing cancer, and with the other two, you're finding cancer. If your colonoscopy is normal, it's every 10 years.

Patient: Okay, so twofold question on that one - what are risk factors for colon cancer and how treatable is it if you get it?

Valerie: One of the biggest risk factors is having a family history. Tobacco use, obesity, and probably a poor diet. There's some studies suggesting that a lot of red meat intake may increase the risk of colon cancer. It's a horrible disease. My father died from colon cancer at 65. It was a horrible way to go and I 100% believe he wouldn't have died if he would have got his colonoscopy, so don't let that happen to you. There are grandchildren to see, so we want you here. However, if it's found early, colon cancer is very treatable.

Patient: I also have a couple questions about my family. A friend of mine told me that her 16-year-old daughter is supposed to have a chlamydia screening done, and I was surprised. I have a 16-year-old daughter too; does she need this screening, and if so, how come?

Valerie: We highly recommend it. We suggest it to everyone, whether they tell us they're having sex or not, because they often don't want to tell us if they're having sex. About 90% of women have no symptoms when they have chlamydia, so they don't know. If you do have symptoms, it could feel painful when you urinate, you might have some vaginal discharge, and some pelvic pain. Men may have some burning with urination as well, or testicular pain, but for the majority of cases, men also have no symptoms, so we simply find it on screening. It is easy to treat. You and your partner take antibiotics and you'll be cured. However, if you are not treated or treatment is delayed for long periods of time - in women, chlamydia affects the fallopian tubes. It can scar the fallopian tubes, and it's a significant risk

factor for infertility. So, by screening your daughter when she's young, if she has the infection, we can treat it and it can help prevent infertility later in life.

Patient: That makes sense. Similarly, when I was younger, I had to have a pap smear at age 16. How come my daughter doesn't need it until she's 21?

Valerie: Well, there's a good reason for that. Now we know what causes cervical cancer, which we didn't really know back then. Cervical cancer is caused by a virus called the human papilloma virus (HPV), and after one sexual encounter, studies have shown that 80% of women will have some form of HPV exposure. Most types of HPV do not cause cervical cancer. Some types cause genital warts, which do not cause cervical cancer, but some of the high-risk ones which are HPV 16 and 18, can cause cancer if left untreated. The good news is it can be treated if you're screened regularly with a pap test. The reason why we delay it now is because if a young woman becomes sexually active before her 20s, she will probably have HPV, but it will go away, usually in one to two years. But if we start screening early, we find these things, paps are abnormal, we worry about it. Now we know the body will clear it in most cases. It can take 10 years, as well, from infection to cancer, so we have time. That's why the screenings change. We start at 21, and between 21 and 30 it's every three years, if your pap is normal. From 30 to 65, it's every five years. At age 65, we usually stop, unless a woman is sexually active with new partners and may be at risk.

Patient: What if someone's had hysterectomy?

Valerie: It depends. If they had a hysterectomy for cancer, they may still be getting vaginal paps done. Some people who have had hysterectomies had their cervix left. If you have your cervix left, you still would need paps.

Patient: This question is more about my husband. Is there a screening test he needs to have done for prostate cancer?

Valerie: Prostate cancer is one that's a conversation to have with your male patients. If you have a family history, you're definitely at higher risk for prostate cancer. The problem is kind of similar to ovarian cancer. We really don't have a good screening test. We have a test called the PSA, which is a prostate specific antigen, and it's a tumor marker, just like that CA 125. Sometimes we still use it because it's all we have, but if it's elevated you have to prove that you don't have cancer, and it can be elevated for other reasons. It's really a conversation to have with each patient based on their risk factors: if they smoke, if they have a family history, and their concerns for developing that type of cancer.

Patient: Are there any other screenings that are specific to men or is that the primary one?

Valerie: That's one of the major ones. Another one is screening for abdominal aortic disease, or abdominal aneurysm. That's recommended for men who smoke and are over the age of 65. We also do have lung cancer screening now. If you've had over 15 years of smoking, you may be a candidate for that. Often insurance does pay for that, and it's a low-dose CAT scan that is done yearly to look for lung cancer. Oftentimes, by the times it's visible on a chest x-ray, it's more advanced.

Patient: I think I've mostly run out of questions. Is there anything else you think I should know about my health or staying healthy?

Valerie: Just come in and talk to us - please come in. A lot of times, people come in for one thing and it's often the thing at the end of the visit that they're really worried about. If you can't come in, we can do telehealth for some things. I apologize - I know we're all busy, and patients say, "Oh I can't get in." If you really need to be seen, I always tell my patients, let me know. That's a good MyChart message. Let me know. We do our best to try to help our patients and get them in. The longer you wait, things just get worse.

Community Q & A

Community Member: It can be difficult to get into your primary care provider, and there are some health conditions that can't wait three weeks, so you end up at urgent care. Is there a better route? Do you have recommendations for what people should do in those situations?

Valerie: Message your PCP, and let them know. We do try to make things happen for people when they need to happen. Maybe you think you have a urinary tract infection. We can at least order urine analysis and you can come in drop it off, if we can't squeeze you in for an appointment. But we prefer to see you, so we'll try.

Community Member: What are your thoughts on things like somatic healing and what role do you think other medical approaches have working with Western Medical approaches?

Valerie: That's a great question! Personally, I love thinking outside of the box. Acupuncture I think is great. I think anything that doesn't involve medicines is wonderful. Medicines are helpful but can all harm us too. Anything you can do that's mind, spirit, body, that doesn't involve medicine is great. If you want to do yoga, meditation, any of those alternative things.

A couple of cautions: one is herbal medicines. I actually just finished an education course on herbal medicine and it was amazing how many can really have some pretty serious side effects. Just remember, if you're taking anything that's non-prescription and it has an effect, it's a medicine and it can have side effects too. Make sure you tell your provider what you're using. Unfortunately, we don't always have a lot of data or studies on herbal medications, but we can do our best to research that for you and just make sure that whatever you're using, you're doing safely. And we need insurance to jump in on that because a lot of times we struggle with getting coverage for acupuncture or massage or things like that.

Community Member: Why does grapefruit react to statin drugs? What statin drugs have the least reaction towards grapefruit?

Valerie: Oh, I think they all do. The problem with grapefruit is the acidity, and it affects the way that your statin is absorbed. You can still have your grapefruit, but just wait an hour after you take your medication. Someone will probably say, "No, you shouldn't have it at all." But, if you're going to have it, at least space it out.

Community Member: Are there any other ways to lower cholesterol besides using statin drugs?

Valerie: Yes, there are. Statin drugs are obviously the most effective, but one tip is to increase your fiber, specifically like Metamucil. What that does is it binds to cholesterol, and it removes it through your stools. And go more plant-based. Cholesterol only comes from animals. You're only going to get it

from dairy, beef, chicken, pork, and fish. Fish, of course, can have some healthy fats as well too, but you're not going to get it from your fruits or your vegetables, or the whole grains by themselves. So, add more of those to your diet; exercise more. The other thing that raises cholesterol in a lot of patients is alcohol. So, how much should you drink? Currently for women, it's seven drinks or less a week, and for men, it's 14 or less a week. That depends upon the person, but women often don't know that if you're drinking two drinks a night, you have a significantly increased risk of breast cancer. A little is good, too much is too much; back to that old saying.

Community Member: What if cholesterol runs in my family?

Valerie: If cholesterol runs in your family, the reason that that happens is your liver just makes too much. You can have the best diet in the world, and you could be a marathon runner, and you could still have high cholesterol, and you could still be at risk for heart disease. For those patients who really have a family history we often suggest that they are on a statin just to lower the risk. It'll lower the risk on average about 30%.

Community Member: How important is exercise to weight loss? It can be really hard to be consistent with it. How does it tie into diet? Between diet and exercise, is one more impactful than the other?

Valerie: I think they're both equally important. If you're sedentary, like a lot of us are every day in front of the computer, you don't burn any calories, and if you don't burn any calories, you can't eat very much, and that's the simple equation there. Exercise increases your metabolism. Weight training specifically increases your metabolism, so exercise is very important. Exercise tones you, your body looks better, you have more energy, you feel good. When you exercise, you're putting time and you're investing in your body, and a lot of times it helps people to want to invest in how they eat. It's just a motivation, and it will help decrease your risk. And it doesn't have to mean, "you got to go to the gym." You just move your body. Twenty minutes every day, go for a walk, put on some music, dance around the house, go out and work in your garden - do something. All of that will help. Even 10 minutes a day of walking decreases heart disease risk.

It has to be fun. If you don't like what you do, you're not going to do it. You might do it for a week, but it's not going to be consistent. So, think outside of the box. What is something you used to do? You used to like? Or, what is something you always thought about, like trying Pilates, or kickboxing, or something fun? Start with a baby step.

Community Member: Do you have an opinion on CBD for anxiety and pain?

Valerie: It goes from person to person. Lately, I've been seeing patients who've been using marijuana every day for anxiety, getting off of it and saying that they feel less anxious off of it. I think there's probably better ways to manage anxiety, such as through behavioral therapy, exercise or meditation. You can use it once in a while if it's helpful for you, but I would not highly recommend doing it every day.

One of the things we're seeing in adolescents and young people is cyclic vomiting syndrome from marijuana. When they're using marijuana consistently, they start developing nausea and vomiting, and it can get bad enough to send them to the ER multiple times for it, simply from the marijuana. So, it's not without risk. For pain, the CBD creams and things, I don't see a problem in trying those. They don't contain the THC, the drug ingredient that was formerly illegal. You can try it.

Community Member: When you see commercials for prescription medications, are these generally medications that one would recommend? Or is it just to drive business for pharmaceutical companies? I have a hard time understanding the return on investment for these companies, but I assume they must work. How do I know when to trust a commercial for a pharmaceutical recommendation?

Valerie: I would say, if you see a commercial, just ask us about it, if it's appropriate for you. A lot of those commercials don't always tell you what it's for. For instance, when Prilosec, which is an acid medicine, first came out, they had a commercial that said, you know, "get the purple pill, get the purple pill," Well, they didn't tell people what the purple pill was for, but everybody wanted the purple pill. Just ask us about it. The reason drugs are on TV is because they're new, and they may be helpful for you. For instance, there's a lot of really helpful new diabetes drugs.

Community Member: Can you speak to eating tofu and the potential increase of cancer in women? I want to eat more plant-based, but I worry about the risk.

Valerie: You'd have to eat a whole lot of tofu. You probably couldn't eat that much tofu to increase your cancer risk, So, have your tofu.

Community Member: I've just been diagnosed with Osteopenia and I'm wondering if you have any words of hope and wisdom.

Valerie: Most women will get osteopenia after menopause. Estrogen is what keeps our bones healthy and strong, and when we go through menopause our estrogen levels drop dramatically. You lose the most bone you're going to lose in your lifetime in the first seven years from your last menstrual cycle. Things you can do to help prevent that or prevent the decline would be to take Calcium, take Vitamin D, and do some weight-bearing exercise. Not only for your legs, but for your upper body.

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