



The Bill Edwards Heart Beat

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Ischemic Strokes Rise Steeply with Age Even in Young

In group of patients, females outnumbered males under age 30; traditional risk factors common

FRIDAY, Feb. 27 (HealthDay News) -- Modifiable risk factors for stroke, such as high cholesterol and hypertension, were common in a group of younger stroke patients, according to research published online Feb. 26 in the journal *Stroke*.

Jukka Putaala, M.D., of the Helsinki University Central Hospital in Finland, and colleagues analyzed data from 1,008 ischemic stroke patients aged 15 to 49 admitted to a single hospital over a recent 13-year period.

Stroke occurrence increased exponentially with age, the researchers report. Overall, patients were more often male (ratio 1.7 to 1), but under the age of 30, patients were more commonly female (56 percent versus 44 percent), the investigators found. Common risk factors included dyslipidemia (60 percent), smoking (44 percent) and hypertension (39 percent). Traditional stroke risk factors were more common in men and individuals over the age of 44, the authors note.

“Our findings contribute to the understanding of the spectrum of risk factors, mechanisms, and imaging features in young brain infarct patients. Traditional stroke risk factors were common in this patient population, but in the young a

meticulous search for each patient’s all potential risk factors is crucial for appropriate secondary prevention. These data suggest that the evolution of etiology takes place mainly because of accumulation of vascular risk factors along aging,” Putaala and colleagues write.

<http://www.modernmedicine.com/>

Editors Note-

Dyslipidemia is defined in Wikipedia as: “In western societies, most dyslipidemias are hyperlipidemias; that is, an elevation of lipids in the blood, often due to diet and lifestyle. The prolonged elevation of insulin levels can lead to dyslipidemia. Increased levels of O-GlcNAc transferase (OGT) are known to cause dyslipidaemia.”

Guidelines on Controlling Pain Without Raising Your Blood Pressure

Does your pain reliever raise blood pressure? Recently the American Heart Association (AHA) released a warning about the increased risk of heart attacks and strokes in people taking pain medications called nonsteroidal anti-inflammatory drugs (NSAIDs) -- not only celecoxib (Celebrex) but also over-the-counter pain relievers such as ibuprofen (Advil, Motrin) and naproxen (Aleve). The only exception was the NSAID aspirin, which actually protects against heart attacks and

strokes.

But evidence is growing that NSAIDs (including aspirin) and non-NSAID pain medications such as acetaminophen (Tylenol) may raise blood pressure as well. If this news leaves you confused, here's our advice on gaining control of pain without hurting your heart or blood vessels.

What the Research Says -- Several recent studies suggest that pain medications can lead to the development of hypertension. A 2007 study that looked at some 16,000 healthy men (average age 65) over four years found that those who took 15 or more pain relief pills a week had a 48% higher risk of hypertension than those who took no pills.

An earlier study found similar results in 5,000 women ages 34-77. Those who regularly took more than 500 mg of acetaminophen or more than 400 mg of an NSAID daily were close to two times as likely to develop high blood pressure as those who did not take these medications. Ibuprofen and naproxen were the most commonly used NSAIDs.

These studies did not include enough people to separate out the effects of the individual NSAIDs. But a recent meta-analysis of 19 randomized, controlled trials of NSAIDs for the treatment of arthritis found that the NSAID Celebrex -- a COX-2 inhibitor -- caused a small rise in blood pressure of 3/1 mm Hg, compared with a placebo, but was no more likely to raise blood pressure than other NSAIDs such as naproxen.

The first two studies were observational, meaning that participants were not randomly assigned to take a certain pain medication or a placebo.

And even though the researchers controlled for factors that could explain the link between pain medication and hypertension, some unknown factor may be responsible for the association. In fact, the link may simply be that chronic pain itself causes changes in the body that make people susceptible to high blood pressure.

That said, pain relievers do have effects that could lead to high blood pressure. For instance, these medications inhibit the synthesis of prostaglandins, substances that cause blood vessels to dilate and relax, thus lowering blood pressure. In addition, NSAIDs cause the kidneys to retain sodium and water, which raises blood pressure. What's more, acetaminophen and NSAIDs can impair the function of the lining of blood vessels so that these vessels do not dilate in response to increased blood flow.

So should you think twice about popping a pill for pain relief? The AHA's new guidelines on NSAIDs suggest that you should proceed with caution. So here's some advice for dealing with pain if you have or are at risk for hypertension:

- **Try nondrug options first.** Depending on the cause of your pain, one or more of the following self-care strategies may offer relief: rest, physical therapy, regular exercise, cold or hot compresses, weight loss, or orthotic shoe inserts. Complementary medicine options such as acupuncture, massage, yoga, tai chi, or stress reduction may help, too.
- **Choose aspirin over other NSAIDs or acetaminophen when self-care measures are insufficient.**
- **Follow the AHA's advice when aspirin is not helpful or you cannot take it. Start with**

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acetaminophen, and when that doesn't work progress from over-the-counter NSAIDs like naproxen and then ibuprofen to prescription naproxen (Naprosyn) and then diclofenac (Cataflam, Voltaren).

- **Celebrex is your pain reliever of last resort.** Even though this medication does not appear to raise blood pressure any more than other NSAIDs, there's plenty of evidence that Celebrex, like the two other COX-2 inhibitors taken off the market -- rofecoxib (Vioxx) and valdecoxib (Bextra) -- raises the risk of both heart attacks and strokes.

- **Use the lowest effective dose for the shortest time possible, regardless of the pain reliever you choose.** For example, do not exceed 500 mg a day for acetaminophen or 400 mg daily of an NSAID.

- **Last but not least, if you regularly take pain relievers, make sure that you get your blood pressure checked at each doctor's visit, and let your physician know what pain relievers you take and how often you take them.**

Posted in [Hypertension and Stroke](#) on February 24, 2009

Exercise Necessary for Permanent Weight Loss

More than 50 percent of Americans are overweight and can expect a premature death because of it. One of the largest scientific studies on weight loss shows that calorie restriction (below 1700 calories per day) is the most important factor that helps people lose weight and that its effect is temporary and dependent on constant reinforcement (NEJM February 26, 2009).

The ratios of carbohydrate, protein and fat were irrelevant. Furthermore, most dieters are incapable of following diets that restrict the proportion of carbohydrates, fats or proteins. Although the dieters were placed on diets with different protein ratios, measuring their urinary nitrogen showed that they ended up with close to the same protein intakes. Carbohydrate restriction, as measured by a drop in HDL cholesterol, showed there was little difference in carbohydrate intake.

People in this study lost about 13 pounds in six months regardless of the type of nutrient restriction. However, after 12 months they started to regain the weight that they lost, and after two years their average weight loss was down to six pounds. This suggests that many will eventually regain all the weight that they lost. If you want to reduce your weight to normal permanently, you need an exercise program that involves other people so you will stick with it permanently. The more you exercise, the more weight you are likely to lose. You also need a social environment in which your companions eat the way you should eat, and constant exposure to people who are trying to follow healthful eating and other lifestyle behaviors.

Reports from DrMirkin.com

Stents and Bypass Each Have a Role In Treating Coronary Artery Disease

February 2009

The nature of your condition and your health history will determine a course of action. Blockage in one of your coronary arteries, the

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vital pipelines that provide blood to your heart, can lead to chest pain or worse, a heart attack, if the blockage is so severe that blood flow actually fails to supply the organ tissue. For many years, blocked arteries were treated with bypass surgery, in which the chest was opened up and a blood vessel from elsewhere in the body was used to redirect circulation around the obstruction. Then stents were developed and doctors were able to insert flexible tubes into arteries to open them up without surgery.

So if one or more of your coronary arteries is becoming blocked, what is the best course of action? First, it's important to understand the degree of blockage that would warrant some type of intervention.

"Blockages considered severe enough to stent or bypass are defined as narrowings of 70 percent or more in one of the three major coronary vessels: left anterior descending artery (LAD), right coronary artery (RCA), or circumflex artery (CIRC) or 50 percent or more in the left main trunk (LMT)," explains Cleveland Clinic cardiologist Adam Grasso, MD. "This is the threshold at which the narrowing tends to be hemodynamically significant—flow-limiting under conditions of stress, such as physical exertion."

In most cases, the choice to use stents or coronary artery bypass graft (CABG) are not simple either-or decisions. Dr. Grasso says there are a number of circumstances to consider: length of blockage; location of blockage and the number of blockages in the arteries.

Treatment Criteria

An artery containing a long area of severe narrowing, known as diffuse disease, is still often best treated with a bypass.

"Such blockages are technically more difficult to place stents in, and in general, are better treated with CABG," Dr. Grasso says. "At the other end of the spectrum, 'focal' or 'discrete' narrowings are less technically challenging and are often well-

treated with stents."

Perhaps even more important than the length of the blockage is its location. Dr. Grasso notes that while severe narrowings in the LMT have traditionally been treated with bypass surgery, left main stenting is becoming more common. However, if the blockage occurs where the LMT branches into the LAD and/or the CIRC, for example, bypass usually is the preferred treatment because of the complexity of the condition and limited ability of currently available stents to effectively open up Y-shaped blockages.

[What if all three coronary vessels are blocked? The answer usually remains bypass surgery. "We still prefer to treat such disease with CABG, since there are well-established benefits," Dr. Grasso says. "Stenting can be done for 'complete revascularization,' but is still not as common as bypass surgery."

Pros and Cons

In cases where there is truly a choice between stenting and bypass, patients and physicians should discuss the nature of each procedure, the recovery time for each and long-term prospects, Dr. Grasso advises.

Bypass surgery is usually a longer-lasting fix compared to stenting and can treat complex lesions that cannot be opened with stents. Patients with stents typically take the antiplatelet drug clopidogrel (Plavix), which is not usually required of bypass patients.

"Stents can block up and additional stenting procedures in the future are frequently necessary," Dr. Grasso notes. "In elective stenting (not during a heart attack), an unequivocal benefit in terms of decreased cardiovascular events or death has not been shown."

However, compared to patients with stents, bypass patients face higher risks of post-

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operative complications, such as bleeding, arrhythmias, infection and neurocognitive impairment.

One of the most appealing aspects of stenting is the less-invasive nature of the treatment and shorter recovery time.

“With CABG, recovery time is longer and the patient is generally discharged from the hospital five to seven days after surgery,” Dr. Grasso says. “Stenting has a much shorter recovery time and the patient is generally discharged the day after the procedure. Stenting is also very effective at relieving symptoms such as chest discomfort and shortness of breath.”

The Last Word

Understanding the advantages and disadvantages of stenting and CABG, as well as the conditions that make one approach preferable over another, will help you feel better about the approach your doctor recommends. Dr. Grasso says it’s important to talk with your doctor about the near-term and long-term expectations with these or any medical procedures, and feel free to ask as many questions as you need to in order to be comfortable with your treatment plan.

The Cleveland Clinic, Heart Advisor, February 2009

Magnetic Heart Valves May Ease Replacement Surgeries

March 2009

Researchers at Cleveland Clinic are investigating new technology to make repeat heart valve operations faster and safer.

As heart valve patients continue to live longer,

healthier lives after surgery, the need for subsequent valve replacement procedures continues to grow. An artificial valve may last 10 or 12 years, or longer, though in some difficult cases, a valve may need to be replaced in a matter of months.

Researchers at Cleveland Clinic are working on a device that would make that follow-up valve replacement surgery easier and faster. And the keys to the new technology are magnets.

Kiyotaka Fukamachi, MD, PhD, is developing a new heart valve that uses a magnetic coupling to keep the valve in the proper position. But another big advantage is that when it comes time to replace the valve, only part of it has to be removed and no stitches have to be taken out or sewn back in.

“Traditionally, when the valve has to be replaced, they have to remove old sutures and stitch the new valve into place,” says Dr. Fukamachi. “It’s time consuming because the heart has to be stopped and the patient is on a heart bypass machine, and there is a risk because the procedure can damage the coronary arteries. But with this (magnetic) one, the second surgery can be easier than the first.”

How it Works

To put it simply, the magnetic valve has two parts—a base magnet that is connected to heart tissue with sutures and a magnetic ring that holds the actual valve. Both magnets are made of neodymium iron boron and are encased in very thin stainless steel. Once the base magnet is sewn into the tissue surrounding the opening where the faulty valve had been, the ring containing the new artificial valve is “mated”

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to the base without sutures or other permanent attachment methods. The simple force of magnetic attraction keeps the two parts together.

Dr. Fukamachi's team has also created a special tool that can be placed in between the beveled edges of the ring and the base to separate the two parts—think of a small pair of scissors spreading open. A new ring and replacement valve can then be quickly mated to the base, which has remained in place. And because the two parts fit so tightly together, there is little chance of tissue growing in between the rings, Dr. Fukamachi says.

Applications

Dr. Fukamachi says magnetic valves one day could be used in any of the heart's four valves—the tricuspid valve (between the right atrium and right ventricle); the pulmonary valve (between the right ventricle and the pulmonary artery); the mitral valve (between the left ventricle and left atrium); and the aortic valve (between the left ventricle and the aorta). Healthy valves that allow blood to flow in only one direction through the heart's chambers are critical to cardiovascular health.

Valvular disease, in which the valves either fail to close completely (which leads to regurgitation of blood back into a chamber) or fail to open properly (which forces blood through a smaller opening), can lead to heart failure, heart enlargement, blood clots and other serious, potentially life-threatening complications. In some cases, valves can be repaired, but often the defective valve is removed and a mechanical or tissue valve is put in its place.

Dr. Fukamachi says he and his team first began

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developing the magnetic heart valve while they were working on a mechanical heart and had to replace one of the valves.

The Future of Magnetic Valves

The development of magnetic valves is still in the experimental phase and Dr. Fukamachi hopes that more funding becomes available to continue his research, so that the valves can begin to be used in wide clinical application. He adds that the new valves may also one day be put in place using minimally invasive procedures, rather than open heart surgery. The need continues to grow for advancements that reduce time on heart-lung equipment for older and more frail patients. "Reducing the length of surgeries and the amount of time on heart bypass machines is especially important for high-risk patients, whose risk of death is increased in those situations," Dr. Fukamachi says.

Cleveland Clinic, Heart Advisor, March 2009

Test Can Check Stroke, Heart Attack Risk

Elevated Protein Level Can Predict Major Health Emergency

TheOmahaChannel.com

updated 1 hour, 17 minutes ago

OMAHA, Neb. - A simple test can help determine your risk for a heart attack or stroke, conditions which strike thousands of metro residents every year.

Janet Walker, 46, said she has gone through quite a few changes in the past year."I lost 32 pounds so far," Walker said. "I dropped my

cholesterol at least 150 points.”

Walker was motivated to make the change after a test showed that her levels of high-sensitivity C-reactive protein were too high. Hs-CRP is made in the liver in response to arterial inflammation.

“Variations in very low levels, in otherwise non-inflamed patients, is what really predicts the risk of heart disease and stroke,” said Dr. Scott Shurmur of the University of Nebraska Medical Center.

Smoking, diabetes, high blood pressure and cholesterol can all increase levels of the protein, doctors said. All can also increase the risk of heart attacks or strokes.

Shurmur said that hs-CRP testing is simple, affordable and accurate. However, because the test is relatively new, it’s not part of every physician’s routine screenings. Patients may need to specifically ask for it.

Shurmur said he recommended Walker adjust her lifestyle to bring her hs-CRP levels down. In spite of a disability, which makes exercise difficult, she said she was determined to change.

“I didn’t go on any special diet,” she said. “I just went to low fats, calories, sodium and carbs. I watched everything I ate.”

“She’s an excellent demonstration of what lifestyle can do beneficially for CRP,” Shurmur said.

Walker said her success is what has kept her motivated.

“I feel great. I feel so much better, but I’m not done yet, either,” she said.

<http://www.msnbc.msn.com/id/29437445/>

High Intake of Red and Processed Meats Linked to Increased Mortality Risk

High intake of red and processed meats is associated with increased risk for death in older adults, while white meat may have a protective effect, reports *Archives of Internal Medicine*.

More than a half million adults aged 50 to 71 completed food-frequency questionnaires and then were followed for 10 years; during that time, some 48,000 men and 23,000 women died.

After adjustment for confounders including BMI and smoking status, men and women in the highest quintile of red meat intake had significantly increased risks for overall mortality, cancer-related deaths, and cardiovascular-disease-related deaths, relative to those in the lowest quintile. High intake of processed meat was also associated with increased mortality risks.

Conversely, consumption of white meat (poultry and fish) was associated with significantly decreased risks for total and cancer-related mortality.

Physician’s First Watch for March 24, 2009

Treat Periodontitis to Help Prevent Arterial Disease

It's been well established that gum disease can be a sign of cardiovascular problems. A study published in the Dec. 1 issue of the American Journal of Cardiology shows that gum disease is often a sign of inflammation—high sensitivity C-reactive protein (CRP) levels—and is common among those with cardiovascular disease (CVD) risk factors. Now a study in the Federation of American Societies for Experimental Biology Journal (online Dec. 12) shows that treating gum disease and lowering the oral bacterial load can reduce your risk of atherosclerosis (the build-up of plaque in the arteries). Researchers examined the carotid arteries of 35 otherwise healthy people who had mild to moderate periodontal disease before and after having the gum disease treated. One year after treatment, researchers observed a reduction in the thickening of the blood vessels (associated with atherosclerosis) and a reduction in oral bacteria and immune inflammation. "There is a lot of literature out there suggesting that periodontal disease increases the risk of heart disease. The association has to do with chronic inflammation," says Leslie Cho, MD, editor-in-chief of Heart Advisor.

Talk to Your Doctor Before Stopping a Medication

Here's a common scenario: You already take medications to regulate your heartbeat and lower your cholesterol, and your doctor prescribes an additional drug to bring down your blood pressure. After taking the medication for a few days, you feel dizzy and nauseous. Do you stop taking the medication and tell your doctor at your next visit in three weeks, or call your doctor and report your symptoms but keep taking the medication? Far too many patients choose the first option, according to Leslie Cho, MD, director of preventive cardiology at Cleveland Clinic and editor-in-chief of Heart Advisor. "Many patients stop taking medications without talking to their doctors first," she says. "Patient non-compliance is a huge problem. Stopping a medication is not trivial; sometimes, it has life-threatening consequences."

The Cleveland Clinic Heart Advisor, March 2009

Coming Events

LIONS GATE HOSPITAL CARDIAC REHAB – CARDIO METABOLIC PROGRAM

Education Schedule--2009

Monday April 6

Risk Factors-How to Reduce Them and Live Forever
Dr. Kevin McLeod, Internal Medicine Specialist

Monday April 20

Exercise and Heart Health
Min Van Velzen, Exercise Specialist

Monday March 2

Cardiac Rehab Champions
Guest Speakers Monique, Jennifer and Members of the NSCR

Classes Held in the Lions Gate Hospital Auditorium (ground Floor) at 7:00 PM

PLEASE NOTE: Nutrition education and counseling is available through Lions Gate Hospital. Please let us know if you would like to be directly referred to this program.

Vancouver Coastal Health Diabetes Drop-In Information Series

<i>Topic</i>	<i>Time</i>
Diabetes and Natural Medicine	Tuesday, February 17th, 1:30 PM
Why Can't I Control My Eating? An exploration of compulsions, comfort food and diabetes.	Tuesday, March 10th 7:00 PM
Diabetes: Getting Back on Track	Tuesday April 21st, 1:30 PM
Is An Insulin Pump For You?	Tuesday, May 21st, 7:00 PM

All sessions will be held in the Diabetes Education Center, Classroom 2, Lions Gate Hospital.

For more information please call:
604-984-5752

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Recipes

Spring Chicken & Barley Soup

You might think of barley as an addition to hearty, wintery soups, such as mushroom-barley or beef-barley soup, but it also works well in lighter soups like this one with chicken, asparagus and peas.

Makes 4 servings, about 2 cups each

ACTIVE TIME: 45 minutes

TOTAL TIME: 1 1/4 hours

EASE OF PREPARATION: Easy

1 tablespoon extra-virgin olive oil

1/2 cup finely chopped onion

1/2 cup finely chopped celery

2 cloves garlic, divided

6 cups reduced-sodium chicken broth

1 large bone-in chicken breast (10-12 ounces), skin removed, trimmed

1/3 cup pearl barley

1 15-ounce can diced tomatoes

1 cup trimmed and diagonally sliced asparagus (1/4 inch thick)

1 cup fresh or thawed frozen peas

1/2 teaspoon coarse salt

Freshly ground pepper to taste

1/2 cup lightly packed torn fresh basil leaves

1 strip orange zest (1/2 by 2 inches)

1. Heat oil in a large saucepan over medium heat; add onion and celery and cook, stirring, until beginning to soften, 2 to 4 minutes. Grate or finely chop 1 clove garlic; add to the pan and cook, stirring, until fragrant, about 1 minute. Add broth, chicken and barley. Bring to a gentle simmer. Cover and cook over low heat until the chicken is cooked through, about 20 minutes. Transfer the chicken to a plate with a slotted

spoon. Return the broth to a simmer and cook until the barley is tender, 20 to 30 minutes.

2. Meanwhile, shred the chicken or cut into bite-size pieces; discard the bone.

3. When the barley is done, add the chicken, tomatoes and juice, asparagus, peas, salt and a grinding of pepper; return to a simmer. Cover and cook over low heat until the asparagus is tender, about 5 minutes more.

4. Coarsely chop the remaining garlic clove. Gather basil, orange zest and the garlic and finely chop together. Ladle the soup into bowls and sprinkle each serving with a generous pinch of the basil mixture.

NUTRITION INFORMATION: Per serving: 265 calories; 6 g fat (2 g sat, 3 g mono); 39 mg cholesterol; 28 g carbohydrate; 24 g protein; 7 g fiber; 745 mg sodium; 405 mg potassium.

Nutrition bonus: Vitamin C (40% daily value), Vitamin A (30% dv), Iron (15% dv).

1 1/2 Carbohydrate Servings

Exchanges: 1 1/2 starch, 1 vegetable, 2 lean meat

MAKE AHEAD TIP: Prepare through Step 3, cover and refrigerate for up to 2 days. Reheat the soup, thin with broth if desired and finish with Step 4 just before serving.

From EatingWell Magazine March/April 2009

Vegetable & Sausage Skillet Supper

This satisfying supper is a great way to use up leftover rice and those pesky bits of leftover vegetables that always manage to clog the crisper. Serve with some grated cheese on top and some warm cornbread alongside.

Makes 4 servings, about 1 1/2 cups each

ACTIVE TIME: 35 minutes

TOTAL TIME: 35 minutes

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EASE OF PREPARATION: Easy

8 ounces low-fat kielbasa, cut into 1/2-inch-thick slices

1 tablespoon extra-virgin olive oil

2 medium onions, finely chopped

2 medium zucchini, cut into 1/2-inch dice

1 large red bell pepper, seeded and diced

2 jalapeno peppers, seeded and minced

2 cloves garlic, minced

1/2 teaspoon ground cumin

1/2 teaspoon dried oregano

1/2 teaspoon salt, or to taste

2 cups cooked brown rice (see Tip)

1 15-ounce can black beans, rinsed

1/2 cup water

Hot sauce, such as Tabasco, to taste

1. Cook kielbasa in a large nonstick skillet over high heat, turning from time to time, until lightly browned, about 2 minutes. Transfer to a plate.

2. Add oil to the pan. Add onions, zucchini, bell pepper, jalapenos, garlic, cumin, oregano and salt; cook, stirring, until the onions are tender, 4 to 5 minutes. Stir in rice, beans and water; cook, stirring, until heated through, about 4 minutes. Add the reserved kielbasa and season with hot sauce. Serve hot.

NUTRITION INFORMATION: Per serving: 355 calories; 6 g fat (1 g sat, 3 g mono); 20 mg cholesterol; 58 g carbohydrate; 17 g protein; 10 g fiber; 861 mg sodium.

Nutrition bonus: Vitamin C (180% daily value), Vitamin A (30% dv), Iron (20% dv), Potassium (16% dv).

TIP: Tip: To cook brown rice: Place 2/3 cup brown rice, 1 2/3 cups water and a pinch of salt, if desired, in a small saucepan; bring to a simmer. Cover; cook over low heat until rice is tender and most of the liquid

has been absorbed, 45 to 50 minutes. Makes about 2 cups.

From *EatingWell Magazine* Winter 2004

Cinnamon Oranges

This simple dessert works any time of the year, but its flavors will be the best and brightest in the winter when oranges are at their peak.

Makes 4 servings

ACTIVE TIME: 10 minutes

TOTAL TIME: 10 minutes

EASE OF PREPARATION: Easy

4 navel oranges

2 tablespoons orange juice

2 tablespoons lemon juice

1 tablespoon sugar

1/4 teaspoon ground cinnamon

With a sharp knife, remove rind and white pith from oranges. Cut each into 5 or 6 slices and arrange on 4 plates. Whisk together orange juice and lemon juice, sugar and cinnamon. Spoon over the orange slices.

NUTRITION INFORMATION: Per serving: 86 calories; 0 g fat (0 g sat, 0 g mono); 0 mg cholesterol; 22 carbohydrate; 1 g protein; 3 g fiber; 2 mg sodium; 258 mg potassium. Nutrition bonus: Vitamin C (150% daily value).

1 1/2 Carbohydrate Servings

Exchanges: 1 1/2 fruit

<http://www.eatingwell.com/recipes/>

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