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Caregiver's HOME COMPANION

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HELPING THOSE WHO HELP OTHERS

Adrift in a Sea of Specialists

Sorting Out Medical Opinion Overload

When her grandmother experienced a sudden onset of dizziness, slurred speech and facial drooping, Kafi Grigsby found herself in an emergency department waiting room, surrounded by five doctors with four different opinions on what had occurred and how to treat it.

She recalls the confusing and stressful scene this way: "The ER doctor said it could be a stroke. My grandmother has a blood condition, and the neurologist said that a blood clot could have caused a TIA. The hematologist said, no, her blood looked good. The vascular surgeon suggested that her veins were thin, allowing blood to 'leak' through. The primary care physician deferred to the neurologist."

Where do you turn when your loved one's health care team reaches an impasse, even as an urgent medical problem calls for decisions and choices that you simply don't feel qualified to make?

Sorting out your loved one's complex case is a specific function of several groups of health professionals. But don't wait for them to find you first; most likely you'll have to "flag them down" and explicitly ask for their help.

"All these doctors with all these scenarios," Grigsby says. Yet, "we didn't have any understanding of what happened. None of these reasons they gave, at that time or later, addressed her slurred speech."

Grigsby, who is director of communications and public relations for the Washington-based Center for the ▶

INSIDE THIS ISSUE

3 **Food Safety and the Elderly** Keeping Mom's Kitchen Safe

4 **Caregiver as Advocate** How a Care Plan Can Safeguard Your Loved One's Interests

6 **Helping Assure a Safe Return Home** Dealing with Loved Ones Who Wander

8 **Lights, Camera, Colonoscopy** What to Expect When Your Doctor Wants an Inside Look

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Editor and Publisher
Chris Pederson

Marketing Director
Shelly Harvey

Strategic Business Development Director
Karen B. Knowles

Custom Publishing & Operations Director
Robert G. Whitton

Art Director
Laura D. Campbell

Circulation Director
Noah Pederson

Webmaster
NOW Interactive Solutions
webmaster@caregivershome.com

Mail
Caregiver's Home Companion
P.O. Box 693
Southport, CT 06890-0693

Phones
Subscriptions & Customer Service:
(877) 259-1977

Advertising & Sales: (203) 254-3538

Administration & Editorial:
(203) 254-3538

Custom Publishing: (203) 438-0810

e-mail Inquiries:
editor@caregivershome.com

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Caregiver's Home Companion is produced by caregivers and professional healthcare workers. While this publication is not intended as a substitute for professionally administered medical advice, the practical suggestions, advice and tips made in this newsletter have been tested or reviewed by an individual or organization involved in caring for elderly other loved ones. *Caregiver's Home Companion* also strives to obtain the input of educators and researchers in all branches of medical and scientific research. We welcome your comments and suggestions at editor@caregivershome.com.

When medical wires are hopelessly crossed, "I would pick up the phone and call every one of the providers and say, 'we have conflicting information; I'm trying to get everybody on the same page here,'"

—Ann Mayo, gerontology nurse specialist

Sorting Out Medical Opinion Overload
Continued from page 1

Advancement of Health, says the situation left her and her family feeling frustrated and overwhelmed.

Choosing a Leader

You may need to look no further for than your loved one's primary care physician (PCP) for help in navigating a perplexing health care system.

"That's exactly what a general internist does," says Dr. Sandra Fryhofer. "We help coordinate the care. It's like the captain of the ship. When there are conflicting recommendations from specialists, we speak up."

Putting all the pieces of a case together is not a conversation to shoehorn in during a physical examination. "For something complex like that, an appointment is good," says Fryhofer, who practices in Atlanta and is the past president of the American College of Physicians. She also is a clinical associate professor of medicine at Emory University School of Medicine in Atlanta.

"In acute situations, if someone is having a heart attack, the cardiologist would be in charge and at different times, other physicians take the lead," Fryhofer says. "But in the whole scheme of things, the PCP is the underlying thread holding it all together."

Case managers who are affiliated with an insurance company also can help coordinate a patient's care. However, they are under pressure to act in the best interests of the health plan. Another route is for patients to seek out an unaffiliated case manager, which would be a separate cost.

Or they could turn to a new breed of medical provider. Although "any competent internist should be able to function in that role, as a bit of a choreographer of care," says Dr. Bernard Kaminetsky, "physicians are very busy to the point of being overwhelmed."

Kaminetsky is the medical director of MDVIP, in Boca Raton, Florida, a company of medical practices that provide what most people think of as "concierge medicine." But "we don't like the term 'concierge,'" he says. "It conjures up images of heated towel racks. We call it

continues on page 5

MOM'S HEALTH CARE ADVOCATES

Here's a checklist of various experts you may tap to play a key role in helping sort through your loved one's medical care:

Geriatric Specialist: A geriatrician is a physician with an additional focus on meeting the medical needs of the elderly. The US Administration on Aging offers an Eldercare Locator website for finding local resources: www.eldercare.gov/Eldercare.NET/Public/Home.aspx.

Clinical Nurse Specialist: The CNS is a master's-prepared advanced practice RN who works closely with patients and families. To get a CNS on your case, speak to the nurse manager or nursing director for the unit or facility.

"Concierge" Doctor: An extended-care warranty of sorts: by signing up for a concierge or personalized medicine practice, you secure directional services for the day when your condition becomes highly complicated.

Insurer-Based Case Manager: Insurer-based case management is triggered by a physician referral or hospital, acute care or nursing home discharge. A specific diagnosis on a claim can also alert health plans that a case manager might be needed.

Internist/Family Physician: For complex cases involving multiple specialists, ask your primary care provider for a sit-down appointment, which may lead to a multidisciplinary meeting of the minds. Depending on the insurer, the cost of such an appointment may be covered.

Patient-Centered Medical Home: Medical homes strive to make patients "active partners in their care." See the Patient-Centered Primary Care Collaborative website at www.pcpcc.net/content/about-collaborative.

Unaffiliated Case Manager: You can ask for a referral from your health care provider. Local departments of aging and disabilities or health and social services agencies may offer—or refer you to—case management services.

Food Safety and the Elderly

Keeping Mom's Kitchen Safe

By Kelly D. Morris

When my grandmother broke her hip and was unable to prepare her own meals, her children and grandchildren began taking turns cooking for her. That's when we discovered the expired food. She had a lot of canned goods that had expired. A lot! Who knows how much bad food she had already eaten?

Why did she have so much expired food? Well, she had grown up during the Great Depression. Many elderly people who grew up during the Depression hoard food and don't want to throw anything out. They remember those bad days all too well.

My grandmother also purchased food in bulk whenever something was on sale. While that can be a good, thrifty thing to do, she bought more than she could reasonably eat. So she ended up with a whole pantry full of expired food.

While this is not uncommon among the elderly, it can be quite dangerous. In fact, 76 million people in the United States develop food borne illnesses every year. Of those, 325,000 are hospitalized and 5,000 die.

The elderly are much more likely to die from food-borne illnesses than the general population. They're just more susceptible than others, and that's because of such factors as the decreased production of their stomach acids, decreased motility (movement) of their aging intestines, excessive use of antibiotics, and generally poor health.

What is food poisoning?

Food poisoning is a general term used to describe illnesses caused by eating contaminated foods. Food can be contaminated by bacteria, viruses, or toxins either from the environment or found in the food itself. Salmonella is a common culprit. It can cause nausea, vomiting, abdominal pain, diarrhea, headaches, and fever.

Most often, contaminated foods are animal products such as beef, chicken, milk, or eggs. Any food can become contaminated, though. Thorough cooking kills salmonella, so it's important to cook food properly.

Is it food poisoning?

It can sometimes be difficult to determine if someone is suffering from food poisoning or if they simply have a bug. Symptoms of food poisoning include nausea, vomiting, abdominal cramps, and diarrhea. Vomiting and diarrhea can lead to dehydration, which can be very dangerous in the elderly. In severe cases of food poisoning, fever, chills, bloody stools, and nerve damage may occur.

Symptoms of food poisoning usually begin within 48 hours of consuming the tainted food. It may affect just one person, or it may affect a whole group of people who ate the same food. That is called an outbreak.

Do you need to go to the hospital?

You should seek immediate medical care if the illness lasts more than two days, if you vomit blood or have bloody stools, if you can't keep any liquids down, if you have a fever, or if you have a disease that affects the immune system, such as HIV or AIDS, cancer, or kidney disease.

In cases of mild food poisoning, with vomiting lasting only a day or two and minor bouts of diarrhea, you can treat the problem at home. You should drink plenty of clear liquids. You can use sports drinks like Gatorade, but you should dilute them with water because otherwise they have too much sugar, which can make diarrhea worse. Don't eat solid foods while you are still nauseous or vomiting, but once those symptoms have passed, you can try small amounts of bland food.

If you have to go to the hospital, you will probably receive an IV drip for rehydration. Medication may be given to stop vomiting and diarrhea. Medicine can also be used to treat fever. Antibiotics are rarely given for food poisoning. In some cases, antibiotics can make symptoms worse. In rare cases, though, they are warranted.

Depending on the severity of the food poisoning and your response to treatment, you may be admitted to the hospital. In fact, the elderly are most likely to need close observation, so they are often admitted.

How do you prevent food poisoning?

You can help your loved one avoid food poisoning by taking a few simple steps.

Help your loved one clean out their kitchen cupboards and refrigerator. Check all the expiration dates on food products. If your loved one is reluctant to clean out the cupboards, you can simply offer to help them with some "spring cleaning." They can help you clean out your own cabinets and fridge, too.

Your loved one might also be reluctant to throw out food, even if it has

continues on page 7

Caregiver as Advocate

How a Care Plan Can Safeguard Your Loved One's Interests

By Molly Shomer

If your loved one enters a nursing home, rehabilitation center or even an assisted living facility, you'll soon become familiar with an important planning process in structuring their care. And you'll soon learn how important a formal care planning conference—and your role in that conference—can be in advocating proper care.

As your loved one's family caregiver, you should be invited to attend a care planning conference on a regular basis. Assisted living facilities may hold care plan conferences less frequently than a medical facility such as a nursing home, but they still should conduct care conferences on a scheduled basis.

Every skilled nursing facility that accepts Medicare or Medicaid funds must complete an initial assessment within the first seven days (Medicare) or 14 days (Medicaid). Within seven days of this initial assessment, the initial care plan must be completed. A care plan conference to review your loved one's progress and make necessary changes to the care plan must be held at least every three months thereafter and whenever there is an important change in the patient's status.

The care plan is the "road map" document that a care facility uses to keep the professional caregiving staff on track with care for a patient or resident. Rather than allowing every discipline in a facility to stagger forward without coordinated goals, each discipline participates in assessing a resident's abilities and needs, and the team then prepares a coordinated plan. Ideally, all staff members, the patient or resident, and the family then work together to reach their common goals.

Who Attends a Conference?

The care plan conference is usually attended by the supervising nurse, the social worker, the physical therapist, the activities director, the dietician, a family representative, and the patient if they are able. Some families want to include a care manager or the ombudsman, or both, which should be just fine with the facility. But remember that your attendance and participation is critical.

Scheduling a Conference

The resident and family representative should receive a written notice with the date and time of the scheduled care conference. Many facilities schedule all their care conferences on a specific day of the week.

If you are not able to attend at the scheduled time, you may reschedule. However, keep in mind that because of work-shift schedules and the needs of other patients, some members of the care team may not be able to attend a rescheduled conference.

It is important to realize that these care planning conferences are often extremely short, often as short as 10 or 15 minutes per resident, with one scheduled right after another. A good care planning conference should be thorough and in-depth.

A comprehensive team conference will require as much as an hour or more – and you should push for this time and attention. Experienced care managers and other advocates suggest that you request a specially-scheduled private care conference, if your loved one's facility tries to condense the scheduled time slot.

What Will Be Discussed?

Members of the care team, including the patient and a family representative, should discuss both medical and non-medical concerns. Medical and nursing care, therapies, meals and food service, activities, emotional needs and personal concerns should be addressed.

Issues and goals should be written in easily understood language on a dated care plan document, with measurable ▶

goals and responsibilities and a timeline clearly defined.

You should receive a copy of the new care plan before you leave.

Prepare for the Conference

If this is not the initial planning conference, request a copy of the previous care plan before the meeting, if you don't have one.

Prepare a written list of your questions and concerns. Talk with siblings and other family members for their input. If you have praise for anything or anyone pertaining to your loved one's care, make sure to include this on your list so you don't forget. Sometimes praise can go a long way in helping insure your loved one gets just a bit more special care.

Use the questions below as your own preparation guide:

1. Have there been any changes to your loved one's health, behavior or physical abilities since the last conference? What are the professionals' assessments of the reason for any changes? What are your own thoughts?
2. When was the last time your loved one saw their doctor? Has the doctor ordered any treatment or medication changes?
3. What are the special therapy goals (physical therapy, occupational therapy, speech therapy), if any? Is the patient making progress toward these goals, or do they need to be modified in any way?
4. Is your loved one eating and drinking well? Has the patient's weight changed since the last conference? Have there been any issues or concerns about the food?
5. Is the resident participating in activities? Are there any activities the resident would enjoy that could reasonably be added to the activity schedule?
6. Does the patient need anything you may not be aware of, such as new clothing, personal care items, reading or craft materials? Are vision or hearing assessments needed? Can these be done on-site?
7. Have there been any important changes in direct care or administrative staff since the last conference?
8. What changes would the staff recommend that have not already been discussed?
9. What changes would you and your loved one recommend that have not already been discussed?
10. Praise and compliment any improvements or progress you have noted since the last conference. Nothing is too small.

Mutual Respect is the Key

You catch more flies with honey, and you'll almost always make more progress when you approach care conferences with the assumption that the facility has your resident's best interests at heart.

Be fully aware of your resident's rights, but try to avoid putting the facility staff on the defensive, if you can. Always do your best to prioritize your concerns, so that the most important topics are addressed first. ■

__Molly Shomer__ is a family caregiving specialist and licensed geriatric care manager. She is a nationally recognized expert on eldercare issues and the author of The Insider's Guide to Assisted Living. Her website is www.eldercareteam.com, and she can be reached at molly@eldercareteam.com.

Sorting Out Medical Opinion Overload
Continued from page 3

personalized medicine."

He says concierge practices allow doctors more opportunity to read the latest journals, research new protocols and reconcile treatment recommendations—and time is a luxury beyond the reach of internists working 16-hour days.

"In this type of scenario, a family has to have confidence that there is someone who is coordinating care, looking at specialists' notes, making tough choices," he says.

Yet another option: families might consider a specialist in the care of the elderly to act as the bridge between patient and specialists.

Ann Mayo, DNSc, is a gerontology clinical nurse specialist (CNS) at the University of San Diego. Mostly employed by acute care hospitals, the gerontology CNS "works within the patient sphere, the nurse sphere—and the system sphere," she says.

"Ideally the hospital employs CNS's who can intervene early on, but if not, by the time a family calls me and says, 'we want you to advocate for us', they are usually discouraged and they're getting mad," Mayo says.

In cases where medical wires are hopelessly crossed, "I would pick up the phone and call every one of the providers and say, 'we have conflicting information; I'm trying to get everybody on the same page here,'" she says. "I would get everybody—including family and patient—together and have a multidisciplinary meeting: 'Let's talk about what we know and what we don't know.'"

Your Voice in the Discussion

It's only natural for doctors to look at cases through the lens of their own specialty, Fryhofer says. "Sometimes you have to weigh risks and benefits. It's not all black and white, or decisions would be easy."

Kaminetsky agrees: "There are very hard decisions, and usually no 'right' answer. Some considerations are: Does the health care surrogate know the patient's wishes? Is there a living will? Specialists may all have their biases, one way or another. No intervention? Aggressive treatment? You need someone to sit down with the family and sort through all these issues. In rare instances, I've gotten hospital ethicists involved in the discussion."

Sometimes patients turn to the practitioner they trust most and elect to follow their advice.

"Collectively, as a family, we decided on the vascular surgeon," Grigsby says. "He was the most thorough, and as a hospitalist [a hospital-based doctor], he could see medical records electronically and firsthand. In the end, we followed the protocol he recommended."

Ideally, those adrift in a sea of specialists could find an anchor in a "medical home," in which patients have access to more treatment coordination and support from a care team. But while the medical home concept is gaining support, it's a long way from being widely available.

As it is, patients and families must get involved when doctors disagree, Fryhofer says. "You have to have these kinds of discussions or the patients will be pushed around like little checkers." ■

—By Health Behavior News Service

Helping Assure a Safe Return Home

Dealing with Loved Ones Who Wander

By Rachel Davidson

I remember how frightened we all were when Aunt Josie turned up missing along with her car. She was no longer a safe driver. Dementia had destroyed her ability to think rationally, and she'd reluctantly given up her driver's license and car keys months earlier.

Her children reported her missing. At that time, there were no programs in place to help us. All our family could do was ask if anyone had seen her, pray for her safety, notify the authorities, and hope she'd be found safe. Three frightening days later, Aunt Josie popped up 450 miles away. When asked how she got there, she replied, "I don't know. Why are you all so excited? I just went to see my sister."

All too often, when people's minds wander, they do too. According to the Alzheimer's Association, more than 60% of dementia sufferers are affected by the life-threatening behavior called wandering. More than two-thirds become repeat wanderers. For caregivers, the stress of keeping an aging loved one in place can become unbearable. All in all, the situation becomes one of caregiving's most challenging.

"We do not know precisely what causes wandering, and we do not have any anti-wandering drugs," laments Dr. George T. Grossberg, of the department of neurology and psychiatry at St. Louis University School of Medicine.

According to the Alzheimer's Association, if your loved one has dementia, wandering is among the biggest challenges you face as a caregiver. Beth A. Kallmyer, director of client and information services at the Alzheimer's Association in Chicago, explains, "People don't understand. Wandering is not just about someone getting lost. Up to half the people not found within 24 hours will suffer serious injury or death."

Kallmyer cautions about a typical caregiver approach: "Caregivers are often in denial when it comes to wandering. They say, 'I'm not concerned. Mom's never shown any sign of wandering.' Or they think they can keep a close enough eye on their loved ones to protect them."

You cannot watch your loved one 24-7. You need to answer the phone, sleep, bathe, etc. In the time it takes for any of these activities, your loved one can slip away. Familiar faces and places become frightening and unfamiliar to them. Panic and paranoia set it. Confused and potentially unable to ask for help, they are vulnerable to weather, traffic, and people who may take advantage of them.

Help for your loved one

You can significantly improve your loved one's probability of being found quickly and safely by enrolling them in the MedicAlert + Safe Return Program, an identification and support program that works through local Alzheimer's Association chapters 24 hours of every day. It provides emergency response services for dementia patients who wander off.

More than 160,000 family caregivers have registered an elderly loved one in the program since it's inception in 1993. Safe Return has helped locate and return to their families more than 16,000 registrants, for a 99.7% success rate compared to less than 50% for those not enrolled. Eighty-eight percent are found within the first four hours of being reported missing, a critical period for achieving a "safe return," according to law enforcement experts.

How to enroll

You can enroll your loved for one year for $49.95, plus $4.95 for shipping and handling. After the first year, a $25 renewal fee is required. If you are unable to afford it, financial assistance may be available from your local Alzheimer's Association chapter.

During enrollment, you will be asked to provide your loved one's medical history, contact information, and a recent photo. These are put in a confidential, national computerized database that will be used if a person wanders away.

Included in your enrollment packet is a program identification bracelet or pendant and a wallet card. Clothing labels and key chains are also available. Each of these items contains the program's nationwide toll-free phone number and your loved one's unique identifier.

As a caregiver, you are not immune to illness or an accident when caring for your loved one. For an additional one-time $25 fee, you can register yourself in the program, naming two adults you want notified if you get sick or injured. You will also receive a bracelet with the program's toll-free number on it along with an inscription that reads, "I am a caregiver of a person registered with Safe Return." Once Safe Return becomes aware of your incapacity, they will notify your designated individuals so they can make any necessary arrangements for you and your loved one. ▶

__Rachel Davidson__ is a freelance writer focusing on elderly care. She published a quarterly magazine for nursing home administrators for 15 years, as well as a caregiver newsletter for five years. Rachel lives in Baraboo, Wisconsin and can be reached at families@centurytel.net.

SIGNING UP FOR 'SAFE RETURN'

Caregivers have four ways to sign up loved ones with Alzheimer's or another dementia in the Safe Return program:

Phone: Call 888-572-8566 between 6 a.m. and 7 p.m., Monday-Friday, and 8 a.m. and 5 p.m. Saturday (PST). You will need to provide:

- Member's name and contact information
- Medical conditions
- Allergies
- Medications, including dosages
- Member's exact wrist measurement, if ordering a bracelet
- At least two contact names, addresses, and phone numbers
- Credit card number and expiration date

Mail: Complete and mail the enrollment form located at www.medicalert.org/forms/SafeReturnSignUp.aspx or call 888-572-8566 to have a form sent to you. Mail the payment and your loved one's photo to: Medic Alert + Safe Return, 2323 Colorado Avenue, Turlock, CA 96382.

Fax: Print the completed form and fax it to 800-863-3429

Online: Enroll online at www.medicalert.org/forms/SafeReturnSignUp.aspx

If your loved one is reluctant to wear the jewelry, Lyn Roche, of Sebring, Florida, author of *Coping with Caring When Someone You Love has Alzheimer's or a Related Condition*, has a couple of suggestions to gain their cooperation. "You can present it as a gift from her favorite grandchild," she says. "Another option is to say, 'Please do it for me. I'm going to wear one for you, so that if we're ever separated, they can put us together again.'"

Locating a lost loved one

If your loved one is missing, the first 24-hours are critical. Safe Return advises you to immediately alert local and emergency responders. "Let them know what she was wearing when she disappeared," Roche says.

Next call Safe Return's number (800-572-8566). They will create and fax photos, flyers, and the critical medical information that you provided during enrollment to emergency responders, community members, local hospitals, and law enforcement agencies to assist in their search.

Your local Alzheimer's Association chapter will provide your family support and assistance while the search and rescue are being conducted. "When a Good Samaritan or a response team member finds the lost person, they call our 800 number and provide us with the individual's unique identifier located on his or her necklace or bracelet," Kallmyer says.

"We then conference the person who found him into our database so he can talk to the caregiver," she adds. "Together, we'll facilitate getting that person back home. Later, the local Alzheimer's chapter will follow up with the family and together they'll discuss what can be done to prevent this from happening again." ■

RESOURCES

Area Agency on Aging has additional information on dealing with wandering, at www.agingcarefl.org/caregiver/resources/wandering and 888-861-8111.

The Alzheimer's Association offers free 24-hour professional advice both from its national office and local chapters for dementia caregivers, at http://alz.org/we_can_help_24_7_helpline.asp and 800-272-3900.

Geriatric care managers believe wandering often occurs because the individual is bored or restless. For creative solutions, check out **Gilbert Guide's Activities,** at www.gilbertguide.com/2008/07/10/activities-for-dementia-patients.

Food Safety and the Elderly

Continued from page 5

expired. You might be able to get around this resistance by offering to take them shopping to replace the bad food. You need to be firm about throwing out the food, though, even if they don't want to get rid of it.

Another thing to watch out for is food that should be refrigerated but isn't. Mike Andrews, of Mansfield, Ohio, says his aunt Ann would open cans of food, eat a few bites, and then put them back in the cupboard. Not only can this cause food poisoning, it can attracts bugs or rodents.

You also need to make sure that cold foods stays cold and hot foods stay hot. When foods are not kept at the proper temperature, bacteria can quickly grow and produce toxins that cause illness. Foods are considered to be in "the danger zone" when the temperature is between 41 and 140 degrees. Cold food should be kept at temperatures lower than 41 degrees, and hot foods should be at temperatures higher than 140 degrees. You can buy a thermometer designed for testing food temperatures.

Keeping foods cold was a problem for both my grandmother and Mike's aunt Ann. I once found several frozen pie shells in my grandmother's cupboard. Obviously they weren't frozen anymore. I had to throw them out. And aunt Ann should have refrigerated the canned food she didn't eat at one sitting rather than put it back in the cupboard, and in any event she should have stored the food in a clean, non-metal container.

As you can see, food poisoning is a real risk for the elderly. Fortunately, it's pretty easy to prevent. It just takes a little diligence on your part. ■

***Kelly Morris** is a former social worker and home health and hospice worker whose writing has appeared in a number of health-related journals. She lives in Mansfield, Ohio, and can be reached at multihearts@hotmail.com.*

COMING UP IN MAY

- Technology is changing the face of caregiving. We'll tell you about advances and investments on the part of industry to make your caregiving and elder care in general more streamlined through innovation. First article in a three-part series.
- Just when you think it's safe to think about slowing down and plan for retirement, caregiving hits. And suddenly retirement seems likes a distant, if not impossible goal. Strategies for staying the course while caring for a loved one.
- Hospital care can be hazardous to your loved one's health – it's a sad but all too common truth that the institution designed to heal and cure sometimes does the opposite. Tips for every caregiver to help an aging family member through the hospitalization maze.
- From the wonders of aromatherapy putty to games designed to keep aging memories fresh, we'll tell you about the latest caregiving gadgets and gizmos that just may make your caregiving a little easier.

Lights, Camera, Colonoscopy

What to Expect When Your Doctor Wants an Inside Look

Colorectal cancer is one of the most commonly diagnosed cancers in the United States with more than new 145,000 cases each year. And while it is also one of the most preventable cancers, the National Cancer Institute says colorectal cancer claimed nearly 50,000 lives last year.

Colorectal cancer is more common in people over 50, and the risk increases with age. Colorectal is cancer of the colon and/or rectum, which are parts of the digestive—or gastrointestinal—system. The body uses the digestive system to turn food into energy. What the body cannot use is removed through bowel movements. Cancer occurs when cells in the colon and/or rectum grow out of control and lose their normal function.

Many colorectal cancers can be detected early and effectively with a colonoscopy, an important medical test unnecessarily dreaded by some. However, Dr. Dale Burleson, colorectal surgeon on the medical staff at Baylor Medical Center in Frisco, Texas, explains the details of the test—and shows it's not as scary as some people think:

Preparation. The most difficult part of the colonoscopy may be the prep, which involves taking a laxative pill or drink to empty or "flush" the colon. "It's not nearly as bad as it's made out to be," says Burleson. "It only takes a few hours. By the time you're ready for bed, you're all set." Why is it necessary? The cleaner the colon, the better the view, and the less likely that something small might get missed.

Exam. The exam itself is probably the easiest part, says Burleson. "The patient is awake, but with sedation, there's little or no discomfort," he says. "Many patients have told me it wasn't nearly as scary as they expected."

During the procedure, the physician inserts a long, flexible tube with a tiny video camera into the body. The camera sends images to a monitor, allowing the physician to get a good look around. The resulting images can be printed and stored in the computer.

Evaluation. What are doctors looking for? Inflammation, bleeding, ulcers, changes in color and polyps, which are small growths of tissue. Although most polyps are non-cancerous, they are generally surgically removed and a biopsy is taken—just to be sure. "The normal lining of the colon should look like the inside of a cheek; completely smooth," adds Burleson. "We're looking for anything that might signal a digestive condition or early signs of cancer.". ■

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Caregiver's HOME COMPANION

HELPING THOSE WHO HELP OTHERS

Alcohol and the Elderly: An All-too-Common Bond with Serious Consequences

By Paula McCarron

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