
CENTRAL PA HEALTH CARE QUALITY UNIT

NEWSLETTER FOR HEALTHY OUTCOMES

December 2008 - Volume 8, Issue 12

a monthly newsletter provided by the Central PA Health Care Quality Unit

M.C. 24-12,100 North Academy Avenue, Danville, Pa. 17822 Phone: (570) 271-7240 Fax: (570) 271-7241

Website: <http://www.geisinger.org/bcqu>

Safely Handle And Prepare Stuffing

A traditional holiday meal often includes stuffing either cooked inside a whole turkey, chicken or other bird, or cooked separately in a casserole. Mishandled or improperly prepared stuffing can lead to foodborne illness - not a satisfying ending to a delicious meal. Following the United States Department of Agriculture's (USDA) Food Safety and Inspection Service (FSIS) *Be Food Safe* recommendations can ensure a safe meal. As you prepare your holiday meal, remember these four easy to tips - **Clean, Separate, Cook and Chill**.

Clean: When preparing stuffing, wash hands and surfaces often. Bacteria can spread throughout the kitchen and contaminate hands, cutting boards, knives and countertops. Frequent cleaning can keep that from happening. Always wash hands with warm water and soap for 20 seconds before and after handling ingredients for stuffing such as sausage, giblets, shellfish, vegetables, bread, rice, pasta and fruits.

Separate: Don't cross-contaminate. Stuffing should not be prepared ahead. The dry and wet ingredients for stuffing can be prepared separately ahead of time and chilled, but do not mix wet and dry ingredients until it will be cooked. The stuffing should be moist - not dry - because heat destroys bacteria more rapidly in a moist environment.

Cook: Cook stuffing to a safe minimum internal temperature. For optimal safety, cook stuffing separately. If you are cooking the stuffing inside of the bird, it is essential to use a food thermometer to determine the internal temperature of the bird and stuffing. Immediately place the stuffed, raw bird in a preheated oven set to 325 °F or higher. Even if the turkey itself has reached the safe minimum internal temperature of 165 °F (as measured in the innermost part of the thigh, the wing and the thickest part of the breast), the stuffing may not have reached a temperature high enough to destroy bacteria that may be present. Bacteria can survive in stuffing that has not reached 165 °F, which may cause foodborne illness.

Chill: Promptly refrigerate or freeze leftover stuffing. Bacteria spread fastest at temperatures between 40 °F and 140 °F, so chilling food safely reduces the risk of foodborne illness. Place leftovers in shallow containers. Refrigerate (40 °F or below) or freeze the cooked poultry and stuffing within 2 hours after cooking. Use refrigerated leftovers within 3 to 4 days; frozen food within 4 months. Reheat leftovers to a safe minimum internal temperature of 165 °F.

If you purchase pre-made stuffing or pre-stuffed birds at grocery store, FSIS offers the following advice:

Premixed Stuffing: Some retail stores sell premixed stuffing. If sold as a cooked product, the stuffing is safe to use. However, do not stuff raw poultry with this cooked product. At home, reheat it to 165 °F before serving.

Fresh Pre-Stuffed, Uncooked Whole Poultry: USDA does *not* recommend buying retail-stuffed, uncooked fresh turkey, roasters, Cornish hens or other whole stuffed poultry from a retail store or restaurant. These products are highly perishable and present a potential bacterial hazard. **DO NOT USE THEM.** If you have purchased one of these products, discard it or return it to the place of purchase.

Frozen, Pre-Stuffed, Uncooked or Cooked Poultry (Whole): If the packaging displays a USDA or State mark of inspection it has been processed under federally- or state-controlled conditions and therefore is safe to consume. Store frozen, pre-stuffed birds in the freezer and follow the package directions for safe handling and cooking. **DO NOT THAW** a commercially pre-stuffed frozen turkey before cooking. Follow the manufacturer's recommended cooking directions. A frozen stuffed turkey should reach a safe minimum internal temperature of 165 °F as measured with a food thermometer.

The information offered in this newsletter is to increase your awareness of health related conditions and situations and not intended to be a substitute for professional medical advice.

INSIDE THIS ISSUE	
1	Safe Handling of Stuffing
2	Irritable Bowel Syndrome
3	Phobic Disorders
4	Personality Patterns May Affect Weight

IRRITABLE BOWEL SYNDROME

IBS affects millions of people, but has no known cause and no effective remedy. It's probably the number one reason people see gastroenterologists and accounts for as many as 3.5 million physician visits. Today, IBS affects 10%–22% of otherwise healthy adults. While it's believed to affect both sexes nearly equally, men and women may suffer different symptoms.

Irritable bowel syndrome may well be the most challenging functional GI disorder for patients and doctors alike. A recent study found that patients with IBS have a significantly lower quality of life than patients without the syndrome, and that the illness is seriously under diagnosed. Through the years, IBS has been called by many names — spastic colon, spastic bowel, colitis, mucous colitis, and functional bowel disease. None of the names is quite accurate.

About 70% of patients are considered to have mild symptoms, and their lives are minimally impacted. About 25% have moderate symptoms, which may cause them to miss work occasionally. About 5% have severe symptoms that greatly affect their daily lives. Symptoms usually begin in your 20s, 30s, or 40s, although the syndrome can occur in children. Symptoms include cramps or pain in the lower abdomen, frequent bowel movements, loose, watery stools, bloating, excess gas and constipation.

There's no organic basis for IBS. That is, there's no physical abnormality or disease at the root of the problem. IBS is a disorder in the functioning of the intestinal tract. Some experts suspect that it involves disturbances in the nerves or muscles in the gut. Others believe that abnormal processing of gut sensations in the brain may hold the key, at least in some cases. In addition, IBS can be triggered by emotional upset, stress, or other psychological factors. While emotional conditions can worsen symptoms, however, researchers suggest that other factors are also important.

Colon motility (the contractions of intestinal muscles and the movement of its contents) is controlled by nerves and hormones and by electrical activity in the colon muscle. The electrical activity acts like a “pacemaker,” similar to the mechanism that regulates the heartbeat. Movement of the colon propels the contents slowly back and forth, but mainly in the direction of the rectum. A few times a day, strong contractions move down the colon, pushing the contents ahead, and sometimes resulting in a bowel movement. Some researchers have found that the colon muscle of a person with IBS begins to spasm after only mild stimulation. The colon seems to be more sensitive than usual, so it responds strongly to stimuli that wouldn't affect other people. Sometimes, the spasms lead to diarrhea; other times, to constipation. But some studies show that most of the time, colonic motor activity is no different for IBS patients than for anyone else.

Hormones produced in the GI tract have also been suspected of triggering IBS symptoms through their effects on bowel motility, but studies have not been definitive. Women with IBS often have more symptoms during their menstrual periods, suggesting that changes in reproductive hormones can increase IBS symptoms.

Certain medicines and foods trigger spasms in some people. Sometimes the spasm delays the passage of stool, leading to constipation. Chocolate, dairy products or large amounts of alcohol are frequent offenders. Some people simply can't tolerate certain dietary substances. Caffeine causes loose stools in many people, but is more likely to affect those with IBS. Fat in any form (animal or vegetable) is a strong stimulus of colonic contractions after a meal and can also contribute to IBS symptoms.

Stress is known to stimulate colonic spasms in people with IBS. The process is not completely understood, but scientists point out that the intestines are controlled partly by the nervous system. Some studies have shown significantly higher stress levels among people with IBS compared to healthy individuals. And stress reduction or relaxation training or counseling has helped relieve IBS symptoms in some people.

Because there are no tests for irritable bowel syndrome, the diagnosis is most often made on the basis of a person's medical history, including a careful description of symptoms. A physical exam and laboratory tests likely will also be done, and a stool sample may be tested for evidence of bleeding. In some cases, the doctor may also recommend diagnostic procedures such as endoscopy (specifically sigmoidoscopy) and x-rays. However, the idea is to use as few costly, invasive tests as possible.

The most common dietary recommendation for IBS is adding fiber to increase the stool's bulk and speed its movement through the GI tract. A high-fiber diet doesn't always improve bowel symptoms, but many clinical trials have shown that it does seem to relieve constipation and ease abdominal pain. And it can even improve diarrhea.

Phobic Disorders

From MerckSource.com
(From a previous newsletter)

Phobias involve persistent, unrealistic, intense anxiety and fear in response to specific external situations. People who have a phobia avoid situations that trigger their anxiety and fear, or they endure them with great distress. However, they recognize that their anxiety is excessive and therefore are aware that they have a problem.

AGORAPHOBIA

Agoraphobia is diagnosed in about 4% of women and 2% of men during any 12-month period. Most people with this disorder develop it in their early 20s; agoraphobia rarely develops after age 40. Although agoraphobia literally means "fear of the marketplace," the term more specifically describes the fear of being trapped in situations or places with no way to escape easily if anxiety or panic develops. Typical situations that are difficult for people with agoraphobia include standing in line at a bank or supermarket, sitting in the middle of a long row in a theater or classroom, and riding on a bus or airplane. Some people develop agoraphobia after experiencing a panic attack in one of these situations. Other people simply feel uncomfortable in these settings and may never, or only later, develop panic attacks. Agoraphobia often interferes with daily living, sometimes so drastically that it leaves the person housebound.

If agoraphobia is not treated, it usually waxes and wanes in severity and may even disappear without formal treatment, possibly because the person has conducted some personal form of behavior therapy. Exposure therapy, a type of behavior therapy in which the person is exposed repeatedly to the anxiety-provoking situation, is the best treatment for agoraphobia, helping more than 90% of people who practice this therapy faithfully.

SOCIAL PHOBIA

Although some anxiety in social situations is normal, people with social phobia have so much anxiety that they either avoid social situations or endure them with distress. About 13% of people have social phobia sometime in their lives; the disorder affects about 9% of women and 7% of men during any 12-month period. Men are more likely than women to have the most severe form of social anxiety, avoidant personality disorder. Some people are shy by nature and show timidity early in life that later develops into social phobia. Others first experience anxiety in social situations around the time of puberty. Some social phobias are tied to specific performance situations, producing anxiety only when the person must perform a particular activity in public. The same activity performed alone produces no anxiety. Situations that commonly trigger anxiety among people with social phobia include public speaking; performing publicly, such as playing a musical instrument; signing a document before witnesses; and using a public bathroom. People with social phobia are concerned that their anxiety will be obvious—that they will sweat, blush, or that their voice will quaver; that they will lose their train of thought; or not be able to find the words to express themselves.

Social phobia often persists if left untreated, causing many people to avoid activities in which they would otherwise like to participate. Exposure therapy is effective, but arranging for exposure to last long enough to permit getting used to the anxiety-provoking situation and growing comfortable in that situation may not be easy. Antidepressants and anti-anxiety drugs can often help people with social phobia.

SPECIFIC PHOBIAS

Specific phobias, as a group, are among the most common anxiety disorders but are often less troubling than other anxiety disorders. During any 12-month period, about 13% of women and 4% of men have a specific phobia. Some specific phobias, such as fear of large animals, the dark, or strangers, begin early in life. Many phobias stop as the person gets older. Other phobias, such as fear of rodents, insects, storms, water, heights, flying, or enclosed places, typically develop later in life. At least 5% of people are to some degree phobic about blood, injections, or injury. These people can actually faint due to a decrease in heart rate and blood pressure, which does not happen with other phobias and anxiety disorders. In contrast, many people with other phobias and anxiety disorders hyperventilate, which can cause them to feel as though they might faint, although they virtually never faint.

COMMON PHOBIAS: **Acrophobia**-Fear of heights, **Amathophobia**-Fear of dust, **Astraphobia**-Fear of lightning, **Aviophobia**-Fear of flying, **Belonephobia**-Fear of needles, **Claustrophobia**-Fear of confined spaces, **Gephyrophobia**-Fear of crossing bridges, **Hydrophobia**-Fear of water, **Odontiatophobia**-Fear of dentists, **Phasmophobia**-Fear of ghosts, **Triskaidekaphobia**-Fear of all things associated with the number thirteen, and **Zoophobia**-Fear of animals - usually spiders, snakes and/or mice.

Personality Patterns May Affect Weight

WebMD Health News - Reviewed by Louise Chang, MD Oct. 31, 2008

Ever wonder why some people are more successful than others when it comes to weight loss?

It's not just about calories or logging time on the treadmill. It's also a matter of personality; experts told a packed conference hall of dietitians in Chicago for the annual meeting of the American Dietetic Association (ADA). At the meeting doctors and dieticians described 21 personality types and how each personality approaches eating, exercise, and stress.

Those personality types are described in *Counseling Overweight Adults: The Lifestyle Pattern Approach and Tool Kit*, a book written for the ADA by Blatner, Kushner, and Kushner's nurse-practitioner wife, Nancy Kushner, MSN, RN. Blatner is an ADA spokeswoman. See if these personality patterns sound familiar.

The 7 Personality Patterns

In their book, the Kushners and Blatner list personality patterns that are common in overweight people who have problems losing weight for good.

Following are the seven personality patterns linked to eating:

- Meal skipper: often skips meals
- Nighttime nibbler: munches at night
- Convenient diner: eats out often
- Fruitless feaster: skimps on fruits and vegetables
- Steady snacker: snacks a lot
- Hearty portioner: eats big portions
- Swing eater: swings between being a dietary "goody two-shoes" and then lapses



These are the seven personality patterns related to exercise:

- Couch champion: a sedentary person (think couch potato)
- Uneasy participant: feels self-conscious about exercise
- Fresh starter: an exercise novice
- All-or-nothing doer: "They'll be gung ho and then do nothing."
- Set routine: does the same exercise routine over and over
- Tender bender: limited by aches and pains
- Rain-check athlete: has good intentions that don't get realized



And here are the seven personality patterns related to coping with stress:

- Emotional eater: Someone who turns to food when emotional
- Self-scrutinizer: Someone with a negative self-image who's harsh on himself or herself
- Persistent procrastinator: Someone who delays taking action
- People pleaser: Someone who focuses so much on others that there's no time or energy left for his or her own health
- Fast pacer: Someone who lives on the go, with too little time for a healthy lifestyle
- Doubtful dieter: Someone who's tried to lose weight in the past and doubts he or she can succeed
- Overreaching achiever: Someone who sets unrealistic goals and then gets discouraged



Please check out our **WEB BASED COURSES** at www.geisinger.org/hcqu If you have any questions, suggestions or problems, you can call Kristy Campbell at (570) 214-4753 or e-mail her at kacampbell@geisinger.edu **Check out our new course on Falls Prevention.**