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Welcome to the August 2014 issue of the

YOURology **Update!**

Whew. . .the heat is on! But believe it or not, in many parts of the country, summer is just weeks away from being over. Hard to believe, isn't it?

But summer is officially still here, and we're going to keep on grilling outdoors as long as we can, so we're sharing a recipe for Grilled Beer-Brined Chicken. Did you know that brining chicken offers the ultimate in moistness and flavor?

And when summer winds down, it's time to get ready for a new school year. Buying supplies is the easy part. There are less tangible things you can do as well. We're offering some ways to help you and your child get ready the back-to-school days.

August 28 marks the 51st anniversary of Dr. Martin Luther King, Jr.'s famous "I Have A Dream" speech as part of the March on Washington. We're sharing some facts about this monumental event that you might not know.

On the medical side, be sure to read our articles about over-active bladders and sex and the male senior citizen.

We hope that you and your family are making the most of the dog days of summer for as long as you can!

- Dr. Shahram Shawn Gholami

"Rest is not idleness, and to lie sometimes on the grass under trees on a summer's day, listening to the murmur of the water, or watching the clouds float across the sky, is by no means a waste of time."

~ John Lubbock

OAB – When You Really Gotta Go!

OAB (over-active bladder) is found in both men and women and is associated with the symptoms of urgency, frequency, nocturia and urge incontinence.

Regulation of bladder storage and voiding involves both sympathetic and parasympathetic control.

Bladder voiding is primarily regulated by the parasympathetic nervous system via the neurotransmitter acetylcholine. Muscarinic receptors (M1-M3-M5) are mediated by acetylcholine in controlling the contraction of the bladder muscle and relaxation of the internal sphincter to facilitate voiding.

M2 and M3 are predominate muscarinic receptors found in the bladder. The antimuscarinic (Ditropan, Ditropan XL, Vesicare, Sanctura, Gelnique, Toviaz and Enablex) all work by blocking the receptor, leading to a reduction in bladder contractions. Because they block the acetylcholine receptor systemically, they can be associated with constipation and dry mouth.

Bladder storage is primarily regulated by the sympathetic nervous system via the neurotransmitter norepinephrine. Norepinephrine released from the sympathetic nerve activates the adrenergic receptors causing the bladder to relax and close the external sphincter.

There are three types of beta adrenergic receptors expressed in the bladder. The beta-3 AR makes up 97% of bladder receptors and is predominately responsible for the detrusor muscle relaxation. The drug Myrbetriq has recently been released and is a Beta 3 adrenergic receptor agonist which leads to increased relaxation of the bladder.

In contrast to the anti-muscarinics which cause constipation and dry mouth, this is much less common with Myrbetriq which has a small incidence of an increase in blood pressure. Monitoring the patient's blood pressure is important in patients with a history of hypertension.

A Phase 3 trial in over 400 men and women complaining of OAB symptoms was recently conducted with 3 arms, Tolterodine ER (Detrol LA) Myrbetriq and placebo arm. The incidence of dry mouth was 5 times higher in the Detrol arm than in the Myrbetriq group (10% vs 2%).

It should be noted in all of the clinical trials with both Myrbetriq and the antimuscarinics, the increase in urinary voided volume was typically in the range of only 1 or 2 ounces. Both approaches do result in a significant decrease in the incidence of urge incontinence.

A few key points that we have found important in treating OAB patients includes:

1. The treating doctor can use a combination of an anti-muscarinic and Myrbetriq to decrease symptoms of OAB especially in patients with severe symptoms that do not respond to either agent alone.

2. In contrast to prior thinking, there is a very small incidence of urinary retention with the use of either anti-muscarinics or Beta-3 agonists. However, caution should be used in men who really don't have OAB but have impending urinary retention where they have large residual urine volumes as treatment with anticholinergics or a beta-3 agonist can only exacerbate the situation. Since most primary care physicians don't have access to a bladder scan, but the PCP can use the tried and true oldfashioned way of simple percussion of the lower abdomen to determine if there is, indeed, significant residual urine.

3. The use of anti-muscarinics in patients with closed angle glaucoma is a contraindication. In patients with a history of glaucoma, we typically give the patients a prescription for their OAB suggest that the patient check with their ophthalmologist prior to initiating treatment.

4. There are a number of tips and coping suggestions in patients with over-active bladder that include: Timed voiding, reduction in caffeine and alcohol, reduction in fluids prior to bedtime and Kegel exercises when patients have strong urges to void. All of these suggestions can help. I provide the patient with a handout on coping suggestions which I have found effective. In fact, numerous studies have shown that behavior modification is as effective as medical therapy.

5. For patients who are unresponsive, an intake and output diary can be of help in determining how big a factor fluid intake can be, as well as, monitoring actual response to treatment.

6. It also is important to realize that many patients complain primarily of nocturia. Nocturia can be a result of numerous urologic as well as nonurologic conditions including CHF, venous insufficiency, and increased fluid intake at night. This is certainly a case where a voiding diary also can be of benefit. For patients whose primary complaint is nocturia, DDAVP .1 to .2 mg. can be used but it is important to monitor the serum sodium for hyponatremia.

7. For patients refractory to either combination or individual drug therapy, there are additional alternatives:

a. Percutaneous posterior tibial nerve stimulation involves a small acupuncture sized needle being placed in the ankle and a minimally perceived current transmitted up to the spinal lumbosacral nerve center where one can "reprogram" the bladder. This is indicated for patients unresponsive to oral medication.

b. For patients with refractory OAB symptoms, Interstim therapy can be utilized. Interstim involves an initial percutaneous trial followed by implanting leads from the spinal cord to the nerves supplying the bladder along with a programmed stimulator, which markedly suppresses and reduces urinary symptoms.

Grilled Beer-Brined
Chicken

Brine and Chicken
2 cups water
¼ cup kosher (coarse) salt
¼ cup packed brown sugar
4 cans or bottles (12 oz. each) beer or nonalcoholic beer, chilled
2 cut-up whole chickens (3 to 3 1/2 lb. each)

Barbecue Rub
1 tablespoon paprika
1 teaspoon table salt
½ teaspoon onion powder
½ teaspoon garlic powder
½ teaspoon pepper
¼ cup vegetable oil

1. In 6 to 8-quart noncorrosive container or stockpot, mix water, kosher salt and brown sugar, stirring until salt and sugar are dissolved. Stir in beer. Add chicken. Cover; refrigerate at least 8 hours but no longer than 24 hours.

2. Line 15x10-inch pan with sides with foil. Remove chicken from brine; rinse thoroughly under cool water and dry with paper towels. Discard brine. Place chicken in pan. Refrigerate uncovered 1 hour to dry chicken skin. Meanwhile, in small bowl, mix all rub ingredients except oil; set aside.

3. Heat gas or charcoal grill for indirect cooking. Brush oil over chicken; sprinkle rub mixture over chicken. For two-burner gas grill, heat one burner to medium; place chicken on unheated side. For one-burner gas grill, place chicken on grill over low heat. For charcoal grill, move medium coals to edge of firebox; place chicken over drip pan. Cover grill; cook 15 minutes.

4. Turn chicken over; cover grill and cook 20 to 30 minutes longer, turning occasionally, until juice of chicken is clear when thickest piece is cut to bone (170°F for breasts; 180°F for thighs and drumsticks).

Sex and the Male Senior Citizen

You are 60 years of age and you note that your erections are not as strong as there were at 40 years of age. It takes longer to get an erection than a decade ago and once you ejaculate it takes longer to get the next erection. Welcome, guys to the middle ages. These are normal consequences of aging for men. This doesn't mean that you pack up your penis and never use it again. It means that you will use it differently than years ago.

What are the normal, expected changes in a man's penis as he ages?

Appearance. There are two major changes. The head of the penis (glans) gradually loses its purplish color, the result of reduced blood flow. And there is a slow loss of pubic hair. You don't have to worry about your manscape as nature will take care of your pubic hair for you.

Penis Size. Weight gain is common as men grow older. As fat accumulates on the lower abdomen, the apparent size of the penis changes. A large clump of fat in the lower abdomen makes the penile shaft look shorter. If you want a bigger penis, check out your core and trim it down and your penis will grow larger. . . .or at least it will appear to be longer. In addition to this apparent shrinkage (which is reversible) the penis tends to undergo an actual (and irreversible) reduction in size.

The reduction — in both length and thickness — typically isn't dramatic but may be noticeable. "If a man's erect penis is 6 inches long when he is in his 30s, it might be 5 or 5-and-a-half inches when he reaches his 60s or 70s. What causes the penis to shrink? At least two mechanisms are involved, experts say. One is the slow deposition of fatty substances (plaques) inside tiny arteries in the penis, which impairs blood flow to the organ.

This process, known as atherosclerosis, is the same one that contributes to blockages inside the coronary arteries — a leading cause of heart attack. Another mechanism involves the gradual build-up of relatively inelastic collagen (scar tissue) within the stretchy fibrous sheath that surrounds the erection chambers. Erections occur when these chambers fill with blood. Blockages within the penile arteries — and increasingly inelastic chambers — mean smaller erections.

As penis size changes, so do the testicles. Starting around age 40, the testicles definitely begin to shrink. The testicles of a 30-year-old man might measure 2 inches in diameter, he says; those of a 60-year-old, perhaps only 1.5 inches. Curvature. If penile scar tissue accumulates unevenly, the penis can become curved. This condition, known as Peyronie's disease, occurs most commonly in middle age. It can cause painful erections and make intercourse difficult. The condition may require surgery.

Sensitivity. Numerous studies have shown that the penis becomes less sensitive over time. This can make it hard to achieve an erection and to have an orgasm. Libido or sex drive As men get older the testosterone level falls. Testosterone is the hormone produced in the testicles that is responsible for the sex drive. It reaches a peak in the 20's and early 30's and slowly declines at a rate of 2% a year. Men who have this problem can obtain a blood test, a serum testosterone test, and if it is low and there is no history of prostate cancer, then the man can receive testosterone supplements in the form of an injection every two weeks, the application of a daily gel to the lower abdomen or shoulders, or the insertion of a pellet under the skin which lasts for 4-6 months.

Bottom Line: Yes, there are changes that are going to occur as a man ages just as there are changes in muscle mass, bone density, memory, hearing, and vision. But this doesn't mean the end of a man's sex life. With good health, a willing partner, and a desire to pleasure your partner, you, too, can enjoy sexual intimacy in your silver years.

Help Your Child Prepare for Back to School

1. Re-Establish School Routines:
Use the last few weeks of summer to get into a school-day rhythm by having your child practice getting up and getting dressed at the same time every morning and eating around the times they will eat at school.

2. Nurture Independence:
Get him ready for independence by talking about organizing his school materials, writing down assignments, and bringing home homework.

3. Create a Launch Pad:
Parents and teachers should do whatever they can to facilitate a child being responsible. At home, you can designate a spot where school things like backpacks and lunch boxes always go to avoid last-minute scrambles in the morning.

4. Set Up a Time and Place for Homework:
Head off daily battles by making homework part of your child's everyday routine. Establish a time and a place for studying at home.

5. After-School Plans:
School gets out before most working parents get home, so it's important to figure out where your children will go, or who will be at home, in the afternoons such as an after-school program through the school, the YMCA, or a Boys and Girls Club.

6. Make a Sick-Day Game Plan:
Before school begins, line up a trusted babysitter or group of parents that can pinch-hit for each other when children get sick. You may have to sign forms ahead of time listing people who have your permission to pick up your child.

7. Attend Orientations to Meet and Greet:
These are good opportunities for you to meet the key players: your child's teachers, school counselors, the principle, and most importantly, front desk staff.

8. Talk to the Teachers:
When you talk to your child's teachers, ask about their approach to homework. Some teachers assign homework so kids can practice new skills while others focus on the accuracy of the assignments they turn in.

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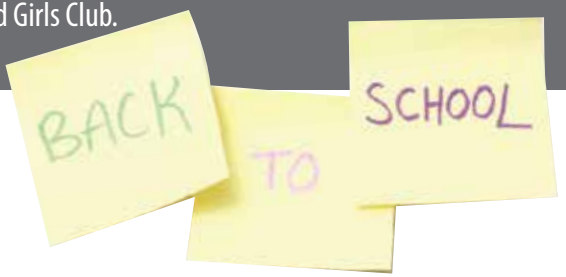

Fascinating Facts About MLK's "I Have A Dream" Speech

The speech was delivered to an estimated 250,000 people who came to Washington, D.C., to march for civil rights. And they weren't disappointed by the iconic event.

1. The official event was called the "March on Washington for Jobs and Freedom." On June 11, 1963, President Kennedy made a nationally televised address calling for a drive for more civil rights. That same night, NAACP leader Medgar Evers was murdered in Mississippi.

2. People almost never clearly heard Dr. King's speech. An expensive sound system was installed for the event, but it was sabotaged right before it. The Army Corps of Engineers were called to fix the system.

3. "W. E. B." Du Bois, the co-founder of the NAACP, died on the day before the event at the age of 95 in Ghana. Roy Wilkins asked the marchers to honor Du Bois with a moment of silence.

4. Dr. King almost didn't give the "I Have a Dream" part of the "I Have A Dream" speech. Singer Mahalia Jackson urged Dr. King to tell the audience "about the dream," and Dr. King went into an improvised section of the speech.