

## A Diagnostic Dilemma, Vertigo Relief, Goodbye Gray Hair + Generic vs Branded

**Peter:** [00:00:31] Hello and welcome to Bedside Matters, the podcast that addresses the medical issues that impact all of us every single day. We're hopefully going to give you the answers you're looking for so you can be more informed and, of course, healthier. I'm Peter Tilden, one of your hosts. Anna Vocino is also one of our hosts. And Dr. David Kipper, of course, the most important part of the group here is the guy with the medical degree, who can answer the questions. And we've got a very interesting show today, very varied.

**Anna:** [00:00:56] We're going to be talking about a diagnostic dilemma that Dr. Kipper went through this weekend that I think is going to be useful for all of us to hear, as well as vertigo. And what happens when you feel dizzy.

**Peter:** [00:01:08] And, in This Just Happened, you may not see people with gray hair pretty soon, possibly. And also in Hey, What About Me? someone is calling in to ask about their child's ADHD medicine, and also the impact of generic rather than branded products, because we hear all the time from people, it didn't work as well, it was generic. Is that true? Is it myth? And does it apply to specific groups of medications? So, we'll find that out. So, let's launch this episode.

**Anna:** [00:01:33] Yes. So, Dr. Kipper was telling Peter and myself off the air about an experience that happened this weekend, and we decided we needed to talk about it on the air because I think we need to know about it for patient advocacy. So, David, what happened this weekend?

**Dr. Kipper:** [00:01:48] This is not an unusual story, but it happens frequently enough that it's concerning, not only to the patient but to the treatment team. Patient of mine ends up in the hospital, in another hospital that I'm not associated with, with what he's told is a heart attack. So he calls me from his hospital bed and says, "I'm having a heart attack." My first reaction was, "I don't think you're having a heart attack," without knowing anything, because I've known this man 35 years and I know the status of his heart.

So, this not only was a little confusing to him, because he's been told by me that his heart is in good shape and the doctors are saying, no, you've had this terrible heart attack. And so now where this becomes interesting for me is that I'm now dealing with the hospital staff. I have the patient's history and they appropriately are looking at this data, which is pointing to a heart attack.

So everybody's confused. It's a diagnostic dilemma. The patient is frightened and we're all scratching our heads. And here are the clues that gave the doctors in the emergency room the appropriate direction to looking at this as a heart attack. His symptoms? He had symptoms of chest pain. His chest pain was in the middle of his chest. It was radiating to his left arm and into his jaw. These are typical symptoms. He had an EKG, which is the monitoring of the heart patterns. That was questionable. It wasn't definitive, but it was questionable. And you can have that, especially in the beginning of a heart attack.

And he had a laboratory test, specifically an enzyme called troponin. Troponin is an enzyme that's made by the heart cells. And when the heart is under attack, that level of troponin goes up. The normal level is less than 0.04. That's what we have as our upper limit of normal. His troponin level was 1.8. This is a huge number because a typical heart

attack may not even get up to the 1 area. It might end up being 0.1, but 1.8 was a significant amount of enzyme, indicating a significant amount of damage to the heart cells.

Here's what didn't make sense. One issue is that the pain, with a heart attack, you get pain primarily when you're active. When you're active, you are requiring more oxygen to the heart muscle and all the other tissues in the body. So early on, heart attacks, you're not getting pain when you're sitting at rest. You're getting pain when you're being more active and requiring more activity. So an important symptom that you should all be aware of is that, if I'm only getting this pain when I'm sitting still, but not when I'm active, and this man admitted that he was playing tennis all the way through up until a day or so before he went to the hospital, and he was having this pain for weeks.

**Peter:** [00:04:56] While he was exercising?

**Dr. Kipper:** [00:04:57] No, while he was at rest. Again, not atypical for heart attack. You can have the beginning and the development of a heart attack over a few weeks. And then it finally hits a certain threshold, and that blood vessel...

**Peter:** [00:05:11] David, can I just ask you one thing about the pain? Because I know you have a lot of symptoms and stuff. I've heard a million times, I'm having a heart attack, I'm having chest pain. Pain is an interesting thing to try and explain and describe.

So I've heard people say it felt like an elephant was sitting on my chest. Is that the pain? Is that what it is? It's a pressure pain? Is it a sharp pain? I mean, because every time I've heard about it, no one has explained specifically. They say it radiates out because your arm. But what is the pain? What does it feel like?

**Dr. Kipper:** [00:05:39] As always, Peter, a very smart question because the pain of a heart attack tends to be crushing. It tends to be a pressure that people are feeling. If you have a sharp pain, you have to entertain other possible diagnostic issues. Did they pull a muscle around the middle of the chest? Around the sternum? Is it a nerve pain? And the pain for heart attacks, this was very interesting. The center of the pain fibers for the heart shares the same pain fibers as the stomach. So when you come in with chest pain, you are either having a heart problem or you're having some acid reflux.

So, one of the things that we have to determine right away is, does eating make this worse? Does exercise or activity make this worse? Does the pain radiate up into the middle of the chest in a more sort of sharp pain that would be more associated with reflux, acid reflux? So the quality of the pain, the distribution of the pain, these are all very important things, Peter, so great question.

He had from my history with him, he had what was called a normal coronary calcium study, which is why I was confused because coronary calcium is called a EBCT. You should all ask your doctors to consider doing a coronary calcium once you're 45 and above, to establish whether or not you're putting your cholesterol plaque into the blood vessels.

People go to the doctor, they have high cholesterol. The doctor immediately puts them on a statin or some kind of medicine. Not everybody needs that. A lot of people have high cholesterol, but it doesn't deposit into the arteries. We've talked about this on previous shows.

**Anna:** [00:07:28] Is that the same as the CAC calcium score test?

**Dr. Kipper:** [00:07:31] Yes, exactly. CA stands for calcium. So, now I'm aware and this is an advantage I had over the doctors in the emergency room that this would be very unlikely for this man who, again I've known a long time, he's had multiple coronary calcium studies that have all been normal. And it would be unlikely for him to have a heart attack if he's not putting the cholesterol into the arteries.

There is another laboratory test, which is called a D-dimer, and a D-dimer is another marker that goes up if you're having a pulmonary embolism, which can explain why you're having chest pain. But with a pulmonary embolism, you're also going to be short of breath. And he wasn't short of breath. So all these things were going on at the same time. And I'm not believing that this is truly a heart attack. Although I can't ignore the high troponin level, I can't ignore the chest pain that went to his jaw and to his hand.

But there's other things that I'm thinking about. One of the questions that I asked him early on, and I'm going to throw this back to you guys to see if you can help with the diagnosis. I had asked him if he had had any infections over the past month and he said, "No, I really haven't. I've been fine." So, with all these clues, for not only the primary doctor, but also the emergency room doctors, what other things would you want to think about that could be causing chest pain?

**Peter:** [00:09:07] Stress would be number one.

**Anna:** [00:09:08] Yeah. Stress. Or I come back to the acid reflux or even a gallbladder thing, I don't know.

**Dr. Kipper:** [00:09:12] Great. All of that.

**Anna:** [00:09:14] You talk about the quadrants of the body like where the pain is to narrow things down, but that chest pain is scary sounding.

**Dr. Kipper:** [00:09:22] Those are all very important other diagnostic possibilities. And so now what has to happen is that he with that troponin level and that pain distribution, he's heading for an angiogram to look at the vessels in the heart. And the reason for that is, if he's got a vessel that's compromised and vulnerable and you do the angiogram, you might be able to put a stent in a vessel that is, in fact, ready to go off.

So the next morning I speak to him. He's going to be transferred to the hospital where I'm working. And I said to him, "Are you sure that you've not had any exposure to Covid?"

**Anna:** [00:10:04] Oh, no.

**Dr. Kipper:** [00:10:05] He said, "Well, actually, as a matter of fact, on the 8th of January I had what I thought was Covid, but I tested negative, so I didn't think I had Covid."

So it turns out, and I'll cut to the chase, it turns out that he had a Covid infection on the eighth, tested negative, and we've all talked about how those tests might be unreliable. And because he didn't think he had Covid, he didn't think he had any kind of serious infection, but remember what Covid does. Covid creates inflammation all over the body, and we know that there are cardiac issues that can create inflammatory changes, not so much in blood vessels, but in the muscle heart and in the lining of the heart to pericardium.

And that's where we see these high levels of troponin. And so, at that point, bingo. But that doesn't get him out of an angiogram because in case my thinking is off, then I'm hearing from his lawyers. And not to mention the fact that I've lost a friend. So we sent him for the angiogram. The angiogram is perfect. He has no blockages in his heart, and, in fact, he had a Covid-induced myocarditis or pericarditis, which is an inflammation of the muscle of the...

**Anna:** [00:11:20] ...heart.

**Dr. Kipper:** [00:11:21] Or the lining of the heart and those...

**Anna:** [00:11:23] Is there anything to be done about that?

**Dr. Kipper:** [00:11:25] Yes. So while he's in the hospital and we're ruling out the heart attack, he's put on heparin. He's put on a blood thinner to make sure that if there are clots that are floating around, they're not going to stick.

So that was one treatment. The other treatment was trying to scrape him off the ground emotionally and his wife. So the treatment for an inflammatory process is an anti-inflammatory, is prednisone. So, with prednisone, I started prednisone on him. And within 24 hours all of his pain went away and he was fine and he had a normal angiogram.

So my point is, that it's always interesting to try to make these diagnoses. You have to know your patient. If you have a primary care doctor and you end up in one of these situations, make sure you bring them into the conversation because they're going to be able to provide information that the emergency room doctor isn't going to have.

**Peter:** [00:12:24] I'm curious, how underreported do you think this myocarditis from Covid happens if a lot of people get it but don't go to the hospital, don't call their primary because they figure it's not a heart attack. How do we know what's a real incident rate is of inflammation in myocarditis in people?

**Dr. Kipper:** [00:12:44] We don't for that very reason. But I will say that people that are having an inflammatory process in the heart, they're not going to feel well, they're going to have chest pain. And it's more likely than not that they will get diagnostic and therapeutic help from an emergency room.

**Peter:** [00:13:00] It hurts that much? I mean, it's that intrusive, the pain?

**Dr. Kipper:** [00:13:03] Yes. So, I think the take-home lesson for everybody is that if you do end up in a precarious situation, that's scary, try to bring in whatever history you have by contacting your private doctor. And obviously that conversation, all three of us, the patient, the ER staff, myself, we were all scratching our heads over this. What could this be?

So it's not always straightforward in medicine. There are diagnostic dilemmas. They're puzzles that have to be solved. And, frankly, it's the thing about medicine that I find the most fascinating is that you have to sometimes think out of the box and you have to put this information together, and they don't always fit into a perfect formula.

**Anna:** [00:13:50] Well, moving on, I was going to say, in a completely different direction. But then again, we're talking about vertigo. We're talking about dizzy spells. I've actually heard this is caused by a virus, but I want to hear from you, Dr. Kipper, about dizziness.

I'm very interested in this because a lot of my perimenopausal friends have been afflicted with vertigo, and it sounds extremely debilitating.

**Dr. Kipper:** [00:14:09] So, vertigo and dizziness are almost two different things. Vertigo is where the room is spinning around you, and any movement creates that kind of disequilibrium where you have to lay down. People get dizzy for a number of other things. So it's a nuance, but it's an important diagnostic differentiation. So let's stick with vertigo where the room is spinning around and you're nauseous and you're vomiting and now your heart rate goes up, you're anxious, it's not comfortable.

And these things can last for a couple of days. They can last for a couple of months. And so it's a really rough illness to have. And the causes of this are not really viral necessarily, although they can be. And I'll mention it's sort of a lesser cause. What usually happens is that the inner ear structure, which has that little thing that looks like a snail, the cochlea. In that structure, in the inner ear, you can get calcium deposition and the calcium can break away and float into that fluid that normally keeps your balance, where it's like a miter box in the inner ear that keeps your body in balance. If a piece of calcium gets into that fluid, the whole thing gets thrown off, everything gets inflamed and there's your vertigo.

But, Anna, to your point, if you have an ear infection, whether it's viral or bacterial, that can also inflame the inner ear and upset that miter box. Head injury can do that. And certain medications can upset the structures in the inner ear. So, yes, there are other things. Some medicines, heart medicines, in particular. Foods, there are foods that can actually create these problems. Aged cheeses. Processed meat. Coffee, chocolate, MSG. And, believe it or not, alcohol.

**Anna:** [00:16:07] So, all of the good things.

**Peter:** [00:16:09] But cheese? Shouldn't they have "May cause vertigo"...

**Anna:** [00:16:13] "May cause vertigo" on your cheddar label.

**Peter:** [00:16:15] I had a vertigo issue recently, David, and I want to ask you about this. So I went away with Jason on a speaking tour or whatever, and he bought me a massage for my birthday, and they said, "Do you want Swedish massage or deep tissue?" And I said, "Swedish massage." I go in the room and it's this woman who does regularly, does deep tissue.

So I'm noticing that the massage is a lot harder than I've ever had a massage. And she goes, "I'm sorry, do you want me to back off?" And I said, "No, you know what? Let me see if I can brave this and get through stuff, because my muscles are really tense on my neck, and my wrists hurt really badly."

She was excellent and she really hit the pressure points, but I really had to breathe through it. But when she turned my head sideways, David, and I was lying on my stomach and she put my arm, really did a thing with my arms and got deep, the room started spinning. And I said to her, "Hold on a second. I'm getting dizzy. The room is spinning. I'm getting nauseous." And she said, "That's because I've hit a thing that's releasing tension. It will get better." And it did. It got better in a couple of minutes. But what was that? I mean, can muscle release do that? Can it create vertigo?

**Dr. Kipper:** [00:17:20] A number of things can do that. Number one, your blood pressure and pulse, and those issues, your hemodynamics, the things that control your heart, they may have shifted a little bit from the stress of that. And so that's one thing that could have done that.

And, yes, she could have tweaked some nerves in there that created another set of nerves in response to that. But that wouldn't have dislodged any calcium deposits in the area. And it went away, right, Peter?

**Peter:** [00:17:53] It went away about ten minutes later. But when I got up from the table, it was like a drunken sailor for about five minutes and she said, "Have cold water, sit down and it will go away," she said, "But I really was going deep and working out some stuff." And I'm sitting there almost in tears, but breathing through it, thinking, all right, I've never had this before, this deep.

And then later on it did feel better. She hit all my pressure points and everything felt great and was about five, ten minutes and I felt fine. Is that healthy, by the way? A deep tissue massage?

**Dr. Kipper:** [00:18:19] If you can tolerate it. Chanel can do those. The harder the better. Bricks, you throw bricks at her, she's happy. Me, I'm the opposite of that.

**Anna:** [00:18:28] You need the tender touch.

**Dr. Kipper:** [00:18:30] I'm there to go to sleep and relax.

**Peter:** [00:18:32] And that's what I thought I was going to do. Listen to some Yanni, close my eyes and wake up an hour and a half later. Instead I'm going, oh my God, I've being tortured. And then you have to decide how much of a tip you're giving somebody for having hurt you for an hour and a half.

**Dr. Kipper:** [00:18:46] By the way, you mentioned something really interesting about this. And that's the treatment for this. Being put into a weird position is the treatment for vertigo. It's called the Epley maneuver. And you can look this up. Epley. There's 500 YouTubes on this. The Epley maneuver. If you lay somebody down on their back and their head is hanging over the end of the bed or couch or whatever it is, and you move their head in a 45 to 90 degree angle down, and you keep them there for one minute, that often will take that calcium crystal and put it back or move it away.

**Peter:** [00:19:28] Like a computer reset, is what it is.

**Dr. Kipper:** [00:19:29] Yes, pretty much. And then you do the other side, if that didn't get better. And you can keep repeating that. It works in a great number of cases. Doesn't work all the time. But, if you're home and you're experiencing this, look this up before you need it so you know how to do it.

[music]

**Peter:** [00:21:06] David, in This Just Happened, there will be no more gray hair in the near future. Is that correct?

**Anna:** [00:21:13] Do I not have to go to the hairdresser every three weeks anymore?

**Dr. Kipper:** [00:21:16] If you choose. I mean, there are some people that are okay with having gray or white hair. You're speaking to one of them. But 75% of people between the ages of mid 40s and mid 60s are going to have some gray hair. This is just what happens.

But what they figured out, which is why this is interesting, is why people get gray hair. And now having figured it out, we have a chance to do something about it. So we all know about stem cells. Stem cells are primal cells that turn into other things. They can turn into, melanocytes, which are the cells that color our skin, our eyes, our hair. They can turn into muscle cells. They can turn into nerve cells. So stem cells that are around the hair follicles that would normally turn into the melanocytes, the coloring cells, can't do that.

And the reason they can't do that is that they get stuck around the hair follicle and those cells that are developing, the hair follicles. But because there are different compartments around the hair follicle, and if those stem cells get stuck into one of those compartments, they can't move around and pick up the protein that they need to turn that stem cell into a melanocyte.

So if you're not going to make a melanocyte because that cell is stuck in some other glue or something, you're not going to get any cells that can color the hair follicles and color your hair. So having figured that out, they can now try to figure out how do you get those stem cells to move more freely into that compartment and therefore provide the color? Remember we talked about this, I think a couple months ago about what they figured out about hair growth, the hair growing cells, it turns out that those hair follicle stem cells, we thought were dead. And that's why people went bald and lost their hair.

Turns out they didn't die. They just went to sleep. They just weren't working as well. Remember this conversation? And so they have figured out that if they manipulate those stem cells and they give them some growth factors, and so whatever else they put in that soup, you can actually revitalize those stem cells and the hair grows back.

So now we're looking at this hair follicle from two different perspectives. One is to get more hair. And the other one is to color that hair. So it's pretty interesting technology and research. And now we can go forward and try to figure this out, so everyone will have a full head of hair, whatever color.

**Peter:** [00:23:56] Dark.

**Anna:** [00:23:57] Whatever color you want.

**Dr. Kipper:** [00:23:58] Right.

**Peter:** [00:23:58] Lustrous hair. And the industry will go down the tubes and medical, you know, what else are you going to say? Grows hair and also colors it – Ozempic. I mean, you find out like one drug...

[laughter]

**Anna:** [00:24:07] It really is a wonder drug.

**Peter:** [00:24:10] That's pretty interesting. How far away are we from that, David?

**Anna:** [00:24:12] Because I was going to say, when do we get to access this?

**Dr. Kipper:** [00:24:14] We're within a couple of years because they've already figured it out. They've already, in Australia, they worked with the hair growth issue, the hair growing stem cells. And they've managed in humans to make that better. And so this is just a nuance to that research. I have a feeling these two groups will come together. I think we're closer than we think.

**Peter:** [00:24:37] Amazing. All right. In the Hey, What About Me? issue today, we have a caller who's asking about something that we all probably think about. And it's generics, specifically for ADHD.

**Caller:** [00:24:47] I read an article recently about a mom who is managing her son's ADD medication, and found that the generics produced inconsistent behaviors. Can Dr. Kipper explain if generics are really safe and what is the difference in a brand version?

**Anna:** Yeah, I'm very curious about this because I always thought we were supposed to get generics because then you save money and I didn't know that, like, maybe it's not the best idea.

**Dr. Kipper:** [00:25:11] This is a really important question, and it's a question that I get a lot in my office because I'm prescribing medications. And, to Anna's point, the generics are generally cheaper. And so that's a better option now because some drugs are incredibly expensive.

Here's a story that our caller was referencing. There is a mom whose son had ADD, but he also had an allergy to red dye 40 so and those medicines that are specifically vulnerable to these problems are the seizure medicines, the heart rhythm medicines, the psychiatric meds, ADD, anxiety, depression medicines, anticoagulants, the blood thinners.

So you do have to be careful and you have to speak to your physician about this. As doctors, we don't always know the specifics and nuances that pharmacies will often, I don't want to demean the pharmacies, but there is a cost issue. If you sell a generic, there tends to be a little more profitability in a generic medicine than there is in a brand medicine, and the brands are very expensive. So if you're selling these medications, it might be easier and more profitable to sell a generic version of this. Again, this isn't all pharmacies.

**Peter:** [00:26:37] Let me ask you this. So, if I go to a pharmacy that I don't know or I don't have a relationship with, and they say, "Hey, you know, there's a generic for this and you can save a bunch of money. We don't have your brand in right now, we're out of yours." Should you say, "I'd rather not have the generic. I need the brand, when will it be in? Or if you have it now, let me know or give it to me right away. I'm almost down to my last."

Do you hold their feet to the fire, in a sense, to find out if they have it, or just saying it, or if they're really out of your medication? How do you test that? What power do you have when you go in?

**Dr. Kipper:** [00:27:08] So, Peter, that's the take-home message here. If you're going to get your medication and they're going to offer you the generic because they don't have the brand, you can't afford the brand. It could be any of that. Buy the brand for a month. See if that brand is giving you the same clinical effectiveness.



And so that becomes up to the patient. And it may be better for you to buy the generic because it's cheaper and, if it's working just as well, then you're good. First of all, why does something go from brand to generic? A brand is what the manufacturer is, the standard that they produce. The generics become available when their patent runs out.

Then anybody can take that formula and make a version of that. Those are the generic. The generics add in fillers into their product. So you have the basic, manufactured product, maybe not all of it. And they put in fillers that might extend the life of that medicine if it's an extended release form. But the fillers are the things that change these and make these a different product.

**Anna:** [00:28:20] Now, I'm absolutely terrified. Anybody else?

**Dr. Kipper:** [00:28:22] I can't answer that. But what I will say is that there are pharmacies that we all go to that are better at making their generics. Costco. Safeway. Target. Walmart. They make good generics in relationship to everywhere else. So if that's where you have your prescriptions and you're getting generic drugs, you are more likely to get good products. And I have no relationship to these places.

**Anna:** [00:28:49] Okay, to sum up, we had a very informative episode. We talked about Dr. Kipper's patient this weekend and how to get to the bottom of, was he having a heart attack or not.

**Dr. Kipper:** [00:28:57] So, collaboration in medicine is very important so that all the doctors have to speak to each other because you want to share information that might lead you down a different road. And, in that process, you also have to think about your patient, who now is becoming confused, even more scared. So it's really an important thing to have dialog between all those people involved.

**Anna:** [00:29:20] And then we discussed dizziness, vertigo, etc. The Epley maneuver. Did I learn that phrase today?

**Dr. Kipper:** [00:29:27] The Epley maneuver. So, look up Epley. This is the take-home message here on YouTube. See how you do it before you get vertigo. Or someone in your family or someone in your life gets vertigo. And, again, hopefully you'll understand where it comes from. Some dysfunction in the inner ear. Plus, these are very upsetting symptoms, and to know that you have the advantage of something to do at home. And, if that's not working, then call your doctor.

**Peter:** [00:29:58] And in the This Just Happened segment, we found out in the future you won't see people walking around with gray hair or potentially bald anymore. Everybody's going to have a thick, lustrous head of hair.

**Dr. Kipper:** [00:30:07] So, once again, stem cells come into this equation. And for hair coloring, these stem cells that will turn into the melanocytes that do the coloring process of the hair are not working as well. They're not able to get around that follicle. There's a protein that they need. And if they can't access the protein, they can't become a melanocyte. And if they don't become a melanocyte, you have gray hair. But we're going to figure this out. So you're going to have plenty of hair and...

**Peter:** [00:30:37] It's going to be amazing.

**Dr. Kipper:** [00:30:38] ...all colored the way you like it.

**Peter:** [00:30:40] And then of course in Hey, What About Me? we had a caller who was concerned about medication and the difference between generic and branded medication.

**Dr. Kipper:** [00:30:48] So, generics don't have to be bad. They are more affordable, which is a good thing. But just know that all medications are not created equal. All generics are not created equal. So speak to your pharmacist, and your pharmacist is your best answer and your best professional to help you navigate that confusion.

**Anna:** [00:31:09] If you have a question for Dr. Kipper, why don't you head on over to [BedsideMatters.org](https://www.BedsideMatters.org)? Enter it in there and your question might just be answered on the air. Also, we have socials: [@BedsideMattersPodcast](https://www.instagram.com/BedsideMattersPodcast) on Instagram; [@BedsideMattersPod](https://twitter.com/BedsideMattersPod) on Twitter/X.

**Peter:** [00:31:22] And, by the way, I want to thank Dr. Kipper for being part of this, because, if not, we'd just be questions and no answers. And the book is called *Override*, where you can take control of your sabotaging behaviors because you learn it's all about your brain chemistry. And there's a quiz in there that tells you what kind of brain chemistry you are and how you're sabotaging your behaviors. So check that out.

And of course, Anna Vocino, she has the sauces. She has the recipes. She has the website, [AnnaVocino.com](https://www.AnnaVocino.com). Check it out. It can change your life. And, of course, thank you for listening to Bedside Matters. If you're sick and tired of being sick and tired, we're here to help you, offering new episodes every Monday. So follow us, like us, and have a terrific healthy week.

**Announcer:** [00:32:01] The information on Bedside Matters should not be understood or construed as medical or health advice. The information on Bedside Matters is not a substitute for medical or health advice from a professional, who is aware of the facts and circumstances of your individual situation. Thank you for listening. If you enjoyed the show, please share it with your friends. We'll see you next time.