A sticky situation

The photo above depicts Ryan Ballou, center, whose BallouSkies charity raises money solely to support Associate Professor Subha Raman’s Duchenne muscular dystrophy research in the OSU Heart and Vascular Center. Ballou is surrounded by a group of triathletes who proudly wear the BallouSkies logo during their races to help market the charity to a wider audience.

For more about Ballou and his contribution to Raman’s research, see pages 2-3.
Spreading the wealth — and the peanut butter

Homegrown charity donates profits from peanut butter sales to benefit muscular dystrophy patients

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Spreading the wealth — and the peanut butter

Peanut butter goes great with jelly (or bananas if you believe Elvis). But the sticky spread also is the perfect complement to heart research being conducted at Ohio State.

For every jar of BallouSkies Peanut Butter sold in Giant Eagle grocery stores around Columbus and Pittsburgh, 100 percent of the profit goes to support the work Subha Raman is doing to diagnose, prevent and treat heart muscle disease in muscular dystrophy (MD) patients.

The peanut butter was the brainchild of Pittsburgh resident Ryan Ballou, a 23-year-old with Duchenne MD (one of the most prevalent types of the disease, characterized by rapid muscle degeneration), who has been coming to OSU for treatment since he was 6. It was during one of his four annual trips when he was introduced to Raman’s research. He was so excited about the possibilities of prolonging the lives of MD patients that he and his family wanted to support Raman any way they could.

They started BallouSkies charity and began looking for ways to raise money. Ballou’s father Ty runs a food distribution business, so the family already had the connections to develop a peanut butter product.

“Funding is hard to get for any research to get done,” Ballou said. “So when we saw Dr. Raman’s research, we said, why wait when we can get it going? We got more involved in getting kids to get MRIs of the heart done, which they’re doing to track the disease. When you have muscular dystrophy, the main cause of death is heart or respiratory failure, and since there’s no cure, hopefully they can find some new things out.”

Between the peanut butter sales, a charity walk, a fund-raiser happy hour, a Facebook causes page (search: BallouSkies) and promotion of the charity by various triathletes who wear the charity’s logo during their races, BallouSkies raised $27,000 for Raman last year. This year Ballou said he hopes to make it $50,000.

“We seek to be as productive as possible with the funds, multiplying their benefit by engaging expert collaborators who have been generous with their time and expertise like Drs. John Kissel, Jill Rafael-Fortney and Paul Janssen. The opportunities for the enthusiastic student researchers involved have been incredible as well,” said Raman, clinical director, Cardiac MRI and CT in the OSU Heart and Vascular Center. “We sort of think of these as very precious funds that literally represent the sweat and tremendous efforts of a lot of great people. We think we’ve already been very successful and we hope to do even more.”

Raman’s research is already being put to use helping patients. She and her team developed some non-invasive methods using magnetic resonance imaging to detect early heart muscle changes prior to patients having congestive heart failure or abnormal heart rhythms.

“We sort of think of these as very precious funds that literally represent the sweat and tremendous efforts of a lot of great people. We think we’ve already been very successful and we hope to do even more.”

— Subha Raman, Associate Professor of Cardiovascular Medicine
— to help advance heart research at Ohio State

Points to ponder about Duchenne Muscular Dystrophy (taken from the Muscular Dystrophy Association website)

- Duchenne muscular dystrophy (DMD) was first described by the French neurologist Guillaume Benjamin Amand Duchenne in the 1860s.
- The gene that, when mutated, causes DMD is located and identified in 1986.
- In DMD, boys begin to show signs of muscle weakness as early as age 3. The disease gradually weakens the skeletal muscles, those in the arms, legs and trunk. By the early teens or even earlier, the boy’s heart and respiratory muscles also may be affected.
- Many children with DMD lose the ability to walk some time between ages 7 and 12.
- Diet has not been shown to influence the onset and progress of symptoms, although exercise can help build skeletal muscle, keep the cardiovascular system healthy and contribute to feeling better. But experts caution that too much exercise could damage muscle.
- Women do not commonly have full-blown DMD because it is a sex-linked disease, passed down through the X-chromosome. When a girl inherits a flawed dystrophin gene from one parent, she usually also gets a healthy dystrophin gene from her other parent, giving her enough of the protein to protect her from the disease.

Ryan Ballou’s parents were understandably devastated upon finding out their son had muscular dystrophy. But all the 5-year-old Ballou could think about as he left children’s hospital in Pittsburgh was how exciting it was to get to eat out again.

“I didn’t understand the severity of the diagnosis,” said Ballou, who is now confined to a wheelchair at age 23.

Still, he never let the disease overrule his desire to have a childhood. He could walk until he was 18. He played baseball. As the disease progressed, his acceptance of who he is and will be has changed.

“It is a struggle and, I don’t want to sound cliché when I say this, nobody wants to be disabled, but it defines my outlook and how I live my life,” Ballou said. “It brought my family closer together and you have to be thankful for what you have. I’ve had my ups and downs healthwise, and emotionally it’s been hard, but I have a good outlook. It’s formed how I see life having to be in a wheelchair and having to deal with this my whole life.”

That’s why he has put all his effort into raising money for Subha Raman’s research — finding methods to be proactive in diagnosing and treating muscular dystrophy patients at risk for heart failure at the OSU Heart and Vascular Center. Through her success, Ballou hopes those with MD can have an even better future.

“If we can research this and tackle this problem, we can move on to other problems,” Ballou said. “We need to compartmentalize the issues and solve them that way. Hopefully it has implications for all of heart failure and not just this disease.

Raman said having Ballou support her work has been something short of inspirational.

“It’s been a great joy to meet Ryan and his family,” Raman said. “They motivate our team to overcome hurdles and keep trying to improve diagnosis and treatment so that people like Ryan can live healthier, longer lives. I think they all have tremendous spirit and passion and their team spirit is something we share at Ohio State.”
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Federal grant expands Med Center expansion

What already was the largest construction project in Ohio State’s history got a little bigger April 8 when the Board of Trustees voted to add a floor to the new hospital building currently under construction. The board authorized the revision of the Medical Center Expansion Project to include construction of a new radiation oncology center and expansion of radiation oncology services, which will be added to the third floor of the hospital.

The building now will rise 28 floors, or 294 feet off the ground, and the budget has increased from $1 billion to $1.1 billion.

The center will be funded as part of a $100 million grant from the federal Health Resources and Services Administration to the Medical Center last December for CURE, the cancer hospital component of the expansion project.

The new radiation oncology center will be located in expanded space within the new Critical Care Tower.

When the grant was first announced, the initial plan was to build a separate building to house radiation oncology, but the word came with just enough advance notice that a floor could be added to the existing plan. Besides the tower — which will include a 144-bed critical-care hospital and a 276-bed cancer hospital — the expansion includes new lab and office space, upgrades to the electrical and plumbing systems in the Medical Center and completion of three floors of the Biomedical Research Tower.

The plan also includes re-routing of Cannon Drive to reclaim about 12 acres of developable space along the river. Also at the Board of Trustees’ April meeting, members authorized the release of another $111.35 million for the expansion project for construction and related services.

Besides the HRSA grant, the project is funded by $925 million from university bond proceeds and $75 million from development funds.

The building is scheduled to be completed by mid-2014.

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Contact: Nancy Rades, nancy.rader@osumc.edu
(614) 947-3700, ext. 3300

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Contact: Suzanne Haussermann, suzanne.haussermann@osumc.edu
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Be sure to contact the coordinator of the group you’re interested in attending to find out when a new session begins. Sessions are subject to change. For more information about starting a Weight Watchers at Work group, contact Linda Holmes, Weight Watchers, Inc., at lindah@newcoils.com or call (614) 635-7200, ext. 1145.

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Here's to your health: OSU Health Plan has your back

The Ohio State University Health Plan offers a number of programs to enhance the health and wellness of OSU employees, ranging from flu shots to help in finding some of the best walking routes around campus.

Educational programming
OSU encourages faculty and staff to take advantage of educational programs that inspire healthy lifestyles and behavior change.

Building on the success of the former “Lunch and Learn” workshop series, the new generation of educational programming offers enhanced topics, a wider selection of workshop times and a more experiential format.

Most educational programs are free of charge, and can earn you points in the Your Plan for Health Incentive Program. See osuhealthplan.com/members/wellness/ for details.

For some programs, including live sessions, you’ll need to register in advance. For a full list of educational programming, visit osuhealthplan.com/wellness.

The educational program series now offers brief educational programs for details.

Incentive Program. See osuhealthplan.com/wellness/walking-routes/index.php for tips on how to walk for fitness — including correct posture, arm swing, stride and even dress — and for walking routes of various distances and at various spots around campus such as the Oval, Fisher College of Business or Chadwick Gardens.

Health Fair
The Annual Rally for Wellness! Health Fair occurs each September and offers OSU State faculty and staff the opportunity to meet more than 100 campus and community health and wellness exhibitors, receive a biometric screening, purchase produce at a farmer’s market, and learn about health and wellness resources.

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Heart disease, which includes coronary heart disease, myocardial infarction and heart failure, is the leading cause of death in Ohio and the United States. Among the 50 states and the District of Columbia, Ohio ranks 14th highest for heart disease mortality. The estimated direct and indirect cost of heart disease for the United States in 2008 was $287.5 billion. This figure includes direct costs such as hospital, nursing home and physicians’ care and prescriptions, as well as indirect costs from productivity lost due to morbidity and mortality. Heart disease is a major public health concern and economic burden for the United States and Ohio. In 2005, heart disease caused 27 percent (28,995) of Ohio deaths. This includes 21,900 deaths attributed to coronary heart disease. Based on an average life expectancy of 75 years, in 2005, Ohioans lost more than 139,000 years of potential life due to heart disease. In addition, in 2003, there were more than 190,000 hospitalizations for heart disease, accounting for $8.4 billion in charges. While the mean age for heart disease death among Ohioans is 77 years, 19 percent of these deaths occurred before age 65. The burden of heart disease is disproportionately greater for Ohio's black population. The mortality rate for black males was 21.8 percent higher than for white males and 26.1 percent higher for black females compared to white females. Black Ohioans also are more likely to die prematurely from heart disease, compared to white Ohioans. On average, black males die seven years earlier from heart disease than white males and black females die nine years earlier than white females. Modifiable risk factors for heart disease include high blood pressure, diabetes, elevated blood cholesterol, physical inactivity, obesity and cigarette smoking. Many adult Ohioans report having these risk factors and are at an increased risk for heart disease. In 2006, 5.6 percent of Ohio adults reported they had been told by a health care provider that they had coronary heart disease (CHD). Males (5.9 percent) had a slightly higher prevalence of CHD than females (5.3 percent). More males than females report having had a heart attack. In 2006, the prevalence for males was 6.7 percent and 4.0 percent for females. The average age of the first heart attack was 53.2 years for males and 60.0 years for females. The prevalence of coronary heart disease among heart attack victims varied by race/ethnicity and sex. In 2004-06, Hispanic males (7.6 percent) and white males (5.3 percent) had the highest prevalence of coronary heart disease; Hispanic males (7.2 percent) and males of other races (Asian, Native Hawaiian, Pacific Islander, American Indian, Alaskan Native or races other than white or black) (7.4 percent) had the highest prevalence of heart attack compared to other racial/sex groups. More than half of adults with a history of heart attack (50.8 percent) or CHD (51.7 percent) reported limitations of daily activities compared to approximately 18 percent of those who did not report either condition. The majority of adults with cardiovascular disease (53.0 percent) reported Medicare as their primary insurance coverage. More than 80 percent (82.1 percent) of adults with cardiovascular disease reported that they need or take medication for their chronic condition, in comparison to 38.4 percent of adults who did not have cardiovascular disease. Of adults who reported they had a heart attack, 39.2 percent reported receiving outpatient rehabilitation. (from Ohio Dept of Health)

America’s Heart Disease Burden

In 2006, 63,166 people died of heart disease. Heart disease caused 26 percent of deaths — more than one in every four — in the United States. Heart disease is the leading cause of death for both men and women. Half of the deaths due to heart disease in 2006 were women. Coronary heart disease is the most common type of heart disease. In 2005, 445,687 people died from coronary heart disease.

Every year about 785,000 Americans have a first heart attack. Another 470,000 who have already had one or more heart attacks have another attack. In 2010, heart disease will cost the United States $316.4 billion. This total includes the cost of health care services, medications and lost productivity. (from Centers for Disease Control and Prevention)

Everyone could use some TLC 

From the US Department of Health and Human Services; National Institutes of Health; National Heart, Lung and Blood Institute

TLC stands for Therapeutic Lifestyle Changes, a three-part program that uses diet, physical activity and weight management.

Heart Disease Risk Factors

Risk factors are conditions or behaviors that increase your chance of developing a disease. For heart disease, there are two types of risk factors — those you can’t change and those you can. Fortunately, most of the heart disease risk factors can be changed.

Risk factors you can’t change

- Age — 45 or older for men; 55 or older for women
- Family history of early heart disease — father or brother diagnosed before age 55, or mother or sister diagnosed before age 65
- Risk factors you can change

- Smoking
- High blood pressure
- High blood cholesterol
- Overweight/obesity
- Physical inactivity
- Diabetes

Cholesterol Classifications

Total Cholesterol

Less than 200 mg/dl — Desirable
- 200–239 mg/dl — Borderline high
- 240 mg/dl and above — High

LDL Cholesterol

Less than 100 mg/dl — Optimal (ideal)
- 100–129 mg/dl — Near

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HDL. lower triglycerides and raise types of drugs — about 20-55 percent. Statins stop an enzyme that makes cholesterol. They are called "lifestyle drugs" because they are given to help you change your eating habits and lower your cholesterol. They are usually taken with a statin. simvastatin, fluvastatin, lovastatin, pravastatin, atorvastatin, rosuvastatin. Atorvastatin and rosuvastatin.

The major types of cholesterol-lowering drugs are:

- Statins — lovastatin, pravastatin, simvastatin, atorvastatin, rosuvastatin. Simvastatin or statins stop making cholesterol by about 20-55 percent and also moderately lower triglycerides and raise HDL.

- Ezetimibe. This drug reduces the amount of cholesterol absorbed by the body. Ezetimibe is combined with statins to get more lowering of LDL. Ezetimibe lowers LDL by about 18-25 percent.

- Fat acid reomoves. These bind with cholesterol-containing bile acids in the intestines and are then eliminated from the body in the stool. They lower LDL cholesterol by about 15-30 percent.

- Nicotinic acid — also called niacin. This is a water-soluble B vitamin that should be taken only under physician supervision. It improves all lipoproteins — total cholesterol, LDL, triglycerides, and HDL. When taken in doses well above the vitamin requirement, LDL levels are usually reduced by about 5-15 percent, and up to 25 percent in some patients.

Fibrates. They mostly lower triglycerides and, to a lesser degree, raise HDL levels. Fibrates are less effective in lowering LDL levels.

**The Skinny on Fats**

Fat is a nutrient that helps the body function in various ways: for example, it supplies the body with energy. It also helps other nutrients work. But the body needs only small amounts of fat, and too much of the saturated type will increase cholesterol in the blood. There are different types of fat, and they have different effects on cholesterol and heart disease risk. Here's a quick rundown.

Saturated-fat. This fat is usually solid at room and refrigerator temperatures. It is found in greatest amounts in foods from animals, such as fatty cuts of meat, poultry with the skin, whole-milk dairy products and lard, as well as in some vegetable oils, including coconut and palm oils. Studies show that too much saturated fat in the diet leads to higher LDL levels. Populations that tend to eat more saturated fat have higher cholesterol levels and more heart disease than those with lower intakes. Reducing the amount of saturated fat in your diet is a very effective way to lower LDL.

Unsaturated fat. This fat is usually liquid at room and refrigerator temperatures. Unsaturated fat occurs in vegetable oils, most nuts, olives, avocados, and fatty fish, such as salmon. There are types of unsaturated fat — monounsaturated and polyunsaturated. When used instead of saturated fat, monounsaturated and polyunsaturated fats help lower LDL levels and HDL, lower triglycerides and raise others may not. When you talk with your doctor about taking a cholesterol-lowering drug, be sure to mention other medicines you're taking — even over-the-counter remedies. And if you have any side effects from a medicine, tell your doctor as soon as possible. The amount or type of drug can be changed to reduce or stop bad side effects. If one drug does not lower your LDL enough, you may be given a second medication to go with it.

The major types of cholesterol-lowering drugs are:

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Heart health

Polyunsaturated fats help lower blood cholesterol levels. Mono-
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plants, including olive, canola, sunflower and peanut oils.
Polyunsaturated fat is found in greatest amounts in foods from
plants, including safflower, sunflower, corn, soybean and
cottonseed oils, and many kinds of nuts. A type of polyunsatu-
rated fat is called omega-3 fatty acids, which are being studied to
see if they help guard against heart disease. Good sources of
omega-3 fatty acids are salmon, tuna and mackerel.

Trans fat. Also called trans fatty acids, it tends to raise blood
cholesterol similarly to saturated fat. Trans fat is found mainly in
foods made with hydrogenated vegetable oils, such as many hard
margarines and shortenings. The harder the margarine or shorten-
ing, the more likely it is to contain more trans fat.

Total fat. This is the sum of saturated, trans, monounsatu-
rated and polyunsaturated fats in food. Foods have a varying mix
of these types. The types of fat you eat have more to do with
your LDL level than the total fat you take in.

Fiber Solutions

How can you add soluble fiber to your diet? Choose hot or
cold breakfast cereals such as oatmeal and oatbran that have
3-4 grams of fiber per serving. Add a banana, peach, apple,
berries or other fruit to your cereal. Eat the whole fruit instead
of, or in addition to, drinking its juice — one orange has six times
more fiber than one 4-ounce glass of orange juice.

Heart health (from page 11)

polysaturated fats help lower
blood cholesterol levels. Mono-
unsaturated fat is found in greatest
amounts in foods from
plants, including olive, canola,
sunflower and peanut oils.
Polyunsaturated fat is found in
greatest amounts in foods from
plants, including safflower,
sunflower, corn, soybean and
cottonseed oils, and many kinds
of nuts. A type of polyunsatu-
rated fat is called omega-3 fatty
acids, which are being studied to
see if they help guard against
heart disease. Good sources of
omega-3 fatty acids are salmon,
tuna and mackerel.

Trans fat. Also called trans
fatty acids, it tends to raise
blood cholesterol similarly to
saturated fat. Trans fat is found
mainly in foods made with
hydrogenated vegetable oils,
such as many hard
margarines and shortenings. The
harder the margarine or shorten-
ing, the more likely it is to
contain more trans fat.

Total fat. This is the sum of
saturated, trans, monounsatu-
rated and polyunsaturated fats
in food. Foods have a varying mix
of these types. The types of fat
you eat have more to do with
your LDL level than the total fat
you take in.

Fiber Solutions

How can you add soluble
fiber to your diet? Choose hot or
cold breakfast cereals such as
oatmeal and oatbran that have
3-4 grams of fiber per serving.
Add a banana, peach, apple,
berries or other fruit to your
cereal. Eat the whole fruit
instead of, or in addition to,
drinking its juice — one orange
has six times more fiber than one
4-ounce glass of orange juice.