

UW Health Link

Connecting you to health news and resources in your community

Fall 2005

Behind the screen

Health-care screenings can be valuable... but only when taken in proper context.

Tests and screenings have always been a vital part of medicine, giving doctors important information they need to make and clarify a diagnosis. But as the consumer's role in health care has expanded, so has the availability of tests.

What was once the sole domain of the doctor's office and specialty clinic has now expanded into all sorts of unexpected venues. It's not uncommon to find stroke screenings and heel bone density tests at churches, shopping malls and health fairs, even in parking lots. Sometimes the tests offered are free of charge. In other cases, there's a significant fee.

But what isn't usually present is an appropriate medical context. Without it, say experts, a screening loses its meaning.

"Screening means exactly what it says," notes Shari Zeldin, a senior outreach specialist with UW Health's Osteoporosis Clinical Research Program. "It's designed to identify people who may be at risk for a serious disease, but it's not a diagnosis. All it can do is predict, so we can recommend diagnostic followup when appropriate."

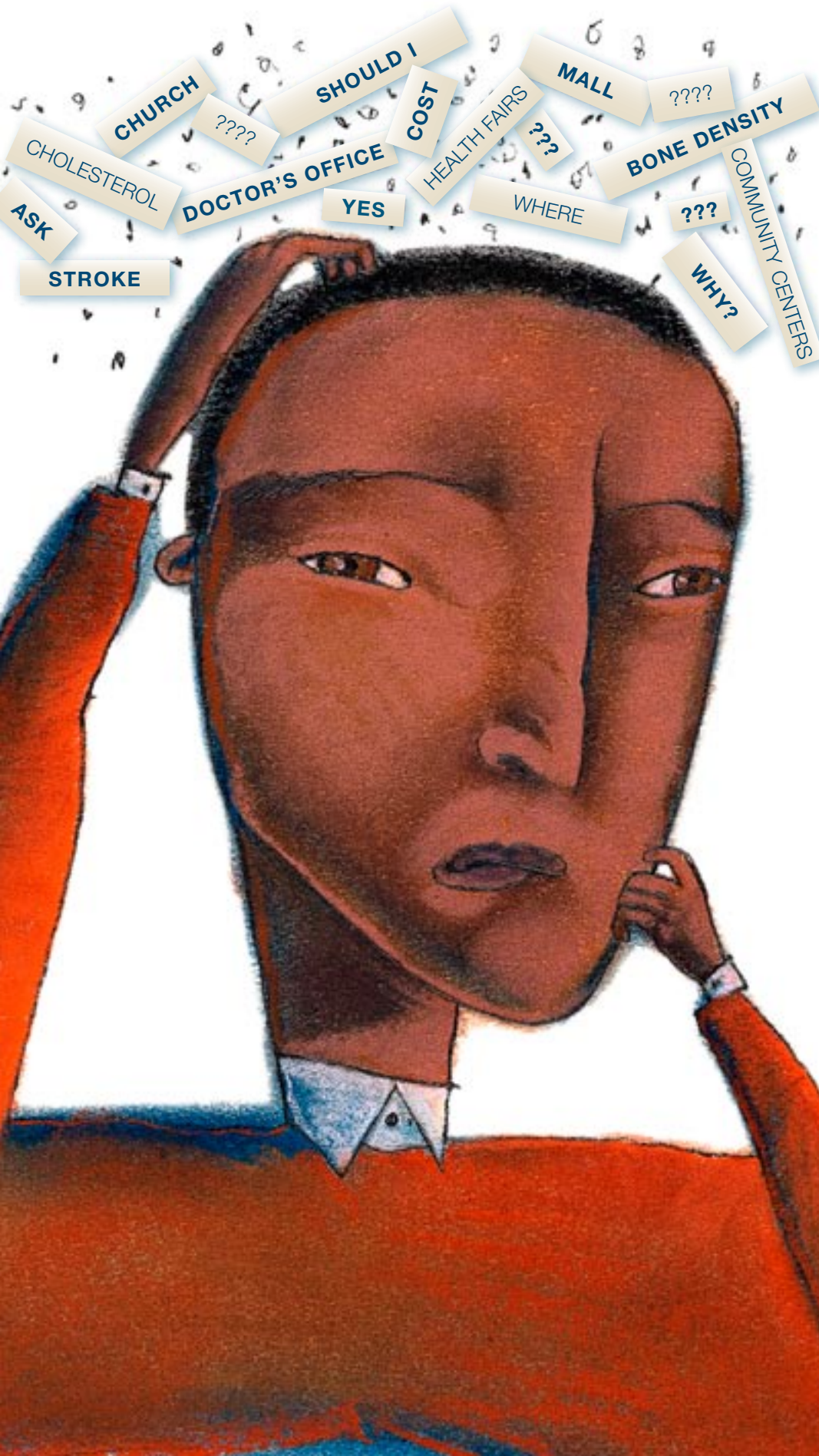
Take the heel bone density scan, a test often found at health fairs that uses a mild pulse of radiation to measure the thickness of the bone in your heel. The results of the test are assigned a number based on criteria developed by the World Health Organization. One sizable problem: The WHO criteria apply only when diagnosing the spine and hip in a postmenopausal woman. In other words, a person who has a low score at the heel wouldn't necessarily be considered to have osteoporosis, even though their test result might suggest low bone density.

"Screenings can be useful, but you have to have the appropriate medical context," says Zeldin. "Sometimes, they can do more harm than good."

Dr. Howard Rowley, a UW Health radiologist and professor at UW Medical School, spends a good deal of his time administering and reading MRI scans. He shares similar concerns about isolated tests and screenings.

"Different tests have different degrees of precision for disease detection. Anyone getting a test has to be ready to deal with positive or negative results in an informed and rational way," he says.

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Connecting patients to family and friends

The scenario is familiar: A loved one is in the hospital. Family members spend their days at the bedside, and their nights updating family and friends on their loved one's health care journey. It's an exhausting cycle.

UW Hospital hopes to ease part of this strain through a new service called CarePages—private Web pages that help patients and their families communicate with concerned loved ones, before, during and after hospitalization.

"CarePages are set up and maintained by the patient or family member after a staff member explains the service," explains Jay Schneider, director of the UW Health office of e-Health Innovation and Policy. "Beyond that point, staff are no longer involved and the information shared on the page is completely private among the patient, family members and friends."

Maureen McCausland, senior vice president, patient care services and chief nursing officer for UW Hospital and

Clinics, says CarePages is an exciting patient-centered service her organization is proud to offer. "CarePages provide a way for patients and their families to stay more connected to their friends and family for emotional support," she says. "Anything we can do to assist them and help ease some of their stress is very rewarding."

Once a page is set up, the family member instructs friends and other family members how to access the secure site. They can then log in for updates and send messages of encouragement back to the patient and/or family members.

Available to all patients at no charge, CarePages can be accessed directly from any computer with internet access, or by clicking on a "CarePages" icon that appears on uwhealth.org.

Patients and family member can also provide feedback for UW Health staff members through Care Compliments, another feature of the service.

Screenings from page 1

Unfortunately, with fee-for-service screenings that take place outside the clinical setting, information to understand results may be lacking. In some states, private companies have begun to offer full-body or site-specific MRI scans, touting technology that, say the providers, can catch cancers and heart disease in one fell swoop.

Not only do these scanners tend to cut corners, but they often deliver far more than patients bargain for.

"Many patients will have lesions or nodules detected that are completely benign, and would have never caused problems," says Dr. Rowley.

The findings can cause undue anxiety, as well as potentially risky and expensive treatments, biopsies and surgeries that may not have been necessary in the first place.

"Before entering into any type of screening test, we have to understand how valid that test is for the disease we're trying to find, and what we're going to do with the information," says Dr. Rowley.

Dr. Rowley points to cholesterol screening as an example of a basic test that works well and provides clear information to both the patient and doctor. "We know cholesterol is linked to heart disease and stroke, and we also have something we can do about it—diet modification and medication," he notes.

One of the more controversial tests that's popping up in local malls, churches and community centers claims to gauge an individual's risk of developing stroke by using an ultrasound screen to measure disease buildup in the carotid arteries of the neck.

In most cases, the results are provided without the benefit of professional medical consultation.

Dr. John Keevil, a UW Health preventive cardiologist, likens these calcium screenings to playing at a casino—in rare instances, the test will reveal the jackpot of a life-threatening problem, staving off disaster. In most cases, however, the information the test conveys isn't nearly as clear as one might hope, and the customer loses a little bit of money.

An even more high-tech test is a CT scan to measure calcium buildup in the heart arteries. "Frequently, the result you get with this test is an intermediate number," says Dr. Keevil. "And that information isn't interpreted in the full context of the patient's overall health and lifestyle—do they exercise or have high blood pressure? What's their family history? All those layers are missing."

Interestingly, Dr. Keevil and his colleagues at UW Health don't even use calcium scoring or carotid ultrasound measurements as first-line tests. Instead, these tests are used to help clarify a decision for a patient who may be on the borderline of needing more aggressive management of their cardiovascular disease with medication, diet and exercise. Dr. Keevil also points out that individuals who receive a normal calcium screening score may still be considered at moderate risk to have a heart attack or stroke, due to family history or lifestyle factors.

"Tests like these can convey both false worry and false assurance," says Dr. Keevil. "Medical tests are supposed to answer questions, but when you flip things and do the test first, these questions lose their contextual meaning."

The best advice is to involve your physician before you pay for a health-care screening, and ask if a particular test will help you and your physician make a decision about your care.



“If you can repair the heart valve early enough, you can prevent long-term damage.”

Mitral Valve Repair

A shift in thinking suggests early intervention is key

Dick Hinrichs knew his heart wasn't working at full strength. And so did his doctors. In 2003, tests revealed that Hinrichs had multiple cardiovascular problems, including a heart murmur and, worse, a mitral valve that was leaking blood from his heart and putting pressure on his lungs.

Even though Hinrichs' heart felt fine, his heart was working harder than it had to just to get through the routine of the day. The Middleton native was able to manage the set of office warehouses he owns and travel frequently to Russia and Mongolia to do missionary work. Hinrichs' doctors had instructed him to watch carefully for any changes in his health.

“I thought I was in good shape. I had no symptoms or problems at all,” he recalls. Two years later, however, an echocardiogram delivered disturbing news. “I hadn't slowed up at all, but my heart had dropped to 60 percent efficiency.”

Other parts of Hinrichs' heart had tried to pick up the slack, and had become enlarged in the process. It was time, his doctors said, to see a cardiac surgeon and have the leaking valve replaced.

Or so he thought.

Replace or Repair?

There are two ways for surgeons to fix a damaged mitral valve—replace it or repair it.

The former involves removing the natural valve and replacing it with one from a pig or a mechanical valve, a

treatment that comes with significant drawbacks. Pig valves last about 10-12 years, requiring a second replacement surgery. Meanwhile, patients who choose mechanical valves must often use blood thinners, a poor option for patients who are older or have other medical problems or for patients like Hinrichs, who hope to stay active or travel frequently.

Repairing the valve, by contrast, preserves the heart's natural geometry and is often a more permanent fix that avoids the need for blood thinners.

Hinrichs was referred to Dr. Niloo Edwards, chair of UW Health cardiothoracic surgery, an international expert at repairing mitral valves. Dr. Edwards has successfully repaired 87.5 percent of the damaged valves that have come his way—more than twice the national average of 40 percent.

“A leaky mitral valve is an insidious problem,” says Dr. Edwards. “You're not likely to have a heart attack or suddenly drop dead. Instead, the wear and tear from having to pump all that extra blood damages the heart muscle to the point where it fails. That's why, if you can repair the heart valve early enough, you can prevent long-term damage.”

Doctors have debated for years whether it's better to act immediately when it's discovered a patient has a leaky valve or wait until problems begin to appear.

“Traditional timing has suggested that we wait until the heart is showing signs

that it's not working well,” says Dr. Edwards. “More recent studies are suggesting that even before the patient starts having symptoms, damage is being done to the heart. If the valve is repairable and the patient is leaking a severe amount, we should go ahead with surgery as long as the valve can be repaired.”

The longer a patient waits to receive treatment after showing symptoms, the poorer his or her outcome is likely to be, even if the valve repair is successful.

“If a patient knows they have a leaky valve, they need to follow up with a cardiologist, have their risk assessed and evaluate the timing, if any, for an intervention,” says Dr. Edwards.

In Hinrichs' case, the problem was identified and treated in plenty of time. Dr. Edwards operated on Hinrichs at UW Hospital on a Monday in early July, repairing his mitral valve, erasing his heart murmur and fixing a mildly blocked artery in the process. Six days later, Hinrichs was up and active, walking more than a mile. He progressed to 4-5 miles a day within two weeks. The lung congestion that once troubled his sleep is now a thing of the past.

“I feel wonderful,” Hinrichs says. “I'm looking forward to getting back to full physical activity.”

To learn more about mitral valve repair or to schedule a consultation, call **(608) 263-0439** or visit **uwhealth.org**.



Dr. Niloo Edwards
Chair, Cardiothoracic Surgery

Catching the leak

Patients who have a leaky mitral valve usually experience shortness of breath and easy fatigue, as well as a swelling in their legs. Even though it's possible to enjoy normal quality of life with a damaged valve, Dr. Edwards cautions patients to treat the condition very seriously.

“We're not advocating that everyone who has a leaky valve needs to have it fixed right away,” says Dr. Edwards. “But it's essential for patients to see a physician who has experience with leaking valves who can assess it appropriately. Someone who can tell you, ‘Your valve's leaking and you're going to be okay’ or ‘Your valve's leaking and if we don't intervene early we're going to end up with heart muscle damage that's going to impact your survival and quality of life.’”

The advertisements are arresting, enough to unnerve even a minimally health-conscious woman.

“If you’re a gambling woman, then getting a Pap test is just fine,” trumpets one ad. In another, a grim-faced woman clutches herself protectively while the text below her blasts, “You’re not failing your Pap test, but it might be failing you.”

The ads, which have appeared in several popular national women’s magazines

“The Pap smear is a perfectly good screening tool,” says Dr. Wait. “The utility of the HPV test, by contrast, is limited.”

HPV is extremely common, especially if a woman has had multiple sexual partners. Some medical studies have suggested that if a woman has had more than 10 partners, her chance of contracting HPV is as high as 60 percent; conversely, if she’s only had one, the percentage drops to eight percent.

Although a basic Pap test isn’t infallible—experts estimate that it misses pre-cancerous cells about 20 percent of the time—most of those cells can take as long as seven years to develop into full-blown cervical cancer. Assuming a woman’s lifestyle and genetic history doesn’t place her at a higher risk to develop cervical cancer, an annual Pap test is sufficient. “Given the general progression of cervical cancer, we have time,” Dr. Wait notes.

A Pap that looks for HPV

For women who might be at higher risk—those with multiple sexual partners, who smoke tobacco or suffer from conditions that may have compromised their immune system—Dr. Wait recommends a thin-prep Pap smear,

worthwhile as a person. Some of my patients almost have a panic reaction.”

Then there’s the issue of cost. The HPV test is more expensive than a straight Pap smear—in some cases, nearly three times as pricey—and may not be covered by all health insurance plans. For Dr. Wait, this raises a significant risk-benefit question.

“If they’re coming to see their physician frequently, I’d have to say the risk-benefit is fairly low,” he says.

Dr. Wait says it’s uncommon for women who visit his clinic to ask for (or even have heard of) the HPV test, suggesting that the ads have yet to make much impact.

Still, Wait finds the ads exasperating, because, like many modern



over the last few months, are promoting a test for the human papillomavirus (HPV). HPV is the virus responsible for more than 90 percent of cervical cancers in women. The manufacturers of the test assert it is a necessary companion to a woman’s annual Pap test, able to catch abnormal cervical cells that the other test might miss.

There’s one problem. According to Dr. Erik Wait, a board-certified ob/gyn at UW Health’s Fitchburg clinic, the HPV ads are dramatically overstating the case.

In addition, HPV isn’t necessarily a serious cause for concern for most women. The virus comes in many types, and the body’s immune system is equipped to deal with most of them. Since the virus often has no physical symptoms, an HPV infection may come and go without leaving a clue.

Only a small handful of HPV types have a more serious consequence: Over the course of time, they can alter basic cervical cells, tilting them toward cancer.

HPV or PAP?

a more complex version of the Pap test that includes a check for HPV. Thin-preps are also recommended for women whose Paps come back abnormal or who are experiencing troubling symptoms, like bleeding after sexual intercourse.

“In cases like that, a thin-prep or an HPV test can help guide me, tell me how closely I’m going to watch a patient for the development of cervical cancer,” he explains. “For most women, it’s not going to be necessary.”

Unlike the Pap smear, the biggest issue with the HPV test isn’t accuracy, but emotional fallout. In Wait’s experience, many women who test positive for HPV find it hard to accept they’re carrying a sexually transmitted virus.

“They’re horrified,” Dr. Wait attests. “They often say they feel dirty, less

pharmaceutical ads, they play on patients’ fears. “They’re sensationalistic, and they don’t weigh the pros and cons of the issue.”

If a woman is serious about reducing her risk of cervical cancer she needs to do three things:

- Limit sexual partners and engage in safe sex.
- Quit smoking. Carcinogens in cigarette smoke collect in cervical mucus, increasing a woman’s chances of developing cervical cancer two- to five-fold.
- Continue receiving a Pap test each year.

For more information about cervical cancer, HPV and pap tests, call **(608) 274-5300** or visit **uwhealth.org**.

Substance Abuse

Millions of men and women in the U.S. struggle daily with drug and alcohol abuse. But for women, receiving the help and treatment that could help them overcome their addiction can often be more difficult than it is for men. Michael Waupoose, director of UW Health's Gateway Recovery, an outpatient mental health and drug and alcohol recovery program and Penny Raimer, an Alcohol and other Drug Addiction counselor with Gateway Recovery, recently sat down to shed some light on the challenges women face.

Is it true that the barriers to receiving treatment for drug and alcohol abuse are different for a woman than for a man?

MW: The research shows that one of the biggest barriers to women entering treatment is child care. It's interesting, because one of the main reasons women will go into treatment is for their children.

The child-care issue disproportionately affects single women. And single women are typically going to be of a lower socio-economic status, meaning that they're going to lack the financial resources to seek help.

PR: Women are still considered primary care givers, especially for children, so coming in for treatment is often challenging for them. In some cases, they don't have child care or transportation.

Are there other barriers to treatment that affect women differently?

MW: We find there's a greater stigma attached to a woman for having a drinking or drug problem. There's still a tendency to under-suspect, under-diagnose or under-report alcohol problems with women. People don't want to say that a woman, who is a mother and a caregiver, is an alcoholic or

drug addict. There is still a huge amount of shame for women to self-identify as having a substance abuse problem.

PR: Many women have substance abuse problems, but it doesn't always become noticeable. Family members might be trying to hide it. There may be a woman who is pregnant and using drugs, and people really look at that as bad behavior rather than a situation in which a woman is unhealthy and unable to get help.

Aren't there also physiological differences in how men and women experience substance abuse?

MW: We know that alcohol and drugs affect women differently from men—physically, emotionally, psychologically, economically. Women experience complications from their alcohol abuse more quickly and more severely than men do. There are some studies that suggest that it's related to how women process alcohol.

PR: I saw a study suggesting that Wisconsin women rate number one in the country in binge drinking—that's frightening.

What are the risks for a woman who tries to seek help, but is unable to consistently receive treatment?

MW: When a woman is sporadic in her attempts to seek treatment, we're very careful that we don't attribute that to a lack of motivation or sincerity in her attempts. We really need to try to understand that behavior from the perspective of her life. It requires the treatment program to be responsive, to work with her in identifying resources in the community that can help. There are programs that will help her with child care, with transportation.



worried about their homes, whoever it is they care for.

I always tell people that the only thing people truly need to do is to sit down with an alcohol and drug professional and have an evaluation—sit down and talk about what's going on in their lives. Then decide at that point what you want to do. Give yourself permission to talk about your problems. That's the first step.

PR: It's okay to be afraid. Pick up the phone and call us at (608) 278-8200. It's confidential.

There is help in the community, and many people recover from this disease. We may not

always realize it, because people aren't anxious to talk about it. You may not know that the person in the next office is in recovery.

If it feels too threatening or scary to call a substance abuse counselor, start by talking with your primary

What advice would you offer to a woman who's struggling to get control of her abuse?

MW: A woman needs to acknowledge that she has a right to a happy, healthy, full life. She has a right to get well. She has a right to have people pay attention to her. There's this horrible misperception that when people go into treatment, they're going to go away someplace for 30 days. When women think that, they're worried about their children, they're worried about their job, they're

care physician and be honest about how much you are drinking or using. Your physician can often give you emotional support to contact a substance abuse therapist. Help is only a phone call away. Why wait? It may save a life.

To learn more about UW Health Gateway Recovery's programs to help those struggling with substance abuse, call **(608) 278-8200**. All calls are confidential.

No Sweat

Surgical technique provides relief to those with overactive sweat glands.

Sweat. We all do it. When we're nervous, when we're hot, when we're stressed out, glands in our bodies attempt to cool things down by releasing sweat from the pores in our hands, foreheads and armpits.

Normally, that's a good and helpful thing, even when sweaty hands and brows betray us at the most inopportune moments. But for patients with a condition called hyperhidrosis, overactive sweat glands create a situation that's not just socially embarrassing, but can actually interfere with everyday life. We're not talking the stress-inspired sweat Albert Brooks endured in "Broadcast News." We're talking about constant, persistent sweating.

"Patients with hyperhidrosis can sit still and literally drip," explains Dr. Tracey Weigel, a UW Health thoracic surgeon. "Some patients can't write their paperwork because they smear it, or they can't pick things up because their hands get so slippery. Others have to change their

clothes multiple times a day. It's not just a little sweating—it's a lot of sweating."

While physicians aren't sure what causes hyperhidrosis, Dr. Weigel and her colleagues at UW Health have an extremely effective way to treat it—with a surgical procedure called thoracic sympathectomy.

Surgeons make a pair of five-millimeter incisions on each side of the patient's body, under the pectoral muscle and in the armpit. Using a telescopic camera, they locate and remove a two-inch piece of the sympathetic chain, the part of the body that controls the distribution of sweat to the hands and feet, literally cutting off the supply of sweat.

Following the procedure, sweat levels are drastically reduced or even eliminated on the hands or armpits. The rest of the body continues to sweat normally, so there's no added risk of overheating during strenuous activity. Although the procedure requires a general anesthetic, patients often go home the same day.

According to Dr. Weigel, the procedure is 95 percent effective—in fact, some patients' hands become so dry that a little hand lotion often helps to keep skin from cracking.

About a half to a third of patients may notice a small increase in sweat elsewhere on their bodies, usually on the torso, back or legs. "Most patients find that sweat in those areas of the body is more socially acceptable than on the hands or face," says Dr. Weigel.

Hyperhidrosis tends to affect individuals in their 20s and 30s, although Dr. Weigel has operated on a patient as young as 11. Some patients have tried other therapies, like medicated hand creams, before turning to surgery. One popular option is Botox, the toxin popularly used to relax muscles and erase facial wrinkles. While Botox is approved by the U.S. Food and Drug Administration and is effective in controlling hyperhidrosis, it's only a temporary solution. Patients must come in

every 4-6 months for another round of Botox injections.

"When Botox came out, a lot of people came out of the woodwork, saying, 'I've had this problem, help me,'" says Dr. Weigel. "When they find out what Botox entails, or decide they don't want to go through it again, they come to us."

Patients are happy with the results of the surgery, Dr. Weigel attests. No longer do they have to feel self-conscious in social situations, or feel that sweat is holding them back professionally. "A lot of patients may not have wanted to step up and say how much their condition was bothering them," she says. "But once it's gone, they realize how socially ostracizing it was."

To make an appointment or to learn more about thoracic sympathectomy, call **(608) 263-7502** or **265-0499** or visit **uwhealth.org**.

Rethinking annual physicals

For as long as most people can remember, an annual physical has been a normal part of maintaining your health as an adult. Once a year, even if you felt perfectly healthy, you were supposed to see your doctor to make sure your body was in tip-top shape.

But evidence-based guidelines developed among physicians over the past few decades have suggested that if you're not suffering symptoms, you may not need to deal with that tongue depressor and cold stethoscope every year after all. This prevailing wisdom says that annual physicals don't really help detect diseases any earlier and could, in fact, be a waste of your time and a strain on your clinic's medical resources.

Research has found important benefits from interventions such as Pap smears, mammograms, cholesterol screenings and counseling about healthy diet and exercise. However, no studies have demonstrated the advantage of being examined by a health provider once a year if you're healthy.

Even these tests need not occur annually. Although in the past, women were counseled to have annual Pap smears, recent studies have shown that after three consecutive normal Pap smears, low-risk women (those who don't have multiple sexual partners) only need to repeat the test every three years.

Many tests (blood tests, mammograms, colonoscopy) don't even require a visit to a primary care provider. If a person

feels well and doesn't have a disease such as diabetes, high blood pressure or cancer, there is no need to see a physician every year.

Dr. Bruce Slater, a UW Health internal medicine specialist, points out other benefits of routine health visits.

"There are other reasons to see your doctor besides the chance of discovering a medical condition," Dr. Slater says. "In fact, these meetings are the perfect time for you to develop a good relationship with your doctor. This is one of the best ways to help your doctor give you the best care possible whether a disease is ever detected or not."

Another great way to boost the quality of your care is to come prepared to your visit. "When patients take the time to ask questions and look up health information on the Internet, they show that they are serious about participating in their health care," says Dr. Slater. "But using the Internet as a replacement for a doctor isn't a good idea. Instead, use what you find as a starting point for a conversation with your doctor during your next visit."

Dr. Slater says that how often a patient needs a preventive visit depends on factors like their age and health history. "Patients are 'trained' from a young age that they need to see their doctor every year and they hang on to this idea as they get older," he says. "You don't necessarily need to go in for annual physicals at every age, but you should

still see your doctor every few years just to check up on things."


"I like to call these meetings 'health maintenance visits,'" he adds. "There is no real pressure to find or see how a disease is doing—it's just a chance to check up on things in general and to chat about your health."

So how often should you meet with your primary-care physician? Dr. Slater advises that adults visit their doctor more often as they age. "For men, I recommend a couple of visits in your 20s, three visits in your 30s and then annual visits for prostate exams after age 40," he says.

Women should visit their doctors for a general health assessment every one to two years from age 18-49 and every one to three years after 50. Plan on getting a Pap smear every one to three years, and mammograms regularly after age 40.

Of course, these guidelines apply to healthy patients without symptoms or problems. Diseases like diabetes require more frequent doctor visits to monitor medications and to look for complications. Patients with pain, weight loss, fatigue or other symptoms should definitely schedule an appointment for diagnosis and treatment.

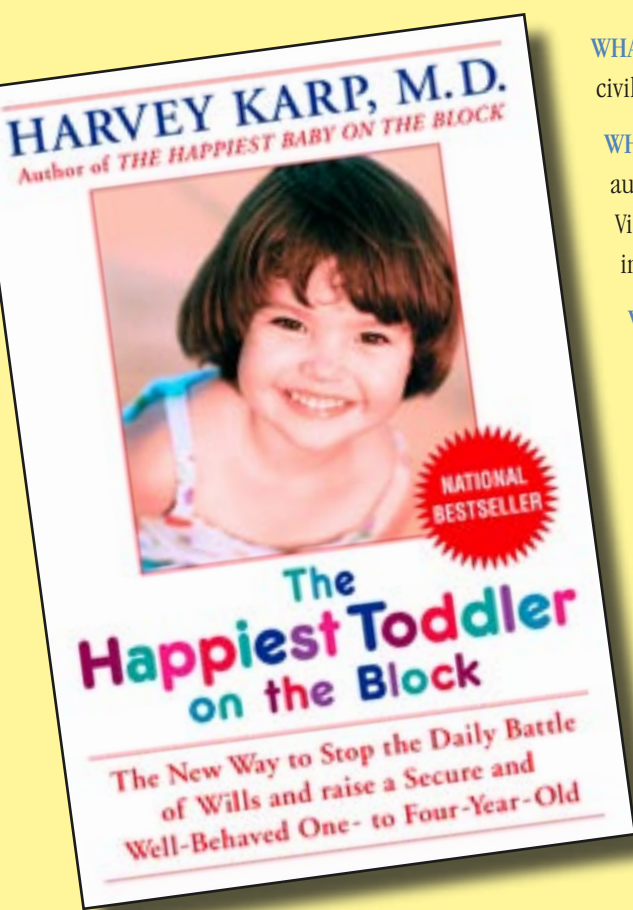
Since everyone's health needs are different, only you and your doctor can decide how often you should be meeting. So stay in touch with your doctor—it's the best way to stay on top of your health!



"You don't necessarily need to go in for annual physicals at every age, but you should still see your doctor every few years just to check up on things."



Paula Spencer in Madison: The basics



WHAT: “Raising a happy and semi-civilized toddler”

WHO: Paula Spencer, best-selling author and award-winning journalist. Visit paulaspencer.com for more information

WHEN: Thursday, October 6, 7 p.m.

WHERE: Madison Marriott West, 1313 John Q Hammons Drive, Middleton

HOW MUCH?: Free and open to the public. Registration is required in advance by visiting wecanaeyc.org or calling (800) 783-9322, Ext. 7280.

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Relieve the stress from raising your toddler

Looking for more enjoyment and less stress while raising your toddler? Make plans to hear award-winning journalist Paula Spencer when she presents a talk, “Raising a Happy and Semi-Civilized Toddler,” Thursday, October 6 at 7 p.m. at the Madison Marriott West in Middleton.

Sponsored by UW Children’s Hospital, the Wisconsin Early Childhood Association and the Wisconsin Children’s Trust Fund, Spencer’s talk is free and open to the public. Advance registration is required by visiting wecanaeyc.org or calling (800) 783-9322, Ext. 7280.

A mom of four children—ages 5 through 12—who writes “The Mom Next Door” column in *Woman’s Day* magazine and has authored several books, Spencer has written for the past 15 years about parenting and family, pregnancy, women’s health

and other social issues. A contributing editor to *Parenting*, *Baby Talk* and *Woman’s Day*, Spencer has a growing following among parents who appreciate her authentic approach.

“I’m not an MD or a PhD,” Spencer says, “but as the mom of four, I have studied at the feet of experts, both tall and small.”

As the co-author (with Harvey Karp, MD) of the bestselling book “The Happiest Toddler on the Block,” Spencer wants parents to enjoy parenting more, while obsessing and stressing less.

“With so much information out there, we parents start to feel like the amateurs when we are, in fact, the experts,” Spencer says. “Part of my message is that parents need to trust their instincts and realize there is no one perfect path to childrearing. So much of

the advice we get today is so serious that we tend to lose sight of the fun and joy that comes with raising a toddler.”

Among the techniques Spencer will discuss is “The Fast-Food Rule,” a communication technique of Dr. Karp’s that effectively relieves tension from the daily battle of wills with a toddler.

“When you order fast food at a drive-through,” Spencer says, “the voice always repeats your order back to you to confirm everything. With toddlers, we can apply the Fast-Food Rule by using a language called Toddler-ese to repeat what our child is saying to show him that we got the message.”

Toddler-ese, Spencer says, is a way of talking in a toddler’s style that incorporates short phrases, repetition, correct voice tone, facial expressions and body gestures.

“Because toddlers have limited language skills, use of Toddler-ese by a parent shows the child—in his or her terms—that you understand where they are coming from. You might feel like a dork doing it, but it’s amazing how many parents find it effective.”

Wisconsin’s First Lady Jessica Doyle also has been invited to appear at the October 6 presentation to speak briefly about early literacy. Several popular parenting and children’s books will be available for purchase before and after Spencer’s talk.



Paula Spencer