Baker’s cyst

YOUR Health IN YOUR HANDS
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Baker's Cyst

A Baker's cyst is a fluid-filled cyst that causes a bulge and a feeling of tightness behind your knee. The pain can get worse when you fully flex or extend your knee or when you're active.

A Baker's cyst, also called a popliteal (pop-luh-TEE-ul) cyst, is usually the result of a problem with your knee joint, such as arthritis or a cartilage tear. Both conditions can cause your knee to produce too much fluid, which can lead to a Baker's cyst.

Although a Baker's cyst may cause swelling and make you uncomfortable, treating the probable underlying problem usually provides relief.

Symptoms

In some cases, a Baker's cyst causes no pain, and you may not notice it. If you do have signs and symptoms, they might include:

- Swelling behind your knee, and sometimes in your leg
- Knee pain
- Stiffness and inability to fully flex the knee

Your symptoms may be worse after you've been active or if you've been standing for a long time.

When to see a doctor

If you have pain and swelling behind your knee, see your doctor. Though unlikely, a bulge behind your knee may be a sign of a condition more serious than a fluid-filled cyst.

Causes

A lubricating fluid called synovial (sih-NO-vee-ul) fluid helps your leg swing smoothly and reduces friction between the moving parts of your knee.

But sometimes the knee produces too much synovial fluid, resulting in buildup of fluid in an area on the back of your knee (popliteal bursa), causing a Baker's cyst. This can happen because of:

- Inflammation of the knee joint, such as occurs with various types of arthritis
- A knee injury, such as a cartilage tear

Complications

Rarely, a Baker's cyst bursts and synovial fluid leaks into the calf region, causing:
Computer generated text
Baker’s cyst

Back view of leg muscles

Baker’s cyst

Side view of knee joint

Normal knee joint fluid

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- **Follow the R.I.C.E. principles.** These letters stand for rest, ice, compression and elevation. Rest your leg. Ice your knee. Compress your knee with a wrap, sleeve or brace. And elevate your leg when possible, especially at night.
- **Try over-the-counter pain-relieving medications.** Drugs such as ibuprofen (Advil, Motrin IB, others), naproxen sodium (Aleve, others), acetaminophen (Tylenol, others) and aspirin can help relieve pain. Follow the dosing instructions on the package. Don't take more than the recommend dosage.
- **Reduce your physical activity.** Doing so will reduce irritation of your knee joint. Your doctor can offer you guidance on how long you need to reduce your activity levels, and he or she may be able to suggest alternative forms of exercise you can do in the meantime.

### Preparing for your appointment

Here's some information to help you prepare for your appointment.

What you can do:

- **Write down symptoms you have,** including any that may seem unrelated to the reason for which you scheduled the appointment.
- **Write down key personal information,** including recent life changes.
- **List all medications,** vitamins and supplements you're taking.
- **Write down questions to ask** your doctor.

Your time with your doctor may be limited, so preparing a list of questions can help you make the most of your time together. For a Baker's cyst, some basic questions to ask your doctor include:

- What caused this cyst to develop?
- What tests do I need? Do these tests require special preparation?
- Is a Baker's cyst temporary or long lasting?
- What treatments are available, and which do you recommend?
- What side effects can I expect from treatment?
- What steps can I take on my own that might help?
- Do I need to limit my activity? If so, how much and for how long?
- I have other health conditions. How can I best manage these conditions together?

Don't hesitate to ask other questions.

### What to expect from your doctor

Your doctor is likely to ask you a number of questions, such as:

- When did your symptoms begin?
- Do you feel pain or stiffness all the time, or does the pain come and go with activity?
- Does your knee swell, feel unstable or lock?
**Exercised-induced Asthma**

Exercised-induced asthma is a narrowing of the airways in the lungs that is triggered by strenuous exercise. It causes shortness of breath, wheezing, coughing and other symptoms during or after exercise.

The preferred term for this condition is exercise-induced bronchoconstriction (brong-koh-kun-STRIK-shun). This term is more accurate because the exercise induces narrowing of airways (bronchoconstriction) but is not the root cause of asthma. Among people with asthma, exercise is likely just one of several factors that can induce breathing difficulties.

For most people with exercise-induced bronchoconstriction, treatment with common asthma medications and preventive measures enable them to exercise and remain active.

**Symptoms**

Signs and symptoms of exercise-induced bronchoconstriction may begin during or a few minutes after exercise, and they may persist for 30 minutes or longer if left untreated. The signs and symptoms may include:

- Coughing
- Wheezing
- Shortness of breath
- Chest tightness or pain
- Fatigue during exercise
- Poorer than expected athletic performance
- Feeling out of shape even when you're in good physical shape
- Avoidance of activity (a sign primarily among young children)

**When to see a doctor**

See your doctor if you experience any signs or symptoms of exercise-induced bronchoconstriction. Because a number of conditions can cause similar symptoms, it's important to get a prompt and accurate diagnosis.

**Get emergency medical treatment** if you have worsening symptoms:

- Shortness of breath or wheezing that is quickly getting worse
- No improvement even after using a prescription inhaler for asthma attacks

Medical researchers are exploring several ideas regarding the cause of exercise-induced bronchoconstriction. There may be more than one biological process that can lead to the condition. Researchers do know that in people who experience exercise-induced bronchoconstriction, strenuous exercise sets in motion molecular events that result in inflammation and the production of mucus in the airways.

Factors that may increase the risk of the condition or act as triggers include:

- Cold air
- Dry air
- Air pollution
- High pollen counts
- Chlorine in swimming pools
- Chemicals used with ice rink resurfacing equipment
- Respiratory infections or other lung disease
- Activities with extended periods of deep breathing, such as long-distance running, swimming or soccer

Exercise-induced bronchoconstriction that is not treated can result in:

A lack of beneficial exercise
Poor performance in activities you would otherwise enjoy
Serious or life-threatening breathing difficulties, particularly among people with poorly managed asthma

In addition to asking questions about your symptoms, your doctor will conduct a medical exam. He or she will also order tests to assess your lung function and rule out other conditions that may be causing your symptoms.

Your doctor will likely administer a spirometry (spy-ROM-uh-tree) test to assess how well your lungs function when you aren't exercising. A spirometer measures how much air you inhale, how much you exhale and how quickly you exhale.

After you do the test, your doctor may give you an inhaled medication to open your lungs (bronchodilator). You'll repeat the test, and your doctor will compare the results of the two measurements to see whether the bronchodilator improved your airflow. This initial lung function test is important for ruling out underlying chronic asthma as the cause of symptoms.
An additional test that enables your doctor to observe and assess symptoms is an exercise challenge. You will run on a treadmill or use other stationary exercise equipment that increases your breathing rate. This exercise needs to be intense enough to trigger the symptoms you’ve experienced. If needed, you might be asked to perform a real-life exercise challenge, such as climbing stairs.

Spirometry tests before and after the challenge can provide evidence of exercise-induced bronchoconstriction.

### Alternates challenge tests

As an alternative to the exercise challenge, your doctor may use an inhalation test that simulates the conditions that would likely trigger exercise-induced bronchoconstriction. If your airways respond to these stimuli, then the test should produce virtually the same lung function you have when exercising.

Again, spirometry tests before and after the challenge test provide information about changes in lung function. These challenge tests include the following:

- **Methacholine challenge**, the use of an inhaled agent that interacts with certain smooth muscle cells in airways and results in bronchoconstriction
- **Eucapnic voluntary hyperventilation (EVH) challenge**, inhaling a mixture of dry air composed of oxygen, carbon dioxide and nitrogen that simulates the exchange of air when breathing is difficult
- **Mannitol challenge**, inhaling a dry powder that can trigger water loss on the surface of the airways and switch on molecular activity that controls inflammation — conditions that cause bronchoconstriction in people with oversensitive airways

### Ruling out other conditions

Your doctor may order additional tests to rule out other conditions with symptoms similar to those of exercise-induced bronchoconstriction. These conditions include:

- Vocal cord dysfunction
- Allergies
- Lung disease
- Irregular heartbeats (arrhythmia) or other heart conditions
- Gastroesophageal reflux disease

### Treatment

Your doctor may prescribe drugs to take shortly before exercise or to take daily for long-term control.

Pre-exercise medications
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- Pets
- Exercise
- Pollen
- Bugs in the home
- Chemical fumes
- Cold air
- Fungus spores
- Stress
- Anger
- Pollution
- Strong odors

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Your doctor may prescribe a drug that you take before exercise to minimize or prevent exercise-induced bronchoconstriction. Talk to your doctor about how much time you need between taking the drug and exercising. Drugs in this group include the following:

- **Short-acting beta agonists (SABAs)** are inhaled drugs that help open airways. These are the most commonly used and generally most effective pre-exercise medications. Daily use of a SABA is not recommended, however, because you may develop a tolerance to its effect. These drugs include albuterol (ProAir HFA, Proventil HFA, Ventolin HFA), levalbuterol (Xopenex HFA) and pirbuterol (Maxair).
- **Ipratropium (Atrovent HFA)** is an inhaled medication that relaxes the airways and may be effective for some people. A generic version of ipratropium also can be taken with a nebulizer.

### Long-term control medications

Your doctor may prescribe a long-term control drug in addition to daily use of a pre-exercise medication, to manage underlying chronic asthma or to manage symptoms when pre-exercise treatment alone isn't effective. These medications, usually taken daily, include the following:

- **Inhaled corticosteroids** help suppress inflammation in your airways. You may need to take the drug two to four weeks before they will have maximum benefit. These medications include fluticasone (Flovent Diskus, Flovent HFA), budesonide (Pulmicort Flexhaler), mometasone (Asmanex Twisthaler) and beclomethasone (Qvar).
- **Combination inhalers** contain a corticosteroid and a long-acting beta agonist (LABA), a drug that relaxes airways. While these inhalers are prescribed for long-term control, your doctor may recommend use prior to exercise. Combination inhalers include fluticasone and salmeterol (Advair Diskus), budesonide and formoterol (Symbicort), and mometasone and formoterol (Dulera).
- **Leukotriene modifiers** are oral medications that may block inflammatory activity for some people. These drugs may be used daily or as a preventive treatment before exercise if taken at least two hours in advance. Examples include montelukast (Singular), zafirlukast (Accolate) and zileuton (Zyflo, Zyflo CR). Potential side effects of leukotriene modifiers include behavior and mood changes and suicidal thoughts. Talk to your doctor if you experience these signs or symptoms.

### Don't rely only on quick-relief medications

You can also use pre-exercise drugs as a quick-relief treatment for symptoms. However, you shouldn't need to use your pre-exercise inhaler more often than your doctor recommends.

Keep a record of how many puffs you use each week, how often you use your pre-exercise inhaler for prevention and how often you use it to treat symptoms. If you use it daily or you frequently use it for symptom relief, your doctor may adjust your long-term control medication.

### Lifestyle and home remedies

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Steps you can take to prevent or minimize symptoms of exercise-induced bronchoconstriction include the following:

- Do a 10-minute warm-up that varies in intensity before you begin regular exercise.
- Breathe through your nose to warm and humidify the air before it enters your lungs.
- Wear a face mask or scarf when exercising, especially in cold, dry weather.
- If you have allergies, avoid triggers. For example, don't exercise outside when pollen counts are high.
- Avoid strenuous exercise if you have a cold or other respiratory infection.
- Exercise regularly to stay in shape and promote good respiratory health.

At school:

Talk to your doctor about writing an action plan if your child experiences exercise-induced bronchoconstriction. This document provides step-by-step instructions for teachers, nurses and coaches that explain what treatments your child needs, when treatments should be administered and what to do if your child experiences symptoms.

**Alternative medicine**

There is limited clinical evidence of alternative therapies that may modify the severity of exercise-induced bronchoconstriction or provide additional benefit to standard treatments. Possible beneficial interventions include:

- A low-salt diet
- Fatty fish, such as salmon and tuna, or fish oil supplements
- Fruits and vegetables rich in vitamin C (strawberries, oranges, broccoli, leafy vegetables and others) or vitamin C supplements

**Preparing for your appointment**

You're likely to start by seeing your primary care doctor. He or she may refer you to a doctor who specializes in asthma (an allergist-immunologist or pulmonologist).

Be prepared to answer the following questions:

- What symptoms have you experienced?
- Do they start immediately when you start exercising, sometime during a workout or after?
- How long do the symptoms last?
- Do you experience breathing difficulties when you're not exercising?
- What are your typical workouts or recreational activities?
- Have you recently made changes to your exercise routine?
- Do the symptoms occur every time you exercise or only in certain environments?
- Have you been diagnosed with allergies or asthma?
- What other medical conditions do you have?
- What medications do you take? What is the dosage of each medication?
What dietary supplements or herbal medications do you take?


Depression in Children

What is depression?

Depression is a mental illness marked by persistent feelings of sadness, irritability, loss of interest in activities, feelings of hopelessness and worthlessness, and sometimes, thoughts of suicide. It affects the way one feels, thinks, and acts. Often, people who are depressed also experience changes in their sleeping and eating habits and have trouble concentrating. A diagnosis of depression is made when symptoms persist for two weeks or longer and interfere with a person’s ability to function.

Can children suffer from depression?

Yes. Childhood depression is different from the normal “blues” and everyday emotions that occur as a child develops. When symptoms persist and interfere with social activities, interests, schoolwork, and family life, however, a child may have depression.

Depression is not a passing mood, nor is it a condition that will go away without proper treatment. Depression is often not diagnosed and treated because the symptoms are passed off as normal emotional and psychological changes that occur during growth. Keep in mind that while depression is a serious illness, it also is a treatable one. Parents should speak with their child’s pediatrician or contact a mental health professional if they have any concerns about changes in a child’s mood or behavior.

How common is depression in children?

The National Institute of Mental Health estimates that at least 3.3% of children 13 to 18 years old have had episodes of severe depression. The American Academy of Adolescent Psychiatry estimates this number to be 5%. Suicide is the third leading cause of death in young people between the ages of 10 and 24.

What causes depression in children?

As in adults, depression in children can be caused by any combination of factors, such as:

- Physical illness (such as diabetes or epilepsy)
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- Stressful life events
- Environment (including family problems)
- Family history (others in the family have depression)
- Alcohol or drug use

**How can I tell if my child is depressed?**

Every child with depression may present with a unique set of symptoms. Signs and symptoms of depression in children include:

- Irritability, anger, or being “on edge”
- Persistent feelings of sadness, hopelessness
- Withdrawal from previously enjoyed activities as well as from friends and family
- Increased sensitivity to rejection or criticism
- Changes in appetite (either increased or decreased)
- Changes in sleep (sleeplessness or too much sleep)
- Crying or temper tantrums
- Difficulty concentrating and focusing
- Fatigue (tiredness) and low energy
- Physical complaints (such as stomach aches, headaches) that do not respond to treatment
- Reduced ability to function during activities at home or with friends, in school, extracurricular activities, and in other hobbies or interests
- Feelings of worthlessness or guilt
- Thoughts or talk of death or suicide

Not all depressed children will have all of these symptoms. In fact, most will have different symptoms at different times and in different settings. Although some children may continue to function reasonably well in structured environments, most kids with significant depression will suffer a noticeable change in social activities, loss of interest in school and poor academic performance, or a change in appearance. Experimentation with drugs or alcohol may also be a sign of an underlying mental illness.

Although relatively rare in youths under 12, young children do attempt suicide, and may do so impulsively when they are anxious, angry, or upset. Girls are more likely to attempt suicide, but boys are more likely to actually succeed in killing themselves when attempting suicide. Children with a family history of violence, alcohol abuse, or physical or sexual abuse are at greater risk for suicide, as are those with symptoms of depression. Children are also at risk when they have access to firearms or medications at home.

**How is depression in children diagnosed?**

If concerning symptoms in your child have lasted for at least two weeks, you should schedule a visit with his or her doctor to make sure there are no physical reasons for the symptoms and to make sure that your child receives proper treatment. The doctor may recommend that your child see a mental health care professional who specializes in treatment of children.
There are no medical (blood or imaging) or psychological tests that can diagnose depression. A mental health evaluation should include interviews with you (as the parents) and your child, and if necessary any additional psychological testing or questionnaires. Information from teachers, friends, and classmates can be useful for showing that these symptoms are a definite change from previous behavior.

**A parent’s perspective**

As a parent, it is sometimes easier to deny that your child has depression because of the social stigmas associated with mental illness. It is very important to understand that a combination of factors contribute to depression (see question about causes). Treatment of depression can allow your child to continue to develop into a healthy adult, physically and emotionally. Without treatment, depression has the potential to affect your child throughout the rest of his or her life.

Parents should be especially alert for signs that their child is at risk for suicide. Warning signs of suicidal behavior in children include:

- Severe depressive symptoms (significant changes in eating, sleeping, activities)
- Social isolation
- Talk of suicide, hopelessness, or helplessness
- Increased acting out behaviors (sexual/behavioral)
- Increased risk-taking behaviors
- Frequent accidents
- Drug and/or alcohol abuse
- Focus on morbid and negative themes
- Talk about death and dying
- Increased crying or reduced expression of emotions
- Giving away possessions

As with any other medical emergency, if you feel that your child is in danger, take your child to the nearest emergency department or call 911.

**How is childhood depression treated?**

Treatment options for children with depression are similar to those for adults and include psychotherapy (counseling), medication, or a combination of the two. The severity of symptoms often guides the mental health professional in making a particular recommendation for your child. For example, if symptoms are mild, your child's doctor may suggest psychotherapy first, and consider antidepressant medicine as an additional option if there is no major improvement over the next few months.

Although many antidepressants are routinely used in treating children with depression, the two FDA-approved medications are fluoxetine (Prozac®) for ages 8 and older and escitalopram (Lexapro®) for ages 12 and older. Antidepressants must be used with caution, however, as some individuals may have no improvement or feel worse (i.e., more suicidal than when they started taking the medication).
Additional notes about antidepressant medications:

- Different children can react differently to the same drug.
- It is important to avoid potentially harmful drug interactions, such as with cold or asthma medications.
- If the doctor prescribes antidepressant medication for your child, you need to watch the child's condition closely. Parents should clarify with the physician the goals and limitations that can be expected from a particular medication. Further, parents should be familiar with common and serious potential side effects.
- No patient should suddenly stop taking antidepressants, because this may cause side effects such as agitation or increased depression.
- Since suicidal thoughts often go with depression, guns should be removed from the home and large quantities of medications (including over-the-counter drugs) should be locked away.

Sources: American Academy of Pediatrics - Mental Health and Teens: Watch for Danger Signs; American Academy of Family Physicians: Depression in Children and Teens; American Academy of Child and Adolescent Psychiatry: The Depressed Child; Centers for Disease Control and Prevention: Suicide Prevention
The Use of Cold and Ice (Cryotherapy)

Cryotherapy is the use of cold in the treatment of acute and sub-acute injury as well as to decrease the discomfort after athletic reconditioning. The most common cryotherapy tools used after Physical Therapy include ice packs, and ice massage; used alone or in combination with electrical currents.

Cryotherapy generally produces a three to four stage sensation; first an uncomfortable sensation of cold, followed by a stinging, then burning or aching feeling and finally a numbness. Generally, a minimum of 10-15 minutes is required to achieve an extreme analgesic (pain relieving) effect while lowering the temperature to the injured area, thus reducing the metabolic rate and swelling associated with tissue injury. Cold is extremely useful in the acute phase of common inflammatory conditions such as bursitis, tenosynovitis and tendonitis.

Ice therapy for injuries initially constricts local blood vessels and decreases tissue temperature. This constriction decreases blood flow and cell metabolism, which can limit hemorrhage and cell death in an acute traumatic injury. After approximately 20 minutes of ice, blood vessels in the injured area dilate (open) slowly, increasing the tissue temperature, an effect which is termed “reactive vasodilation.”

The most useful local therapeutic cold applications include management of edema, muscle spasm, bleeding, and traumatic pain. The vasoconstriction effect of therapeutic cold is beneficial for reducing posttraumatic swelling and pain or for reducing hemorrhage into soft tissues.

Depending upon the application method and duration, the basic physiologic effects include the following:

- Decreased local metabolism
- Vasoconstriction
- Reactive hyperemia
- Reduced swelling/edema
Decreased hemorrhage
Reduced muscle efficiency
Analgesia secondary to impaired neuromuscular transmission

**Key Considerations**

Inflammation, edema and swelling are NOT synonymous terms. Each symptom is associated with a different phase in the 'continuum of resolving inflammation'. The specific clinical problem and the desired mechanism of action should guide the selection of the intervention.

**Is there an optimal dosage of cryotherapy?**

There is no optimal dosage that is ideal for all body locations. Consider the nature of the tissue when icing:

- The duration of icing for a small area with minimal fat and muscle, such as a finger, would be significantly less (~3-5 minutes) than that for a larger area and deeper tissue such as at the hip (~20 minutes).

- Intermittent icing (e.g., 10 minutes on: 10 minutes off) may be more effective for management of acute inflammation than icing for 20 consecutive minutes.

**Type/duration of cooling dependent upon the goal**

- Cooling to reduce pain will likely require less intense (ice pack) and shorter durations (5 minutes).
Cooling to reduce metabolism of uninjured cells will likely require more intense cooling (ice bath or ice chips in a wet towel) for longer durations (10-15 minutes).

The hierarchy of the efficiency of cooling from most to least: ice-water immersion, crushed ice, frozen peas and gel pack.

Possible Risks/Undesirable Effects

Inhibit muscle function

Cooling can temporarily inhibit muscle function with potential for increased risk of injury/re-injury.

Be cautious when having patients weight bear/undertake complex exercise after icing a lower extremity.

Ice burn

Elderly patients with impaired sensation and/or circulation will be more vulnerable to an ice-burn, therefore consider using less intense icing techniques (e.g., moderately cold ice pack wrapped in an insulating layer(s) of toweling).

Younger patients with intact sensation and circulation may benefit most from direct immersion of the limb in cold water then progressively adding ice cubes.

Cold gel packs stored in a freezer have a surface temperature below 0°C (32°F) and thus an insulating layer should be used between the cold pack and the patient’s skin.

Cryotherapy-induced nerve injuries

Most common when cold is applied in combination with compression.
Check capillary refill during application of ice combined with compression therapy to ensure adequate blood flow.

**Generalized cooling and decrease in core temperature**

Shivering and piloerection are signs of decrease in core temperature which may compromise patient safety (especially in the elderly and those with fever).

The application of therapeutic cryotherapy should produce only local effects.

**Reduced range of motion (ROM)**

Ice may contribute to shortening of collagen fibers in connective tissue.

After gaining ROM by warming, stretching and then strengthening in the newest part of the ROM, it is likely counterproductive to cool the tissue in a shortened position.

If one wishes to cool the tissue post stretch and exercise, it is best to do so with the tissue in a lengthened position.

In patients with significantly restricted ROM due to scar tissue, it may be preferable not to use ice.

**Counter-Indicators and Warnings**

Cryotherapy is contraindicated when the following are conditions are present:

- Hypertension (due to secondary vasoconstriction)
- Raynaud disease
- Rheumatoid arthritis / Rheumatism
- Local limb ischemia
History of vascular impairment, such as frostbite or arteriosclerosis

- Cold allergy (cold urticaria)
- Paroxysmal cold hemoglobinuria
- Cryoglobulinemia or any disease that produces a marked cold pressor response
- Pelvic inflammation
- Sciatica
- Paralysis
- Areas of impaired sensation

Cold packs applied to the abdomen cause increased gastrointestinal motility and gastric acid secretion; therefore, this treatment is contraindicated in those with known peptic ulcer disease.

What If...

What if 'What If?!' didn't exist?
What if money was no issue?
What if you could go where you wanted to go & do what you want?
What if the impossible was possible?
What if you start right now?
What if tomorrow doesn't come?
What if you have something to say today, but you don't?
What if the one you want to say it to dies in their sleep?
What if you do?
What if tomorrow comes and you put it off again?
What if you think of something new?
What if you dream of something old?
What if you stop being scared?
What if you stop dreaming?
What if you stop thinking?
What if you stop living?
What if you start?