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My favorite 5 articles found in recent medical journals

High Protein Diets Harmful and Unnecessary for Endurance Athletes

Level of dietary protein impacts whole body protein turnover in trained males at rest by Patricia Gaine in the April 2006 issue of *Metabolism* found in five male endurance runners that, "a protein intake of 1.2 g/kg or 10% of total energy intake is needed to achieve a positive nitrogen balance." The source of protein was beef and vegetarians were excluded from the study. No advantage was found for consuming higher levels of protein. The high protein diet (30% protein, 30% fat, and 40% carbohydrate—like the Zone diet) provided insufficient carbohydrates to replenish muscle glycogen and may result in fluid imbalances and dehydration according to the researchers.

Comment: Protein is the most "sacred" of all nutrients, especially for athletes—like most people, they are unnecessarily worried about getting enough. Protein supplements, bars, and shakes many times push these athlete's diets beyond limits that could be achieved by ordinary eating. But in the end they fail to benefit and do much harm by believing the "protein means performance" myth. Performance comes from efficient fuel, and that fuel is carbohydrate. Furthermore, excess protein can inhibit performance by causing a diuresis which can lead to water loss and a relative condition of dehydration. Over several years all that protein and associated acid will tear down the bones.

With rice at 8%, potatoes at 10% and beans at 28% protein, along with an abundance of carbohydrate and other essential nutrients, a diet based on plant foods makes ideal nutrition for an endurance athlete. This is the reason science-based recommendations for physical performers are consistently to make high carbohydrate starches their meal centerpiece—and that is exactly what the winners do.

See my September 2003 newsletter article: Building Your Own High-Performance Athletic Body for more details on diet and winning athletes.

Gaine PC, Pikosky MA, Martin WF, Bolster DR, Maresh CM, Rodriguez NR. Level of dietary protein impacts whole body protein turnover in trained males at rest. *Metabolism.* 2006 Apr;55(4):501-7.

Plavix Fails Heart Patients and Causes Bleeding

Clopidogrel and Aspirin versus Aspirin Alone for the Prevention of Atherothrombotic Events by Deepal Bhatt published in the March 12, 2006 on-line version of the *New England Journal of Medicine* found, "Overall, clopidogrel plus aspirin was not significantly more effective than aspirin alone in reducing the rate of myocardial infarction, stroke, or death from cardiovascular causes." Plus they found an increased risk of moderate to severe bleeding with the combination of Plavix (clopidogrel) and aspirin. There was also an increase in risk of death in Plavix-treated participants who had no previous symptoms of heart disease.

Comment: This study was funded by Sanofi-Aventis and Bristol-Meyers Squibb the partnership that manufactures Plavix (clopidogrel)—so I am surprised it got published. Previous drug company funded research has shown benefits from the combination of aspirin and Plavix in patients who have recently suffered injuries to their heart arteries

from a heart attack (acute coronary syndrome) or angioplasty—this group represents about 2 million people annually in the United States. However, patients in the present study were not that sick yet—they were only at high risk for having heart attacks or heart surgery—like most adults living in Western societies. Consider, if this study had been positive, the effect on potential market for the sale of Plavix—perhaps tens of millions of people would have become customers. The drug company must have been very disappointed with the outcome.

Plavix costs about $3 a tablet compared to less than one cent for an aspirin. Now you can understand why you see daily advertisements on TV and in print media for this drug. Aspirin has been used for many years to prevent heart attacks in people at high risk for future problems. I prescribe one baby aspirin daily for people who have suffered a heart attack or have undergone heart surgery. For people without this history the risk from bleeding and intestinal distress is far greater than the potential for benefit and therefore should not be used.

There seem to be benefits for some people from Plavix—even though I have serious concerns because of the influence on the studies by the funding drug companies. Based on available information, Plavix should be used with caution only for a short time—one to six months—after angioplasty or a heart attack. Even then, the benefits from this therapy are small, the risks are significant and the costs are substantial. If you are now on Plavix you should ask your doctor about stopping it—or to at least supply you with some scientific support justifying continued use.

Bhatt DL, Fox KA, Hacke W, Berger PB, Black HR, et al. Clopidogrel and Aspirin versus Aspirin Alone for the Prevention of Atherothrombotic Events. *N Engl J Med.* 2006 Mar 12; [Epub ahead of print]

Diabetic Pills Kill

Risk of mortality and adverse cardiovascular outcomes in type 2 diabetes: a comparison of patients treated with sulfonylureas and metformin by J.M.M. Evans in the March 9, 2006 on-line version of the medical journal *Diabetologia* found, "…those treated with sulfonylureas only, or combinations of sulfonylureas and metformin, were at higher risk of adverse cardiovascular outcomes than those treated with metformin alone."

This study of 5,700 patients found three times the risk of death from all causes and death from heart disease with the use of a commonly prescribed form of diabetic medication called sulfonylureas. The older, fatter and sicker people were at the highest risk of death from taking these pills. For example, people over 65 had almost 12 times the risk of dying, and 10 times the risk of dying from heart and blood vessel diseases when taking sulfonylureas compared to metformin.

Comment: As many as one-third of type-2 diabetics are prescribed sulfonylureas. Since the early 1970s every single edition of the Physician's Desk Reference, found in every doctor's office, has carried this warning in heavy back print for their diabetic patients:

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY

Sulfonylureas cause fundamental changes in the function of cells that increase the risk of heart attacks.[2] These drugs, which are called "antidiabetic agents" by the pharmaceutical companies, ***never cure diabetes***—and they have been shown to more than double the risk of heart attacks and almost triple the risk of early death in patients after an angioplasty.[3] I do not prescribe this type of diabetic pill, and always ask my patients to stop them. On rare occasions I find the need to prescribe metformin and this is usually because the patient is worried about not being on medication. On even rarer occasions I will prescribe insulin for type-2 diabetes (I always prescribe insulin for type-1 diabetics).

You can learn more about my thoughts on type-2 diabetes by reading my February 2002 newsletter article: Type-2 Diabetes – the Expected Adaptation to Overnutrition.

Examples of Sulfonylureas: Amaryl, DiaBeta, Diabinese, Glucotrol, Glucovance, and Metaglip.

Examples of metformin: Glucophage, Glucophage XR, Glumetza, Apo-Metformin, Gen-Metformin, Novo-Metformin, Nu-Metformin.

References:

1) Evans JM, Ogston SA, Emslie-Smith A, Morris AD. Risk of mortality and adverse cardiovascular outcomes in type 2 diabetes: a comparison of patients treated with sulfonylureas and metformin. *Diabetologia.* 2006 Mar 9; [Epub ahead of print]

2) Engler RL, Yellon DM. Sulfonylurea KATP blockade in type II diabetes and preconditioning in cardiovascular disease. Time for reconsideration. *Circulation.* 1996 Nov 1;94(9):2297-301.

3) Garratt KN, Brady PA, Hassinger NL, Grill DE, Terzic A, Holmes DR Jr. Sulfonylurea drugs increase early mortality in patients with diabetes mellitus after direct angioplasty for acute myocardial infarction. *J Am Coll Cardiol.* 1999 Jan;33(1):119-24.

Drugs Fail for Depression

Two studies published in the March 23, 2006 issue of the *New England Journal of Medicine* showed the most commonly prescribed antidepressants fail to cure symptoms of major depression in at least half of all people who take them. One study found that after unsuccessful treatment with a serotonin-reuptake inhibitor (SSRI), approximately one in four (25%) patients had a remission of symptoms after switching to another antidepressant—either sustained-release bupropion (Wellbutrin SR), sertraline (Zoloft), or extended-release venlafaxine (Effexor XR).[1]

The second study evaluated the effects of adding to citalopram (Celexa) either sustained-release bupropion (Wellbutrin) or buspirone (Buspar).[2] Approximately 30 percent of depressed patients had a remission of symptoms after that additional treatment.

Neither of these studies compared their effects with placebo—so the benefits seen with either study could have been partially or totally spontaneous—in other words, unrelated to the effects of the drugs.

Comment: Somewhere between 15 to 20 percent of people are depressed and most of them are being prescribed powerful drugs with less than anticipated benefits and a whole lot of side effects. In the US this represents a $10 billion annual business with three of the top ten selling drugs being SSRI antidepressants.[3]

Unfortunately, depressed patients are never prescribed simple, safe, effective, cost-free, and scientifically tested "natural" treatments, such as a high-carbohydrate diet, exercise, sunlight, and sleep restriction. The treatments are described in detail in my March 2004 newsletter article: A Natural Cure for Depression. If the truth be known, scientific research establishes these therapies to be more much more valuable to the patient than the drugs—but the drugs are much more profitable to the medical and pharmaceutical industries—so little change in practice should be expected.

References:

1) A. John Rush, M.D., Madhukar H. Trivedi, M.D., Stephen R. Wisniewski, Ph.D., et. Al. Bupropion-SR, Sertraline, or Venlafaxine-XR after Failure of SSRIs for Depression. N Engl J Med 2006; 354:1231-1242

2) Madhukar H. Trivedi, M.D., Maurizio Fava, M.D., Stephen R. Wisniewski, Ph.D., et al. Medication Augmentation after the Failure of SSRIs for Depression. N Engl J Med 2006; 354: 1243-1252

3) http://www.nihcm.org/spending2001.pdf

Bragging Rights for Prostate Surgeons

Radical prostatectomy versus watchful waiting in early prostate cancer by Anna Bill-Axelson in the May 12,

2005 issue of the *New England Journal of Medicine* found, "Radical prostatectomy reduces disease-specific mortality, overall mortality, and the risks of metastasis and local progression. The absolute reduction in the risk of death after 10 years is small, but the reductions in the risks of metastasis and local tumor progression are substantial."[1] This was a 8.2 year study of 696 men, average age of 64.7 years; half underwent surgery and half did nothing—a method called "watchful waiting." The overall death rate was similar in the two groups (7.8 surgery vs. 9.8 ww) for the first 5 years. After 10 years the absolute risk of death was reduced by only 5% with surgery. The authors conclude: "Since, in absolute terms, the reduction in mortality is moderate, clinical decision making and patient counselling will remain difficult."

Comment: This study is now used by surgeons to talk their patients into radical surgery—with common side effects like incontinence and impotence. The fact that ten years after diagnosis approximately 85% of men will have not died of prostate cancer regardless of the treatment prescribed (including nontreatment) shows that this is a slow growing disease with a low chance of killing the patient. Most of the patients (90%) diagnosed with prostate cancer would have lived out their entire lives without knowing they were "sick" if it were not for the meddling of the medical businesses.

In this study there was no survival advantage from surgery for men over 65, which makes me seriously question surgeons using these results to try to influence any elderly patient's decision to accept surgery.[2] This study was designed 20 years ago and since then the management of prostate cancer has changed in ways that would favor watchful waiting.[2] This study also chose a select group of men with prostate cancer, and as a result, benefits for men with earlier and more aggressive cancers are completely unknown.[3] Furthermore, a low-fat diet seems to be becoming an accepted additional treatment for improving the outcome for men with prostate cancer.[4]

I remain a proponent of "doing no harm"—first and always. In the case of aggressive prostate cancer treatment I still believe far more harm (side effects from surgery and radiation) is done in most cases than good (improved survival and less suffering). For more information on my thoughts on prostate cancer read my February and March 2003 newsletter articles: Saving Yourself from Cancer - the Prostate (case in point) and A World of Hope and Dreams - Early Detection - The Example - Prostate Cancer.

References:

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2) Munro AJ ACP J Club. 2005 Nov-Dec; 143:57

3) Alibhai SM, Gogov S. In patients with early prostate cancer, is surgery better than watchful waiting? CMAJ. 2005 Jun 21;172(13):1682.

4) Ornish D, Weidner G, Fair WR, Marlin R, Pettengill EB, Raisin CJ, Dunn-Emke S, Crutchfield L, Jacobs FN, Barnard RJ, Aronson WJ, McCormac P, McKnight DJ, Fein JD, Dnistrian AM, Weinstein J, Ngo TH, Mendell NR, Carroll PR. Intensive lifestyle changes may affect the progression of prostate cancer. *J Urol.* 2005 Sep;174(3):1065-1070.