



My Favorite Five Articles from Recent Medical Journals

People Don't Lose Weight on Diets Because They Cheat

Why do obese patients not lose more weight when treated with low-calorie diets? A mechanistic perspective by Steven D Heymsfield in the February 2007 issue of the *American Journal of Clinical Nutrition* concluded, "The small maximal weight loss observed with LCD (low calories diet) treatments thus is likely not due to gastrointestinal adaptations but may be attributed, by deduction, to difficulties with patient adherence or, to a lesser degree, to metabolic adaptations induced by negative energy balance that are not captured by the current models." They consider three possible reasons for diet failures: "Less-than-expected weight loss with LCDs can arise from an increase in fractional energy absorption (FEA), adaptations in energy expenditure, or incomplete patient diet adherence." Lack of adherence was the final verdict.

Comments:

People cheat on their diets and that is why they fail to lose all the extra weight. Last month's discussion of the A TO Z Weight Loss Study, comparing the diets of Atkins, Ornish, and the Zone, found the same thing—overweight people failed to comply with their prescribed diets and lost only 5 to 10 pounds over a year. There are many reasons people fail to comply with recommended weight loss programs, including: 1) Many diets cause people to suffer painful hunger (portion-controlled diets, like Weight Watchers); 2) Some diets make the dieter sick (like Atkins); 3) Diet foods may not taste good (most of them); 4) Diet foods are not readily available; 5) Pressure from friends and family to go off the diet; and 6) Self-destructive feelings sabotage the dieter's efforts.

The McDougall Diet also has problems with getting people to comply. However, we have some advantages over other programs, and these enable many people to adopt our principles for a lifetime—and be happy about it. You never have to be hungry and you feel great (never sick) on the all-you-can-eat McDougall Diet. The biggest bonus is Mary, who has provided over 2500 recipes, with food that is easy to prepare and delicious. If we could only get "McDougall's" fast food restaurants all over the world then the food would be readily available. If more people would learn about and follow our program then there would be even more support from friends and family. I believe our program has the greatest chance for lifetime success for more people than any other program. As people learn about the additional advantages for the environment from following our diet then compliance will be greatly enhanced—doing something for someone else (saving the Earth) is a higher reward for many people than is even self-improvement.

Heymsfield SB, Harp JB, Reitman ML, Beetsch JW, Schoeller DA, Erondur N, Pietrobelli A. Why do obese patients not lose more weight when treated with low-calorie diets? A mechanistic perspective. *Am J Clin Nutr.* 2007 Feb;85(2):346-54.

Angioplasty Fails Again and Again (8 out of 8 times)

Optimal Medical Therapy with or without PCI for Stable Coronary Disease by William Boden in the April 12, 2007 issue of the *New England Journal of Medicine* found after studying 2287 patients, "As an initial management strategy in patients with stable coronary artery disease, PCI (angioplasty) did not reduce the risk of death, myocardial infarction, or other major cardiovascular events when added to optimal medical therapy."¹ In 2004, more than 1 million coronary stent procedures were performed in the United States, and recent registry data indicate that approximately 85% of all PCI procedures are undertaken electively in patients with stable coronary artery disease.

Why Angioplasty Must Fail—The Explanation

If the following explanation proves too complicated and the language too medical then read my September 2006 newsletter article, "The Angioplasty Debacle," first.

The authors explain why angioplasty does not save lives:¹ "Vulnerable plaques (precursors of acute coronary syndromes) tend to have thin fibrous caps, large lipid cores, fewer smooth-muscle cells, more macrophages, and less collagen, as compared with stable plaques, and are associated with outward (expansive) remodeling of the coronary-artery wall, causing less stenosis of the coronary lumen. As a result, vulnerable plaques do not usually cause significant stenosis before rupture and the precipitation of an acute coronary syndrome. By contrast, stable plaques tend to have thick fibrous caps, small lipid cores, more smooth-muscle cells, fewer macrophages, and more collagen and are ultimately associated with inward (constrictive) remodeling that narrows the coronary lumen. These lesions produce ischemia and anginal symptoms and are easily detected by coronary angiography but are less likely to result in an acute coronary syndrome... Thus, unstable coronary lesions that lead to myocardial infarction are not necessarily severely stenotic, and severely stenotic lesions are not necessarily unstable... presumably because the treated stenoses were not likely to trigger an acute coronary event." The authors finally conclude: "PCI can be safely deferred in patients with stable coronary artery disease, even in those with extensive, multivessel involvement and inducible ischemia, provided that intensive, multifaceted medical therapy is instituted and maintained. As an initial management approach, optimal medical therapy without routine PCI can be implemented safely in the majority of patients with stable coronary artery disease."¹

Comments:

Present day heart surgery will go down in history as one of the greatest hoaxes ever perpetrated on the ailing public. And that is not just my assessment—consider the words from this editorial in the April 7, 2007 *British Medical Journal*, "It's easy to feel contempt for deluded practitioners of the past who advocated bloodletting and tonsillectomies for all. Easy, that is, until one considers emerging evidence that coronary stenting and postmenopausal hormone replacement therapy may well be the contemporary equivalents of those now discredited practices."²

Angioplasty and stent placement does work in the setting of an acute heart attack—like within the first few hours—these surgeries reduce the incidence of death and myocardial infarction in patients, but similar benefit has not been shown in patients with stable coronary artery disease. Stable disease is what the bulk of this business is all about. My September 2006 newsletter article, "The Angioplasty Debacle," thoroughly reviews this subject of angioplasty. At the time of this writing all six studies looking at a survival advantage for angioplasty, with or without stents, showed no benefits. Since then, there was a study published in the *New England Journal of Medicine* in December 2006 issue, which showed that this form of invasive heart surgery for high risk heart patients did not reduce the occurrence of death, reinfarction, or heart failure.³ The study I am now writing about in this newsletter brings the total to 8 studies reported to date that show angioplasty fails to save lives—there are no others showing otherwise. The reason angioplasty fails is the treatment does not address the killing part of the disease—the tiny volatile plaques.

How about bypass surgery versus medical treatment? An editorial in the same April 12, 2007 issue of the *New England Journal of Medicine* said, "As for PCI (angioplasty) versus surgery (bypass), guidelines summarize the trial evidence as suggesting that for most patients either procedure is an effective option for the treatment of symptoms, and both are associated with similar long-term outcomes."

Unfortunately, the more than \$100 billion generated annually from this business (in the USA alone) appears to be far more important than doing the right thing—which would be to not do the surgery and give the patient a few marginally effective pills (aspirin and statins). If doctors really took pa-

tients' lives seriously then they would take one bolder step forward and prescribe a serious change in their diets, which would stop the chest pains and heal the underlying sick arteries. But, where's the fun and profit in that simple approach?

- 1) Boden WE, O'rourke RA, Teo KK, Hartigan PM, Maron DJ, Kostuk WJ, Knudtson M, Dada M, Casper-son P, Harris CL, et al. Optimal medical therapy with or without PCI for stable coronary disease. *N Engl J Med.* 2007 Apr 12;356(15):1503-16.
- 2) Loder E. Curbing Medical Enthusiasm. *BMJ* 2007, April 7; 334: doi:10.1136/bmj.39175.409132.3A
- 3) Hochman JS, Lamas GA, Buller CE, Dzavik V, Reynolds HR, Abramsky SJ, Forman S, Ruzyllo W, Maggioni AP, White H. Coronary intervention for persistent occlusion after myocardial infarction. *N Engl J Med.* 2006 Dec 7;355(23):2395-407.
- 4) Hochman JS, Steg PG. Does preventive PCI work? *N Engl J Med.* 2007 Apr 12;356(15):1572-4.

Vitamin Supplements Kill

Trials of Antioxidant Supplements for Primary and Secondary Prevention: Systematic Review and Meta-analysis by Goran Bjelakovic in the February 28, 2007 issue of the *Journal of the American Medical Association* reported, "We did not find convincing evidence that antioxidant supplements have beneficial effects on mortality. Even more, beta carotene, vitamin A, and vitamin E seem to increase the risk of death. Further randomized trials are needed to establish the effects of vitamin C and selenium."

A total of 226,606 people in 68 trials were examined. All supplements were administered orally. Beta carotene, vitamin A and vitamin E singly or in combinations increased mortality. The meta-analysis indicated that the synthetic form of Vitamin A increased death risk by 16%, beta carotene by 7% and Vitamin E by 4%. Vitamin C singly or in combination did not increase mortality. It is likely cancer and cardiovascular death were the reason for an increase in all-cause mortality. Selenium used singly or in combination with other supplements seemed to be of benefit and reduced all-cause mortality. Ten to 20% of the adult populations of North America and Europe (80-160 million people) consume antioxidant supplements.

The researchers' gave an explanation for these negative findings: "Although oxidative stress has a hypothesized role in the pathogenesis of many chronic diseases, it may be the consequence of pathological conditions. By eliminating free radicals from our organism, we interfere with some essential defensive mechanisms like apoptosis, phagocytosis, and detoxification. Antioxidant supplements are synthetic and not subjected to the same rigorous toxicity studies as other pharmaceutical agents."

They also emphasized this important point: "Because we examined only the influence of synthetic antioxidants, our findings should not be translated to potential effects of fruits and vegetables."

Comment: Nutrients, such as vitamins and minerals, are present in natural packages (grains, legumes, vegetables, and fruits) that have developed through 400 million years of evolution (and/or by Divine Creation). Obviously they are perfect and interact with our bodies in a beneficial manner—all of the individual nutrients interacting within our cells to insure that we remain healthy. When a single concentrated nutrient is ingested in isolation, chemical imbalances are created within the cells—the end result, as this and many other studies have shown, is an increased risk of disease and earlier death.

This kind of publicity should be devastating for supplement manufacturers—if the public would only listen. Unfortunately, most people are looking for the easy way out—rather than give up their bacon and eggs for breakfast they put their hopes for salvation in vitamin pills. Supplements create multi-billion dollar businesses—at best their concoctions are medicines (with side effects) and at worst, they are toxins causing sickness and premature death.

Further information can be obtained from these previous McDougall newsletter articles:

[October 2005: Folic Acid Supplements are a Health Hazard](#)

[August 2003: Plants, not Pills, for Vitamins and Minerals](#)

[November 2004: Vitamins Do Not Prevent Cancer and May Increase Likelihood of Death: How Supplements Can Make You Sicker](#)

[July 2005: Neither Aspirin Nor Vitamin E Will Save Women](#)

[February 2004: Treating Homocysteine with Vitamins Fails](#)

Bjelakovic G, Nikolova D, Gluud LL, Simonetti RG, Gluud C. Mortality in Randomized Trials of Antioxidant Supplements for Primary and Secondary Prevention: Systematic Review and Meta-analysis. *JAMA*. 2007 Feb 28;297(8):842-57.

Salt Restriction May Be Good for the Heart

Long term effects of dietary sodium reduction on cardiovascular disease outcomes: observational follow-up of the trials of hypertension prevention (TOHP) by Nancy R. Cook in the April 2007 on-line edition of the *British Medical Journal* found, "Sodium reduction, previously shown to lower blood pressure, may also reduce long term risk of cardiovascular events (strokes and heart attacks)." This paper looks at the results of the two Trials of Hypertension Prevention studies. People were asked to lower their sodium intake and they did by about 2 to 2.6 grams a day. In the groups that were instructed to lower their sodium intake (compared to control groups) there were approximately 25% reductions in strokes and heart attacks—even though their blood pressures were reduced by little (-1.7/- .08 mmHg), or not at all, by the salt reduction.

Comment: People love the taste of salt—that attraction is naturally built into us by the taste buds on the tips of our tongues. Industry knows this, and as a result, it dumps loads of salt into almost every food we consume. Even Dr. McDougall's Rightfoods Soup Cups have added salt—because "No Salt means No Sale." The food company is at this moment formulating a lower salt line for Dr. McDougall's cups, but has been warned by the grocery market that the products are doomed to failure (because the buying public loves salt).

The food at the McDougall 10-day Live-in Program in Santa Rosa, CA is made low in sodium, but salt shakers are on every dining room table in order to make the foods more enjoyable for those unaccustomed to a low-sodium taste. Even with this added salt, our participants are able to get off their blood pressure medications in almost every case and their blood pressures decrease, on average, by 15/13 mmHg (when elevated initially to 140/90 mmHg or greater). Note that in the two Trials of Hypertension Prevention studies there was no meaningful reduction in blood pressure even with sodium reduction. So something besides salt must be accounting for any observed benefits.

The biggest problem with salt is that it is consumed mostly in packaged and prepared foods (not from the salt shaker). In these forms it is mixed with animal fats, vegetable oils, cholesterol, animal proteins, sugars, refined flours, and chemicals. Because these prepared products deliver a multitude of sins, it is impossible to determine if the benefit seen in studies that reduce salt intake are really due to lowering the sodium, or simply eliminating other known toxins. I believe it is the latter.

The basic McDougall Diet contains (daily) about 500 mg of sodium that is naturally present in the starches, vegetables, and fruits. If a half teaspoon of salt (about 1100 mg of sodium) is added to the surface of the dishes, then the salt intake is increased to about 1600 mg a day. If a person has a heart attack and is placed in the CCU of their local hospital on a low-sodium diet, they get 2000 mg of sodium a day. Thus, the McDougall Diet as served at our clinic is actually low sodium even with added salt.

I believe a small amount of salt (say a half teaspoon a day added to the surface of the foods daily) causes no negative health consequence for most people. On the other hand, this added salt has a very positive consequence—it makes our starch-based meal plan so much more delicious—as a direct result, people stick with our recommended diet. Their general health is dramatically improved as is shown by the numbers—reductions in blood pressures, cholesterol, triglycerides, body weight, and numbers of medications taken. People who focus on salt to the exclusion of the other qualities of the foods they eat are doomed to failure—they will not improve their overall health. I am not encouraging people to be unconscious of their salt intake; since there are no known negative consequences to eating less sodium—and for a few people this restriction may make a real difference.

Cook NR, Cutler JA, Obarzanek E, Buring JE, Rexrode KM, Kumanyika SK, Appel LJ, Whelton PK. Long term effects of dietary sodium reduction on cardiovascular disease outcomes: observational follow-up of the trials of hypertension prevention (TOHP). *BMJ*. 2007 Apr 20;

Cured Meat Hurts the Lungs

Cured Meat Consumption, Lung Function, and Chronic Obstructive Pulmonary Disease among United States Adults by Rui Jiang in the April 15, 2007 issue of the *American Journal of Respiratory and Critical Care Medicine* found, "Frequent cured meat consumption was associated independently with an obstructive pattern of lung function and increased odds of COPD." People who ate cured meats 14 times or more a month had twice the risk of COPD as those who did not eat these meats. COPD is chronic obstructive pulmonary disease, commonly known as emphysema.

Comments: Cured meats, such as bacon, sausage, ham, and luncheon meats, are high in nitrites, used as preservatives, antibacterial agents, and for color fixation. Nitrites generate reactive nitrogen compounds that may damage the lungs, producing emphysema. Therefore, in addition to obvious lung toxins, like cigarette smoke, what people eat can also cause debilitating lung disease. At the other end of the spectrum of food choices, eating fruits and vegetables is associated with healthier lung function.

Foods can be an important part of lung disease prevention, and a healthy diet can also help people with lung disease in three ways:

- 1) A low-fat diet will improve the flow of blood to the lungs. A high-fat diet has been shown to reduce the oxygen in the blood by 20%.
- 2) Removal of dairy products, and sometimes wheat products, will decrease the amount of thick mucous produced in the airways.
- 3) Losing excess weight will reduce the compression on the lungs caused by an obese abdomen.

Jiang R, Paik DC, Hankinson JL, Barr RG. Cured Meat Consumption, Lung Function, and Chronic Obstructive Pulmonary Disease among United States Adults. *Am J Respir Crit Care Med*. 2007 Apr 15;175(8):798-804.