



Volume 6 Issue 5

CELEBRITY CHEF WEEKEND



Alex Bury



Kevin Dunn



Mary McDougall and many more
June 15-17
Santa Rosa

[Click Here for Sign-up Information](#)



Join us for the
McDougall 10-Day
Live-in Program
August 3-12, 2007

Call us today!

800-941-7111
www.drmcDougall.com

When Friends Ask: "Why Did You Quit Meat?"

In my youth, I thought meat meant good health and strength. I reasoned this must be ideal food for my body, because my body is made up of meat; just like the body parts of cows, pigs and chickens; therefore, these foods must contain every nutrient I could possibly require. Logically, could anything be better for building muscle than eating muscle? This kind of faulty reasoning caused me to suffer problems as ordinary as acne and as rare as a stroke by the time I was 18 years old. I am alive and healthy today at 60 because 35 years ago I changed to primarily plants for my foods. (It is not too late for you.) PAGE 2

Who Should Take Statins?

Cholesterol-lowering medications, commonly referred to as statins, are considered so beneficial that some enthusiastic doctors declare, "they should be put into the drinking water." The pharmaceutical companies and their sales staff (most medical doctors) would like you to believe that simply lowering your cholesterol number is the major solution to your health problems. And that is untrue.

Statins do reduce cholesterol measured in the blood, but what is unclear is the real benefit for the patient—will the patient live longer and/or healthier? Or will he or she simply have a fatal heart attack the same day (as would have occurred without the medication), but with a lower blood cholesterol level? The decision to take these medications should not be made lightly. This is a lifetime commitment and for a young person this could mean 50 years of drug-therapy with the potential of serious side effects at a cost of more than \$1000 per year. PAGE 5

Update on "Death by Veganism" by Nina Planck:

The Public Editor of the NY Times was asked to comment; here is his response on this matter:

I asked David Shipley, the editor of the Op-Ed page, for his thoughts. He said, "I think Nina Planck is on firm ground in her Op-Ed. Her reading of the science is that it is indeed the case that children (and all of us) need animal-derived nutrients, and she's able to summon studies backing up her assertion -- just as the vegans are able to summon up studies showing that you can indeed survive on plants alone." PAGE 10

Featured Recipes

- No-Huevos Rancheros
- Hummus
- Potato Chowder
- Artichoke Spread
- Three Bean Chili
- Black Bean Dip

PAGE 10



When Friends Ask: "Why Did You Quit Meat?"

In my youth, I thought meat meant good health and strength. I reasoned this must be ideal food for my body, because my body is made up of meat; just like the body parts of cows, pigs and chickens; therefore, these foods must contain every nutrient I could possibly require. Logically, could anything be better for building muscle than eating muscle? This kind of faulty reasoning caused me to suffer problems as ordinary as acne and as rare as a stroke by the time I was 18 years old. I am alive and healthy today at 60 because 35 years ago I changed to primarily plants for my foods. (It is not too late for you.)

John McDougall, MD

Meat Is Cat Food—Plants Are People Food

Every animal has an ideal diet. Meat is an ideal food for my pointy-toothed carnivorous cats and my power

Undeniable Evidence That Meat-centered Diets Are Wrong:

Nearly Everyone Who Eats That Way Is Sick

Affluent people can afford to eat a diet with a central focus of beef, pork and/or chicken, and almost all do. Most also have one or more risk factors that predict premature death and illness:¹

- ✓ 1/3 have elevated cholesterol
- ✓ 1/3 have hypertension
- ✓ More than 30% are obese
- ✓ More than 65% are overweight
- ✓ 10% are diabetic

Diseases of affluence are epidemic among meat-eaters:

- ✓ 1/2 die prematurely of heart disease
- ✓ 1/2 of men develop life-threatening cancer
- ✓ 1/3 of women develop life-threatening cancer
- ✓ Over age 60, 30% have gallbladder disease
- ✓ One in seven suffers with serious arthritis
- ✓ 60% complain of bad breath (halitosis)
- ✓ Most have GI troubles (indigestion to constipation)

ful-jawed omnivorous dog. Cows and cockatoos are herbivores, and would soon sicken on a diet of meat. The same happens with people when they consume a meat-centered diet.

Meat Is Promoted for Its Good Nutrition

According to the National Cattlemen's Beef Association (NCBA), "Red meat plays an important role in a healthful diet by providing more than 10 percent of the Recommended Daily Allowances (RDA) for protein, iron, zinc, niacin, Vitamins B6 and B12."² These nutritional facts are accurate for people eating the typical rich diet, and will scare many of them into including generous amounts of meat—unless they consider the fact that nutritional deficiencies due to protein, iron, zinc, niacin, Vitamins B6 and B12 are essentially unheard of in people who have enough of any kind of food to eat. Do you know anyone with "deficiencies diseases" caused from lack of any of these nutrients? (Almost all iron deficiency in people is due to bleeding, not from dietary deficiency.)

National Cattlemen's Beef Association (NCBA) also fails to explain in their promotional materials that meat fails to provide sufficient amounts of calcium, dietary fiber, essential fats, and vitamin C to support the health of human beings. Nor do they mention the problems caused by the "excesses" in meat. Have you ever heard of illnesses due too many calories, or too much fat, cholesterol, protein, infectious microbes, and chemical contaminants? With excess lies the problem.

People Don't Like the Taste of Meat

Advertisements for Pizza Hut's Meat Lovers'® Pizza, Arby's Super Roast Beef Sandwich®, Wendy's Buffalo Crispy Chicken®, and McDonalds Double Quarter Pounder® could lead us to believe that "the meat" is the main attraction. However, it's not the slices of tasteless brown beef hidden in the center of the Arby's sandwich that people want—instead, they salivate over the "green leaf lettuce and ripe tomatoes, all topped with a zesty red sauce on a toasty sesame bun."

The human tongue has no taste buds for the protein and fat—the ingredients in the beef—but we do have taste buds on our tongue's tip which are excited by sugar and salt—the ingredients that make up the lettuce, tomato, sauce, and buns—these are what drive repeat sales. My cats would enjoy the meat. They have taste buds for amino acids (the building blocks of proteins) embedded in their tongues' surfaces; but the garnishes would be wasted on these carnivores.

What's Meat's Attraction?

If people have no senses for appreciating the taste of meat, then why is it so popular? Meat's appeal is driven by money and egos. Until recently, the high cost of meat restricted it to the plates of the wealthy. This is a status symbol—meat-eating enhances class distinction. Consider the Beef Industry's most famous slogan: *Beef—Real Food for Real People*. This is known as a *bandwagon argument*—used to appeal to a person's desire to be popular, accepted or valued—ignoring evidence and relevant reasoning.³ The message implies that food, other than beef, is not real food, and that people who do not eat beef, are not real people.³

If eating muscle turned into body muscle then most men living in affluent societies would resemble bodybuilders without a noticeable potbelly—no point in arguing the obvious. Scientific research confirms that meat is viewed as a superior masculine food.⁴ If the truth were known, real men would switch to real plant foods overnight. During a man's reproductive years meat-eating decreases ejaculate volume, lowers sperm count, shortens sperm life, and causes poor sperm motility, genetic damage, and infertility.^{5,6} Meat-eaters are likely to become impotent because of damage caused to the artery system that supplies the penis with the blood that causes an erection.⁷ Erectile dysfunction is more often seen in men with elevated cholesterol levels⁸ and high levels of LDL "bad" cholesterol⁹—both conditions are related to habitual meat-eating. Later in life, men who follow a meat-centered diet face prostate enlargement (benign prostatic hypertrophy) and prostate cancer.^{10,11} *Beef—Real Food for Real Sexual Dysfunction*.

Meat-eating Characterizes a Person

Meat Has Unhealthy Ingredients

A look at the individual components of meat explains why this is such an undesirable food.

There are no carbohydrates in meat. Carbohydrate is the human body's primary intended fuel—ask any endurance athlete. Carbohydrate is essential for the brain, red blood cells and kidney cells (glomeruli cells).

Meat is usually high in fat. The fat promotes obesity, type-2 diabetes, artery damage, heart disease, and many forms of cancer.

Meat is usually high in protein. Excess protein overworks and damages the liver and kidneys.

Meat proteins are high in acid. The acid is neutralized by the bones causing bone loss, osteoporosis and calcium-based kidney stones.

Meat proteins are high in sulfur. The sulfur-containing amino acids cause foul-smelling body odor, breath, and flatus, and promote heart disease, inflammatory bowel disease, cancer, and shortened longevity.

There is no dietary fiber in meat. Fiber provides the bulk for the stool, controls blood sugar and cholesterol, and detoxifies cancer causing chemicals.

Cholesterol is only in animal foods. Excess accumulates in our arteries, skin, tendons, and all other tissues.

Meat concentrates environmental contaminants. Toxic chemicals concentrate in food supply as they rise up the food chain.

Infectious agents live in meat. In USA, there are approximately 76 million cases of food-borne illness annually.

Antibiotics are in meat. Antibiotics are used to prevent animal infections and stimulate growth.

There are four well traveled roads to eating a meatless diet: health, personal appearance, the environment, and animal rights. As a medical doctor, I have mostly traveled the roads of health and appearance for the sake of my patients. That journey would have not been possible if I had not changed my personal diet 35 years ago. People have trouble seeing beyond their own habits—ridding my dinner plate of animal foods has allowed me to become sensitive to equally important issues—the environment and animal rights.

Many people would rather die than give up their meat—and that's OK with me. But I find it unacceptable that some of these same people would be willing to destroy Planet Earth than give up their meat. According to a report, [*Livestock's Long Shadow –Environmental Issues and Options*](#), released in November of 2006 by the United Nations Food and Agriculture Organization, livestock emerges as one of the top two or three most significant contributors to every one of the most serious environmental problems.

The killing and suffering of animals for human food might be justified, if meat were necessary for better human health, but the opposite is the case. Informed people should not remain silent about senseless suffering of food-animals.

We stand on the brink of life-ending health and environmental catastrophes. It is time we shed our hypocrisies. Doctors interested in healing patients of dietary diseases must eat a plant-food-based diet themselves. People who profess their love for animals must stop eating them. A true environmentalist will no longer contribute to the major source of planetary destruction by feeding himself and his family with products from the livestock industry. Making meat-eating a social disgrace in this generation, just like we did with cigarette smoking in the last generation, is a fundamental change that must take place in order to advance our society to the next level and ensure our personal survival.

Additional information on this subject is found by referring to my Hot Topics—Protein, Meat and Poultry at www.drmcDougall.com:

References:

- 1) Mulrow C, Kussmaul W. The middle-aged and older American: wrong prototype for a preventive polypill? *Ann Intern Med.* 2005 Mar 15;142(6):467-8.
- 2) <http://www.beefusa.org/newssciencevidencepointstoimportanceofmeatinamericandiets4394.aspx>
- 3) http://www.termpapergenie.com/decision_making.html
- 4) Roos G. Men, masculinity and food: interviews with Finnish carpenters and engineers. *Appetite.* 2001 Aug;37(1):47-56.
- 5) Allen NE. Hormones and diet: low insulin-like growth factor-I but normal bioavailable androgens in vegan men. *Br J Cancer.* 2000 Jul;83(1):95-7.
- 6) Rozati R . Role of environmental estrogens in the deterioration of male factor fertility. *Fertil Steril.* 2002 Dec;78(6):1187-94.
- 7) Feldman HA. Erectile dysfunction and coronary risk factors: prospective results from the Massachusetts male aging study. *Prev Med.* 2000 Apr;30(4):328-38.
- 8) Bodie J. Laboratory evaluations of erectile dysfunction: an evidence based approach. *J Urol.* 2003 Jun;169(6):2262-4.
- 9) Walczak MK Prevalence of cardiovascular risk factors in erectile dysfunction. *J Gend Specif Med.* 2002 Nov-Dec;5(6):19-24.
- 10) Suzuki S. Intakes of energy and macronutrients and the risk of benign prostatic hyperplasia. *Am J Clin Nutr.* 2002 Apr;75(4):689-97.
- 11) Divisi D, Di Tommaso S, Salvemini S, Garramone M, Crisci R. Diet and cancer. *Acta Biomed.* 2006 Aug;77(2):118-23.

Who Should Take Statins?

Cholesterol-lowering medications, commonly referred to as statins, are considered so beneficial that some enthusiastic doctors declare, "they should be put into the drinking water." The pharmaceutical companies and their sales staff (most medical doctors) would like you to believe that simply lowering your cholesterol

number is the major solution to your health problems. And that is untrue.

Statin medications inhibit the activity of an enzyme involved in the production of cholesterol in the liver. The name of the enzyme is 3-hydroxy-3-methylglutaryl-coenzyme A reductase. Thus the drugs are called HMG-CoA reductase inhibitors—or a much easier name, statins. When this enzyme is blocked, the liver makes less cholesterol and the blood levels of cholesterol fall.

Statins do reduce

cholesterol measured in the blood, but what is unclear is the real benefit for the patient—will the patient live longer and/or healthier? Or will he or she simply have a fatal heart attack the same day (as would have occurred without the medication), but with a lower blood cholesterol level? The decision to take these medications should not be made lightly. This is a lifetime commitment and for a young person this could mean 50 years of drug-therapy with the potential of serious side effects at a cost of more than \$1000 per year.

No One Dies of High Cholesterol

During my forty years of medical practice, I have never seen anyone die of high cholesterol (and neither has any other doctor). Cholesterol is a risk factor—this means it is a sign that reflects: the richness of the person's diet, his or her ability to metabolize the rich foods, and most importantly, the overall health of the body. The cholesterol molecules, themselves, in the bloodstream are relatively non-toxic. If cholesterol, itself, were the problem, then their predictive value for heart attacks and strokes would be close to 100%—high cholesterol would always mean sick arteries. However, I know many people with cholesterol levels over 300 mg/dL, with perfectly clean arteries—and just the opposite, people with levels below 170 mg/dL who have suffered a major heart attack. Furthermore, when the arteries of patients taking statins are studied over time, regression of the underlying artery disease, atherosclerosis, occurs in only a minority of patients, even if cholesterol drops profoundly under the influence of powerful medications.

The underlying truth is: there is a strong correlation between the richness of a person's diet (reflected by cholesterol and saturated fat content of the food choices) and the level of cholesterol found in that person's blood. The richer the diet, the higher the blood cholesterol. The association continues: the higher the cholesterol in the diet and in the blood, the more likely disease will happen—such as heart attacks, strokes, and a variety of cancers. The real culprit is the rich diet—the elevated cholesterol is, more or less, a secondary finding.

Because of the enthusiastic and dishonest promotion of these high profit drugs, many patients actually believe they are "cured" of their health problems—as a result they may see no more need to make beneficial diet and lifestyle changes, which in truth make a far greater difference than any medications. One recent analysis found smoking cessation and the use of plain aspirin to be much more cost-effective than the prescription statins.¹

High Risk Patients Show the Greatest Benefits

Patients with the greatest risk of a future tragedy should receive the most intensive treatment with diet and/or medications, because they will experience the greatest benefits with reduction of heart attacks and strokes, at the most reasonable costs.

The risk of future tragedies is predicted by observing signs, called risk factors. These include high blood pressure, cholesterol, triglycerides, uric acid, and blood sugar, as well as, being overweight. Information on family history, alcohol use, exercise, and smoking is also important. An even more reliable predictor of future problems is a person's history of having problems with his or her arteries. Thus, people with a history of a heart attack, stroke, bypass surgery, and/or angioplasty are at the highest risk and the ones most likely to benefit from statin therapy.

Increasing the Market by Disease Mongering

When I started in medicine in the 1970s, a high cholesterol level was considered to be above 350 mg/dL. The pharmaceutical industries were in their infancy and the primary medications for lowering cholesterol

were the low-profit vitamins, niacin, and cholesterol binding agents. These drugs also had disturbing side effects like flushing (niacin) and constipation (binding agents). Using this definition (350 mg/dL or greater) there was only a small market for cholesterol-lowering medications.

By no coincidence, with the discovery and popularization of high-profit statins over the past two decades, the definition of high cholesterol has fallen so that anyone with a cholesterol level above 200 mg/dL is abnormal. Over half the people following the Western diet are now potential customers for statins by this definition. Lately, expert opinions have suggested that ideal cholesterol would be below 150 mg/dL. That means, almost everybody needs to be on statins—we might as well put these drugs in the drinking water.

Most Women Should Avoid Statins

General agreement among doctors is that people at low risk should not be taking statins. Women, especially before menopause, have a much lower risk of developing heart disease, than do men of a similar age. To date, none of the large trials involving women who already have heart disease (secondary prevention) has shown a reduction in overall mortality in women from using statins.² For women who have never had heart disease (primary prevention), trials have shown neither an overall reduction in death (mortality benefit), or a reduction in heart attacks or surgery. One meta-analysis suggested that overall mortality may actually be increased by 1% over 10 years in both men and women.²

Muscle Damage from Statins

Relative Potency of Statins and Risk of Muscle Damage ⁴		
	Potency*	Fatal Rhabdomyolysis**
Fluvastatin (Lescol)	1	0
Pravastatin (Pravachol)	2	.04
Lovastatin (Mevacor)	3	.19
Simvastatin (Zocor)	6	.12
Atorvastatin (Lipitor)	12	.04
Cerivastatin (Crestor)	200	3.16

*Relative potency of 60 mg daily, with Fluvastatin equal to 1
 ** Cases per million prescriptions

Most medical doctors think statins have few side effects—and that these are mild and reversible. Complaints by patients on statins are often dismissed by their doctors as unrelated to the medication, and the issue of side effects has not been well studied, therefore, the true incidence is unknown. (See below for common side effects.)

The most serious adverse effect of taking these medications is damage to the muscles, called rhabdomyolysis, which can occasionally result in death. An estimated 1% to 5% of people on these medications experience muscle inflammation and pain (myositis). The more potent the statins; the greater the risk of muscle damage. A recent study, with electron microscopy and biochemical approaches, examined the

muscle tissues of patients on statins. They found muscle cell damage in over 70% of people on statins, *even when they had no complaints of pain.*³

Alternatives Medications to Statins

There are also alternative cholesterol-lowering medications, such as time-honored niacin and a cholesterol-binding agent (Colestid, Questran, and Welchol), which have been used since I started practice and have benefits equal to statins (which are limited as we have discussed).

There are also newer medications recently introduced, like Zetia and Tricor. No doubt they lower cholesterol, but life-saving and health-improving benefits have not been demonstrated. (See below for a more complete description of cholesterol-lowering medications.

There are several "natural" cholesterol-lowering medications that according to published studies lower cholesterol. The ones I use most often are garlic, oat bran, vitamin C, and guggulipid. (I no longer use vitamin E because studies show it increases heart disease and death.⁵) Because of the low cost, and minimal side effects I recommend these often. However, my experience has been that few patients attain a substantial reduction in cholesterol by this approach. Therefore, when I feel the indication to lower cholesterol is clear, I resort to prescription medications. (More information on these "**natural**" **cholesterol-lowering medications** can be found in my September 2002 newsletter.)

I Do Prescribe Statins and I Hope I Guess Right

As a medical doctor I am obliged to offer every one of my patients the best care possible, based on the best evidence available. Unfortunately, most of that evidence on the efficacy of medications has been heavily tainted by pharmaceutical companies—so the truth is hard for me to know. Based on current published research, I try to do the best for my patients, but I reserve the right to change my opinion on any drug I use.

I see many people with elevated cholesterol levels who also have a past history of heart disease—heart attacks, angioplasty and bypass surgery—and some with strokes. I usually offer these high risk patients the statins. But, I always qualify my prescription by telling them that I am only guessing (and hoping) that I will be doing them more good than harm. My guess is educated because I have been practicing (a descriptive word) for about 40 years and I have read and understand most of the research on this subject. Thus, I would not make the offer if I did not believe it to be correct.

Possible Scenarios with Cholesterol above 200 mg/dL

A 60 year-old woman who is trim, exercises daily, does not smoke, and has no family history of heart disease = no cholesterol-lowering medication.

A 40 year-old man who suffered a heart attack last month = yes, cholesterol-lowering medication.

A 50 year-old overweight man with diabetes, no exercise and is unable to change his diet = yes, cholesterol-lowering medication.

A 45 year-old overweight man who has decided to make serious diet and lifestyle changes, and also hates to take drugs = no cholesterol-lowering medication.

A 75 year-old woman who is going to follow the diet and exercise, but has a premonition that she is going to die of heart disease and insists on the medication = yes, cholesterol-lowering medication.

A 65 year-old man with a recent history of an angioplasty, who took statins, but developed muscle pains = yes, cholesterol-lowering medication, like niacin and Colestid, but no statins.

In these cases other decisions can be easily justified, but with little supporting evidence.

I also make it clear that since I am offering only my best guess, that the patient must be involved in the decision. Some people are very uncomfortable about having a high cholesterol level regardless of how much I try to reassure them that I believe they are in good health and at very low risk of a problem. Others fear the drugs, and would take almost any risk to avoid them. My decision to write a prescription weighs heavily on each person's feelings.

When I believe the situation warrants aggressive treatment, one of my goals is to lower total cholesterol below 150 mg/dL. The LDL-cholesterol should be below 80 mg/dL.

Preferred Statin?

Some statins are able to cross cell membranes easily—they are referred to as the fat-soluble statins (also hydrophobic and lipophilic statins). These include lovastatin, simvastatin, fluvastatin, and atorvastatin. There is concern that these fat-soluble statins may enter the cell and interfere with various substances essential for cell function, thus reducing their lifesaving benefits.⁶

All statins lower total cholesterol and LDL-cholesterol, and sometimes they show a small reversal of atherosclerosis. But the fat-soluble statins, in one recent review, showed less reduction of cardiac events (heart attacks, angioplasty, bypass surgery, sudden death, and overall mortality) than did a statin that is not fat soluble (and enters the cells less readily), called pravastatin (Pravachol).⁶ The primary goal of treatment is to reduce life-damaging events (not just lower cholesterol).

Based on this paper⁶ and the fact that pravastatin is generic (less costly), I am inclined to prescribe this vari-

Common Prescription Cholesterol-lowering Medications

It's important to remember that medications are a supplement to--not a substitute for--diet, exercise, and weight loss. Medications are even more effective when combined with a no-cholesterol, low-fat diet.

Statins:

Warnings and side effects: Never take statins during pregnancy or while breastfeeding. You should also avoid statins if you have liver disease, or if the drug gives you an allergic reaction. Common side effect include abdominal pain, abnormal heartbeat, accidental injury, allergic reaction, arthritis, back pain, bronchitis, chest pain, constipation, diarrhea, dizziness, flu symptoms, fluid retention, gas, headache, indigestion, infection, inflammation of sinus and nasal passages, insomnia, joint pain, muscle aching or weakness, nausea, rash, stomach pain, urinary tract infection, and weakness.

Advicor: a combination of extended-release niacin and lovastatin (Mevacor)

Altacor: an extended-release form of the cholesterol-lowering drug lovastatin, which releases small amounts of the drug throughout the day

Altoprev: an extended-release form of the cholesterol-lowering drug lovastatin, which releases small amounts of the drug throughout the day

Caduet: Atorvastatin with amlodipine (a blood pressure medication)

Crestor (rosuvastatin): Some cardiologists call Crestor "the Gorilla" statin.

Lescol XL, Lescol (fluvastatin)

Lipitor (atorvastatin)

Pravachol (pravastatin)

Vytorin: a combination of simvastatin + ezetimibe

Zocor (simvastatin)

Non-Statins Cholesterol-lowering Agents:

Colestid (colestipol), Questran and Questran Light (cholestyramine resin), and Welchol (colesevelam hydrochloride): cholesterol binding agents, also referred to as a bile acid sequestrant because they work by binding with cholesterol-based bile acids and take them out of circulation. This prompts the liver to produce a replacement supply of bile acids, drawing the extra cholesterol it needs out of the bloodstream. More common side effects may include: constipation, indigestion, muscle aches, sore throat, and weakness. Because they inhibit the absorption of other medications they should not be taken at the same time.

Niaspan (niacin 500mg extended-release tablets): In large doses this B vitamin (niacin) lowers cholesterol and triglycerides. More common side effects are flushing, elevation of blood sugar and liver injury.

Tricor (fenofibrate capsules): works by promoting the dissolution and elimination of fat particles in the blood. Risk of rhabdomyolysis is increased when combined with statins. Taken with meals.

Zetia (ezetimibe): acts by diminishing the absorption of dietary cholesterol through the intestines. More common side effects are: abdominal pain, back pain, diarrhea, joint pain, and sinusitis. Zetia is not recommended for people with moderate to severe liver disease, or for children under 10.

ety over the others. (Most statins sell for the same price for a pill regardless of the strength; eg. 80 mg, 40 mg, 20 mg. To cut costs even further, tablets—except for time-release tablets—can be split in half.)

How Long Should Patients Take Cholesterol-lowering Drugs?

When the medications are stopped the cholesterol rises—usually to pretreatment levels. So once you are on these medications, you may be on for life; unless you make serious dietary and lifestyle changes. With a change in diet, not only does the cholesterol drop, but the artery disease heals. This is referred to as “reversal,” and can be seen in 82% of people by the first year.⁷ After the first year, the benefits continue with even more reversal and healing seen. Dean Ornish, MD, says, “According to the PET scans, 99% of the patients stopped or reversed the progression of coronary heart disease.”⁸

The decision as to when to stop taking statins is based again on guess work. If the patient with a past history of heart artery disease has made remarkable improvements in health through diet and exercise (reflected in weight loss, vigor, blood pressure and other risk factors, improved feelings of well-being, etc.), then my guess is one to five years of cholesterol-lowering therapy may be enough. To help with this decision, I check cholesterol levels after the medications are stopped. If the cholesterol level remains below 150 mg/dl without medication, I feel even more confident that the patient will do well (another guess).

The Diet Is Forever

A no-cholesterol, low-fat diet (The McDougall Diet) is the first step to lowering elevated cholesterol and cleaning out the arteries. You can expect a reduction in cholesterol by 20% to 45% with strict adherence. In general, the higher the initial level the greater the reduction after a change in diet. There are no side effects to this approach, and most people reduce their food bills by 40% or more (especially those in the habit of eating out). Plus, this is the same diet that benefits the rest of the body by causing loss of excess weight, relieving aches and pains, regulating bowel function, lowering other common risk factors (blood pressure, blood sugar, triglycerides, etc.), and reducing the risk of future diseases and prolonging life—what a deal! If only money could be made from you changing your diet!

Regardless of the patient’s chances of benefits and risk from medications, diet and lifestyle changes should be the first and most enthusiastic prescription made by all doctors for their patients. Only then, as a last resort, the patient and the doctor should look into medications.

References:

- 1) Franco OH, der Kinderen AJ, De Laet C, Peeters A, Bonneux L. *Int J Technol Assess Health Care*. 2007 Winter;23(1):71-9.
- 2) Kendrick M. Should women be offered cholesterol lowering drugs to prevent cardiovascular disease? No. *BMJ*. 2007 May 12;334(7601):983.
- 3) Draeger A, Monastyrskaya K, Mohaupt M, Hoppeler H, Savolainen H, Allemann C, Babiychuk EB. Statin therapy induces ultrastructural damage in skeletal muscle in patients without myalgia. *J Pathol*. 2006 Sep;210(1):94-102.
- 4) Bruce J, Rabkin E., Martin V. Rhabdomyolysis associated with current use of simvastatin and Nefazodone: Case report and current review of the literature. *Advanced Studies in Medicine* 2003; 3: 168-172.
- 5) 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.
- 6) Ichihara K, Satoh K. Disparity between angiographic regression and clinical event rates with hydrophobic statins. *Lancet*. 2002 Jun 22;359(9324):2195-8.
- 7) Ornish D, Brown SE, Scherwitz LW, Billings JH, Armstrong WT, Ports TA, McLanahan SM, Kirkeeide RL, Brand RJ, Gould KLC. Can lifestyle changes reverse coronary heart disease? The Lifestyle Heart Trial. *Lancet*. 1990 Jul 21;336(8708):129-33.
- 8) Ornish D. Dean Ornish, MD: a conversation with the editor. Interview by William Clifford Roberts, MD. *Am J Cardiol*. 2002 Aug 1;90(3):271-98.

Update on "Death by Veganism" by Nina Planck:

The Public Editor of the NY Times was asked to comment; here is his response on this matter:

I asked David Shipley, the editor of the Op-Ed page, for his thoughts. He said, "I think Nina Planck is on firm ground in her Op-Ed. Her reading of the science is that it is indeed the case that children (and all of us) need animal-derived nutrients, and she's able to summon studies backing up her assertion -- just as the vegans are able to summon up studies showing that you can indeed survive on plants alone."

My own view, which I expressed to Shipley, is that, given how important and fraught with emotion the subject of children's nutrition is, the Times owed its readers an Op-Ed by another contributor debating Planck.

Because there is science to support another view, it should have been aired at the same time, or very close to the same time.

David Shipley's view is that, "Op-Ed readers understand that they are reading an argument and that there is almost always another side to the argument." I'd feel better if the Times had actually presented that other side in this particular instance.

Sincerely,
Clark Hoyt
Public Editor
The New York Times

The Public Editor says he (or an associate) reads all letters. You can write to Clark Hoyt at: public@nytimes.com

You can send your thoughts to the Op-Ed editor of the New York Times, David Shipley, at: oped@nytimes.com

Further background on Nina Planck:

Ms. Planck is a food writer and has no formal education in dietetics, nutrition, health, or medicine. One of her claims to fame was her position as the director of Greenmarket, New York's system of farmers markets. She was dismissed after 5 1/2 months on the job. She is solidly supported by the anti-vegetarian organization, the Weston A. Price Foundation.

Sally Fallon, the president of the Weston A. Price Foundation writes about Planck's book, *Real Food: What to Eat and Why*:

Much of her book is devoted to debunking the lowfat, vegetarian message. She tackles the notion that meat causes cancer or that farm animals are bad for the environment in her chapter on meat--"Why Even Vegetable Farms Need Animals." Planck endorses what even the grass-fed movement has denigrated--animal fat in the form of marbled beef, bacon and schmaltz. There's more on the virtues of saturated fat in a chapter called "Real Fats," and paeons to butter and cream in a chapter on "Real Dairy." Planck extols the health and economic benefits of raw milk as well.

Planck's love of food and robust optimism shine through every page of this delightful book--of course she enjoys life, she eats plenty of good fat. Egg-white omelets and skinless chicken breasts, those darlings of the dietitians, those icons of food puritanism, get the whacking they deserve--Planck calls them culinary abominations--as do soy, vegetable oils, trans fats, farmed fish and corn syrup. Let's all help her get on the best-seller list by buying a copy. (<http://www.westonaprice.org/bookreviews/real-food-review.html>)



Featured Recipes

by Mary McDougall

No-Huevos Rancheros

The idea for this recipe came from the Mexican breakfast of scrambled eggs over tortillas and beans, topped with salsa. The scrambled tofu topping could also be rolled up in a burrito shell with salsa, or just eaten plain. This is fairly quick to put together if you have leftover pinto

beans in your refrigerator, as I usually do.

Preparation Time: 10 minutes

Cooking time: 8 minutes

Servings: 4-6

1 cup salsa

2 cups mashed pinto beans (recipe in June 2003 newsletter)

8-10 soft corn tortillas

Tofu Scramble:

1 pound firm, water-packed tofu (not silken)

¼ cup vegetable broth

½ cup chopped green onions

1 tablespoon chopped green chilies (optional)

1 teaspoon soy sauce

¼ teaspoon turmeric

freshly ground pepper

dash sea salt (optional)

Drain tofu well, mash finely with a bean masher and set aside. Heat the mashed pinto beans in a saucepan. Place the vegetable broth in a large non-stick frying pan, add the green onions and cook, stirring frequently for 3 minutes until softened. Add tofu and the remaining ingredients. Mix well and continue to cook, stirring frequently for 5 more minutes. Set aside.

To assemble:

Heat the tortillas briefly on a dry non-stick griddle to warm and soften them. Take one tortilla and place on a plate. Spread beans on one side, cover with a second tortilla and spread beans over the top of that tortilla also. Spoon some of the tofu scramble over the tortillas and beans, then top with several spoonfuls of salsa. Repeat process for each serving.

Hints: Other toppings could also be added such as shredded soy or rice cheese, and/or tofu sour cream. Sprinkle with some fresh chopped cilantro, if desired.

Potato Chowder

This is always a favorite at the McDougall Program and it is quick and easy to make as well. Buy bags of frozen, chopped hash brown potatoes (with no added oils) for really easy preparation of this delicious soup.

Preparation Time: 10 minutes

Cooking Time: 30 minutes

Servings: 4-6

4 cups vegetable broth

1 onion, chopped

2 stalks celery, chopped

1 leek, white and light green part, sliced

6 cups frozen chopped hash brown potatoes

2 cups soy or rice milk

½ teaspoon sea salt (optional)

⅛ teaspoon white pepper

2 tablespoons parsley flakes

2 tablespoons dried chives

dash liquid smoke

Place ½ cup of the broth in a large soup pot with the onion, celery and leeks. Cook, stirring occasionally for 5 minutes, until softened. Add the remaining broth and the potatoes. Bring to a boil, reduce heat, cover and cook for 20 minutes. Using an immersion blender, process the soup while still in the pot. (Unless you are using a non-stick pan, then place the soup in a blender jar and process until fairly smooth. Return to pan.) Add the remaining ingredients and heat through, about 5 minutes.

Three Bean Chili

This recipe is from Colleen Patrick-Goudreau, one of the McDougall Program's cooking instructors. This is al-

ways a favorite in her classes. This is a delicious, colorful dish that doesn't take much time to prepare and can be served in a variety of ways (see hints below).

Preparation Time: 20 minutes

Cooking Time: 45 minutes

Servings: 6-8

½ cup water
1 onion, chopped
1 yellow bell pepper, chopped
1 red bell pepper, chopped
1 orange bell pepper, chopped
2-3 cloves garlic, minced
2 tablespoons chili powder
1 teaspoon ground cumin
1 teaspoon ground coriander
1 teaspoon dried oregano
¼ teaspoon cayenne
1 15 ounce can chopped tomatoes
1 ½ cups frozen corn kernels
1 15 ounce can kidney beans, drained and rinsed
1 15 ounce can black beans, drained and rinsed
1 15 ounce can pinto beans, drained and rinsed

Place the water in a large pot and add the onion, bell peppers and garlic. Cook, stirring occasionally until vegetables soften slightly, about 5 minutes. Add the seasonings and mix in well. Add remaining ingredients, stir well to mix, bring to a boil, reduce heat, cover and cook for about 40 minutes.

Hints: Serve over brown rice, rolled up in a burrito shell, or in a shallow bowl with cornbread on the side. Serve with some shredded soy or rice cheese sprinkled over the top, or some tofu sour cream. Sprinkle with some chopped fresh cilantro or parsley. If the chili gets too thick while cooking, add a bit of water to the pot to thin it out before serving. Choose whatever color of bell peppers that you prefer, the more color variety, the prettier the dish. The same is true for the beans, choose whichever color you prefer.

Hummus

There are many variations of Hummus in most supermarkets and natural food stores. Many of them have added olive oil and most have tahini. Some people are convinced that Hummus without tahini is just not Hummus. However, I have been making no tahini Hummus for years and it is delicious, plus it is healthier for your body. If you can't stand the thought of Hummus without tahini, then add 1 tablespoon of it to this recipe, realizing that you are also adding some fat to the recipe.

Preparation Time: 5 minutes

Servings: makes 1 ½ cups

1 15 ounce can garbanzo beans, drained and rinsed
3 tablespoons lemon juice
2 cloves garlic, crushed
1-2 tablespoons water
dash sea salt

Place all ingredients in a food processor and process until very smooth.

Hints: Add other ingredients to this basic Hummus, for flavor and variety.

1. ½ cup roasted red peppers plus ½ teaspoon ground cumin
2. ½ cup chopped parsley or cilantro
3. 1-2 teaspoons chopped jalapeno pepper

Artichoke Spread

This is delicious as a spread for sandwiches, as a dip for crackers or veggies, or stuffed into pita and topped with chopped tomatoes, cucumbers and sprouts.

Preparation Time: 10 minutes

Servings: Makes about 3 cups

2 14 ounce cans artichoke hearts in water, drained and rinsed
1 15 ounce can white beans, drained and rinsed
4 tablespoons lemon juice
2 cloves garlic, crushed
4 green onions, chopped
1 tablespoon soy sauce
1/8 teaspoon cayenne pepper

Combine all ingredients in a food processor and process until smooth.

Black Bean Dip

This is such a simple dip that you won't believe it can taste so good. Make it a day ahead of when you plan to use it so the flavors can blend. Serve with baked tortilla chips, baked pita chips or on bruschetta or crackers. We also like it with cold, boiled potatoes as a snack.

Preparation Time: 5 minutes

Servings: variable

2 15 ounce cans black beans, drained and rinsed
1 cup fresh salsa

Place the beans and salsa in a food processor and process until smooth. Refrigerate overnight for best flavor.

Hints: Vary this dip by using different salsas or beans. To make bruschetta, slice bread quite thin, rub with a cut clove of garlic, if desired, and toast in the oven or on a grill until crisp.