



Favorite Five Articles from Recent Medical Journals



Gum (Periodontal) Disease and Diet

Relationships Between Eating Habits and Periodontal Condition in University Students by Takaaki Tomofuji, published in the December 2011 issue of the *Journal of Periodontology*, found that, "In overweight students, the frequent consumption of fatty foods and infrequent consumption of vegetables were associated with an increase in periodontitis.¹ Dietary fat causes obesity. During the past 50 years, the Japanese diet has become higher in fat and the result has been increasing obesity, especially among the youth.

In a related article, **Association Between Chronic Periodontitis and Vasculogenic Erectile Dysfunction**, by Anuj Sharma, published in the same issue of this journal, investigators found an association between vascular disease, in this case erectile dysfunction, and chronic periodontitis.² Most cases of erectile dysfunction are caused by arterial insufficiency to the penis (atherosclerosis) due to the Western diet. This same disease causes heart attacks.³ This research provides a link between the health of the mouth and its blood supply.

Comments: Chronic periodontitis is a chronic inflammatory condition of the gums (gingival tissues) that results in the loss of both the attachment of the periodontal ligament and bony support of the teeth. Because of the poor health of the gums, bacterial infections occur concurrently. However, treatment with antibiotics is ineffective, because the underlying poor health of the gums is not resolved.⁴ At the foundation of periodontal disease is malnutrition caused by the Western diet. In the general population, severe forms of periodontal disease are found in almost 5% of people. If the disease progresses without successful intervention, then the final outcome can be the loss of the teeth.

Multiple studies have found that people with coronary artery disease and diabetes have a higher rate of gum disease.^{5,6} The common denominator is the food. The study of worldwide populations shows that a diet high in starches, vegetables, and fruits, and low in sugar and fats will protect both oral and general health.⁶ All tissues in the body must receive nutrients directly or indirectly from blood vessels. Compromise of the circulation causes many common health problems, from head to toe. Therefore, it should be no surprise that the same poor eating habits that sicken all other parts of the body also result in poor oral health.

Disease from Poor Circulation (from the top down):

- Macular Degeneration
- Hearing Loss
- Periodontitis
- Stroke
- Heart Attacks
- Aortic Aneurysm
- Bowel Infarction
- Kidney Failure
- Degenerative Disk Disease
- Erectile Dysfunction
- Claudication
- Gangrene

Healing of periodontal disease is accomplished by better nutrition and improved dental hygiene. Over my years of practice I have seen remarkable improvements, including complete resolution of periodontitis and reduction of the size of "pockets" between the teeth and gums. Along with eating a starch-based diet, visits to the dental hygienist and conscientious home care are crucial for healing. In addition to brushing, flossing, and water picks, I like [inter-dental brushes](#) for the thorough cleaning they provide.

- 1) Tomofuji T, Furuta M, Ekuni D, Irie K, Azuma T, Iwasaki Y, Morita M. Relationships Between Eating Habits and Periodontal Condition in University Students. *J Periodontol*. 2011 Dec;82(12):1642-9.
- 2) Sharma A, Pradeep AR, Raju P A. Association Between Chronic Periodontitis and Vasculogenic Erectile Dysfunction. *J Periodontol*. 2011 Dec;82(12):1665-9.
- 3) Montorsi P, Ravagnani PM, Galli S, Salonia A, Briganti A, Werba JP, Montorsi F. Association between erectile dysfunction and coronary artery disease: Matching the right target with the right test in the right patient. *Eur Urol*. 2006 Oct;50(4):721-31.
- 4) Angaji M, Gelskey S, Nogueira-Filho G, Brothwell D. A systematic review of clinical efficacy of adjunctive antibiotics in the treatment of smokers with periodontitis. *J Periodontol*. 2010 Nov;81(11):1518-28.
- 5) Kinane D, Bouchard P; Group E of European Workshop on Periodontology. Periodontal diseases and health: Consensus Report of the Sixth European Workshop on Periodontology. *J Clin Periodontol*. 2008 Sep;35(8 Suppl):333-7.
- 6) Moynihan PJ. The role of diet and nutrition in the etiology and prevention of oral disease. *Bull World Health Organ*. 2005 Sep;83(9):694-9.

More Death from Meat Eating

Red Meat Consumption and Mortality. Results From 2 Prospective Cohort Studies by An Pan, published in the online edition of the March 12, 2012 issue of the *Archives of Internal Medicine*, found that, "Red meat consumption is associated with an increased risk of total, CVD (cardiovascular), and cancer mortality." This prospective observation of 37,698 men is from the Health Professionals Follow-up Study (1986-2008) and 83,644 women from the Nurses' Health Study (1980- 2008). The investigators estimated that substitutions of 1 serving per day of other foods (including fish, poultry, nuts, legumes, low-fat dairy, and whole grains) for 1 serving per day of red meat were associated with a 7% to 19% lower mortality risk.

Comments: Simply put: meat is the wrong food for people. I also teach that poultry, fish and low-fat dairy have no place in a healthy diet. The reason these foods were found to be "beneficial" in this observational study is that people who purposefully choose to avoid red meat will instead choose to eat chicken, fish and low-fat dairy. These behaviors (avoiding red meat and picking chicken, fish and low-fat dairy) also identify people who in general have a much healthier diet and lifestyle.

Many components of animal foods, including too much iron, sodium, saturated fat, cholesterol, and chemical contaminants, and too few carbohydrates, dietary fiber, and micronutrients, have been blamed for shortening the lives of people with more heart disease and cancers. Furthermore, these authors found processed meat to be even more risky. Likely, all the unhealthy components of meat have not been identified. However, all you have to understand in order to take appropriate actions is that meat is not your food: although it is an ideal food for cats, humans should stop eating animal-derived foods.

Dean Ornish, MD (one of our guest speakers for the September 7–9, 2012 [Advanced Study Weekend](#)) wrote an editorial in this same issue of the *Archives of Internal Medicine*. He placed the problem of meat eating in a worldlier perspective, discussing the world hunger, global warming, environmental ruin, and fossil fuel costs from livestock production. The title of this editorial is, "Holy Cow! What's Good For You Is Good For Our Planet."

- 1) Pan A, Sun Q, Bernstein AM, Schulze MB, Manson JE, Stampfer MJ, Willett WC, Hu FB. Red Meat Consumption and Mortality: Results From 2 Prospective Cohort Studies. *Arch Intern Med*. 2012 Mar 12.
- 2) Ornish D. Holy Cow! What's Good For You Is Good For Our Planet: Comment on "Red Meat Consumption and Mortality." *Arch Intern Med*. 2012 Mar 12.

White Rice and Diabetes

White rice consumption and risk of type 2 diabetes: meta-analysis and systematic review by Emily Hu, published in the March 16, 2012 issue of the *British Medical Journal*, found, "Higher consumption of white rice is associated with a significantly increased risk of type 2 diabetes, especially in Asian (Chinese and Japanese) populations."¹ This report involved a collection of studies (a meta-analysis) that reported risk estimates for type 2 diabetes, by rice intake levels.

Comments: Confounding, the presence of another hidden variable, is of particular concern in this study because socioeconomic status is both a risk factor for type 2 diabetes and a predictor of rice consumption in Asian and Western populations.² In other words, within a particular population (say in China or Japan), those who eat more white rice are also the wealthier people who eat more meat, oil, refined food, etc. Poorer people purchase less white rice and less rich food (they also work physically harder), and as a result, they are trimmer with little chance of developing type 2 diabetes—a condition directly [resulting from obesity](#).

Worldwide, the populations with the lowest rates of diabetes are those that eat the most rice and other starches; type 2 diabetes is all but unknown in rural Asia, Africa, Mexico, and Peru, where a high-carbohydrate diet is the cultural norm.³⁻⁶ Some of the highest rates of obesity and diabetes are, however, found among people of Hispanic, Native American, Polynesian, and African descent—but not because of their genetic make up or the starch-based diets of their distant ancestors. These ethnic groups became fat and sick when they adopted a high-fat, high-protein Western diet.⁷

I recommend people eat whole-grain (brown) rice, but I do not consider white rice a deal-breaker. Because of social status (refined people eat refined rice) and lack of availability, many people tell me they cannot eat brown rice. I understand. When you are out and about, and all you can find is a Chinese restaurant for lunch, and you are given a choice of white rice to fill your hungry belly, or fried pork, go with the white rice.

1) Hu EA, Pan A, Malik V, Sun Q. [White rice consumption and risk of type 2 diabetes: meta-analysis and systematic review](#). *BMJ*. 2012 Mar 15;344:e1454. doi: 10.1136/bmj.e1454.

2) Neal B. White rice and risk of type 2 diabetes. *BMJ*. 2012 Mar 15;344:e2021. doi: 10.1136/bmj.e2021.

3) Hu FB. Globalization of diabetes: the role of diet, lifestyle, and genes. *Diabetes Care*. 2011 Jun;34(6):1249-57.

4) Janket SJ, Manson JE, Sesso H, Buring JE, Liu S. A prospective study of sugar intake and risk of type 2 diabetes in women. *Diabetes Care*. 2003 Apr;26(4):1008-15.

5) Kitagawa T. Increased incidence of non-insulin dependent diabetes mellitus among Japanese schoolchildren correlates with an increased intake of animal protein and fat. *Clin Pediatr (Phila)*. 1998 Feb;37(2):111-5.

6) Llanos G. Diabetes in the Americas. *Bull Pan Am Health Organ*. 1994 Dec;28(4):285-301.

7) Egede LE, Dagogo-Jack S. Epidemiology of type 2 diabetes: focus on ethnic minorities. *Med Clin North Am*. 2005 Sep;89(5):949-75, viii.

Doctors Ignorant about Mammograms and PSA Testing

Do physicians understand cancer screening statistics? A national survey of primary care physicians in the United States by Odette Wegworth, published in the March 6, 2012 issue of the *Annals of Internal Medicine*, found, “Most primary care physicians mistakenly interpreted improved survival and increased detection with screening as evidence that screening saves lives. Few correctly recognized that only reduced mortality in a randomized trial constitutes evidence of the benefit of screening.” Primary care physicians were more enthusiastic about the screening test supported by irrelevant evidence (5-year survival increased from 68% to 99%) than about the test supported by relevant evidence (cancer mortality reduced from 2 to 1.6 in 1000 persons). (Screening is performed by early detection tests, like mammograms to find breast cancer and PSA tests for prostate cancer.)

Comments: Survival statistics are susceptible to lead-time and over-diagnosis biases. While your doctor should know this basic information, most don’t; and you and your family will pay dearly for his or her ignorance.

Lead-time bias occurs when disease is found earlier, but the day of death remains the same. For example, if a person is destined to die in June of 2017 of cancer, and the cancer is found in June of 2016, then the person would have lived for only a year knowing about the cancer. However, if aggressive testing is used and by “earlier detection,” the cancer is found in June of 2012, then the person lived much longer aware of the cancer (for five years), but he/she still dies the same day. If cure is defined as “living for five years,” then, in this example, the person was cured by early detection, but still died the same day.

Screening can also detect cases of cancer that are not destined to progress and cause harm, a phenomenon known as over-diagnosis. Not all cancers grow into life-threatening disease: without meddling doctors, the patient would have never known that

they were ill. In other words, when looking hard for abnormalities, cancers, which would have never surfaced during a person's life, are found. When these abnormalities are treated, the patient believes he or she has been cured, even though their life was really never threatened. This is a serious problem because for every life saved by doing regular mammograms, between 5 and 20 women's (and their families') lives were destroyed by the diagnosis of breast cancer and the treatments that follow. For men with prostate cancer, 48 men are over-diagnosed for every one life saved.

Cancer mortality rates are, however, unaffected by lead-time and over-diagnosis biases. Mortality statistics simply divide the number of deaths from cancer by all people in the study population. Thus, the number of deaths in the group that received screening tests is compared with a group that is not subjected to this rigorous examination. Doctors should be aware of these biases in order to provide proper consultations to you.

My general recommendation for people is to not participate in early-detection screening tests for breast and prostate cancers. However, there are limited benefits from PAP smears done every 3 to 5 years for sexually active adult women until age 50 and one colon exam ([a sigmoidoscope](#)) performed between ages 55 to 64. Small benefits also come from checking the skin and the mucous membranes of the mouth for early changes that may lead to cancer. When considering any screening tests, realize that you are risking your life today (for example, a perforation of your colon during a colonoscopy) in exchange for the possibility that you will have less chance of dying of cancer one to four decades from now.

Wegwarth O, Schwartz LM, Woloshin S, Gaissmaier W, Gigerenzer G. Do physicians understand cancer screening statistics? A national survey of primary care physicians in the United States. *Ann Intern Med.* 2012 Mar 6;156(5):340-9.

Diabetes Cured by Surgery. No Surprise!

Two small headline-generating studies published in the *New England Journal of Medicine* on March 26, 2012 found that, "In obese patients with uncontrolled type 2 diabetes, 12 months of medical therapy plus bariatric (weight loss) surgery achieved glycemic (blood sugar) control in significantly more patients than medical therapy alone." And "In severely obese patients with type 2 diabetes, bariatric surgery resulted in better glucose control than did medical therapy."

Comments: These two studies confirmed the obvious: Major surgery, designed to damage the functional capacity of a person's stomach and intestines, results in sufficient malnourishment to cause the patient to lose large amounts of weight. With weight type 2 diabetes is almost always cured. These findings will be viewed by patients and doctors alike as legitimate medical therapies, and will be paid for by your insurance companies, your employers, and your tax dollars. The suffering and side effects of these surgeries are often incapacitating and permanent.

What kind of society do we live in where we are purposefully harming a patients' body in order to cure them of their gluttony, without first offering them an opportunity to learn the cause of their obesity and to then make simple dietary corrections? What's next? Remove an obese diabetic's teeth so they can't eat? Dentists once wired people's teeth together so they could not eat. Will oncologists soon be taking their share of the lucrative weight-loss industry? Slow poisoning with their drugs results in weight loss, and lower blood pressure, cholesterol, and blood sugars. Will future headlines read, "Lobotomies performed by brain surgeons reduce appetite and cure diabetes?" How about infecting people with tapeworms? Bilateral amputations so the obese diabetic can't get to the refrigerator?

There is only one way to really cure type 2 diabetes and that is to stop the cause: the rich Western diet. Simply shift to the traditional human diet based on beans, corn, potatoes, pasta, and breads. There are no obese people in parts of rural Asia where the diet is still based on rice (white rice). Thus, there is no need for weight-loss surgeries to cure type 2 diabetes in any of these people.

1) Schauer PR, Kashyap SR, Wolski K, Brethauer SA, Kirwan JP, Pothier CE, Thomas S, Abood B, Nissen SE, Bhatt DL. Bariatric Surgery versus Intensive Medical Therapy in Obese Patients with Diabetes. *N Engl J Med.* 2012 Mar 26. [Epub ahead of print]

2) Mingrone G, Panunzi S, De Gaetano A, Guidone C, Iaconelli A, Leccesi L, Nanni G, Pomp A, Castagneto M, Ghirlanda G, Rubino F. Bariatric Surgery versus Conventional Medical Therapy for Type 2 Diabetes. *N Engl J Med.* 2012 Mar 26. [Epub ahead of print]