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Type-2 Diabetes – the Expected Adaptation to Over-nutrition

Sixteen million people in the United States have type-2 diabetes, which shortens life-span by up to 15 years, leads to almost 300,000 deaths annually, and costs about \$100 billion annually. Since 1980 the incidence has increased by 30%. Born in the year 2000, your male child's lifetime risk of developing type-2 diabetes is nearly 33%, and a female's risk will be 39% when following the Western diet.¹ Worldwide, 135 million people have type-2 diabetes and by 2025 the incidence is predicted to reach 300 million people worldwide.

This form of diabetes was once referred to as "adult-type diabetes" because in the past, type-2 diabetes was rare in children. However, over the last two decades, there has been a 10-fold increase in incidence of type-2 diabetes in children, because of the rapidly growing numbers with obesity from an escalating exposure to rich foods, compounded by a lack of exercise.²

The general state of poor health of Westerners, as reflected by diabetes, escalates unchecked for 3 important reasons:

- 1) This growing epidemic of type-2 diabetes and obesity is fueled by huge profits generated by a food industry super-sizing everything by stuffing their irresistible morsels with fat, sugar, refined flour, and calories.
- 2) Medical doctors continue to prescribe remedies that have never cured a single case of diabetes. Furthermore, the usual "poly-pharmacology" of medications they rely upon promotes weight gain, heart disease, and hypoglycemia, along with other serious adverse effects. From all these expensive medications there is a small reduction in complications, such as kidney and eye damage, which still fails to offset the tremendous harm done by their efforts.
- 3) The American Dietetic Association has remained steadfast in their recommendation of a portion-controlled version of the Western (American) diet – an impossible diet to follow (because of its complex rules and semi-starvation nature) – made up of ingredients, like fat, sugars, refined foods, and cholesterol, that caused the patients' prob-

lems in the first place.

In 1927 Dr. E. P. Joslin, founder of the famous Joslin Diabetic Center in Boston, suspected a high-fat, high-cholesterol diet might favor the development of diabetes and its major complication, atherosclerosis.³ He prophetically wrote: "I believe the chief cause of premature atherosclerosis in diabetes, save for advancing age, is an excess of fat, an excess of

Type-1 vs. Type-2 Diabetes

Type-2 diabetes is often referred to as "adult-type" diabetes because it usually develops later in life (as people gain weight from more rich food and less exercise) – however, this nomenclature is now less relevant as more children in Western societies become overweight and diabetic. This form is also referred to as "non-insulin-dependent diabetes" because insulin injections (or diabetic pills) are not required to stay alive. The pancreas of a person with type-2 diabetes produces a plentiful supply of insulin, but the insulin is relatively ineffective in this condition. In other words, the body becomes resistant to the effects of insulin – a condition commonly called "insulin resistance."¹³ Usually type-2 diabetics are overweight; however, when they are of trim body weight, I usually find these people have actually lost some of their ability to produce insulin (their pancreas has been damaged), and therefore, they would be better classified as "a partial type-1 diabetic."

Type-1 diabetes is also referred to as "childhood-type" diabetes because it has traditionally been the form of diabetes seen most often in young people. However, half of those with this disease are diagnosed after the age of 19 years – so "childhood" is also a somewhat misleading term for this disease. In this form of diabetes the insulin-producing cells of the pancreas have been damaged or destroyed and insulin production is insufficient for blood sugar control. Because insulin injections are required for survival, this type is referred to as "insulin-dependent diabetes." (Allergic reactions to cow-milk proteins are usually the cause of type-1 diabetes – see my July 2002 Newsletter article, "The Pancreas - Under Attack by Cow-Milk," for more information.)

Diabetics have a metabolic handicap which impairs the body's ability to defend and repair itself from injuries caused by the Western diet. As a result of this deficiency, diabetics of both types have an even higher risk than the general public of diseases like heart attacks, kidney failure, vision loss, strokes, cancer, and osteoporosis. For this reason alone people with diabetes need to take especially good care of themselves with the McDougall diet and a healthy lifestyle

fat in the body (obesity), an excess of fat in the diet, and an excess of fat in the blood. With an excess of fat diabetes begins and from an excess of fat diabetics die, formerly of coma, recently of atherosclerosis.” And now, 75 years after Joslin’s farsighted message, diabetes is the fastest growing disease in the world.

Type-2 Diabetes: A Runaway Epidemic Caused by Rich Foods

The cause of this skyrocketing health tragedy is easily seen by observing everyday people striving for the “good life.”⁴⁻⁶ Feasting from the king’s table brings on the diseases of royalty, like obesity, gout, and diabetes. Worldwide, the incidence of type-2 diabetes increases in direct proportion to the consumption of meat, dairy products, sugars, fats, and calories by the residents. Type-2 diabetes has taken the greatest toll on “minority” populations brought to the Western diet by migration to cities and giant industries providing cheap fast food.

Native Americans, for example the Pima Indians of Arizona, introduced to the Western diet over the past 75 years, are now afflicted so severely that as many as one-half of them has diabetes.⁷ However, their genetic cousins, the Tarahumara Indians of Mexico, following a diet consisting of 90% corn and pinto beans (chili), and vegetables (like squash), are free of type-2 diabetes – as well as obesity and heart disease.^{8,9} Similar dramatic rises – from immunity to epidemic proportions – of type-2 diabetes have been seen in other people like Africans, African-Americans, Mexicans, Chinese, and Polynesians, as they adopt the Western diet with enthusiasm.¹⁰⁻¹² There are no exceptions to this observation that when populations of people following a starch-based diet (rice, corn, potatoes, sweet potatoes, etc.), switch to a diet of rich foods – meats, dairy products, added oils, and refined foods – they become overweight and diabetic, and develop heart disease, breast, prostate and colon cancers, gallbladder disease, arthritis, multiple sclerosis, and bowel problems. No exceptions!

Diabetes Is an Adaptive Response to Overnutrition

Without the protective effects of “insulin resistance” you might never stop enlarging.



“Insulin resistance” has been treated like a disease, but actually can be a lifesaver for those who eat large amounts of unhealthy foods.

The malnutrition caused by the high-fat, low-fiber Western diet places serious burdens on the body and requires it to make adaptations in order to survive under adverse conditions. The calories consumed in excess of our needs cause us to gain fat – this is a natural, expected change. Soon a point is reached when this accumulation becomes counterproductive – a point when any further excess body weight is likely to cause serious physical harm. When this hazardous excess is reached, the body puts “the brakes on” in order to slow the rate of gain. This is accomplished by a variety of changes that cause the hormone insulin to become less potent.^{13,14} In other words, our cells become resistant to the actions of the fat-gaining hormone, insulin – a state referred to as “insulin resistance.”

One of insulin’s primary jobs is to push fat into the fat cells – thus saving fat for the day when no food is available (which for Westerners never comes). If it were not for the adaptive mechanisms which allow for the

development of “insulin resistance,” people would commonly expand until they became so large that they could not get out of bed or fit through a doorway – a very rare condition that does occur in 1000-pound sized people who need a fork-lift to move them to the hospital. (They make headlines in the newspaper.)

One of insulin’s other important jobs is to let sugar into the body’s cells – with a state of “insulin resistance” the sugar cannot get into the cells easily – so it rises in the blood. The hallmark of the diagnosis of diabetes is an elevated blood sugar above normal (usually normal is below 115 mg/dl fasting). With impotent insulin, the calories of fat and sugar we consume cannot easily enter the cells; the body is essentially starving itself from the inside in a desperate attempt to compensate for the overfeeding coming from the outside. To further reduce the burden of obesity, the body eliminates calories by allowing sugar to spill over into the urine, like water falling over a dam. At this stage sugar is found with a urine test – another common way to diagnosis diabetes. Most doctors and patients view the elevated blood sugar as the enemy to be beaten down with medications – the result is a fat, sickly patient with a slightly lower blood sugar.

The Reason Medical Therapy Should Be Your Last Choice

Diabetic medications have never cured anyone of diabetes and actually compound the patients’ problems. The patient goes to the doctor, is diagnosed with diabetes, placed on medication, and told to lose weight. Unfortunately, these medications make insulin more effective, causing more fat to be stored in the fat cells. The average initial weight gain when diabetic medications are started is 8 to 20 pounds – due to partially counteracting the protective effects of “insulin resistance.” Thus the well-behaved patient takes the medications as directed, but then gains weight, and as a result of the added weight his diabetes becomes worse. The patient returns to the doctor, is given a firm scolding for gaining weight, and then more medications are prescribed because his sugars are even higher than before – this additional medication makes the patient even fatter and the diabetes more out of control. The vicious cycle continues – and the patient and doctor are left guilt-ridden and confused about their obvious medical failure. After all, they followed the pharmaceutical company’s instructions exactly. Worse yet, the patients are not one bit healthier from all this effort and expense.

More than 30 years ago, when I was in medical school, I remember doctors arguing about the benefits from aggressive use of medication to make the blood sugars lower, a practice referred to as “tight control.” Ideally, keeping the blood sugars close to normal makes sense, but in real life more harm than good is done for type-2 diabetics. First of all, no matter how hard the patient and the doctor work at their goal, the blood sugar readings are all over the place – one test shows 60 mg/dl and the next 260 mg/dl. Soon it becomes obvious to the patient that the short-term goal of “normalizing” the blood sugar levels is impossible using medications.

The next carrot held out is for long-term benefits: preventing complications later in life. In truth, studies have shown there is some benefit for the eyes and the kidneys with better control of blood sugar (especially for type-1 diabetics).¹⁵⁻¹⁷ However, the major threat to the life of a diabetic is from heart attacks and strokes – diseases of the large blood vessels. Intensive medical therapy using the most high-tech drugs to lower blood sugars has failed to reduce the risk for, and improve survival from, these two major killers. In fact, the medications used to combat sugar will actually create more sickness and death from heart disease.

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 medications: "SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY." The most commonly prescribed diabetic medications, known as sulfonylureas,* cause fundamental changes in the function of cells that increase the risk of heart attacks.¹⁸ These drugs, which are called "antidiabetic agents" by the pharmaceutical companies, have recently been shown to more than double the risk of heart attacks and almost triple the risk of early death in patients after an angioplasty.¹⁹ I never prescribe this type of diabetic pills, and always ask my patients to stop them. All diabetics should be actively looking for a better approach – and so should any doctor interested in his patients' welfare.

Diabetic Medications I Never Prescribe

The Sulfonylureas:

Glucovance
Metaglip
Amaryl
DiaBeta
Diabinese
Glucotrol

Diabetic Treatments Increase Heart Disease

Unfortunately for the patient, the doctors, and the drug companies "antidiabetic treatments" – pills and injectable insulin – are actually "anti-diabetic-patient" in the sense that they commonly hurt the customer. Consider the results of these major studies:

- The Diabetes Control and Complications Trial (DCCT) is the largest study done to show the effects of drug therapy on diabetics.²⁰ Six and a half years of treatment with intensive insulin therapy for type-1 diabetics resulted in more weight gain, as well as higher cholesterol, LDL (bad) cholesterol, triglycerides and blood pressure compared to people treated less aggressively. As expected from the rise in cholesterol, there was an increase in the risk of heart disease and stroke for the treated patients.
- The Veterans Affairs Cooperative Study in Glycemia Control and Complications in NIDDM study showed an increase in cardiovascular events in those receiving intensive therapy.²¹ In this research paper diabetic patients with a history of a heart attack were studied, and those treated with insulin or diabetic medications had an increased risk of death.
- In a large European study by The TRACE Study Group, investigators found diabetic patients with a history of heart attacks treated with diabetic pills and/or insulin had almost twice the death rate as those diabetics treated with diet alone.²² Diabetics treated without medications (diet only) had the same death rate as people without diabetes.

The Treatment of Type-2 Diabetes with a Low-Fat, Plant-Food Diet

Multiple studies dating as far back as the 1920s have shown the benefits of a high-carbohydrate, low-fat diet in the treatment of type-2 diabetes.²³ For example, studies from the University of Kentucky Medical School reported as many as two-thirds of diabetics were able to discontinue insulin and almost all stopped oral agents.²⁴ A recent thorough review of the use of a vegetarian diet in the treatment of type-2 diabetes was published in the September 2003 issue of the *American Journal of Clinical Nutrition*. In this review article Dr. David Jenkins reported on research showing improvements in blood sugars in diabetics with 39% stopping insulin and 71% stopping diabetic pills after three weeks of therapy.²⁵ Re-

lief of diabetic neuropathy pains, reduced lipids (cholesterol and triglycerides), and weight loss have also been reported with a low-fat, pure-vegetarian diet. Another recent research paper has reported similar findings with a low-fat vegetarian diet.²⁶ Many of these people with type-2 diabetes are cured of their disease within three weeks, and most will be cured of their diabetes over time as they adhere to a low-fat, high carbohydrate diet, exercise, and lose all of their excess body fat.

This same kind of diet (in large part because of the restriction of animal protein) has been shown to dramatically improve the health of the kidneys of diabetics (protein in the urine, a sign of diabetic kidney damage, decreases and disappears).^{27,28} Research has also shown diabetic damage found in the eyes (retinopathy) can be reversed with a low-fat diet.^{29,30} It's interesting how kidney and eye damage, the two purported benefits from drug therapy, are actually better treated with diet than with medications, at no cost and no side effects. A low-fat vegetarian diet has also been shown to reverse heart disease (atherosclerosis), the number one killer of diabetics.³¹ Many other researchers have praised a low-fat vegetarian diet as the best approach to prevent and treat most diseases that plague people in modern societies, including people with diabetes.³²⁻³⁵ Possibly the most important effect of this dietary approach (combined with exercise) is the scientifically established fact that this is the easiest and most effective way to lose weight permanently.³⁶⁻³⁹ Obesity is the underlying cause of diabetes.⁴⁰

Practical Steps to Cure Type-2 Diabetes

If you are one of the millions of diabetic patients facing a hopeless future of worsening diabetes, obesity, loss of vision, kidney failure, heart attacks, strokes, gangrene, and early death and disability – even though you have visited your doctors regularly, and taken your medications faithfully – then it is time to break this downhill spiral by changing your diet and exercise program. At the same time ask your doctor to provide you with sensible, conservative, care. I do the following with my patients:

1) **Stop diabetic pills and reduce or eliminate insulin.** In most cases, I have my patients stop all of their diabetic pills the day they start the McDougall diet and exercise program and/or at least half of their insulin. If this reduction is not made in a timely manner, then they run a real risk of developing hypoglycemia (too low blood sugar). I increase or reduce medications based on the patient's response and as a general guideline I try to keep their blood sugars between 150 to 250 mg/dl while I am trying to adjust their medication needs. Stopping and/or reducing the medications reverses the weight gain immediately. (Insulin cannot be stopped in type-1 diabetes, but the dosage is often reduced.)

2) **Change them to a low-fat, high-fiber, plant-based diet: the McDougall diet.** The diet should be based around starches with the addition of fruits and vegetables – there are no added vegetable oils. Sample foods are: oatmeal, whole wheat pancakes or potatoes for breakfast. Lunch can be soups, salads, and sandwiches. And dinner may be thought of in terms of ethnic dishes, like Mexican burritos, Chinese Mu Shu vegetables, Thai curried rice, or Italian whole grain pasta.

- 3) **Ask them to exercise.** Start at a comfortable level and gradually build up. Exercise should be increased to the equivalent of at least a half hour of walking a day.

- 4) **Check their other risk factors** for indications of serious disease, such as cholesterol, triglycerides, and blood pressure. Then make diet and lifestyle modifications to correct these (for example, fewer fruits and juices with high triglycerides and cholesterol, and less salt with high blood pressure).

- 5) **Have them take appropriate medications only.** For example, I prescribe:
 - Small doses of insulin for too much weight loss or if my patient develops symptoms of diabetes, like too frequent urination or excessive thirst.

 - Cholesterol (and triglyceride) lowering medications in order to reach ideal levels of 150 mg/dl, especially for patients at high risk for a stroke or heart attack. (See my September 2002 and June 2003 Newsletters.)

 - Blood pressure lowering medications, are sometimes indicated in high-risk patients whose blood pressure remains at 160/100 mm Hg or greater for months. (See my August 2002 Newsletter.)

A prescription of a low-fat diet and exercise can be taught by any interested physician or dietitian. Most diabetics respond within days – and with continued weight loss, most can be expected to stop all diabetic medications – and regain lost health and appearance. The most difficult task for people with diabetes is to break from tradition – the following words may help. “The diet recommended by the American Diabetic Association virtually guarantees all diabetics will remain diabetic,” claimed the pioneer nutritionist, Nathan Pritikin, 30 years ago. His experiences from treating thousands of people with this disease convinced him that type-2 diabetes is largely curable by following a healthy diet and moderate exercise. Obviously the failure of modern diabetic management has been known long before most diabetics developed their disease – yet nothing changes for the better. Your only chance is to rebel against commonly accepted advice. Don't you think a revolt is long overdue based on the poor results you have experienced so far?

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Widespread Infection with Leukemia Virus from Meat and Milk

One little Holstein dairy cow from a Yakima, Washington farm introduced mad cow into America's food supply and changed the world forever. Can you imagine the response when consumers discover 9 out of 10 of the herds in the US (89%) are infected with leukemia virus?¹ This means millions of cows presently have live, infectious, leukemia viruses – bovine leukemia virus – living inside them. These viruses are known to cause cancers of the immune system, called leukemias and lymphomas, in these cows. More startling will be the reaction when they learn that consuming tainted beef has already infected as many as 74% of people living in the US.¹

Hopefully, this will be a wake-up call that turns people from sausages to sweet potatoes and porterhouse to potatoes. A revolution is long overdue, especially since scientists have known about this health hazard for more than 35 years. Yet, you have heard little or nothing about leukemia viruses infecting your food supply because of the spin placed on this information by the cattle industry and the United States Department of Agriculture. They have taken the position: "until proven guilty beyond any doubt, eating live leukemia viruses is perfectly safe." Crude testing methods available during the past two decades have failed to find evidence of widespread infection in humans from this cancer-causing virus. Now however, that excuse for keeping the public in the dark is gone forever. Using state-of-the-art detection methods, in December of 2003 researchers from the University of California, Berkeley published their findings that three-fourths (74%) of people from their community – a study population of 257 humans – have been infected with bovine leukemia viruses. This conclusion was based on the discovery of antibodies against this infectious agent in the people's blood.¹ The investigators hedged on the relevance of their conclusions by taking the position that this common presence of antibody could have been from dead, thoroughly cooked, viruses, as well as live, highly infectious ones. Anyone who remembers eating burgers or steaks "pink on the inside" knows exposure to live viruses is universal. The virus resides in white blood cells (blood lymphocytes) where circulating antibodies are unable to neutralize it. Therefore, once an animal is infected with the virus, it is infected for life. (This is the case with humans, too.)

Disregard for the importance of this widespread problem is not universal. Many European countries have conducted programs to eliminate infected herds. For example, in 1996, after thirty years of effort, Finland completely eradicated the infection from its cattle.² Obviously, the Finns take eating live leukemia viruses seriously. However, in other countries, where the beef and dairy industries make up a large part of the economy, there has been no effort to clean up this cesspool of infection; for example 84% of herds in Argentina and 70% in Canada are found to harbor the bovine leukemia virus.³⁻⁵

The spread of infection in cattle arises from accepted practices in the cattle industry, such as feeding blood from slaughtered cows as a formula and feeding pooled colostrum (early milk) to calves – and the use of syringes, tattooing, and de-horning instruments on multiple animals without proper sterilization between uses.⁶ BLV is also passed directly from mother to calf through her milk. Most infected cattle do not live long enough to develop actual disease – they remain "healthy" and therefore, are not separated from the herd. Approximately 1% to 5% of infected cattle do develop leukemia or lymphoma – many of these obviously diseased animals still become part of our food supply. This virus is easily spread from cow's milk to other species of animals, and once infected they can become ill with leukemia. For example, in 1974 it was reported that when 6 infant chimpanzees were fed infected cow's milk 2 died of leukemia within a year.⁷

So what more evidence could there be that these well-known animal infections are a threat to you and your family (who, by the way, are also animals)?

In the laboratory this virus can infect the cells of many species of animals, including humans.⁸ The bovine leukemia virus has been classified in the same group as the Human T-cell Leukemia/Lymphotropic virus type 1 (HTLV-1), which is known to cause leukemia and lymphomas in humans (Adult T-cell leukemia/lymphoma).⁹ Nationwide and worldwide, leukemia is more common in higher dairy- and beef consuming populations.^{10,11} An increased incidence of leukemia has been found among dairy farmers in multiple studies.¹²⁻¹⁵ A recent study of Canadian workers found that those individuals working in occupations associated with cattle have approximately twice the risk of developing leukemia and lymphoma.¹⁶ In addition to infecting white blood cells, these viruses also attack other cells in the body, such as cells of the breast and the lymph nodes. Leukemia viruses infect the cells of a cow's mammary gland (udder).¹⁷ One recent worrisome study found the virus in the breast tissues of 10 of 23 human breast cancer patients.^{18,19} Beef and dairy product consumption in various populations has been found to correlate directly with an increasing incidence of another cancer of the immune system called lymphoma.²⁰⁻²⁴

Meat from a thousand beef cattle often makes up a single hamburger patty, because many body parts from many different cows are processed at a single meat packer. Most milk, cheese, and other dairy products are infected with these viruses, since the milk from many dairy farms is mixed in large vats at the dairy factory before processing and packaging. Pasteurization of milk kills many types of microorganisms, but it is not foolproof. There is also concern that pasteurization may break the viruses into fragments that may become even more dangerous.²⁵

If you live in the United States, Canada, Argentina or any other country whose government is indifferent to this problem, you can be pretty sure you will be consuming beef with live whole viruses, and dairy products containing whole viruses or fragments. Avoiding meat and dairy products is the most effective means to prevent future infection. You are maybe thinking that the smart move is to switch to chicken and other poultry. Unfortunately, they are also infected with cancer causing viruses.²⁶ Your only safe choice is a pure vegetarian diet.

Each year about 30,000 new cases of leukemia and 70,000 new cases of lymphoma occur for "unknown reasons" in the USA. I find it hard to believe that none of these are due to infection with bovine leukemia viruses. Viruses causing leukemia should not surprise people – after all, you take your cat to the veterinarian for feline leukemia virus vaccinations in order to prevent leukemia in your cat. As always, the burden of proof of safety of a product lies with those selling the food to you and your family. It has not been proved safe to eat leukemia viruses – and the evidence is even more damning now that we know these viruses infect the vast majority of people who eat meat and milk products.

Don't despair. If you live in a country where people follow the Western diet, your risk of developing leukemia or lymphoma each year is only one in 3000. Plus, these are primarily diseases of children and the elderly, suggesting the strength of our immune system largely determines whether or not we will develop this kind of cancer. Our diet is the major controllable asset we have for strengthening this defense system. Even if you are infected with bovine leukemia viruses already, a change to a plant food based diet, like the McDougall diet, will still reduce your risk of developing leukemia.²⁷ Preventing infections in the first place is the most sensible action parents can take with their children by never feeding these tainted foods – meats and dairy products – to their children. Clearly, there is sufficient evidence to take

action; furthermore, there are no negative nutritional consequences from removing these hazardous foods from your diet.

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Atkins Was Grossly Overweight and Sick But the Media Loves the Dead Guy

On Tuesday, February 10, 2004 the fall of the Atkins Empire began with the publication of a medical report on Atkins' body by the Office of Chief Medical Examiner, the City of New York. This report was obtained legally and without deception by Richard Flemming, MD, a cardiologist from Omaha, Nebraska. The report was then sent to Neal Barnard, MD, of the Physicians' Committee for Responsible Medicine. This organization gave the report to the *Wall Street Journal* and they made these findings public with an added note from the Journal that with a weight of 258 pounds and a height of 6 feet he would be properly classified as "obese." That week I appeared on several national TV and radio shows, and was quoted in newspapers worldwide, including the *New York Times* – taking the position that his medical report was fair game because he was an icon in the diet industry, and the lessons learned from his poor health would save lives.

[Atkins Medical Report](#) (attached to end of article)

Since I am a friend of Dr. Barnard and a diametrically opposed opponent of the Atkins philosophy, it was natural for me to take the position that these findings are important and should be public. They are important because the health and appearance of this diet guru reflect the merit of his advice. The man was grossly overweight for all of the 10 years that I knew him and I had met with him personally on several occasions. He looked very unhealthy to me every time we met – and his medical reports and the history that has been released by his organization confirm this. At the very least he suffered from severe heart damage known as cardiomyopathy. The Atkins organization says this was due to a virus – this is possible, but is an extremely rare cause for this condition. The most common reason for this severe loss of heart muscle is coronary artery disease due to a high-fat, high-cholesterol diet. In April of 2002 he suffered a cardiac arrest and almost died. Information from the Atkins web site tells us that he had coronary artery disease and suggests he recently had an angioplasty. His history also includes congestive heart failure and hypertension. The medical examiner's report says he had a heart attack also – but I have no other history to confirm this. He is reported to have died from head injuries from a fall on the ice.

The Atkins organization denies he was grossly overweight and claims he weighed between 180 and 195 pounds. They say his medical records indicate he weighed 195 pounds just before he entered the hospital at the time of his death. They claim the additional weight, totaling 258 pounds reported by the medical examiner, was from fluid accumulation during his 9 days of hospitalization prior to his death. That would mean 60 to 80 pounds of fluid, equal to 8 to 10 gallons of water, would have been added to his body. Any medical doctor who allowed this much fluid accumulation in a

patient in 9 days should have his medical practices reviewed.

Michael Fumento of Scripps Howard News Service obtained the records that reported on Atkins' weight of 195 pounds. He wrote, "The 'records' were merely part of a page from an echocardiogram report, not admittance documents as one might expect. Conspicuously, the blood pressure numbers were covered."... "The echocardiogram report did show Atkins' weight at 195, but the head of the echocardiography laboratory told me they don't even have a scale. 'Sometimes we get the weight from ER, and sometimes we don't and don't put anything down,' he said. 'Do you ever just estimate?' I asked. 'Yup,' he replied."

[See complete Fumento Article](#)

At the present time the media coverage of this story is largely in defense of Atkins. Some of the press has labeled the release of the report of his poor health as a "Vegan Agenda," and Mrs. Atkins, on *Dateline* (TV show), Friday, February 20, 2004, said those speaking against her husband are the "vegetarian Taliban" and "they're nasty." No harm is intended for the Atkins family, but all this controversy is an opportunity to save countless lives of people who fail to understand the truth about human nutrition, and especially those who have been misled by Dr. Atkins and his organization. If people keep talking about the science behind low and high carbohydrate diets, then the evidence will eventually come out. My hope is that the fight escalates. For those of you who think maligning a dead man is in bad taste – think again – Atkins' image is alive and well on TV, radio, newspapers, fast food restaurant menus, and supermarket shelves – making \$100 million a year for Atkins Nutritionals Inc., selling people worldwide a program that results in short term weight loss (at best), is nearly impossible to follow, and eventually causes extremely poor health – the diet's founder, Dr. Atkins, is one important piece of the proof. When the Atkins business stops promoting him, I will stop criticizing him.

12/29/03 MON 13:50 FAX

CONFIDENTIAL

OFFICE OF CHIEF MEDICAL EXAMINER
THE CITY OF NEW YORK



CHARLES S. HIRSCH, MD
CHIEF MEDICAL EXAMINER

520 FIRST AVENUE
NEW YORK, NY 10016-6402

REPORT OF EXTERNAL EXAMINATION

NAME OF DECEASED: ROBERT ATKINS SLE # M-03-2038

DEVELOPMENT NUTRITION / OVERALL APPEARANCE: _____

HEIGHT 6 FT 0 IN WEIGHT 258 LB SKIN COLOR W RACE W AGE 72

RIGOR MORTIS well developed LIVOR MORTIS (R) ports pop TEMPERATURE: cool to warm

OTHER POST MORTEM CHANGES: none

HAIR TEXTURE wavy OTHER INCLUDING INJURIES glued hair on (R) facial pores intact

COLOR white

LENGTH upto 3 IN

MUSTACHE/BEARD stubble IN

EYES IRIDES hazel

CONJ redness, petechiae, jaundice

ORAL CAVITY AND TEETH: partial dentures

TORSO ANTERIOR unremarkable

POSTERIOR _____

EXTREMITIES UPPER 3 ports

LOWER 3 ports - prominent edema esp. knees

GENITALIA unremarkable; prostate gland large testis not palpable

SCARS: see notes

TATTOOS: (R)

THERAPEUTIC PROCEDURES: SEE notes

EXAMINED BY: [Signature] DATE OF EXAM: 4, 17, 03 TIME 5:00 AM/PM

ME2002 (REV 6/97)

Feb 10 04 05:54p

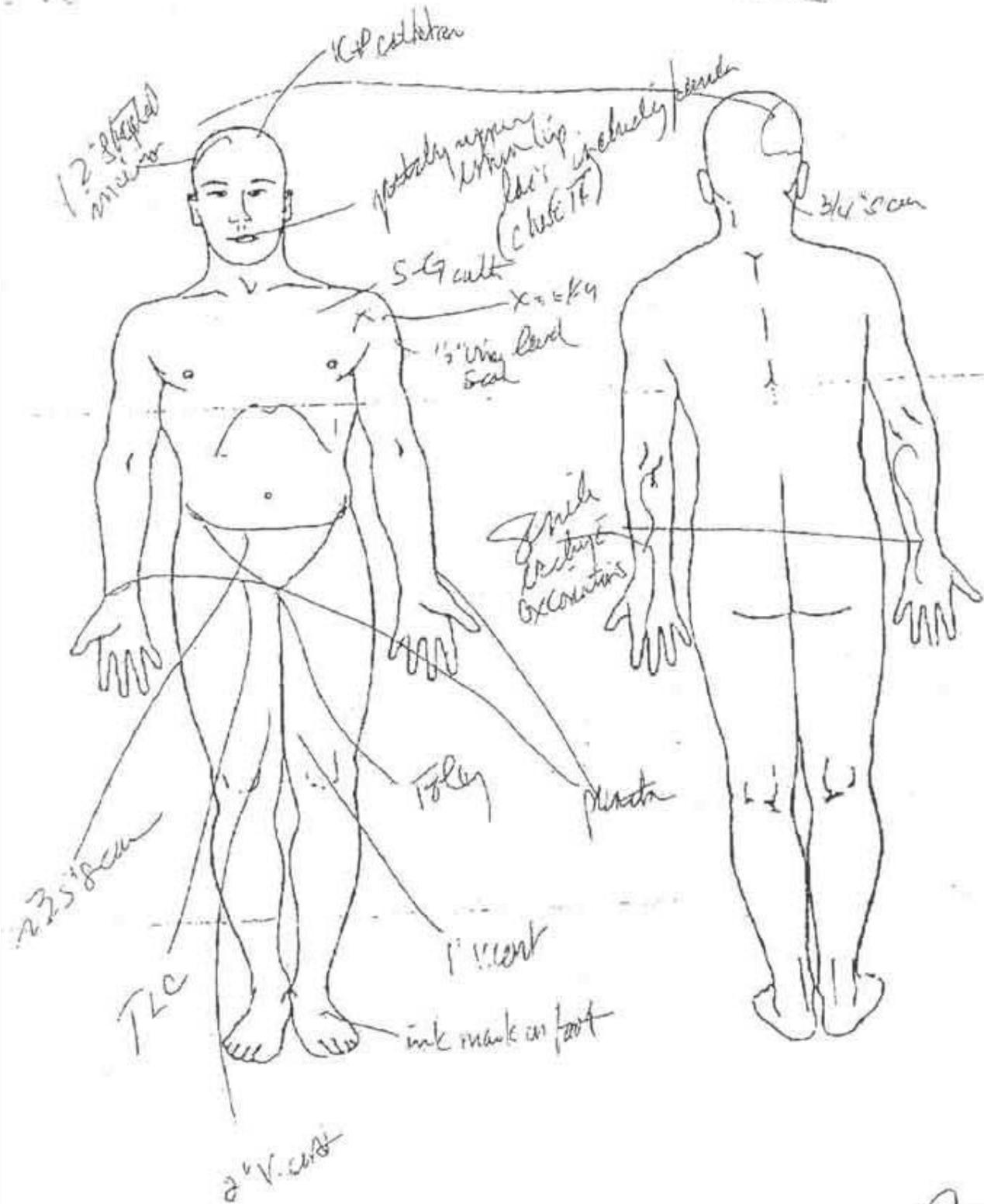
PCRM

202-686-2818

P. 2

2/29/03 MON 13:51 FAX

CONFIDENTIAL



Handwritten signature and date: 4/17/03

CONFIDENTIAL

CASE WORKSHEET		M.E. CASE # M03-2038			
NAME OF DECEDENT ROBERT ATKINS		AGE 72	RACE W	SEX M F	<input type="checkbox"/> ALTOPSY <input checked="" type="checkbox"/> NO ALTOPSY (Exam) <input type="checkbox"/> PURSUANT TO LAW
MEDICAL EXAMINER DR: THOMAS WILSON		DATE 4/17/03	TIME 5:00	<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	

PART 1: DEATH WAS CAUSED BY: Pending Further Studies

- a. Immediate cause
BLUNT IMPACT INJURY OF HEAD WITH EPIDURAL HEMATOMA
- b. Due to or as a consequence of
- c. Due to or as a consequence of

PART 2: Other significant conditions contributing to death but not resulting in the underlying cause given in part 1:

d.

MANNER OF DEATH:

- PENDING STUDIES
- NATURAL
- THERAPEUTIC COMPLICATION
- ACCIDENT
- SUICIDE
- HOMICIDE
- UNDETERMINED

PLACE OF DEATH: (Name of hospital, facility, or street address)

NEW YORK CORNELL HOSPITAL

TYPE OF PLACE:

- Hospital in-patient
- Hospital ED / outpatient
- Hosp DCA
- Nursing home / long term care
- Hospice facility
- Decedent's residence
- Other, specify: _____

DATE AND HOUR OF DEATH: 4/17/03 4:01

INJURY: Date 4/8/03 Time: UNKNOWN

AT WORK YES NO

TYPE OF PLACE: (Home, Street, etc.) STREET

LOCATION:

HOW INJURY OCCURRED: FELL FROM UPRIGHT POSITION

IF TRANSPORTATION INJURY: Driver/operator Pedestrian Passenger Other, specify:

IF FEMALE:

- Not pregnant within one year of death
- Pregnant at time of death
- Not pregnant at time of death, but pregnant within 42 days of death
- Not pregnant at time of death, but pregnant 43 days to 1 year before death
- Unknown if pregnant within one year of death

if within one year of death, outcome of pregnancy

- Live birth
- Spontaneous termination
- Induced termination
- None

Date of outcome mm / dd / yyyy

/ /

Did tobacco use contribute to death? Yes No Probably Unk.

For infant under 1 year, Name and address of hospital or other place of birth

M03-02038



WORKSHEET



Feb 10 04 05:54p

PCRM

202-686-2818

P. 7

CONFIDENTIAL

NAME OF DECEASED: ROBERT ATKINS M.E. CASE #: M03-2038
 MEDICAL EXAMINER: DR. THOMAS GILSON DATE OF DEATH: 4/18/03
 HOMICIDE PRISONER OTHER RUSH TODAY'S DATE: 4/18/03

COMPONENTS OF MEDICOLEGAL CASE RECORD NEEDED	FOR CERTIFICATION:	FOR FILE COMPLETION
TOXICOLOGY REPORT		
HISTOLOGY SLIDES		
NEUROPATHOLOGY REPORT		
REPORTS(S): <input type="checkbox"/> POLICE <input type="checkbox"/> FIRE MARSHAL <input type="checkbox"/> MLI		
CULTURES: <input type="checkbox"/> BLOOD <input type="checkbox"/> TB <input type="checkbox"/> OTHER:		
CONSULTANTS: <input type="checkbox"/> ANTHRO <input type="checkbox"/> RADIOLOGY <input type="checkbox"/> OTHER:		
HOSPITAL OR MEDICAL RECORDS		
SCENE INVESTIGATION FOR SUSPECTED S.I.D.S.		
OTHER:		

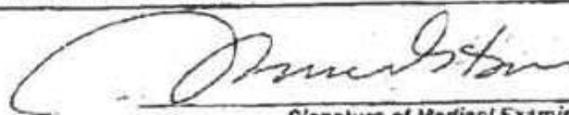
For Pediatric Cases: Is there suspicion of abuse at this time to report this case: YES NO
 If Yes, Call 1 (800) 635-1522

AUTOPSY INVENTORY

NEUROPATH: <input type="checkbox"/> YES <input type="checkbox"/> NO	X-RAYS: <input type="checkbox"/> YES <input type="checkbox"/> NO	PHOTOS: <input type="checkbox"/> YES <input type="checkbox"/> NO
HISTOLOGY: STOCKBOTTLE(S): 1 2 3 4 BOTTLE(S) REQUESTING SLIDES: <input type="checkbox"/> YES <input type="checkbox"/> NO 1 2 3		OTHER STUDIES:
MICROBIOLOGY: <input type="checkbox"/> YES <input type="checkbox"/> NO SPECIMEN SOURCE:		
EVIDENCE: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CLOTHING <input type="checkbox"/> BALLISTICS X _____ (#) <input type="checkbox"/> PERSONAL PROPERTY <input type="checkbox"/> OTHER:		
FORENSIC BIOLOGY: <input type="checkbox"/> BLOOD <input type="checkbox"/> HAIR: SCALP-PUBIC <input type="checkbox"/> RAPE-KIT <input type="checkbox"/> SWABS: ORAL-ANAL-VAGINAL <input type="checkbox"/> NAILS <input type="checkbox"/> OTHER:		
TOXICOLOGY: SOURCE:	BLOOD BILE URINE GASTRIC CONTENTS BRAIN LIVER	VITREOUS HUMOR SUBDURAL BLOOD OTHER:
INDICATED <input type="checkbox"/> YES <input type="checkbox"/> NO		
<p>If death may be a suicide or the result of a motor vehicle accident or a fire indicate below. If death may be due to chemical agents or if toxicology is needed to exclude other causes of death indicate below.</p>		
COMMENTS: <u>72yo. WMC w/ MI, CHF, HTN full on 4/18 - struck head & spinal hematoma</u> <u>1/22/04 10:20 - E H/O</u> DURATION OF MEDICAL THERAPY OR RESUSCITATION: _____		

M03-02038

C
 INVENTORY 


 Signature of Medical Examiner

My Favorite Five Articles Found in my Recent Medical Journals

One Virtual Colonoscopy Best at Age 55 to 60

Computed Tomographic virtual colonoscopy to screen for colorectal neoplasia in asymptomatic adults by Perry Pickhardt in the December 4, 2003 *New England Journal of Medicine* found a much safer and less expensive examination for precancerous colon polyps which works as well as, or better than, optical colonoscopy – a procedure where a 6-foot long, ½ inch diameter, flexible tube is snaked up and down your colon looking for polyps.¹ Polyps are precancerous lesions – if they are removed they will not progress to actual cancer which is incurable. Most gastroenterologists will give you the hard sell to have this procedure performed and one obvious reason is the approximately \$2000 charged for the performing the optical colonoscopy. Plus, this procedure requires intravenous administration of sedatives, a general anesthesia and/or recovery time – and has a real risk for bowel perforation, even in the best of hands (which all gastroenterologists claim they possess).

Virtual colonoscopy involves pre-procedure cleansing of the bowel with laxatives and an enema, patient-controlled inflation of air through the rectum to fill the bowel, followed by multiple CT scanning x-rays. The procedure does cause discomfort, but most preferred the virtual instead of the optical procedure. Time for the virtual (CT) procedure is about 14 minutes compared to 32 minutes for the optical colonoscopy. One disadvantage to the virtual colonoscopy is if a suspicious polyp is found then an optical colonoscopy must follow to remove the polyp.

The recommendation I gave for examination for prevention of bowel (colon) cancer in 1998 in [The McDougall Program for Women](#) book was: Since 90% of cancer occurs after the age of 55 years and the time required for transition from a normal colon to cancer is between 10 and 35 years, an effective way to screen would be to do one exam between the age of 55 and 60.² This would find most of the cancers already beginning as polyps. If no disease was present at this time, future examinations would be unlikely to benefit the person--since it takes so many years for a cancer to develop, and finally to kill. Colonoscopy examination with a long flexible tube is most often recommended for evaluation of the colon and rectum; however, my preferred alternative, because of much lower costs and fewer complications, is a double-contrast barium enema and a flexible sigmoidoscope.

Based on these recent findings of the effectiveness, safety, and patient acceptability of virtual colonoscopy, I recommend this procedure to be performed once around age 55 to 60 years – especially for people who have followed the Western diet which causes colon polyps and colon cancer. For more information see my December 2002 Newsletter article at www.drmcDougall.com. The real benefits for people who have followed a healthy diet for many years are unknown.

1) Pickhardt PJ. Computed tomographic virtual colonoscopy to screen for colorectal neoplasia in asymptomatic adults. *N Engl J Med*. 2003 Dec 4;349(23):2191-200.

2) Atkin W. Prevention of colorectal cancer by once-only sigmoidoscopy. *Lancet*. 1993 Mar 20;341(8847):736-40.

Treating Homocysteine with Vitamins Fails

Lowering homocysteine in patients with ischemic stroke to prevent recurrent stroke, myocardial infarction, and death: the Vitamin Intervention for Stroke Prevention (VISP) randomized controlled trial by James Toole in the February 4, 2002 issue of the *Journal of the American Medical Association* found no benefit from treating patients following a stroke with a high dose vitamin formula intended to reduce their homocysteine levels. The homocysteine levels in the blood decreased by 2 units (umol/L) from this treatment, but there was no difference in risk of future strokes, heart attacks, or death compared to a control group on a low dose vitamin preparation. (Normal homocysteine level is considered less than 10 units.) The experimental vitamin preparation used contained 25 mg of pyridoxine (B6), 0.4 mg of cobalamin (B12) and 2.5 mg of folic acid.

Multiple studies have shown a correlation between elevated levels of the amino acid homocysteine and various diseases common in people who follow the Western diet (stroke, heart attack, deep vein thrombosis, Alzheimer's disease, etc.). The "medical" way to solve this problem is to find a pill – in this case a multivitamin. Unfortunately, as in most cases where dietary problems are treated with drugs, the results are a failure. The reason is the high homocysteine is not the problem, but only a sign (also called a "maker" or risk factor) elevated by the real problem: an unhealthy diet. Other signs of an unhealthy diet that are treated with drugs include cholesterol, triglycerides, glucose, and blood pressure. The results from lowering these signs with drugs are also disappointing and far less than would be seen by correcting the cause. Therefore, if you wish to lower your homocysteine (as well as other risk factors) and improve your health (at no

cost and with no side effects), consume a diet based on starches with the addition of fruits and vegetables. (See my August 2003 Newsletter lead article, "Plants, not Pills, for Vitamins and Minerals" for more information on this subject.) Toole JF. Lowering homocysteine in patients with ischemic stroke to prevent recurrent stroke, myocardial infarction, and death: the Vitamin Intervention for Stroke Prevention (VISP) randomized controlled trial. *JAMA*. 2004 Feb 4;291(5):565-75.

Buckle Up Your Back Seat Passengers

Car occupant death according to the restraint use of other occupants: a matched cohort study by Peter Cummings in the January 21, 2004 issue of the *Journal of the American Medical Association* found your risk of death in a car accident is 21% higher if you fail to have the passenger behind you in the back seat buckle up. The risk of death is lowest when all occupants are restrained with seat belts. Their conclusion was obvious: Persons who wish to reduce their risk of death in a crash should wear a restraint and should ask others in the same car to use their restraints. Sounds like I should get my 120-pound Rottweiler dog his own safety belt.

Cummings P. Car occupant death according to the restraint use of other occupants: a matched cohort study. *JAMA*. 2004 Jan 21;291(3):343-9.

A Little Exercise Makes a Big Difference

Effects of the amount of exercise on body weight, body composition, and measures of central obesity: STRRIDE--a randomized controlled study by Cris A. Slentz in the January 12, 2004 issue of *The Archives of Internal Medicine* found that **even without changing their diet** most people can prevent weight gain with a small amount of daily walking. Those walking 30 minutes a day (12 miles a week) weighed 2.4 Kg (5.3 pounds) less than those people who did not exercise at all (the control group), after eight months. More intense exercise (17 miles a week) resulted in more weight loss compared to those who did no exercise – 4.6 Kg (10.1 pounds) more. The study results implied that as little as 15 minutes a day (6 miles a week) could prevent weight gain with no dieting at all. Everyone has 15 to 30 minutes a day, which can be dedicated to walking. Add to this activity a healthy diet – there is no extra time or effort required here – you have to eat regardless of anything else you choose to do – and you have a surefire way to a trim healthy body.

Slentz CA, Duscha BD, Johnson JL, Ketchum K, Aiken LB, Samsa GP, Houmard JA, Bales CW, Kraus WE. Effects of the amount of exercise on body weight, body composition, and measures of central obesity: STRRIDE--a randomized controlled study. *Arch Intern Med*. 2004 Jan 12; 164(1): 31-9.

Be careful About Experimental Trials

Comparison of outcomes in cancer patients treated within and outside clinical trials: conceptual framework and structured review by Jeffrey M Peppercorn in the January 24, 2004 issue of the *Lancet* found that volunteering for an experimental trial in cancer therapy has not been proven to be in your best interest.

Potential patients are encouraged to participate in "trials" by such false advertising statements as: "treatment in a clinical trial is often a cancer patient's best option," and "clinical trials are proven to offer children the best chance of survival." Unfortunately, these promises have not been shown to be true. You may want to become part of an experiment in order to benefit mankind, but it is wrong to falsely lead you to believe that it is in your best interest. So far cancer therapy for most tumors has been a failure. If you have cancer you need to place effort into making sure your doctors do you no further harm. You should research any proposed treatment at www.nlm.nih.gov. I always recommend a healthy diet as an important part of cancer treatment and prevention. Read more in "The McDougall Program for Women" book and in my August 2003 Newsletter article, "Lower Cholesterol for Improved Cancer Survival."

Jeffrey M Peppercorn, Jane C Weeks, E Francis Cook, Steven Joffe. Comparison of outcomes in cancer patients treated within and outside clinical trials: conceptual framework and structured review. *Lancet* 2004 Jan; 363:263-270.

February 2004 Recipes

JAMAICAN THREE POTATO CURRY

By Wendy McCrady

This recipe was sent to me by a former participant at the McDougall Live-In Program. It is wonderful for curry lovers (I am one of them) and potato lovers, too. It is very easy to make, but be careful of the turmeric because it is a very strong yellow dye and it will stain garments and porous surfaces.

Preparation Time: 15 minutes

Cooking Time: 30 minutes

Servings: 6

1 onion, chopped
2½ teaspoons turmeric
1¼ teaspoons ground cumin
½ teaspoon allspice
½ teaspoon ground ginger
5 cloves garlic, minced
1 large white potato, coarsely chopped
1 medium sweet potato, coarsely chopped
1 medium yam, coarsely chopped
1 bell pepper, chopped
1-2 cups water
1 tablespoon cornstarch mixed in ¼ cup cold water

Place onion in a large non-stick pan with about ¼ cup water. Cook and stir for about 3 minutes, until softened slightly. Add spices and continue to cook and stir for 5 minutes. Be careful not to burn the spices. Add a splash more water, if necessary. Add the garlic and cook another 1-2 minutes.

Add the potatoes and yams and stir to coat with spices. Add the bell pepper and just enough water to barely cover the vegetables. Bring to a boil, cover, reduce heat and simmer for 15 minutes.

Add the cornstarch mixture, stir and cook until thickened.
Serve over brown rice. Add some chopped cilantro for garnish, if desired.

Hints: Sweet potatoes are often confused with yams, and vice versa. True yams are entirely different from sweet potatoes, and are not often found in the US. In our supermarkets, usually the lighter skinned and pale-fleshed variety are labeled as sweet potatoes and the darker skinned and orange-fleshed variety are labeled as yams. They are interchangeable in most recipes. The orange-fleshed variety is usually moister.

PASTA SAUCE PUTTANESCA

By Roberta Joiner

Roberta is a past participant in the McDougall Live-in Program. She is an excellent gourmet cook and she volunteers her time teaching one of the cooking classes during the 10-day program. This is one of her many creations. It is a delicious and interesting way to improve a jar of store-bought Marinara sauce.

Preparation Time: 12 minutes

Cooking Time: 15 minutes

Servings: 4

1 onion, chopped
2-3 cloves garlic, minced
2 tablespoons red wine

1 tablespoon balsamic vinegar
1 26 ounce jar fat-free Marinara sauce
1-2 tablespoons Italian seasoning
1/3 cup capers
1/2 cup pitted kalamata olives
1 can hearts of palm, drained and chopped

Place the onion, garlic, red wine and vinegar in a large non-stick frying pan. Cook, stirring frequently, for 5 minutes. Add the Marinara sauce and Italian seasoning. Cook for an additional 5 minutes. Add the remaining ingredients, heat through and serve over pasta.

Variation: To make an Arabiata sauce, add 1/2 teaspoon chili pepper flakes when you add the Italian seasoning.

REUBEN SANDWICHES

This is one of those recipes that can easily be varied according to how many people you want to serve. I usually have most of these items in my pantry and refrigerator, so this is an easy, fast meal for those days when you don't have much time to think about your meals.

Preparation Time: 15 minutes

Cooking Time: 5 minutes

Servings: variable

sliced rye bread
fat free honey-mustard dressing
baked tofu or tempeh, thinly sliced
sauerkraut, drained
sliced tomatoes
sliced onions
soy cheese (optional)

Lay the bread slices out on your cupboard and spread both sides with a thin layer of the dressing. Place the tofu or tempeh on one side of the bread. Next add a thin layer of the sauerkraut, then the tomatoes and onions. Finish with a small amount of soy cheese, if you wish. Place another slice of the bread over these ingredients to make a sandwich. Repeat as many times as necessary to serve everyone.

Heat a non-stick griddle to medium-low. Place the sandwiches on the griddle, probably 2 at a time. Grill until browned on one side (about 1 minute) then flip over and grill on the other side. This usually takes only a very short time. Remove from griddle, slice in half and serve warm.

Hints: Baked tofu is sold in packages in most natural food stores, usually in various flavors. Look for the brands that are lowest in fat content. Tempeh is made from fermented soybeans, sometimes flavored, sometimes with other ingredients added. To marinate the tempeh before using, place about 1/3 cup of fat-free soy-ginger or teriyaki sauce in a bowl with the tempeh. Turn several times to coat. Drain, then briefly sauté in a non-stick frying pan. Slice either the baked tofu or the tempeh rather thinly crosswise, so you are working with larger thin sections rather than thin strips. Your natural food store should have both of these products available in the refrigerated section. Water-packed sauerkraut can also be found in the natural food store, usually by the canned vegetables or pickles.

SOUTHWEST COUSCOUS SALAD

This has become one of the favorite salads served at the McDougall Program. This is easy to vary each time you serve it by changing a few of the ingredients. Try using a fire-roasted salsa for a delicious smoky flavor.

Preparation Time: 15 minutes

Cooking Time: 2 minutes to boil water

Servings: 6-8

2 cups water

1 $\frac{3}{4}$ cups uncooked couscous

1 15 ounce can black beans, drained and rinsed

1 15 ounce can small red beans, drained and rinsed

2 cups frozen corn kernels, thawed

1 green bell pepper, chopped

1 yellow or orange bell pepper, chopped

1 tomato, chopped

$\frac{1}{2}$ cup chopped green onions

$\frac{1}{2}$ cup chopped cilantro (optional)

$\frac{3}{4}$ to 1 cup fresh salsa

Bring the water to a boil in a medium pan. Add the couscous, stir, turn off heat, cover and let rest for 10 minutes. Meanwhile, chop the vegetables and combine them in a large bowl. Add the beans and corn. Add the soaked couscous and salsa. Toss to mix. Serve warm or cold.

Hints: Use any combination of beans or use all one kind. Vary the kinds of bell peppers used. This is especially good in the late summer when fresh tomatoes and peppers are found in abundance. There are many excellent fresh salsas found in supermarkets and natural food stores. Start by using $\frac{3}{4}$ cup and add a bit more if necessary. The couscous will absorb some of the salsa as it stands.

CREAMY BEAN & VEGETABLE TOPPING

Preparation Time: 15 minutes

Cooking Time 30 minutes

Servings: 4-5

$\frac{1}{2}$ cup vegetable broth

1 onion, chopped

1 green bell pepper, chopped

$\frac{1}{2}$ pound sliced fresh mushrooms

$\frac{1}{2}$ cup unbleached white flour

3 cups unsweetened soy milk

1 15 ounce can garbanzo beans, drained and rinsed

1 15 ounce can water-packed artichoke hearts, drained and quartered

1 4 ounce jar chopped pimientos

1 tablespoon soy sauce

1 teaspoon Worcestershire sauce

$\frac{1}{8}$ to $\frac{1}{4}$ teaspoon white pepper

2 tablespoons cornstarch mixed in $\frac{1}{4}$ cup cold water

Place the vegetable broth, onion and bell pepper in a large pot. Cook, stirring occasionally, for 5 minutes. Add the mushrooms and continue to cook another 5 minutes. Stir in the flour, and cook for another 2 minutes while stirring. Add the soy milk, a small amount at a time, while stirring. Then add all the remaining ingredients except the cornstarch mixture. Bring to a slow boil, stirring frequently. (This should take about 10 minutes.) Stir in the cornstarch mixture and cook and stir until thickened, about 5 minutes. Serve over whole wheat toast or muffins, baked potatoes, brown rice or other whole grains.

Hints: There are several brands of water packed artichoke hearts on supermarket and natural food store shelves. Look for them on the top shelf of the canned vegetable section. Be sure not to get the marinated ones packed in oil. Look for vegetarian Worcestershire sauce in your natural food store.