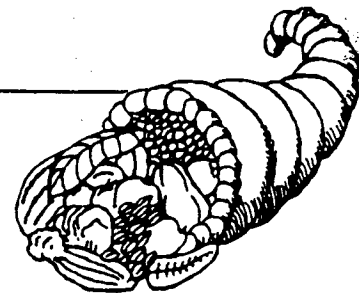


THE NEWSLETTER MCDOUGALL



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INFORMATION FOR YOUR HEALTH

TESTING FOR OSTEOPOROSIS:

Osteoporosis is a Disease: Osteoporosis is not a natural part of growing older. Women are supposed to maintain bone strength throughout life—bones are not supposed to dissolve away at age 55, but they so often do with 1 to 2 million osteoporosis related fractures occurring yearly in the United States at an annual health-care cost of 7 to 10 billion dollars. By time a bone is weak enough to easily fracture a person has lost 50% to 75% of her bone material. If a woman lives to be 90 she has a one in three chance of suffering a hip fracture.

Because the loss of bone is a *painless* progressive disease, tests that would identify people likely to suffer a future fracture would be helpful; especially if a treatment was available to prevent further bone loss. However, measuring bone mineral is not a simple procedure and is subject to many errors. Pressure to do these tests comes from worried patients and from those who would like to tap in on a very profitable market (including your local hospital.)

Tests for Bone Thickness

X-Rays—Plain X-rays will not detect bone loss until more than 30% of bone material is already missing. Furthermore, the appearance of bones on X-ray film depends upon the technique used in making the film. If the X-ray technician overexposes the film with too much X-ray, then the bones appear thin and a false diagnosis of osteoporosis can easily be made.

Multiple fractures seen in the ribs and vertebrae are an excellent clue to the diagnosis of osteoporosis. Unfortunately by the time this reliable sign is seen, bone loss is severe.

Single Photon Absorptiometry (SPA) — A beam of electromagnetic energy, called photons, can be focused through a bone and the photons transmitted are recorded by a camera placed directly opposite the beam source. Many factors are taken into consideration, but basically the density of the bone is calculated from the amount of photon energy absorbed by the bone. Thicker bones absorb more energy. Single-photon absorptiometry can produce accurate measurements only at sites that have very little soft tissue (fat and muscle); like the forearm and the heel. This technique is not valuable for assessing mineral content of the spine or hip—very likely areas to fracture. Costs \$35 to \$120. (Charges do not

include office visits to interpret and discuss test results.)

Double Photon Absorptiometry (DPA): By using a radioactive source that produces photons with two energies, a dual-photon absorptiometer adjusts for variable amounts of soft tissue in the scan path. Dual-photon absorptiometry measures the mineral in or near the spine. Cost \$50 to \$300.

CAT Scan Tomography: Technically advanced computed tomographic scans (CT) of the spine uses computers and X-rays to generate cross-sectional images of selected vertebrae. They are more accurate for certain bone assessments, but more expensive, involve more radiation, and are less reproducible than the above photon absorption techniques. Cost \$100 to \$350 per test.

Value of Screening:

The rationale for bone mineral screening is based on an assumption that it is possible to identify persons at risk for fracture. Recent investigations, however, using a variety of methods and areas for measurement (including the hip), show a weak correlation between hip fractures and bone mineralization. Studies using dual-photon absorptiometry have shown that the majority of women with hip fractures have a density of the hip that is within the normal range for age. Thus the groups that have hip fracture are indistinguishable from elderly women who do not.

Serious problems of accuracy exist—measurements made on one machine are not necessarily those found from another machine. The bone at one site (say the wrist) may not reflect the bone density at the site of potential fracture (the hip.)

One more valid criticism of screening is that in most cases these tests merely document what is known already; that women lose bone mineral rapidly after menopause, primarily in response to estrogen loss. Indeed, knowledge of age alone permits the bone density of the lumbar spine or femoral neck to be predicted with a standard deviation of only about 10 percent.

The general agreement in the current medical literature tells us screening in inexperienced hands is probably more harmful than helpful. It contributes little to the understanding of the disease or its treatment, does not tell us when treatment should be initiated, nor provide further information about the value of a particular therapy, such as estrogens, diet or exercise. (Hall F NJM 316:212, 1987.)

Let's hear what the experts say:

***We believe that large-scale bone mineral screening of perimenopausal and postmenopausal women is not justified at this time and that third-party reimbursement for this examination should be discouraged. We question the usefulness of a screening examination that is based on controversial data and unanswered questions and that identifies a disease with an extremely high eventual prevalence. This is particularly true when there is a known effective treatment that an increasing number of authorities believe may be indicated, regardless of bone mineral measurements. Screening for osteoporosis is an extremely useful research tool and obviously can be helpful in specific patients or clinical situations—Concluding remarks from Ferris M. Hall, M.D., "Bone Mass Screening for Osteoporosis" The New England Journal of Medicine, 316:212, 1987.

***It makes intuitive sense that someone with a low bone mass may be at a higher risk for fractures than someone with a high mass, but physicians should not start large, expensive screening programs until they are certain of the value of the tests...Unfortunately, such programs already exist, and advertisements suggest that most women between 45 and 70 years should be screened for osteoporosis.

After working with several of the new techniques of measuring bone mass, I believe that such advertisements are misleading. The new technology does show great promise. The problems with accuracy will probably be resolved soon, and newer techniques for improving reproducibility are already being developed. Thus, in a few years these methods will probably be useful in evaluating therapy in patients who already have osteoporosis. However, the value of these tests for predicting fractures is still in doubt, and longitudinal studies are needed. Methods of assessing the quality as well as the quantity of bone may be necessary. At this time, the use of these tests for screening perimenopausal women is premature, albeit profitable — Concluding remarks from Susan Ott, M.D.; "Should Women Get Screening Bone Mass Measurements?" *Annals of Internal Medicine* 104:874, 1986)

***Densitometry is a valuable research tool that should not yet be used routinely for general screening of the female population to assess the risk for future fractures. If prospective studies establish that densitometry is valuable in predicting hip and vertebral fractures, then screening may be valuable for the postmenopausal woman whose decision about taking estrogen therapy depends on an assessment of her risk for fracture.

Serial measurements are not sufficiently precise to be useful for measuring short-term rates of bone loss in untreated persons or in women taking common prophylactic therapies, such as estrogen and calcium. The ability of serial measurements to predict future rates of loss and fractures is uncertain. Serial measurements of vertebral density are appropriate for monitoring patients receiving expensive or potentially toxic treatments that are expected to produce large changes in vertebral bone density in many, but not all patients—Concluding remarks from the Health and Public Policy Committee, the American College of Physicians, *Annals of Internal Medicine* 107:932, 1987.

***After five years of deliberation, the Public Health Service's Office of Health Technology Assessment (OHTA) has recommended that the feds not reimburse

for bone scans performed with dual-photon absorptiometry (DPA). DPA is widely used to help evaluate osteoporosis because, unlike single-photon absorptiometry (SPA), it can measure axial bone in the hips and spine; nonetheless, it is not considered a cost-effective mass-screening tool.

If the Health Care Financing Administration (HCFA) accepts OHTA's recommendation, as it usually does, it is likely that private third-party insurers will follow suit. In 1985, the Blues recommended that its members not pay for DPA scans—From *Medical Times* 28:1, 1987.

McDougall's Conclusions:

There is little disagreement in the scientific medical community that tests for osteoporosis are not worthwhile, yet your community hospital and possibly your doctor may be encouraging you to have your bones periodically checked. Why? I would rather assume their intentions are honest, and they are simply ignorant of the true value and potential harm of these tests. I have seen many women destroyed by the results of an "osteoporosis test." From the time she receives the x-ray report she lives with the fear that her next step might well be her last. And the report is likely wrong or irrelevant.

Should every woman just take estrogens?

One implication made by doctors assessing the usefulness of bone screening is that all women should be on estrogens past menopause regardless of their bone density. I don't believe this and some of the reasons are discussed below in MEDICAL RESEARCH. I do, however, believe all women should be on a diet low in animal protein and they should all remain physically active—thus, dealing with the cause of osteoporosis.

MEDICAL RESEARCH

THE ADVERSE EFFECTS OF HORMONE THERAPY by Bush T. Columbia University School of Public Health, New York, New York. *Cardiol- Clin.* 1986 4: 145, 1986. Estrogen therapy must be cycled with progestin therapy in women with intact uteri in order to prevent uterine cancer. However, these women cannot be expected to benefit (with regard to cardiovascular disease) from any estrogen-induced changes in the lipoprotein profile, as progestins will either negate or overwhelm any estrogen effects. However, such women will definitely benefit from estrogen's effects with regard to menopausal symptoms and bone loss. These clearly beneficial effects of estrogen-progestin therapy are not outweighed by any known risks. However, in women without uteri (approximately 30 per cent of women), unopposed estrogen therapy in the menopause may protect against cardiovascular disease, as well as have beneficial effects on bone metabolism and menopausal symptoms. In this special case, the beneficial effects of unopposed estrogen therapy clearly outweigh any known risk. (Author-abstract.)

COMMENT: I was recently told by one of my colleagues, "Every good doctor in this country puts his female patients on estrogen hormones at the time of

menopause." Frankly, I don't believe that. Above is one paper that weighed the benefits and risks and came to a different conclusion; the risks outweigh the benefits for women still having their uteruses (70%); however, the author feels the benefits outweigh the risks for that 30% who have already had a hysterectomy (thus the risk of uterine cancer is removed.) But he hasn't considered the alternatives for many well-informed women who would rather deal with the causes of health problems.

Present day estrogen-progestin therapy re-establishes and continues menstrual periods in women past menopause. Apparently one goal of the medical profession is to wipe out menopause, and have every woman bleed monthly until she leaves this earth. Many women look forward to the freedom from menstrual periods, as well as looking forward to a healthy second half of their life. I know you can have both.

There are benefits to estrogen therapy in the postmenopausal years—less bone loss (hip fracture risk is cut in half), avoidance of hot flashes, increased feelings of well-being, prolonged sexual function, and a decrease in death from heart disease (this seems to be the newest selling point.) The drawbacks are an increase in the risk of uterine cancer, breast cancer, and gallbladder disease. Side effects include fluid retention, breast tenderness, nausea, skin pigmentation, headaches, mental depression, and changes in sexual drive.

When progesterones are added to reduce the risk of uterine cancer, then the blood cholesterol and triglycerides change unfavorably and increase the risk of heart disease.

Based on a prevalent style of practice, I think most doctors are losing sight of the problems and have come to some erroneous conclusions, such as:

- 1) Menopause is a healthy condition—a disease to be treated away.
- 2) Osteoporosis is due to "estrogen pill deficiency."
- 3) Heart disease is caused by "estrogen pill deficiency."

Osteoporosis is due primarily to excess protein intake in the diet, and heart disease is caused by animal fat and cholesterol. Estrogen pills are no substitute for a healthy diet and daily exercise. Your physician is out of focus in his professional duty when he or she fails to deal enthusiastically with the cause of your health problems and instead focuses on drug therapy, which always is a double edged sword of desirable and undesirable (side) effects.

My recommendations to prevent osteoporosis are:

- 1) Follow a starch-based diet (low protein, low fat, no cholesterol), and exercise.
- 2) Do not take estrogen and progestins after menopause, unless you have definite reasons, like intolerable hot flashes, or unquestionable severe bone loss.
- 3) If you choose to be sexually active—treat vaginal dryness with lubricants and if necessary use estrogen vaginal creams in small amounts—say once a week. These creams are absorbed—presumably the local effects will be much greater than the systemic effects.

4) Women uninterested or unaware of a healthy diet and lifestyle must weigh the benefits and risks of estrogen therapy. You will be the one with the uterine cancer or the broken hip. You become informed and decide where you want to take your risks.

PATIENT PROFILE

Dorothy Chedwick



A Born Again Dieter

For years people told me my migraines were probably due to my diet. So I tried—one week I'd eliminate chocolate, the next oranges. I never got better and now I know why. It takes a complete change in diet to search out the culprits.

I have only had a very few headaches over the past four months since I left the program. I was taking oxygen and Demerol for my headaches; I sent the tank back, and stopped the narcotics.

My story went out on the "Prayer Chain" from our church. Everyone has been asking me how I am and did the program work and where do I get my calcium and my protein. A lot of the questions I had before I went through the Program. Actually all the information is in the McDougall Books. But, most people need the program.

I'm not concerned about health really—I don't care about my cholesterol or worry about dying. The incentive for me is my looks and avoiding headaches. I thought before starting the diet I'd lose my busts, and maybe my health without my meat and cheese. Not so, but I did lose my hips and stomach.

I use to move my bowels only once a week; I no longer have constipation. I always thought I was constipated because I didn't have enough fat in my diet to lubricate things. My girl friend eats ice cream to have a bowel movement, I thought that was a result of the fat—now I know why (lactose intolerance.) There are so many things I once believed that have turned out to be just the opposite. No wonder I was sick.

It does make people unhappy when I'm not eating the way they do. I suppose they feel that my habits might rub off on them and they'll have to make some sacrifice. My son says we should be eating more like "the basic four food groups"—he gets that from school. But I do see even him changing. You know proper nutrition is like other values—the children don't get their morals from going to church one day a week; they have to get them from the home.

When I came to the Program I was sick with migraine headaches every week. I was incapacitated—no use to anyone and my family was worried about me. They're so happy now that I'm well.

RECIPES

WALDORF SALAD

Servings: 6
Preparation Time: 15 minutes
Cooking Time: 5 minutes
Chill: 2 hours

1 1/2 cups pineapple juice
2 tbsp. cornstarch
5 cups apples, diced with peels on
1 cup celery, diced
1/2 cup walnuts, roasted and chopped
1/2 cup raisins
1/2 tsp. lemon juice

Dissolve cornstarch in pineapple juice in saucepan. Bring mixture to a boil over medium-high heat and continue to boil for 1 minute or until clear, stirring occasionally. Chill dressing. Fold chilled dressing into salad ingredients.

DOUBLE RICE AND GREENS

Servings: 4
Preparation Time: 15 minutes
Cooking Time: 60 minutes

1 cup long grain brown rice
1/2 cup wild rice
3 cups water
1 lb. spinach, washed and chopped
1 bunch green onions, chopped
1/2 lb. mushrooms, sliced
1 1/2 cups fresh mung bean sprouts
2 tbsp. soy sauce

Bring the 3 cups water to a boil, add both kinds of rice, bring to boil again, cover, reduce heat and simmer for about 45 minutes. While rice is cooking, clean spinach and prepare remaining ingredients. Sauté the onions in a small amount of water for a few minutes. Add mushrooms and cook until both are tender. Stir in spinach and bean sprouts. Cover pan and cook over low heat just a short time (3-4 minutes). Stir in soy sauce and cooked rice. Mix well and serve at once.

HINT: For a little more zip, try adding a few dashes of Tabasco and a dash of crushed red pepper when you add the soy sauce.

LETTERS TO THE MCDUGALLS

*(Letter from a medical student after working in the McDougall Program) As I told you, my main intent was to see if the program worked. Although the group's cholesterol values did not improve much, I saw other evidence of healing. For example, lower blood pressure, less pain, and increased exercise tolerance. I am impressed with the body's ability to heal itself in such a short period of time, given the proper environment.

I already feel the frustration of working with another doctor now that I have this "new" knowledge and enthusiasm to apply it. The other day I went in to see a 47 year old obese gentleman who was not satisfied with his Tenormin prescription as it interfered with his sex life. As I spoke with the man he expressed an interest in lifestyle and diet change. Needless to say, I was gearing up for an interesting conversation with this guy. My dreams shattered as the attending physician came in and changed him to Captopril without advising him on lifestyle changes. I think my best bet is to keep my mouth shut, study hard, and do it my way when I have my own practice. S.S. Moraga, CA

* I am a nurse and my husband a physician, who practiced in the field of internal medicine for over 25 years.

I had developed migraine headaches in 1968 after the birth of my last child and the pain had become so intense that I was taking about 60-75 grains of ASA per day and knew I had reached maximum dose levels when my ears rang so loudly that I could not hear. I was in bed for 1-3 days about every month and the rest of the time coped with pain almost every day. In July, just after my 50th B.D. in May, I was in bed for 5 weeks and knew that I could live this way no longer. I went on the plan in Sept. of this year with a cholesterol level at 218(!) and after 10 weeks my cholesterol is now at 170 and my headaches are under control and I feel great! My husband says that I would have had all his patients on your diet and they would have been cured-except that most of them wanted a "magic pill" to get well and really exert no effort or give up present lifestyles! S.C. (RN) Loomis, CA (edited)

TAX-DEDUCTIBLE DONATIONS TO THE MCDUGALL PROGRAM

All donations are deductible for Federal and State income tax purposes. Contributions to either fund sent to The McDougall Program, c/o St. Helena Hospital, Deer Park, CA 94576. The McDougall Lifestyle Change Research Fund—2574.1040 will be money I personally manage for research and education. This fund has already accumulated nearly \$10,000 with a future promise of several hundred thousand dollars. The McDougall Program Fund—12574.1039 will be money managed by The McDougall Program administrative staff, and used for research and education.

MORE HELP

The McDougall Plan—\$8.95. McDougall's Medicine—A Challenging Second Opinion by New Century—\$8.95. Volume I & II of the Cookbooks—\$7.95 each. Add postage (\$2 first book-\$1 each additional)—send to POB 14039, Santa Rosa, CA 95402. The McDougall Program at St. Helena Hospital, Deer Park, CA. Two weeks of physician supervised live-in care designed to get people off medication, out of surgery and living again—call 1-800-358-9195 (outside California) or 1-800-862-7575 (California).

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