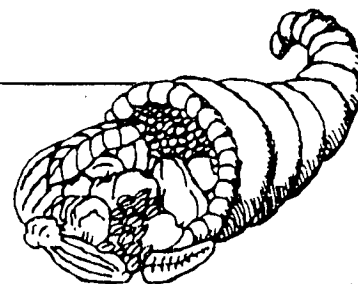


THE MCDUGALL NEWSLETTER



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INFORMATION WOMEN ARE SLOW LOSERS

More women are overweight than men and they expend more effort to lose weight. According to a 1990 Gallup survey nearly half of all adults, 51% of women and 43% of men, consider themselves overweight. The average American woman who considers herself overweight is 28 pounds heavier than her ideal weight. The average man is 24 pounds heavier. Older women report weighing more than young women.

The average American woman begins dieting at age 26, with one out of four saying they began dieting at age 17 or younger. Market research suggests dieting is a way of life: 60% of all women diet, 25% continually, and 35% sporadically, "as the need develops." Even with all this interest and effort, women still have a more difficult time losing their excess fat than men.

ARE WOMEN NATURALLY FATTER?

A century ago in America and Europe being overweight was a sign of prosperity, particularly for women. Many advantages have been attached to carrying this extra body fat. An overfat woman has been considered an asset to her family because during difficult times she could work long after food became scarce. Body fat accentuates attractive body curves, provides insulation from the cold, and padding to protect the bones from hard surfaces. Some people would say the natural design of women is to carry around a little extra body fat, when compared to men. However, most women find these explanations (excuses) unacceptable, much less uncomplimentary. There is, however, one sensible purpose: fat provides for the extra calories that may be needed for pregnancy and nursing.

Because of their fundamental biologic role of reproduction, women accumulate fat easily, and hold on to it tenaciously. For the preservation of our species, women must be able to have children even during adverse times when food is scarce. Stored body fat improves their chances, especially since famine has been a common event throughout human history. Unfortunately, for women living during times of plenty, this efficiency of fat accumulation makes too many overweight and chronic dieters.

METABOLIC EFFICIENCY FOR PREGNANCY

During pregnancy a woman's appetite increases so she will consume more calories, protein, vitamins and other nutrients required for the growth of the baby, placenta, uterus and breasts. An estimated 80,000 calories and 2 pounds of extra protein is needed. Progesterone, called "the pregnancy hormone" because of its important role during pregnancy, probably increases a woman's appetite. The average weight

gain during pregnancy of a woman on the standard American diet is 27.5 pounds. About 8 pounds of this gain is fat. Already overweight women gain more weight and more fat.

The extraordinary efficiency of a woman's metabolism is demonstrated during times of food scarcity. Women living in underdeveloped countries, such as the Philippines and Africa, where food supply is often sparse and food intake during pregnancy may actually decrease, bear normal healthy children without difficulty. (Tuazon M. Lancet 2:1129, 1987; Lawrence M. Lancet 2:363, 1984) An increase in efficiency of metabolism provides for the raw materials for her pregnancy. Part of this efficiency is seen as a decrease in basal metabolic rate in the first half of pregnancy and a slight decrease in physical activity to balance a pregnant woman's caloric needs.

One of the greatest challenges to normal human reproduction was seen in the Western Netherlands during the difficult times of World War II. Until November of 1943 the diet for these women contained 1800 calories and 60 grams of protein. By mid-November of 1944 a blockade had been set up by Germany that cut off supplies to the north and west of the Netherlands. This resulted in severe food shortages for all the inhabitants, including pregnant women. A period of 6 months followed where pregnant women consumed about 450 calories a day--one-fifth the recommended level of 2300 calories/day. The deprivation of food was so consequential that women who were not pregnant stopped their menstrual periods (a natural change that controls populations of mammals during times of famine).

If maternal malnutrition led to fetal malnutrition, the food deprivation experienced by these casualties of war should have easily been seen. However, there was no increase in infant mortality or malformations, and the birth weight of these babies was only 8 ounces less than in times of plentiful food supply. A comprehensive follow-up of these babies showed no evidence of mental retardation in the offspring when examined at the age of 19 years (Stein Z. Science 178:708, 1972).

WOMEN CARRY EXTRA WEIGHT EFFICIENTLY

Another important part of a woman's efficiency is her ability to carry extra weight without increasing energy expenditure. (Jones C. Lancet 2:1331, 1987). Eight women were tested while walking on a motorized treadmill contained within a whole-body calorimeter (an apparatus for measuring energy expenditure). They carried loads of up to 45% of their body weight, as much as 66 pounds, on their heads for 15 minutes at a time. These women were able to carry 40% of their "fat-free mass" (weight of muscles, bones, organs and other parts, excluding fat), either as body fat or external load, or a combination of the two before they increased their energy expenditure. Because they had less fat to carry, thin women were found to be able to carry more external weight without increasing their energy expenditure than fat women. Thus, a woman weighing 100 pounds could carry an extra 20 pounds (20% of her weight) without increasing her energy consumption above that when walking without a load.

This conservation of energy during physical activity added to her metabolic efficiency explains why a woman effortlessly carries around extra fat and has a very difficult time losing that last 20 to 50 pounds--amounts consistent with pregnancy.

WOMEN'S SPECIALIZED FAT STORAGE

Fat deposits serve as an important natural storage for women to ensure that adequate calories are available for pregnancy and lactation. Because of this role, sites of fat distribution and the impact of excess fat on health are very different between men and women. Women maintain a relative preponderance of the gluteal (buttocks) and femoral (upper leg) deposits, while in men the abdominal deposits are the largest. The term "android" obesity is used to refer to upper body and abdominal type of apple-shaped obesity common to men, and "gynoid" refers to the lower body, pear-shaped, fat distribution of women. Another distinction is men deposit fat inside their abdominal cavity and women deposit fat below their skin, subcutaneously. Women also have larger fat cells than men.

Reproductive hormones produce the difference in fat distribution. The lower body fat is a consequence of the female sex hormones; estrogen and progesterone. Abdominal fat is from the effects of male hormone testosterone. In postmenopausal women, as estrogen levels diminish, fat stores begin to look and respond more like men's stores. When men take estrogens as part of the treatment for prostate cancer they feminize their fat deposits.

Because excess fat deposits in women play a natural role in reproduction they are more likely to occur with healthier eating practices. Excess fat accumulation in men does not occur for such innate reasons, and therefore, it is more likely a consequence of unhealthy eating habits (a high fat diet) and a lack of physical activity. As a result, obesity in men is associated with a greater likelihood of health problems. Compared to women of the same degree of relative body weight, men have higher systolic and diastolic blood pressures, cholesterol, triglyceride, glucose, and insulin levels. Women who show an abdominal fat distribution have the same increased health risks as men.

The sexual differences in fat distribution are already seen in the first years of life and possibly prenatally (Karlberg P. Acta Paediatr Scand. Suppl 187:48, 1968). Even grossly obese adults maintain the same sex difference. Dieting will reduce regional fat as a part of overall weight loss, but dieting will not change your basic shape--say from an apple to a pear. Abdominal fat mobilizes more easily than fat around the hips and thighs, which is another way of saying "women lose excess fat more slowly than men."

MORE REASONS FOR SLOW LOSS

In addition to a woman's efficient metabolism in her reproductive role, there are other reasons for slower weight loss compared to men. In general, women have a lower lean body mass than men, which is reflected in a lower resting metabolic rate (RMR) than men. Therefore, women burn fewer calories to maintain basic life functions. The RMR can be as low as 1,000 Calories for small women and 1,600 Calories for larger ones. The range in men is 1,350 to 2,140 for men.

Women lose slower by expending less energy with physical activities. Generally, they are lighter than men; therefore

they require fewer calories to carry around their smaller bodies during daily activities. In our society sports are encouraged more for men than women. Because of this, women are less physically active than men and expend less energy.

ADVANTAGES FOR WOMEN

You may be envious of the easy weight loss attained by men, but you have advantages that can give you better control of your weight in the long run. Women are generally more concerned about their looks than men and are used to putting effort into their appearance. More time and effort is spent at hair salons, fixing nails and make up, and at wardrobe selection by women. Surveys show women more often consider themselves overweight and spend more time dieting than men. Combined with the right information, this heightened interest in yourself can easily be channeled into choosing proper foods and taking the time to exercise--two essential steps to overcoming the metabolic advantages that lead to your fat gain.

Women, realizing their future responsibilities, take better care of themselves in anticipation for the time they will start their family. Once pregnant, most women will make overdue health improvements, like quitting alcohol, coffee, and smoking. Extraordinary attention is given to diet during pregnancy. This experience gives them an opportunity to experience what it feels like to live healthier. Ideally, this improved health will carry over into the post pregnancy years.

OVERCOMING EFFICIENCY

Now that you are aware of the superb efficiency of your female body and the important reasons for such a design, you can take steps necessary to lose undesired fat. Essentially, this means taking extra effort by being very strict on your diet, and putting a little more effort into your exercise program. More specific recommendations for faster and greater weight loss, such as limiting flour products (breads, bagels, and pastas), eating more frequent meals, restricting variety, and increasing green and yellow vegetables, are found in the MAY/JUN 1991 Newsletter. No dieting--you are still expected to eat to the full satisfaction of your hunger drive while following these modifications to a starch-based diet.

RESEARCH

Caffeinated and decaffeinated coffee effects on plasma lipoprotein cholesterol, apolipoprotein, and lipase activity: a controlled, randomized trial by H. Robert Superko in the 1991 American Journal of Clinical Nutrition (54:599), found decaffeinated coffee increased cholesterol more than regular coffee. One-hundred eighty-one men consumed a standard caffeinated coffee for 2 months, then they were divided into three groups: one continued caffeinated coffee, the second switched to decaffeinated, and the third quit all coffee for 2 months. All subjects made their coffee identically by a drip brewing technique with paper filter. Cholesterol, triglycerides, "bad" LDL cholesterol and other heart disease-related factors increased in the group switched to decaffeinated.

	Caffeine	Decaff	Quit
Total Chol.	211.9	215.8	211.1

LDL Chol.	140.6	145.0	142.0
Triglycerides	98.3	106.2	95.7

COMMENT: Americans consume approximately 139 billion cups of coffee annually, and 20% is decaffeinated. Most people are switching to "decaff" because they believe it is better for their health. Based on this study it is not the caffeine that raises cholesterol and triglycerides. Even greater differences may have been seen if the coffee were boiled rather than filtered since the paper filter removes much of the factor that raises cholesterol (see NOV/DEC 1990 McDougall Newsletter).

Coffee has many more pharmacologically active ingredients than caffeine. Another example of the negative effects shared by both kinds of coffee is the acid production in the stomach. It is essentially the same with decaffeinated as regular (N Engl J Med 293:897, 1975). "Decaff" will only relieve the symptoms from the caffeine, like nervousness. The reason to drink coffee for many people is the pleasant stimulation they get from the caffeine. Taking away this drug effect and leaving them with similar health hazards may lead some people to decide to stick with the "high octane" variety. However, the best choice would be to quit both. If you stop caffeine be prepared for withdrawal symptoms, like headaches and depression.

Efficacy of antibiotic prophylaxis for prevention of native-valve endocarditis by Jan Van Der Meer in the January 1992 Lancet (339:135), suggested that the "time-honored" practice of treating people with diseased heart valves with antibiotics before dental procedures and surgery might be of little value. This nationwide case controlled study in the Netherlands found 9 out of 10 people developing infection of their heart valves (endocarditis) had not had a previous dental or surgical procedure. Of the 25 infected patients who had invasive procedures within a month of their infection, 5 had received antibiotics. The authors point out the risk of infection from surgery and dental work is very small and that complete compliance with antibiotic treatment might prevent 5 cases per year in the Netherlands.

COMMENT: I am often asked to prescribe an antibiotic, such as penicillin, for a patient with heart valve disease (even for a condition as minor as mitral valve prolapse). I usually comply because this is the "standard practice of medicine." However, I have realized for years this procedure has never been scientifically substantiated and remains a hotly debated topic in medicine. Prescribing antibiotics costs the patient money and puts the patient at risk for side effects. A false sense of security is also provided, since infection still does occur even with treatment. Unfortunately, a doctor will be much more likely to be faulted (and successfully sued) by a patient who develops an infection when antibiotics were withheld, than by a patient who suffered a harmful reaction from the antibiotics.

Methotrexate and histologic hepatic abnormalities: a meta-analysis by Q. Whiting-O'Keefe in the June 1991 American Journal of Medicine (90:711), found 28% of patients receiving weekly injections of methotrexate had liver disease as seen on biopsy. Advanced liver disease was seen in 5% of patients on this drug. Patients with psoriatic disease were more likely to have liver damage than those with rheumatoid disease. Heavy users of alcohol also suffered more damage. The more methotrexate consumed the worse

the injury to the liver.

COMMENT: Rheumatologist's efforts to relieve arthritis patients are almost boundless. They freely offer highly toxic drugs for temporary relief of pain even though the ultimate benefits on disease progression and survival are highly questionable. Often the drug therapies damage the patient's body and contribute to an earlier death. However, most doctors refrain from asking the ultimate sacrifice from their patients: to change their diets.

Scientific evidence solidly incriminates the standard American diet as the cause of inflammatory arthritides, like psoriatic and rheumatoid disease (See McDougall's Medicine--A Challenging Second Opinion). More importantly for people already suffering from these illnesses is the evidence that says remarkable improvement and sometimes cure are in the future of those who change (strictly) to a starch-based diet (see NOV/DEC 1991 newsletter and The McDougall Program--12 Days to Dynamic Health). If a doctor's first line of attack for these serious diseases was dietary change, many would have no need for toxic drug therapies, such as methotrexate.

RECIPES

VEGETABLES PROVENCAL

SERVINGS: 6

PREPARATION TIME: 25 MINUTES

COOKING TIME: 15 MINUTES

1 garlic clove, minced
 1 tablespoon tomato paste
 2 small zucchini
 1/2 pound eggplant
 1/2 pound ripe tomatoes
 1 medium bell pepper
 1 small red onion
 1/4 pound mushrooms
 fresh ground pepper
 1/4 cup chopped fresh parsley
 1/4 cup chopped fresh basil
 1 teaspoon minced fresh thyme
 1/2 teaspoon minced fresh rosemary
 balsamic vinegar (optional)

Wash and trim all vegetables and cut into 1/2 inch cubes. Place about 1/3 cup of water into a large heavy pot. Add garlic and tomato paste. Heat and stir until well mixed. Add all the vegetables, cover and cook over low heat, until vegetables are tender, but not mushy, about 15 minutes. Season with plenty of fresh ground pepper. Combine parsley, basil, thyme and rosemary. Stir into the vegetables. Serve warm or cold, splashing on some balsamic vinegar just before serving, if desired.

SQUASH AND TOMATO STEW

SERVINGS: 8

PREPARATION TIME: 25 MINUTES

COOKING TIME: 45 MINUTES

1 tablespoon soy sauce
 1/2 cup water
 2 large round onions, finely chopped (too small?)
 2 cloves garlic, minced

- 1 pound tomatoes, peeled, seeded and chopped
- 1 tablespoon chopped fresh oregano
- 1/4 teaspoon freshly ground pepper
- 1/2 cup water
- 4 pounds butternut squash, peeled, seeded and cut into 1 inch cubes
- 2 cups frozen corn kernels
- 1 cup frozen peas
- fresh chopped parsley

Place water and soy sauce in a large soup pot. Heat to boiling. Add onion and garlic, cook and stir until onions soften slightly. Add tomatoes, oregano and pepper. Cook until tomatoes are tender, stirring occasionally, about 3 minutes. Add the water and squash. Cover and simmer until squash is tender, about 30 minutes. Add corn and peas. Cook another 2 minutes. Garnish with parsley before serving.

GRATED POTATO BAKE

Submitted by Andrea Lemieux

SERVINGS: 4
 PREPARATION TIME: 20 MINUTES
 COOKING TIME: 45-50 MINUTES

- 4 medium potatoes (baking, new, or yellow fins), very coarsely grated
- 2 carrots, very coarsely grated
- 1 stalk celery, diced
- 1 medium onion, chopped
- 2 garlic cloves, finely chopped
- 1 tablespoon fresh parsley or dill, finely chopped

Pre-heat oven to 350 degrees. Mix all ingredients well in a large bowl. Put a little water in the bottom of a casserole dish and spoon in vegetables. Bake, covered, 45-50 minutes.

HINT: For a lovely breakfast meal, make with potatoes and onion only.

POTATO LEEK SOUP

(see Vic. Cl. - p. 15)

SERVINGS: 4-6
 PREPARATION TIME: 20 MINUTES
 COOKING TIME 30-40 MINUTES

- 4 cups peeled and chunked white potatoes
- 4 cups water
- 2 leeks, white part only, washed well and sliced
- 1/2 teaspoon onion powder
- 1/4 teaspoon garlic powder
- 1/8 teaspoon ground white pepper

Optional:
 1/4 teaspoon dill weed
 1/2 cup chopped scallions

Place the potatoes, water and leeks in a medium sized soup pot. Bring to a boil, reduce heat, cover and cook until potatoes are tender, about 30 minutes. Transfer to a blender jar and process until smooth and creamy, or transfer half of the soup to a blender jar, blend until smooth and creamy. Return to pan and stir to mix. This results in a creamy based soup with chunks of vegetables.

Add the remaining ingredients. Heat through. Serve.

If using optional ingredients, add them at the end. Cook over very low heat for 10 minutes. Serve hot.

SPINACH MUSHROOM SOUP

SERVINGS: 4-6
 PREPARATION TIME: 15 MINUTES
 COOKING TIME: 20 MINUTES

- 1 large round onion, thinly sliced
- 1 1/2 pounds mushrooms, thinly sliced
- 1/4 cup white wine
- 1 quart water or vegetable broth
- 1 package (3.5 oz.) enoki mushrooms
- 2 tablespoons soy sauce
- fresh ground pepper to taste
- 4 cups packed spinach leaves, cut into thin strips

Place onions and mushrooms in a large saucepan with the wine. Cook slowly over low heat about 10 minutes. Add the water or vegetable broth, the enoki mushrooms and the soy sauce. Cook an additional 10 minutes. Stir in the spinach and season with the pepper. Turn off heat. Serve as soon as the spinach is wilted.

HELP

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The McDougall Lifestyle Change Research Fund--2574.1040 will be money I personally manage for research and education. The McDougall Program Fund--2574.1039 will be money managed by The McDougall Program administrative staff, and used for research and education. Send to The McDougall Program, c/o St. Helena Hospital, Deer Park, CA 94576. ALL TAX DEDUCTIBLE.

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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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