



The McDougall Newsletter

THE NEWSLETTER WITH JOHN & MARY McDOUGALL

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MAMMOGRAPHY: A BENEFIT OR A BURDEN?

A Desperate Effort to Save Lives

There is no evidence that a doctor's physical examination of your breasts, your own breast self-examination, or breast ultrasound will reduce your chance of dying of breast cancer (BMJ 309:1076, 1994). Your only hope for early detection, with the possibility of saving your life, is mammography. Even though there is some evidence that mammography may add a few years on the life of selected women, its potential benefits have been greatly oversold. Many people have been misled to the point where they consider mammography to be breast cancer prevention. In truth, widespread use of mammography will unquestionably increase the number of women with a diagnosis of breast cancer for the obvious reason that more cancers will be found. Instead of an increase in survival for many women, all early detection will mean is an increase in life with the knowledge of disease.

Mammograms were first performed in 1913 by Salomon, a surgeon who used x-rays to image his mastectomy specimens. The technique was first performed on patients in 1930, but did not gain widespread acceptance until 1947. This screening test came into general use in the early 1960s, with rapidly increasing use in the 1980s. Medicare pays for, and most states mandate some form of insurance coverage for mammography.

According to a recent Lancet article "If one were to believe all the media hype, the triumphalism of the profession in published research, and the almost weekly breakthroughs trumpeted by the cancer charities, one might be surprised that women are dying at all from this cancer"

(Lancet 341:343, 1993). Even though we have been promised less death from breast cancer with early detection efforts, the incidence of breast cancer rose 33% between 1973 and 1988 with no change in mortality (deaths per 100,000 population) from the disease (Cancer 72:788, 1993).

The Mammography Business

Breast cancer is the second most common cause of death from cancer in women (lung cancer recently took the lead), and the most common cause of cancer death

in women 40 to 50 years of age. In 1993, it was predicted that 182,000 new cases of breast cancer would occur in the United States, with 46,000 deaths. Mammography is big business, involving widespread media exposure, including posters, brochures, newspapers, magazines, radio and television advertisements in English and Spanish urging women to have a mammogram "once a year for the rest of your life." With installation of updated mammography equipment at my hospital, "educational" material was sent to all the medical doctors

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on staff, informing them of the importance of this test for their patients.

As of 1992, 74% of U.S. women have had at least one mammogram, and 41% follow the American Cancer Societies guidelines. The cost of mammography varies widely from \$25 to \$200. If the average cost of a mammogram is \$100 and the guidelines from major organizations are followed, the annual cost of mammography would be 5 billion dollars. Add to this the cost of repeat mammograms and biopsies, then the cost rises to 15 billion dollars annually.

In another way, breast cancer detection (or lack of) can be costly to doctors.

Failure to diagnose breast cancer is the leading cause of litigation in the United States today, particularly for primary care doctors.

Overall Study Results:

The test should be negative in 80-90% of women on their first exam and 95% on subsequent exams. Of every 1000 women screened by mammograms five to seven will be found to have cancer on their first exam. Subsequent exams find 0.8 to 3.5 cancers per 1000 women.

The randomized trials for mammography have included nearly half a million women. Only two of the seven studies show a significant reduction in death in those women who are screened. The other five show no significant survival benefit, and their results are largely ignored by those recommending mammography. Furthermore, the benefit is a reduction in mortality. This is not necessarily a certainty of cure or a promise of a normal life for women who have mammograms, but merely a prolongation of years for a few.

Even if survival benefits are not clear, there are two other real advantages for detecting a smaller tumor: a more cosmetically acceptable surgery and an earlier motivation to change your diet. Small tumors are more easily removed without deforming the breast. For most women lumpectomy is the only scientifically supported initial treatment (read McDougall's Medicine—A Challenging Second Opinion). Even after a cancer is diagnosed, scientific evidence supports my belief that a change in diet will cause women to live healthier and longer.

Harmful for Younger Women

Women younger than 50 will have 2.5 times as many biopsies and three times as many procedures for every cancer diagnosed compared to women over 50 years. Yet fewer than 20% of all cancers occur in this younger group. An international workshop on mammograms in February of 1993 found that for every 1000 women under 50 having mammograms, 700 would require further testing, to detect fewer than 15 tumors and 7 cancers would be missed (JNCI 85:1644, 1993). Nine in 10 biopsies in women under 50 find no cancer (JAMA 259:1512, 1988). Breast cancers found in younger women seem to be of low killing potential (frequently carcinoma in situ, which is a type of cancer where

the cells look like cancer, but they have not yet started to spread; therefore do not threaten a woman's life)—fewer than half would develop into invasive, potentially lethal, cancer (compared to 95% of those found in women over 50 years). One reason screening may give such poor results in young women compared to women over 50 is the greater density of breast tissue in younger women, making cancers harder to distinguish from normal tissues. (The breasts are denser because of the stimulation by reproductive hormones in premenopausal women).

The recently reported Canadian trial

breasts are more sensitive to radiation than older women. In women 40 to 50 years old, radiation from 10 mammograms would be expected to cause 60 new cancers in one million women in their lifetimes.

A recent editorial in the Journal of the American Medical Association has reversed their long held position on mammography in younger women by stating "Wishful thinking cannot alter the fact that mammographic screening in women under the age of 50 does not reduce deaths, while those over the age of 50 years it saves lives. The reason for these results are unknown and need to be resolved..." (JAMA 271:152, 1994)

MAMMOGRAM STUDY RESULTS

Study	Location	Year Began	Significant Benefits
Shapiro	United States	1963	Yes - 29% Reduction
Andersson	Malmö, Sweden	1976	No
Tabar	Sweden	1977	Yes-30% Reduction
UK Trial	United Kingdom	1979	No
Roberts	Edinburgh	1979	No
Rutqvist	Stockholm	1981	No
Miller	Canada	1980	No

showed a 36% increase in the risk of dying from breast cancer for women under 50 who underwent mammography compared to those who did not get the test (Can Med Assoc J 147:1437, 1992); The studies done under the direction of Shapiro, Tabar, and Andersson also showed an increase in death for those who had the mammograms (Lancet 337:1576, 1991).

Why did the risk of dying increase for women who had mammography? According to an editorial in the Lancet; "One explanation may be the type of treatment offered to women with mammographically detected breast cancers—usually a combination of surgery and radiotherapy." (Lancet 337:1576, 1991). Treatment kills—and if there is little or no survival benefit to offset these deaths then the overall risk of dying is increased.

This study didn't even measure the few future breast cancers that might be caused by the added radiation. Younger women's

No Benefit for the Elderly
Despite the increasing risk of dying from breast cancer as women age there is no evidence that mammography improves the lives of elderly women. Specifically, no data supports mammography in women older than 69 years. This is reflected in various health policies. The report of the US Preventive Services Task Force states, "Mammography every one or two years is recommended for all women beginning at the age of 50 and concluding at approximately the age of 75 unless pathology is detected." In 1987, the United Kingdom recommended a policy of single-view mammography performed every three years in all women between 50 to 64 years of age. In 1988, Canada recommend that mammography be performed every two years in women between the age of 50 to 69. Similar policies are in Sweden, Finland, the Netherlands, and Australia (N Engl J Med 32:325, 1992).

The Appearance of Benefit

Women who have their tumors found by early detection methods such as mammography appear to live longer for several reasons, but the most important reason is "lead time bias." If a tumor is found earlier—more years before a woman dies—than it appears she lives longer because the time from diagnosis to death was increased. Cancer is also overdiagnosed when women are screened by mammography. Mammography increases the incidence of cancers diagnosed by 25% to 50% (Lancet 339:810, 1992). Sometimes the diagnosis is false or equivocal—as a result women who never had a life threatening cancer are diagnosed with

the disease. Obviously these women would have a much reduced chance of dying of breast cancer. Cancers diagnosed on mammography have been found to be less aggressive than tumors of the same size found without mammography; and therefore, may never have surfaced in her lifetime or ever threatened her life. (Br Med J 304:467, 1992).

The Burden of Proof

Does the treatment of breast cancer detected by mammography prolong life or does detection only prolong the burden of living with the disease? Though early detection screening programs, such as mammography, are of questionable benefit, there is no doubt there is definite harm: cost, inconvenience, unnecessary procedures, and accidental complications, to say nothing of the anxiety, distress, and discrimination felt by cancer victims. Before a screening program is unleashed on the unsuspecting public, the medical profession must prove that the testing will be of benefit.

M. Maureen Roberts, the clinical director of the Edinburgh Breast Cancer Screening Project since 1979 wrote in the British Medical Journal, "We all know that mammography is an unsuitable screening test; it is technologically difficult to perform, the pictures are difficult to interpret, it has a high false positive rate, and we don't know how often to carry it out. We can no longer ignore the possibility that screening may not reduce the mortality in women of any age, however, disappointing this may be...I believe that a rethink is required before the programme goes any further. I feel sad to be writing this; sad because naturally after so many years I am sorry that breast cancer screening may not be beneficial, I am also sad to seem to be critical of the many dear and valued colleagues I've worked with over the years, particularly those who have made such a magnificent contribution to the care and welfare of women with breast cancer. But they will recognize that I am telling the truth." (BMJ 299:1153, 1989) Her article was published posthumously after her death from breast cancer.

Potential Harm from Mammograms

Unnecessary anxiety, worry and false reassurance are a consequence of the inaccuracy of screening. The chance that a lesion found on mammography will eventually be found to be cancer is 20 to 30 percent. Which leaves 70 to 80 percent of women going through an unnecessary procedure. At least one in ten women are asked to come back for further investigations, which really heightens the psychological stress for many. Between 10 to 17% of all cancers will be the non-invasive type

(carcinoma in situ), which many doctors do not consider cancer because they may never threaten a woman's life. Advancing the date of diagnosis of breast cancer whose outcome would be unaltered by the test (because it had already spread or it would have never threatened her life) makes a woman live with a cloud of doom over her head for a longer period of time. Many women are falsely reassured by a negative mammogram; yet mammograms miss a cancerous lump that can be felt in the breast 22% of the time and in 44% these cancers are missed in women under 50 years (Cancer 61:263:1988).

Psychological harm is also created for those who fail to have mammograms. As a result of the overselling of the tests, a woman who never had mammograms and contracts breast cancer may feel needlessly guilty, thinking if she would have had the test her life would have been spared. On the other hand, the woman who had yearly exams may not have lived a day longer from her breast cancer, but she can at least say "she did everything possible."

Overall, 81% of women experience discomfort, classified as pain by 46% of women, and severe pain by 7% of those examined. Pain may not be the only consequence of all that breast squeezing. There is also the possibility that compression of the breast during the test may spread cancer cells. Experiments in animals have shown the amount of spread (metastases) can increase by up to 80% by mechanical manipulation of the tumor. In the Shapiro study in which mortality was reduced by 29%, compression of the breast was not used consistently (Lancet 340:122, 1992). Increased breast compression provides better quality X-ray pictures. In the Malmo study which produced a result of 29% increase in deaths in the screened group of women under 55 years old in the first 7 years, the mammographers used "as much compression as the woman could tolerate." Harm from the radiation is small but real. One cancer induced for every 25,000 mammograms. Last year Congress passed the National Mammography Quality Assurance Act in response to reports that half the facilities and technicians failed to meet minimal quality assurance standards.

Early Detection: A Misnomer

The aim of mammography is to detect the cancer when it is small and before it has had a chance to spread. Understanding the natural history of breast cancer will help you understand why breast cancer

detection and treatment can be of limited value, at best. Breast cancer begins with the change of a healthy cell into a malignant one. This transformed cell then grows at a steady rate. The time one cell requires to divide into two cells is called the doubling time. The average doubling time for breast cancer cells is approxi-

mately 100 days. In other words, 100 days after the beginning of the cancer in one cell, two malignant cells are present in the breast; at 200 days, four such cells are lurking there; and after one year, twelve cells have formed. At this rate of doubling, in six years the cancer mass contains one million cells and is the size of the point of a pencil. A mass of this size is less than one millimeter in diameter and is undetectable by palpation or mammography. By this stage, spread to other parts of the body has occurred in almost every case. In ten years, the

mass is finally detectable, having grown to a size comparable to the eraser of a common pencil. At that stage it consists of about one billion cells and is one centimeter in diameter. Realistically, the best modern mammography can be expected to do is detect a mass one-half centimeter in size, which has been growing on the average more than 8 years.

A Better Way

I've only indirectly answered your question by providing you with the data. If you're under 50 or older than 69 you should avoid routine screening for breast cancer. If you're in the middle-age group, realize the benefits of the test are controversial, and far fewer than advertised, whereas the hazards are real and understated. My enthusiastic support for mammography will be withheld until:

- 1) Studies show consistent benefits—and now they don't.
- 2) All age groups of women show benefits—and now they don't.
- 3) Reasonable explanations for inconsistent benefits between studies and age groups is provided—and they are not.
- 4) Until tests can detect the majority of cancers when they are still curable—now they cannot.
- 5) Until effective treatments for breast cancer are developed—now they are not.
- 6) Until efforts in early detection and treatment show a decrease in the death

Before a screening program is unleashed on the unsuspecting public, the medical profession must prove that the testing will be of benefit.

rate per 100,000 population from breast cancers—and they have not.

Whether you choose a mammogram or not, never consider mammograms breast cancer prevention. A healthy diet is breast cancer prevention.

Consider, the annual cost for a well run national mammography program could be 15 billion dollars, and the benefits are controversial. The money could be used much more wisely; like spent teaching women the benefits of a healthy diet and lifestyle. This would not only reduce their risk of breast cancer, but also cancer of the uterus, ovaries, colon, and kidneys. Everyone in our society would benefit with dramatic reduction in heart attacks, diabetes, obesity, and prostate cancer, to name a few diet-induced diseases. Mammography, like other early detection programs and most treatments, is highly profitable. Unfortunately, prevention, which is non-toxic, cost-free, self-administered, ecologically-sound, is also not-profitable, which limits its popularity. But it works, so eventually, health-care based on principles of a healthy diet and lifestyle will triumph. ✱

BENEFITS AND DISADVANTAGES OF MAMMOGRAPHY

Benefits:

- Possible improved survival for cases detected in women ages 50 to 69
- Less radical treatment for smaller tumors
- Reassurance with negative results
- Strong incentive for change in diet

Disadvantages:

- Increase in death for young women
- Increased suffering with awareness of disease
- Anxiety and distress for those falsely diagnosed
- Unnecessary treatment for those falsely diagnosed
- Overdiagnosis of questionable tissues
- Increase in testing and treatment for all
- False reassurance
- Physical discomfort
- Cost

The Look of Cancer

A mammogram usually consists of 3 views using a specialized machine which produces a black and white film by a film screen technique (like a routine X-ray) with low radiation exposure. Most cancers (85%) are seen as a spiculated mass, suspicious calcifications, or both. A finding is more likely cancer if:

- 1) A solid mass is found that is poorly defined, with irregular margins, and with numerous fine strands or spicules radiating out from the mass.
- 2) Calcifications are found with irregular shapes of varying sizes clustered, often within a mass; or fine branching calcific deposits filling ducts.

RESEARCH

PLANT ESTROGEN

"Biological Effects of a Diet of Soy Protein Rich in Isoflavones on the Menstrual Cycle of Premenopausal Women," by Aedin Cassidy in the September 1994 issue of the American Journal of Clinical Nutrition found the addition of 2 ounces (60 grams) of soy protein daily for one month to a woman's diet changed her menstrual cycle in a favorable manner (60:333). Six healthy women (21-29 years of age) with normal menstrual cycles (on no medication) had blood tests drawn every three days while on a control (non-soy) diet and then on a soy diet. The soy diet began on the first day of their period. The control diet and the soy diet had similar amounts of protein, fat and carbohydrate. The soy protein used was 60 grams per day (dry weight) of a textured vegetable protein (Protovég). This provided an extra 45 milligrams of isoflavones.

Two pituitary hormones (luteinizing hormone and follicle-stimulating hormone) were reduced by 200 to 300%. These hormones stimulate the ovaries causing the production of female hormones (estrogen and progesterone). Overall female hormones were decreased, along with an increase in estradiol, a weaker estrogen. Cholesterol decreased by 9.6 %. The first part of the menstrual cycle known as the follicular phase was increased by an average of 2.5 days. The second phase of the cycle, which occurs after ovulation—the luteal phase—remained the same.

The effects were believed to be due to nonsteroidal estrogens called isoflavones that have both an agonistic (stimulating) and an antagonistic (blocking) effect. They concluded "The responses to soy protein are potentially beneficial with

respect to risk factors for breast cancer and its correlation with a high soy intake in Japanese and Chinese women."

COMMENT: Breast cancer is believed to be an environmental disease because there are great differences in incidence worldwide. In general, women who eat a rich diet, based on meat, dairy products, and processed foods, have a much greater chance of getting breast cancer, whereas those who eat a starch-based diet centered on rice, beans, pastas and/or potatoes have a low chance of getting breast cancer.

Flavones are plant pigments with biologic activities. The three believed to influence a woman's hormones most are equol, daidzein and genistein. Miso—a fermented soy protein—has been shown to have greater effects on a woman's hormone activity than textured vegetable protein. Isoflavones are found in all plant products but are especially abundant in soy beans, other beans, peas, lentils and some dried fruits.

Changes in menstrual cycle may account in part for the reduction in risk of breast cancer. Asian women have a longer menstrual cycle than Western women (Western women have an average cycle of 26 to 29 days). Women with breast cancer have an even shorter menstrual cycle than other women (26.4 vs 28.6 days) (JNCI 70:17, 1983). Most of the cell divisions in breast tissue take place in the luteal phase of the menstrual cycle. Increased cell divisions are associated with greater chance of a cell becoming cancer. With a shorter menstrual cycle, due to a shorter time spent in the follicular phase, more of a woman's life is spent in the time of rapid breast cell division—the luteal phase—increasing her chance of cancer.

The low mortality from prostate cancer found in Japanese men may also be due to consuming a low-fat diet with a high-content of plant foods, rich in isoflavones (Lancet 342:1209, 1993). Four isoflavonoids were assayed in Japanese men and Finnish men. Levels of these hormone altering substances were 7 to 110 times higher in the Japanese men. Isoflavones have been shown to inhibit the growth of prostate cancer in animals and tissue cultures (Prostate 22:335, 1993).

BOTTLE FEEDING MEANS BRAIN DAMAGE

"Neurological Differences between 9-Year-old Children Fed Breast Milk or Formula-Milk as Babies," by C. I. Lanting in the November 1994 issue of the Lancet studied 135 breast-fed and 391 formula-fed children and found twice as many

abnormalities of the nervous system in the bottle-fed children (344:1319). Only three weeks of breast-feeding was required to be in the breast-fed group. The authors believed the difference was due to the higher concentration in breast milk of fats essential to the normal development of the nervous tissues—longer-chain polyunsaturated fats, particularly arachidonic and docosahexaenoic acid. The source of these fats early in life is breast milk. Few infant formulas contain detectable amounts of these essential fats.

COMMENT: Breast milk is best. Feeding formulas synthesized by drug companies does immeasurable harm to mother and child. The Lancet reported in 1992 an 8.3 point advantage in I.Q. for preterm children breast-fed early in life (Lancet 339:261, 1992). The effects were dose-dependent—the more breast-feeding a child had, the better the I.Q. score.

Breast-fed children have 2 to 4 times less chance of crib-death (SIDS), one-third the chance of serious illness and hospitalization during the first year of life, as well as less risk of developing obesity, childhood diabetes, asthma and other serious diseases. Besides the nutritional value, breast-feeding provides for the physical and psychological well being of the mother and child. Any parent who feels a glass bottle and rubber nipple are as comforting as the real thing ought to try cuddling up to an artificial one for just one night to experience the real difference.

Many women have excuses for not breast-feeding that could be remedied if they would seek some help. Almost every town has a breast-feeding support organization known as La Leche—look the number up in the phone book.

LOW PROTEIN SAVES KIDNEYS

"Effect of Moderate Dietary Protein Restriction on the Progression of Overt Diabetic Nephropathy: a 6-Month Prospective Study," by F. Raal in the October 1994 issue of the American Journal of Clinical Nutrition showed a change in diet could decrease the loss of protein by the kidneys and prevent further loss of kidney tissue. Two groups of insulin-dependent diabetics were assigned either to unrestricted protein intake or a moderate restriction. Those on the unrestricted diet lost 1.1% of their original kidney function per month (1.3 mL/min/month of glomerular filtration rate). While those on the lower protein diet stabilized their kidney function over the six months. The benefits occurred

independent of blood sugar or blood pressure control. The higher protein diet had twice as much protein as the low-protein diet.

COMMENT: Excess dietary protein is never stored, but eliminated from the body through the kidneys. In this process, flow pressures and rates are increased in the kidney tissues causing damage. Multiple studies have shown the rate of deterioration of the kidneys can be slowed or stopped by a change in the patient's diet. In this study patients on the higher protein diet were losing over 13% of their original kidney function per year.

The typical American diet contains 1.5 grams of protein/Kg of body weight/day. The unrestricted diet in this study had 1.6 grams and the restricted groups had 0.8 grams/Kg of body weight/day. The diet I recommend for kidney patients has between 0.3 and 0.6 grams/Kg of body weight/day of vegetable protein per day. This is similar to the Kempner Rice diet used since the 1940s at Duke University to treat kidney patients; which was based on about 0.3 grams/Kg of body weight/day of protein derived from rice and fruit daily. This is a highly effective means to treat kidney patients before they reach end-stage and need a kidney machine. The American Diabetic Association realizes the potential benefits of a healthy diet for the diabetic and recommends a restriction of protein to 0.8 grams/Kg/day in all diabetics except children, and pregnant or lactating women.

Unfortunately, few patients are enthusiastically encouraged by their doctors or dietitians to make such a helpful change. Instead the patient is treated as if he or she is too stupid and disinterested in life to make such improvements in their diet, and that all will be remedied by the kidney dialysis machine. Life on a dialysis machine is as close to a modern day torture chamber as I can imagine. All patients with diabetes, and especially those with early kidney disease, should be asked to serve time on a dialysis ward to see what life could all too soon be like. The authors of this study reported excellent compliance, and the participants planned to continue the protein restricted diet after the study period. And so would you, faced with the facts and a scientifically backed alternative to sickness and premature disability and death.



RECIPES

Holiday Stuffed Pumpkin

This makes a festive main dish for a holiday meal. Serve with mashed potatoes, gravy, assorted vegetables, salad and bread or rolls.

Servings: 6-8

Preparation Time: 1 hour

Cooking Time: 1-1/2 hours

1 loaf whole wheat bread, cut into cubes

3 cups vegetable broth

1 onion, chopped

2 stalks celery, chopped

2-3 tablespoons soy sauce

1 tablespoon parsley flakes

2 teaspoons thyme

2 teaspoons sage

1 teaspoon marjoram

1-2 teaspoons poultry seasoning

1/2 teaspoon rosemary

several twists of fresh ground pepper to taste

1 medium pumpkin or large winter squash

Preheat oven to 300 degrees.

Place the bread on a baking sheet and bake for 15 minutes.

Place the broth, onions, celery and seasonings in a medium saucepan and cook over medium heat for 20 minutes.

Meanwhile, cut the top off the pumpkin or winter squash and save for a cover (as if you were going to make a jack-o-lantern). Clean out the seeds and stringy portion, leaving plenty of the squash flesh along the sides. Rinse well and set aside.

Place the bread cubes in a large bowl, pour the cooked broth over the bread and toss well until bread is saturated with the liquid. Cover the bowl and allow liquid to be absorbed for about 10-15 minutes. Taste and adjust seasonings (adding more poultry seasoning and ground pepper, if needed).

Preheat oven to 350 degrees.

Place the stuffing into the cleaned pumpkin and cover with the pumpkin top. Place in a large baking dish. Add 1 inch of water to the bottom of the baking dish. Bake for 1 1/2 hours or until fork pierces the side of the pumpkin easily.

Hint: To save some time, cube the bread the night before and allow it to sit uncovered in a single layer overnight. This will eliminate the need to bake the bread cubes in the oven for 15 minutes.

Continued from page 5

CREAMY MASHED POTATOES

Servings: 6-8

Preparation Time: 20 minutes

Cooking Time: 45 minutes

*10 medium potatoes, peeled
water to cover*

Cut potatoes in half and place in a large pot with the water. Cover and cook over low heat until potatoes are very tender, about 45 minutes. Remove from heat. Drain potatoes, reserving the cooking liquid. Beat the potatoes with an electric mixer, adding small amounts of the cooking liquid to the potatoes while mashing. Beat until smooth and creamy. Season with a small amount of salt and pepper, to taste, if desired.

Hint: To make the potatoes even more creamy, replace some or all of the reserved cooking liquid with non fat soy or rice milk. Add the milk to the potatoes while mashing as above.

RICH BROWN GRAVY

Servings: makes 6 cups

Preparation Time: 20 minutes

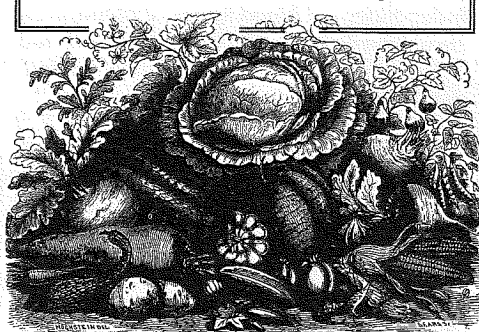
Cooking Time: 20 minutes

*1/4 cup water
1 onion, chopped
1 cup whole wheat flour
5 1/2 cups water
1/2 cup soy sauce
fresh ground pepper to taste*

Place the 1/4 cup water and the onion in a medium saucepan. Cook, stirring occasionally until onion softens, about 5 minutes. Add the flour and mix in well. Continue to cook for another 3 minutes, stirring constantly. (This will toast the flour and give it a rich flavor.) The flour and onions will clump together. Add the remaining water and soy sauce. Cook for another 5 minutes, stirring frequently. Remove from heat. Blend in batches in a blender jar until smooth. Place in a clean pan. Cook over medium heat, stirring frequently, until gravy thickens, about 10-15 minutes. Season with fresh ground pepper, to taste.

Hint: If the gravy fails to thicken to your satisfaction, you may want to add an extra thickener to the gravy. Use a mixture of 2 tablespoons cornstarch mixed in 1/4 cup cold water. Add a small amount to the gravy while stirring until it is thick enough for serving.

RECIPES



CAJUN RED BEANS

Servings: 4-5

Preparation Time: 20 minutes (need cooked beans)

Cooking Time: 30 minutes

*1/2 cup water
1 onion, chopped
1 green pepper, chopped
2 bunches scallions, chopped
2 cloves garlic, minced
1 8 ounce can tomato sauce
1 tablespoon Worcestershire sauce
1 teaspoon Dijon mustard
1/2 teaspoon ground oregano
1 bay leaf
1/16 - 1/8 teaspoon cayenne pepper
1/2 - 1 1/2 teaspoons Tabasco sauce
fresh ground pepper to taste
4 cups cooked small red beans (3-15 ounce cans, drained and rinsed)*

Place water in a large saucepot with the onion, green pepper, scallions and garlic. Cook, stirring occasionally, over low heat for 10 minutes. Add remaining ingredients. Cook, covered, over low heat for 20 minutes. Remove bay leaf. Serve over brown rice.

Hint: This is very spicy if you use the maximum amount of cayenne and Tabasco. Use the lesser amount to begin with and add more if your taste buds permit.

SOUTHWEST KASHA BAKE

Servings: 6-8

Preparation Time: 20 minutes (need cooked grains)

Cooking Time: 1 hour 15 minutes

*1/2 cup water
1 medium onion, chopped
1/4 cup diced celery
1/2 cup diced carrot
2 cloves garlic, minced
1 tablespoon canned chopped green chilies
1 1/2 teaspoons ground cumin*

*1 1/2 teaspoons ground coriander
1 teaspoon chili powder
2 1/2 cups cooked kasha (or other whole grain)
1 cup cooked kidney beans
1 chopped fresh tomato
1/4 cup frozen corn kernels, thawed
2 tablespoons chopped fresh parsley
2 tablespoons chopped fresh cilantro
1 cup salsa*

Preheat oven to 350 degrees. Put the water in a large saucepan with the onion, celery, carrot, garlic and chilies. Cook, stirring occasionally, until vegetables are tender, about 15 minutes. Add more water if necessary to keep vegetables from sticking to pan. Remove from heat and stir in all the remaining ingredients. Spread into a 13" x 9" baking dish and bake for 1 hour.

SOUTH OF THE BORDER SALAD

Servings: 6-8

Preparation Time: 20 minutes

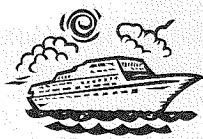
Chilling Time: 6 hours

*2 15.5 ounce cans kidney beans, drained and rinsed
1 small red onion, chopped
6 stalks celery, chopped
1 green bell pepper, chopped
1 cup baby corn, cut in 1 inch pieces
1 cup roasted red bell peppers, sliced
1 14-15 ounce can water-packed hearts of palm, drained & sliced in 1/2 inch pieces
1 15-16 ounce can water-packed artichoke hearts, drained and cut in half
1/4 cup chopped cilantro
1 teaspoon finely chopped canned jalapeno peppers (or to taste)
1 large fresh tomato, seeded and chopped
1 bottle Kozlowski Farms Fat Free No Oil South of the Border Salad Dressing*

Combine all ingredients together. Cover and refrigerate for at least 6 hours.

BULLETIN BOARD

Alaska Cruise



7-Day Cruise to Alaska leaving from Anchorage on May 24, 1995; arrives Vancouver May 31, 1995 on Royal Odyssey by Royal Cruise Lines. Prices start at \$1269 double occupancy, plus airfare. Call for information and reservations—The McDougall Cruise Desk at (800) MONTROSE or (800) 666-8767. If you live in the Los Angeles area, call (213) 245-3158 or (818) 248-9081. All McDougall Food and great McDougall Educational opportunities. Book early; this will fill up very soon - just like our cruise to Mexico did in the Summer of 1994.

Upcoming Half-Day Classes

39.95

A great Holiday Gift Idea!

Call (800) 570-1654 or
(707) 576-1654 for reservations

January 8—Emeryville (close to Berkeley)—Holiday Inn

January 14—Santa Rosa—
Luther Burbank Center

January 22—Napa—Sheraton Inn

February 5—San Rafael—
Embassy Suites

February 12—Los Angeles—
LAX Marriott

February 25—San Diego—
Marriott Mission Valley

March 4—Palm Springs—Hilton

Upcoming McDougall Programs at St. Helena Hospital

Call (800) 358-9195 information and reservations

12-Day Live-in Programs for 1995

January 8

January 29

February 26

March 26

April 16

May 7

June 18

Alumni Programs—3 day

March 12

June 4

McDougall Radio Shows

Daily show on KSRO 1350 from 11AM until noon PST. You can call in with your questions from anywhere in the country and talk to Dr. McDougall (often there is a guest the first half hour, so call at 11:30 AM PST) at (707) 270-1350

FOR YOUR GOOD HEALTH is a syndicated Sunday evening radio show between 7 P.M. to 9 P.M. throughout California (with plans to go national soon). In California listen on:

A NEW STATION: KPSL 1010 AM
Palm Springs

KABC 790 AM Los Angeles

KSDO 1130 AM San Diego
(Replayed Sunday 1-3 P.M.)

KSTE 650 AM Sacramento

KQMS 1400 AM Redding

KSCO 1080 AM Monterey/Santa Cruz

KVEN 1450 AM Ventura

KVON 1440 AM Napa

KGLW 1340 AM San Luis Obispo

KYSO 1480 AM Modesto/Merced

KINS 980 AM Eureka

KSRO 1350 AM Santa Rosa

Donations to the McDougall Program

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. Helen Hospital, Deer Park, CA 94576. ALL TAX DEDUCTIBLE.

Return of the McDougall Newsletter

The contents of the McDougall Newsletter reflect only the thoughts and beliefs of John and Mary McDougall. Other contributors are no longer included.

McDougall Quick Recipe Search
We are looking for recipes to be included in a new "Quick Cuisine" book. Recipe preparation times (apart from cooking times) should be less than 15 minutes. Please send us your recipes to be considered - you will receive credit in the book if they are used! Send to: McDougall Quick Recipes, P.O. Box 14039, Santa Rosa, CA 95402

M c D O U G A L L O R D E R F O R M



ITEM	PRICE/UNIT	QUANTITY	TOTAL
The McDougall Program for Maximum Weight Loss	\$23.95		
The New McDougall Cookbook	\$24.00		
The McDougall Program	\$12.00		
The McDougall Plan	\$10.95		
McDougall's Medicine	\$11.95		
The McDougall Health Supporting Cookbook, Volume I	\$9.95		
The McDougall Health Supporting Cookbook, Volume II	\$9.95		
The McDougall Audio Tapes (6 tapes)	\$39.95		
The McDougall Video	\$25.00		
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The McDougall Newsletter (Bi-monthly)	\$20.00		
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**The McDougall Newsletter, P.O. Box 14039,
Santa Rosa, CA 95402.**

Previous issues available at \$2.75 per copy.

GIVE A GIFT

Send us your name and address, the names and addresses of the people you want to give gift subscriptions to, and a check for \$20.00 for each one. A beautiful Holiday Gift Idea!

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