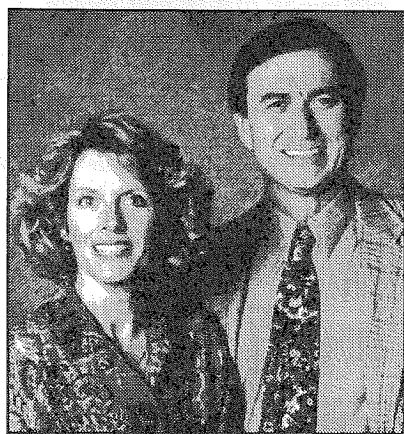


# The McDougall Newsletter

THE NEWSLETTER WITH JOHN & MARY McDUGALL



MARY & JOHN McDUGALL

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#### NEW VIDEO

"Dietary Myths that Make You Fat & Sick" 60 minutes for just 14.95+S&H.

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"A Concise Intro. to the McDougall Program." 40 minutes of information for just \$9.95 +S&H.

See pp.7 & 8 for details & ordering information.

## "EARLY" DETECTION OF CANCER

### Cancer—The Costly Killer

About 1,359,150 people will be diagnosed with a potentially fatal cancer in 1996. Twenty-four percent of Americans die from cancer; this will amount to 554,740 deaths in 1996 (more than 1,500 people a day). Men have a 1 in 2 chance, and women a 1 in 3 chance, of developing an invasive cancer over a lifetime. Half of all cancer deaths are due to three types of cancer: lung, breast, and colon-rectum (colorectal). Estimated annual expenditure for cancer diagnosis and treatment is greater than \$50 billion, accounting for 10% of the money spent on health care.

### Early Detection

Because treatment methods to date have been so ineffective at reducing death and disability, efforts have been placed on prevention and early detection. Trying to detect cancer early enough to reduce the burden of suffering from disease by testing a population is the goal of screening programs. The ideal screening test should be sensitive (few false negatives) and specific (few false positives), simple to perform (both for the patient and the physician), and low-cost.

The aim of early detection techniques is to find the disease when it is small; before it has had a chance to spread to

other parts of the body (metastasize). Early detection tests that have the potential to make the biggest difference rely on finding cells before they have actually turned into cancer (precancerous cells). Most of the time cells will demonstrate precancerous changes that can be seen under a microscope prior to becoming actual cancer cells that divide to form a lump. If the suspicious area is treated before actual cancer develops, and spread to other parts of the body occurs, then the risk of eventually dying of cancer may be decreased.

This search can be successful for precancerous lesions found in the mouth (leukoplakia), on the uterine cervix (cervical dysplasia), on the skin (dysplastic nevi), and in the large intestine (colon polyps).

### Early Detection Is a Misnomer

A few uninformed doctors and many lay people believe that cancer goes through a series of

### LIFETIME RISK FOR CANCERS

|               |         |
|---------------|---------|
| Breast:       | 1 in 8  |
| Cervical:     | 1 in 65 |
| Colon-rectal: |         |
| men:          | 1 in 16 |
| women:        | 1 in 17 |
| Endometrial:  | 1 in 42 |
| Lung:         |         |
| men:          | 1 in 12 |
| women:        | 1 in 19 |
| Ovary:        | 1 in 70 |
| Prostate:     | 1 in 5  |

steps:

**Step 1:** The cancer begins and grows slowly in the tissue (for example the breast)

**Step 2:** The cancer becomes larger

**Step 3:** The cancer spreads to the lymph nodes

**Step 4:** Finally, the cancer spreads to the rest of the body.

### **The assumptions underlying early detection programs are:**

- People without symptoms may harbor disease;
- Tests and exams can detect this disease at an earlier stage than it would otherwise be discovered;
- That some intervention can improve or cure the disease.

Unfortunately, this stepwise progression from a harmless mass to a body full of disease almost never occurs. Rather, dissemination throughout the body takes place by way of the blood stream and occurs very early in the growth of cancer. Spread to the lymph nodes is incidental and only reflects how long the cancer has been growing.

Understanding the natural history of cancer will help you understand why cancer detection and treatment are of limited value. Breast cancer, for example, begins with the change of one 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 (as well as most other solid tumors) is approximately 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 tip of a lead pencil. A mass of this size is less than one millimeter in diameter and is undetectable by breast self examination or mammography. By this stage, spread to other parts of the body has occurred in essentially every case.

After ten years (on the average) 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 8 to 9 years or more.

Once the tumors are large enough to be found by X-ray or felt as a lump the disease has spread to the liver, lungs, bones, and brain, where it kills the patient. Because of this unfortunate fact,

finding the tumor earlier does not improve the outlook, but only assures a longer period of time the patient will have to bear the label and have the anxiety of knowing they have cancer.

Everyone knows someone who has survived major cancer, so how could this pessimistic explanation be true? Cancer is usually very slow growing. For example, it takes about 14 years for half the women with breast cancer to die. But even after 14 years a certain percentage (2% to 4%) die every year. Many women live 35 and more years after diagnosis, only to die of their original disease. Also many cancers are incorrectly diagnosed. For example, women with carcinoma in situ are told they have cancer, when in truth they do not. This is actually a precancerous lesion that usually does not turn into cancer.

### **Adverse Consequences of Early Detection:**

When performing tests on apparently well people, the benefits clearly must outweigh the risks. The benefit expected is a longer disease free life. But, the costs of early detection are not negligible:

**Cancer Phobia:** Asking you to closely look at, feel, and perform various medical tests on your body and its excretions and secretions, adds considerably to your fear of getting cancer. A significant price is paid with emotional distress as patients undergo biopsies and further testing, and receive treatments of questionable value. Overdiagnosis wastes resources and also increases the number of women who have to experience the grief of believing that they may be developing a fatal illness.

**Financial Costs:** Some tests, like breast self examination are free, while others, such as colonoscopy are costly.

**Inconvenience, Time and Discomfort:** Reporting to the hospital to have your breast pressed between the jaws of an x-ray machine rivals bending over for a rectal-prostate exam for degree of embarrassment and discomfort.

**Hazards:** X-ray examination of the breast is unique in that the technique used carries a risk of causing the disease it is supposed to be detecting (although the risk is small).

Cervical screening can lead to hemorrhage, infection, cervical stenosis, and unnecessary hysterectomy (*BMJ* 309:590, 1994). Women with positive smears also run the risk of being consid-

ered promiscuous by others, since it is widely believed that cervical cancer is associated with multiple sex partners and venereal disease (papalomalavirus-es)—their character as well as their cervix is smeared.

**Unnecessary Examinations and Treatments:** Positive findings on mammography usually lead to surgery—a biopsy. The likelihood of a false positive resulting in a breast biopsy may be as high as 20% to 30% over a course of 20 examinations in a 10 year period (*Diagn Imag* p121-128 1993). If all suspicious cells are treated, then much unnecessary surgery, radiation, freezing and burning therapy are given.

**Missed Diagnosis:** Women quite frequently have a suspicious breast lump, yet are told on the basis of a negative mammogram that "There is nothing to worry about." These X-rays, however, incorrectly diagnose over 22% of cancers in women over age 50, and 44% of cancers in younger women (*Cancer* 61:263, 1988.) Screening should not be relied solely upon to make decisions.

**False Reassurance:** Many cancers are missed by early detection methods and effective treatments for those found are lacking.

## **SCREENING**

### **POTENTIAL BENEFITS**

- Improved survival for some cases
- Less radical treatment for some cases
- Reassurance for those with negative results

### **POSSIBLE DISADVANTAGES**

- Knowing you have cancer longer
- More treatments for a longer time
- Over treatment for questionable tumors
- Unnecessary treatment for false positives
- False reassurance for false negatives
- Anxiety for false positives
- Harm from tests
- Cost to individual and country

### **Recommendations for Early Detection**

#### **BREAST CANCER**

An estimated 184,300 new cases of invasive breast cancer will be diagnosed in

women in 1996, with an expected 44,300 deaths.

**Physical Examination:** The American Cancer Society recommends monthly breast self examination after the age of 20 years. Clinical (by a professional) examination every 3 years between age 20-39; age 40 and over, yearly. Over 90% of cancers are found by women, not their doctors.

Studies fail to support survival benefits of breast self examination. For example, a study of 63,636 women between 45-64 years in England offered breast self examination education had a higher death rate from breast cancer than a comparison group of 127,117 not offered such class instruction (*Lancet* 1:411, 1988). Another study found more risk of developing advanced breast cancer in women who reported they performed breast self examination, than those who did not (*J Natl Cancer Inst* 83:260, 1991). However, self-examination will find smaller tumors that can be removed more often by a non-deforming lumpectomy.

**Mammography:** The American Cancer Society recommends mammography for women age 40-49 every 1-2 years; yearly after age 50.

Studies show limited survival benefits only for women between 50 to 69 years. A recent article published in the *Lancet* after reviewing the six randomized controlled prospective breast cancer screening studies concluded, "Since the benefit achieved is marginal, the harm caused is substantial, and the costs are enormous, we suggest that public funding for breast cancer screening in any age group is not justifiable." They reported, "No study showed a significant benefit for women under the age of 50." "The two early studies showed a significant relative reduction in mortality from breast cancer of 23-31%...whereas the four most recent studies showed no significant benefit at any age." "The later trials are probably a more accurate reflection of the limited value of screening." (*Lancet* 346:29, 1995).

## COLON RECTAL CANCER

Cancer of the colon and rectum (colorectal cancer) is the second leading cause of death due to cancer with 55,000 death, and 135,000 new cases in 1996.

The American Cancer Society recommends digital rectal exam yearly after age 40, stool blood tests yearly after age 50, and sigmoidoscopy every 3 to 5

years after age 50.

**Digital rectal Examination (DRE):** Like all physical examination procedures, DRE has not been tested in properly designed studies.

**Occult Blood Test:** This is one of the most controversial areas of screening. Bleeding usually begins in the late stages of cancer when cure is unlikely. "Based on our observations in the screening setting, fecal blood appears to be a poor marker for colorectal neoplasia. Most cancers and the vast majority of polyps will be missed. Hemocult and HemoQuant are similarly insensitive." (*JAMA* 269:1262, 1993). Fecal blood screening failed to detect 70% of colorectal cancers and more than 90% of polyps.

**Sigmoidoscopy Exams:** In one often cited study sigmoidoscopy examination once every 10 years reduced the risk of dying from colorectal cancer by 59%. More frequent screening gave no better results (*N Engl J Med* 326:653, 1992).

**Polyp removal:** Cancer begins with a small symptomless polyp (*Lancet* 347:1744, 1996). Studies support survival benefit for detection of precancerous polyps; but no survival benefit for detection of actual colorectal cancers. The National Polyp Study of more than 1418 patients who had complete colonoscopy with one or more polyps removed had an incidence of colon cancer 76% to 90% lower than expected (*N Engl J Med* 329:1977, 1993). The same study showed screening every three years was as beneficial as annual screening.

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 (*Lancet* 341:736, 1993; *Gastroenterology* 109:1781, 1995). This would find most of the cancers already beginning as polyps. If no disease were 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 final kill.

Colonoscopy examination with a long flexible tube is most often recommended for evaluation of the colon and rectum; however, the preferred alternative, because of costs and complications, is a double-contrast barium enema and a flexible sigmoidoscope (*Cancer* 70:1272, 1992).

## CERVICAL CANCER

There are estimated to be 15,700 new cases of cervical cancer with 4,900 deaths in 1996.

The American Cancer Society recommends a Pap test be performed on women annually who are 18 years old or sexually active. After three or more consecutive annual exams with normal findings, the Pap test can be performed less frequently at the discretion of the physician

Many studies have shown a fall in death rate from cervical cancer at the time of introduction of Pap smears. However, some investigators feel this change is due to other factors than Pap smears, and mass screening may be doing more harm than good (*Lancet* 1:207, 1989; *Lancet* 346:246, 1995). They point out that death rates were declining before screening began, and by the time 80% of the coverage was achieved in 1972, almost half the mortality rate had occurred. One recent study of screening in Bristol, England of 225,974 women found that during each 5-year screening period, 15,000 healthy women were being incorrectly told that they are "at risk," and over 5,500 are being investigated for disease that would have never troubled them—being left with problems that include lasting worries about cancer, difficulties in obtaining life insurance, and worries concerning the effects of treatment on their future reproductive abilities. Yet, the effect on death rate was too small to detect. (*Lancet* 345:1469, 1995).

"The limitations of screening stem not only from the fact that abnormal cells can be found in the smears of numerous women never destined to get cervical cancer, but also from the fact that local treatment of CIN (carcinoma) does not ensure the prevention of invasive disease in every case." (*Lancet* 345:1469, 1995).

Many health organizations recommend discontinuation of smears after the age of 60 to 65, for healthy women with normal Pap smears (*Ann Intern Med* 117:520, 1992). One large study in Scotland found 798 cases of cervical cancer over a 3 year period. Almost all cases (711) were in women under 46. Of the 26 cases in women diagnosed over the age of 50 years, none had participated in an adequate screening program. The authors concluded, "Cervical intraepithelial neoplasia typically occurs in younger women. All women over 50 with an adequate history of negative results on smear testing every

three years may be safely discharged from further screening if these findings are confirmed in other populations." (*BMJ* 306:967, 1993). After a hysterectomy Pap smears should be stopped. After analyzing studies published between 1966 and 1995 a recent article in the *Journal of the American Medical Association* found "...there is insufficient evidence to recommend routine vaginal smear screening in women after total hysterectomy." (*JAMA* 275:940,1996)

#### UTERINE CANCER

The American Cancer Society says a Pap smear is only partially effective. Women at high risk should have an endometrial tissue sampling (biopsy) at menopause.

The Canadian Task Force was unable to recommend any screening techniques for endometrial cancer and the American College of Physicians agrees (*Ann Intern Med* 110:177, 1989).

#### OVARIAN CANCER

Ovary cancer is the fifth commonest cancer of women, and the leading cause of death from gynecologic malignancies. An estimated 26,700 new cases will be diagnosed and 14,800 women will die in 1996. The overall prognosis is poor, with 65-75% of cases appearing in an advanced stage of disease.

The American Cancer Society says periodic pelvic exams are important. Transvaginal ultrasound and a tumor marker, CA 125, may assist in diagnosis.

Pelvic examination is not effective and bimanual examination should not be performed as a routine screening in asymptomatic women (*BMJ* 309, 1994). "There is no evidence available yet that the current screening modalities of CA-125 and transvaginal ultrasonography can be effectively used for widespread screening to reduce the mortality from ovarian cancer nor that their use will result in decreased rather than increased morbidity and mortality." (*JAMA* 273:491, 1995).

#### LUNG CANCER

The American Cancer Society says early detection is difficult.

Lung cancer is so advanced by the time of diagnosis with chest X-ray or tests of sputum that there is little hope of helping patients.

#### PROSTATE CANCER

The American Cancer Society recom-

mends men over 40 should have a digital rectal exam as part of their regular physical checkup; men over 50 should have a rectal exam and a PSA test once a year.

After a thorough review of the scientific literature, authors of an article in the *Journal of the American Medical Association* concluded, "Our analysis does not support using PSA (prostatic specific antigen), TRUs (ultrasound), or DRE (digital rectal examination) to screen asymptomatic men for prostate cancer. Screening may result in poorer outcomes and will increase costs dramatically." (*JAMA* 272:773, 1994).

#### TESTICULAR CANCER

The American Cancer Society offers no recommendation.

An editorial and a paper in the *Journal of Screening* concluded the evidence currently available does not justify routine screening by doctors or men themselves. (*J Screening* 3:2, 1996) "In the unlikely event that testicular self examination reduced mortality by a half, 50,000 men would need to carry out regular examination for 10 years in order for one death to be prevented."

#### SKIN CANCER

The American Cancer Society says early detection is critical. Adults should practice skin self-exam once a month, and any suspicious lesions should be evaluated by a physician.

Many precancerous and early cancers of the skin can be simply and effectively treated. An occasional look is safe and cost-free.

### McDougall's Recommendations

The benefits from screening will be much less for people following the McDougall Program, because most of these cancers are due, at least in part, to the rich American diet. Based on my understanding of the current scientific literature I can make the following general recommendations for otherwise healthy people:

#### BREAST CANCER

No breast self or clinical examination  
No mammography under 50 and over 69

No definite recommendation for women 50 to 69

The benefits are limited, at best  
(Consider the evidence before deciding)

#### COLORECTAL CANCER:

No DRE or occult blood tests

One Sigmoid Exam combined with a double contrast barium enema age 55 to 60

#### CERVICAL CANCER:

Pap smears every 3 years after 2 consecutive normal annual smears between age 18 (or sexually active) and 50. Certainly, no Pap smears after age 60 or after hysterectomy.

#### SKIN CANCER:

Periodic examination of the skin for lesions.

#### SCREENING NOT RECOMMENDED FOR:

uterine,  
ovary,  
lung,  
prostate, or  
testicular cancer.

### Prevention Saves Lives

If someone believes they will be saved by early detection and treatment, they will be less likely to take steps toward prevention. Consider how the sexual practices have changed: once there was gonorrhea and syphilis, treated easily with a shot of penicillin, and the attitude was "free love." Incurable herpes and AIDS have made us look toward the only true salvation—prevention. Understanding the lethal course of cancer, unchecked by treatment in most cases, and the very limited benefits from early detection will send more of us towards prevention. To prevent cancer we must focus on the controllable factors; like radiation, occupational chemical exposure, air pollution, medications, diet, and viruses. The National Cancer Institute estimates a 30% reduction in tobacco use would yield a 10% reduction in cancer deaths, whereas widespread screening for breast and cervical cancer would yield only a 3% reduction.

## RESEARCH

### MORE CHILDREN WITH DIABETES

**Increased Incidence of Non-Insulin Dependent Diabetes Mellitus Among Adolescents** by Orit Pinhas-Hamiel in the June 1996 issue *Journal of Pediatrics* found the number of patients with a diagnosis of adult-onset diabetes rose from approximately 4% of new diagnoses of diabetes from birth to age 19 before 1992 to 16% in 1994 (128:608). Among patients age 10 to 19 this form



of diabetes accounted for 33% of the diagnoses in 1994. The incidence increased ten-fold between 1982 and 1994. Girls were almost twice as common as boys.

This authors of this study concluded, "There is an increasing incidence of NIDDM (non-insulin dependent diabetes mellitus) among adolescents in Greater Cincinnati, accompanying the national rise in adolescent obesity."

#### COMMENT:

There are two general types of diabetes:

The most common form in children, caused by an autoimmune reaction to cow's milk protein, is insulin dependent diabetes mellitus (IDDM); also called type I or childhood diabetes. In this case the insulin producing cells of the pancreas are destroyed.

The most common form in adults is non-insulin dependent diabetes mellitus (NIDDM); also called type II and adulthood diabetes. This type of diabetes is caused by too much rich food, especially those high in fat and low in carbohydrates. The fat in the blood paralyzes insulin activity and the resulting obesity contributes to the resistance of the activity of insulin. The risk of diabetes doubles for every 20% excess of body weight.

This study found the presence of diabetes due to obesity has risen dramatically. One-third of all new cases are due to enthusiastic consumption of rich foods and lack of exercise. There was a family history of a first-degree relative with NIDDM in 65% of cases and a first- or second-degree relative in 85% of cases. This means diabetes runs in the family, but only when people eat a fattening diet and live a fattening lifestyle. There may be a genetic predisposition, but more likely, and more importantly, is people learn their habits from family members.

Moreover, there is a strong racial difference in susceptibility, with Hispanics and blacks having much higher incidences than Asians and whites. Genetics or habits? I believe it's mostly due to the recent availability of meats, dairy products, and fatty processed foods provided in abundance by incomes from better jobs and generous food stamp programs.

Fortunately, all this is easily turned around, especially when changes are made in young people, before much damage is done. A low fat, high carbo-

hydrate, diet with exercise and accompanying weight loss will cure the diabetes in almost every one of these kids. If they don't change, then they're looking forward to a short life, filled with heart attacks, blindness, kidney failure, and bottles full of medications.

## SALT'S OK?

**Effect of Reduced Dietary Sodium on Blood Pressure. A meta-Analysis of Randomized Controlled Trials** by Julian Midgley in the May 22/29, 1996 issue of the *Journal of the American Medical Association (JAMA 275:1590)* found, "Dietary sodium restriction for older hypertensive individuals might be considered, but the evidence in the normotensive population does not support current recommendations for universal dietary sodium restriction." The authors looked at 56 previous studies. People with high blood pressure showed an average drop in systolic blood pressure (top number) of 3.7 mm Hg and 0.9 mm Hg for diastolic pressure (lower number) when the sodium in a person's diet was reduced by one teaspoon of salt (2300 mg) a day. For people without high blood pressure the reduction in blood pressure for the same salt reduction was 1 mm Hg systolic and 0.1 mm Hg for diastolic pressure. Older people with high blood pressure showed a greater responses to salt reduction.

The average daily sodium intake for adults in the US per day is 3900 mg. If the general population decreased sodium intake by 2300 mg as seen in these studies they would be consuming only 1600 mg of sodium a day to achieve these reductions in blood pressure. This low intake would be impossible to achieve for almost everyone in our society. Even if this could be attained the benefits would be minuscule. It has been assumed that prevention of heart disease is accomplished with a low sodium diet. However, a recent study showed those people who ate the least sodium had the highest risk of a heart attack (*Hypertension 25:1144, 1995*). Other studies suggest low-salt diets may raise cholesterol and triglycerides (*Am J Hypertens 4:416, 1991; Hypertension 11:743, 1993*).

COMMENT: Because the study was funded by Campbell's Institute for Research and Technology (salty Campbell's soups) the research and conclusions are suspect. A series of articles in the May 18, 1996 issue of the *British Medical Journal* take serious issue with the conclusions of this article and

attribute the industry's pressure to the lag in progress in getting people to cut their salt intake (312:1239). They state, "Faced with a growing scientific consensus that salt increases blood pressure and the fact that most dietary salt comes from processed foods, some of the world's major food manufacturer's have adopted desperate measures to try to stop governments from recommending salt reduction. Rather than reformulate their products, manufacturers have lobbied governments, refused to cooperate with expert working parties, encouraged misinformation campaigns, and tried to discredit the evidence."

However, there is more to high blood pressure than salt; and more to heart disease than high blood pressure. Blood pressure decreases on the average 6 mm Hg systolic and 3 mm Hg diastolic in 24 hours in my patients at St. Helena Hospital (analysis of 1068 patients). If the blood pressure was initially over 150/90 then the drop was 20 mm Hg systolic and 11 mm Hg diastolic in one day. Furthermore most of the people on blood pressure medications were taken off of their medications between the first and second readings. These fantastic results are obtained because of three general changes.

First, the pump action of the heart is decreased by removing people from their stressful environments and by stopping their coffee.

Second, the volume of fluid the heart must pump around is decreased by lowering the sodium and increasing the potassium by feeding a starch-based diet.

Third, the resistance to blood flow is decreased when the vegetable and animal fats are removed from the diet. Fats make the blood cells stick together, increasing the resistance to flow.

High blood pressure is a sign of poor circulation and disease of the blood vessel system. The vessels are diseased by an unhealthy diet (high fat and cholesterol, low fiber) and an unhealthy lifestyle (smoking, no exercise). Your efforts should be to correct the underlying problems.



## SPEEDY GAZPACHO

Servings: 6-8  
Preparation Time: 10 minutes  
Chilling Time: 2 hours

1 32 ounce jar spicy tomato juice  
1 cucumber  
1 green bell pepper  
1 stalk celery  
2 green onions  
several dashes Tabasco sauce

Chop all the vegetables in large chunks. Using a blender, process the vegetables in batches in the tomato juice. Mix well and place in a large covered jar or pitcher. Refrigerate at least 2 hours to blend flavors.

### RECIPE HINT:

I make this very often during the summer. We use it as a fast meal or a snack food. Just pour it into a mug and drink it on the road. It is delicious and very refreshing.

## TEN MINUTE CHILI

Servings: 4  
Preparation Time: 5 minutes  
Cooking Time: 10 minutes

2 15 ounce cans kidney beans,  
drained and rinsed  
2 cups fat free spaghetti sauce  
2 teaspoons chili powder  
1 teaspoon ground cumin  
dash cayenne pepper (optional)

Combine all ingredients in a saucepan and heat for 10 minutes, stirring occasionally.  
Ladle into bowls and serve.

### RECIPE HINT:

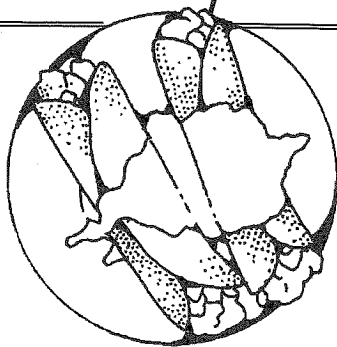
This simple recipe appeals to many children. Try serving it with baked tortilla chips to scoop up the chili.

## SPINACH-RICE ENCHILADAS

Servings: 4-6  
Preparation Time: 15 minutes (need cooked rice)  
Cooking Time: 30 minutes

¼ cup water  
1 onion, chopped  
1 6-ounce bag triple washed  
baby spinach leaves  
2 cups cooked brown rice  
1 tablespoon soy sauce  
1 teaspoon ground cumin  
2 16 ounce jars Parrot Brand Enchilada  
Sauce  
8-10 soft corn tortillas

# Recipes



Preheat oven to 350 degrees.

Place the water and onion in a medium saucepan. Cook, stirring occasionally, until onion softens slightly, about 3 minutes. Add the spinach, stir until spinach softens, about 2 minutes. Remove from heat. Add the rice, soy sauce and cumin. Mix and set aside.

Take one cup of the sauce and spread over the bottom of a covered casserole dish. Take the tortillas, one at a time, spread a line of the spinach-rice mixture down the center of the tortilla. Roll up and place seam side down in casserole. Repeat until all ingredients are used. Pour the remaining sauce over the tortillas, cover and bake for 30 minutes.

## POLENTA WITH MUSHROOMS

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

1 24 ounce package Pre-cooked polenta  
½ cup water  
2 tablespoons sherry  
1 tablespoon soy sauce  
½ pound fresh shiitake mushrooms, sliced  
½ pound fresh cremini mushrooms, sliced  
¼ pound fresh oyster mushrooms, sliced  
1 small onion, chopped  
1 teaspoon minced fresh garlic  
1 tablespoon thinly sliced fresh basil  
1 tablespoon chopped fresh parsley  
several twists fresh ground pepper

Preheat oven to 375 degrees.

Slice polenta into ½ inch thick slices. Place on a non-stick baking sheet and bake for 15 minutes.

Place all the remaining ingredients in a non-stick frying pan and cook, stirring occasionally for 10 minutes.

Serve the mushrooms over the baked polenta.

### QUICK TIP:

Slice Ready Made Polenta Rolls—found on the supermarket shelves, this is a traditional Italian corn-based alternative to pasta, bread, or rice. Microwave for 60 to 90 seconds, brown on a non-stick griddle for five to ten minutes or bake in an oven for 15 minutes. Serve plain or top warm polenta with sauces and salsas. Polenta is delicious with many different sauces.

## MEATY MUSHROOM STROGANOFF

Servings: 6  
Preparation Time: 15 minutes  
Cooking Time: 30 minutes

1 16 ounce package fettucini  
½ cup water  
1 large onion, chopped  
1 pound fresh sliced mushrooms  
1 8-ounce package Beyond Roast Beef,  
thawed and sliced  
dash cayenne  
2 tablespoons white wine  
2 tablespoons soy sauce  
1 cup soy milk  
1 cup vegetable broth  
2 tablespoons cornstarch mixed in ¼ cup  
cold water

Put a large pot of water on to boil. When boiling, drop in the fettucini and cook according to package directions. Place the water and onions in a large non-stick frying pan and cook for 2-3 minutes. Add mushrooms and cook until mushrooms are slightly limp. Add remaining ingredients, except for the cornstarch mixture. Mix. Cover and cook over low heat for 20 minutes, stirring occasionally. Add cornstarch mixture to pan, cook and stir until thickened. Serve over the fettucini.

### RECIPE HINT:

Beyond Roast Beef is made by Ivy Foods in Salt Lake City. It is sold frozen in most natural food stores. Savory Seitan by Lightlife Foods in Greenfield, MA is another delicious gluten product that may be used in this recipe. These products are made from wheat gluten and taste very similar to meat. They are often referred to as "meat from wheat".

### RECIPE CORRECTION:

The recipe for Onion Soup in the March/April 1996 Newsletter contained duplicate ingredients. The Worcestershire sauce, soy sauce, and minced onion should only be added once, not twice.

# BULLETIN BOARD

## Women's Health

A new book presently titled the **McDougall Program for Healthy Women** is now being written, and I need your help. Please share with me any experiences you have had with a healthier diet and lifestyle, and problems that are common (but not exclusive) to women. Many of you have lost weight, resolved intestinal problems, headaches, body aches and arthritis. PMS, heavy menstrual periods, breast tenderness, and breast lumps have also gone away. Any of you who have used my recommendations for hormone replacement therapy (estrogen/progesterone replacement), osteoporosis, heart disease, breast feeding, mammograms, PAP smears, weight loss, to avoid unnecessary surgery of the uterus, breasts, or other body part, or any other information that has helped you, please write me. If you have any story that needs to be told to other women, here is your opportunity - Send a letter with your experience to The McDougall Program for Healthy Women, P.O. Box 14039, Santa Rosa, CA 95402. Thank you.

John McDougall, M.D.

## McDougall TV Show

"McDougall" the TV show, airs across the country on the American Independent Network Nationwide. Call (805) 373-7681, ask for Chauncy, if you need more information or know of a TV station that would like to carry us.

## Nationwide McDougall Seminars

We're expanding our reach to your neighborhood. Help us improve the lives of the people you love. John and Mary McDougall will deliver their life-altering half-day seminar on a weekend, day or evening. You can have a group sponsor them or help us arrange for people to sign up at the seminar by calling our 800 number. If we sponsor the seminar, we need at least 150 people to make it work. One of the best ways to help us is to arrange media contacts such as talk radio, newspapers and TV. We also need seminar rooms. Call Louise at (800) 570-1654 for information.

## New Video: Dietary Myths that Make You Fat & Sick

With wrong information, you are powerless to improve your health. You continue to make efforts to become the person you know you should be, but still you remain trapped in your tired, overweight, deteriorating, diseased body. There is no hope for you until you understand some basic truths about the foods we eat and their monumental impact. This one hour video will change your life by correcting the following myths:

*Myth 1: Starches Make Me Fat*

*Myth 2: I Must Eat Meat to Get Protein*

*Myth 3: Milk Builds Strong Bones*

*Myth 4: Chicken Is Low Cholesterol*

*Myth 5: Vegetable Oil Is Health Food*

Fortified with sensible information that is easily verified by your own experiences and the scientific literature, you will be taking a big step towards regaining lost health and appearance.

\$14.95 plus S&H. Also available in bulk pricing of 10 or more. Call (800) 570-1654.

## New Audio Tape: A Concise Intro. to the McDougall Program

Did you ever want an audio tape short enough yet sufficiently powerful, for your unconvinced friends and relatives? Here is 40 minutes of information to help people regain lost health and appearance for just \$9.95 plus S&H. Also available in bulk pricing of 10 or more. Call (800) 570-1654.

## Upcoming Half-Day Classes

*A lively and informative presentation that may change your life!*  
Call (800) 570-1654 or (707) 576-1654 for reservations

August 11 - Detroit  
Detroit Holiday Inn (near Dearborn)  
1:00 pm - 5:00 pm

September 12 - San Francisco  
San Francisco Learning Annex  
(415) 788-5500

September 15 - Santa Rosa  
Luther Burbank Center  
1:00 pm - 5:00 pm

September 21 - Portland, Oregon  
Red Lion Inn  
1:30 pm - 5:30 pm

## McDougall's Right Foods

Products are available now in natural food stores and supermarkets in Northern California. They also may be ordered by mail. Distribution will spread throughout the country during the year. Mail or FAX us, and we'll send you an order form. We'll also provide you with ordering information to help you get these meals in your local stores.

**Dr. McDougall's Right Foods**  
101 Utah Avenue  
South San Francisco, CA 94080  
(415) 635-6000  
FAX (415) 635-6010

*Instant Oatmeal w/Maple Spice*

*Instant Oatmeal & Five grains - Apple Cinnamon*

*Baked Ramen Noodles - Chicken Flavor*

*Baked Ramen Noodles - Beef Flavor*

*Mediterranean Pasta & Beans*

*Rice & Pasta Chicken Flavored Pilaf*

*Minestrone with Pasta*

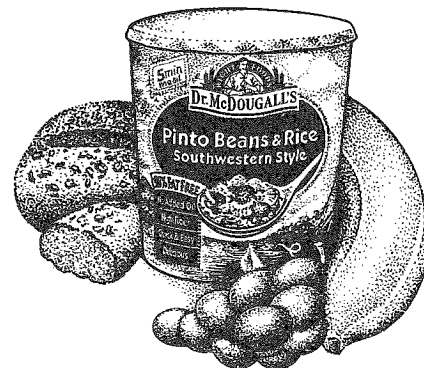
*Split Pea Soup with Barley*

*Tortilla Soup w/Baked Tortilla Chips*

*Southwestern Style Rice & Pinto Beans*

*Tamale Pie w/Baked Tortilla Chips*

*Vanilla Rice Pudding*



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| The McDougall Program for Maximum Weight Loss                         | \$11.95    |             |       |
| The New McDougall Cookbook  | \$24.00    |             |       |
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| The McDougall Plan  | \$11.95    |             |       |
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| The McDougall Health Supporting Cookbook, Volume I                    | \$9.95     |             |       |
| The McDougall Health Supporting Cookbook, Volume II                   | \$9.95     |             |       |
| New Audiotape A Concise Introduction to the McDougall Program 40 min. | \$9.95     | <b>NEW!</b> |       |
| The McDougall Audio Tapes (6 tapes)                                   | \$39.95    |             |       |
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