

The Hypoglycemic Health Association

NEWSLETTER

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The NEWSLETTER of the Hypoglycemic Health Association is distributed to members of the Association and to Health Professionals with an interest in nutritional medicine and clinical ecology.

Treasurer's Report by Sue Litchfield. Yet another 3 months have passed me by and have now settled into life back home and looking forward to seeing and catching up with you all at the next meeting. NOTE IT IS SUBSCRIPTION TIME IN DECEMBER. I have also noticed that there are still a number of subscriptions that are overdue. I may add that all unpaid subscription WILL NOT in future receive newsletters I may also add that no receipts are issued when renewing you subs However if one is required please send a self addressed envelope and I am only too happy to send it by return mail. With many thanks to all those who have given all the very generous donations this year as a result the committee has decided to leave the annual subscriptions unchanged BUT WE DO HAVE TO ADD 10% TO THE FEES BECAUSE OF THE GST so the fees will now be \$16.50 for Pensioners and \$22.00 for the normal membership. Sorry about this but I am not the treasurer of this wonderful country of ours. However if the amount of donations do not live up to expectations we will be forced to increase them next year. Please note that all donations over \$2.00 are tax deductible. The raffle tickets are selling at a steady rate which is pleasing as we now need every cent we can get our hands on as costs seem to be as always on the rise. I am always on the lookout for interesting things to raffle. If anyone would be so generous to donate a raffle. (E.G a gift voucher from a department store, electric jug, iron, toaster and so the list goes on) I will love you for life. It also has been drawn to my  Page 9

Our Next Public Meeting will be at 2.00 PM
on Saturday, the 1 September, 2001
at **YWCA**

5-11Wentworth Ave, SYDNEY

This time we are organizing a
Questions & Answers Panel

With
Dr George Samra
Jurriaan Plesman
Sue Litchfield

The Association hopes that members will attend the next public meeting and take advantage of the unrehearsed discussions on topics relating to hypoglycemia and other illnesses.

Dr. George Samra will handle questions from the audience in regard to nutritional medicine and medications and other illnesses.

Jurriaan Plesman will answer questions in regard to emotional disorders, such as depression, drug addiction and Psychotherapy.

Sue Litchfield shall be on the panel to answer any questions in her capacity as dietary advisor and food preparations.

It is expected that this will result in a lively discussion among our members, who are free to ask any questions.

Previous Copies of the Hypoglycemic Newsletter

Back issues of the Hypoglycemic Newsletters are available at the NSW State Library, Macquarie Street, Sydney. They are filed under NQ616.466006/1 in the General Reference Library.

Other libraries holding copies are: Stanton Library, North Sydney; Leichhardt Municipal Library; The Tasmanian State Library; The Sydney University; The University of NSW and Newcastle University. The Association will provide free copies in PDF format to any library upon request to jurplesman@hotmail.com

The Association also has a web site at: <http://www.hypoglycemia.asn.au> where there are some Newsletters in PDF format, as well as articles on clinical nutrition and self-help psychotherapy.

Books for sale at the meeting

Sue Litchfield: **SUE'S COOKBOOK**
Dr George Samra's book

The Hypoglycemic Connection
(now out of print) is only available in public libraries).

Jurriaan Plesman: **GETTING OFF THE HOOK**

This book is also available in most public libraries (state and university). By buying this book at the meetings you are supporting

Any opinion expressed in this Newsletter does not necessarily reflect the views of the Association.

the Hypoglycemic Health Association.

The Newcastle branch of the Association are still meeting with the assistance of Bev Cook. They now meet at ALL PURPOSE CENTRE, Thorn Street, TORONTO. Turn right before lights at Police Station, the Centre is on the right next to Ambulance Station. For meeting dates and information ring Mrs. Bev Cook at 02-4950-5876.

Entrance donations at meetings

Entry donation is tax deductible and for non-members will be \$5, for members \$3 and family \$5. People requiring a receipt for tax purposes will be issued when asked for it.

Donations for raffle

One way of increasing our income is by way of raffles. If any member has anything to donate towards the raffle, please contact Dr George Samra's surgery at 19 Princes Highway, Kogarah, Phone 9553-0084 or Sue Litchfield at 9971-5657 or (litch.grip@bigpond.com).

At the last meeting on the 2 June 2001, Suzan Sloambe won the lucky door prize. This consisted of a radio clock and donated by Geoff Grady of Nowra. The Association thanks Geoff very much for this wonderful donation.

Lorraine Smith won the first raffle and Suzanne Sloambe won the second raffle.

Fund raising activities

We need money, ideas, donations, bequests (remember us in your will), donations over \$2 are tax deductible.

Raffles

Conducting raffles is an important source of additional revenue for the Association. Raffle tickets are available at \$2 each or \$5 for three tickets at Dr George Samra's surgery. Items to be raffled should be on display at the surgery and will be raffled at the next public meeting of the Association.

The Hypoglycemia support group meets every 3 months at 19 Princes Highway Kogarah (1st floor Dr. Samra's surgery) at 1.45 p.m. The members of this support group meet every second Saturday of the months of February, May, August and November. The cost is \$1. Afternoon tea provided - family and friends welcome. For further information please telephone - Lorraine on 02-95209887 or Jeanette on 02-95259178

The Hypoglycemic Health Association of Australia has now a new web site at:
<http://www.hypoglycemia.asn.au>

Thanks to Amitee Robinson

Nutrition in Schizophrenia By Viv. Rendall

The excellent article in the June issue of this Newsletter by Jurriaan Plesman has given a much needed shot in the arm I feel to mainstream psychiatry in this country. I think that most psychiatrists in Australia are not involved in clinical nutrition. In fact I know from my experience in talking to many psychiatrists, that they have a very shallow understanding of what nutrition offers for mental illnesses. It is obvious this area of therapy is left undone when other therapies are used as needed. But using nutrition in conjunction with medication is not without its difficulties. Most psychiatrists will tell you that good nutrition helps, but to use it in a special way with particular nutrients that are therapeutic for the patient, is just too much to ask of them, I've found. From my experience though over more than a thirty year period, *correct* nutrition *does* help, very much more.

Back in 1966 just after we got married my wife came down with schizophrenia. This was a hell of a shock to me as of course I knew

nothing about the illness and thought my marriage was over. She was hospitalized and prescribed Melleril. In course of time she came home and still on Melleril made but very little more improvement over a considerable period of time. It was of course distressing and I wanted to know as much about the illness as I could. In a bookshop I came across a book by Hoffer. In this book he talked about using very large doses of Vitamin B3 which he claimed helped people reduce their symptoms or get rid of them entirely. I thought this is amazing! How could this be so? Why is our psychiatrist not using this also? After talking to him about it I quickly understood that this was entirely new territory and not well accepted in mainstream psychiatry if at all. He said that Vitamin B2 would help, but for an entirely different reason.

Well I couldn't get this out of my mind and I decided to try Vitamin B3 in the form of Niacinamide in conjunction with Melleril. I told our psychiatrist. He was not impressed but didn't insist that we not use it. I gave my wife 500mg/day for a few weeks. This was nowhere near what Hoffer had given to his patients which was in the order of three or more grams/day and Vitamin C was used as well. On just this relatively small amount, I could see that it did have some positive benefit

in reducing her delusions and her progress seem to increase. I dropped it out after some weeks as I was afraid of side effects. In the course of about 9 months after this she had no delusions on the Melleril alone.

About a year later she had a further relapse not as severe as the first. This time I decided to give her 50mg/day Vitamin B6 once again in conjunction with the Melleril. This time she made a much more noticeable improvement than when I had given her B3 the previous time. Further relapses happened but each one was not as severe as the one proceeding and each time I gave her B6. She now has no psychosis and has had none for a period of 16yrs. Now this is the rub. Those 16yrs have been without medication and only using good nutrition rather like a diet for hypoglycemia.

Now many psychiatrists and others would say that this is not due to the diet, that the progress was an example of the wide spectrum of eventual outcomes of the illness. That may be so. But what causes wide variations? It would be inconceivable to suggest that diet, apart from environment and genetics, does *not* have any influence on mental illness, because it certainly does on medical illnesses! After all the brain is flesh and blood just like the body is.

Why meditation? (1)

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BACKGROUND

While many general practitioners perceive meditation as an acceptable, even mainstream, health care strategy, it is paradoxically a poorly understood discipline.

OBJECTIVE

To define meditation, outline the broad types of meditation and give an overview of the extent and validity of available evidence for its efficacy.

DISCUSSION

The basic question of what constitutes meditation and what separates it from relaxation therapy has been an impediment to formulating quality studies in order to research meditation techniques. Examining the literature using evidence based criteria reveals that, while meditation does appear to have therapeutic potential, there is a great need for further research before definitive conclusions can be made. Researchers have yet to systematically compare different techniques of meditation to compare their profiles.

Meditation is seen by a number of researchers as potentially one of the most effective forms of stress reduction. (1) While stress reduction techniques have been cultivated and studied in the West for approximately 70 years, the data indicates that they are not consistently effective. (2)

Meditation however, has been developed in Eastern cultures and has a documented history of more than several thousand years. Eastern meditative techniques have been developed, trialed and refined over hundreds of generations with the specific intention of developing a method by which the lay person can regularly attain a state of mental peace and tranquility, ie. relief from stress. It is a strategy that can easily be adapted to the needs of clinicians and their patients in the West.

A US study for example, showed that a short course of behaviour modification strategies that included meditation led to significantly fewer visits to physicians during the six months that followed. The savings were estimated at over \$200 per patient. (3)

A study of insurance statistics showed that the use of medical care was significantly less for meditators compared to non meditators. (4)

The growing emphasis on:

- quality of life outcomes
- concepts such as psychoneuro-immunology or mind-body medicine, (5) and
- reducing health care costs

suggest that stress reduction and improving mental health are becoming increasingly relevant to health care.

The need for an evidenced based approach

A recent survey of Australian general practitioners showed that while GPs perceived meditation as an acceptable, even mainstream, health care strategy, it is paradoxically a poorly understood discipline. In view of this, the authors concluded that well designed trials and education on meditation are urgently needed to inform GPs' decision making. (6)

Meditation vs relaxation

Implicit in the fact that the term 'meditation' exists separately from that of 'relaxation' suggests that there should be clear differences between the two phenomena. However, there is as yet insufficient evidence to draw a clear distinction. Moreover, researchers have yet to systematically compare different techniques of meditation to determine whether or not these techniques use different or similar mechanisms or have differing effect profiles.

Lack of quality research

Despite the breadth of information available on meditation, a report of the US National Research Council (NRC) on meditation raised concerns about weak methodology and poor definition of the process. (7)

Examining the literature using evidence based criteria reveals that while meditation does appear to have therapeutic potential, there is a great need for further research before definitive conclusions can be made. The body of knowledge currently suggests that not all meditation techniques are the same; most techniques are probably elaborate relaxation methods while there are others that may well involve physiological processes unique to meditation.

The Meditation Research Program (MRP) is one of the ongoing activities of the Natural Therapies Unit at the Royal Hospital for Women in Sydney. The MRP is committed to thorough scientific evaluation of meditation, its physiological effects and its potential for health care.

What is meditation?

There are many forms of meditation, ranging in complexity from strict, regulated practices to general recommendations. If practised regularly, meditation is thought to help develop habitual, unconscious microbehaviours that can potentially pro-

duce wide-spread positive effects on physical and psychological functioning. Meditation even for 15 minutes twice a day has been shown to bring beneficial results. (3)

How does meditation work?

Parasympathetic response

Most theories are based on the assumption that meditation is a sophisticated form of relaxation involving a concept called the parasympathetic response. Psychological stress is associated with activation of the sympathetic component of the autonomic nervous system which, in its extreme, causes the 'fight or flight response'. Meditation and any form of rest or relaxation acts to reduce sympathetic activation by reducing the release of catecholamines and other stress hormones such as cortisol, and promoting increased parasympathetic activity which in turn slows the heart rate and improves the flow of blood to the viscera and away from the periphery.

Other neurophysiological effects

Other proponents claim that meditation involves unique neurophysiological effects; however, this remains to be proven. Research at the MRP suggests the limbic system may be involved in Sahaja yoga meditation (SYM) since significant effects involving mood state have been consistently observed.

Defining what we mean by meditation

The most important issue that must be addressed in this field of research is to clearly define meditation and then subject that definition to scientific testing. Meditation is popularly perceived to be any activity in which the individual's attention is primarily focused on a repetitious cognitive activity. This very broad definition is, in the opinion of the MRP, the main cause for much of the inconsistent outcomes seen in meditation research.

'Thoughtless awareness'

If one closely examines the authentic tradition of meditation it is apparent that meditation is a discrete and well defined experience of a state called 'thoughtless awareness'. This

1) Australian Family Physician Vol. 29, No. 12, December 2000 • 1135

is a state in which the excessive and stress producing activity of the mind is neutralised without reducing alertness and effectiveness. Authentic meditation enables one to focus on the 'present moment' rather than dwell on the unchangeable past or undetermined future. It is this state of equipoise that is said to be therapeutic both psychologically and physically and which fundamentally distinguishes meditation from simple relaxation, physical rest or sleep.

Reducing 'background mental noise'

According to this perspective, stress is the inevitable byproduct of an overactive mind. The unsilenced mind is responsible for almost continuous 'background mental noise' the content of which is mostly unnecessary and unproductive. Yet it is this 'mental noise' that impinges on our otherwise natural tendency toward psychological, mental and spiritual health.

Quasi-meditation

Most commercialised meditation techniques do not reliably give the key experience of mental silence or 'thoughtless awareness' hence they can more precisely be described as 'quasi-meditative'. These include methods that use constant repetition of syllables (such as mantras), visualisations or other thought forms. This does not mean they may not be useful as they do encourage relaxation by reducing or simplifying mental activity or focusing attention. However, well designed physiological and clinical trials have, on the whole, shown little difference between these techniques and physical rest or relaxation. (8)

Types of meditation

There are many meditation techniques available to consumers. Three notable examples include transcendental meditation, mindfulness and Sahaja yoga.

Transcendental meditation

Transcendental meditation (TM) is the commonest form of mantra meditation. It aims to prevent distracting thoughts by use of a mantra. Students are instructed to be passive and, if thoughts other than the mantra come to mind, to notice them and return to the mantra. A TM student is asked to practise for 20 minutes in the morning and again in the evening.

Transcendental meditation is said to be associated with clinical outcomes such as blood pressure reduction (9) and physiological changes such as lowered blood cortisol levels. (10)

Adverse effects

There are however, a number of case reports in the mainstream medical literature describing occasional adverse psychological (11,12) and physical effects (13) that appear to be causally related to the technique. These adverse events range from mild to severe and warrant further systematic investigation. (14)

Cost issues

The technique is taught using a commer-

cial system in which one begins by purchasing a mantra. Further instruction entails an escalating system of fees that can be cost prohibitive. Moreover, the TM organisation has on occasion been implicated in unethical and cultic practices. (15) In light of this information, medical practitioners have no choice but to recommend caution with regard to this method.

Mindfulness and Vipassana meditation

Mindfulness is a general method that serves as a basis for techniques such as Vipassana meditation. It aims to use focused attention (often by using a physical sensation such as the breath) to cultivate mental calmness. Regular practice enables one to objectively observe one's thoughts and therefore enhance one's self understanding. Mindfulness approaches have been shown to be effective in certain clinical applications such as chronic pain. (16)

Vipassana is both a general term referring to a specialised form of mindfulness meditation and also a specific brand name. The following information refers to the latter. Vipassana is taught in Australia via a number of Vipassana retreats and centres. The retreats involve up to 10 days of intensive meditation, several hours per day, and other strict observances such not talking and encouragement to maintain strict postures for long periods of time. There is no fee for these retreats but 'recommended donations' are described. These retreats are unsuitable for the average person, particularly those unfamiliar with meditation, due to the extreme physical and psychological demands. Adverse events associated with Vipassana have been described although it is unclear as to which form these reports refer. (17)

Sahaja yoga meditation

Sahaja yoga meditation (SYM) is the technique of choice in the MRP. Sahaja yoga meditation aims to promote the experience of 'thoughtless awareness' based on the original meditative tradition. Meditators in the MRP consistently describe the ability to achieve this experience. They are encouraged to practise twice daily for approximately 15 minutes. Sahaja yoga meditation is well suited for the general population and for research, because it is easy to learn and is taught free of charge. Sahaja yoga meditation is currently used in three Sydney hospitals for patients, staff and public. Feedback from management teams and anecdotal reports from patients and carers are favourable. As yet no adverse effects have been reported in the MRP's trials, clinics or in the literature.

The MRP has conducted a number of small and large trials on SYM which have generated promising results in Australian conditions. A randomised controlled trial of meditation for moderate to severe asthma compared SYM to a relaxation control. SYM was more effective in a number of objective and subjective endpoints.

A number of locally conducted pilot studies examining the effect of SYM suggest that it may have a beneficial role in menopausal

hot flushes, severe migraine and psychological stress. Randomised controlled trials are underway in order to obtain definitive data. Studies in India suggest that SYM is more beneficial than mimicking exercises in the treatment of epilepsy and hypertension. (18) **Recommending meditation techniques to patients**

General practitioners must exercise commonsense and discrimination when recommending meditation to their patients as they have a duty of care to ensure the safety of their patients' health and finances. Meditation is contraindicated in those suffering from psychosis and should only be applied with great caution in those with severe psychological problems. The medicolegal implications of recommending a technique that leads to an adverse event have not been explored.

A simple and effective rule of thumb when choosing or recommending a meditation technique is to assume that 'the best things in life are free'. Organisations involved in the commercialisation and marketing of often costly 'meditation' techniques, courses and 'master classes' are least likely to be selling an authentic method. Unfortunately in these situations the welfare of the individual and the community usually become secondary to profit or fame.

SUMMARY OF IMPORTANT POINTS

- Meditation can be an effective form of stress reduction and has the potential to improve quality of life and decrease healthcare costs.
- Although meditation differs from relaxation techniques, the components which constitute this difference have not yet been clearly defined.
- Meditation involves achieving a state of 'thoughtless awareness' in which the excessive stress producing activity of the mind is neutralised without reducing alertness and effectiveness.
- Authentic meditation enables one to focus on the present moment rather than dwell on the unchangeable past or undetermined future.
- There is little quality evidence comparing one meditation technique with another or meditation with relaxation techniques.
- The theoretical explanation for the effects of meditation and relaxation techniques is that the release of catecholamines and other stress hormones are reduced and parasympathetic activity is increased.
- Whether meditation involves other unique neurophysiological effects remains to be proven.

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Red Meat, Colon Cancer And Yoghurt

by Anne Blair Gould

Source: <http://www.rnw.nl/science/html/cancer010227.html>

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Cancer of the large intestine, known as colon cancer, is one of the most common types of cancer in the western world. Recent studies have suggested that increased risk of colon cancer may be linked to regular consumption of red meat. Up to now, scientists have been unsure how this might work. But new Dutch research explains how red meat increases the chance of developing colon cancer, and why eating more dairy products may counteract this greater risk.

Colon cancer is the second biggest cause of death from cancer here in the West - second after lung cancer in men and breast cancer in women. For decades, scientists have suspected that there's a link between diet and increased risk of colon cancer. They point to the example of Japan, where the number of cases has increased dramatically since the 1950's. That was when the Japanese began to eat a much more western type of diet and less fish. And the main suspect has always been meat.

Red versus White Meat

Further recent studies showed that eating chicken and other types of poultry is not a risk factor for colon cancer, unlike red meat such as beef, lamb and pork. So Dr Aloys Sesink, a researcher at the University of Groningen in the north of the Netherlands, decided to find out what it was about red meat that might explain the link with colon cancer. The most obvious difference between red and white meat is the colour - and the thing that causes the 'red' in red meat is *haem*, the same substance which makes our own blood red.

"Haem is one of the forms of iron in red meat; you have normal inorganic iron, and then you have the haem iron which is very specific for red meat. And when you compare the amount of haem in meat, red meat contains about 10 times as much haem as white meat."

Too much Red Meat

While iron - particularly the sort of iron found in ham - is essential to the human body, you don't need very much. In fact only a small proportion of the haem ingested by red-meat eaters is absorbed by the body.

"The amount of haem absorbed in the small intestine is very limited. In fact you only

absorb a maximum of about 10% of what you ingest. So the other 90% plus passes on to the large intestine - the colon."

So then Dr Sesink wanted to know what effect all that extra haem would have on the lining of the colon. He tested this by feeding purified haem to groups of rats.

"We found that in the rats which had been fed an amount of haem which was equivalent to eating 130-150g of red meat per day, there was a much higher rate of cell division in the cells lining of the colon. And a higher rate of cell division is of course a precursor to increased risk of cancer."

The mechanism showing how this haem actually increases cell division is not yet totally clear, but it seems that haem binds with another - as yet unidentified - substance in the large intestine. This new compound somehow damages the colon walls, making it much more "leaky". The colon then tries to repair this damage by increasing the rate of cell division.

Dairy Products to the Rescue

There was a second part to Dr Sesink's research, in which he investigated the effect of eating lots of dairy products on the risk of getting colon cancer. But why dairy products?

"Dairy products contain a lot of calcium, and calcium combines with other substances in the diet to make bigger compounds. These big calcium compounds in turn bind to things like fatty acids and bile acids, which are known to play a role in the development of colon cancer. So we thought that perhaps these calcium compounds might also bind to the haem, and prevent it damaging the colon wall, so reducing the risk of colon cancer."

Indeed, Dr Sesink's tests showed that adding substantial amounts of calcium to the diet of rats fed on high amounts of haem did have the effect of reducing the increase in colon cancer.

So perhaps it may well be wise in future to drink a glass of milk with your T-bone steak!

Addictions

By: Sharon Meadows, PhD

Addictions afflict millions of people in the United States alone. Alternative practitioners believe that conventional methods fail because mainstream methods do not recognize the genetic and biochemical imbalances that research has shown to be at the heart of addiction. By focusing on readjusting these imbalances through diet and nutritional supplementation, herbal medicine, acupuncture, and biofeedback, alternative practitioners are contributing to significant, long-lasting and positive changes.

Definition of Addiction

Addiction can be defined as any physical or psychological dependence which negatively impacts a person's life. Although a person can be addicted to many forms of behaviors i.e., gambling, overeating, sex, or reckless behavior, the term "addiction" is most commonly used to refer to dependency on cigarettes, alcohol, and drugs (both legal and illegal). In severe cases, addiction can become so obsessive that it may seem to take on a life of its own, and the individual's true identity can take second place to the personality of the addiction.

According to James Braly M.D., medical director of Immuno Labs, Inc., in Fort Lauderdale, FL., fundamentally all addictions are biochemically the same. He notes that, addictive substances become a "Necessary ingredient of body chemistry", so that withdrawal occurs when the substance is withheld. "Addiction means that the body has made an unhealthy adaptation that must slowly be reversed". Dr. Braly explains "until then, nerve impulses are confused and biochemistry is scrambled". When someone with an addictive behavior is deprived of, or attempts to abandon, his or her addiction, the resulting withdrawal symptoms demand a solution. During withdrawal from the addictive substance, something must be done to keep the painful, sometimes unbearable, symptoms at bay.

Causes of Addictions

According to Leon Chaitow, N.D., D.O., Of London, England, experts are unable to agree on what causes addiction. Long perceived as a problem of weak willpower, substance abuse is now considered by most researchers in the field to be a "disease" similar in development to diabetes. In other words, according to Dr. Chaitow, a genetic predisposing condition is usually present that is

triggered by familial, environmental, societal, and dietary factors. As a result, even stabilized, an addict must closely monitor the addictive substance throughout his or her lifetime.

Biochemical Imbalances

The body produces its own natural mood enhancers and painkillers called neurotransmitters, which in healthy individuals work efficiently. Dr. Chaitow cites research into brain function that suggests that the addictive personality may lack these natural stimulants (catecholamines) and relaxants (endorphins) and that the addictive brain may send wrong or garbled messages to the body through malfunctioning neurotransmitters. Because of this malfunction, addictive personalities may seek alternatives to natural mood enhancers through the artificial stimulus of addictive substances.

Janice Keller Phelps M.D., author of "The Hidden Addiction and How To Get Free From It", asserts that addiction stems from individual biochemistry and unique genetic makeup. She believes there is a difference in addictive bodies from birth, and that an addictive body may be evident in childhood by the presence of colic, hyperactivity, loss of sleep, irritability, crying and learning disabilities. Additionally, Dr. Phelps says "long before a child can get involved in alcohol and drugs, he's often gotten very addicted to sugar". Substantiating this line of thought, Dr. Chaitow points to the link between brain chemistry and food addictions. Serotonin (another neurotransmitter) is a calming, analgesic-like substance which is secreted in response to carbohydrate and sugar consumption. Sugar addiction may be a misguided attempt to replenish serotonin in the system. A Massachusetts Institute of Technology study describes groups of people who feel depressed, anxious and tense—the right conditions for substance abuse—before eating a carbohydrate snack, and who feel peaceful afterward, their bodies were sated with calming serotonin.

Kathleen Des Maisons, M. ED, president of Radiant Recovery in Burlingame, California, believes that many addictive people have an actual biochemical flaw in the way they process sugar and carbohydrates. This flaw in metabolism causes an addict to respond to sugar as if it were alcohol and to white flour products as if they were sugar. Genetically, these people have biochemically sensitive

bodies, which invite chemical imbalance. Substances like sugar, by creating insulin and rapidly penetrating the cell wall, actually after the permeability of the cell. The normal person, Des Maisons states, has stronger, more impermeable cells which prevent the rise and fall of blood sugar and the jagged peaks and valleys of violent emotions that plague addictive personalities.

Sugar is like an opiate drug that can make life manageable. The child who used sugar becomes the adolescent who discovers alcohol, which is the perfect drug because, beyond its high sugar content, it has an anesthetic property. The addictive personality moves naturally into other drugs. The whole syndrome is really about pain management.

The Addiction/Allergy Connection

James Braly, M.D., Medical Director of Immuno Labs Inc, in Fort Lauderdale, Florida, believes there is a strong correlation between addictions and allergies. We become addicted to foods as a way of adapting to allergic reactions to them, and we tend to crave foods we are allergic to because we need them to keep withdrawal symptoms at bay. When we reach this point and need a particular food in order to feel good, or rather, in order not to feel bad, we are addicted to it. This Topsy-Turvy phenomenon is called the Allergy/Addiction syndrome.

Recent research in the field of addiction suggests that excessive craving for any substance indicates an allergic condition in relation to that substance. "According to this theory" says Dr Chaitow, by constantly exposing themselves to an addictive substance, addicts prevent themselves from experiencing the more violent displays of allergic symptoms. The substance masks the allergy, in other words, Dr. Chaitow points out, that an addict's withdrawal symptoms are almost identical to the symptoms which occur when an allergic substance is removed from the diet—ranging from tremors to prostration, cramps, vomiting, sweating, and hallucinations. Any food or drink which is commonly consumed or craved, may in fact, be an allergic substance for an individual if withdrawal from it makes one feel unwell, or if consumption of it produces euphoria. Dr. Chaitow says that alcohol is the classic substance fitting this description.

Treating Addictions

Over the last decade, substance abuse treatment in the United States, has been focused

primarily on 12 step support groups and individual talking therapies, controlled by medication such as methadone and antidepressants, expensive month long hospital stays, and of course, criminal punishment. It is still unknown whether these methods, combined or individual, will be successful in the long run. However, a 1980 Rand Corporation study confirmed earlier research which found that the addictive population studied, once sober, or "clean" had less than a 15 or 20 percent rate of continued abstinence. Compared to such low success rates, the following alternative approaches offer great Promise.

Diet

Proper diet is essential in treating addictions, according to Kathleen Des Maisons "My main focus is to reverse symptoms of addiction by changing the clients neurochemistry and nutrient deficiency through dietary intervention". She states "this principle is called 'biochemical restoration'. If this is accomplished, then the addictive behavior that has previously been unmanaged can be reversed. Ultimately, the goal is to teach our clients how to recognize and modulate their feelings by paying attention to the foods they eat. Since their main problem is processing sugar and carbohydrates, Maisons approach is to immediately place them on a program of three meals a day which an emphasis on eating proteins at each meal. Most people in an addictive state are very protein deficient. First of all, normally they have not been eating regularly, and secondly, they don't have protein when they do eat because their bodies are craving sugar and simple carbohydrates. So by getting them to eat regularly of protein foods, which are the most complex foods and take the slowest time to breakdown in the stomach, you start to alter their neurochemistry. They become able to maintain a very stable blood sugar level and a very consistent supply of serotonin and dopamine (neurotransmitters) to the brain, so that they do not crave the artificial high from alcohol or drugs.

In addition, complex carbohydrates are permitted, including beans grains and veggies. Also a little fat such as olive oil, because healthy fat leads to the body's production of serotonin, creating a sense of well being and relaxation. We often have people who have been given anti-anxiety medication and no one has bothered to ask them what they have been eating and drinking. Clients who follow this eating plan will normally notice significant changes in how they feel, often in three or four days. Its simple and sometimes startling, Des Maisons says. For example, for a cocaine addict who is suicidal and is trying to get sober, who hasn't eaten in days, sometimes all it takes is a turkey sandwich to stabilize him so he can begin the recovery process.

Nutritional Supplementation

In boosting the body's biochemical defenses against addiction, Dr. Phelps uses nutritional supplements and adrenal and adrenal supports, such as Vitamin C, Pantothenic acid (B5), and adrenal extracts in her treat-

ment regimen. She also stresses that a patient must remove all addictive substances from the diet, including sugar and caffeine. Megavitamin therapy is commonly cited as one of the most vital tools for replenishing Vitamin deficiency, which according to Dr. Aeosoph, affects more than 50% of all alcoholics. She points out that narcotic addicts often suffer from a deficiency of essential minerals, especially magnesium, calcium, and potassium. She explains that since alcohol enhances free radical formation (the molecules responsible for damaging and possibly aging the body), antioxidants are needed to oppose their effects, such as selenium and zinc, E and C. She adds that chromium aids in stabilizing the erratic blood sugar seen in alcoholic Hypoglycemia. Choline and Folic acid are also commonly cited as important supplements to assist in the body's recovery from addiction. Intravenous therapy for withdrawals in severe cases is often used in Dr. Braly's treatment. He states that those with severe withdrawal problems can benefit from three or four consecutive days of Intravenous therapy consisting of Vitamin C, Calcium gluconate, Magnesium sulfate, Pantothenic acid and vitamin B6. "Withdrawal symptoms can often be eliminated completely after one or two days of using this approach", Dr. Braly says. Other nutrients he recommends include Evening Primrose Oil, Vitamin B Complex, Max EPA, and Glutamine (amino acid).

Dr. Corazon LLarina M.D. of the Biomedical Health Center in Reno, Nevada treated a Marijuana addict with an intensive program of mineral supplements. By analyzing the patient's hair, Dr. LLarina determined that the patient was suffering from elevated aluminum, lead and nickel, and beryllium levels. She started the patient on a treatment program that included magnesium, chromium, and manganese supplements, thymus and pancreatic extracts, and high doses of Vitamin C to fight the patient's high toxic levels. After supplementation, Dr. LLarina states "there was a dramatic improvement in lowering the toxicity levels of the patient, and the craving for marijuana and alcohol was alleviated.

Other Methods Used In Treating Addictions

Acupuncture and Traditional Chinese Medicine
Chiropractic procedures
Biofeedback Training and Brainwave Therapy
Herbal Medicine
Ayurvedic Medicine

. Information taken From the Book:

Alternative Medicine the Definitive Guide/
Compiled by the Burton Goldberg Group
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From Clinical Nutrition Review July 2001 American Ginseng reduces postprandial Glycemia

Previous research has shown that 3g American ginseng administered 40 minutes before an oral glucose challenge significantly reduces postprandial glycaemia in subjects without diabetes. Whether this effect can be replicated with doses less than 3g and administration times closer to the oral glucose challenge is unclear, so that the object of this study was to more closely examine the dosing and timing effects of American ginseng on postprandial glycaemia.

In a random crossover design, 12 healthy individuals with an average age of 42 years received 16 treatments: 0 (placebo), 1, 2 or 3g American ginseng at 40, 20, 10 or 1 minute before a 25g oral glucose challenge. Capillary blood was collected before administration and at 0, 15,30,45,60 and 90 minutes after the start of the glucose challenge.

Two-way analysis of variance showed that the main effects of treatment and administration times were significant. Glycaemia was lower over the last 45 minutes of the test after doses of 1, 2 or 3g ginseng than after placebo; there were no significant differences between doses. Glycaemia in the last hour of the test and area under the curve were significantly lower when ginseng was administered 40 minutes before the challenge than when it was administered 20, 10 or 0 minutes before the challenge.

Reduction in glycaemia in subjects without diabetes was time dependent but not dose dependent; an effect was seen only when the ginseng was administered 40 minutes before the challenge. Doses within the range of 1-3g were equally effective.

Vuksan V, Sievenpiper JL, Wong J et al (2001). American ginseng (*Panax quinquefolius* L) attenuates postprandial glycaemia in a time-dependent but not dose-dependent manner in healthy individuals. *Am J Clin Nutr* 73,753-S (2001)

Memory enhanced by Ginkgo and Ginseng combination

In this 14 week trial, 256 healthy middle-aged adults (average age 56 years) received a combined ginkgo/ginseng supplementation. Changes in memory were assessed using the Index of Memory Quality. Capsules were made of 60mg standardized extract of ginkgo biloba plus 100mg standardized extract of Panax ginseng and subjects received 2 different dose regimes (160mg, b.i.d. or 320mg o.d). Average improvement in memory from 12 weeks was 7.5% and could be measured for both working memory and long-term memory.

Wesnes KA, Ward T, McGinty A, Petrini O (2000), The memory enhancing effects of ginkgo biloba/panax ginseng combination in healthy middle-aged volunteers,

Psychopharmacology152: 353-361

A Diet for Living With Hypoglycemia

Extract taken from Hypoglycemic Association Inc. of America.
(Source: <http://fred.net/slowup/haidiet.text>)

Start THE DIET with only FOODS ALLOWED.

We in HAI have been discussing diet with many individuals for a number of years, and if there is one thing we can contribute to the hypoglycemic's welfare, it is a summation of the joint experiences of many who tried THE DIET. Many persons had been struggling along for a year or more on low carbohydrates, dissatisfied and even frustrated. These individuals had been including items on the NON-RECOMMENDED list. Some individuals never improve or do not progress as much as they can until they omit these items.

Familiarize yourself with the FOOD ANALYSIS PAGE. We do not count calories, as a rule, we count the grams of carbohydrates and limit them to 100 grams per day. Some persons feel better on 60-100 g of carbohydrates, adjusting up or down to allow for size and occupation i.e. physical labor. Eating less than 60 grams per day may aggravate a return to undesirable symptoms.

The National Research Council suggests 55-65 grams (g) of protein for women and men respectively, and higher amounts for growing children. Hypoglycemics may find it helpful to start with 100g of protein or more, and then gradually adjust that amount to suit. Each must determine his own needs. At least 6 weeks is usually required to show marked change. One may feel worse at first as a result of withdrawal symptoms from giving up caffeine, sugars, refined starches, etc. Then one may feel better for a short period of time and then get worse for several weeks before starting to feel better again. Many adjustments, including your thinking, are going on in your body.

If one feels worse after starting THE DIET, there are several possible reasons:

1. If THE DIET is drastically different from one's previous diet, one's intestinal bacteria may change also. During this changing one may have diarrhea or constipation. Supplements of acidophilus may be needed.
2. Withdrawal symptoms may occur upon sudden removal of items of addiction such as caffeine, alcohol, drugs, tobacco, refined starches and sugars. There is a question of whether to quit gradually or "cold turkey". These symptoms may be so severe as to discourage a person from continuing.
3. With the increased protein, protein digesting enzymes from the pancreas may be needed, and also hydrochloric acid, which is usually produced by the

stomach for the breakdown of food, especially protein. See Bul. #153, p. 2 The Heidelberg Test for hydrochloric acid. Also consult your physician. For a simple test for the hydrochloric acid, if you have no symptoms of an ulcer, sip one or two teaspoons of apple cider vinegar in water with meals. If this relieves after-meal discomfort, hydrochloric acid may be needed.

A good breakfast is a MUST and a hearty one is advisable. Bedtime snack is a MUST, and should be larger than other snacks which are usually just one or two bites. Between-meal snacks are as important as THE DIET itself. They help maintain the blood sugar level. Frequency of snacking is an individual matter. If you have taken the Glucose Tolerance Test you should eat your snack about 20 minutes before your blood sugar dropped on the test. This may be as short as 1/2 hour or as long as 2 1/2 hours, but just often enough to prevent symptoms. One soon learns the body's signals requiring the next snack. The best and easiest snack is a small portion saved from the previous meal. Learn to carry a snack with you wherever you go.

Excellent for snacks and as a source of minerals are mixtures of nuts and seeds, preferably raw and well chewed. The mixture will tend to provide a more complete protein with balanced amino acids than any one of them alone. Those with the highest amounts of carbohydrates (and this includes peanuts) should be used sparingly at first. (See list of nuts). Cashews which are beans and very high should not be used as first. Dry roasted nuts may contain starch and/or sugar and are not preferred. A daily intake of 1 1/2 oz. (1/2 cup) of nuts is considered to be adequate. Use them for snacks throughout the day rather than eating them all at once.

Other snacks could be 1/4 apple sliced in thirds. Carry in zip lock bag wrapped in paper towel to prevent browning. In a cooler carry small portions of meat, chicken, turkey, hard boiled egg, raw vegetables, or cheese. Vary your snacks so that you are not constantly eating the same foods. If you are going to be out 4 hours and you need to eat every hour, carry 4 snacks. If you get caught without a snack take some water and a little salt. "Always carry water". Some people find protein tablets helpful. Avoid those with added sugar.

"About Salt": Salt is very important and is not restricted due to the tendency to sodium

depletion. The majority of hypoglycemics tend to have low blood pressure. If you have some question on this check with your doctor. Diamond Crystal Kosher salt has no additives. It is not iodized but a kelp tablet or two daily will supply iodine. Hain's Iodized Sea Salt could be used for the table. It helps in handling stress to take some vitamin C with a glass of water and a pinch of salt, adding about 2 oz. of juice.

"About Bread": Any bread which contains wheat in any amount is to be avoided. Read the labels. Soy bread made with soy flour and eggs is a good substitute and is filling. Celery, lettuce and other leafy vegetables can be the "bread" of any meal or snack.

"About Milk": On a diet with no sugar, milk will begin to taste delicious and will be an easy snack, but not a preferred snack. It contains more carbohydrates than protein. Four glasses of milk, which is considered to be a very large amount, contains 48.4 grams of carbohydrate, one half the day's allowance. Continuous large amounts of milk will also deplete the bodies stores of magnesium. (Like-wise large amounts of magnesium will cause a depletion of calcium.) For some persons, milk and milk products can cause intestinal problems or muscle pain. Butter is fine. Natural cheeses, the aged cheeses, may be used in moderate amounts. Processed cheeses and cheese food are not preferred.

"About Fruit": All fresh fruits are permitted, but note that those high in carbohydrates are to be used sparingly; only one-half banana a week, and just a few grapes. Occasionally you may find a person who cannot tolerate any fruit. Fruit after 4 PM may interfere with sleep for some people. Eat fruit in small portions, along with some protein and fat. In time, a whole fruit, eaten alone, may be tolerated. Not that melons are low in carbohydrate. Before breakfast, fresh fruit taken as a source of bioflavonoids is preferable to juice. Fruit also takes a little longer to digest than juices thereby causing a slower rise in blood sugar. A fast rise results in a rapid fall, which may be avoided. Within twenty minutes of eating the fruit, breakfast must follow with protein and fat to maintain the blood sugar level. Fruit, juices, like milk, must not be used too freely as snacks. Use them in limited amounts, diluted with one half water to one half fruit juice, preferably during the day. The 5% vegetable juices may be used. Juices and milk are to be considered foods and not thirst quenchers, and they must be counted in the

total carbohydrates for the day. Water is always the best thirst quencher.

“About Intestinal Bacteria”: Lactobacillus acidophilus is very important for the gastrointestinal tract. It aids with digestion and assimilation. It also helps correct gas, bloating, constipation, and diarrhea. It can be found in health food stores. Some vitamin companies have their own brands. Read the contents labels. Yoghurt, with sugar added, is helpful, and buttermilk is a poor substitute but better than none at all. A little milk or whey powder taken with any of these will provide lactose for the continuing growth of the beneficial bacteria in the intestinal tract.

Read ALL LABELS of foods, drugs, and vitamins. Many products unsuspectingly contain corn, sugars, starches, or caffeine. “Plant protein” may be either wheat or corn and should be avoided. Carmel coloring is made from corn or burned sugar. Most canned soups contain sugar or starch. Chili sauces, ketchups, some canned and frozen meats, vegetables, salad dressings and mustard contain sugar.

The Sugars: Glucose, sucrose, dextrose, lactose, fructose, and sorbos are all sugars. Manitol, hexitol, and sorbitol, technically called alcohols, are sugar derivatives; are slower acting carbohydrates, and cause a lowering of the blood sugar.

Some individuals are very sensitive to additives of any kind, even artificial sweeteners. Processed or manufactured foods should be used with care. The best food is that which is closest to its natural form. (Butter is preferred to margarine.) If you find butter constipating, soften it with an equal amount of good quality oil.

If you are not getting well fast enough, try a complete vitamin complex (the 1-a-day type), or a Vitamin B complex, desiccated liver tablets or organ meats. It may be very important to check for sensitivity to some of the allowable food. Wheat or wheat products (wheat germ) in even the smallest amount are very suspect. Milk, beef, peanuts, or almost any other food can cause distress or problems

for some people, especially the food you like the best and consume most frequently. Some are affected by yeast and molds and probably canned tomatoes. Also check your mealtime atmosphere. Stress and tension may hamper the digestion. If your blood sugar drops a normal amount you will get hungry, eat, then be satisfied. If it drops lower you may have intense cravings, a feeling of never being satisfied no matter how much you eat. At an even lower level, you may lose your appetite. A further drop can cause nausea. These levels may differ with each individual. If you lose your appetite or have feelings of nausea, it's time to check your stresses, physical and emotional. Under stress, the body defense system sends its energy to the muscles and nervous system and away from the digestive system until the stress is alleviated.

In general, overweights tend to lose on THE DIET, and underweights gain. If you are having difficulty keeping your weight down do not eat less frequently, just eat less each time. If you find yourself hungry after a reasonable meal, try ending it with fat, such as a salad with plenty of dressing. Fat tends to satisfy the appetite. Reversing dinner and breakfast calorie-wise helps to lose weight. For some, milk and milk products make it difficult to lose weight. An additional aid to weight loss is the habit of eating in small bites and chewing well. Cholesterol is usually lowered as long as one eliminates sugars and refined carbohydrates as explained by E.R. Pinckney, M.D. in *“The Cholesterol Controversy”*, (Sherbourne Press, Los Angeles, 1973.)

Ham and bacon are usually cured with some sugar, most of which is lost in the curing process. Prepared meats such as cold cuts, frankfurters and sausage usually contain sugar. Some individuals cannot tolerate these. They also may have other additives such as nitrates and nitrites. Some prepared meats are now available without these additives.

Spices are permitted. They have been found to produce an abundant flow of saliva, with unusually high enzyme content. Also providing enzymes are raw fruits and raw vegetables.

Frequently we are asked, *“What can I take*

for my symptoms?” The answer to that is, “It is not so much you TAKE as what you LEAVE OUT.” The reason certain foods are to be avoided is that they will cause various problems. If one has eaten some of these, misery and inability to handle stress result. It usually helps at this time to eat fat, protein, salt, Vitamin C (ascorbic acid or the alkaline sodium or calcium ascorbate), and just a little carbohydrate. If one feels like going on a binge, or feels depressed, it helps to take a 500 mg tablet of Vitamin C, a glass of half water and half juice to which has been added a few grains to 1/4 teaspoon of salt (should not taste salty) and follow with some protein and fat.

“To Sum Up”, apart from supplements as may be needed by the individual, this diet must include salt, fat, Vitamin C, protein and slowly absorbed carbohydrates, which are foods such as vegetables and fruits having the least number of grams of carbohydrate on the food charts. Absolutely to be avoided are: readily absorbed carbohydrates, caffeine, and alcohol. Non-recommended items should be entirely avoided at the beginning of the treatment. (These medications contain caffeine: empirin, Anacin, B.C., A.P.C, A.S.A. compound, Stanback, aspirin compounds, Caffergot, Fiorinal, Trigesic, 4-way Cold Tablets, Midol, Salfayne, and Coriciden.)

Finally, when you feel well enough to try some starches after a period of up to 6 months or less of eating the basic diet, start slowly adding more foods, such as a little baked potato, eating the skin only with some of the potato which adheres. As for the breads, cereals, grains, and flours, those made from rice, barley, whole rye and dried beans may be better tolerated than wheat or corn. One can by now eat more fruit and possibly small amounts of dried fruit. If one feels less well on those items then one should go back to the basic diet again.

However, for many of us, THE DIET, with minor changes, must become a way of life.

“Further Reading”: The Saccharine Disease, T.L. Cleve. Keats Publishing Inc., 36 Grove St., New Canaan, CT 06840, 1984.

(Continued from Page 1)

attention that the number of members attending our meetings have been down at a few of our meetings so every one please make an effort to come as the speakers do put in a lot of preparation for their lectures fore our benefit and please these meetings are only for 3 hours every 3 months and the delicious afternoon tea provided is free now what is a better deal is that?

I believe Jur has had a successful operation on his arm even if it has kept him very quiet on the computer front. Looking forward to seeing and catching up with everyone at the next meeting. Sue Litchfield
Email: litch.grip@bigpond.com

My Hospital Experience Jurriaan Plesman

In early April 2001 I fell off the push-bike - and don't tell a Dutchman "you shouldn't ride a bike" - and tore my muscle on my left arm. This turned out to be more serious than first thought. A muscle was torn from the bone and I finished up having a 'rotator cup operation' in the Prince of Wales Hospital (POW). I never cease to be amazed at the professional dedication of the surgeon carrying out the operation, nursing staff, physiotherapists despite the limited resources available at the hospital. Since leaving the hospital I am not exactly home-sick, but I can only have the warmest memory of nurses coming in the middle of the night and attending to my painful wounds, the patience when they took me to the bathroom to have a shower. After a week or so a special squad of field nurses and physiotherapists drove me

home in a specially designed sling, that my wife kept on calling my bum-bag. With only one arm available I was completely dependent on my wife for most of my simplest needs. I was unable to use the computer - but I sneaked in a few sessions with my right index finger.

After six weeks I returned to the hospital to see my friendly surgeon and his bevy of students. I could from now on crawl out of the sling, and return to hospital in two months for a further check. However, he was sad to say that I may have to see another doctor, because doctors have been told to pay for their own insurance now. This means that honorary doctors would have to pay for the privilege of offering their services to the public hospital and for teaching the next generation of students. He said he prefers to retire. I then realized that Australia is rapidly descending into a third world country.

International Clinical Nutrition Review

GLUCOSAMINE SULPHATE: LONG-TERM EFFECTS

The goal of the pharmacological treatment of osteoarthritis is to control the symptoms and this may be achieved through the use of NSAIDs, but sometimes NSAIDs worsen progression of this disabling condition and patients often experience significant side effects with long-term ingestion of NSAIDs. The short-term trials on glucosamine sulphate to date, however, have never demonstrated a worsening of symptoms, but rather a consistent symptom-modifying effect has always been shown. Glucosamine sulphate is the sulphate derivative of the natural aminomonosaccharide, glucosamine, and a normal constituent of glycosaminoglycans in the cartilage matrix and synovial fluid. In this study Reginster and colleagues assessed the long-term progression of osteoarthritis when treated with glucosamine sulphate at a dose of 1500mg once daily for 3 years. No significant joint space loss was recorded in the 106 patients with osteoarthritis in the knee in this 3 year trial of the long-term effects of glucosamine sulphate. Not only did the knee joint spaces remain stable, but all the patients also experienced symptom improvement.

Two hundred and twelve patients were recruited for this trial from the outpatient clinic of a research unit attached to a university hospital in Belgium. Major exclusion criteria were a history or active presence of other rheumatic diseases which could cause secondary osteoarthritis, and also obesity. The crystalline glucosamine sulphate used in the trial was a pure substance synthesised from chitin. The main outcome measure for the trial was the mean joint-space width of the medial compartment of the tibiofemoral joint measured by X-ray. The medial rather than the lateral space was chosen as it is subjected to the greatest pressure and thus the most osteoarthritis cartilage loss. The symptoms of arthritis were assessed using the WOMAC osteoarthritis index, which is a validated questionnaire with 23 questions designed to assess severity of joint pain, stiffness and limitation of physical function.

The results showed there were significant improvements in pain and physical function with the glucosamine sulphate treatment, but the changes in stiffness were not significant for either group. Joint medial compartment measurements did not worsen on glucosamine sulphate and there were smaller but not significant results for the lateral compartments. Reginster and colleagues conclude that "long-term administration of glucosamine sulphate over 3 years can prevent joint structure changes in patients with

osteoarthritis of the knee with a significant improvement in symptoms", but they call for further studies with even longer follow-up to assess whether the changes noted might modify for example the indication for possible joint surgery or the time to substantial disability.

Reginster JY, Deroisy R, Rovati LC et al. Long-term effects of glucosamine sulphate on osteoarthritis progression: a randomised, placebo-controlled clinical trial. **Lancet** **357**, 251-6 (2001)

CINNAMON IMPROVES GLUCOSE AND INSULIN METABOLISM

In 1998 researchers found that bioactive compounds from cinnamon potentiate insulin activity in rat epididymal adipocytes. The researchers suggested that these compounds, like insulin, affect protein phosphorylation-dephosphorylation reactions in adipocytes. They concluded that bioactive cinnamon compounds may find further use in studies of insulin resistance in adult-onset diabetes.

Since then researchers at the US Agricultural Research Service have evaluated the possible effects on insulin function of 49 herbs, spices and medicinal plant extracts. Their technique measured direct stimulation of cellular glucose metabolism. They found that cinnamon was the most bioactive of these, followed by witch hazel, green and black teas, allspice, bay leaves, nutmeg, cloves and brewer's yeast. Cinnamon is able to restore the ability of fat and muscle cells to respond to insulin in diabetes mellitus type II. The most likely phytochemical in cinnamon responsible for these effects is the polyphenol methylhydroxy chalcone. These results "suggest a possible role for cinnamon in improving glucose and insulin metabolism".

Imparladosevich J, Deas S, Polansky MM et al. Regulation of PTP-1 and insulin receptor kinase by fractions from cinnamon: implications for cinnamon regulation of insulin signalling. **Horm Res** **50(3)**, 117-82 (1998)

Broadhurst CL, Polansky MM, Anderson RA. Insulin-like biological activity of culinary and medicinal plant aqueous extracts in vivo. **J Agric Food Chem** **48(3)**, 849-52 (2000)

LUTEIN, ZEAXANTHIN IN THE HUMAN RETINA AND AGE-RELATED MACULAR DEGENERATION

Age-related macular degeneration is a leading cause of blindness among those over seventy-five years of age. Macular pigment has been hypothesised to function as an antioxidant in the human retina by inhibiting the peroxidation of long-chain polyunsaturated fatty acids. The purpose of this first study was to determine whether lutein (also called xanthophyll) and zeaxanthin, the major carotenoids in the macular pigment, are present in rod outer segment (ROS) membranes, where

the concentration of long-chain polyunsaturated fatty acids, and susceptibility to oxidation, is the highest.

Retinas from human donor eyes were dissected, the carotenoid concentrations were determined and the lutein and zeaxanthin were analysed by high-performance liquid chromatography. The results showed that the combined concentration of lutein plus zeaxanthin was 70% higher in ROS membranes than in residual membranes. This lead the researchers to conclude that "the presence of lutein and zeaxanthin in human ROS membranes raises the possibility that they function as antioxidants in this cell compartment. The finding of a higher concentration of these carotenoids in ROS of the perifoveal retina lends support to their proposed protective role in age-related macular degeneration".

Bruno and colleagues suggest from their review of trials into lutein and zeaxanthin that dietary supplementation can influence macular pigment density. It is suggested that individuals with greater dietary intake of these carotenoids can reduce the risk of age-related macular degeneration.

Rapp LM, Maple SS, Choi JH. Lutein and zeaxanthin concentrations in rod outer segment membranes from perifoveal and peripheral human retina. **Invest Ophthalmol Vis Sci** **41(5)**, 1200-9 (2000)

Bruno RS, Medeiros DM. Lutein, zeaxanthin and age-related macular degeneration. **J Nutraceut Med Foods** **3**, 79-85 (2000)

CHROMIUM-BASED THERAPEUTIC COMPOUNDS AND DIABETES

This review examines the molecular mechanism of chromium activity and its association with diabetes. Recent research has suggested that the biologically active form of chromium is the low-molecular weight chromium-binding substance (LMWCr), an oligopeptide that is widely distributed in various tissues including liver, kidney, brain, intestine and spleen. It possibly functions through an insulin-signalling autoamplification mechanism. The relationship between the proposed mode of action of LMWCr and diabetes, and potential benefits of supplementation are discussed.

Research suggests that chromium supplementation has beneficial effects in subjects with glucose intolerance; the response may be pharmacological or due to the restoration of the chromium balance. The potential of a synthetic multinuclear chromic assembly, called compound 1, was found to mimic LMWCr in promoting the activity of insulin receptor kinase activity, and was also shown to affect total cholesterol, plasma triglycerides, HDL-cholesterol and LDL-cholesterol following 12 weeks of supplementation in rats. Vincent comments that the "synthesis of second generation chromic carboxylase assemblies, which more closely approximate the structural, spectroscopic, and functional properties (Continued on page 11)

Sue Litchfield Recipes

How often have you looked at a recipe and the heading says flourless whatever cake only to find it has plain flour as an ingredient. The muffin that is gluten free, again only to find it has wheat germ as an ingredient or better still the sugar free dessert, again only to find it is sweetened with honey.

I feel it is about time if anyone find that this is the case please do not hesitate to write to that particular magazine because one of these days someone not knowingly will make up the recipe with dire results. I have already approached the Coeliac Society on quite a few recipes that are supposed to be Gluten free except they have an ingredient that contains gluten

RECIPES

Sorry about the lack of them in the last newsletter but due to an illness in the family, and trying to organise myself to get away it was just too hard. That's why I would really love a few of you members to send in a few of your favourites as a back up.

INDIVIDUAL FRITTATTAS

100 gr finely chopped ham
90 gr crumbled goat cheese or sheep's cheese

14 cup chopped chives or use a mixture or fresh herbs if preferred

6 eggs
1/2 cup yoghurt of choice (Sheep's Yoghurt is fine)

Grease a patty cake tin (12). The easiest way is with "Pure & Simple"

Combine ham cheese and herbs in a small bowl; divide the mixture evenly into 12 and place into the patty cake tins.

Combine the eggs and yoghurt and whisk lightly together. Pour even amounts into each cup.

Bake in a moderate hot oven (190- C.) for about 10 mins or until golden brown. Turn onto a cake cooler to cool. Serve as a snack hot or cold or if preferred as a meal with a salad.

SWEET POTATO & POTATO CAKES

Served Herbed Yoghurt
200 g potato peeled and grated
200 g. sweet potato peeled and grated
1 onion finely chopped
2 tabs flour of choice e.g rice or barley flour
2 tabs fresh basil chopped
2 eggs ,lightly beaten

Combine all the ingredients for the cakes in a bowl. Stir to combine

Spray a frying pan with cooking spray. Place 2-3 tabs of mixture into the pan and press down to form a cake.

Cook for 3-4 mins on each side or till golden. Cook 3-4 at a time

Cook 3- 4 cakes at a time.
Serve with the herbed Yoghurt

HERBEL YOGHURT

200 g Natural Yoghurt of choice
1 Tab fresh basil
1 tabs fresh oregano
1 tab fresh thyme
Or choice of herbs to taste
Finely chop the herbs and combine with yoghurt

EASY BAKED PUMPKIN RISOTTO

1 cup Arborio rice
2 1/2 cups chicken stock or vegetable stock
60g margarine or butter
350g Jap or Butternut pumpkin, peeled and diced
2 1/2 cup grated Parmesan cheese (OPTIONAL)
Pepper and salt to taste
1 tabs chopped parsley

Pre heat the oven to 190C.

Place the rice stock butter and pumpkin in an ovenproof dish and cover with a tightly fitting lid or foil. Bake for 30 mins or until the rice is soft. Stir in the cheese if using add pepper and salt to taste. Then add parsley and serve

OATCAKES

2 1/2 cups oat bran (unprocessed)
1 tab fructose or 1 tab Rice syrup
1/2 teas salt
1/2 teas baking powder
80 gr butter (cubed)
1/2 cup water

Preheat the oven to 180.C. Line 2 baking trays with non-stick baking paper.

Place the oat bran fructose/rice syrup. Salt and baking powder in a medium mixing bowl and stir well to combine.

Place the butter and water in a small saucepan and heat over a low heat giving the odd stir until the butter just melts. Add to the oat mixture and use a wooden spoon to combine well. Use your fingertips to bring together to form a dough. Turn the dough onto a well-floured surface and knead for 1 or 2 mins or until pliable. Divide the dough into 4 equal portions.

Use a lightly floured rolling pin to rollout 1 portion of the dough on the floured surface and roll till about 5mm.thick. Use a round 6.4 cm cutter to cut into rounds and place them onto a lined tray. Repeat with the 3 remaining portions of dough

Cook the oatcakes in preheated oven for 12-15 mins or until a light golden and cooked through. Cool on the trays

These are great served with Meredith Blue vein sheep's cheese also any tasty cheese will do

Continued from page 10

of LMWCr, would appear a promising area for further investigation to develop potential therapeutics".

Vincent JB. Quest for the molecular mechanism of chromium action and its relationship to diabetes. *Nutr Rev* **56(3)**, 67-72 (2000)

ALMONDS, PECANS AND WALNUTS LOWER LDL-CHOLESTEROL

Studies throughout the 90's suggested that frequent consumption of nuts may provide some protection against coronary heart disease. The fatty acid composition of nuts may explain this protective effect as they are usually relatively high in polyunsaturated and monounsaturated fatty acids. Both polyunsaturated fat-rich walnuts and monounsaturated fatty acid-rich almonds have been shown in previous studies to lower LDL-cholesterol in American subjects.

In this study the researchers randomly assigned 20 Japanese men and 20 women to follow two mixed natural diets for 4 weeks in a crossover design. Both diets conformed to the average Japanese diet and contained identical foods and macronutrients, except that 12.5% of the energy of the walnut diet was derived from walnuts. The results showed that total cholesterol concentration was 0.16mmol/L lower for the men and 0.22mmol/L lower for the women. The results for LDL-cholesterol were similar. The researchers concluded that while blood pressures did not change on the walnut diet, incorporating moderate quantities of this nut into the average Japanese diet "decreases serum total cholesterol concentrations and favourably modifies the lipoprotein profile" in the Japanese, particularly in women.

An 8 week randomised, controlled study of 19 people with normal cholesterol levels was carried out at New Mexico State University where 10 subjects ate approximately 3/4 cup (68g) pecans daily along with a self-selected diet. The results of this study also demonstrated significant decreases in total serum cholesterol and LDL-cholesterol in the pecan group compared to controls despite the higher energy and higher total fat intake. Body weights also remained unchanged in the pecan group. The conclusion is that "these results tend to support the hypothesis that the kind of fat in the diet (monounsaturated and polyunsaturated fat vs saturated fat) is more important than total fat intake".

Morgan and Clayshulte add a note of warning too: "if dietary monounsaturated fat is kept at a higher level, an appropriate intake of protective nutrients such as antioxidants would be a prudent recommendation".

Iwamoto M, Sato M, Kono M et al. Walnuts lower serum cholesterol in Japanese men and women. *J Nutr* **30**, 171-6 (2000)

Morgan WA, Clayshulte BJ. Pecans lower low-density lipoprotein cholesterol in people with normal lipid levels. *J Am Diet Assoc* **100**,312-318 (2000) (Continued on p 12)

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From Page 11

TAURINE MAY HAVE THERAPEUTIC USE IN ALCOHOL WITHDRAWAL

Neuronal death and neurotoxicity seen in the brain of alcoholics may be attributable to neurotransmitter changes associated with chronic exposure to alcohol and withdrawal. Research suggests that glutamate may play a role in neuropathology. This study used rats to examine changes in inhibitory and excitatory amino acids following withdrawal from chronic ethanol administration.

Glutamate increased significantly in the first 12 hours after withdrawal of ethanol. Five hours from the beginning of withdrawal, rats received an intraperitoneal injection of either taurine or ethanol. The latter increased taurine microdialysate, and delayed the decrease in glutamate toward the end of the 1.2 hour study period. The increase in glutamate after withdrawal was significantly inhibited by the taurine injection. Dahchour and De Witte concluded that "taurine may interact with glutamate, possibly by inducing a blockade of glutamate release during ethanol withdrawal". They further comment that taurine may have "therapeutic properties that could be of use in the treatment of the adverse effects of glutamate during ethanol withdrawal", and recommend additional research.

Dahchour A, De Witte P. Taurine blocks the glutamate increase in the nucleus

accumbens microdialysate of ethanol-dependent rats. **Pharmacol Biochem Behav** 65(2), 345350 (2000)

FREE MEMBERSHIP is offered to anyone who is willing to join the Committee to participate in decision making. The Editor also would like a volunteer to help out in taping lectures and transcribing them. This volunteer should have access to a computer with email capacity.

Attention is drawn to our new Web Site at:

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where you'll find articles on clinical nutrition and self-help psychotherapy.

We also have an article dealing with the treatment of drug addiction. Copies of Newsletters are also available.

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