

The FELIX Letter

Nos. 90 & 91

A COMMENTARY ON NUTRITION

1997

POSITION PAPER

Many moons ago I wrote about the joys of squatting--a time-honored stance for such pastimes as playing marbles, swapping yarns 'round a campfire, giving birth, and, yes, having bowel movements. Readers wrote to thank me for alerting them to a singular way to avoid or ease common problems, i.e., constipation, hiatal hernia, and hemorrhoids, that typically require medical and/or pharmaceutical attention. This trio afflicts multitudes in our country but seems to skip folks in pre-industrial cultures.

No, beefing up our fiber intake is not THE magic solution, it's only part of it. That's the approach MDs and dietitians extoll. The one they DON'T talk about is squatting. It's too....gross. Probably for this reason alone, the U.S. plumbing industry has never been challenged to provide a toilet designed to facilitate a squatting stance. Hot on the trail of a truly *low* toilet, your intrepid researcher learned the only ones extant are in kindergartens and similar institutions, but these are *little* toilets made for very small tushies. Also, these toilets hook up to power flushing units and don't work with standard home toilet tanks.

I'm happy to report that Australian medical researchers are taking the matter *seriously*. [Christine Dimmer, Brian Martin, et al., "Squatting for the Prevention of Hemorrhoids." *Townsend Letter for Doctors & Patients*, Oct. 1996.] They write: "One of the changes brought about by western industrialization has been the posture for defecation. The traditional posture was squatting, and this remains the method used by most of the world's population. It is only in the past hundred years or so that use of the pedestal toilet has become common in Europe, North America and a few other places."

It seems there is "a significant angle, called the anorectal angle, between the rectum, where faeces are stored, and the anal canal....Tagart (1966) measured the anorectal angle in various postures,

finding that the angle is partially straightened out when squatting. He argues that squatting thereby reduced the pressure required for defecation..."

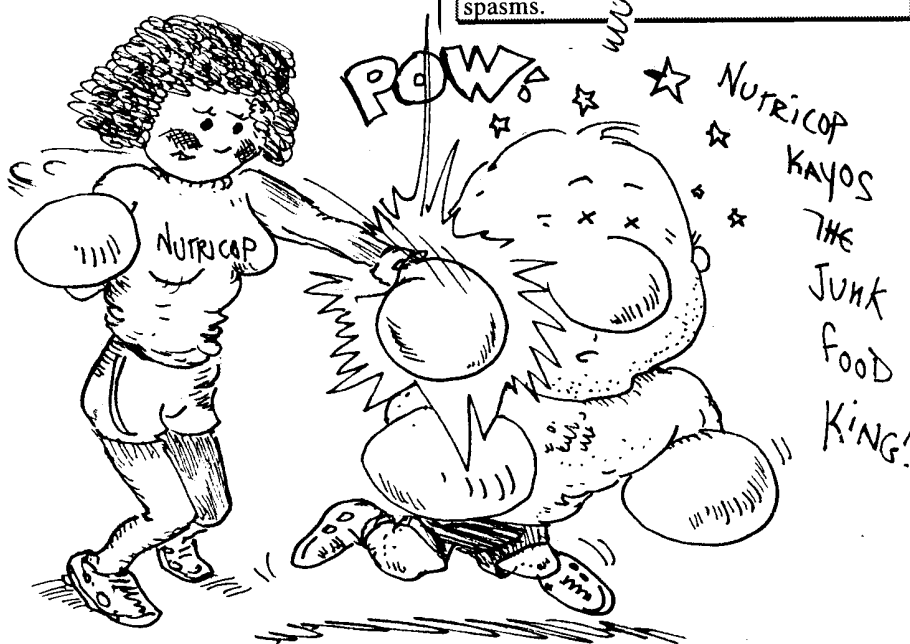
The Australians say only a few hardy medical workers have pursued this subject. In 1987 an Israeli doctor, B.A. Sikirov, reported lasting improvement (12 to 30 months later) in 18 out of 20 hemorrhoid sufferers who followed advice to (1) **wait until the urge to defecate was strong;** and (2) **to proceed in a squatting position.** A few years later, Sikirov's experiment with 30 volunteers showed that squatting reduced substantially both the time required for full emptying of the bowels and, more important, *the number of episodes of straining.*

Straining at stool is known to be one of the causes of hemorrhoids. In 1984, *FL#18*, I quoted the British doctor, Denis P. Burkitt, who worked in Africa and was one of the pioneers in determining why native people on fiber-rich diets avoided ailments that are common in the industrial world. Not only does a highly refined diet cause a multitude of problems, he said, but these are compounded by the modern pedestal toilet:

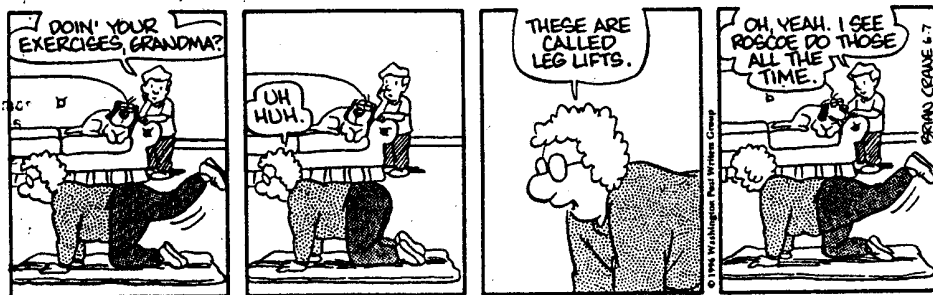
"The valsalva maneuver, comparable to straining at stool, raises intraabdominal pressures to a greater extent than does weight-lifting."

Thus, when we have bowel movements while sitting on a raised toilet seat, intraabdominal pressure below the diaphragm is so great that after years of such straining, it can force the junction of esophagus and stomach *upwards, above the diaphragm.* This condition, known as *hiatal hernia*, causes painful acid reflux, especially during sleep. The first time the burning pain woke my father at age 40, he thought he was having a heart attack. He eventually learned to cope by flooding himself with antacids and sleeping uncomfortably, every night of his long life, in a full sitting position.

Here's a report on another pesky ailment that may be related to pedestal toilets. A baby-boomer friend has a typical bum back--no herniated disks, etc., just a tendency every few months or so to have back muscles seize up in a painful spasm that puts her out of commission for hours and sometimes days. After years (since age 35) of this "out of the blue" phenomenon, a light dawned. "(a) It always happened in the morning when the house and I were chilly. (b) *It usually happened after the morning bowel movement.* I suddenly recalled your advice in a newsletter about a friend who avoided hemorrhoids by climbing up and squatting on the toilet seat." The baby-boomer tells me she's now had six months free of back spasms.



Pickles/Brian Crane

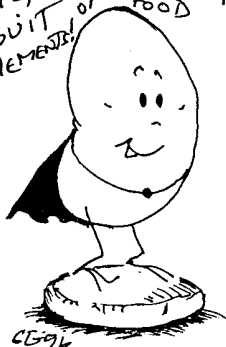


So, in view of the plumbing industry's disinterest in developing a squat toilet, what's to keep us from reinventing the wheel, i.e., planting our feet on our pedestal toilet seat? Anatomy, for one thing: not everyone can squat comfortably, at first. It requires muscle tone and flexible knees. Squatting takes practice. Then there's the safety matter: what to cling to while perching. A bar can be installed if there's a close-by wall or other sturdy surface. The Aussie researchers say some medical advocates have "developed devices that fit on or around pedestal toilets, allowing squatting." This could be a project for home carpenters. I picture something easily removed that slides onto the sides and front of the toilet. If a removable top is added, the device could double as a small table or extra seat for the bathroom.

For those for whom none of the above is feasible, one doctor advises simply bending forward while seated on the toilet so that one's back is almost parallel to the floor. "This achieves the required angle between the torso and legs," though it's a poor second to squatting insofar as stimulating effortless and complete evacuation goes.

When all else fails, we can always revert to thunder mugs! [See FL#23.]

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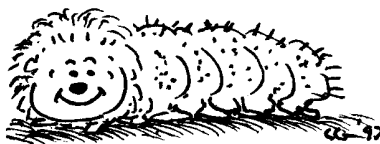


The writers note that "anal functions are largely taboo topics" in modern western societies where "the pedestal toilet is well and truly entrenched." Also, squatting "does not fit the medical model of high-tech intervention," doesn't require doctors, nor does it "provide any advantage to other powerful interests such as the pharmaceutical industry." I might add that research on squatting doesn't win Brownie points for the researchers, either, let alone ready grant monies.

"Yet there are some possible bases for change," the Aussie scientists conclude. "It is possible that visitors from countries where squatting is standard, such as Japan,* [my emphasis] may push for squat toilets, at the same time that pedestal toilets make inroads into these same countries. Finally, if the squatting option demonstrates its effectiveness, then people will push for changes."

I have hopes. We may be a little ahead of our times, but sometimes our dreams do come true. In 1993 I wrote (FL#72): "If some devoutly vegetarian chemists put their minds to it, I suspect they could come up with vegetarian EPA and DHA supplements. Sea plants such as the innumerable kelps probably would be the logical starting point. If readers have any ideas, let me know and I'll pass the word along."

Well, by golly, Martek Biosciences Corp. of Maryland has done it! Read on for this story. □



* How intriguing. I wonder if the Japanese incidence of hemorrhoids, hiatal hernia, etc. compares with ours? Maybe the Asian ingenuity that transformed America's gas-guzzlers into compact, efficient vehicles could be applied now to our pedestal toilets.

A BETTER FUTURE FOR BABIES

In February I attended a dinner at the elegant Mark Hopkins Hotel, high on a San Francisco hill, hosted by David Kyle, PhD, Martek's vice president of research and development. The 50 or so guests were pediatricians, obstetricians, nurses, nutritionists, and medical journalists. Dr. Kyle and I had met at the ISSFAL Congress in 1995, where I first learned of the algae-derived DHA his company had developed [see FLs 83/84]. They're marketing it worldwide, chiefly for infant formulas but also as general supplements. The latest research on infant development confirms that DHA is the w3 especially needed for eye and brain development. Unlike fish oils which contain mixtures of fatty acids, Martek's product is pure DHA. It doesn't have a fishy smell, making it adaptable both for infant formula and commercial food products, as well as attractive to vegetarians. Martek also makes algae-derived pure ARA (w6 arachidonic acid)--the other major PUFA in the brain.

Long before they enter the world, babies need DHA and ARA for eye, nerve, and brain, etc. development. These fatty acids have to come, first, from the mother through the placental blood. After the baby is born, mother's milk becomes the primary source. In his after-dinner talk Dr. Kyle cited studies showing poignant consequences in infants who've been short-changed. Conversely, both IQ and vision benefit when these fatty acids are supplied to babies.

In Korea, Japan, and most of Europe, makers of infant formula are adding DHA and ARA to their products. (Some are adding another valuable PUFA: gamma-linolenic acid, also found in breast milk.) As of now, major U.S. formula makers are getting ready to make the leap or have just done so.

It's been a long, tough fight; I think we're going to win it. □





I APOLOGIZE!

Edward N. Siguel, MD, PhD, wrote to chide me that Donald O. Rudin, MD, was *not*, as I blithely wrote in *FLs* 88/89, "the first scientist to point out that the abrupt loss of w3 [omega-3] in modern western diets led to disruption of a major *essential fatty acid*-based hormonal governing system that, in turn, led to multiform diseases." Dr. Rudin himself, of course, never claimed he was "first" but, rather, drew upon the pioneering concepts of Ralph T. Holman, Hugh M. Sinclair, and J. Reed, whom he credited warmly in his writings (including the two Omega-3 books I coauthored), as well as citing contributions of a number of other researchers who paved the way for understanding the pivotal role of this overlooked family of fats.

Dr. Siguel has been fighting the good fight, too. In the preface to his book *Essential Fatty Acids in Health & Disease* (1994, Nutrek Press, P.O. Box 1269, Brookline MA 02146), he writes:

"While I was in medical school I proposed that abnormalities of EFA [essential fatty acid] metabolism and EFA deficiency cause alterations of cell membrane fluidity and other biochemical changes that cause disease. I developed a method to measure EFA deficiency which is about 10 times more sensitive than methods used by previous researchers. In the 1980's I published several studies with my new methods. I proposed that EFA deficiencies were highly prevalent in the U.S. Unfortunately my theories were not taken seriously, and in fact my research funds ended up being practically eliminated..."

"I have learned a sad lesson on the politics of nutrition research... This should not be surprising, since...huge amounts of government money are wasted on useless research, aimed at testing old hypotheses about saturated fat and cholesterol while avoiding the fundamental role of EFAs in human nutrition. My research indicated that current recommendations encourage people to eat foods low in EFAs and high in trans fatty acids, and therefore contribute to the premature death of hundreds of thousands of Americans....It is my position that current food labeling encourages companies to develop unhealthy products low in EFAs and total fat.

"Because EFAs are cheap and found in inexpensive oils and vegetables, it would be difficult for drug companies to recover millions spent on advertising new drugs to lower cholesterol. ...Government agencies who developed nutritional recommendations which omit the role of EFAs could fear the embarrassment (or even unemployment) which ought to follow a discovery that millions of dollars have been wasted. When I came forward with evidence that EFA abnormalities are quite common, and are a major contributory factor in coronary artery disease and abnormal cholesterol levels, I found that my research was rejected by major public health organizations and my research funds were in great part eliminated by the Federal Government."

Fortunately the tide turns; the American College of Cardiology acknowledges his work and Siguel's papers now appear in medical journals. I met him in Bethesda in June, 1995, where he spoke at the 2nd International Congress of ISSFAL (Int'l Society for the Study of Fatty Acids & Lipids, see *FLs* 83/84), describing how an improved method he developed for analyzing plasma fatty acids reveals that EFA insufficiency and imbalances, contrary to medical gospel, are not rare but very common in the U.S. population.

On the subject of EFA and mental disorders--I found this compelling excerpt: "A linolenic acid (w3) deficient diet, combined with a history of low w3 intake, causes rapid depletion of w3 body stores. It is not surprising, therefore, that we are finding many elderly individuals with impaired mental abilities. We have found EFA abnormalities in patients with Parkinson's, Huntington's and Alzheimer's Diseases as well as many undefined neurologic-psychiatric abnormalities.

"I suspect that many "psychiatric" abnormalities have a biochemical basis in EFA deficiency. Until recently these views were heresy for which I could be burned. I now have evidence that psychiatric disorders can be caused by EFA abnormalities. Recently, I analyzed two patients with severe fat malabsorption who had non-specified neurologic symptoms. When neurologists found no "organic" disease, one patient had been recommended for long-term psychiatric treatment. The other patient had decreased long term memory and vague mental impairments. In both patients I found severe EFA deficiency, particularly linolenic acid (w3). Once treated with intravenous lipids, the "psychiatric" disorders disappeared, while memory and mental abilities improved. I suspect that progressive loss in memory and mental abilities caused by abnormal EFA metabolism is a common unrecognized disorder.

"..While we spend billions to find a genetic cause or miracle drugs, we are overlooking the most common reason for mental impairments, a nutritional deficiency of the very long chain PUFAs [polyunsaturated fatty acids] that are the building blocks for brain function."



Grease for our Gray Matter!

Compared with pre-industrial diets, ours now are very low in w3s. For the first time in the history of the race, mothers stopped breastfeeding; 20th-century U.S. babies routinely have gotten formulas minus DHA, the brain-building w3 in breast milk.

Two scientists with the National Institute of Alcohol Abuse & Alcoholism, Joseph Hibbeln and Norman Salem Jr., say that epidemiological studies in various countries and in the United States in the last century suggest **decreased w3 fatty acid consumption correlates with increasing rates of depression** (*American Journal Clinical Nutrition* 62, July 1995). Societies consuming large amounts of fish and w3 fatty acids, as in Taiwan, Hong Kong, and Japan, have far lower rates of major depression than North American and European populations.

Conditions associated with 22:6n-3 [DHA] depletion, "including alcoholism, multiple sclerosis, and postpartum states, are also associated with curiously high rates of depression. One mechanism may be disruption of the biophysical properties of neuronal membranes, which are critically determined by long-chain polyunsaturated fatty acid composition."

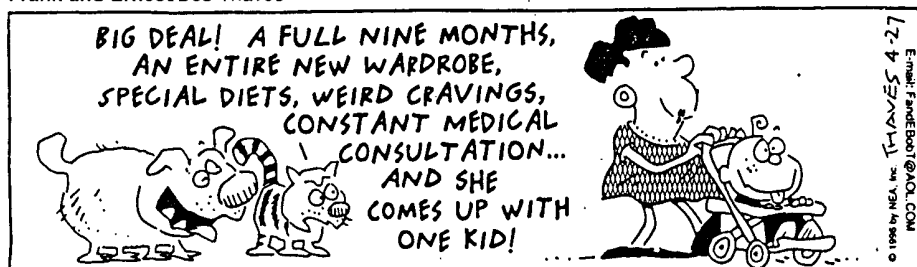
Biophysical properties of these membranes directly influence our output and use of brain chemicals such as serotonin, a lack of which often is linked to depression.

In **Omega-3 Oils** (Donald O. Rudin, MD & Clara Felix. Avery Publishing Group, Garden City, NY, 1996), Dr. Rudin reestablishes contact with Debi Erin, the first of 12 mentally ill volunteers in his 1980 pilot study that also included 32 mentally normal people. She tells how, at age 26, the two tablespoons of flax oil he had her begin taking started a process that restored her eventually to full normal life. She had been treated for schizophrenia since age 15. Few recoveries are as dramatic, but the lesson is clear: *treatment for emotional disorders has to include nutritional support for the brain.* □

Pickles/Brian Crane



Frank and Ernest/Bob Thaves



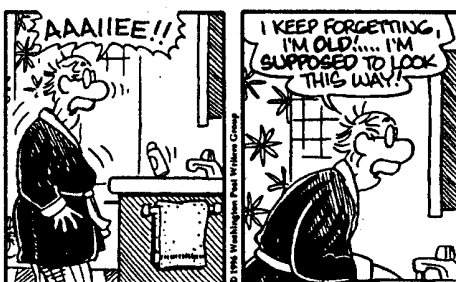
SALT & OSTEOPOROSIS

Australian researchers have documented an overlooked cause for loss of calcium: **high salt intake**. Normally, we conserve much of the calcium that would be lost in the urine: our marvelously efficient kidneys reabsorb it and send it back to the bloodstream. The kidneys do the opposite, too: use urine to get rid of **overloads** of various elements. Unfortunately, when we challenge the kidneys with too much salt (sodium chloride), calcium is dragged along and excreted in urine along with the excess sodium.

In the case of the postmenopausal women in the 2-year Australian study, **high-salt habits correlated with significant bone loss, especially in the ankle and hip**. The more salt eaten (reflected in higher urinary sodium excretion), the greater the women's bone losses.

The amount of calcium we need to take in thus may depend, in part, on how much salt we add to foods. (Natural sodium in foods is not the problem.) The researchers suggest that from 1/3 to one teaspoon of salt a day allows postmenopausal women to do okay on an intake of about 1200 mg/day of calcium.

Salt intake by the women in their study, however, was higher--about one and 1/3 teaspoons daily. To make up for extra calcium lost in urine, the Aussie doctors say the women would need an intake closer to 1700 mg/d, to ward off bone loss. (A. Devine et al., *Am J Clin Nutrition*, Oct 1995, 740-5.) □



SORRY, I MEANT WHEAT GRASS!

Beatrice Trum Hunter, that sterling nutrition journalist who keeps a kindly eye on *The Felix Letter*, wrote me regarding *FLs* 88/89: "To my knowledge, the gluten in gluten-containing grains does not disappear in sprouting the grains. It is *still* present and can create havoc for celiacs, and others with health problems that respond unfavorably to gluten..."

Mea culpa! She was referring to my *incorrect* statement: "The gluten that causes trouble--typically in people who don't know their favorite foods are their nemesis--is a complex mixture of proteins in, mainly, wheat, rye, and barley. Gluten exists in the seeds, i.e., the grain, so sprouts of wheat, rye, or barley are okay since they don't have gluten."

In reply I wrote Beatrice Hunter: "I just spoke with Donald Kasarda, the dean of gluten biochemistry, and he cleared up the matter for me. It's my wording, not my understanding, that was askew. I was visualizing wheat GRASS, not the sprouted grain itself. He explained that if the wheat grass [or rye or barley grass] is sheared off from the grain, and no heads are forming where seeds would be, then the gluten proteins (gliadin, glutenin, etc.) would be absent. In other words, eating sprouted GRAIN would not be safe for gluten-intolerant people, but eating the seed-free (grain-free) products of wheat grass, etc. might be--at least they would qualify as nongluten products."

"Dr. Kasarda, who is with the Western Regional Research Center of the USDA in Albany, CA (just a nice walk from where I live in Berkeley), said they have examined the electrophoretic patterns at different stages of sprouts (of wheat, rye, etc.) to determine whether the gluten proteins are diminishing, but he said it happens so gradually that the sprouting grains contain gluten practically forever and there's no practical way to make the sprouted grains glutenfree."

"At least the sprouted *grasses* minus the seeds (he said "sheared from the seeds with only green showing") ARE glutenfree."

Thank you, Beatrice!

I Hate to Nag, but....

My file on gluten intolerance (celiac disease) grows fat. This grossly inconvenient reaction to 'the staff of life' still receives short shrift in U.S. medical literature. Joseph A. Murray, MD, professor of medicine at the Univ. of Iowa, is that rare American bird--a celiac disease mayven. He says our medical students are being taught outmoded information--that many future gastro-intestinal specialists have never seen a case during their training, nor have many of their faculty. Aside from general disinterest by the U.S. medical establishment, one difficulty is that adult celiac disease is a "great mimic of other diseases." For instance, non-gastrointestinal manifestations can be as varied as *joint pains, dental enamel defects, bone pain and fractures, depression, or infertility.*

There's a growing awareness that it can fuel mysterious neurological ailments such as lack of coordination or muscle weakness. Doctors in New Hampshire treated a 63-year-old man who had suffered for 3 months from progressive ataxia (failure or irregularity of muscular coordination), difficulty with concentration, and confusion. Biopsies of his small intestine showed the typical destruction of digestive and absorptive surfaces seen in celiac disease. "His mental status and ataxia improved after he started a gluten-free diet with added water-miscible vitamin E (400 U three times a day)," the doctors wrote (*Lancet* 1996; 347:p.446).

In the U.K., when Dr. Marios Hadjivassiliou and colleagues tested people with undiagnosed neurological symptoms, 57 percent showed antibodies to gliadin, a component of gluten, while 16 percent had full-blown celiac disease. "The association of neurological disease with gluten enteropathy is well known; at least 8% of patients with coeliac disease develop neurological illness....A gluten-free diet has been shown to improve neurological dysfunction in some patients with gluten enteropathy" (*Lancet* 347, p903-4, March 30 1996).

Delayed diagnosis, thy name is celiac!

In the same issue, UK doctors describe the case of a woman whose symptoms, at age 32, of diarrhea and weight loss *had gone undiagnosed.* Beginning at age 43, she had progressive loss of vision which was diagnosed as macular degeneration. She was almost blind at age 52, when she saw the doctors "because of weight loss, lethargy, and burning feet. On

investigation she was anaemic, had a positive IgA antigliadin antibody, high faecal fat excretion, and total villous atrophy on jejunal biopsy."

(Villi are millions of tiny "shag carpet" extrusions on the inside of intestinal walls which do major digestive and absorptive work for us. Their atrophy leads to chronic, severe deficiencies. The confounding variety of celiac symptoms probably depends on which tissues or organs are more vulnerable.)

"She had a good symptomatic response to a gluten-free diet, antigliadin antibody fell to normal, and her progressive visual loss seemed to stabilise.

"We suggest that this macular degeneration is associated with coeliac disease and that this predated her visual problem. Control of her coeliac disease with a gluten-free diet has arrested her visual deterioration, and this would be more consistent with deficiency as a cause rather than some form of neurotoxicity associated with antibodies."



And now...depression

Untreated gluten intolerance often manifests itself as chronic unhappiness in children, pervasive depression in adults. Mood improvement takes place on a gluten-free diet but is quickly lost when gluten foods again are eaten. Reported abnormalities in the way celiac patients metabolise serotonin, a neurotransmitter in the brain, may have something to do with these moody blues. (I should add that a majority of psychologists and psychiatrists are not tuned in to gluten sensitivity as a cause of depression--even their own.)

Celiacs have a hard time digesting fats and oils. It occurs to me another big factor in their depression could very well be a chronic deficiency of the PUFA needed for brain function.

It May Not be Rare, After All!

Until recently, celiac disease in North America was thought to have an incidence of no more than 1 in 5000, compared with 1 in 250 to 300 in Europe. A study summarized in *Gastroenterology*, April 1996, in which 2000 healthy U.S. donors' blood was screened, found the incidence of celiac possibly to be as high as 1 in every 250 persons.

State-of-the art blood tests for antigliadin and endomysium antibodies are available now in many U.S. laboratories, proving to be almost as accurate as intestinal biopsies for diagnosing gluten intolerance. My advice to those who suspect they have this problem: (1) Get yourself tested. (2) If you turn out to be sensitive to gluten, stock up on books and recipes that describe safe foods and how to buy and/or prepare them. (3) *Always keep good supplies of nongluten foods handy.* Bless the foods you *can* eat and fill up on these so you're not tempted by the other stuff! (4) Call the Celiac Sprue Assoc. in Omaha, 402/558-0600. Ask how to get on their mailing list. (5) Do the same for the Celiac Disease Foundation in Studio City, CA, 818/990-2354. There are active celiac groups and newsletters all over the country--I exchange subscriptions with several. They provide encouragement, recipes, practical information, and they push for "celiac awareness" in schools, the food industry, and medical world.

After all, today's U.S. population of close to 250 million could mean a million of us may be celiacs--a force to be reckoned with! □



LEAVING THE OLD COUNTRY

Just beginning to be explored is one scenario for heart disease that belies the high animal fat, high-cholesterol theory. The typical diet in the U.K. of Asian Indian immigrants in upper socio-economic classes, as reported in *Lancet*, Nov. 2, 1996, p.1241, is cereal-based, low fat, and lactovegetarian--just what heart experts love, right? Yet during recent decades this group has experienced a sharp rise in non-insulin-dependent diabetes, a cluster of insulin-resistance disorders, and cardiovascular disease. The authors suggest these are *linked ailments* having a common origin: very low intake of longer chain polyunsaturated w3's, i.e., EPA and DHA, coupled with comparatively high intake of polyunsaturated w6's mainly in their cooking oils.

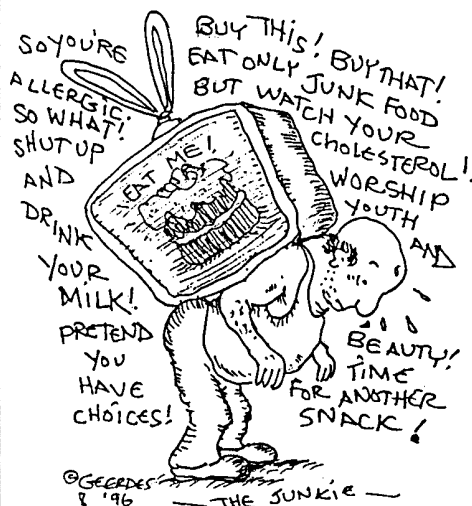
Longer chain w3's are needed for normal insulin action, hence a deficiency promotes insulin resistance, the authors say. Insulin resistance leads to the panoply of problems besetting Asian Indians in the U.K.: *increased abdominal obesity, high blood sugar, high blood triglycerides, and low HDL (good) cholesterol.* These are presented as likely factors in the Indians' high incidence of coronary heart disease.

It's a well known phenomenon that people who emigrate and abandon traditional diets often pay a stiff price healthwise. For centuries India has grown flax and pressed the seeds for their high w3 oil content, just as China does today. The 1903 *Yearbook* of the U.S. Dept. of Agriculture described the flax plant (*Linum usitatissimum*) as having originated in the far East and having been known "since the times of Moses and Homer. Flax is an annual, and at present is cultivated in nearly every country of the globe, especially in Russia and India."

My father once described to me the "fresh, golden oil" that his mother bought regularly from a peddler, who sold it from a little horse-drawn wooden cart to villagers in the Ukrainian town where my papa was born over a hundred years ago. Pressing oil from flaxseeds didn't require high-tech equipment, while the pressed cake became food for livestock. Still is.

Times, alas, have changed since 1903. More "cold-weather" w3s are needed in a chilly place like England compared with India, but it's unlikely flaxseed oil is a staple there. Undoubtedly, U.K. markets

display the same high w6 oils seen in U.S. markets. Too bad. A tablespoon a day of "old country" flaxseed oil would benefit all U.K. dwellers, especially folks who don't eat fish. □



SUCH GOOD NEWS!

There's a glorious stack of medical papers on my desk, one after another concluding that vitamin E, from food and/or supplements, helps us to avoid or ameliorate heart disease.

Of 2000 men in a 1996 U.K. study who suffered from the ailment, the 1000 who took daily supplements of either 400 or 800 IU of natural-source vitamin E had 77% fewer nonfatal heart attacks than the placebo group (*Lancet*, Vol 347, Mar. 23, 1996).

At Karolinska Hospital in Stockholm, doctors learned the more vitamin E that 64 male survivors of heart attacks had in their LDLs, the fewer stenotic lesions they had, i.e., the less severe their coronary artery disease was (*Am J Clin Nutr* 63, March 1996). LDLs (low density lipoproteins) normally transport cholesterol in the blood. Vitamin E helps to protect LDLs from oxidative damage that can lead to coronary artery disease.

Among 34,000 healthy postmenopausal women in the Iowa Women's Health Study, the risk of death from coronary heart disease was 58% lower in those with the highest dietary vitamin E intake (at least 12 IU daily) than in the women who consumed the lowest amounts (less than 5.7 IU per day) (*New Engl J Med*, 334:1156, 1996).

Over 11,000 persons, 67 to 105 years old, participated in a National Institute on Aging survey between 1984 and 1993, in which their use of nonprescription drugs and vitamin supplements was chronicled. By the end of the study, when causes of death of 3490 men and women were evaluated, those who had used vitamin E alone, or both vitamins E and C, had impressively fewer deaths from heart disease and all causes than individuals who had not taken the supplements (*Am J Clin Nutr* 64: Aug 1996).

The Experts Still Balk

Earlier, the *San Francisco Chronicle*, June 21, 1995, reported that Univ. of So. Calif. researchers led by Dr. Howard N. Hodis enrolled 156 men in a trial of cholesterol-lowering drugs. The men had undergone coronary bypass surgery because one or more arteries in their hearts had become totally narrowed by plaque.

Although not required in the study, some of the men were taking 100 to 400 units of vitamin E. At the end of the two years, this group had slowed the development of new plaque in their arteries significantly, compared with the men who took no extra vitamin E at all.

You'd think Hodis' group would be jumping for joy and cheering for vitamin E, wouldn't you? Not on your life. *Caution* is the watchword. Still more studies are needed. An American Heart Assoc. (AHA) spokesman said vitamin E could be an important supplement but "he too urged more tests."

And even though the AHA gave a high rating to the 1996 advances in vitamin E heart research, their news release at the end of the year stated: "The American Heart Association recommends that healthy people get adequate vitamin intakes from eating a variety of foods rather than from supplements."

Compare the medical establishment's 50-year foot dragging on vitamin E supplementation, with their swift okays on the steady stream of pharmaceuticals-of-the-month! The drug industry's newest promo gimmicks are 3-page blazing color ads in *popular magazines* for prescription drugs, to get readers to pressure their docs for these life-giving nostrums. □

THEY SET THEM FREE

Medical battlefields are littered with career-corpses of those who stray from the straight 'n narrow. One of my classmates in UC Berkeley's nutrition department 20 years ago, a brilliant young woman who fought to use her PhD for charting new research territory, told me, "You really have to play it safe when you're in the field because if you don't, you get drummed out of the corps. The consequences of being creative are dire!"

We owe more than can be told to unshakeable, principled clinicians like Abram Hoffer, MD, PhD. "I have been involved in megavitamin controversies since 1955..." the psychiatrist from Victoria, British Columbia, writes in "The Vitamin Paradigm Wars" (*Townsend Ltr for Drs & Pts*, June 1996).

In the paradigm of *vitamin-as-prevention*, from which he says the medical community is beginning to emerge, the rules or beliefs are:

"1) That vitamins are catalysts and therefore are needed in very small doses since they can be recycled almost indefinitely.

"2) That they are needed only to prevent deficiency disease..."

It follows that many medical societies consider any use of vitamins which disobeys these rules to be "unethical practice or malpractice."

"If they are needed only in small doses the use of large doses must be forbidden. If they are used only to prevent disease, any use to treat other disease must be forbidden," Hoffer writes. "...A physician friend and colleague lost his medical license in Saskatchewan. One of the charges against him was that he gave a patient intravenous ascorbic acid."



Felix '81

"If GOD WANTED US TO HAVE VITAMINE, HE WOULD HAVE PUT IT IN VACUUM, BRAD,"

Now gaining medical acceptance, albeit grudgingly, is the *vitamin-as-treatment* paradigm: "1) That optimum doses should be used in both prevention and treatment and that these doses vary from very small to very large..."

"2) That vitamins may have activity which appears to be unrelated to their properties as vitamins. This was a very difficult concept to accept but the introduction of the word *antioxidants* struck a responsive chord and many physicians who were terribly fearful of using vitamins had no compunction against using the same vitamins as antioxidants. This fits in with the increasingly popular view that hyperoxidation, the formation of free radicals, is basic in the pathology of a large number of conditions including cancer, senility and so on."

Hoffer and Humphry Osmond had shown in repeated careful trials beginning over 40 years ago that megadoses of nicotinic acid (niacin) restored many of their schizophrenic patients to normal life. They found it worked best for early or acute patients, but not demonstrably for chronic ones. (Even that changed, as I'll describe.)

Early on, their work was distorted and dumped on malignantly by the American Psychiatric Assoc. (APA), which effectively killed interest in the use of vitamins for treating schizophrenia. Hoffer writes, "The APA bears major responsibility for preventing the introduction of a treatment which would have saved millions of patients from the ravages of chronic schizophrenia."

Later, the APA used the most powerful weapon of all: *silence*. Hoffer's work doesn't exist, as far as it's concerned. My forays in UC Berkeley's libraries led me, starting years ago, to Hoffer's lucid writings in the *Journal of Orthomolecular Medicine*. So, imagine my disgust when I was conducting a computer search on Medline a few months ago to learn Medline deliberately excludes this vital journal from its indexed resources! The blanket of silence still covers psychiatry.

Trading Schizophrenia for "Tranquilizer Psychosis"

Meanwhile, the parade of healed schizophrenic patients grew...and grew. Orthomolecular treatment now included other nutrients in addition to niacin, and Hoffer was finding encouraging stirrings even in his chronic patients. But the

profession had latched on to a new cure-all in the late 50s--the tranquilizers--that blotted out everything else on the horizon. Hoffer says: "Just as the APA was once captured by psychoanalysis, it is now captured by tranquilizers."

Tranquilizers, however, do not cure schizophrenia. Tranquilizers *are* helpful in reducing and eliminating symptoms and signs from schizophrenic patients. At first this is exactly what they do, Hoffer writes (*J of Orthomolecular Medicine*, 9:1, 1994). But as the patients improve, they begin to respond to the antipsychotic tranquilizing drugs as if they were well, i.e., *the drugs make them sick, producing the "tranquilizer psychosis."* Physical symptoms include lethargy, incoordination, tremor, fatigue, sleepiness, impotence, and excessive weight gain.

"But the mental symptoms are even worse. They include difficulty in concentration, decrease in memory, disinterest, apathy, depression and irresponsibility....Tranquilizers convert one psychosis to another...[preventing] the unfortunate patient from becoming a normal member of society..." With these symptoms, of course, they effectively are barred from decent jobs and social relations.

Hoffer believes in taking advantage of the swift effectiveness of the drugs, the solution being to combine drug treatment with nutrients, as is done by orthomolecular psychiatrists. "...one takes advantage of the rapidity of the drugs with the much better final effect of the vitamins and minerals..." Eventually with most acute patients the drug is either eliminated, or diminished to such a low dose it no longer produces tranquilizer psychosis. "As the patient recovers, the nutrients gradually take over and once the patient is well they will in most cases keep them well. If they do relapse it is not nearly as severe and usually they respond much more quickly the second time around...I have seen patients who had 30 admissions [to hospital] when they were started on this program who eventually did not need any more admissions."

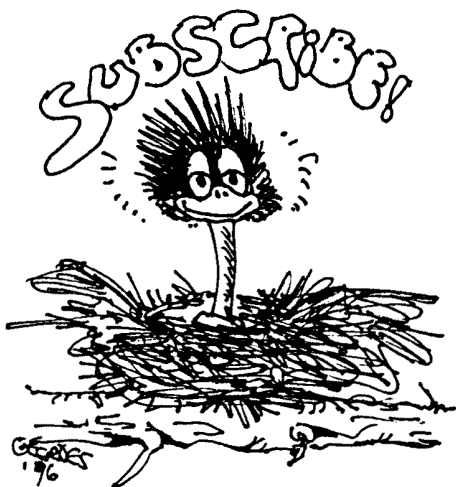
Chronic Schizophrenics Respond

Since 1965 he also has treated a very large number of chronic patients using the entire orthomolecular approach. "We had recommended many years ago that they not be treated since we had seen no positive results. I was wrong because I had not persevered long enough. This long paper is my attempt to correct the record and to apologize to all the chronic patients who have not been treated and have been condemned to permanent disability."

He describes a psychiatrist who headed an outpatient clinic where 1200 chronic schizophrenics came for their injections of parenteral tranquilizers. "He was so fed up with the whole procedure and with seeing none of the patients ever get any better he had decided to retire from psychiatry. However after he had started the orthomolecular program, within a month he began to see remarkable improvement in his patients. He now found going to work each day very exciting and he would ask himself which patient today will I see starting to get better. He has since become an excited and dedicated orthomolecular psychiatrist."

The profession as a whole remains as uninformed and suspicious of niacin plus other nutrients in the treatment of schizophrenia as they were in the 1950s. Hoffer writes: "They ignore over 200 books published in the past fifteen years which detail orthomolecular treatment and the results. The current psychiatric journals refuse to accept clinical papers, and the current medical index refuses to abstract and enter these papers when they are published in journals such as this."

Yet, many doctors have visited him over the past 35 years, and about 60 have become orthomolecular practitioners. (Several as a result lost their licenses!) "Seventeen young men became schizophrenic in their teens. They recovered with orthomolecular therapy, took medicine and psychiatry and are today practising. This may surprise you, but one is a chairman of a large department in one of the medical schools in a well-known U.S. university, another was for a year president of a large psychiatric association, one is a research psychiatrist...; all are well." □



How about
SOME
VITAMINS?



To my patient readers: Your editor has been fighting rough beasts since midOctober, aiding a best friend who has colon and liver cancer. We were in Tijuana, Mexico to get help from Hulda Regehr Clark, PhD, ND, after first reading her shocker of a book, *The Cure for All Cancers*, then her second one with its equally offputting title, *The Cure for All Diseases*. Everything in both books turned my world upside down, but it *did* explain why someone living a good life could get cancer. Life now revolves around techniques for avoiding or killing *common food-derived parasites*; and checking for and avoiding *noxious solvents, metals, and mycotoxins* (e.g., isopropyl alcohol, benzene, mercury, aflatoxin) from food, beverages, and home products. I believe it's paying off. I'll report developments.

Meanwhile, take the plunge and get her books. You're in for a scary but hope-making ride. If your book and health food stores don't sell them, you can order them, plus her new one on AIDS (!), from ProMotion Publishing in San Diego, 800-231-1776. I also recommend veteran medical journalist Morton Walker's review, complete with initial deep skepticism of Clark's concepts, in *Townsend Ltr for Drs & Pts*, Feb/Mar 1997.

Ann Louise Gittleman set the stage for the concept of parasites as major bringers of modern diseases--yes, even in sanitized middle-class lives!--in her insightful 1993 book *Guess What Came to Dinner* (Avery

Publishing Group), but I didn't read it until a few weeks ago.

It's nice to be back with you! □

OMEGA-3 OILS by Donald O. Rudin, MD, & Clara Felix is in book stores now. Dr. Rudin's case histories of patients who recovered when their "oil was changed" are unforgettable. Thousands of new medical studies now confirm why "oil-changing" worked for arthritis, immune problems, and emotional disorders. We show how "Omegafying" one's diet benefits complexion, mood, sexual health, and blood circulation; how it can be implemented in pregnancy and infant feeding; how it can slow down premature aging. If it's not in your book or health food store, you can order it from Avery Publishing Group, 800-548-5757.

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