



Volume 2 Issue 3

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**A World of Hope and Dreams – Early Detection
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A Very Painful Story

What I am about to tell you has generated more hate mail to me than any other subject I have ever talked about. If you are one of those people who would rather live in a world of hopes and dreams, than learn the hard, but sometimes painful, facts, then please stop reading this article.

One day on my daily radio show several years ago I announced that I was going to have a special guest; one of the world’s experts on breast cancer, a famous surgeon and author, Dr. Robert Kradjian, from Seaton Medical Center in Daly City, California (near San Francisco). My original plan was to talk to him about his new book on diet and breast cancer – *Save Yourself from Breast Cancer*. I was in a challenging mood that day, and decided to change the focus of the show. I questioned him for the hour on the early detection and treatment of breast cancer. Those 60 gut-wrenching minutes angered my guest and some of my radio audience.

A few days following the show, I received a letter telling me, “I will never listen to your show again. You ruined the lives of four of my best friends with breast cancer. I asked them to tune in to hear about diet and breast cancer. You and your guest told them that they were going to die of cancer, suffer needlessly from painful and disfiguring treatments, and that their doctors had essentially lied to them. You took away all of their hopes.” And that is certainly one way to look at what I had done. This letter hurt me – I could feel the pain that I had caused for these women and others, who possibly for the first time had learned the truth about cancer. I read the letter on my radio show, and asked my listening audience for their responses. All of the calls I received for that hour were from women and they were unanimous, “Tell us the truth – no matter how much it hurts.” So here is the truth. However, to take some of (see page 2)

Restrict Protein – Save Your Kidneys¹

The popularity of high protein diets (like Atkins, Zone, Sugar Busters, Suzanne Somers, etc.) and the common use of protein supplements, especially among body builders, are increasing the risk of life-threatening kidney failure for millions of people. Although the damage caused by excess dietary protein has been recognized for more than 100 years, most people believe this nutrient is the most important one to seek in their diet. Certainly you need to get enough protein from your foods. However, the truth is, it is virtually impossible to fail to do so with any diet of natural unprocessed foods – even when these foods are all vegetarian. The problem is always with getting too much protein – and the consequences of failing to understand this fact, solidly based in science, can mean a miserable life tied to a dialysis machine and a premature death from uremia (the build up of toxic byproducts of metabolism). (See page 11)

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The Example – Prostate Cancer

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the emotional edge from the subject I have chosen prostate cancer as my example – the subject of breast cancer is just too disturbing for many people – but the story is the same – breast cancer in women is essentially the same disease as prostate cancer is in men.¹

We're Losing the War on Cancer

I would love to be able to tell you that we are winning the war on cancer – believe me, I do not want to see people suffer. Unfortunately, with the present day strategies of early detection, surgery, radiation, and chemotherapy, we are definitely not. In fact, your risk of dying from cancer (adjusted for your age) has increased by 6 percent from 1970 to 1994 (189.6 vs. 200.9 per 100,000 people).² According to Dr. John Bailar, from the Department of Health Studies, University of Chicago, author of a landmark 1997 *New England Journal of Medicine* article, “The war against cancer is far from over. Observed changes in mortality due to cancer primarily reflect changing incidence or early detection. The effect of new treatments for cancer on mortality has been largely disappointing. The most promising approach to the control of cancer is a national commitment to prevention, with a concomitant rebalancing of the focus and funding of research.” (As you will learn soon, the principle way early detection changes mortality figures is by finding cancer earlier – making it appear people live longer – but not actually changing the day of a person’s death.)

The failure to make a difference is not because of lack of money. The National Cancer Institute’s budget has increased 20-fold since passage of the 1971 National Cancer Act. Unfortunately, the funding for research and public information on primary prevention of cancer has been minimal.³ According to Samuel Epstein, MD, Professor of Occupational and Environmental Medicine, University of Illinois School of Public Health, “The cancer establishment bears major responsibility for the cancer epidemic, due to its overwhelming fixation on damage control--screening, diagnosis, treatment, and related molecular research--and indifference to preventing a wide range of avoidable causes of cancer, other than faulty lifestyle, particularly smoking.”

You see – some of the most respected experts in the country understand, and are willing to publicly admit, that early detection and treatments for cancer fail, and that the right course of action is through prevention by a healthy diet and lifestyle.

Early Detection for Prostate Cancer: PSA and DRE

There are two tests that are commonly recommended by doctors for the early detection of prostate cancer: The *PSA* and *DRE*. *Prostatic Specific Antigen* (PSA) is a substance made exclusively by the prostate gland. Chemically, it is a sugar and a protein molecule (glycoprotein), which naturally leaks out into the bloodstream. The *PSA test* measures the level of this substance in a man’s blood. Inflammation (prostatitis), enlargement (benign prostatic hypertrophy), and cancer of the prostate can result in elevated test results. The PSA test is not foolproof and can rise without there being cancer present. It can also be normal when there is cancer. Approximately 2 out of 3 men with an elevated PSA level will not have prostate cancer.⁴ The higher the level of PSA, the more likely the problem is to be cancer. A cancer must grow to the size of 1 centimeter (cm) or about a half inch – before it is large enough to make the PSA rise above normal levels (above 4 ng/ml).^{5,6} (Remember this fact.)

The digital rectal examination (DRE) is a physical examination of the rectum performed by the examiner’s finger. Through the wall of the rectum the doctor can feel the prostate gland in a man. In most cases, the cancer must be the size of a small marble (1 cm) for the doctor to feel an abnormality. (Remember this fact.)

Startling (But Honest) Recommendations for Screening with PSA and DRE

The U.S. Preventive Services Task Force, in December of 2002, published their guidelines and said, “The USPSTF does not recommend for or against routine screening for prostate cancer using DRE or PSA testing... The USPSTF concludes that evidence is insufficient to determine whether the benefits outweigh the harms for a screened population.”⁷

The European Union Advisory Committee on Cancer Prevention concludes (August 2002), “As long as randomised studies have not shown an advantage on prostate cancer mortality or related quality of life, screening for prostate cancer is not recommended as a healthcare policy.”⁸
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The Canadian Urological Association discourages the practice of screening for prostate cancer.⁹ American College of Preventive Medicine (July 1998) recommends against routine population screening with DRE and PSA.¹⁰

The American College of Physicians (this is the official organization for Internal Medicine specialists – I belong to this organization) writes, “Despite its time-honored place as part of a complete physical examination, routine digital examination has not been shown to reduce a patient’s chance of dying of prostate cancer or to improve quality of life.” About PSA they say, “Routine measurement of PSA has not been proven to reduce the overall or disease specific mortality rate or to improve health-related quality of life.”¹¹

The list goes on with most organizations worldwide recommending against routine screening for prostate cancer with a PSA or DRE. There are a few organizations, like the American Cancer Society, the American Urological Association, and the American College of Radiology that recommend these screenings – I believe these trade organizations have placed the physician’s financial interests ahead of patient’s well being.

The evidence that early detection fails is so convincing that Dr. Mack Ruffin from the University of Michigan Medical Center wrote in the April 1995 issue of the *Journal of the American Medical Association*, “As a part of the informed consent discussion, physicians should disclose to patients that DRE, PSA, and TRUS (ultrasound) are unproven screening procedures. To do otherwise is deceptive and harmful to the trusting physician-patient relationship”¹² “A cynical reading of ‘free prostate screening’ by urological practices suggests an underlying motive of income substitution -- from transurethral prostatectomies to ultrasound plus biopsy. We question the ethics of physicians using their trusted positions of authority to recommend unproven screening procedures for financial gain.” Patients are subjected everyday to free PSA tests as part of “Prostate Cancer Awareness,” an industry-sponsored advertising campaign which began in 1989 and has been targeted to men older than 50 years.¹³

Two Kinds of Prostate Cancer:

Worldwide the incidence of prostate cancer, as found by microscopic examination of the prostate at autopsy, occurs in about 30% of men over the age of 50 years.^{14,15} In the USA the rate of microscopic prostate cancer is even higher at all ages; 30% of men in their 30s, 50% of men in their 50s, and more than 75% of men older than 85 years.¹⁶ However, for most men these cells that look like cancer never spread, and therefore never threaten a man’s life. These kinds of cancer are referred to as *latent cancers*. The cancers that kill are referred to as *advanced cancer*. I believe the rich Western diet is the determining factor that changes latent cancer into life-threatening, advanced cancer. Unfortunately, doctors cannot tell by looking at the prostate tissues under the microscope whether or not the cancer will ever become life-threatening. As a result, most men found with either type of cancer will be treated aggressively – surgery, radiation, castration, and/or chemotherapy – for a discovery (latent cancer) that would have never threatened their life. Just as tragic is the fact that those men who have the aggressive form of this disease also fail to benefit from treatment because in this case the discovery is far too late to be of any help. You will know why after you learn about the natural history of this disease.

The Natural History of Cancer¹⁷

The next few paragraphs are probably more than you ever wanted to know about cancer – but for you to understand the truth about cancer you need to know how cancer grows and spreads.

The argument for early detection of prostate cancer rests on the belief that the test can discover cancer in its early stages – before it has spread to other parts of the body. Unfortunately, the argument is groundless. Many lay people, and very few physicians, believe that prostate cancer goes through a series of steps in which it remains within the prostate for some time period until it spreads to the lymph nodes and then to the rest of the body. In their minds the process looks something like this:

Step 1: A cancer manifests and starts to grow slowly in the tissue (in this case, the prostate).

Step 2: With time, the cancer grows into a larger tumor.

Step 3: Eventually, the cancer spreads to the lymph nodes.

Step 4: Finally, the cancer spreads from the lymph nodes to the rest of the body.

Unfortunately, this step-by-step progression from a harmless mass to a body full of disease almost never occurs. Rather, cancer spreads to other parts of the body via the bloodstream in the very early stages of its development.

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The spread of cancer to the lymph nodes actually occurs simultaneously with the spread of the cancer to other parts of the body.

Normal, healthy cells multiply only when necessary, such as during the growth of tissue or repair after an injury. Cancer cells, however, divide at *their own free will* and spread to other parts of the body where they continue this uncontrolled growth without respect for the body as a whole. This is how they transform a major organ into a non-functioning cancerous mass and eventually kill the patient. Like most other cancers, prostate cancer begins with the mutation of a single healthy cell into a malignant one. Once this transformation occurs, the single cell begins to replicate, or divide. The time it takes one cell to divide and become two cells is called *the doubling time*. The average doubling time for prostate cancer cells (as well as for most other solid tumors) is approximately 100 days. This means that in 100 days, a single cancer cell will have become two cancer cells. In 200 days, that one cell will now have become four cells in a prostate that consists of about 100 billion healthy cells.

After one year, that tumor now contains twelve malignant cells. At this doubling rate, it takes about six years for the single cancer cell to become one million malignant cells, which together form a tumor that is about the size of the tip of a lead pencil. A mass of this size is less than one millimeter in diameter, and is undetectable by digital rectal examination (DRE), or by PSA.

Even though the cancer is so tiny that it cannot be detected, it nevertheless has already spread, or metastasized (in medical terminology), to other parts of the body in virtually every case of true cancer (as opposed to the latent form of cancer). It is the cancer cells that have spread to, say, the liver, lungs, bones, and brain, that kill the patient, and *not* the cancer cells confined to the prostate.

After about 10 years of growth, the average cancerous mass inside the prostate is about one centimeter in diameter, or about the size of an eraser on the end of a pencil, and consists of about one billion cells. This is the earliest stage at which most tumors can be felt by the physician's probing finger. Also, the tumor must reach a similar mass of one centimeter before it begins to elevate the PSA level into the abnormal range (above 4 ng/ml).^{5,6} As you can see, early detection is a misnomer -- three-quarters of the disease has already happened unbeknownst to the patient or his doctor.

A Very Positive Note: Please let me add, you now understand the natural history of prostate cancer so you know how changing to a healthy low-fat, plant-based (McDougall type) diet can save a patient's life. The *average* doubling time for a cancer cell is 100 days. However, in some cases the cells double every 24 days – at the other extreme, cancer cells may double every 800 days for a specific patient. The goal is to slow the doubling time so he would have to live to be 175 years old to die of prostate cancer. *Diet is the key to slowing the doubling time.*

Treatment for those Who Don't Need It

It is commonly quoted that “many more men die with prostate cancer than from it.”¹⁸ Considering that 30% of men over age 50 years have prostate cancer as determined by microscopic examination, and only 3% die of it, there is great potential for over-diagnosis and over-treatment with resulting harm to the patient.^{14,15,19} Radical prostate surgery rates have increased six-fold between 1984 and 1990, since the development of the PSA test, yet the death rate from prostate cancer has remained essentially unchanged for the past 30 years.²⁰

The consequences of over-diagnosis are serious. Just knowing you have cancer is life-changing. You and your family now worry about you dying, you can no longer get health and life insurance, and sometimes this knowledge may keep you from your choice of employment. The consequences of over-treatment can be impotence, and incontinence (requiring a diaper or permanent catheter), and occasionally death.

Because the treatments sometimes do kill, especially in populations of older men, there is even the argument that cancer screening will actually increase the number of deaths in older men. According to one letter in the *Journal of the American Medical Association*, a PSA campaign to screen 50,000 men age 75 and older is estimated to result in 123 more deaths than the 436 men that would be expected to die without surgery.²¹

According to Otis Brawley of the National Cancer Institute, “The benefits of screening and early detection, although theoretically possible, are yet unknown, whereas the risks and harms of screening and resultant treatment are definite.” And he put it another way, “Although it (screening) may truly cure a few men who need to be cured, this benefit may be achieved at the cost of causing a large number of men with prostate carcinoma to undergo unnecessary treatment

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and resultant morbidity (illness).²² There are two large trials underway in the US by the National Cancer Institute, and in Europe by the European Cancer Programme, that will add further to our understanding of benefits and harms of early detection. However, except for the hype that follows the release of the study results, I don't expect the facts will change much.

Your Prostate is For Sale

Four years ago I was a guest on the Charlie Brennan morning talk show on KMOX radio from St. Louis, Missouri (one of the nation's most powerful radio stations). I briefly mentioned a few facts about prostate cancer and PSA tests – explaining why I felt men should avoid this test and how a healthy diet is where they should put their energies (see the February 2003 McDougall Newsletter for more about diet). Following the show I received a call from the producer saying that another doctor had complained vigorously about my comments – and said I was doing great harm to men. I suggested a debate and asked, "Who had made the complaint?" William J. Catalona, M.D., professor of surgery and director of the Division of Urologic Surgery at George Washington University Medical School. We met on a Friday morning – both of us on the phone with our hosts on the Charlie Brennan radio show. I presented many of the facts you have just finished reading. He countered with "Thousands of men die of prostate cancer every year and our only hope is to detect it early." How could I contradict decades of brainwashing? I was losing. So I tried a desperation move. I said, "I would like to state that I have no financial ties with prostate cancer. Would my opponent admit to any connection that might influence his opinion? This information is vital for people to understand the disparity in our views on the use of the PSA test." He would not answer, and the host (Carol Daniel) did not insist on a full disclosure. But, Dr. Catalona immediately changed his attitude toward the discussion and said, "Everything Dr. McDougall has said is true." One point ahead for me – but not for long. He won the audience back by appealing to what they had always learned to be true – *detecting cancer early is the only way to save your life*. I could not counter years of education from the cancer business.

Finally, at the end of the show he was confronted by the host, "Before we end, would you like to answer Dr. McDougall's question concerning your financial ties to the prostate cancer business?" He began with a denial. Then I interrupted, "Dr. Catalona, do you know anything about a company called Hybritech, Inc., of San Diego, California? Doesn't this company pay for your research? Do you receive money to speak for this company?"

Hybritech, Inc. manufactures PSA tests, and he admitted this company paid for his research and for him to speak on its behalf – but added that this had no influence on his research outcomes or opinions. Only the careful listener understood the importance of this admission. Money – not honest scientific evidence – determines the medical care you receive and ultimately the quality and length of your life, and your family's welfare and happiness.

[If you want to learn the information on early detection and breast cancer – mammography and breast self-examination – please read the *McDougall Program for Women* book and the February 2002 McDougall Newsletter.]

References:

1. Coffey DS.. Similarities of prostate and breast cancer: Evolution, diet, and estrogens. *Urology*. 2001 Apr;57(4 Suppl 1):31-8.
2. Bailar JC 3rd. Cancer undefeated. *N Engl J Med*. 1997 May 29;336(22):1569-74.
3. Epstein SS. The crisis in U.S. and international cancer policy. *Int J Health Serv*. 2002;32(4):669-707.
4. Woolf SH. Screening for prostate cancer with prostate-specific antigen. An examination of the evidence. *N Engl J Med*. 1995 Nov 23;333(21):1401-5.
5. McNaughton C. Early detection of prostate cancer. Serendipity strikes again. *JAMA*. 1997 Nov 12;278(18):1516-9.
6. Brawn PN. Prostate-specific antigen levels from completely sectioned, clinically benign, whole prostates. *Cancer*. 1991 Oct 1;68(7):1592-9.
7. Harris R . Screening for prostate cancer: an update of the evidence for the U.S. Preventive Services Task Force.

Ann Intern Med. 2002 Dec 3;137(11):917-29.

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8. Advisory Committee on Cancer Prevention. Recommendations on cancer screening in the European Union. *Eur J Cancer.* 2000;36:1473-8.
9. Ramsey EW. Early detection of prostate cancer. Recommendations from the Canadian Urological Association. *Can J Oncol.* 1994 Nov;4 Suppl 1:82-5.
10. Ferrini R. American College of Preventive Medicine practice policy. Screening for prostate cancer in American men. *Am J Prev Med.* 1998 Jul;15(1):81-4.
11. Coley CM. Early detection of prostate cancer. Part I: Prior probability and effectiveness of tests. The American College of Physicians. *Ann Intern Med.* 1997 Mar 1;126(5):394-406.
12. Ruffin MT 4th. Screening for prostate cancer. *JAMA.* 1995 Apr 19;273(15):1175.
13. <http://www.pcaw.com/about/index.asp>
14. Franks LM. Proceedings: Etiology, epidemiology, and pathology of prostatic cancer. *Cancer.* 1973 Nov;32(5):1092-5.
15. Holund B. Latent prostatic cancer in a consecutive autopsy series. *Scand J Urol Nephrol.* 1980;14(1):29-35.
16. Sakr WA. The frequency of carcinoma and intraepithelial neoplasia of the prostate in young male patients. *J Urol.* 1993 Aug;150(2 Pt 1):379-85.
17. Friberg S. On the growth rates of human malignant tumors: implications for medical decision making. *J Surg Oncol.* 1997 Aug;65(4):284-97.
18. Selley S. Diagnosis, management and screening of early localised prostate cancer. *Health Technol Assess.* 1997;1(2):i, 1-96.
19. Ries L. SEER cancer statistics review, 1973-1997. Bethesda, MD.: National Cancer Institute, 2000 (NIH Publication no. 00-2789.)
20. Lu-Yao GL. Changes in prostate cancer incidence and treatment in USA. *Lancet.* 1994 Jan 29;343(8892):251-4.
21. Robbins AS. PSA and the detection of prostate cancer. *JAMA.* 1994 Jan 19;271(3):192-3.
22. Brawley OW. Prostate carcinoma incidence and patient mortality: the effects of screening and early detection. *Cancer.* 1997 Nov 1;80(9):1857-63.

Project Healthy Beginnings Sponsors California Resolution for Healthier School Lunches



It was a very proud day when my oldest child, Jack, entered kindergarten. He didn't cry at all. But I did. I was filled with pride and excitement for him. Just one little thing bothered me – a lot: The school lunch menu. I had talked to many parents, vegan/vegetarian and non-vegetarian, who also wanted to see healthier plant-based lunches offered in the cafeteria, so I decided to call the director of our Child Nutrition Department with my concerns. She graciously requested I send in some menu ideas. I immediately solicited the help from two health conscious friends whose children attended the same school. They were on board immediately and *Project Healthy Beginnings* was born.

It took us several meetings in the park, toddlers in tow – but we ended up creating one dozen plant-based lunch menus that included nutrient breakdowns and met all USDA requirements. We were inspired. When we submitted the menus we included a pro - vegetarian health article by the late Dr. Spock, and heartfelt letters written by our children. We were very proud. Alas, our requests were ultimately dismissed on the basis that our children were a small minority (and here I thought all children needed healthy foods) and because our “philosophy of life” was “not recognized or appropriate to promote.” according to the Assistant Superintendent. We disagreed. And we didn't give up. We have been advocating for the inclusion of Vegan/vegetarian children and the

health of all children ever since. We may be a small minority, but we are a strong minority with truth and love on our side.

With time and commitment, our persistence has begun to pay off. Our last monthly school lunch menu boasted 40% vegetarian lunches –including a weekly veggie burger - and an enhanced salad bar that would include beans so that *all* children could benefit from building an entire USDA meal from the salad bar – beans fulfilling the “meat – alter-nate” requirement. And the chocolate milk and hot dog posters are giving way to colorful promotions for fruits and vegetables with the 5-a-day message. We are making a difference!

Last December I decided to put together a Project Healthy Beginnings packet of support materials and take our case to the state legislature. I was met in Sacramento by 3 more motivated women and our goal was to find an author to introduce a State Resolution that would call for an optional plant-based daily lunch entrée. We would base our resolution on a similar resolution passed in Hawaii last year. It was my first attempt at lobbying – a far cry from PTA politics – and I tried to keep my expectations in check. The experience ended up to be exhilarating and inspiring. *Every* office I met with was receptive and enthusiastic. It was such a contrast to the initial response of my local school district. The very next morning I received a call from Assemblyman Joe Nation's office (of Marin) with an offer to author the Resolution.

A long list of support is building for ACR 16, including the California State Superintendent of Public Instruction, the California Federation of Teachers, the California Association of Student Councils, and the National Resource Defense Council.

It has passed through the education committee and we are confident ACR 16 will be passed into law sometime later this year.

As we watch our children grow, so too grows our commitment to the American values of choice, health, and respect for diversity. We know that parents everywhere support our mission to create a healthier environment and future for all children. They understand the vital link between better health and better grades; better health and a higher quality of life. The time has come for schools to live up to their educational obligation by including this critical information and the vegetarian perspective in health education for all grades.

As I write this article, I am reflecting with pride on the academic awards both Jack and his sister Lucy received just last week. They are bright, active vegan kids and they, along with other vegan/vegetarian children deserve to have their lifestyle acknowledged and affirmed within the school community. It is my aspiration that the passage of ACR 16 will pave the way for *all* kids to learn a healthier way of life in – of all places – school. For more information visit our website www.veggieschoollunches.com or contact Barbara Gates at sphbeginnings@aol.com (see page 8)

Project Healthy Beginnings Sponsors California Resolution for Healthier School Lunches

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* Barbara Gates is the mother of two elementary age school children and active as the PTA health representative at their school in East San Diego County. She co-founded Project Healthy Beginnings in 2000 with other concerned PTA moms to bring together parents, students, health professionals, environmentalists, and religious leaders to promote plant-based vegetarian options in school. Gradually, she is also returning to her other passions – acting/singing and writing. She currently teaches an after school drama program.

Parents and Grandparents, Unite – Act Now To Change the World

Children believe their schools provide the truth – almost without question. They learn through their senses. In most classrooms, sight and hearing are the main pathways for acquiring knowledge. In the lunchroom, education is through all 5 senses: sight, smell, taste, touch and hearing. Yes, hearing. Children are told that the lunch they are served is good nutrition – and that simply is not true. The foods they are served will rob them of their health and beauty – they are eating a very high-fat, highly-processed version of the standard American diet. The impact of this education lasts a lifetime. The National School Lunch Program of the United States Department of Agriculture, which gives schools more than \$6 billion each year, is supposed to provide healthy meals to children, regardless of family income. Yet, at the same time they are supposed to subsidize agribusiness, by promoting the sales of beef and milk. In 2001, the USDA spent a total of \$350 million on surplus beef and cheese for schools -- more than double the \$161 million spent on all fruits and vegetables, most of which were canned or frozen.

Matters are made worse because even the current harmful recommendations are not being followed. Despite a government mandate that school lunches and breakfasts meet federal dietary guidelines, University of California-San Diego researchers found California middle school students eat one-half, rather than the recommended one-third, of their daily allowance of fat, in their school cafeteria lunches.¹

Our Children are Fat and Sick

A study by the University of Minnesota in Minneapolis, of 6728 adolescents in grades 5 to 12, found that approximately 24% of the population was overweight. Almost half of the girls (45%) reported that they had at some point been on a diet, compared with 20% of the boys.² Eating disorders were reported by 13% of the girls and 7% of the boys. These overweight children were also found to be more likely to have low self-esteem, depression, suicidal tendencies, and substance abuse.

But the story is more tragic. As a general doctor (internist), I have cared for hundreds of children – and most of them are sick. Through my personal conversations with them I have discovered the vast majority suffers from headaches, body aches, and stomach aches. Their skin is oily and marked with acne. Constipation is a constant problem and when relief comes it is often painful and accompanied by bloody bowel movements. If these harms were inflicted upon children with a wooden stick, the perpetrators would be put in jail. Since the source of injury is a fork and spoon, and these practices are sanctioned by the US government through the school lunch programs, their suffering is accepted almost without question.

Fat and sick children soon become adults with even worse health problems and the costs become staggering with cancer, heart disease, and strokes, as well as orphaned children, lost spouses, reduced productivity, and financial burdens from extravagant medical care. The problem must be stopped and our children are the place to start.

You Say Children Won't Change – Wrong!

I learn my most important lessons from my students and patients – school children are no exception. In 1980 I gave my first talk to high school students at Punahou in Honolulu, Hawaii. The usual questions about protein and calcium followed my one-hour presentation, and then one student caught me by surprise by asking, "How do we get our parents to eat this way?" Other students followed with similar concerns. In the past, all I had heard was from the parents in my office who complained their children would never give up ice cream and burgers. I now realized that acceptance of this healthful message has nothing to do with age – it just requires people who care about themselves, wanting the most out of life. Our children want to be healthier – but they need our help. (see page 10)

Parents and Grandparents, Unite – Act Now To Change the World

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Change One Child and Change the World

For adolescents there is nothing more important to them than their physical appearance. Remember what happened when one trend-setter in a middle or high school introduced a new hair, makeup, shoe, or dress style? Within two weeks most of the other children followed these fashions, which changed their superficial appearance. Deeper improvements in personal attractiveness are not so easy. No matter how much they cake on the Clearasil, the greasy skin and pimples remain. Every effort to hide their expanding abdomens and thighs fails. And the hurt from this ugliness goes deep into their souls.

Imagine the impact of one overweight, pimply-faced boy or girl drastically improving his or her appearance. The stampede for this "magic potion" would be unstoppable – even if the miracle was a healthy low-fat, vegetarian diet and some exercise. Furthermore, when it was discovered that the foods were more delicious than the standard fare provided by their school, and that this kind of eating was good for the planet and furry animals, all resistance would cease. The ripple effect would be enormous. From one student to an entire school, to the school system, to a community, to the country, to the world – just like short skirts, teased hair, pink lipstick, ninja turtles and hoola hoops once did.

Now is The Time to Begin

Changes are beginning in small ways. You can read about them in this issue in the article on "Healthy Beginnings." Meet with your school board and PTA. Demand a healthy plant-based alternative for the school meal program. You will be amazed at how little resistance you will encounter – the time is now for better health through proper nutrition for our children. My goal – as is yours – is: *Stop the Suffering from the Malnutrition Now Rampant in Our Schools.*

References:

1. Zive M. Sources of dietary fat in middle schools. *Prev Med.* 2002 Oct;35(4):376-82.
2. Neumark-Sztainer D. Weight-related behaviors among adolescent girls and boys: results from a national survey. *Arch Pediatr Adolesc Med.* 2000 Jun;154(6):569-77.

Restrict Protein—Save Your Kidneys

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Kidneys Filter Out Protein

Your two kidneys are two vital organs located in your abdomen. They filter the blood, removing excess water, nutrients and impurities from your body. The protein you eat, that your body does not use, must be eliminated (there is no storage depot in the body for excess dietary protein). This excess is filtered from the blood by the kidneys and put into the urine for elimination. You can actually observe the effects of eating too much protein when you see the formation of frothy bubbles in the toilet bowl after urinating following a single high protein meal. You can also smell the asparagine amino acid from protein found in high concentration in asparagus when you urinate.

As you consume more protein, the kidneys must increase their filtration rate. Higher filtration rates (called the Glomerular Filtration Rate – GFR) result in higher pressures and flows in the kidneys' filtration system (nephrons). This high pressure in medical terms is called *intraglomerular hypertension*. This hypertension over long periods of time permanently damages the kidneys' tissues – and kidney function is lost.

Damage for All – Disease for Some

For most people this damage is inconsequential because their kidneys have such an overabundance of reserve capacity. Two-thirds of kidney function must be lost before illness even begins. Estimates are that the average American loses only about one-third of his or her kidney function after 70 years of eating the amount of excess protein in the typical American diet – nothing is noticed. However, this is a different story for someone who already has lost kidney tissue from another cause – such as donating one kidney (half of function is lost) or losing a kidney from an accident. People with diabetes, hypertension, atherosclerosis, and nephritis – all conditions caused by the American diet – lose kidney function as well. In these cases, the excess protein typically consumed with the American diet can be deadly. Even worse, high protein diets commonly used to lose weight (temporarily) and protein powders to build muscle, can be expected to put many more people at risk for failing kidneys. (High protein diets and protein powders really don't build muscle – if the excess protein we ate went into our muscles, then all Americans would look like Arnold Schwarzenegger.)

Eat the Right Amount of Protein – A Natural Design

The diet I recommend is centered on starchy vegetables, like rice, corn, potatoes, sweet potatoes, breads, and pastas. The protein content of these foods is ideal as designed by nature through eons of evolution – about 6% to 14% of the calories. Another advantage of the foods I recommend is they are made of vegetable proteins which are much less troublesome for the kidneys to process than are proteins derived from animal foods. There are some higher-protein, starchy vegetable foods classified as legumes (beans, peas, and lentils) – these are about 28% protein. In general, I recommend that a healthy person limit these to, on average, one cup of cooked legumes a day (for example, one day you may have three cups and none for the next two days). People with loss of kidney function must restrict these legumes even more. Most green and yellow vegetables are high in protein, but the absolute amount of protein consumed from these low calorie foods is so small that the proteins in these vegetables are rarely of any consequence. Fruits are low in protein.

As I mentioned, the most burdensome foods for the kidneys are animal products, because they are loaded with protein. Interestingly, those animal foods lowest in fat are highest in protein. So, often-recommended white fish, turkey, chicken and skim milk products are going to provide more damaging protein than the higher fat versions of these meats and dairy products.

Understanding the truth about protein will not only protect you from kidney damage, but also osteoporosis. Plus, the high protein foods your friends are dying for are also loaded with fat and cholesterol leading to heart disease and cancer. The well-informed consumer will understand that Nature designed her plant foods to be complete and well balanced long before they arrived on the dinner table for your enjoyment.

1) Knight EL. The impact of protein intake on renal function decline in women with normal renal function or mild renal insufficiency. *Ann Intern Med.* 2003 Mar 18;138(6):460-7.

Recipes

CARAMELIZED ONIONS

These are basic instructions for very flavorful onions that may be used in many other recipes. It takes a bit of time and attention, but the result is worth it. The onions may be made ahead of time and refrigerated for a couple of days, although we think they taste best when they are freshly made. The onions cook down quite a bit while caramelizing, so you need to start out with more onions than you think you'll need.

Preparation Time: 5 minutes

Cooking Time: 30 minutes

Servings: makes about 1 cup

2 extra large onions, cut in half and sliced lengthwise
1 $\frac{3}{4}$ cups vegetable broth, or more, if needed

Heat a heavy non-stick frying pan over medium heat. Add 2 tablespoons of vegetable broth and a dash of salt. Add onions and cook, stirring frequently, until onions begin to stick to the bottom of the pan. Add more broth, about $\frac{1}{4}$ cup at a time, stirring occasionally, until onions begin to stick again. Add more broth, another $\frac{1}{4}$ cup, and repeat this process over and over. You'll notice that the onions begin to change to a golden color about halfway through the cooking time. Continue to add broth, stir and cook until the onions are very soft and a light brown color, each time making sure the onions begin to stick before adding broth. The finished onions will be very soft and flavorful, a medium brown color and slightly stuck to the bottom of the pan.

Options: Add some fresh chopped or sliced garlic to the onions about $\frac{3}{4}$ of the way through the cooking time. Continue to cook and stir as described above.

HINT: You can make a lot of this when you have some extra time. It keeps in well in a covered container in the refrigerator for about 1 week. Use to add a sweeter, richer flavor to many dishes that call for sautéed onions.

PUMPKIN AND BLACK BEAN SOUP

This recipe was sent to us by Pam Howe of Frederick, MD. She says it is one of her favorites. She *McDougallized* a recipe that she found and makes it often. We tried this a couple of nights ago and we like it, too! It is very easy to make and only takes a few minutes to put it together.

Preparation Time: 5 minutes

Cooking Time: 10 minutes

Servings: 4-6

1 medium onion, chopped
 $\frac{1}{4}$ cup water
3 cups vegetable broth
1 14.5 ounce can diced tomatoes in juice
1 15 ounce can black beans, drained and rinsed
1 15 ounce can pumpkin puree
1 $\frac{1}{2}$ teaspoons curry powder
1 teaspoon ground cumin
3 pinches cayenne pepper (optional)
dash salt

Place the onion and water in a soup pot. Cook, stirring occasionally, for about 5 minutes until tender. Add remaining ingredients and mix well. Bring to a boil, reduce heat and simmer for 5 minutes. Adjust seasonings to taste.

Hints: Serve in a bowl, with a spoonful of tofu sour cream, if desired. This would also be delicious as a topping over grains or potatoes. Leave out 1 cup of the vegetable broth to make it a bit thicker and serve on a plate over brown rice, other whole grains or potatoes.

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Recipes

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SOLDIER BEAN SOUP

I found these wonderful, heirloom beans at a market last week and decided to make a simple soup from them. They cook up rich and creamy with a unique taste so they don't need much in the way of seasonings.

Preparation Time: 5 minutes

Cooking Time: 4 hours

Servings: 6-8

2 cups dried soldier beans

8 cups water

1 large onion coarsely chopped

2-4 cloves garlic coarsely chopped

Place all the ingredients in a large pot. Bring to a boil. Reduce heat, cover and simmer for 4 hours or longer, stirring occasionally. Season with salt and pepper before serving.

Hint: This may be made in a slow cooker. Cook 8-12 hours on high. An easy way to have a delicious dinner ready when you get home from work. This may also be made with other heirloom beans. Heirloom beans are specialty beans that have wonderful flavors and colors, not commonly found in the mass-markets. Look for them in natural food stores or farmer's markets. To find out more about heirloom beans and discover the many different varieties, go online to Heirloom Beans-The Bean Bag. Varieties include: Black Calypso, Peruano, Chestnut Lima, Scarlet Runner, Jackson Wonder, Speckled Brown Cow, Appaloosa, Butterscotch Calypso, Tiger Eye, Trout, Dalmation, European Soldier, plus many more; most of them take 3-4 hours to cook.

GREAT BARRIER REEF GNOCCHI

John & Mary just returned from 3 weeks "down under". One of those weeks was spent on a dive boat on the Great Barrier Reef. The cook prepared wonderful vegan meals during that week—this is Mary's version of one evening's meal. This is prepared in several steps and then tossed together at the end. It is delicious hot, warm or cold!

Preparation Time: 30 minutes

Cooking Time: 60 minutes

Servings: 6-8

½ cup pine nuts, toasted

1 onion, chopped

4 large cloves garlic, chopped

1 butternut squash, baked, peeled and chopped

2 cups fresh spinach

½ cup slivered fresh basil

1 ½ cups asparagus pieces (1½ inches)

2 packages potato gnocchi

Preheat oven to 350 degrees. Cut squash into 4 large pieces, clean out seeds and stringy portion, place into a baking dish, add 1 cup water to the bottom of the baking dish, and bake for about 1 hour, until easily pierced with a fork. Cool, remove skin, and chop into chunks. Set aside.

Meanwhile, place the raw pine nuts in a dry non-stick frying pan. Cook over medium heat, stirring constantly, until lightly browned, about 5 minutes. Remove from pan and set aside.

Place the onion and garlic in a pan with a small amount of water, Cook, stirring occasionally, until softened, about 5 minutes. (Or use caramelized onions for this step.) Set aside.

Place the asparagus in a small amount of boiling water and cook for 2-3 minutes, until just slightly tender. Set aside.

Bring a large pot of water to a boil. Drop the gnocchi into the water, stir well, and cook until gnocchi rises to the top, about 3-4 minutes. Drop the spinach into this water, stir several times, then remove gnocchi and spinach with a strainer. Place in a large heated bowl. Add squash, pine nuts, onions and garlic, asparagus and basil. Mix well. Season with a small amount of salt and pepper. Serve hot, warm or cold.

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Recipes

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Hint: This may seem like a lot of effort, but the results are worth it! If you start the squash first and then do the remaining steps, the squash should still be warm when you put the finished dish together. Everything can be prepared ahead of time, except for the gnocchi & spinach. Put the water on to boil just before the squash is done, remove the squash, let cool slightly, peel & chop, drop gnocchi into water, mix the squash with the onions, garlic, asparagus & pine nuts in a heated bowl. Then add cooked gnocchi and spinach, toss with the fresh basil and serve.

I have also made this using acorn squash instead of the butternut squash. We found that the acorn squash doesn't infuse the dish with as much squash flavor as the butternut squash does.

HEATHER'S PASTA AND FAGIOLI

Heather makes this dish often, usually just throwing ingredients together depending on her mood. It always tastes delicious and it is quite an easy meal. The last time she made this, we wrote down the ingredients and instructions as she went along so that we could share this delicious meal with you. This is an excellent place to use some of those caramelized onions that you made ahead of time!

Preparation Time: 10 minutes

Cooking Time: 30 minutes

Servings: 6-8

2 large onions, sliced
4-6 cloves garlic, sliced
2 ¾ cups vegetable broth
1 15 ounce can white beans, drained and rinsed
1 15 ounce can fire-roasted diced tomatoes
16 ounces rigatoni pasta
4 cups fresh spinach
2-4 tablespoons fresh basil, slivered

Place the onions in a large non-stick frying pan with 2 tablespoons of the broth. Cook, stirring frequently until onions start to stick to the bottom of the pan. Add more broth and continue this process until onions are caramelized (see complete directions above) adding the garlic to the onions shortly before they are done. Set aside. *(OR use 1 cup of caramelized onions that you have prepared ahead of time.)*

Meanwhile, place 1 cup of the vegetable broth in a saucepan. Add beans and tomatoes, mix well and simmer until mixture becomes thick and creamy, about 20 minutes. Mash slightly in pan with bean masher. Set aside.

Bring a large pot of water to a boil. Drop in pasta and cook until al dente, adding the spinach during the last minute of cooking. Drain and place in a heated bowl. Add beans mixture, onion mixture and fresh basil. Mix well. Season with salt and pepper if desired. Serve hot, warm or cold.