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May 2002 Vol. 1 No. 5

Die With Your Gallstones

This article continues a series exploring the health of your intestinal tract. Consider the strongest contact with the world around you is through your food, processed and absorbed by your intestine.

You would think gallstones are a normal part of the human anatomy with over 20 million people in the US harboring gallstones (15% of the US population). As we get older these stones become even more common -- half of all women in the US over the age of 70 have gallstones.

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No Breast Self Examination

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Prostate Trouble From Your Food

An article in the April 2002 issue of the *American Journal of Clinical Nutrition* by Sadao Suzuki found a causal association between a common prostate disease, called benign prostatic hypertrophy (BPH) and the intake of more calories, total protein, animal protein, and vegetable fat.

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Exercise Lowers Blood Pressure

Effect of aerobic exercise on blood pressure: a meta-analysis of randomized, controlled trials by Seamus Whelton in the April 2002 issue of the *Annals of Internal Medicine* found exercise lowers blood pressure in people with and without hypertension.

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LAKE TITICACA SOUP GOLDEN BEAN STEW CHOCOLATE DELIGHT

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Heather McDougall with a degree in English and a love for cooking, especially with her mother, will be a frequent contributor to the newsletter. We invite you to contribute your thoughts and recipes to the McDougall Newsletter also. Write heather@drmcDougall.com.



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May 2002 Vol. 1 No. 5

DIE WITH YOUR GALLSTONES

You would think gallstones are a normal part of the human anatomy with over 20 million people in the US harboring gallstones (15% of the US population). As we get older these stones become even more common -- half of all women in the US over the age of 70 have gallstones. The huge prevalence of this disease has the potential for big medical business. Consider, even now there are 800,000 hospitalizations, and \$2 billion spent annually on gallbladder disease. With more honest consumer information all of these figures could be cut to a fraction of the present figures.

Gallbladder Symptoms:

Fortunately, gallstones cause no symptoms in the vast majority of patients. They may be discovered by a routine chest x-ray or other diagnostic tests looking for problems unrelated to the gallbladder. The risk of people with gallstones developing mild symptoms is 1% to 3% annually.¹ Once diagnosed with gallstones, within the first five years 10% of patients develop symptoms, and within 20 years, 20% have symptoms. This means someone with stones has an 80% chance of living without symptoms – that is, they remain asymptomatic. Unfortunately, the greatest threat to an asymptomatic patient is the meddling doctor – trying to help patients who don't need help.

Simple pain, rather than serious complications, is the first symptom of gallbladder disease in over 90% of people with stones, therefore waiting has few serious consequences. These facts: most people with gallstones remain asymptomatic and symptoms when they do occur are usually not life threatening, mean: "you should be allowed to die with your gallstones."

If doctors actually helped people by removing symptomatic gallstones, then the medical business would be actively trying to eradicate the "gallstone plague" upon our society by setting up x-ray booths and surgical units on every other corner in every town across the US. This action would cause well-deserved criticism, because the scientific research clearly and consistently shows that your risk of death and disability is much greater if you take a course of immediate surgery upon discovery of gallstones, rather than "watchful waiting," until some symptoms develop.^{2,3}

Gallbladder Colic:

Most people who develop symptomatic gallbladder disease have pain in the mid-upper or right-upper section

of the abdomen and it often radiates to the right shoulder blade. This pain is caused by obstruction of the bile-carrying duct, called the cystic duct, which leads from the gallbladder to the small intestine. The pain is sometimes referred to as “colic,” which would indicate mild, transient pain. However, this is a misnomer because the pain is usually severe, steady, and lasts from 15 minutes to 6 hours. The pain is often at night and not related to meals. Once the first pain has occurred, the probability of a second attack is between 50% and 70% within 2 years (if no change in diet is made). Nausea and vomiting are also common. Between attacks everything is usually normal.

When the obstruction is prolonged (more than 6 hours), then distention and inflammation can develop with secondary bacterial infection in about 50% of cases. This is a serious complication that usually requires immediate medical attention. Stones can also block the ducts draining the pancreas and cause pancreatitis.

The diagnosis of gallstones is usually made by an ultrasound examination (sound waves that penetrate the abdomen and find stones). This test can painlessly detect 95% of stones larger than 2 mm (the size of a rice grain).

TREATMENT OPTIONS

Expectant Management Until Symptoms or Complications Develop:

“Expectant management,” in other words, no treatment at all, is what I recommend for people with asymptomatic disease because the risk of attacks and complications is so small. If you have had one attack, then you can likely change your condition to “asymptomatic” again by following the “time-honored” treatment for gallbladder attacks -- a low-fat diet. Physical activity may also prevent progression of gallbladder disease. One study found 34% of men with gallstones were able to prevent development of symptoms with 30 minutes of endurance exercise 5 times a week.⁴ Therefore, by cost-free, pain-free diet and exercise practices you may be able to avoid surgery and in this way you can “die with your gallstones.” Patients with recurrent attacks that cannot be prevented are generally referred on to surgery. However, after reading about surgery, there may be some other options you might want to consider.

Immediate Surgery:

Gallbladder removal for stones and disease is called a cholecystectomy. The first such operation for symptomatic gallbladder disease was performed in 1882. This surgery is performed by cutting a 4 to 8 inch hole in the right upper quadrant of the abdomen. The gallbladder is directly visualized and removed by the surgeon.

Laparoscopy cholecystectomy was introduced in 1987. This technique is done using a small scope through which the gallbladder is removed. Small incisions, leaving barely visible scars, are made and the patient has a much quicker recovery than with open surgery. Because of the convenience of this procedure, the number of gallbladder surgeries has dramatically increased and more people with questionable indications – asymptomatic disease and those with symptoms not caused by the gallbladder – are undergoing gallbladder

removal. The number of surgeries in the US has increased from 500,000 annually in 1987 to 770,000 in 1996 – largely because of this new procedure. Over half the operations these days are done on an elective basis and are done for symptoms of indigestion and dyspepsia (see the February 2002 newsletter for tips on relieving these common problems) that are not related to the gallbladder. Laparoscopic cholecystectomy has a lower death rate than open cholecystectomy, but because of the increased number of cholecystectomies now performed, there may be no decrease in the total number of deaths associated with gallbladder removal.

Patient surveys, two to 24 months after both open and laparoscopic cholecystectomy, indicate that 40-50% of patients have one or two symptoms that continue, such as abdominal discomfort from excess bowel gas or dull pain, although 80-90% regard the operation as highly successful.

One of the most serious complications of gallbladder surgery is injury to the common bile duct. Because of the limited visibility with laparoscopy surgery compared to open surgery, this injury is more common with laparoscopy surgery. (Major bile duct injuries occur in about 0.33-0.5% of laparoscopic operations, compared with about 0.06% in open procedures.)

Reasons to Keep Your Gallbladder:

Long-term consequences of removal of your gallbladder are related to the lack of a storage sack for bile acids. Bile is continuously synthesized by the liver. The purpose of the gallbladder is to store this greenish fluid between meals. When you eat, the gallbladder contracts, emptying its contents into the small intestine, where the bile mixes with the food. If there is no storage sack (gallbladder), then the bile constantly drips into the intestine, even when no food is present. In this concentrated form, the bile acids are very irritating to the linings of the intestine. Immediately, irritation of the large intestine by bile acids often causes diarrhea – and long-term the irritation can cause colon cancer.^{5,6} This is the reason cancer of the right side of the colon is more common in people who have had their gallbladders removed.

These long-term side effects can be reduced or eliminated for people who have no gallbladder by eating a low-fat, high-fiber diet. Fat is the primary stimulus for bile acid production. On a low-fat diet much less bile acid is produced. Dietary fiber (which is only present in plant foods) will combine and deactivate bile acids, thus protecting the bowel. Therefore, after removal of the gallbladder it is doubly important to follow a healthy low-fat, plant-food based diet. If this change in your diet fails to relieve diarrhea, then the next step in treatment is to use bile acid sequestering agents, such as activated charcoal or doctor-prescribed cholestyramine (Questran) or colestipol (Colestid).

Extracorporeal Shock Wave Lithotripsy (ESWL):

ESWL has been used for over 15 years to break up kidney stones. During this treatment, shock waves generated outside the body are focused on gallstones in order to fracture them into smaller particles, the size of sand granules. The success rate with small stones (<20 mm) is 77%, larger stones is 60%, and multiple stones is 41% -- success means complete disappearance in 6 months.⁷ The addition of bile acids (see

below) to dissolve the small fragments may improve upon the success rate.⁷ This approach is of particular value for those patients who are poor surgical candidates and for those wanting to keep their gallbladders.

Bile Acid Treatment:

In the normal gallbladder, bile acids keep the cholesterol in solution, preventing stone formation. Two bile acids, chenodeoxycholic acid (CDCA) and ursodeoxycholic acid (UDCA), when given as medications have been found to dissolve gallstones in people. CDCA has significant side effects, like diarrhea and abnormal liver tests. UDCA has few side effects. Successful treatment is most commonly seen with noncalcified stones of less than 5 mm. The rate of dissolving is about 1 mm per month. A combination of CDCA with UDCA has about a 50% rate of complete dissolving of noncalcified stones with 6 months of therapy.⁸ The addition of cholesterol-lowering medications, known as “statins,” like lovastatin (Mevacor) and simvastatin (Zocor), improve the effectiveness of UDCA therapy.^{9,10} These cholesterol-lowering agents reduce both serum and bile cholesterol in humans, and also inhibit cholesterol gallstone formation in animals. With the same cholesterol-lowering benefits, a healthy diet helps dissolve gallstones when used in combination with ursodeoxycholic acid.^{11,12}

Ursodeoxycholic acid (UDCA) is sold as Actigall, manufactured by Watson Pharmaceuticals, Inc. A doctor's prescription is needed.

Drench Your Stones in a Gasoline Additive:

An ether, MTBE (methyl tert-butyl ether), which has been a popular gasoline additive, can be infused into the gallbladder onto the gallstones through a tube placed by an endoscope (from the mouth to the small intestine) or by sticking a needle through the skin into the gallbladder. In properly selected patients, the stones dissolve in 95% of cases. Unfortunately, they recur in 40% of patients with solitary stones and 70% with multiple stones in five years.¹³ Serious side effects are mostly related to the procedures for infusing the MTBE (endoscope and gallbladder puncture). The MTBE can cause nausea and vomiting.

What to Do?

Try to keep your gallbladder – it has important functions that may be missed. Many times removal of the gallbladder will not relieve symptoms and often times there are serious and troublesome side effects from treatments. You may have not thought about this, but your gallbladder may save your life by screaming at you whenever you eat fatty foods. In this manner, your suffering gallbladder can help you prevent heart disease, strokes, cancer, and may be the most effective weight-loss aid you could ever wish for.

- 1) Prevention of gallbladder disease with a high-fiber, no-cholesterol diet is your goal.
- 2) If you fall into the 15% of the population that has asymptomatic gallstones, then live with these stones and work every day to stay asymptomatic by following a low-fat, plant-food based diet.
- 3) If you have gallbladder pains (along with proper diagnosis by your doctor), change to a healthy, low-fat diet and exercise to help prevent future attacks.

- 4) Consider a "statin" cholesterol-lowering medication to further reduce the cholesterol content of your bile, reducing the risk of new stone formation and the size of existing stones.
- 5) If dietary change does not relieve symptoms, then consider Actigall therapy, along with a healthy diet and possibly "statin" drugs.
- 6) If you still have symptoms after all of the above, then consider lithotripsy, with diet, Actigall, and / or a "statin" drug.
- 7) If the above fails, then consider having your gallstones dissolved with MTBE (this will be difficult to find since this is not a commonly performed treatment).
- 8) If you still are troubled, then your next, best choice will be laparoscopic surgery.
- 9) Open surgery may be your last choice when all else has been considered.
- 10) Change to a low-fat, high fiber diet after surgery to eliminate troublesome post-surgery side effects, like chronic diarrhea, gas, and abdominal pains.

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NO BREAST SELF-EXAMINATION -- SAYS THE CANADIAN TASK FORCE

Preventive health care, 2001 update. Should women be routinely taught breast self-examination to screen for breast cancer? by Nancy Baxter in the June 26, 2001 issue of the *Canadian Medical Association Journal* found there is "fair evidence of no benefit, and good evidence of harm..." from BSE (breast self-examination) instruction.¹ (See below to read entire study.) "To date, 2 large randomized controlled trials, a quasi-randomized trial, a large cohort study and several case-control studies have failed to show a benefit for regular performance of BSE or BSE education, compared with no BSE. In contrast, there is good evidence of harm from BSE instruction, including significant increases in the number of physician visits for the evaluation of benign breast lesions and significantly higher rates of benign breast biopsy results " These recommendations reflect the commitment of the Canadian Task Force of Preventive Health Care.

The two most important studies that caused these prominent researchers to reach this conclusion are the *Shanghai randomized controlled study of Chinese textile workers* between the ages of 31 and 64 and *the Russian/WHO randomized controlled study of women from Leningrad* aged 40 to 64. Both studies showed no difference between those who did self-examination and those who did not. More biopsies for benign tumors were performed in those who faithfully did their examination.

In the Shanghai study, 133,375 women received education using silicone breast models, and personalized instruction. They were compared with a similar sized group that received no instruction. No difference in size or stage of the tumors was found between the groups. In the Russian study, 122,471 women were divided into two groups. One group was trained in small groups by doctors and nurses to perform BSE. The other received no training. **There was no difference in tumor grade or mortality between the two groups.**

COMMENT: Breast cancer is the most frequently diagnosed cancer among women of Western societies. Approximately one in eight women will develop this kind of cancer in her lifetime. Because most women who develop breast cancer have no identifiable risk factors, early detection by means of mammography and BSE has become heavily promoted to save lives. The effectiveness of mammography has been seriously questioned by the Cochrane Review (see the February 2002 McDougall Newsletter). In this prestigious review, examination of the studies supporting mammography was found to be seriously flawed and biased towards benefits that really do not exist.

This current article reviews the research on BSE and comes to similar conclusions as the Cochrane Review

for mammography: this examination also does not save lives and actually causes women harm.

The reason both BSE and mammography fail is it takes approximately 10 years for a tumor to grow to the size of detection (approximately ½ inch or 1 cm in size). By this time, if the tumor is really cancer, it has already spread to other parts of the body, beyond the reaches of surgery and radiation. Therefore, “early detection” is actually “late detection.”

So what harm can come from touching your breasts monthly? If you find nothing suspicious then you remain unharmed. However, if you find a questionable area then you are off on a journey that will likely cause you to never be the same again. The least you will suffer is the worry that will haunt you until you are given a clean bill of health. This worry may snowball into serious anxiety and depression. Many unpleasant visits to your doctors’ offices usually follow your discovery. If you need a biopsy, you will be left with a physical scar and maybe deformity.

If the worst happens, and you are diagnosed with cancer, then you become a “cancer victim.” Now you are ineligible for health and life insurance and maybe unemployable. People from that date on think of you first as a “cancer victim.” The treatments that can follow have been described by some women as “hell on earth.”

To be fair, there are two advantages to finding a breast tumor early. First, if you find it early then it is more likely to be smaller, which should lead to a cosmetically more acceptable surgery, like a lumpectomy. Second, finding breast cancer will force many women to closely examine their diet and lifestyle and make long-overdue changes to a low-fat, plant-based diet and exercise. There is very good evidence that a healthy diet will prolong the life of a woman with breast cancer (See [the McDougall Program for Women](#) book).

So now the Cochrane Review and the Canadian Task Force on Preventive Health Care have taken away your hopes and dreams of being saved by the medical business. What is left for you to do? Your best chance to win the war on cancer is to eat a healthy diet (low-fat, no added vegetable oil, no cholesterol, high fiber, low-pesticide, plant-food based diet). This is the McDougall diet that I have been teaching for the past 25 years. Little has changed except for the number of people who realize the truth about the fallacy of the high-profit early detection business and the benefits of the no-profit, low-fat pure vegetarian diet and exercise program. If only money could be made from the truth, then many more women and their families would be saved from this horrible disease and hellish treatments.

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1) Baxter N. Preventive health care, 2001 update: should women be routinely taught breast self-examination to screen for breast cancer? *CMAJ*. 2001 Jun 26;164(13):1837-46.

Click here to read the entire study: <http://www.cmaj.ca/cgi/content/full/164/13/1837>.



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DO YOU WANT A PROSTATE ENLARGEMENT WITH THOSE FRIES?

An article in the April 2002 issue of the *American Journal of Clinical Nutrition* by Sadao Suzuki found a causal association between a common prostate disease, called benign prostatic hypertrophy (BPH) and the intake of more calories, total protein, animal protein, and vegetable fat.¹ Data on 51,529 men in the Health Professionals Follow-up Study was used for this study. Of the 33,344 men with complete data, 3,523 were found to have BPH.

COMMENT: Benign prostatic hypertrophy is a disease commonly found in aging men in Western countries. Approximately 70% of men aged 70 years and older suffer with this problem. By autopsy examination, between 40% aged 50-60 and 90% of men age 80-90 years have this condition. By age 80 nearly one man in four has undergone treatment to relieve symptoms. In 1994 nearly 400,000 surgeries were performed in the US at a cost of \$5 billion. This common condition is caused by overgrowth (hyperplasia) of the prostate tissue to the point of compression of the urethra, causing obstruction of the flow of urine from the bladder. Male hormones (testosterones) stimulate the prostate tissues and are believed to be the most important factor causing prostate enlargement. A high-fat, low-fiber diet raises testosterone levels in men throughout their lives.²

Reduced stream, urgency, hesitancy, nocturia (frequent urination at night) and increased frequency of urination are the most common symptoms of BPH. Recent evidence has linked impairment in sexual function with BPH. Treatments have also been associated with sexual problems.³ For example, surgery (the standard TURP-- Transurethral Resection of the Prostate) has been reported to cause retrograde ejaculation (ejaculation into the bladder) in three-quarters of men and impotence in 13% of treated men.

So what should men do if they develop symptoms of prostate trouble?

- 1) Change to a healthy diet (low-fat, plant-based) so the problem doesn't get worse.
- 2) Treat symptoms like frequency and nocturia with fluid restriction, especially in the evening, and discontinue bladder irritating substances, like coffee.
- 3) Take herbal medications like Saw Palmetto.^{4,5}
- 4) Use alpha adrenergic blockers, like Flomax (tamsulosin HCl).
- 5) Try Transurethral Microwave Thermography (heating the prostate through a catheter).⁶
- 6) As a very last resort, submit to standard surgery (TURP)

Even though a low-fat diet would not be expected to reverse the long standing changes of BPH, there is one very important health benefit for the prostate derived from a change to healthy diet. A low-fat, high-fiber diet and exercise intervention has been found to cause changes in the serum of men, which inhibit the growth of prostate cancer cells grown in a laboratory.⁷ Since 30% of men over the age of 50 already have prostate cancer, this scientific finding should cause all men to start taking better care of themselves today.

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EXERCISE LOWERS BP / SAVES LIVES

Effect of aerobic exercise on blood pressure: a meta-analysis of randomized, controlled trials by Seamus Whelton in the April 2002 issue of the *Annals of Internal Medicine* found exercise lowers blood pressure in people with and without hypertension.¹ The average reduction was 3.84 mm Hg systolic (top number) and 2.58 mm Hg diastolic (bottom number). There were fifty-four trials that seemed to be of scientific value were examined.

COMMENT: More than 50 million people in the United States suffer from elevated blood pressure. This condition is associated with strokes, heart attacks, heart failure, and kidney disease. But in truth, high blood pressure is a sign of the condition of the cardiovascular system and not a disease in itself. I have never seen a person die of high blood pressure – would their head explode?

People with high blood pressure die of diseases of rotten arteries (atherosclerosis). For example, the arteries of the heart become blocked and the heart muscle dies – the person has a heart attack. The blood pressure elevation does not cause the vessel to burst. Rather the high blood pressure reflects a poor condition of the blood vessels. These arteries are diseased, weakened, and clogged with plaque. What kills are the plaques that burst internally, after they become overstuffed with fat and cholesterol, which cause the artery to close down.

When we treat high blood pressure with medications we reduce the sign of the problem, but this results in little benefit, if any, in lessening the threat of heart attacks, strokes, or death. However, when we eat well or exercise we do something really valuable for our health – we make our arteries stronger and less likely to become clogged from ruptured plaques. So this study showing a lower blood pressure is really important, because this lower blood pressure reflects a healthier condition of the arteries – they are more compliant (supple), less clogged, and most importantly, stronger, so they are less likely to rupture internally. (You can learn much more about plaque rupture by reading The McDougall Program for a Healthy Heart book.)

Lowering blood pressure through exercise is just one sign of the bigger picture – a longer, healthier life. On March 14, 2002 the *New England Journal of Medicine* published a study showing that increased exercise capacity was one of the strongest predictors of a decreased risk of death.² They studied 6,213 men referred for a treadmill stress test and found that their exercise capacity was a stronger predictor of death than other established risk factors like high blood pressure, diabetes, smoking, and changes in EKGs during exercise. Exercise reduces blood pressure, triglycerides, body weight, and blood sugar. Blood vessel function and

tone (elasticity) are improved. The risk of blood clot formation and inflammation of the arteries that leads to blood clot formation is also reduced.

Overall, exercise is a real bonus to your life. It is one of those few things you have complete control over (unlike stress and bad luck, for example). It is cost- and side effect-free, and can be really fun if you pick something you like doing (I'm an avid windsurfer). So today pick your favorite activity, put it into your schedule and do it every day – preferably 30 minutes a day. This along with a healthy diet (low-fat, plant-food based -- which you can also control 100%), will give you the best chances of staying healthy and active until a ripe old age.

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Recipes

This recipe was inspired by a delicious soup we enjoyed on our Peru trip in the year 2000. We visited Lake Titicaca and took a boat trip to Isla Taquile where we hiked into a quaint village to see how the islanders lived. We stopped at a very small restaurant in this village and loved the green soup that they served. Dottie Bray, who has traveled with us on many of our adventure trips, sent me her interpretation of this delicious soup. Heather and I have been working on the recipe with wonderful results and it has become one of our favorites. We hope you will enjoy it as much as we do.

LAKE TITICACA SOUP

Servings: 3-4

Preparation Time: 20 minutes

Cooking Time: 40 minutes

¼ cup quinoa, rinsed
2 cups vegetable broth
1 cup water
2 cloves garlic, minced
1 cup onion, chopped
1 large potato, peeled and cut into matchsticks
1-2 jalapeno peppers, seeded and minced
4 cups fresh spinach, thinly sliced
freshly ground pepper and hot sauce to taste

Place all the ingredients, except the spinach, in a medium saucepan. Bring to a boil, reduce heat, cover, and cook for 30 minutes. Add spinach and cook an additional 10 minutes.

Hints: This recipe can easily be doubled to have some leftovers for the next day. We like to add some heat to this soup with the addition of some hot sauce before eating. To slice spinach, stack leaves 15-20 high and slice through all leaves. Be sure to rinse the quinoa well or it will have a bitter taste. Quinoa can be found in natural food stores and some supermarkets.

We have prepared this stew several times during the past few weeks, with different variations. We never have enough left over to freeze, but if you do have some left, it may be frozen for later use. We like this plain in a bowl, over brown rice, or scooped up with baked tortilla chips.

GOLDEN BEAN STEW

Servings: 6-8

Preparation Time: 25 minutes

Cooking Time: 60 minutes

- 3 cups vegetable broth
- 1 onion, chopped
- 2 stalks celery, chopped
- 2 carrots, chopped
- 1 green bell pepper, chopped
- 1 red bell pepper, chopped
- 3 cloves garlic, minced
- 1 ½ cups baby potatoes, cubed
- 2 ½ cups cooked white beans
- 1 8-ounce can tomato sauce
- 1 8-ounce container prepared hummus
- 1 tablespoon parsley flakes
- 1 tablespoon soy sauce
- 1 teaspoon basil
- ½ teaspoon oregano
- 1/8 teaspoon crushed red pepper
- 1 cup crumbled soy sausage (see hint)
- 1 cup thinly sliced fresh spinach

Place ½ cup of the broth in a large pot. Add onion, celery, carrot, bell pepper, and garlic. Cook, stirring occasionally, for 10 minutes. Add remaining broth, potatoes, and beans. Bring to a boil, cover, reduce heat, and cook for 30 minutes. Add tomato sauce, hummus, and seasonings. Cook an additional 10 minutes. Add soy sausage, mix well, and cook for 5 minutes. Stir in spinach and cook an additional 2 minutes.

Hints: Soy sausage can be found in natural food stores in many varieties. Most of them are previously cooked and may be frozen. Thaw before using in this recipe. If you have soy sausage that is not cooked, such as Gimme Lean, crumble into a separate non-stick frying pan and brown slightly before adding to the stew. Most natural food stores also sell prepared hummus. Or you can make your own by pureeing cooked garbanzo beans with a small amount of broth, garlic, and salt. If you are using canned beans in this recipe, be sure to rinse them before using. This may also be made with garbanzo beans instead of the white beans. If you can't find baby potatoes, use larger red potatoes and chop them into bite-sized pieces. If you want to use chard or kale instead of the spinach, it will need to cook about 5 additional minutes.

This is a delicious, elegant, yet easy dessert. It takes just a few minutes to prepare, but everyone loves it! It keeps well in the refrigerator for several days.

CHOCOLATE DELIGHT

Servings: 8

Preparation Time: 2 minutes

Cooking Time: 5 minutes

Chilling Time: 3 hours

4 cups low-fat chocolate soymilk

1 $\frac{3}{4}$ cups couscous

2-3 tablespoons sugar or honey

Place the soymilk in a saucepan. Heat until almost boiling. Remove from heat, stir in couscous and sweetener. Cover and let rest for 15 minutes, stirring occasionally. Place in a covered bowl and refrigerate for at least 3 hours. Scoop into a dessert bowl and top with fruit, if desired.

Hint: Use fresh fruit in season as a topping, or thaw frozen fruit. Fresh fruit syrups may also be used. We especially like raspberries as a topping for this dessert.