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THE NUTRI-SPEC LETTER

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From:
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Dear Doctor,

Question: How many of your patients go to a "Heart Specialist"?

Answer: One hundred percent of your patients go to a heart specialist.

What do I mean by that? One hundred percent of your patients go to you, and …

YOU ARE THEIR HEART SPECIALIST.

Your patients can be quite secure in knowing that you know the 22 causative factors of cardiovascular disease (CVD). Yet, I have no doubt that the typical cardiologist knows no more than you do about those 22 causative factors, and probably knows far less than you about many of them. Contemplate the absurdity: CVD kills 50% of all people, yet many cardiologists are almost entirely ignorant of many causes of this condition. So --- how valuable are you to your patients, considering that 50% of them are doomed (without your help) to die of CVD?

I'll tell you how valuable you are: You have the ability to sort through these 22 causative factors to construct an effective clinical protocol to serve every one of your patients at risk for CVD. You achieve your clinical power over CVD with your working knowledge of the 10 clinical indicators that inform you completely about the 22 causative factors of CVD. You have objective evidence of those 10 clinical indications of CVD risk, and, you have the means to use those clinical indicators to construct for each of your patients an effective CVD prevention plan.

Meanwhile, what does the conventional heart specialist offer his patients? Think about all your patients who employ the services of a cardiologist; those who have either already had their first heart attacks, or those who experience attacks of atrial fibrillation, or those who suffer from congestive heart failure. After all the exams, the stress tests, the heart scans, the vascular studies, etc, etc, what have your patients actually obtained from their cardiologists? They have all come away from the cardiologist with nothing more than a bucket full of pills, and, (almost comically) they all have the same pills!

That's right! Regardless of the results of all their tests and scans, all these patients are (mindlessly) given the same handful of drugs --- the drugs that are currently accepted as "proper" protocol for CVD treatment. Partly out of ignorance of causative factors, and partly because of the fear of malpractice liability for failing to give a medication generally regarded as "effective" in CVD treatment to a patient who might die of CVD, a cardiologist is compelled to throw everything but the kitchen sink at every patient. So little thought goes into the pharmacological management of CVD patients that you could train a monkey to be a cardiologist.

Seriously, every one of your patients that sees a cardiologist has received the same cookie cutter pharmacological treatment. There are two (sometimes three) blood pressure medications. (Which two is determined almost entirely by trial and error, rather than by any objective interpretation of clinical tests.) There is also usually a drug to control heart rhythm, a Statin drug to destroy the liver's ability to produce cholesterol, Dijoxin, a diuretic, and often a blood thinner. If there was ever a "shot gun" approach to disease care, this is it. At least now your patient can die of a heart attack, and no one can ever doubt that his cardiologist did "everything possible". After his death no one can go back to the cardiologist with the accusation, "What?! You had a heart patient for whom you did not prescribe a beta blocker?" --- or --- "What?! You had a patient at risk for heart disease for whom you did not prescribe a Statin drug?" Under this scenario, the cardiologist, the patient and the patient's family all feel quite secure. The patient feels rotten, but at least secure. Very little has been done to actually decrease the patient's risk of a heart attack or stroke --- but ignorance is bliss.

What are all the consequences of this monkey-brained, ignorance- and fear-based approach to CVD? Here is the short list:

- Many of these drugs are dangerous, with costs that outweigh the benefits (even the illusory benefits imagined by the cardiologists).

- Calcium channel blockers are on the top of this list, for, as you know, they actually increase your patient's chance of having a heart attack or stroke (while at the same time causing potentially suicidal depression, and decreasing mental acuity).

- The Statin Drugs are also on your list of Red Flag medications, certain to do more damage than good.

- Without the 10 clinical indicators of CVD risk that you work with, the cardiologist is almost completely in the dark as to whether his prescribed medications are doing any harm --- that is, until a crisis is precipitated. Dijoxin is a good example of a drug that should be monitored very closely, but very rarely is. The difference between the dose that has a "beneficial" effect, and that which is damaging, is very small.

- Your patient feels absolutely wretched. Fatigue, depression, and pain are common side effects of these drugs. The answer to these side effects? More drugs, of course. An anti-depressant will be prescribed without hesitation. (And this usually means an SSRI --- another devastating Red Flag medication.) Tylenol, (yet another Red Flag) is virtually always among the "try this" pain medications.

- Adding to the absurdity of the pharmacological approach to CVD is that both the beta blockers and calcium channel blockers actually weaken the heart. In a simplistic sense you can consider the heart a pump, and these drugs decrease the pumping ability of the heart. The heart beats more slowly and with less force (that is why these medications lower blood pressure.) So, your typical patient on these drugs has a pulse that is limping along in the 50s to low 60s, and has legs needing to be laboriously dragged around all day feeling like they weigh a ton. Many of these patients experience dizziness upon arising (the orthostatic hypertension you test for with your NUTRI-SPEC procedures), since the heart can't push the blood up to the brain on demand.

- Adding insult to injury, these drugs make it extremely difficult for you to analyze your patients' results for NUTRI-SPEC fundamental imbalances. Calcium channel blockers, beta blockers, ACE inhibitors, Statin drugs, and the diuretic Lasix all cause the appearance of a strong dysaerobic test pattern (high specific gravity, low surface tension, high oxidation index, low urine pH, and high saliva pH). You have no way of knowing whether the patient is anaerobic or dysaerobic. Furthermore, the calcium channel blockers, and beta blockers can cause a false positive parasympathetic test

pattern. Again, you have no idea whether your patient is actually sympathetic.

That brings us to our consideration of how you, a NUTRI-SPEC practitioner, can deal with the pharmacological nightmare you find in CVD patients. Just what do you do when a new patient presents with hypertension or a history of heart problems or stroke, and is taking seven different drugs?

Your first option is to go with the Diphasic Nutrition Plan. This plan will quite effectively protect your patient against the further development of CVD, and will reverse much of the pathological damage in most cases. That is far more than the patient is getting out of his seven different drugs. Your Diphasic Nutrition Plan for these patients looks like this:

- Oxy B = 2 a.m. and 1 p.m.
- Formula ES = 2 a.m. and 2 p.m.
- Taurine = 2 a.m. and 2 p.m.
- Diphasic AM = 3 a.m.
- Diphasic PM = 3 p.m.
- Oxy A-Plus = ?
- Formula EW = ?
- Complex P = ?
- Complex S = ?

How do you handle the question marks in the Diphasic Nutrition Plan for CVD patients? First, consider the Oxy A-Plus and the Formula EW. If you run NUTRI-SPEC procedures and find neither an anaerobic nor dysaerobic test pattern, then begin with the standard 20 drops of A-Plus in the a.m. and 20 drops Formula EW in the p.m. If the patient shows an anaerobic test pattern despite taking one or more of the medications listed above that push him in a strongly dysaerobic direction, then you must assume that he is <u>extremely anaerobic</u>. You will give the patient at least 40 drops of Oxy A-Plus in the a.m., and recommend no Formula EW for now. If the patient shows a dysaerobic test pattern, yet is taking one or more of the medications that push him in a dysaerobic direction, then you must make an educated guess on how to most effectively begin with Oxy A-Plus and Formula EW based upon other Anaerobic/Dysaerobic clinical signs. The first one to consider is constipation vs diarrhea. If the patient has a problem with constipation, then go with 30 drops of A-Plus and 10 drops of EW. If the patient is often bothered by diarrhea, then go with only 10 drops of A-Plus and 30 drops of EW. If the patient reports no problem with constipation or diarrhea, then you are probably best off to begin with the standard 20 drops each of A-Plus and EW.

Now, consider the proper balance between Complex S and Complex P. If your patient shows a sympathetic type blood pressure and pulse combination, i.e., with high systolic blood pressures, and with a somewhat rapid pulse, then you will definitely not use Complex P. You will use one or two Complex S in the p.m. If the patient's orthostatic blood pressure response shows a big jump in both systolic and diastolic upon standing, then again, you will use no Complex P, and will use 2 Complex S in the p.m. If the patient shows a close to normal pulse, and a normal rise in orthostatic blood pressure and clinostatic pulse despite the fact that he is taking either a calcium channel blocker or a beta blocker, then again you will not use Complex P and will use Complex S 2 in the p.m. If the patient is taking a calcium channel blocker or a beta blocker and shows an extremely slow and non-reactive pulse, and shows blood pressures that are non-reactive to orthostatic challenge, then use neither Complex S or Complex P.

When can you use Complex P as part of the Diphasic Nutrition Plan for CVD patients? You may use it only when the patient has a slow, clinostatically unreactive pulse, and an orthostatic drop in either the systolic or diastolic blood pressures, and, you are absolutely certain the patient is not ketogenic.

If you are not doing any NUTRI-SPEC testing at all, yet want to start your CVD patient on the Diphasic Nutrition Plan, you can begin with just the standard recommendation of 20 drops of A-Plus in the a.m. and 20 drops of Formula EW in the p.m., unless your patient reports having a significant problem with either constipation or diarrhea, in which case you will adjust the A-Plus and EW recommendations. In considering Complex S and Complex P, you are best to omit the Complex P altogether, and give Complex S if the patient shows a somewhat elevated resting pulse.

Whether you are doing NUTRI-SPEC testing or not, you must do two things to assure that your patient gets the full benefit of your DNP. You must get the patient off the red flag medications, and begin a slow withdrawal of certain other medications that you carefully select. You must also, within 3 weeks of instituting the Diphasic Nutrition Plan begin the Oxy A-Plus/Formula EW balancing procedure.

Which medications do you want to go after, and how? Here are some guidelines. The Statin drugs are a red flag that should be totally eliminated immediately. There is no need for gradual withdrawal. To convince your patients to make that move, give them the cholesterol presentation as it was written up in two recent issues of this Letter.

Calcium channel blockers are another particularly pernicious red flag. If your patient is taking a calcium channel blocker to control blood pressure, then suggest (actually, insist --- with the aid of the informative handout you have to give these patients) that he switch to an ACE inhibitor. If the calcium channel blocker is designed to control cardic rhythm as well as blood pressure, then suggest that the patient switch to a beta blocker.

If your patient is on a beta blocker, and shows a recumbent pulse one of 60 or less, or, of 68 or less with orthostatic blood pressure failure, then you know the patient is over-medicated. You need to gradually withdraw the beta blocker. The protocol is to delete one day of medication per week for two weeks, then delete two days (for instance, Monday and Friday) for two weeks, then delete Monday, Wednesday, and Friday for two weeks, and then re-evaluate. If the blood pressure is still reasonably well controlled and the pulse is still normal or below, then to go to the next step, which is to only take the medication Monday, Wednesday and Friday, followed after several weeks by a further reduction to taking it only on Monday and Friday, then a reduction to Monday only, then off it completely. If at any time along the way the blood pressure or pulse rises significantly above normal, then just stop at that level of medication.

If calcium channel blockers, cholesterol medications, and beta blockers have all been considered, then it is time to take a look at your patient's ACE inhibitor. If the ACE inhibitor is controlling the blood pressure quite effectively, yet the patient shows a dysaerobic test pattern, then you should begin the same withdrawal procedure just described for a beta blocker. You may find that your patient only needs to take the ACE inhibitor a few days each week, or perhaps, eventually, not at all.

What you have just been given are the steps of analysis the NUTRI-SPEC staff uses to analyze the many CVD problem cases you send us. Now, you understand the rationale behind the way we analyze your drug-overloaded CVD patients. And now, you know how to manage these cases yourself (though you are still welcome to call us for advice --- anytime; every time).

The value of your expertise is incalculable --- you must use it fully in service of your patients. You are their only hope.

Sincerely,

Guy R. Schenker, D.C.