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THE NUTRI-SPEC LETTER

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From:
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Dear Doctor,

How much praise (and how many referrals) would you get from these patients if they were yours?

1) **80-year-old overweight insulin dependent diabetic with recent history of polymyalgia rheumatica**: After only 17 weeks on NUTRI-SPEC --- triglycerides dropped from 244 to 153; HDL increased from 41 to 49; Alc dropped from 7.3 to 6.7. Patient is thrilled with her weight loss accompanying the best labs since she became diabetic.

2) **48-year-old man with diabetes rapidly progressing, hypertension, and high cholesterol**: After only 14 weeks of NUTRI-SPEC --- lost 35 pounds and blood sugar stabilized, completely off both his blood pressure drug and his cholesterol drug.

3) **53-year-old NID diabetic with hypertension, recurring uncontrollable diarrhea, and, on estrogen replacement after hysterectomy**: After only 5 weeks on NUTRI-SPEC --- BP drug decreased to only 4X weekly, yet BP = 138/72; estrogen dose cut in half; diarrhea controlled. After one year --- BP drug only 1X weekly, yet BP = 128/82; diarrhea rarely; never sugar in urine.

What do these 3 patients show you?

- They illustrate the power you have with NUTRI-SPEC --- to empower even your chronically ill patients.

- They highlight your patient-specific approach to caring for your patients. --- In none of these 3 cases was any attempt made to treat diseases. The patients were empowered by their NUTRI-SPEC doctor according to our fundamental principle:

ADAPTATIVE CAPACITY = METABOLIC BALANCE + VITAL RESERVES

- These 3 patients illustrate how NUTRI-SPEC procedures give you the versatility to serve patients with a tremendous diversity of needs. Some of these patients were able to go directly to their life-long, long life Diphasic Nutrition Plan. Some had their clinical progress jumpstarted by addressing their 5 Metabolic Balance Systems through a 3-10 week period of NUTRI-SPEC testing. In all 3 cases --- whether employing the DNP solely, or transitioning to the DNP after several weeks of Metabolic Balancing --- it was the Fundamental Metabolic Imbalances underlying the patients' rather severe pathologies that were addressed.

- All 3 patients show off the amazing metabolic effects of your super-enhanced Complex P and Complex S. --- Remember, Sympathetic/Parasympathetic Balance is the primary source of Adaptative Capacity at the systemic level of biological organization. So --- either Sympathetic/Parasympathetic over-reactivity or Sympathetic/Parasympathetic failure **dominates the lives of nearly all your patients**. If not giving Complex P &/or Complex S to the majority of people you serve, you are under-serving.

Are any of your patients diabetic? All 3 of these patients were. Were they all given a diabetic remedy? Were they all given some NUTRI-SPEC protocol designed to "treat" diabetes? No, of course not --- each patient was given an individualized regimen employing NUTRI-SPEC supplements to increase Adaptative Capacity through some combination of Metabolic Balancing + increasing Vital Reserves. ----- No one is better equipped than you, as a NUTRI-SPEC practitioner, to address the diverse clinical pictures presented by your various diabetic patients.

--- Long term, diabetes is as ugly as it gets. Eventually, the patient is faced with some combination of neuropathy, gangrene, amputation, blindness, cardiovascular disease, and kidney failure. Suppose you could promise all your diabetic patients 10-20 years. Not 10-20 years of prolonging the agony, but 10-20 years of feeling truly alive? After reading this Letter, you can make that promise.

How will you handle your next patient like Patient #1, the 80-year-old insulin dependent diabetic who wanted to lose weight? --- After your staff has completed the NUTRI-SPEC testing, you talk with your patient. You explain that, "Type I diabetes is an autoimmune disease. In other words, some combination of stressors throughout the course of your life has so overwhelmed your immune system that it is hyper-sensitized, over-reactive, to the point of being out of control --- to the point that it is confused and attacking a part of your own body that it believes is a

foreign invader. In the case of Type I diabetes, the immune system is attacking and destroying your pancreas --- the gland that produces insulin to control and distribute your blood sugar."

--- In Patient #1, the sudden onset of diabetes was preceded one year earlier by an equally sudden onset of polymyalgia rheumatica. In such a case, you would explain to the patient that polymyalgia rheumatica is another example of an autoimmune disease, and that it was the foreshadowing of the diabetes to come.

You continue your talk with your patient by painting a very clear picture of what the future looks like for a diabetic. Yes, it is an ugly picture, and you secure an agreement from the patient that she is willing to commit to a lifetime supplement and diet plan to prevent or at least minimize the potentially disastrous sequela of diabetes. You make it very clear up front that you will in no way be "treating" her diabetes. Rather, you will be restoring Metabolic (including immune system) Balance, as well as increasing her Vital Reserves, so that her body is best able to deal with the diabetes.

Now that your patient is as enthusiastic as you are about the life-long service you are offering, you look at her test results. You see in this geriatric Type I diabetic an Electrolyte Stress pattern and a Glucogenic test pattern. How do you proceed? You know from NUTRI-SPEC that the autoimmune aggression of pancreas-destroying diabetes is most commonly associated with a Sympathetic tendency. Yet this patient does not test Sympathetic, but Glucogenic --- an Imbalance that is classically associated with an Acid reactive hypoglycemia, rather than the hyperglycemia of diabetes. How do you reason your way through this?

There are two facts to consider. First, the patient is on insulin plus an oral diabetic medication, both of which are driving her blood sugar down. Second, the patient is 80-years-old, which means that she is (like all people over age 53), suffering from some degree of generalized autonomic failure. In other words, both her Sympathetic and Parasympathetic Adaptative Capacity are fading. So, with the effects of the drugs, plus an age-related inability to mount a Sympathetic response, the patient does not show the expected Sympathetic test pattern. What do you do? This patient's NUTRI-SPEC practitioner put her directly on an individualized Diphasic Nutrition Plan. It was individualized in consideration of her Electrolyte Stress pattern for cardiovascular disease (with Formula ES and Taurine), and, it was individualized for insulin dependent diabetes with Complex S.

The next time you have a diabetic patient like this, your results will be just as extraordinary as they were in Patient #1. In no time at all, she

had by far the best labs of her diabetic life, and in fact, the first improvement in her steadily deteriorating condition since becoming diabetic. Did her NUTRI-SPEC practitioner "treat" her diabetes? No. Did her NUTRI-SPEC practitioner "cure" her diabetes? No, of course not. Has this NUTRI-SPEC practitioner served his patient with a more promising future than she ever dared dream of? Yes, absolutely. The patient is thoroughly empowered, and the doctor is rich.

Now that you understand the essence of Type I diabetes, how will you handle the next patient you see like Patient #2? You are presented with a man diagnosed as diabetic two years ago and whose blood sugar refuses to be controlled despite increasing doses of oral diabetes drugs. The patient is also on an ACE inhibitor for blood pressure and a statin for cholesterol. After your staff performs the NUTRI-SPEC test procedures on this patient, what kind of talk do you have?

You explain to this patient that there are actually two types of diabetes. Type I diabetes is the destruction of the insulin-producing part of the pancreas by an immune system that has been pushed past its limit and is now attacking the pancreas as a foreign invader. Type II diabetes is associated with what is called Metabolic Syndrome or Syndrome X. Type II diabetes is an entirely self-inflicted condition. It results from excess intake of dietary carbohydrates and sugars. The condition progresses through stages of abdominal weight gain, increased blood pressure, elevation of triglycerides, fatty deposition in the liver, hypertension, and then full-blown cardiovascular disease.

Along the way, the driving force behind the pathology is insulin resistance. A person who develops Type II diabetes is (probably genetically predisposed to be) Parasympathetic and/or Glucogenic and/or Ketogenic and/or Anaerobic, which means he is an insulin reactor. He produces more insulin in response to a given amount of food, or carbohydrate, or sugar, than the average person does. After years and years of over-stimulating the pancreas, the body becomes resistant to the excessive amounts of insulin produced. So now in response to a meal, the patient puts out his typical massive squirt of insulin, but the insulin does very little. The result is that the blood sugar stays high and the insulin in the blood also stays high. It is the combined elevation of sugar and insulin that causes the Metabolic Syndrome.

Now in your talk with Patient #2 you have to give him the unfortunate facts. "Mr. Patient #2, you are not only diabetic, you have both types of diabetes at the same time." You further explain to the patient that he will need to go on the insulin that his physician has been suggesting --- but --- if he follows through with a lifetime commitment to the plan you

will individualize for him, the need for insulin will be minimized. You explain further that the insulin resistant type of diabetes that he also suffers can be totally reversed if he will make the necessary commitment to comply with your NUTRI-SPEC eating plan.

The patient is devastated to learn the news about the insulin, yet understands clearly the task that lies ahead. "Let's go for it," he says. --- So now you are given the green light go, but go in what direction? --- The patient tests Anaerobic and Sympathetic, and that is all you need to know. You give the appropriate supplements and dietary recommendations, and on his first follow-up in one week, the Anaerobic Imbalance is already controlled, and the patient tests only Sympathetic. Also on that first follow-up, the patient's blood pressure is all the way down to 110/74, and he immediately starts backing off the blood pressure drug. He, based on the information you give him on statins, immediately stops the cholesterol drug.

The patient drops his 35 pounds by the 14th week. He is on the small dose of insulin he will need the rest of his life, but off completely the oral diabetic drugs. --- Think of it --- the patient is lean, strong, full of energy, entirely drug-free except for the little bit of insulin replacement, with perfectly normal blood pressure, cholesterol, and triglycerides. How happy is he? How rich is his NUTRI-SPEC practitioner?

Now that you understand clearly the difference between Type I and Type II diabetes, how do you handle Patient #3? --- You have many, many patients like Patient #3. Serving their particular needs may be one of the most valuable things that you ever do with NUTRI-SPEC --- yet --- your incredibly valuable efforts will never be fully appreciated. You will be literally a life-saving hero to these patients --- but, neither they nor their family will ever give you the thanks you deserve, because no one appreciates the power of <u>prevention</u> you have with NUTRI-SPEC.

You see, Patient #3 is already a Type I diabetic, but her physician does not know it, and probably has not given the patient's condition much thought. Patient #3 is one of the many, many patients who are in the early stages of autoimmune pancreatic destruction. The autoimmune process is not yet particularly aggressive, so the pancreas is just slowly being destroyed bit by bit year after year. The patient is being treated as a Type II diabetic with oral drugs, while the physician simply waits for the inevitable day when insulin will be required.

How do you know this patient is the victim of a slowly progressing autoimmune pancreatic destruction and not a case of Type II insulin resistant diabetes? You recall that Type II diabetes is entirely self-inflicted --- a lifetime of excess carb/sugar intake. One look at this

patient, and you realize she is not the least bit overweight, what little body fat she has is not excessively distributed in the abdomen, her triglycerides are not high, her diet is far, far better than average, and, the patient's blood sugar is scarcely affected at all by the oral diabetic drug she is taking. During the many years she has been taking it, her blood sugar and Alc never improved dramatically as you would expect if her sugar problem were related to insulin resistance. Furthermore, you look at her NUTRI-SPEC tests as just performed by your staff, and you see none of the four Imbalances (Ketogenic, Glucogenic, Parasympathetic, or Anaerobic) typically associated with insulin resistance.

What do you see? --- On the initial testing you see Electrolyte Stress and Dysaerobic test patterns. However, the patient's blood pressure medication is a beta blocker, which almost always causes a false positive Dysaerobic test pattern. The only reason why you might consider the patient could be Dysaerobic even without the effect of the drug, is that she does have chronic diarrhea --- a typically Dysaerobic or Parasympathetic symptom. There is not the expected Sympathetic test pattern on this presumed Type I diabetic, but you also realize that the beta blocker would be hiding any Sympathetic test pattern. If you proceed as did Patient #3's NUTRI-SPEC doctor, you address only the Electrolyte Stress test pattern at this point but include Immuno-Synbiotic because you know the diabetic is under extreme INE stress.

On the initial follow- up after a week on the ES regimen and Immuno-Synbiotic, this patient continues to show the Dysaerobic test pattern and the Electrolyte Stress test pattern, but now clearly shows Sympathetic as well. You add Complex S to this patient's regimen, and since her blood pressure has come all the way down to normal in just a week, you put her on the protocol for weaning off her beta blocker. The patient is well on her way to living happily-ever-after.

After another couple months, the beta blocker has been all but eliminated, yet the patient still tests Dysaerobic and has experienced occasional bouts of diarrhea. At that point, Oxy D+ is added to her regimen as she is transitioned to the Diphasic Nutrition Plan. After a full year, the patient takes a token dose of beta blocker once a week, and maintains perfectly normal blood pressure. She experiences very rare and not particularly disturbing diarrhea, and her blood sugar is better than it has ever been. But the big news here is not what you have done for this patient in a year, but will not happen to this patent over the next 30 years. She will not experience neuropathy, nor blindness, nor kidney failure. She will live well and live long on your individualized Diphasic Nutrition Plan, and while thoroughly grateful for your service, will never fully appreciate all you have done. --- Still, you are rich.