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Request for Feedback

After writing this newsletter for 4 years, I figure it's time to ask for feedback. I struggle with each issue to write in a style and at a level of sophistication that appeals to both the health care professionals and regular folk who receive the newsletter.

I've been told to 'dumb it down,' but others want even more detailed explanation and more science. People say articles are far too condensed to effectively make my points, while others think three full pages for chocolate or fish oil is excessive.

Many of you have requested specific articles, and I'm trying to get around to doing all the ones I feel I can competently address. Keep the ideas and feedback coming. And please give me some idea if you think something should be changed.

If you like what you read, please consider a donation to keep the organization alive.

Contents:

Vitamin: Folate- Health & Risk??	page 1
How Much Cigarette Tax is Enough	page 3
Turmeric: A Healthy Spice	page 3
Unhealthy "Physical" Activity	page 4
Diabetes & Metabolic Syndrome	
Definitions	page 7
Eating Disorder Vignettes	page 8
Donors & Sponsorship	page 8-9
Mission & Products	page 10

The Vitamin Folate & Folic acid – Health & Risk???

by Ann Gerhardt, MD

5/27/09

www.drgsmedisense.com

From information provided in part by Professors of Medicine Joel Mason, MD and Jacob Selhub PhD at the USDA Human Nutrition Research Center on Aging at Tufts University, Boston MA

Bottom Line At The Top: A diet containing an abundance of the vitamin folate confers protection against anemia, dementia, birth defects, nerve dysfunction, colon cancer, infection and elevated homocysteine. Since 1998 food cereal grain products have been fortified with folic acid to prevent neural tube birth defects and huge numbers of people take high dose folic acid supplements to lower homocysteine levels. High folic acid intake, particularly in the elderly, may not be perfectly safe. It may mask
continued on page 2

Folate

continued from page 1

dementia due to vitamin B12 deficiency and may accelerate growth of pre-existing cancer cells. These adverse effects may be related to the interaction of folate and B12 or the difference between folic acid supplements and natural dietary folates. To be safe, get your daily 400 micrograms (mcg) of folate from food. If you must take folic acid supplements, prevent B12 deficiency with food or supplements and be on the look-out for cancer.

Folate is one of the B vitamins essential for life.

Deficiency may cause:

- Anemia
- Severe neural tube defects in babies (birth defects of the brain and spinal cord, the most common of which are spina bifida and anencephaly (no brain))
- Cognitive dysfunction (not thinking straight),
- dementia (not thinking at all) and neuropathy (nerves don't work), because of its crucial role in DNA and protein metabolism.
- Diarrhea, since folate promotes a functional intestinal lining.

- High homocysteine levels (an amino acid by-product of protein metabolism that is associated with heart attack risk)
- Colon and rectal cancer
- Infection: Natural killer lymphocytes need folate to be able to fight off infection.

Scientists have identified these deficiency states, but there must be even more, since every cell in the body requires folate for metabolic processes absolutely crucial for cell function, repair and replacement.

Green vegetables, nuts, beans and whole grains supply the bulk of natural dietary folate. Nutritional supplements and food fortification uses a different form of the vitamin, folic acid. The Recommended Daily Allowance for folate is 400 micrograms (mcg), easy to achieve without supplements or food fortification. For example, a day's diet including 1 cup oatmeal, ½ cup cooked spinach, 1 ounce peanuts, 1 cup baked beans, 1 cup broccoli and ½ cup avocado meets the requirement. For most people 400 mcg suffices, but many don't consume even this much.

continued on page 5

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Jozeffa Greer MFT is a Marriage & Family Therapist who encourages her clients to be in the moment, where all real change happens. She has been in practice in Midtown Sacramento and Auburn for 18 years.

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How Much Of A Cigarette Tax Boost Is Enough?

by Ann Gerhardt, MD

5/27/09

www.drugsmedisense.com

On February 4 President Obama signed into law Congress' federal cigarette tax boost of 62 cents per cigarette pack to \$1.01 per pack. As part of the Children's Health Insurance Program Reauthorization Act of 2009, the new cigarette tax and lesser increases on other tobacco products took effect on April 1, 2009.

The Campaign for Tobacco-FREE Kids anticipates that the increase will induce more than 1 million adult smokers to quit and prevent 2 million kids from becoming addicted. Increased tax dollars will pay for health-related consequences of smoking and smoking cessation programs.

Prior to the increase, the federal excise tax on cigarettes was 39 cents per pack. Congress last voted to raise the federal cigarette tax in 1997, when it passed a two-stage increase of 10 cents that went into effect January 2000 and another five cents that went into effect January 2002. The resulting 39-cent rate, with its gradual introduction, failed both as a disincentive to light up and to keep up with the inflationary price of cigarettes.

In spite of past cigarette tax escalation under Presidents Reagan, George H. W. Bush and Clinton to the 39 cent rate, increases have not keep up with the times. Thirty nine cents is significantly lower in real dollars and as a percentage of cigarette prices than the tax that existed before the first Surgeon General's report on smoking in 1964.

The 1960 rate of 8 cents per pack accounted for almost a third of the average retail cigarette price (26 cents per pack). The average retail price for cigarettes now is more than \$4.00 per pack (range \$2-\$10), and the pre-hike federal tax of 39 cents per pack accounted for less than 10 percent of the average retail price.

Raising federal cigarette tax rates back to the 1960 level of 31 percent of the average retail price would have required an increase of 95 cents per pack. To keep the federal excise tax in line with the Consumer Price Index, the tax should have been increased by \$1.13 per pack.

The average state cigarette tax has increased from 5 cents to \$1.19 per pack, far out-pacing federal increases, because states bear the brunt of tobacco-related health care costs. Cigarette tax in European Union nations ranges from \$2 to \$10 per pack. We could have done more, but a 62 cent increase is better than nothing. ¶

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Suzanne Kilmer, M.D.

Turmeric, a Healthy Spice

by Ann Gerhardt, MD

5/27/09

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Bottom Line at the Top: Turmeric is a healthy spice. Use it in food whenever you can. Curcumin is the best-studied component of turmeric, but turmeric may also contain other active substances. If you take large amounts in pill form, be careful of stomach problems and drug interaction.

Turmeric, a common spice in Indian and Asian cuisine, comes from the root of an Asian perennial shrub, *Curcuma longa*. A member of the Ginger family, it gives Indian food its yellow color and "bite". US food manufacturers use it to color mustards and other foods yellow since the often-used chemical yellow dye #5 can cause asthma.

The most-studied active component of turmeric is curcumin, a naturally occurring polyphenolic phytochemical known for its anti-inflammatory, anti-bacterial and anti-carcinogenic properties. While other spices may contain curcumin, turmeric is the most concentrated source, at 1.06% to 5.7% by weight.

As with other herbal remedies, alternative medicine practitioners claim that turmeric cures a wide range of ailments ranging from infections and arthritis to stomach, menstrual, liver and heart problems.

Real evidence for health benefits so far: People whose diets are rich in turmeric have lower rates of breast, prostate, lung and colon cancers. Experiments in test tubes, animals and humans have been promising but so far inconclusive for a benefit in cancer, heart disease, arthritis and infections. Experimentally verified activity includes reducing platelet clotting, inhibiting cyclooxygenase, reducing alcohol's liver toxicity, and acting as an anti-oxidant.

continued on page 4

Turmeric

continued from page 3

Curcumin inhibits the development and progression of colon cancer in experimental animals and induces death of colon cancer cells in test tube experiments. A standard chemotherapy treatment, cisplatin, kills cultures of ovarian cancer cells faster if they are exposed to curcumin. Hamsters given a carcinogen know to induce lung cancer, and then fed 2% of diet as curcumin grew 75% fewer lung cancers and had half the death rate. Curcumin inhibits pancreatic cancer cell growth in laboratory experiments. Breast cancer spread less often to the lungs of mice treated with curcumin plus the chemotherapy agent Taxol than with either treatment alone.


Turmeric may have a role in the prevention and treatment of Alzheimer's disease. Villagers in India have very low Alzheimer's disease rates. Animal studies have shown that curcumin blocks the formation and accumulation of plaque that characterizes Alzheimer's.

Side effects: Turmeric and curcumin may cause heartburn, ulcers, stomach and intestinal upset with high doses. The German E Commission, which advises about herbal medicine, recommends that people with gallstone obstruction not use turmeric or curcumin. It is a member of the ginger family, and should be avoided by people allergic to ginger. Pregnant women should not take it, since it can stimulate uterine contractions. Be careful with high non-dietary doses, since it blocks drug metabolism in the liver, raising blood medication levels.

A note about names: Turmeric is a spice. Curcumin is a medicinally active compound. Curry powder is a mixture of various spices, often including cardamom, turmeric, fenugreek, cumin, fennel and other spices. In spite of the name similarity, cumin is the seed of a member of the parsley family and is not related to curcumin. Chinese herbalists use it as a stimulant, carminative (prevents or relieves gas) and anti-microbial, completely different medicinal uses than curcumin.

Dose: The standard dose turmeric/curcumin dose is 400 mg, standardized to 95% curcuminoid content, taken two to three times a day. It is not absorbed well. No one knows how much turmeric one would have to add to food to deliver health benefits.

I heard a scientist who was presenting a paper about turmeric preventing cancer in animals say that an equivalent dose was possible as a spice in the human diet. The turmeric to body weight ratio fed to his animals would translate into 2.5 teaspoons of turmeric daily, enough to turn every food bright yellow and give every food the same biting sour taste.¶



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Pounding heart from anxiety

Run a company

Walk the line

Make excuses

Folate

continued from page 2

Two major impetuses launched a push for adequate and even higher folate intake. In 1998, in order to prevent neural tube birth defects, **the US Food and Drug Administration mandated folic acid fortification of grain products**, including enriched breads, flour, corn meal, pasta, rice and cereals. Since 1998 neural tube defects have decreased by 25-50%. Initial over-fortification, subsequent correction and the advent of extremely popular low carb-there-goes-the-folic-acid diets threw a few blips in the curve of folate intake, but the program continues to work to keep neural tube defect incidence low.

The second impetus relates to homocysteine. High blood levels are associated with heart attacks and other blood vessel occlusions. Normal metabolism utilizing folate and vitamin B12 keeps homocysteine levels low by converting it into methionine (an amino acid crucial for normal brain function) or using vitamin B6 to turn it into another amino acid, cysteine. Levels go up with a deficiency of any of the three vitamins. Homocysteine also accumulates in the face of alcohol consumption or renal failure.

Numerous factors and vitamins influence homocysteine levels, but, rather than address all of them, **many doctors treat high homocysteine levels only by prescribing high doses of folic acid**. Not only does this ignore the infinite complexity of human metabolic processes, but it doesn't solve the problem if folate deficiency wasn't the cause in the first place. When folic acid food fortification started, the prevailing view held that extra folic acid would not only prevent neural tube defects, but would also lower homocysteine levels and prevent heart attacks. In actuality fortification has had only a measly effect on cardiovascular disease, but patients continue to fill folic acid prescriptions for 1000 mcg or more.

So what? Since folate is a water-soluble B vitamin, one would predict no adverse effects of high doses. Turns out there are a few, with only theories about their causes.

The first adverse effect relates to vitamin B12 deficiency dementia: Folic acid makes it harder to diagnose B12 deficiency dementia and in some people actually makes it worse. In people whose vitamin B12 status is good, folate supplementation poses little danger. However, superimposing high dose folic acid supplements and fortification on vitamin B12 deficient people is not safe.

What happens is this: A B12 deficient person becomes anemic and cognitively deficient or outright demented. If that person takes high dose folic acid, the anemia corrects, but the mental problems do not. Elderly people risk low vitamin B12 levels more than any other age-group, but we **expect** them to be demented. If they are demented without an anemia typical of B12 deficiency, we don't suspect it or do the test. Thus **folic acid is said to "mask" B12 dementia and neuropathy, which are often irreversible if not caught early.**

Two extra-ominous studies found that, rather than just masking a B12 dementia, folic acid supplements in excess of 400 mcg per day make things worse. **Low B12 along with high folate levels nearly doubles the risk of cognitive impairment, compared to people with low B12 and normal folate.**

Possible cause: We know that B12 deficiency dementia results from not being able to convert homocysteine to methionine, a deficiency of which leads to deficient S-adenosyl methionine (SAM). SAM is necessary for normal brain function.

Folate's job in the body is to facilitate the transfer of single carbons (methyl groups) from one molecule to another. Once done, the active forms of folate need to be regenerated by completing a cycle. That cycle includes the B12-mediated conversion of homocysteine to methionine. Without B12, the blocked cycle builds-up 5-MTHF, a folate that can't correct for the lack of B12.

In a B12 deficient person, folic acid supplements pour in a supply of active folate, enabling on-going DNA and protein synthesis for cell growth. But it siphons off methionine (it is, after all, an amino acid needed to make protein), depleting it and SAM even further and worsening dementia. Perhaps the balance between B12 and folate is as important as maintaining adequate levels of each.

As an aside, 5-MTHF does not convert into the form that transfers inside cells, so in B12 deficiency cell folate content declines, even as inactive blood levels rise. **For this reason, the best measure of functional folate adequacy is red cell folate, not serum level.**

The second potential problem with supplementation is cancer. A huge amount of scientific data links dietary folate intake with protection against colon cancer growth in both humans and animals. Folate also seems to protect against lung, pancreas, mouth, throat, esophagus, cervix and ovarian cancers, neuroblastoma and leukemia. A few dissenting studies exist, but over 30 case-control and prospective cohort studies found that people consuming diets high in folate and with high blood folate levels, have

continued on page 6

Folate

continued from page 5

a 40–60% reduction in the risk of developing colon or rectal cancer or their precursor lesion, the adenomatous polyp. Moderate-to-heavy alcohol drinkers benefit more from folate, probably because alcohol blocks folate function. A benefit for breast cancer is more iffy and probably confined to those women who are moderate-to-high imbibers of alcohol.

However, inklings that high dose supplemental **folate might paradoxically accelerate cancer growth**, date back to studies in the 1940's. Two groups of investigators gave large doses of folic acid to patients with acute leukemia and observed what was politely termed "the acceleration phenomenon", whereby the leukemia went out of control.

More recently, of 25,000 postmenopausal women, those taking folic acid supplements (average 853 mcg/day) had a significantly higher risk of developing breast cancer. In people who have had colonic polyps removed, folic acid supplements don't affect polyp recurrence within the first three years, but more than double the number of polyps, including dangerous ones at 6-8 years. These results argue that,

given enough time in a high risk group of people who tend to grow new pre-cancerous cells, high dose folic acid might help those cells to turn into cancer.

Short term studies don't generate as ominous results, but would only apply to you if you plan to live short term. In the first year after mandatory folic acid food fortification in 1998, an extra 5 colon cancers per 100,000 individuals were diagnosed nationwide.

Studies using folic acid supplementation (to lower homocysteine) have yielded variable results concerning cancer incidence, but none included adequate numbers of subjects to come to meaningful conclusions. Plus there is the confounding probability that supplementation might correct a deficiency state and prevent cancer.

To summarize the effects on cancer, **under most circumstances adequate availability of dietary folate protects against cancer, presumably by enhancing genetic stability. However, in select circumstances in which an individual who harbors a neoplasm or group of abnormal pre-neoplastic cells consumes excess folate, it may instead facilitate cancer promotion.**

Theory: Cancer cells proliferate at a rapid rate, requiring large quantities of folate to maintain DNA synthesis. **Folate's central role in the synthesis of genetic material means that it might help cancer cells to reproduce even faster.** This might propel pre-cancerous and small malignant neoplasms to full-blown dangerous growth.

Alternate theory: There may be some adverse effect of free folic acid. Folic acid, used for fortification and supplements, is not a naturally occurring form of the vitamin folate. The intestine converts both dietary folate and folic acid supplements to 5-MTHF in the process of digestion and absorption. Folic acid supplements in doses as light-weight as 200 mcg, can overwhelm the conversion mechanism, resulting in detectable levels of free folic acid in the blood. Daily 400 mcg doses lead to sustained circulating folic acid levels, which isn't normal. Eighty one percent of supplement users have unmetabolized folic acid circulating chronically in the bloodstream.

Cancers afflict the elderly more than the young. Forty percent of US adults over 60 years of age regularly consume at least 400 mcg folic acid as a supplement. When fortification started, adding an estimated ~100-200 mcg /day from fortified food, supplement users' already high folate levels rose 62%. That puts them most at risk for folic acid induced cancer growth, should they have nascent cancer cells lying in wait.

Another alternate theory: Preliminary data suggests that folic acid supplements improve immune function up to a point, but if total intake surpasses 633 mcg per day, one of the body's crucial immune defenses, **natural killer cells, lose their lethal effect. These cells not only fight infection, but also kill isolated cancer cells** before they can become full-blown cancers. High dose folic acid might block this function.

Yet another alternate theory: Folate doesn't work alone. It is both myopic and misleading to attribute all of folate's effects to it alone. Folate's active form has to continually be regenerated, requiring vitamins B6 (pyridoxine), B12 and B2 (riboflavin), critical cofactors for pivotal enzymes in the regeneration process. Marginal vitamin status is far more common than we would hope, and low levels of vitamin B6, B2 and B12 occur in as many as 20% of the population. **These vitamins are essential to known functions involving folate, so why should we think that folate acts alone in preventing or promoting cancer?**

Dilemma: Countries now dealing with folic acid fortification issues must balance 1) the clear benefit of adequate folate levels for all with respect to anemia, cognitive function, gut and immune function and homocysteine levels, and 2) the extra benefit for child-bearing women and their offspring at risk for neural tube defects, against 3) incomplete knowledge about the potential for harm in older individuals at risk for cancer or B12 deficiency cognitive dysfunction.

The benefit of fortification in relation to neural tube
continued on page 7



DIABETES & METABOLIC SYNDROME DEFINITIONS

by Ann Gerhardt, MD

5/20/09

www.healthychoicesformindandbody.org

I've been asked to clarify the definitions for metabolic syndrome, diabetes and the phases preceding overt diabetes. See DrG'sMediSense articles about metabolic syndrome, diabetes and fructose in the September 2006, November 2007 and February 2008 issues for background.

Metabolic syndrome predicts risk for diabetes, with all its concomitant complications – nerve damage, blindness, kidney failure, heart attack and vascular disease. It usually runs in families and is associated with abdominal obesity and lack of exercise.

Criteria for the metabolic syndrome from The National Cholesterol Education Program Adult Treatment Panel-III (NCEP ATP-III) used in the United States and the International Diabetes Federation (IDF) are shown.

Folate *continued from page 6*
defects would be negated if just 1 in 100,000 subjects eating folic acid-fortified food experiences a serious adverse effect. Mandatory fortification exposes the entire population to extra folic acid, including those who might be susceptible to harm.

In addition, malaria parasites seem to like folate. People who are folate deficient tend not to become infected with malaria. Universal food fortification could put millions of Third World people at greater risk for malaria.

Thus, *under select circumstances* folate supplementation contributes to disease. In the face of B12 deficiency, an overly abundant folic acid intake worsens cognitive function. In someone with pre-cancerous cells lurking in the background, folic acid supplements promotes cancer cell proliferation. Have we set people up for these problems by the fortification effort to prevent neural tube defects and the prescription of high dose folic acid to lower homocysteine levels? Since **adequate** folate levels prevent cancer, anemia, dementia and high homocysteine levels, the problem is not simple. **We all need adequate levels, not high, not low.** More is not better: Such an un-American concept.

Solution: The ideal solution requires all people, especially women of child-bearing age, to consume a folate-rich diet of vegetables, legumes, nuts and whole grains and stop drinking alcohol, so they don't need folic acid supplements or fortified food.

Fat chance that all people will suddenly eschew their crappy diets and alcohol and eat their vegetables and beans. To prevent neural tube defects we at least need grain fortification. But do we really need high dose folic acid supplements? If we do, we need to be more vigilant in our suspicion for and diagnosis of B12 deficiency, dementia and cancer. ¶

NCEP ATP III Must have ≥ 3 of 5

IDF Central Obesity + any other 2 factors

Waist

Men	> 102 cm (40 in)	≥ 94 cm (37 in)
Women	> 88 cm (35 in)	≥ 80 cm (31.5 in)

Triglycerides

≥ 150 mg/dl	≥ 150 mg/dl or being treated for it
-------------	--

HDL-cholesterol

Men	< 40 mg/dl	< 40 mg/dl (<1.03 mmol/L)
Women	< 50 mg/dl	< 50 mg/dl (< 1.29mmol/L)

or being treated for low levels

Blood Pressure

≥135/≥90 or on treatment for hypertension	≥130/≥90 or on treatment for hypertension
--	--

Fasting Glucose

≥100-125 mg/dl	≥100 (5.6 mmol/L) & strongly recommend oral glucose tolerance test. Or previously diagnosed diabetes
----------------	--

Diabetes experts have identified two pre-diabetes states, Impaired Fasting Glucose and Impaired Glucose Tolerance. Anyone with a fasting glucose of 100 -125 mg/dl has Impaired Fasting Glucose. Those who have normal fasting glucose, but don't clear sugar out of the

continued on page 8

Diabetes & Metabolic Syndrome

continued from page 7

blood expeditiously after eating have Impaired Glucose Tolerance, defined as two-hour glucose levels of 140 – 199 after consuming 75 grams of glucose.

A diabetes diagnosis requires a fasting glucose of > 126 mg/dl or a glucose two hours after a sugar load of \geq 200 mg/dl. Glycosylated hemoglobin (HgbA1c) is a measure of what glucose levels have been over the last three months. Perfectly normal HgbA1c is <5%. Acceptable HgbA1c for good diabetes control is \leq 7%.

EATING DISORDER

VIGNETTES *by Ann Gerhardt, MD*

www.drugsmedisense.com 5/29/09

Rather than lecture to you about eating disorders, I thought a few vignettes might help to understand more about them (and why they can be difficult to treat.)

A woman with a good job calls to make an appointment for her son with an anxiety disorder who is losing weight because he can't make himself eat. He's unusual for eating disorder patients in that he wants help. I tell her that I don't bill insurance, but she can bill her own insurance and that her insurance reimburses fairly well. She calls before the appointment to cancel because she doesn't want to spend the money. Her out-of-pocket cost might have been \$50 after reimbursement. If her priorities are such that \$50 is worth more than her son's health, I'm guessing I know the source of some of his psychological problems. Sigh.

A teen has bulimia and somatization, a disorder in which she experiences emotional feelings as physical symptoms. She responds to treatment because she is open to change, her father switches his job hours so he can attend family therapy, and the mother learns to parent with clear rules and boundaries. Smile.

A daughter of a well-to-do community figure becomes depressed and anorexic, so much so that she requires hospitalization for irregular heart beats and suicide attempts. She wants to row for a crew team, while Dad expects her to swim competitively. She wants to do music, while the parents push for the sciences and college. Her sister is very thin and has no menstrual periods, but has never been diagnosed officially with an eating disorder. The father blames his daughter for creating problems in his otherwise perfect family. Absolutely essential to her recovery is effective family therapy, but 'perfect' Dad won't participate. The daughter attempts

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Eating Disorders, continued

suicide again, the parents fire the doctors and Mom and Dad divorce. So much for the perfect family. Double sigh.

A 34 year-old woman with low self-esteem and an inability to be assertive has practiced bulimia since she was a teen. She decides it's time to work on the problem. She struggles through therapy and doctor appointments for 3 years. Gradually, so much so that she doesn't know why it's happening, she sheds the need to binge and purge and learns to advocate for her own needs and be less of a co-dependent. She now accepts her curvy shape as natural and healthy. Her husband likes her even more now. Double smile. ¶

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- 1) Educating children and adults to understand the components of healthy lifestyles and how to incorporate those components into their own lives;**
- 2) Changing standards of beauty and health to those that do not define us by our weight and do not promote eating disorders, including anorexia, bulimia, binge eating disorder, and compulsive overeating that may lead to obesity; &**
- 3) Interpreting health-related news within the context of existing medical knowledge to enable individuals to apply it to their own lives.**

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