

# The Hypoglycemic Association

# NEWSLETTER

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The NEWSLETTER of the Hypoglycemic Association is distributed to members of the Association and to Health Professionals with an interest in nutritional medicine and clinical ecology.

**FEES:** Fees have not changed despite increases in costs. These are \$15 per family or \$10 for pensioners and students. This is an entirely voluntary organisation and the cost of producing this Newsletter and conducting public meetings depends on finance provided by the membership. By supporting this Association you help in educating the public to appreciate the importance of clinical nutrition and ecology, and to encourage doctors to use natural means to restore or promote health among the general population. Looking back over recent years it is obvious that many people have become aware that health is very much a matter of lifestyle, environment and nutrition. Our Association has contributed - as have similar voluntary organisations - in promoting this awareness. Many doctors are already committed to treating their patients through natural health in combination with more traditional medical practice. As an Association we support those doctors and health practitioners but above all our members who seek this kind of treatment, armed with a basic knowledge in natural health. But we still have a long way to go, and therefore it is important that you keep supporting the Hypoglycemic Association by not only sending in your fees but also recruit new members. **Please note that the expiry date is in the top right hand corner of the address labels.**

Our Next Meeting will be at 2 PM  
on Saturday, the 5th June, 1993  
at the YWCA,  
2 Wentworth Ave, Sydney and  
our guest will speak at 2 PM.

## Michael McInerney

will be speaking  
on the subject

### ***“Introduction to Health”***

**Michael McInerney** a former pharmacist for 20 years is currently a chiropractor and naturopath with a practice in Hurstville.

He has been in his current profession for the last ten years.

He has extensive experience in natural health and was a practitioner at the Hopewood Health Centre at Wallacia. He is married with three children and said that "he practises what he preaches".

The Association really appreciates Mr McInerney giving up his Saturday afternoon to share his knowledge with our members.

Any opinion expressed in this Newsletter does not necessarily reflect the views of the Association

PREVIOUS COPIES  
OF  
NEWSLETTERS

Previous copies of the Hypoglycemic Newsletters are now available at the NSW State Library.

*Steve Duff telephone advisory service*

Our life member Steve Duff is willing to talk to any person by phone on any problems relating to hypoglycemia, allergies and diet. This voluntary advice is based on his personal experiences with hypoglycemia and allergies and any problems of a more complex nature will be referred to nutritional practitioners. If you would like to have a talk with Steve,

please ring him at his home on 529-8040.

**Books for sale at the meeting**

Jur Plesman: **GETTING OFF THE HOOK**  
Sue Litchfield: **SUE'S COOKBOOK**

**Contributions of articles** by members and by practitioners are very welcome. If you would like to contribute an article to this Newsletter, please contact the Editor.

**The Newcastle branch of the Association** are still meeting with the assistance of Bev Cook. They meet on the last Saturday of each month beginning 1.30 PM to 3.30 PM at the Hillsborough Primary School. Enter the school from the Waratah Avenue. For further information ring Mrs. Bev Cook at 049-59-4369.

**Organise local meetings**

If any member would like to organise meetings in their local area or meet other members, we can help by advertising your name and phone number in this Newsletter.

**Entrance fee at meetings**

Because of increase in costs the Committee has decided to charge an entrance fee of \$2 per person or \$3 per family at our public meetings.

**Donations for raffle**

One way of increasing our income is by

**Word Process Operators**

The following members have offered to assist the Editor in typing manuscripts for publication in this Newsletter. They are;

- **Chantal Frappier** of Coogee
- **Betty Jones** of North Rockhampton

The Committee would like to express their appreciation for their help.

way of raffles. If any member has anything to donate towards the raffle, please contact Dr George Samra's surgery at 32-38 Montgomery, Kogarah.

**Raffle Winners**

Pauline Alder won the Lucky door price and Barabara Grady won the Raffle at our last meeting on the 6 March, 1993

*Food provides one with that replete, satisfied feeling of well-being, that cannot fail to provoke wisdom of some kind. Peter de Vries, for one, can be wise after the event:*

**"I wished now that I had gone to the restaurant across the street where the food had at least the merit of being tasteless."**

# SPIRITUAL ASPECTS OF HEALTH

by  
Col Taylor

**Note:** The following is a summary of notes provided by Mr Col Taylor our last speaker at the March, 1993 meeting. It is important to stress as with other articles published in our Newsletter that opinions expressed are not necessarily those of the Hypoglycemic Association.

The policy of the organisation is to ensure that medical doctors and tertiary qualified scientists make up the bulk of our speakers. We do however allow others with special qualifications and experience in health to share their knowledge with us, and still appreciate their participation. Some have criticised this talk as not being scientific; nonetheless no one has complained that it was not interesting.

"It has only been in the last ten years that I started to focus my attention on the causes and nature of illness and approaches to healing. Naturally I focused on the problem from a mystical/spiritual angle and tried to see how

different medical systems worked.

My approach to healing is totally different to that used by your average medical doctor.

I see you as a spiritual being using a physical body. You existed before you were born and you will continue to exist when your physical body dies. Your life has a purpose.

When you experience problems in your physical body they are signs that something is wrong in your spiritual body.

The physical body is only the tip of the iceberg, yet that is the level which usually gets all the attention. The physical symptoms are mistaken for the real disease in your spiritual body.

Just in case you have seen the "The Exorcist" or a flamboyant preacher casting out evil spirits, don't worry. The movie idea of "evil spirits" or "demons" is grossly overrated. They are really much more common and much less dramatic than people imagine. They are just one more part of life.

I simply get people to lie down or stay

seated while I place my hands lightly on them and pray silently. Usually they just feel nice and warm and very relaxed while the healing takes place. A very pleasant experience.

Typically, my clients get rapid relief from emotional and mental symptoms and then their physical bodies start healing themselves as they naturally should.

People have the capacity to make decisions and take actions which determines their future circumstances and helps to mould their personal characteristics.

**THERAPIES I USE**

- spiritual healing
- homoeopathy
- flower essences
- hypnotherapy
- neuro linguistic programming
- counselling
- REIKI

People are totally responsible for themselves. They create their own circumstances and their own futures by their thoughts and actions.

A typical session with me takes around 2 hours in total for diagnosis, healing and discussion. Around 8 out of 10 of my clients need only one 2 hour session to get substantial long term benefits. Some cases take longer or need more sessions. We have to work this out as we

go along.

True healing involves some personal growth and may be some change. It is far more than just the removal of some unpleasant symptoms. Thus if someone doesn't want to change then the symptoms may not stay away either.

Remember, you are responsible for your own life. Other people can help you but can't do it all for you. Only you can do that.

Also remember that you are here to learn. That means doing things, taking some risks, taking some knocks, and trying again. Sooner or later, we all make mistakes and we all need repairing.

The keys to succeeding in life include learning from your mistakes and knowing where to get help when you need repairing.

Col Taylor, Healer & Homeopath has his practice at: 19 Staplyton St. WINMALEE, 2777, Ph: 047-54-2480

# UNDERSTANDING ULCERATIVE COLITIS AND CROHN'S DISEASE

## Introduction

Ulcerative colitis and Crohn's disease are among the few remaining mystery diseases. Although ulcerative colitis has been recognised for over 100 years and Crohn's disease for more than 70, we still do not know what causes them. Ulcerative colitis and Crohn's disease are closely related illnesses and often grouped together under the term inflammatory bowel disease.

## What does "inflammatory" mean?

When a part of the body becomes hot, reddened and swollen, it is described as inflamed (literally, "like a flame").

## How does inflammation affect the bowel?

In ulcerative colitis, the mucosa (lining) of the colon (large bowel) becomes red and inflamed. The rest of the bowel is not affected. Crohn's disease can affect any part of the bowel, and where it does, the full thickness of the bowel wall becomes inflamed. The inflammation causes symptoms of bleeding, diarrhoea and pain in both ulcerative colitis and Crohn's disease. Because they are similar, it is sometimes difficult to tell which inflammatory bowel disease (ulcerative colitis or Crohn's disease) a patient has.

## Does this mean they are hereditary?

Both ulcerative colitis and Crohn's disease do occasionally affect more than one member of the family, but the chance of "passing on" inflammatory bowel disease to a child is small.

## What is the cause of ulcerative colitis or Crohn's disease?

Despite much research, we do not know. It is possible that affected people have an abnormal defence system or that an infection (bacteria or virus) which has not yet been identified is the cause. People with Crohn's disease are more likely than normal to be smokers. The reverse is true for ulcerative colitis. We don't yet understand the significance of this.

**This article is a copy of an booklet prepared by the BRITISH DIGESTIVE FOUNDATION. This will be followed by notes on nutritional treatment of the disease as shown by recent literature.**

## ULCERATIVE COLITIS

### What are the symptoms of ulcerative colitis?

For most of the time, most patients feel well with no symptoms, because the disease is inactive (remission). From time to time the disease flares up and becomes active (relapse). The main symptoms of relapse are:

- bloody diarrhoea
- passage of mucus or pus
- abdominal pain, often just before a stool is passed.

If only the final part of the bowel (rectum) is involved, the disease is called proctitis and the usual symptoms are passage of blood and mucus without diarrhoea.

## What causes the disease to relapse (become active)?

Normally, there is no obvious cause for a relapse. In a few cases a triggering event can be identified (though this is not the cause of the disease). For example:

- personal stress or worry
- common infections (eg colds, flu, gastroenteritis)
- some drugs (eg antibiotics, aspirin, and anti-arthritis drugs)
- diet (a small number of people with ulcerative colitis find that cutting out milk products or other foods is helpful, but there is no good evidence as yet that relapse in most patients is due to food allergy).

## How is ulcerative colitis diagnosed?

If the doctor suspects ulcerative colitis, he will usually do a sigmoidoscopy. He passes an illuminated metal tube through the back passage (anus) to see the mucosa, and removes a tiny snip (biopsy) for subsequent inspection under the microscope. Tests may also include:

- stool specimens, to exclude infection
- blood samples
- barium enema X-ray (barium liquid is run into the bowel through the anus)
- colonoscopy (under sedation, a flexible telescope is passed via the anus all round the colon).

## Are other parts of the body ever affected?

Uncommonly, yes.

- The skin may be affected with warm red tender lumps (erythema nodosum) or, very rarely, ulceration (pyoderma)

usually on the legs.

- Pain and swelling may occur in the joints (arthritis) or spine (ankylosing spondylitis).
- Inflammation may also rarely involve the liver (hepatitis), bile ducts (sclerosing cholangitis) eyes (episcleritis, iritis, uveitis, making them red and painful).
- Children with severe disease may grow slowly.

#### **How is ulcerative colitis treated?**

The only cure is surgery, to remove the colon, but for most patients the disease can be controlled with drugs. There are two main kinds:

Steroids (eg prednisolone) which are used during an acute attack to damp down the inflammation. Steroids may be given as tablets, injections, enemas, rectal foams or suppositories.

Sulphasalazine (or mesalazine) is given long-term as tablets, enemas or suppositories to hold the disease in remission and prevent inflammation from redeveloping.

The drug azathioprine may be used in a similar way.

There is more information about these drugs at the end of this article.

#### **When is surgery necessary?**

Most people with ulcerative colitis never require an operation. However, the colon (large intestine) may have to be removed surgically:

- if a very severe attack of ulcerative colitis fails to respond to intensive medical treatment
- if repeated attacks cause chronic ill-health
- if serious pre-cancerous changes are found in the colon, particularly where the whole colon is involved. (See "Living with inflammatory bowel disease").

## **WHAT OPERATIONS ARE AVAILABLE FOR ULCERATIVE COLITIS?**

### **• Colectomy and ileostomy**

This is the standard operation. The whole colon and rectum are removed. The end of the remaining small intestine (ileum) is brought through the abdomen as a spout (ileostomy) which drains into a plastic bag. Specialist nurses train the patient how to care for the ileostomy. Help and support are offered by the Ileostomy Association. After a while, most people adapt extremely well to an ileostomy. The ileostomy bag lies flat on the abdomen. It does not show, even through very light clothes (including bathing costumes), and should not interfere with any activities, including sexual intercourse.

### **• Newer operations**

The ileostomy can be made so that it doesn't drain freely. No bag is needed, but a tube must

be passed to empty it several times a day.

It is possible to avoid the need for an ileostomy by joining the ileum to the rectum or anus. Diarrhoea is quite common and the operation is not always successful.

No operation is perfect. Each has advantages and disadvantages. In each case, the choice of operation has to be made on an individual basis by the patient and surgeon.

Although it is a big step to have an operation, it does mean that ulcerative colitis is cured permanently. Patients who are sufficiently ill to need surgery usually notice a great improvement in their general health.

## **CROHN'S DISEASE**

### **What are the symptoms of Crohn's disease?**

Because Crohn's disease can affect any part of the bowel, the symptoms may be variable. The commonest are:

- Diarrhoea, sometimes with bleeding
- Abdominal pain - this occurs because the inflammation either causes pain directly or causes narrowing of the bowel (stricture) resulting in occasional gripey pains often with windy distension
- Bowel obstruction due to severe stricture formation - this causes vomiting as well as pain and distension and may need surgery
- Loss of weight - nutrients may be poorly absorbed from the diet when the disease is active
- In some patients a leak (fistula) develops through the inflamed bowel into another organ, such as skin, bladder or vagina, causing a discharge.

Although Crohn's disease is a life-long condition, it may remain dormant with no symptoms for long periods.

### **How is Crohn's disease diagnosed?**

- Where Crohn's disease affects the lower intestine (Crohn's colitis) the methods are the same as those for ulcerative colitis (see "Ulcerative colitis").
- If Crohn's disease affects the upper part of the gut, a barium meal or a gastroscopy may be carried out.
- Sometimes the patient swallows a tube so that barium can be run directly into the small intestine for X-rays.

### **Are other parts of the body affected?**

Yes, some people with Crohn's disease may get the skin, joint, liver and eye complications which were described earlier in the section on "Ulcerative colitis".

### **How is Crohn's disease treated?**

Steroids (eg prednisolone) are given as tablets, injections, enemas, rectal foams or suppositories, to minimise the severity of inflammation. Sulphasalazine is given to patients with Crohn's disease affecting the colon

to reduce disease activity. Less often, azathioprine or metronidazole may be used. (See "Living with inflammatory bowel disease").

### **Is surgery the answer?**

Surgery is used in a different way to ulcerative colitis. The chances of needing an operation are quite high, but normally only a small diseased segment will be removed. It is usually possible to rejoin the bowel, but sometimes an opening (ileostomy or colostomy) is made in the abdominal wall. Surgery can cause problems of its own (for example, diarrhoea or a fistula) so diseased areas of bowel which are not causing serious symptoms are usually left alone.

## **LIVING WITH INFLAMMATORY BOWEL DISEASES**

### **How normal a life can I lead if I have ulcerative colitis or Crohn's disease?**

When either disease is inactive, there are no restrictions. If you have diarrhoea, some practical planning is needed when you go out.

### **What about life insurance?**

You should declare your illness. You may have to pay a higher premium, particularly with Crohn's disease.

### **What about pregnancy?**

#### **(a) Fertility**

Except at times of severe disease activity, women with ulcerative colitis have normal fertility. Fertility may be reduced with Crohn's disease. It is important to know that sulphasalazine can cause men to become less fertile. This returns to normal when the drug is stopped.

#### **(b) Effect of pregnancy on the disease**

During pregnancy most women with ulcerative colitis or Crohn's disease feel well. Overall, relapse is probably no more or less likely than in the non-pregnant state.

#### **(c) Effect on the baby**

Miscarriages are possible if either disease is very active or an operation is needed, so it is wise to avoid becoming pregnant during a relapse. Most women have a normal pregnancy and deliver a normal child. There is no increased risk of the baby being abnormal. Sulphasalazine and steroids seem to do no harm to the baby. Some doctors advise women to avoid pregnancy while on azathioprine because of theoretical risks.

### **How important is emotion?**

- There is no evidence that ulcerative colitis or Crohn's disease are caused by emotion. People with these diseases have normal personalities.
- Of course, stress can cause diarrhoea or abdominal pain in patients, just as in normal people.
- Naturally, diarrhoea, incontinence (accidents), abdominal pain and having to rush to a toilet are themselves distressing. It is important to try not to be

ruled by the disease and to take practical precautions, such as carrying extra underwear, pads or toilet paper when the disease is active.

#### **What is nervous colitis?**

This term is sometimes used (wrongly) to describe the irritable bowel syndrome, which is affected by emotion. This is completely different from both ulcerative colitis and Crohn's disease.

#### **What diet should I eat?**

In general, eat what you like. There is much research on diet at present, yet no clear evidence that fibre or food allergy make a difference to these diseases. Milk can exacerbate symptoms in a non-specific way in a few patients, but can be taken without harm by the majority.

#### **Can ulcerative colitis or Crohn's disease lead to cancer?**

Yes, but the circumstances under which this occurs are well understood. The risks are only substantial in patients with ulcerative colitis if it

- affects the whole colon
- has been present for at least 10 years
- has been fairly active during that time.

Warning changes may be detected in the bowel years before a cancer develops. For such patients a colectomy or regular colonoscopic examination may be necessary. The risks are much less for patients with milder disease or with Crohn's colitis. Crohn's disease affecting other parts of the bowel does not lead to cancer. Because patients with ulcerative colitis or Crohn's disease are kept under regular medical review, they are no more likely to die of cancer than other people.

#### **What are the main drugs used in inflammatory bowel disease?**

The same drugs are used in ulcerative colitis and Crohn's disease.

#### **Anti-inflammatory steroids**

These are used when either disease is active and the bowel inflamed (cortisone, hydrocortisone, prednisolone, dexamethasone).

Steroids have revolutionised treatment of inflammatory bowel disease, but like other powerful drugs may have side effects, especially when given for long periods of time.

These can include:

- rounding of the face
- diabetes
- increased appetite and weight gain
- high blood pressure
- thinning of the bones
- changes in mood
- (osteoporosis)
- muscle wasting
- cataracts

When taken in the evening, steroids keep some people awake and are best avoided after

6.00pm.

Steroids are natural products produced by the body. During treatment, the body's own production ceases, so steroid treatment must always be reduced gradually to allow the body's production to resume. Some patients feel "low" as steroids are reduced; a few require special measures to restart the body's own production. Patients on steroids should carry a Steroid Card to ensure this is known if they are in an accident, etc.

#### **Sulphasalazine (Salazopyrin)**

This is a most valuable drug. When taken continuously it reduces by three-quarter the chance of having a relapse of ulcerative colitis. It is also useful for Crohn's colitis. How it works is unknown, despite intensive research. About 10% of patients are unable to take it because of side effects, including:

- headaches
- rashes
- nausea
- anaemia

These usually become apparent soon after treatment starts. Sulphasalazine may cause harmless discolouration of the urine, and in men temporarily reduce fertility while it is taken.

#### **Mesalazine (Asacol)(Aust: Mesalal)**

New drugs resembling sulphasalazine are under development. One already available is called mesalazine (Asacol). This is especially useful for patients who are unable to take sulphasalazine.

#### **Azathioprine (Imuran)**

This is an anti-inflammatory drug which works in a different way to steroids. Evidence for its value is less clear cut and doctors vary in the amount they use it. It may be useful in patients whose disease is difficult to control, but takes several weeks to become fully effective. Regular blood checks are necessary, because azathioprine can cause anaemia. There has been concern that it might cause deformities in babies, or cancer, but this does not seem to be true when used for ulcerative colitis or Crohn's disease. Patients taking azathioprine are less fertile, but conception can occur and some doctors advise patients to use contraception.

#### **Metronidazole (Flagyl)**

This is an antibiotic which may help some patients with Crohn's disease, especially when the skin around the anus is affected. It is taken for a few weeks. It can alter the sense of taste, and with longer use can cause temporary nerve damage with numbness in the fingers or toes. Alcohol should be avoided because it can cause unpleasant flushing.

Metronidazole is beneficial because it only affects certain bacteria - other antibiotics may be harmful in inflammatory bowel disease.

We need to take both the mystery and the misery out of these diseases. If we knew what caused them we could develop more effective treatment. At present there is a lot of research into the influence of lifestyle, diet, smoking, etc. The search for some unknown virus or bacteria which might cause either disease continues. Research into the chemical causes of inflammation is leading to new medical treatment. Surgical research is aimed at producing less disruptive operations. If you have ulcerative colitis or Crohn's disease, you will probably agree that it is vital to solve these problems.

## **WHAT IS THE BRITISH DIGESTIVE FOUNDATION?**

Many people, too many people, suffer from digestive disorders. The British Digestive Foundation was formed to help them.

#### **Research**

We have always supported research. This helps doctors to discover the cause of digestive complaints. In particular, research can tell us how they might be prevented or their treatment improved.

Recent landmarks in gastroenterology include:

- Drugs which have done so much to overcome the pain of peptic ulcers.
- Fibre-optic endoscopy which has transformed the speed and accuracy with which internal examinations can be made.
- A better understanding of the vital importance of our daily diet for our well-being as a whole.

#### **Information**

Now the Foundation wants to help ordinary people to help themselves. We give up-to-date advice on how to live, what to eat, what to avoid and where to get help. These are all vital matters when you consider that one patient in five goes through the surgery door because there's something wrong with their guts.

#### **What can be done?**

The National Health Service does an excellent job but it cannot provide the best of everything. This is where you can help. By your efforts your local hospital could get the equipment or staff to give a service which doctors and surgeons, at present, can only dream of. Why not get in touch with your hospital's gastroenterological unit (GE or GI Unit for short). Please tell them you want to help make their work and their needs better known. **Note: In Australia please contact Australian Crohn's and Colitis Association, PO Box 201, MOOROOLBARK, Vic 3138, (03) 726-9008 or Local Community Health Centre**

## **THE NEED FOR RESEARCH**

## Notes on Crohn's Disease and Ulcerative Colitis

By  
Jur Plesman

In the past, patients with damaged mucosa of the bowel due to Crohn's disease or ulcerative colitis have been advised to reduce dietary fibre intake. Today few support this view. Supplementation with Ispaghula husk has been found to be effective in alleviating gastrointestinal symptoms in patients with ulcerative colitis in remission.<sup>1 & 2</sup>

Fish oil may also be helpful. The severity of active ulcerative colitis tends to correlate with increased levels of leukotriene B4 and more than half a group of 11 patients given omega-3 fatty acids (fish oil) showed a marked decline in illness. It was thought that fish oil would inhibit leukotriene B4, but it was found that colonic mucosal leukotriene levels were not reduced in that study.<sup>3</sup> In another report patients were given 18 MaxEPA tablets (4.24g EPA, 2.16g DHA) per day and they were found to have decreased rectal levels of leukotriene B4 compared to the control placebo group who used vegetable oil.<sup>4</sup>

Ten patients were given 0.75 mg prednisone daily for 14 days, while 11 patients were given a protein free elemental diet. At the end of 4 weeks 8 out of 10 steroid patients and 9 out of 11 diet patients were in remission. Thus the hypoallergic diet was as effective as prednisone without the danger of its side-effects.<sup>5</sup> Again fifteen patients were followed up to 3 years on a hypoallergenic elemental diet. The diet was associated with remissions in 14 patients who tolerated it.<sup>6</sup>

Many studies show that people suffering from Crohn's diseases and ulcerative colitis should restrict refined carbohydrates, especially sugar, and increase their fibre intake. Many sufferers from Crohn's disease were found by questionnaire to have an increased sugar consumption. It was suspected that this could reflect a deficiency in the perception of sweetness by Crohn's patients.<sup>7,8,9,10,11</sup> This seems to confirm that hypoglycemics are at risk of developing serious bowel disorders. Thirty-two patients with Crohn's disease were compared to 30 controls and it was found that patients ate significantly more refined sugar, slightly less dietary fibre, and considerably less fruit and vegetables.<sup>12</sup> Although the cause of Crohn's disease is unknown it seems that the disease can be influenced by an elimination diet. The disease activity of 19 patients were studied and an association was detected between elevated levels of IgG and IgA antibody to baker's yeast (*Saccharomyces cerevisiae*).<sup>13</sup>

It is not surprising that with these diseases that a study of 47 patients (M & F) found them to have a deficiency of many important nutri-

ents, especially vitamin B6, folate, iron (50 % of women), riboflavin (13%), thiamine (21 %), vitamin A (21%).

Of several nutrient studies, serum folate was the only one which correlated with nutrient intake, with low serum folate being predictive of potential risk of deficiencies of vitamin B6, B12, and C.<sup>14</sup> Studies on rat lymphocytes demonstrate that sulfasalazine acts as a folate antagonist.<sup>15</sup> The supplementation of folate may reduce diarrhoea.<sup>16</sup> In a study of 29 patients with ulcerative colitis colonic tissues were assayed for pantothenic acid (B5) and coenzyme A activity. Compared to normal gut mucosa CoA activity was markedly low despite the presence of normal amount of pantothenic acid, suggesting that there is a block in the conversion of bound pantothenic acid to CoA in diseased mucosa.<sup>17</sup>

The deficiency of vitamin A was strongly associated with the activity of the disease,<sup>18</sup> especially in those patients who weigh less than 80% of ideal weight.<sup>19</sup> Yet in one study (and others) 86 patients failed to benefit from vitamin A supplementation (50,000 IU twice daily).<sup>20</sup>

Malabsorption is a serious consequence of the disease and the more so in the case of vitamin B12 which is absorbed in the terminal ileum. Cobalamin B12 is transported by the intrinsic factor, a glycoprotein secreted by the stomach which binds B12. It is subsequently bound by a special receptor in the terminal ileum, where it is released by a releasing factor.<sup>21</sup> Therefore, B12 should be administered by intramuscular injections or perhaps by sublingual tablets which is directly absorbed into the blood stream. Folic acid with the co-enzymes B12 & vitamin C form red blood cells.

In a study of 58 patients 31 % were found to have evidence of vitamin K deficiency, when Crohn's disease was of the terminal ileum or in those with ulcerative colitis and treated with sulfasalazine or antibiotics. Abnormal prothrombin levels returned to normal when patients were treated with vitamin K.<sup>22</sup>

Magnesium deficiency was more likely with patients on IV nutrition<sup>23</sup> and/or after ileal resections for Crohn's disease.<sup>24</sup> While serum levels are rarely decreased, intracellular levels are frequently low and may be associated with weakness, anorexia, hypotension, confusion, hyperirritability, tetany, convulsions, and EKG or EEG abnormalities. Calcium deficiency in ulcerative colitis may be due to loss of absorptive surfaces, steatorrhoea (malabsorption characterized by the passage of pale, bulky, greasy stools), corticosteroid treatment and vitamin D deficiency. Iron deficiency may be due to chronic blood loss through the gut.<sup>25</sup>

Crohn's patients appear to have reduced levels of whole blood selenium compared to controls<sup>26</sup> and also serum zinc levels, although the latter was not associated with malabsorption abnormalities.<sup>27</sup> Nevertheless, one of the clinical manifestations of zinc deficien-

cy may be chronic diarrhoea due to malabsorption, which may, in turn, be due to excessive intake of fibre or phytates.<sup>28</sup> Zinc affects sense of taste which was found to be 65% duller among patients with Crohn's disease.<sup>29</sup>

There is a strong indication that food intolerances play an active role in the development of Crohn's disease. A diet which excludes specific foods to which a patient is intolerant - different in individuals - may keep a patient in remission. In an uncontrolled study, an exclusion diet allowed 51 out of 77 patients to remain well on the diet alone for periods of up to 51 months, and with an annual relapse rate of less than 10%.<sup>30</sup> Sixty-one out of 91 patients or 67% were judged to be possibly allergic, suggesting again that allergies play an important role.<sup>31</sup> In another study foods provoking symptoms most commonly were wheat (69%), dairy products (48%), yeast (31%), corn (24%), potato and tap water (17%) and banana, tomato, wine, eggs (14%).<sup>32</sup> IgG and IgM antibodies to cow's milk proteins were found to be increased in patients<sup>33</sup> and in another experimental controlled study, 10 out of 13 patients on a dairy-free diet had remained symptom free compared to 5 out of 13 patients on a "dummy" control diet.<sup>34</sup> When thinking in terms of allergies it might be well to keep in mind that some practitioners see the problems of food sensitivities as a result of the body's absorption of fragments of amino acids, due to a general dysfunction of digestion, absorption, blood circulation and excretion. For instance Robert Lucy treats allergies by improving all the above aspects of human nutrition.<sup>35</sup>

1 Hallert C, et als., *Scan J.Gastroenterol.*26, 747-750 (1991)

2 Friedman E, et als., *Canc.Lett.*43, 121-124 (1988)

3 Aslan A et al., *Am.J.Clin.Nutr.*87(4), 432-437

4 Stenson WF et als. *Ann.Intern.Med.*116, 609-614 (1992)

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**Angela from Carlton Victoria writes as follows:**

Dear Sir,

When I wake up in the morning I feel terrible. I am really irritable and bad tempered and if anyone even looks at me I either yell or burst into tears. I am sure it is because my blood sugar level has dropped during the night, and it seems the longer I have slept the worse I am. It usually takes about 3 or 4 hours before I start to feel OK. I have tried everything I can think of trying to remedy this - exercise, eating protein, fruit, fruit juices, water, tea, coffee, not having anything - nothing seems to work quickly enough. I wonder if anyone in your association has any ideas, or perhaps a similar

problem. Perhaps you could either print something in your Newsletter or someone could advise me by mail as I would really appreciate some help with this.

Thanking you in anticipation,  
Angela

Dear Angela,

Reading your letter it is apparent that you are suffering from a metabolic disorder including perhaps hypoglycemia and/or allergies. This is not the kind of problem that can be resolved by means of letters. You certainly do not deserve to suffer the way you do and I would advise you to see one of the many doctors in Victoria who deal with these illnesses.

Please contact **Daan Spijjer of Oma of Australia, 13 Hilton Street, Beaumarais, 3193, Phone: 03-589-5733.**

He will give you a number of doctors in your area, who will be able to help you by natural means through appropriate diet and supplementation.

As an alternative you might contact the Australian Natural Therapists Association or a naturopath near your location, listed in either the white or yellow pages of the phonebook.

Yours sincerely,  
Jur Plesman, Editor

## **FOOD SENSITIVITY & JUVENILE ONSET DIABETES**

By *Dr Ian Brighthope*

An article published in

The Journal of

Nutritional and Environmental Medicine,  
May 1992, 4

In the late 1970s I was able to demonstrate in hospitalised patients the improvements in adult onset diabetes by simple fasting and the removal of foods from the diet which showed, on food provocation, were able to significantly raise the individual's blood glucose level. It was interesting to observe simple foods such as zucchini, raising a fasting patient's blood sugar from 5 mmols per litre to over 18 mmols per litre. I believe at this time that there must be certain factors present in some foods which people react to by either reducing insulin output, reducing insulin receptor sensitivity, or by stimulating glucagon release and a subsequent over-production of glucose by the liver, thus raising blood glucose levels.

There has now been demonstrated an association between diabetes and exposure to cow's milk in the first 3 months of life. Dr Charles Verge of the Children's Hospital, Camperdown, in Sydney, has presented the interim results of an epidemiological study into insulin-dependent diabetes among newly diagnosed children aged less than 15 years. The incidence of insulin-dependent diabetes is 12 per 100,000 children of the population. Exposure to cow's milk in the first 3 months of life is a significant risk factor. 54% of cases were exposed to cow's milk compared with 38% of controls. The study included the common infant formulae based on cow's milk and formulae containing cow's milk products. It was demonstrated that an exposure to cow's milk was associated with an increased risk of diabetes of 1.88. 46% of cases were exclusively breast fed for at least 3 months compared with at least 60% of the controls.

Although exclusive breast feeding was associated with only half the risk of insulin-dependent diabetes, there was increased risk with early exposure to cow's milk rather than

a protective effect of breast feeding. It is interesting that children with insulin-dependent diabetes also had a higher incidence of recurrent infections in the preceding 3 months. Nearly 55% of cases reported infections compared with 33% of the controls. I may postulate here that there are some factors in cow's milk and cow's milk formulations which may interfere with immune function and increase susceptibility to infection. In a genetically predisposed individual it may be a combination of factors present in both cow's milk and the infection-inflammation response which precipitate the diabetes.

There were other environmental triggering factors investigated, including attendance at childcare before 3 years of age, the number of people sleeping in the same room, stressful events and parental age. The results here are so far inconclusive. One other finding of significance is that 100% of the children under 3 years of age had insulin auto-antibodies compared with only 53% of the older age group. Dr Verge stated that this may represent a sub-population of insulin-dependent diabetics.

## **POTENTIALLY HARMFUL EFFECTS OF FOOD IRRADIATION**

By

*Dr Ian Brighthope,*

The Journal of

Nutritional and Environmental Medicine,  
May 92, 27

The authors of this paper quote studies from the USA (Los Angeles), India and China. The Los Angeles Coalition to Stop Food Irradiation lists the following effects when food is irradiated:

1. The production of possibly carcinogenic hydrocarbons from proteins.
2. Increase in lipid peroxides in irradiated oil.
3. Destruction of vitamin C and the breaking down of approximately 80 volatile products, including alkanes and ketones.
4. Damage to nucleic acids and cell division in irradiated carbohydrates.

5. Adverse effects on enzymes.

6. Adverse effects on water soluble vitamins (e.g. C, B group, folic acid) and fat soluble vitamins (e.g. E, A, beta-carotene)

7. Reduction in the level of anti-oxidants which help protect us from environmental carcinogens.

In China a study showed that 70 healthy men and women showed an increase in chromosomal abnormalities during the test period after eating irradiated foods. This study was originally published in the "Chinese Medical Journal" and later reported in the "Bulletin of Atomic Scientists". An Indian study of 15 children who ingested irradiated wheat showed 80% of them developed polyploid white blood cells, which have been associated with leukemia and senility and have also been seen in people suffering from direct exposure to ionising radiation.

"Studies Show Unhealthy Effects When Food is irradiated", Arp, Diane, *Co-op Reporter*, August 1991:3.

## **MIGRAINE**

By

*Dr Ian Brighthope*

Editorial article in

The Journal of

Nutritional and Environmental Medicine,  
May 92, 4

According to the report from the Office of Health Economics, absence from work through migraine could be costing the British economy £200 million a year in lost production. This figure does not account for the reduced productivity of people who struggle on at work during an attack, and there is thus likely to be an underestimate. On the other hand, the cost of treating migraine is only £23 million per year or £5 per patient. Sumatriptan, the new boy in the block and a highly selective serotonin agonist, has been described as the best hope for migraine sufferers. The cost of bringing a new drug to the market (£100 million or more) must inevitably be reflected in the cost to the NHS. The benefits of an effective new migraine treatment, or for any other disorder for that matter, do not necessar-

ily accrue to the NHS, although it is the NHS that has to bear the cost. The report goes on to state that for such a common disorder, migraine is a relatively neglected subject, largely because it does not cause death or permanent disability. Migraine does not only cause severe pain and social disruption, but, because of the unpredictability of attacks, it tends to be a source of chronic distress. Migraine is one of the most responsive and easily treated diseases within the realms of nutritional and environmental medicine and a significant number of well-conducted studies have shown that nutritional factors play a major role in the aetiology of migraine. Considering £200 million per year in lost production and £100 million or more to introduce a new drug into the system, the expenditure of approximately £1 million to demonstrate further food-chemical sensitivity and nutrient imbalance states in future migraine studies, may not be generous, but certainly worthwhile.

## HEART DISEASE SUGAR AND FAT - THE REAL VILLAIN!

This editorial states that there is no conclusive evidence that dietary fat or cholesterol is a cause of coronary heart disease; there is stronger evidence for sucrose (table sugar) as a cause than there is for fats. Studies have shown that in about 30 % of men, an experimental increase in dietary sucrose produced all the physiologic changes that are seen in coronary heart disease and peripheral vascular disease. These changes include increase in blood cholesterol and other lipids, increased uric acid and insulin, reduction in high density lipoprotein cholesterol and glucose tolerance, and the production of insulin resistance. Platelets also become more sticky with increased sucrose consumption.

"Diet and Coronary Heart Disease: Why Blame Fat?", Yudkin, J., *Journal of the Royal Society of Medicine*, September 1992; 85: 515-516 from *Nutriscience Research Bulletin* February, 1993

### *Brief Summary of AGM minutes on the 6 March, 1993*

- 1 Apologies: Sue Litchfield, Sue Choc.
- 2 Financial Records accepted unanimously.
- 3 All Committee members re-elected with the exception of Martin Harris. Betty Momodt-Jones considered the secretarial position but declined.
- 3 Catering Committee elected unanimously consisting of Reg Grady, Sue Choc and Mary Page

**Restaurateur Marcel Boulestin:**  
"It is not really an exaggeration to say that peace and happiness begin, geographically, where garlic is used in cooking."

## Recipes

by  
*Joy Sharp*

### **WALNUT COFFEE SLICE**

1 cup of brown rice flour  
2 teaspoons baking powder  
4 oz margarine  
2 1/2 tablespoons of brown rice syrup  
1 cup crumbed puffed rice  
1 cup walnuts chopped  
1 teaspoon vanilla

Combine the margarine and rice syrup and melt. DO NOT BOIL. Add the vanilla. Mix together all the dry ingredients and then add the margarine, rice syrup and vanilla.

Line a slice tray with greaseproof paper and press the mixture into the tray. Bake at 350o F. for 20 to 25 minutes.

#### **Topping**

1 teaspoon decaffeinated coffee  
1 tablespoon margarine  
2 tablespoons arrowroot  
3 teaspoons of hot water  
1/2 teaspoon of stremeline  
Chopped walnuts to sprinkle on top

Dissolve the coffee in the hot water and let cool. Mix the margarine, arrowroot and stremeline to a paste then add the cooled coffee and water and mix smooth.

### **PINEAPPLE DELIGHT** (Supplied by one of Dr Samra's patients)

1 can Crushed unsweetened pineapple  
1 litre can pineapple juice (unsweetened)  
2 sachets gelatine

Bring pineapple juice to the boil and put in a dish, dissolve the gelatine in the juice and add the crushed pineapple. Set in the refrigerator.

### **MELTING MOMENTS**

175 g Becel or Sundew Margarine  
2 teaspoon Vanilla  
5 ml sugarine or 2 tablespoons of Rice Syrup  
2 eggs or 1 egg and 2 egg whites  
2 cups of brown rice flour  
3/4 cup arrowroot

Joy Sharp is asking members to come forward with new recipes for publication in the Newsletter. Please share your culinary skills with other members and forward your recipes to Joy Sharp.

Cream together the margarine, vanilla, sugarine or rice syrup, add the eggs one at a time, then the flour and arrowroot.

Roll the mixture into teaspoon full balls, place on baking tray and flatten with a fork. Bake at 375 degrees F. for 25 minutes or until golden.

#### **Filling**

1 tablespoon of margarine  
2 tablespoons of arrowroot  
1 teaspoon vanilla  
1/2 teaspoon of Stremeline - or any other sweetener of your choice.

Strawberry Jam - Weightwatchers unsweetened.

Cream the margarine and arrowroot in a bowl, add the vanilla, and stremeline and mix to a smooth consistency.

Join two biscuits together with the jam and cream. If you want them to be soft, prepare them well ahead of time otherwise they will be crisp.

## **1993 MEETING DATES**

**6th MARCH - 5th JUNE - 4th SEPTEMBER - 4th DECEMBER**