The Hypoglycemic Health Association

NEWSLETTER

Correspondence: THE HYPOGLYCEMIC HEALTH ASSOCIATION, P.O. BOX 8, SYLVANIA SOUTHGATE, N.S.W. 2224

Phone: (02) 9553-0084, **Fax:** (02) 9588-5290

PATRON: Dr George Samra

***Volume** 14 Number 2* *June, 1998*

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

The Hypoglycemic Health Association is going through a difficult financial times, mainly due to increasing costs. The Committee decided not to increase the membership fees, but to raise income through other means. The Committee has decided 1) to look for an alternative and less expensive venue to hold our quarterly meetings (see page 2 for further information), 2) to raise our entrance fees to meetings from $2 to $3 & families $5 (see next page), 3) To conduct ***ANNUAL FETES*** prior to a meetings sterating next meeting see next page, 4) to encourage professionals to donate $50 or more which will be acknowledged prominently by printing their busines cards in the Newsletter (see example page 9). It would be appreciated if members can send in their annual subscriptions promptly. Introductory members [shown by (INTRO) after their names] should send in their fees as soon as they receive their free copy. Application forms can be copied from the last page. Life members who have paid $150 should ignore the expiry date on their labels which is changed every year for administrative reasons. Many people are now realising that conventional medicine centered around pharmaceuticals, surgical intervention and radiation therapy has its limitations, not only because of ever increasing costs, but also of the faltering infrastructure (hospitals etc). The modern trend in medicine is towards a combination of both conventional and traditional (natural) medicine which opens the way for self-help medicine. People are now able to take greater control over their healing through education. By supporting this Association you help to advance this process.

Our Next Public Meeting will be at 2 PM
on Saturday, the 6 June, 1998
at the YWCA,
2 Wentworth Ave, Sydney and
our guest speaker is

Dr Robyn Cosford

who will be speaking

on the subject of

"Hyperinsulinism, hypoglycemia & weight problems"

Dr Robyn Cosford is well known to this Association. In June 1996 she gave us an informative talk on Down Syndrome (See Newsletter Sept 96 pp 3-7). She is a mother of five children and in addition runs a busy medical practice - Northern Beaches Care Centre at Mona Vale. She graduated from Sydney University with an Honours degree in medicine, and has done pre- and post graduate studies in homeopathy, nutrition, herbalism and acupuncture.

She has a particular interest in mothers and children, in particular children with emotional and learning difficulties.

She has extensive experience in helping families deal with children with behavioural problems through a combination of conventional and complementary medicine. Her topic should be of great interest to members of the Association.

Previous Copies of the Hypoglycemic Newsletter

Back issues of the Hypoglycemic Newsletters are available at the NSW State Library, Macquarie Street, Sydney. They are filed under NQ616.466006/1 in the General Reference Library.
Other libraries holding copies are: Stanton Library, North Sydney; Leichhardt Municipal Library; The Tasmanian State Library; The Sydney University; The University of NSW, Newcastle University. The Association will provide free copies to any library upon request.

Books for sale at the meeting

Jurriaan Plesman: **GETTING OFF THE HOOK**

This book is also available in most public libraries (state and university)

Sue Litchfield: **SUE'S COOKBOOK**

Dr George Samra's book

The Hypoglycemic Connection

(now out of print) is also available in public libraries.

Contributions of articles by members and practitioners are very welcome. The Editor is interested in meeting any person aspiring to research natural medicine and contribute articles as a sub-editor to this Newsletter.

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

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.

Local meetings at Wahroonga

Marina Bridle would like to meet other members for mutual support and discussions. Her phone number is **9487 2910.**

Alternative venue for meetings

As the Association is going into the red because of increasing costs without corresponding increasing income, the Committee has decided to change venues for our public meetings. We found the Quakers Meeting Hall, 119 Devonshire St, Surry Hills, as a possible candidate for the meeting of 5 December 1998 which is close to Central Station. They are renovating the building, but the hall won't be ready for the 5th September 1998 meeting. The Association will be responsible for re-arranging the chairs and other furniture before and after the meetings and so we are looking for three healthy, strong, young men below the age of 75 who are willing to undertake this task. If you fall into the above category and you are willing to help us out, please contact Dr George Samra's surgery at 02 9553 0084 and join the brigade. The reward will be that you don't have to pay the *entrance fees!*

Entrance fee at meetings

Due to diminishing income from our quarterly meetings we regrettably have to increase our fees. Entry fees for non-members will be $5.00, members $3.00 & families $5.00

Donations for raffle

One way of increasing our income is by way of raffles. If any member has anything to donate towards the raffle, please contact Dr George Samra's surgery at 19 Princes Highway, Kogarah, Phone 9553-0084.

At the last meeting, **Jim Gibbons** won the lucky door prize. **Joan Dor** won the raffle at our last public meeting on the 7 March 1998.

Fund raising activities

We need money, ideas, donations, bequests (remember us in your will).

FETE

At the next meeting, please donate a handicraft or a sugar-free cake worth $5 to $20 for the fete to be held from 1.30 pm to 2.00 pm at our next meeting. If donating a cake or other pastry, please, list all the ingredients. If successful we will have fetes every 12 months.

Diagnosing and Managing Multiple Chemical Sensitivities

This is an extract from the upcoming book of **Dr Mark Donohoe**,
***"KILLING US SOFTLY:** multiple chemical sensitivities and low level effects of toxins on health"*

WHAT DO YOU DO if you think you are suffering either multiple chemical sensitivities (MCS) or toxic chemical damage, especially if your doctor is unwilling (or unable) to help?

This section is addressed to sufferers and carers, and is designed to help you determine what is wrong, what to do about it, and how to know when you have succeeded. It is NOT an alternative to finding a quality health practitioner with experience in this specific area, and some of the tests and treatment can only be arranged by medical practitioners in Australia.

This section is designed to provide information and knowledge to help and your practitioner work through the complexities of MCS and long term toxic damage, although not all tests or treatments are required in every person. This is where the experience and education of the practitioner becomes invaluable - prioritising and managing the information as it becomes available, and working with you to develop an optimal management program.

I will be referring to MCS primarily, as many of the principles of diagnosis and management apply to both MCS and chronic toxic damage to health. Where differences arise, they will be noted, especially in the area of detoxication.

Getting support

Do not try this program alone. If you are chemically affected, you need support and feedback, and I am yet to see a program successfully managed by a hermit. This does not just mean support from a practitioner (or team of practitioners, as is so often the case), but from your family, friends, neighbourhood and community. This is important for a number of reasons, not the least is the added burdens placed upon your limited reserves while you attempt to reconstruct their health. It is critically important that you minimise unnecessary stresses upon your health at this time, and keep your energy focused on going through the processes needed for recovery.

Avoid those people who, well meaningly or otherwise, cause you stress. Not forever, but just until you have established a level of health and resilience sufficient to prevent any major deterioration.

Most often, these are people close to you who really are trying to help. If so, be kind yet firm, and let them know that you are taking matters into your own hands for a while, and you need their support more than their advice. In the case with employers, insurers and their doctors, government medical officers, and most medical specialists, this is not the case.

You may simply need to keep out of their way for the time being, and this may require that your practitioner support you by letting them know you are in the middle of a difficult management program, and you will be back to them when you are healthier. No single management, nor any simple combination of approaches is guaranteed to help everyone with MCS. The problem is not so much one of a sick individual, but of a sick environment, and people vary as to their ability to withstand such environmental hazards greatly. What works for one person may make another much sicker or more sensitive. Because of this, I advocate the "sticky trap" method of management in MCS.

The "Sticky Trap"

The sticky trap is a management method and strategy, and arises mainly because of the enormous variability of response to management of MCS. The concept is simple but very powerful, and may help keep you from unnecessary grief and deterioration.

The strategy, simply stated, is this:

1) Use the diagnostic testing to identify the significant factors holding back your health.
2) Work through this information with your practitioner, decide what needs to be managed, and prioritise this management program. That is, decide what needs to be done first, second and so on, so that you are not attempting to do everything at once. See below for more information on prioritising.
3) Write down what needs to be done, and the priority and timing of the management plan.
4) Write down the expected outcomes, the time period required for benefit to be seen, and the "move on" time. This means that you are unlikely to continue any management which is unhelpful, possibly even harmful. If unexpected worsening occurs, if the period of recommended treatment is over, or if no benefit is occurring, then you "move on", and drop what is not working. This is a critical issue in MCS, as the gradual accumulation of many treatments over time is very often a source of more problems, not less. This does not mean that any increased symptoms are a reason to drop a treatment, especially in detoxication, where the increase in symptoms is almost an essential feature of recovery. It is the avoidance of unexpected harm which is so important.
5) Stick with those things that work. When you finally find something, hold on to it, and add it to your toolkit. Persist with those things which provide benefit, building up your own personal management program.

The point of the "sticky trap" concept is that, while you may need to try many different management approaches, not all will help, and some may even worsen you. Identifying and sticking with those which help, while dropping those which don't, ensures that you will reconstruct the best health you can achieve over time. You do not have to get any theories right (although it always helps if you do), and you do not have to put up with the crashes following unsuccessful "big hit" treatment programs.

You just rebuild your health. Piece by piece. No miracle cures, but a steady movement to better and better health. And when you have gained health and confidence, then you may be able to re-visit some of those treatments which made you too sick at the first attempt.

Prioritising

It is not always true that the most important problem should be managed first. In fact, it is often true that the basics of health needs to be reconstructed before the important definable problems are treated.

For example, it is nearly always necessary to manage allergies and the gastrointestinal tract (the gut) before almost any other contributing factor, even when they were clearly not the "cause" of the problem.

Why?

Because, with continuing allergies, malabsorption, leaky gut and poor nutrition, it is unlikely that the major problems will recover. Once these are looked after, recovery is possible. Until they are managed, recovery is unlikely.

The process is analogous to building on solid foundations. The foundations of uncontaminated air, food, and water, along with the best possible nutrition and absorption, are the foundations of health.

In passing, I believe that it is also worth making a point about the cost of management in prioritising a management program.

Most people with MCS are far from financially comfortable, and the costs involved in medical care are frequently excluded from rebate under Medicare or even through health funds. This is grossly unfair, but is a fact of life in Australia until we make politicians and regulators understand the needs and disabilities of MCS sufferers.

When prioritising a program, attention must be paid to the costs of each part of the program. Where two items are ranked similar in importance, the less expensive should be preferred. A budget may need to be set for the management program, with the aim of ensuring that the cost of the program does not induce financial stresses. If possible, once this budget has been set, the sufferer should be shielded from the issue of payment and costs, comfortable that management can be afforded.

I have seen many patients race off to spend thousands on amalgam removal, home renovations, moving home, intravenous vitamin C or chelation therapy, without having ever addressed the basics of environmental management, allergy management and nutrition. People who do this are almost universally disappointed by the result, even when the treatment is an essential component of recovery. Worse, they have spent every last cent on the one big hit, and come to see me penniless and no better.

Do the basics first. Establish a foundation for building health through allergy management, environmental management, and quality nutrition. Then go and do the rest according to what you can afford.

And never, ever skimp on nutrition in order to pay for treatment.

Time-frames for recovery

It is also important to set realistic timeframes and goals. As I have said elsewhere, I do not think that anyone truly fully recovers from MCS. They do not return to the life they enjoyed before the developed MCS. They live a different life, in which they tend to maintain health by minimising unnecessary chemical exposure.

They are also more "brittle" in their health that previously. This means that relatively minor stresses (chemical, physical, infective, emotional, etc) can still cause marked deterioration, whereas before they would hardly have noticed any health effects.

Staying well for a period of time, doing whatever it takes to maintain health, is an important aspect of long term recovery. The longer you are well, the longer you are liable to stay well. Do not book yourself in for a half marathon as soon as you feel well. Recovery requires time, and patience is rewarded more here than anywhere else. I cannot count the number of people I have seen over the years who have recovered well, only to immediately drop their management program, and begin renovating the home! I understand the frustration of the illness, and the desire to escape back to normality, but this approach leads to a frustrating "yo yo" effect, where each recovery is met by a crash lasting weeks or months, requiring the whole program to be restarted from scratch, in turn leading to recovery, a further crash, ad infinitum.

When you feel well, you are half way there! Convalescence, minimising chemical exposure, quality nutrition and rest are the essential ingredients to long term recovery. The investment of time and resources at this point will be repaid many times over, as you are re-establishing your reserves and resilience. Do not skimp on this recovery time.

As a rule of thumb, it is my impression that time to recovery is generally more related to the duration of the illness than to the toxicity of the initial exposure, or the degree of pathology induced. This does not always hold, but a realistic recovery time is in the order of ten to twenty percent of the duration of the illness. For a person who has been sick for a decade, one to two years is realistic, whereas only a few months may be required for a person sick for a single year.

It is, in my opinion, vital to identify this condition early, and to institute a management plan as soon as possible. Not as vital as preventing the problem, but vital nonetheless.

This is also why I find it a tragedy that people struggle for years to gain a diagnosis from disbelieving doctors. This is worse than medical negligence — it is abuse of position.

Such ignorance and prejudice prolongs suffering, delays recovery, and diminishes the degree of recovery which can eventually be expected. Some medical practitioners will never accept the reality of MCS. They have staked their name on it not being "real". Do not waste your time or breath trying to convince them otherwise. Find a practitioner who will work with you, not against you.

If this book does nothing but bring forward the time from the onset of the illness to the diagnosis, then it will have achieved much good. If it prevents the demeaning and soul destroying practice of inappropriate psychiatric referral for sufferers, in fact, I will be more than satisfied!

DIAGNOSIS

The diagnosis of MCS is not really difficult, although documenting the symptoms you suffer and the chemicals which cause most problems can be a painstaking process.

The hallmark of MCS is a symptom known as pathosmia. Simply, this is not only a heightened sensitivity to certain smells, but a sense of disgust or aversion for such smells, and the development of symptoms within minutes of exposure. Without this heightened response, it is difficult to diagnose MCS, although I have four MCS patients who have lost their sense of smell due to accident or infection, yet suffer the symptoms following exposure. This is the strange thing - the first sign they have that they have been exposed is the headache, the slurred speech, the dizziness or the abdominal pain, yet none of them are aware of the smell of the chemicals to which they have been exposed!

The definition proposed by Cullen in 1987 (Cullen MR, *The worker with multiple chemical hypersensitivities: An overview* **Occup Med** 1987;2: 655-661) is still used today, despite the many workshops and conferences held on the subject which have attempted to tighten or alter his proposed case definition.

The critical defining features of MCS may therefore be stated as follows:

- it is an acquired disorder;
- sufferers have recurring symptoms;
- symptoms involve more than one organ system;
- adverse reactions and exacerbations are triggered by many chemically diverse substances;
- reactions persist after the person is separated from the original causative agent(s); and
- adverse reactions and exacerbations occur at levels of exposure considerably lower than would be expected to cause harm in the majority of the population.

While MCS does have effects in a number of organ systems, it is primarily the effects on the brain that gives rise to the majority of symptoms. These neurological symptoms typically include:

- decreased short term memory
- poor concentration, and difficulties in comprehension
- generalised weakness
- profound fatigue
- emotional lability, with rapid inexplicable swings between anxiety and depression in females, and aggression and depression in males (this sex difference is certainly not hard and fast, but a generalisation).

The consequence of exposure is the development of symptoms rapidly following exposure in more than one organ system. Like its close relation, chronic fatigue syndrome, MCS is a complex illness affecting the whole person, with symptoms spread over many organs. This is, in part, why medical practitioners have so much difficulty dealing with MCS. We are used to diagnosing diseases of organs, such as hepatitis, cancer, strokes and heart attacks. Doctors are trained to reduce the complex history and symptoms to a single, simple diagnosis. We do not handle vague, multi-organ symptomatology well. We are even told by psychiatrists that such complaints constitute a psychiatric disorder, namely a somatisation disorder. The having of too many apparently unrelated symptoms becomes a psychiatric disease, by definition! Psychiatry can hardly be considered a science when it creates "undisprovable" categories, simply creating new categories for those illnesses not understood. Somatisation disorder should soon go the way of homosexuality as a psychiatric diagnosis. The basic question needs to be asked of psychiatrists, "How could your opinion of what I suffer be proven incorrect, assuming you were wrong?"

Any hypothesis which cannot define the experiment which would prove it wrong is not science. It is opinion, religion, faith, belief, but it is not science. One should not let any doctor get away with an opinion without asking, "How would I know if you were wrong?" If this receives a reply along the lines of "Trust me, I am a doctor", then you should politely take your leave of that person on the spot.

Assuming that you fit the criteria above, then you do suffer MCS, as long as no other "provable" medical condition which could explain your symptoms exists. It is now time to document your symptoms, to define the dominant issues and disabilities for you. Put them in time sequence, such as:

- immediate withdrawal reaction, and need to get away from smell
- within seconds, irritated nose, throat and eyes, coughing and sneezing, dizziness and disorientation
- within a minute, severe and disabling headache moving from the back of head to area above the eyes
- within five minutes, extreme fatigue, muscle weakness and moodiness

and so on. You should also document when the symptoms settle back to a baseline, indicating the duration of effects from the exposure.

One way of doing this is to ask yourself the question, "If a magic wand were able to rid me of three symptoms, what three things would I wish to be fixed?" See if you can put them in order. Many people will say, "I want my brain back", some may say "I want my energy back", others may say "I want to be rid of headaches". Try to avoid the answer, "I want chemicals not to affect me badly", and be specific about what effects cause the greatest problems. Not only will this document the principle aspects of the illness and disability, it may also provide a focus for you and your practitioner, so that symptomatic treatments appropriately directed.

You may need to document the response for a number of other reasons, as well. The most important is that progress under treatment will be measured against this "baseline", and it is almost impossible for an MCS sufferer to recall what symptoms they suffered and how disabling those symptoms were, at a later date. The importance of this history of response to exposure will become obvious only when you are assessing your health at a later time.

It may also be necessary to document such symptoms for your doctor, so that he or she can determine the degree of disability you suffer for insurers, employers or social security purposes. For this purpose, it is useful to distinguish your background symptoms (those that are there all or most of the time) from those triggered by accidental exposure to chemicals.

Document what chemicals you react badly to. MCS usually starts as an adverse reaction to a specific chemical (such as glutaraldehyde), or a small group of related chemicals (such as petrochemical solvents), but later "spreads" to involve a broader range of unrelated chemicals. Similarly, during recovery, sensitivity to some chemicals may be lost entirely (meaning that they no longer cause symptoms), while others continue to elicit the same response.

The most common chemicals which MCS sufferers report reacting to include (in alphabetical order)

- ammonia
- chlorine and bleach
- cigarette smoke
- diesel exhaust fumes
- household insecticides and disinfectants
- many perfumes (although some are usually ok)
- oven cleaners and other cleaning chemicals
- paints and solvents
- petrochemical (aromatic) agents, such at toluene, xylene, and petrol
- shopping centres and supermarkets, and especially clothing shops and the aisles with cleaners, soap powders, etc

What affects one person with MCS will not necessarily affect another, although in severe and prolonged cases, the range of triggering agents becomes so all encompassing that it is difficult to find chemicals to which they do not react.

One other item which is almost invariably in the history is that the person loses their tolerance for alcohol around the time they develop MCS. People who enjoyed a few beers or half a bottle of wine each evening find that they can barely tolerate half a glass. There is no way that such low doses of alcohol could lead to high blood alcohol levels. The brain has become more sensitive to alcohol, just as it has to other chemicals

TROCHES

By Richard Stenlake, ***B. Pharm. MPS***
169 Oxford St, BONDI JUNCTION

Have you ever dreamed of tailor made hormone replacement therapy designed just for you? Yes, something to match your body type and metabolism that can be adjusted according to your response over time so that side effects and efficacy can be controlled easily. Well it is finally available in the form of troches, which are small square lozenges that are placed between the gum and the cheek where they slowly dissolve through the mucus lining of the cheek. They have been available in Australia for only six months from our pharmacy in Bondi Junction. Prior to this they were only available from American at considerable expense. This is a breakthrough for the thousands of women who find that prescriptions for commercially packaged hormone replacement therapy are too strong and produce too many side effects.

Troches can be mixed so that each individual troche contains a combination of various natural hormones in small doses. For example, a troche can be made containing a mixture of any of the hormones oestrogen, progesterone, and testosterone in any possible doses according to your needs. Small doses of testosterone can be used, such as 1 to 5 mg per troche, so that masculinising side effects such as facial hair, acne, weight gain and voice deepening are avoided. This provides a much more gentle approach than injections or implants of testosterone, or indeed the synthetic testosterone tablets that have been used in the past.

Small doses of testosterone are useful to enhance energy levels, mood and libido without causing side effects.

Troches containing natural progesterone are helpful for premenstrual syndrome and can be taken during the latter half of the menstrual cycle to alleviate depression, tension, and pelvic congestion. They are far superior to tablets containing synthetic progesterone (progestogens).

Menopausal women who have had a hysterectomy can benefit from troches containing natural oestrogens, progesterone, and if needed, testosterone. Your requirements should be determined with a blood test to measure your sex hormones – we recommend tests for blood oestrogen, progesterone and testosterone (free androgen index or F.A.I.).

Today pharmacy is "going back to the future". We are now using century old techniques to create custom tailored medicines for a growing percentage of doctors and their patients. We are creating drugs from scratch, or altering existing drugs to meet specific patient needs. This technique goes back to the original apothecaries of the 1800's who made every prescription by hand. This practice gradually faded from use as pharmaceutical companies began mass producing drugs in set doses and patients had to live with whatever dose was closest to what they needed.

Back in the 1800's medical lozenges were extensively used to treat mouth and throat infections. These were small mildly medicated solid masses intended to dissolve in the mouth. In England they were called a lozenge, in the USA a troche, in France a tab lette, and in Germany a pastillen. Troches first appeared in the Edinburgh Pharmacopoeia in 1841 and then in 1864 in the British Pharmacopoeia – the same book in the standard of today's pharmacists.

Troche making was an art way back then and required a lot of practical experience. The apparatus required to make troches was a smooth marble slab to mix them, a rolling pin, troche cutters, a palette knife, a badges brush with long soft hairs, linen cloth, and troche trays. Yes, the apothecary of the early 19th century required great skill to make this form of medication. This art was still taught at universities until the late sixties when the 20th century really took over. The theory of the troche and pill making was still taught but sadly practical knowledge was left to a bygone age. One could compare the mass produced drugs of today with fast convenience foods and the troches to carefully prepared home cooked meals!

The troches provide a means to deliver custom made medication in small doses directly into the blood stream. Today many drugs, both natural and synthetic, can be used in troche form to gain rapid onset of action and bypass the usual absorption through the stomach. The troches dissolve between the gum and the cheek and are rapidly absorbed into the blood stream, thus bypassing the liver. This reduced the load upon the liver and is especially good for liver toxic drugs.

Through technology from the Professional Compounding Centres of America (PCCA), troches are now a modern day dosage form, available in a variety of bases and flavours that the apothecary of old could not even imagine. There is still an art in compounding them but the equipment required has greatly diminished.

Today the computer has replaced the marble slabs, the wooden trays and brushes, etc, with complex electronic mixers, mint flavoured bases, accruable electronic scales (capable of measuring less than milligram doses) and miniature electric hot plates that make the finished troche an accurate precise dosage form. The finished troches are dispensed in plastic calibrated moulds that easily fit into your handbag. The flavours available from the PCCA now cover over three pages and can satisfy even the most finicky patient. How would you like peanut butter, coca cola, crème de menthe, toffee, kahlua, to name a few of the more exotic. You can try a different flavour every month to prevent boredom!

We find that troches are very well suited to hormone replacement therapy mainly because of the ease in which ingredients in each prescription can be altered. As troches are made up in trays of only 24, you will know after one or two courses if the prescription is correct or is a "little off". By this we mean that there could be a little too much/too little progesterone or too much/too little oestrogen. After a quick consultation with your doctor the formula can be altered and your medication tailor made to your exact requirement. Compare this to mass produced drugs where individual titration of doses is far more limited.

Compounding a medication imparts to the pharmacist a greater stake in the patient's outcome. The pharmacist keeps in close contact with the patient enabling early identification of the patient's needs and any side effects. This allows the pharmacist to use his/her skills to overcome problems through consultation with both patient and doctor to produce the correct dosage form that will result in long term success.

Hypoglycemia: A Forgotten Disease

By Dr George Samra

THE HYPOGLYCEMIC HEALTH ASSOCIATION, of which I am a patron, aims to make the public more aware of the problems of hypoglycemia and natural health in general. In a world where we are bombarded with environmental pollution and artificially manufactured foodstuffs, where food inspectors are being replaced by "contract inspectors" in a self-regulated food industry, where contaminated sea waters produce unhealthy fish, where deforested lands cause unusual droughts and floods, where the world's upper atmosphere is fouled by chemicals altering the earth's climate and where a faltering public health system remains hostage to shareholders of lucrative drug companies. In such a world, those people who take personal responsibility for their health may have a better chance to survive.

People have indeed a choice, provided they are informed on available alternatives. Many modern doctors conscious of the limitations of orthodox medicine, share the philosophy of complementary medicine. It is possible to treat *degenerative diseases* with natural remedies in conjunction with traditional medicine. However, for this to happen we need an informed "consumer market", a public sufficiently educated to converse and consult these modern doctors in the forefront of the medical revolution.

The term *hypoglycemia* is an unfortunate one, and many doctors would say that this condition rarely exists. The word means *low blood sugar*, but should really mean a condition where a person's brain does not get fed properly when they eat sugar. Most doctors know the word hypoglycemia in the context of diabetes, as for example when a patient accidentally overdoses on insulin. The term as used by many nutritional doctors is one that most doctors know very little or close to nothing about.

In my experience hypoglycemia is as common as diabetes which means that 3-4 per cent of the general population may be suffering.

Diabetes have similar underlying problems, namely an unwell pancreas that does not handle sugar properly. After consuming sugar in diabetes, the blood sugar goes up too high, whereas in hypoglycemia patients it is the opposite: they produce too much insulin. After an initial rise in blood sugar, it drops down to low levels. The brain is dependent upon the level of glucose in the blood. When the glucose level is low, the brain does not get nourished and people become easily tired and get depressed.

In my book *The Hypoglycemic Connection*, available in most libraries, I speak of the hypoglycemic syndrome which may be diagnosed by the presence of at least (3) of the following (4) symptoms:

1. Depression
2. Lethargy or tiredness
3. Memory impairment, or poor concentration
4. A history of preference for sugar or sweet foods

Hypoglycemia follows an *autosomal dominant inheritance* patterns, which means a pattern of inheritance in which transmission of a dominant gene can be passed on in 50 per cent of cases to the next generation. Males and females are affected with equal frequency. The prevalence of hypoglycemia in a family may help a doctor have insight into the management of an unruly child as well as the symptoms of a mother who are both affected by a sugar-handling problem.

Associated conditions of hypoglycemia may show up among alcoholics and drug addicts. It usually means that starvation of the brain has driven a person to unacceptable social behaviour. Many crimes - and let us not forget that over 70 per cent of prisoners have an association of alcohol or drug abuse - are the result of hypoglycemia that has gone wrong. I am of the opinion that in most cases hypoglycemia precedes the development of anti-social behaviour, alcoholism or drug addiction. Many alcoholics and drug addicts manifest a Type 1 sugar curve following glucose tolerance testing. This means following the rise in blood sugar, there is a very sharp fall. The body compensates the subsequent sugar starvation by pumping adrenaline from the adrenal glands into the blood, which then raises the sugar levels. High levels of adrenalin may cause mood swings, violent outbursts and emotional instability. People with excessive adrenalin levels may drink alcohol - a calming drug - in order to combat the adrenalin side effects. Alcohol is a legal drug an helps to calm down nerves caused by high adrenalin levels in Type 1 hypoglycemia.

Thus rehabilitation programs based exclusively on "psychological models" are often found to fail as they tend to ignore the metabolic aspect involved in behaviour. Major social issues are tied up in this condition.

An other associated condition is *hyperactivity* or what is now called ADHD or *Attention Deficit Hyperactivity Disorder* where the brain is not fed properly when children eat sugary foods. The behaviour can go either way: the child may withdraw in a corner or it may climb on practically everything. A Glucose Tolerance Test usually indicates which way a child will behave as in both cases they have an underlying sugar-handling problem.

Maturity Onset Diabetes is another associated condition.

People with sleeping problems or who are taking sedatives to cope with their lives may have a hypoglycemic condition.

Glucose Tolerance Test (GTT)

The hypoglycemic condition can be diagnosed with a GTT. I usually order a 4-hour test with blood taken every half hour. These days a diabetic GTT is a 2-hour one. A patient undergoing a hypoglycemic GTT must fast from 10pm the previous night with no special carbohydrate diet. It is a valid test when a laboratory uses a Spectrophotometer as measurements are far more accurate than Glucometers. The glucometer may often be 1 micromol/L out. Accurate figures are required. The relationship between the readings of numbers just half an hour apart in a GTT is very important. A drop of 2.7 mmol/L in any hour or 1.6 mmol/L in any half an hour is indicative of hypoglycemia.

Fasting levels on your sugar curves tell us a lot. People with readings of 3.2-3.6 mmol/L, usually wake up glum and tired in the morning. People with higher readings of say 5.2 mmol/L and higher usually wake up bright and are often cheerful all morning. Thus you can predict more from looking at a sugar curve than just diabetes or hypoglycemia.

Definition of hypoglycemia

Relative hypoglycemia is present if the blood glucose (or sugar) falls sharply (below 3.6 mmol/L) after consuming a 75 g glucose load - usually the fall occurs after 1.5 to 2.5 hours. It is usually due to oversecretion of insulin by the pancreas, although it is recognised that other mechanisms may be involved. Hypoglycemia is a hormonal disease, caused mainly by insulin oversecretion often associated with adrenal oversecretion. Other hormonal conditions such as thyroid and adrenal problems do tie up with hypoglycemia.

Typical symptoms are: tiredness, moodiness, depression, poor concentration, irritability, sugar cravings, nervousness, poor memory. The condition usually runs in families and can include diabetes, alcoholism, ADD, hyperactivity, drug abuse and behav-

iour disorders.

Treatment consists of keeping off the simple carbohydrates such as sugar, honey, glucose and have six small meals everyday. The meals should be roughly equal. Minimum size of a meal should be half a sandwich with the equivalent of a boiled egg or a chicken wing. Packet of Smiths chips, plain. A protein breakfast made up of fish, chicken, mince or eggs is important to provide the necessary fuel for the brain. I usually recommend supplementation with zinc as in the Vitaglow product *Zinc plus C* at the dose of two tablets per day. This product also contains vitamins B3, B5, B6 as well as vitamin C.

Glucose as brain fuel

The brain is highly sensitive to the availability of glucose as a source of nutrition.

Although it comprises two per cent of the body weight, the brain uses close to 50 per cent of all available glucose and more importantly, cannot use other fuels such as free fatty acids, triglycerides and cholesterol. This is in contrast to the heart that can use at least 42 different fuels at any point in time. Thus when there is a hypoglycemic crash, the brain is in trouble, and this triggers the many symptoms.

The hypoglycemic disease often occurs concurrently with many illnesses such as alcoholism, drug abuse, heroine addiction, sedative abuse, hyperactivity, diabetes mellitus, hypothyroidism, postmenopausal hot flushes, depressive illnesses, epilepsy, schizophrenic and migraine sufferers.

One problem with nutritional treatment is that the patient has to be motivated to undergo treatment. An alcoholic who refuses to acknowledge he has an alcohol problem or who does not want to change will not benefit from nutritional management.

Goals of treatment

One should never lose sight of the goals of treatment. First and foremost, one wishes to alleviate all hypoglycemic and diet related symptoms. Secondly, one aims at stabilising blood glucose levels, prevent overstimulation of the pancreas with excessive insulin production and in the long term prevent diabetic complications. To ignore one's hypoglycemic condition may result in the punishment of being diabetic with all its diabetic complications.

Conclusion

Another way of looking at the problem of hypoglycemia is that one's pancreas does not know how to fit into the 20th century, where people are eating a high sugar diet. In a world where modern foods are sugar-loaded all the time the pancreas is not equipped to handle it properly, the blood sugar keeps crashing and the brain keeps getting starved of fuel.

One might claim that hypoglycemia is not a disease, but rather a reflection of the fact that we live in a sick society where we all are made to eat a lot of sugar. Each person now consumes 20 times more sugar than people did 100 years ago and 100 times more per person than 200 years ago.

Hypoglycemic people do not fit into a high-sugar society and so long as such society lasts, we will have more people coming down with hypoglycemia.

Violent or Victim?

by Gee Effess

I am a 47 year old overweight male. I gave up smoking and changed from very active to a very sedentary lifestyle. Not big by some standards, yet uncomfortable, I have had my self esteem and self image take a battering.

Married a local girl in the '70's, had two sons, separated from them and have had life long difficulty maintaining long term relationships since. Life continued, relationships came and went. I seemed unable to maintain any long term relationships, personally or professionally. Something always caused a separation or a break. Sometimes I would initiate the break and other times my partners. I have left my partner, been left by my partner, and have been made redundant three times from jobs.

I consider myself to be a decent member of the community, now. It has taken a lot of work.

During my teen years on many occasions I would "explode". I would react very angrily to many situations and finally run away. I fell foul with both family and authorities and created ongoing turmoil for my parents. They considered I was "uncontrollable" as a child. Every time I was with the authorities I was assessed, questioned and had reports made. When I ended up in court I was told there was nothing wrong with me and my parents would take me back home. Until the next time. These were all juvenile problems. I left school at 15 and went to work. As a young worker I got involved in both very loud verbal and also physical assaults both self initiated and in self defense. Growing up through the 60's I joined local "gangs" and we used to travel around Sydney's suburbs to get involved in street fights with other "gangs".

In the late 60's I joined the Royal Australian Navy. I married my childhood sweetheart and travelled overseas to defend my country. I fought against the Vietnamese, the communists, the hippies, the protestors, and all who opposed the war in Vietnam. Eventually I became a Naval Policeman for a short period of three years before finishing my 12 years with the RAN in 1980.

There was only one common point to all my history through these years. That was my ongoing, sporadic "oubursts" of rage and violence.

Time moved on. I studied hard, worked hard and developed myself professionally and personally.

I was continuously puzzled at why I always had difficulty with female partners. Over the next 10 years I had 3 separate permanent relationships. I must say that domestic life was usually good. I was a happy, hard worker who was building a future. I was not building a family due to the ongoing series of outbursts which I would display. This obviously had an impact on my partners. I will admit to at least 4 occasions in my life when I have been pushed "beyond my limits" and I have physically assaulted my female partners. Strange thing, though is my instant and immediate remorse and deep sorrow and sympathy whenever I have physically reacted. I have not ever "battered" a woman, but I have certainly assaulted, both verbally and physically, in fits of emotional reaction, rage and explosion. Inevitably and eventually a relationship breakdown would occur. Only the time frames differed.

Many of these incidents led me to fall into a depressed state. I experienced all the usual thoughts of suicide. I thought of taking others with me. I thought of going out by making a great headline grabbing departure to tell the world how cruel it had been to me. I was an experienced and trained military man, I knew weapons, I had police training I knew how the system worked, I could sure make one last final impact. A murder/suicide would do that.

Fortunately seeking counsel from close friends and family always managed to lift me out of the depressed sessions. I refused to ever become dependent upon drugs which was all the doctors wanted to give me. They were treating the symptoms but doing nothing to help me find and address the causes of my troubles. Most annoyingly, no Doctor ever tested my blood or system and found hypoglcemia, until recently.

Five years ago I met my current wife who is the most decent and caring, wonderful person one could ever wish for. Twice now. . . it happened again. . . we argued, disagreed, we shouted and I went to hit her. Fortunately, I didn't, I only pushed her and she fell down and I stopped myself from actually hitting her. On the 2nd ocassion I splashed her face with hot water. Why? I didn't want to. I would never want to do that. I reacted and threw my cup of water in her direction. With no intent for harm, but it splashed over her face.

Again I was immediately so sorry. I love her more than I can remember loving another and I did that! Why? What makes me do these things?

Still overweight, I sought professional help. I underwent hypnotherapy. I had initial success, losing 15 kgs over time. Then the weight loss simply stopped. Much worse it came back once I regained weight. The second time, I couldn't seem to shed any weight. My hypnotherapist referred me to a specialist for a physical check.

I presented and he seemed to know straight away what my problem was. Tests confirmed

his diagnosis .... I have hypoglycemia.

He explained to me in summary that it was related to my diet, that it means I am pre-diabetic and that I must change my eating habits forever. I also had three main allergies, strawberry, dairy products and wheat. How is that possible for a person who has eaten all of these as a staple diet all his life?

I had been raised on a junk and fast food diet. Serving in the military, working in security I used to drink up to 10 coffees a day, I used to smoke up to 60 cigarettes a day. I used to drink lots of alcohol. I have eaten sandwiches all my life, I love bread. I love sugar, I love cakes, I love cream. How can I be allergic to them?

Based upon my own personal experiences, I have found now after 12 months on and off my diet, that all of my past "rages, explosions and violent outbursts" have been based upon my body sugar levels. When I remain eating my recommended high protein, carbohydrate sugar free diet and keep away from my my allergic reactive foods, I remain very stable, placid, calm and I believe a decent person. I get on extremely well with my wife who I love dearly and I can function quite well.

On the odd few occasions when I broke my diet and I ate sweets, cakes or pastries I would end up in another argument with my wife. I get pounding headaches when I eat creamy things. I have never reached the "rage reaction level" and exploded again since I have balanced my diet. So I remain a firm believer and walking example of how inappropriate diet coupled with some allergies causes otherwise decent people to move right out of character.

How many other cases or similar to mine are involved in the violent crimes in society which require addressing?

Would that not be a worthwhile issue for Hypoglycemic Health Association to investigate and pursue? How many violent crimes are commited by people who are like I have been, ie., out of control due to their diet?

How are many general medical practitioners letting society down by not addressing and recognising the hypoglycemic members of society? One book which I read details the problem in great detail of how most GP's are not trained to test for and identify hypoglycemia in patients. I am angered at the number of times I have visited GP's throughout my life and have never been sent away to have my bodily functions previously tested to find out I have internal irregularities. New knowledge is very powerful. My studies and research has finally convinced me that to improve my quality of life I must maintain a new dietary regime. Doing so has created an entirely new life for my wife and I.

What studies have been conducted to check the relationship between violent offenders and their dietary lifestyle? Why is it that often violent members of society become placated once they are in gaol? Is there any connection between the change in diet?

I have had many unique experiences as everyone in society does. My experiences say to me that people are not inherently bad. I do believe that people can be rehabilitated from crime and past mistakes. I believe there are a myriad of reasons where some people in society may reach their limits, explode and act violently against others in society due to the chemical reactions which are occurring within them.

Is that worth further investigation?
I contend it is.
Gee Effess

DIET FOR DRUG ADDICTION AND ALCOHOLISM

By Jur Plesman

Drug addiction and alcoholism are invariably associated with unstable blood sugar levels. Wildly fluctuating blood sugar levels may cause all sorts of emotional symptoms such as depression, mood swings, fatigue, nervousness, aggression (worsened by alcohol consumption), and many other health problems, including allergies. This condition has been inherited partly from faulty genes running through one's family, and/or because of a long standing pattern of sugar consumption in sugary drinks and foods and other non-nutritious "junk" foods.

Sadly, most 'professionals' involved with the treatment of drug addiction fail to recognise that one important factor in the disease is a disturbance in the metabolism of food. Most of these 'professionals' come from a background with training in psychology or social work. They carry with them a bias against the rigid 'determinism' implied in the study of biochemistry of behaviour, without realising that an understanding of this field of knowledge broadens the range of 'free will', which is essential in 'psychological' treatment.

Most drug addicts and alcoholics are deficient in vitamins, minerals and essential fatty acids. For a fuller discussion of "Nutrients against drugs and alcohol" see HHA Newsletter, Sept 92, p2, where other helpful nutrients are suggested.

The following diet will assist patients overcome their drug and alcohol problems:

* **Avoid all sugars** in foods and drinks (read ingredients when buying). Avoid such things as sweetened fruit juices and cakes with sugar. Decaffeinated **Diet cokes** and other 'diet' drinks are acceptable. Replace sugar with aspartame, artificial sweeteners, but preferably use *fructose* instead of table sugar. (Oppenheimer Pty Ltd wholesale supplier). Fructose or glycerine mixed with a fruit juice or water is not recognised by the pancreas as a sugar thus avoiding abnormal insulin reactions. They help to overcome "sugar cravings" and stabilise blood sugar levels (and therefore moods).

* Have **three hourly high protein snacks** and complex carbohydrates. These are found in "natural" foods, unprocessed foods, vegetables, especially beans, white meats (chicken, turkey) and fish (sardines, salmon etc.). Avoid dairy products such as milk, but one egg per day is allowed. Soya milk is a good substitute. Eat plenty of fresh fruits and vegetables. Drink lots of filtered water.

* Take 2,000 - 4,000 mg of **Evening Primrose Oil (EPO)** with food per day. This helps the body to produce *prostaglandins series 1* (PGE1) normally produced from essential fatty acids (unprocessed vegetable oils and fish oils). There is some evidence that drug-addicts and alcoholics lack specific enzymes to produce these prostaglandins which have many health consequences, among these the elevation of moods and general feeling of well-being. EPO by-passes the enzymatic blockage. Many drugs (such as caffeine, aspirin, phenytoin, NSAIDs, lithium, some diuretics, excess alcohol and others) interfere with the production of PGE1, and taking EPO will avoid the impediment. High supplements of EPO should be accompanied by one vitamin E capsule (400 IU per day).

* Supplement your diet with;
* **B complex vitamins** tablets which should include **zinc,** folic acid and B12**.** If you can tolerate Brewer's Yeast it would be cheaper and it contains zinc and selenium
* **Vitamin C,** (2,000 - 3,000 mg) divided throughout the day
* Lecithin granules
* Cod Liver Oil (optional)
* There are many other supplements that may be helpful, among these are glutamine (said to stop alcohol craving), calcium, magnesium, choline, Vitamin B1 & B6.
* Don't take supplements after 6 o'clock, except lecithin. (They may keep you awake)

* **Exercise** such as jogging, cycling, swimming etc. cleans out your circulatory system, develop muscle tissues, but above all helps your body to produce internal "*endorphins*", your natural body opioids and tranquillisers.

Research snippets

Lycopene a potent antioxidant

H. Gerster reviews the scientific literature which shows that lycopene is a major carotenoid in Western diet. It is to be found in tomatoes and tomato products, responsible for its red colour. Other sources are in certain fruits such as melon, guava and pink grapes. Lycopene is a 'singlet oxygen' quencher twice as potent as beta-carotene. It is stored in body tissues like the testes, adrenal glands, prostate and to some extent in kidney, lung and liver. Lycopene is heat-resistant, in fact heating with a small amount of oil increases its bioavailability. Scientific interest centres around the possibility that lycopene may provide protection against various forms of cancer. A weekly consumption of 5 or more tomatoes was associated with a decreased risk of cancer in one six-year follow up study. Lycopene intake was inversely related to prostate cancer risk. It is believed to also provide protection against cancer of the digestive tract, stomach, colon and rectum. Reduced lycopene serum concentration have been found among HIV patients. In a study with elderly nuns, suffering from Alzheimer's Disease, lycopene was found to be inversely related to dependency on others for performance of a number of self-care tasks.

Gerster H (1997), The potential role of lycopene for human health [Review], **Journal of American College of Nutrition, 16:** 109-126

Palmitic acid inhibits nitric oxide production

Nitric oxide (NO) is an important relaxant factor produced by endothelial cells, including those of the coronary arterial walls. Atherosclerosis impairs NO production. NO also inhibits platelet aggregation. In an experiment, endothelial cells were incubated with either palmitic acid or stearic acid* for 5 hours. They were then stimulated to produce NO. Palmitic acid, but not stearic acid, inhibited NO production.

*Editor: Palmitic acid and stearic acids are saturated fatty acids common in triglycerides of many animal and vegetable (i.e., palm oil, cocoa butter) fats, to be avoided by diabetics and hypoglycemics.

Moers A, Schezenmeier J (1997), Palmitic acid

ATTENTION ALL HEALTH PROFESSIONALS AND OTHER MEMBERS

In an attempt to raise money for the association we will display your business card in future issues of the Newsletter, when we receive your donation of $50.00 or more. A sample is shown below, which acknowledges your donation at the same time.

The following members and professionals support The Hypoglycemic Health Association.

but not stearic acid inhibits NO-production in endothelial cells, **Exp Clin Endocrinol Diabetes 105** (suppl 2): 78-80

Antioxidant status and lipid peroxidation in NIDDM

467 patients with non-insulin-dependent diabetes mellitus were compared with 180 healthy subjects. Lipid peroxidation was significantly raised within the first two years of diagnosis and superoxide dismutase, catalase and glutathione (all related to antioxidant enzymes), vitamin C and vitamin E were significantly lowered among the NIDDM patients. These changes expose patients with an increased risk of diabetic complication such as atherosclerosis, retinopathy (damage to the retina in the eyes etc.).

Sundaram RK, Bhaskar A, Vijayalingam S et al (1996), Antioxidant status and lipid peroxidation in type II diabetes mellitus with and without complications, **Clin Sci (Colch) 90(4):** 255-60.

Editor: People with diabetes are strongly advised to increase their antioxidant intake such as Vitamins A, E, C, D, zinc, selenium, manganese, preferably under supervision of health professional.

Can cow's milk cause diabetes?

International scientific journals have suspected that milk proteins are somehow related to development of diabetes through processes of auto-immunity. The timing of exposure to cow's milk, genetic sensitivity and possible viral infection have been implicated. Authors assessed the values of the cow's milk antigen, *bovine serum albumin (anti-BSA),* in newly diagnosed diabetics. The prevalence of anti-BSA antibodies was only 11% which was deemed to be of little value in predicting IDDM susceptibility.

Fuchtenbusch M, Karges W, Standl E et al. (1997), Antibodies to bovine serum albumin (BSA) in type 1 diabetes and other autoimmune disorders, **Exp Clin Endocrinol Diabetes 105:** 86-91

Nevertheless other authors claim that anti-BSA antibody although not directly responsible for the development of IDDM, may be an indication of breakdown of tolerance to antigens and that "an impaired expression of an adhesion molecule by gut mucosal cells is common in IDDM patients". These then travel to the islet cells in the pancreas, which could then contribute to the development of IDDM. They recommend a large, prospective randomised controlled trial looking at the timing of cow's milk exposure.

Akerblom HK, Vaarala O, (1997), Cow milk proteins, autoimmunity and Type 1 diabetes, **Exp Clin Endocrinol Diabetes 105:** 83-85

INTERNATIONAL CLINICAL NUTRITION REVIEW

By Editor

Dr Robert Buist, Editor in Chief of the ICNR, has indexed the **International Clinical Nutrition Review** which will be updated in the last issue of each year.

This makes the series of International Clinical Nutrition Review a valuable commodity in one's private library for anyone who is interested in the scientific basis of clinical nutrition.

Researchers from all corners of the world review medical and other scientific literature and cull out the latest news on the clinical application of nutrients in the treatment of disease. The serial also publishes in-depth-editorials written by experts on various topics of concern to clinical nutritionists.

No longer can it be argued that this new branch of medicine is without scientific foundation.

A "must" for naturopaths and doctors with an interest in nutrition, practitioners and interested members of the public can subscribe to this quarterly publication by sending $54.00 (New Zealand Subscribers $64) to:

Integrated Therapies
PO Box 370
MANLY NSW 2095
Australia

Serious students might also consider the one year correspondence course in Nutritional Medicine. The course is registered with ATMS and the $850 fee includes all texts, tapes and study guides as well as subscription to ICNR.

Please write to the above address for brochure.

THE HYPOGLYCEMIC HEALTH ASSOCIATION
P.O.Box 8, SYLVANIA SOUTHGATE NSW 2224

MEMBERSHIP APPLICATION

PLEASE PRINT

Surname: _____

First Name: _____

Address: _____

Town/City: _____ **Postcode:** _____

Phone: _____ **Age:** _____

Membership $15.00 pa
Pensioners $10 pa
Life Membership $150

Please tick √

RENEWAL ☐ **Occupation** _____

NEW MEMBER ☐ _____

Do you have hypoglycemia? YES/NO Does a family member have hypoglycemia? YES/NO

1998 *MEETING DATES ON SATURDAYS*

7th MARCH - 6th JUNE - 5th SEPTEMBER - 5th DECEMBER