

NUTRITION & HEALING

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Take action today: Eight strategies to halt—and reverse—bone loss

By Jonathan V. Wright, M.D.

In the last few years, I've been working with an increasing number of women (and a few more men) with varying degrees of bone loss; many more than I saw 20 years ago. It's likely that *part* of this increase is due to the well-known "aging of the baby boom generation," which has put a greater percentage of us into the at-risk age groups for osteoporosis. But that's not the entire explanation. There are also many more women in their later 40s, whose menstrual periods haven't stopped yet, who are discovering they have "osteopenia" (early bone loss that's significant but not yet osteoporosis).

Myth:

Calcium supplements alone preserve your bones

In this age of exercise and health enthusiasts, it's strange that osteopenia and osteoporosis are on the rise. But many people still think that drinking a lot of milk will keep their bones strong. Many take antacids or pills as their only supplemental calcium. There are still a number of misconceptions when it comes to the proper bone-loss prevention and reversal strategies.

Following is an outline of what you should be doing for your bones in *all* stages of bone health. And a hint—there's much more to it than

taking calcium supplements!

Whole grains and animal proteins promote bone loss if you don't eat enough fruits and vegetables

If you want to prevent (and especially reverse) bone loss, you must eat more vegetables and fruits every day (whether measured by weight or volume) than you do

It's best to cut down on coffee. Some research has shown that drinking more than two or three cups daily is associated with an increased risk of bone fracture.

total animal proteins and grains (whole, of course). Otherwise, you can supplement all the calcium you want, and most or all of it will just go right back out again! Considerable evidence demonstrates that nearly all animal proteins tend to promote calcium and bone loss, as do grains (even the more healthful whole grains). By contrast, nearly all vegetables and fruits help our bodies retain calcium and bone. Decades ago, health researchers demonstrated this point in what some would consider "extreme" dietary fashion. They reported that women who had been strictly vegetarian all their lives had on the average a 30-35 percent greater

bone density when in their 70s than women who'd followed an "omnivorous" diet. (In this case, *omnivorous diet* is *not* related to *omnivores* from Jurassic Park but just means "everything-eating" by today's human population, including animal protein, grains, vegetables, fruits...and, unfortunately, considerable junk food!)

Note: There's still considerable controversy about the above more vegetable/less meat position, as illustrated by a recent issue of a major nutrition journal that includes an article supporting it while also including an editorial in the same issue disputing it! At present, my opinion remains as written.

Sugar, dairy, and coffee are all likely offenders

For some of us, refined sugar (as sucrose) leads to extra calcium loss. Although this effect varies from person to person, there are so many other bad effects from refined sugar—including accelerated aging—that it should be eliminated in any case. It's also best not to drink a lot of coffee. Some research has shown that drinking more than two to three cups daily is associated with an increased risk of bone fracture. On the contrary, light to moderate tea drinking may be associated with

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Our mission:

Nutrition & Healing is dedicated to helping you keep yourself and your family healthy by the safest and most effective means possible. Every month, you'll get information about diet, vitamins, minerals, herbs, natural hormones, natural energies, and other substances and techniques to prevent and heal illness, while prolonging your healthy life span.

A graduate of Harvard University and the University of Michigan Medical School (1969), Dr. Jonathan V. Wright has been practicing natural and nutritional medicine at the Tahoma Clinic in Kent, Washington, since 1973. Based on enormous volumes of library and clinical research, along with tens of thousands of clinical consultations, he is exceptionally well-qualified to bring you a unique blending of the most up-to-date information and the best and still most effective natural therapies developed by preceding generations.

Nutrition & Healing cannot improve on these famous words:

"We hold these truths to be self-evident, that all men are created equal, that they are endowed by their creator with certain unalienable rights, that among these are life, liberty, and the pursuit of happiness."

The inalienable right to life must include the right to care for one's own life. The inalienable right to liberty must include the right to choose whatever means we wish to care for ourselves. In addition to publishing the best of information about natural health care, *Nutrition & Healing* urges its readers to remember their inalienable rights to life, liberty, and freedom of choice in health care. This information is published to help in the effort to exercise these inalienable rights, and to warn of ever-present attempts of both government and private organizations to restrict them.

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improved bone density. (See the February 2001 issue of *Nutrition & Healing*.)

Aside from all the research saying that milk and dairy products don't help weak bones, there are so many reasons *not* to consume these products, including but not limited to increased risk of cataracts, prostate cancer, and ovarian cancer, that many readers know I recommend them for very infrequent use if at all.

Exercise! It doesn't take much, but it's key to bone health.

It doesn't take a great deal of exercise to reap the strengthening benefits; walking briskly for half an hour daily is enough for either sex. If more exercise is possible—even better! Women can sometimes exercise so much that they skip their menstrual periods, or stop them entirely. This disorder, called *amenorrhea*, will cause bone loss. But it's much more common that women exercise *too little* to get the protective benefits they need for healthy bones.

Take the correct nutrient "cocktail"

Calcium is the major mineral constituent of bone, and odds are, if you're currently protecting your bones, you're supplementing with it. But it's possible to take what appears to be plenty of calcium and still lose too much bone, because of deficiencies in nutrients including manganese, magnesium, copper, and zinc for example. It's important that calcium is taken along with nearly every other mineral nutrient (and every vitamin too) that's known to be essential to life.

It's also important to consider the absorbability of calcium. You may be "up to here" with advertisements about the superior absorbability of calcium citrate, but the ads are indeed correct. Calcium citrate and calcium lactate are the best-absorbed forms; calcium carbonate and calcium oxide are the worst-absorbed. Calcium as hydroxyapatite (a form found in bone), aspartate, malate, succinate, and fumarate fall somewhere in between.

Note: Calcium hydroxyapatite is heavily promoted as "natural calcium as it occurs in bone." This claim is true, and taking a proportion of calcium in this form is a good idea. However, in the past, lead has been found in bone-source calcium hydroxyapatite. Now it's necessary for manufacturers to provide assurance that bone-source calcium hydroxyapatite is lead-free. Check labels!

How much calcium is enough? At least 1,000 milligrams daily. If you've already lost some bone, doses of 1,200 to 1,500 milligrams a day would be better. Many people take calcium (along with magnesium) at bedtime; a combination that helps

them sleep a little better. But for better absorption, it's wisest to split quantities if they're over 1,000 milligrams a day. Take one dose in the morning and one before bed.

Keep it in balance—combine magnesium with your calcium

From time to time, a rumor circulates that we should actually be taking more supplemental magnesium than calcium. This is just a rumor! A 2:1 or 3:1 calcium-to-magnesium ratio is best, although some would argue that an even higher ratio is entirely adequate to prevent or reverse bone loss. Keep in mind that for some people too much magnesium can have adverse effects, including loose bowels and general nutrient

malabsorption. It's best to check for any such potential magnesium-induced absorption problem (see Clinical Tip #80 in the December 2000 issue of *Nutrition & Healing*) before taking more than 300-500 milligrams of supplemental magnesium daily.

Your healthy-bones checklist: Look for these key ingredients in the mix

Although there haven't been many research studies on it, **boron** is frequently emphasized as a mineral that helps to conserve bone. Boron should be included in every multivitamin taken to fight bone loss. Such multiples should also contain **manganese** (at least 5 to 10 milligrams daily) and **zinc** (at least 15 to 30 milligrams daily), which are essential for bone formation. They should also contain **copper** (2 to 3 milligrams daily).

Make sure there's **silicon** in your multivitamin as well. It's part of the natural "matrix" of bone and is becoming a common ingredient in anti-bone loss mixtures. It usually comes from a plant source like horsetail or nettles, in amounts of 50 to 100 milligrams of the plant material itself. A final mineral that (in my opinion) should also be in every multiple is **strontium**, a few hundred micrograms to a few milligrams daily.

Most everyone has probably heard that **vitamin D** is good for bones. But you may *not* have heard that there's been a re-examination of how much vitamin D is safe to take. According to a report in a very prestigious nutrition journal (see the August 1999 issue of *Nutrition & Healing*), the previously believed safe upper limit for vitamin D was a dose of 2,000 IU daily. Now research suggests that this may be at least five times too low, and that an upper limit of 10,000 IU may be appropriate. It's not wise to come anywhere close to this newly proposed upper limit without consulting with a physician who's skilled and knowledgeable in nutritional medicine, but I've been recommending 2,000-3,000 IU for my patients whose bones need rebuilding. (Hint: If too much vitamin D is taken, serum calcium levels will rise beyond normal.)

Vitamin K.* Among many other functions (see "Vitamin K: What's it good for?" in the July 2000 issue of *Nutrition & Healing*), vitamin K is necessary for the formation of osteocalcin, a protein key to attracting calcium to bones. Results of various bone-loss tests demonstrate that some people need 5 to 10 milligrams of vitamin K daily, or occasionally even more, to help slow bone loss. Fortunately, both vitamin K₁ (the only form readily available in the United States) and

vitamin K₂ are virtually nontoxic. (Sometimes, adequate quantities of vitamin K are hard to find. For more information contact the **Tahoma Clinic**, tel. (253)854-4900, website: www.tahoma-clinic.com, with which I am, of course, affiliated.)

Vitamins B₆, B₁₂, and folic acid deserve special mention, because they bring elevated levels of homocysteine down to normal. (In addition to contributing to atherosclerosis, homocysteine also promotes bone loss.) After menopause, homocysteine levels may rise in some women who elect not to use replacement bioidentical estrogens (which also bring elevated homocysteine levels down to normal). These vitamins do the same for men, whose homocysteine levels generally start to rise at earlier ages than women's do.

Omega-3 fatty acids have been found to induce the formation of local bone-growth factors in experimental animals. While the same effect hasn't yet been proven in humans, it's overwhelmingly likely to happen. It's probably not random, or a coincidence, that the traditional children's bone builder, cod-liver oil, contains significant quantities of both omega-3 fatty acids and vitamin D. So, for bones and other body structures and functions, 2,000-4,000 milligrams daily is a good range.

Ipriflavone is an isoflavone (one of the many forms of bioflavonoids) derivative that has been shown to simultaneously inhibit bone destruction and promote bone building. Although it is found in some "osteoporosis" multivitamins, for best effects, you should take 200-300 milligrams three times daily.

Stop bone loss and even reverse it with natural HRT

In addition to everything else mentioned above, **bioidentical hormone replacement** is usually necessary after menopause when bone loss has progressed from osteopenia to actual osteoporosis. Unfortunately, some think that progesterone replacement is all that any woman needs for bioidentical (not horse or synthetic) hormone replacement. While progesterone alone may do the job for some, others *must* have estrogen to aid in rebuilding bone—and in many cases a little bit of testosterone too. It's a physiological fact that estrogens are necessary to sensitize progesterone receptors on bone (and elsewhere). Without this sensitization, progesterone can't do its job. It's always wisest to consult with a physician skilled and knowledgeable in both nutritional medicine and bioidentical hormone replacement to find out exactly what's right for you! For men, testosterone is the appropriate bioidentical hormone replacement.

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* Remember: NEVER take vitamin K if you're taking Coumadin®. Consult a physician knowledgeable in nutritional medicine.

Bone density

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Calcium deficiency—could your stomach be the cause?

At the Tahoma Clinic, *all* patients with a diagnosis of osteoporosis are tested for adequate stomach function. A large majority of them (including individuals with osteopenia) have hypochlorhydria (low stomach acid) or achlorhydria (no stomach acid). In these cases, the absorption of calcium and other minerals from food can be impaired—sometimes severely. If you're diagnosed with this problem, there are steps you can take to improve it. It's important to have this test done before starting on a bone-rebuilding program. Please check with your doctor.

Track progress accurately—use the same facility and equipment every time

Ironically, the patenting and marketing of drugs to treat osteoporosis has led to an explosion in the availability of bone-density testing. (Longtime subscribers won't be surprised to read that at least one manufacturer of these patent medicines has made such testing equipment available at little or no cost to physicians who prescribe their medicines.) Whatever type of bone scan you and your doctor choose, keep in mind that for the best comparisons on a year-to-year basis, it's wisest to have your test done using the same equipment at the same facility if at all possible.

While bone-density tests show changes slowly over time, there are several reliable tests of bone loss (please check with your doctor for details) that can show significant change (hopefully less bone

loss) in as little as a month. Monitoring bone loss at relatively frequent intervals is important to make sure a program is working.

Bone loss tests do not test for bone density

At present, there are, unfortunately, no tests for bone rebuilding available, and only the periodic bone-density determination will tell if a bone-rebuilding program is really working. You can't depend on bone loss tests (urine tests) for an overall bone density reading. I always remind my patients that they can still have osteoporosis, even if their bone loss test show that there is very little bone loss. It can happen if the rate of bone rebuilding is slower than the rate of loss.

No matter what your sex or age may be, it's important to protect your bones. As I mentioned earlier, the rates of osteoporosis and osteopenia (in younger women) are on the rise. Fortunately, there's plenty of information available that can provide you with the guidelines to maintain or rebuild bone mass. Reanalyze how you care for your bones—today. ♥

The following nutrients and doses constitute a typical and thorough daily bone-rebuilding supplement program.

- | | |
|------------------------------------|--------------------------------------|
| • calcium 1,000-1,500 mg | • vitamin K 5-10 mg |
| • magnesium 300-500 mg | • vitamin B ₆ 25-50 mg |
| • manganese 5-10 mg | • vitamin B ₁₂ 50-100 mcg |
| • zinc 15-30 mg | • folic acid 1-3 mg |
| • copper 2-3 mg | • omega-3 fatty acids 2,000-4,000 mg |
| • boron 3-6 mg | • ipriflavone 600 mg |
| • silicon (plant source) 50-100 mg | • bioidentical hormone replacement |
| • strontium 500-2,000 mcg | |
| • vitamin D 2,000-3,000 IU | |

Identical-to-human estrogen replacement protects postmenopausal women from heart attacks

In the 1970s through the early 1990s, "generally accepted medical opinion" was that horse estrogens could help prevent heart attacks in human women. In just the past few years, following additional studies of horse estrogen, opinion has changed from positive to negative (or at best neutral) on this topic. (See the November 2000 issue of *Nutrition & Healing*.) Now there's another clue that *human* estrogen actually protects human women against heart attacks.

Women have a greater risk of heart attack during times of low estrogen

According to *Science News* (Dec. 2, 2000), researchers at the University of Quebec found that 20 of 28 women who had heart attacks at unusually young ages (35 to 47 years old) had them within five days of starting their menstrual

cycles, when their estrogen levels were at their lowest. Another researcher, at University College (London, UK), noted unpublished data "suggesting that women's blood vessels are stiffest when estrogen concentrations are low."

As noted in the November issue, women who've had their ovaries surgically removed in their 20s and 30s and have no hormone replacement have the same rate of heart attack in their 40s as men have.

Obviously, *human* estrogen protects *human* women against heart attacks before menopause. It's exceptionally likely that it's protective *after* menopause too, even if not to the same degree. If you're entering menopause and you're a woman with a family history of heart attacks, don't use any hormone replacement that isn't identical in every way to human estrogen!

Herb/drug interactions: Real threats to your health or just exaggerated claims?

I recently received a letter from a longtime patient (who had developed atrial fibrillation) explaining that her doctor wanted to put her on Coumadin® to reduce her risk of blood clots. He also suggested that she stop all her herbal treatments. This woman has multiple sclerosis and had been maintained in remission with the help of her herbal therapy. I wrote back immediately, agreeing that it is wise to be cautious about combining herbs with Coumadin® therapy. I advised her, however, that after her condition was stabilized on the drug, I would be able to suggest herbs she could still take, based on current knowledge and my clinical experience.

It seems these days that almost everyone is concerned about the undesirable potential of herb-drug interactions, often called HDI. But in actuality most of these fears are unfounded. They're mainly the result of exaggerated claims made by the media and of secondhand, misinterpreted information. In general, herbs are safe if you take them with proper safety guidelines in mind. Don't let the media scare you into believing otherwise!

Some potential dangers are just that...potential and speculative

Over the past year, the idea that it can be dangerous to combine herbs with chemical drugs has exploded in the media. For example, a press release in Australia sent out by the pharmacists' professional body implied that herb-drug interactions could kill people...and that the pitfalls in taking herbs are many. This sure sounds frightening, but where's the proof? People aren't dropping dead from taking

herbal supplements. If they were, we would definitely know about it.

Even herbalists are getting in on the act. I recently came across an article by an herbalist suggesting that parsley could not be safely combined with Coumadin®! One of the national dishes of Lebanon is a parsley salad called tabouleh. I pictured thousands of poor Lebanese who are now needlessly deprived of their favorite salad (my favorite too!).

Often, this loose speculation involving HDI appears in eminent and authoritative journals and is then misinterpreted and passed on as fact to the mainstream. One example is from the *Archives of Internal Medicine*, in an article by pharmacist Lucinda Miller.¹ First, the title of the article is *Herbal Medicinals, Selected Clinical Considerations Focusing on Known or Potential Drug-Herb Interactions*. Unfortunately, many people quoting the paper seem to have forgotten what is possibly the most important word in the title—"potential." This term encompasses a wide range of probability. Miller makes the following comment:

"Chamomile contains coumarin, which is reported to exert an antispasmodic effect. However, this effect has not yet translated into any coagulation disorders despite widespread human use. Because chamomile's effects on the coagulation system have not yet been studied, it is unknown if a clinically significant drug-herb interaction exists with known anticoagulants such as Coumadin®."

Most people reading this would assume that if the effects are unknown, they should probably stop drinking their chamomile tea.

But there's been a big misunderstanding. To a phytochemist, the term *coumarin* means plant chemicals based on the coumarin structure. But to pharmacists, the term *coumarin* means anticoagulant drugs derived from or related to phytochemicals in the coumarin group.

Note for practitioners: One of the many misunderstandings made by pharmacists not well-trained in phytochemistry (the chemistry of plants) is confusion around the word *coumarin*. The herb sweet clover (*Melilotus officinalis*) contains coumarin. "Sweet clover disease" was a bleeding disorder first noted in cattle who were fed spoiled sweet clover. Although it was described in the 1920s, it was not until 1941 that the causative factor was identified as dicoumarol.² Dicoumarol, formed from coumarin by bacterial action in damaged hay, was subsequently developed as the first oral anticoagulant. However, its anticoagulant action is slow in onset and difficult to terminate and this has led to the use of synthetic analogues, the most widely used of which is Coumadin®. Properly dried sweet clover does not contain dicoumarol and has no anticoagulant activity under normal circumstances. Coumarin has an anticoagulant activity that is 1,000 times less than that of dicoumarol, because it lacks a 4-hydroxy group in its chemical structure. A double-blind, comparative study involving 41 patients suffering from chronic venous insufficiency found that an oral coumarin/ troxerutin preparation used over six weeks did not cause anticoagulant effects.³ There were no significant

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Herb drug interactions

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changes in coagulation, clotting factors, or fibrinolysis over the treatment period.

In other words, properly dried sweet clover does not contain dicoumarol and has no anticoagulant activity under normal circumstances. Similarly chamomile does not contain anticoagulant coumarins. So, chamomile tea drinkers should have no fear of Coumadin® (other than the normal respect for this highly dangerous drug).

And yet we find that in a press release by the Australian Pharmacists Guild this year, the following claim was made:

“Chamomile affects the anticoagulant or clotting system so anyone taking anticoagulant therapy, such as Coumadin®, should not take it.”

It's amazing what misunderstandings can stem from partial or no knowledge!

Beware HDI information taken from the Internet

Just as with practically every other topic known to man, consumers can learn about HDI on the Internet. But not all websites are updated regularly or contain accurate information to begin with. I came across inaccurate HDI information regarding St. John's wort on a well-respected medical site. The misinformation was based on the now discredited notion that St. John's wort is a clinically significant inhibitor of monoamine oxidase and therefore shouldn't be combined with certain drugs and foods, such as cheese and chocolate. On another Internet site, I found a list of 50 drugs that were said to interact in a positive and/or negative way (whatever that means!) with *Ginkgo biloba*. The real fact is that few of these drugs have

actually been clinically shown to interact with this important and widely used herb.

There are simple guidelines for patients and practitioners for determining the safety of herbs and their possible interactions.

HDI information is a field in which currently “more information” is definitely not “better.” It's no use digging through printed material when we know that it's often inaccurate. So what can we do in the meantime while waiting for better interpretations of HDI and more rigorous research?

Apply the following simple rules:

1. If you are taking any drug and wish to take herbs as well, it is best to seek the advice of

a professional trained in herbal therapy.

2. The following drugs have a narrow therapeutic window (meaning that they can become dangerously toxic or dangerously ineffective with only relatively small changes in their blood concentrations): digoxin, Coumadin®, antirejection drugs, many anti-HIV drugs, phenytoin, and phenobarbital. Never take any herbal supplement with these drugs except under professional guidance.

3. If your heart, liver, or kidney function is impaired, if you are elderly, pregnant, if you have received an organ transplant, or if you have a genetic disorder that

CLINICAL TIP 87

Flying without dying from “economy-class syndrome”

As nearly all of us who've taken an airline trip know, legroom in economy class on nearly all airlines is severely cramped. According to a recent article in the *Wall Street Journal*, approximately 10 people per year arriving at London's Heathrow Airport actually die of blood clots attributable to restricted circulation in the legs. At hospitals near Heathrow, the situation is referred to as “economy-class syndrome.” Other than traveling first-class or business class, what can be done to ensure flying without dying (from economy-class-induced blood clots, that is)?

Chances are there will never be a “placebo-controlled, double-blind” trial of any treatment designed to prevent death from “economy-class syndrome,” but there's plenty of evidence to suggest that a combination of known natural anticlotting nutrients will do the job.

Two to three decades ago, researchers noted that natives of Greenland had approximately half the rate of heart attacks as residents of Europe or the United States. This was traced to their consumption of relatively large quantities of fish and fish oil, which prevent abnormal clotting of the blood. Very recent research has demonstrated that consumption of fish and omega-3 fatty acids (found in fish oil) is associated with a decreased risk of stroke caused by blood clotting. Of course, whenever we take any type of fatty-acid supplementation, it's important to take vitamin E to prevent abnormal “lipid peroxidation” and free-radical formation.

So even though the double-blind research will likely never be done, it's extremely probable that death from “economy-class syndrome” can be prevented by regular consumption of cod-liver oil, 1 tablespoon daily, and vitamin E (as “mixed tocopherols”), 400 IU daily.

deranges normal biochemical functions, do not take herbal supplements with drugs except under professional guidance.

4. Never take drugs and herbal supplements at the same time of day. Always separate them by at least an hour, preferably more.

5. If you have any type of serious disease and are being treated with chemical drugs, do not take any herbal supplement except under professional guidance.

6. Stop all herbal supplements about one week prior to surgery.

7. Research any herbal supplement you wish to take to see if there are **known** (not speculative) HDI. Much is known, for example, about St. John's wort, but there is still some speculation. Learn to differentiate between the two. (In a future article, I will list the more important known HDI.)

8. If you believe that an herbal supplement you are taking is causing an HDI, stop taking it and seek professional advice.

I agree that it is valid to speculate about potential HDI in order to define areas of caution. But these speculations should be rational and should not be presented as confirmed fact. In reality, the best information about HDI will come from case observations and scientific studies. In other words, they will be found by discovery, not speculation and extrapolation.

Note: To find an experienced herbalist in your area, contact the **America Association of Natural Physicians**, tel. (703) 610-9037, website: www.naturopathic.org/index.htm, or the **American Herbalist Guild (AHG)**; tel. (770) 751-6021, fax: (770) 751-7472, website: www.healthy.net/herbalists/. 🍀

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Due to a high volume of reader mail, we may not be able to respond personally to each letter. However, your letter will be read and taken into consideration for future issues and special reports.

Department of "Duh"

MERCURY: Bad from fish... safe from dental amalgams? Don't think so!

Newspapers nationwide carried an Associated Press report in mid-January warning pregnant mothers not to eat swordfish, king mackerel, shark, and tilefish because the mercury these fish naturally contain might be enough to hurt a developing baby's brain, leaving infants with slower cognitive development.

"FDA food chief" Joseph Levitt says, "We want to empower women to protect the health of their unborn children, and the best way they can do that is to avoid eating those four kinds of fish."

According to the AP report, the warning was aimed at pregnant women specifically—but the FDA says it is prudent for nursing mothers and young children not to eat the four "high-mercury" fish either.

What did the FDA say about mercury from dental amalgams? Every physician and dentist using natural means of health care knows there's vastly more mercury taken into our bodies, every day, from mercury-silver dental amalgams than from eating fish. Clinical laboratory studies of human mercury excretion (into the bowel from the liver, the major organ of mercury excretion) show 10 times more mercury from individuals with amalgams than from individuals without them. So if a pregnant mother has mercury-containing dental amalgams, eating fish is the least of her baby's mercury problems.

Oh, yes: Did the FDA warn against mercury-silver amalgams in pregnant mothers? How about nursing mothers, or young children, for whom it's "prudent" not to eat "high-mercury fish"? Where's the warning? By now, you've guessed there wasn't one. The conspiracy of silence concerning the hazards of mercury-silver dental amalgams (especially for developing babies, infants, and young children) isn't going to be broken by the agency charged with guarding public health.

Since the FDA (not to mention the CDC—Center for Disease Control, the USPHS—United States Public Health Service, and assorted other federal and state agencies, along with the American Dental Association) won't warn you, I will.

Don't have dental amalgams placed in pregnant mothers, infants, or young children...and while we're at it, don't put them in anyone else, at any age, either! There are abundant alternatives, most of which are much safer. And, by the way, watch out for the FDA's "favorite four" fish too. Duh!

Natural Response



How to successfully metabolize MSM for pain relief

Q: *Re: the September 2000 letter questioning a possible cause-and-effect relationship between MSM [ingestion] and a terrible headache and your answer suggesting the need for molybdenum supplementation with MSM...*

The Nutrition Desk Reference also confirms that inorganic or endogenous sulfur can affect molybdenum's tissue concentration and that increased sulfur intake causes a decline [in tissue molybdenum].

Upon referring to and re-reading *The Miracle of MSM* by Stanley Jacob, M.D., I see no mention of any problem with molybdenum depletion, even with large doses and prolonged use of MSM, sometimes in conjunction with glucosamine sulfate...

It seems inconceivable to me that [Dr. Jacob] could have overlooked an effect [of MSM] of this biological significance...

I note as a consumer that MSM and glucosamine sulfate are featured in all supplement catalogs, pharmacies, supermarkets, health-food stores, etc. but molybdenum is rarely to be seen.

---M.A., Littleton, NH

A: I'll be the first to admit that I overlook things too! When I do, I appreciate reminders from my colleagues and others that there may be additional factors to consider. As a pioneering investigator and generally outstanding physician, I suspect Dr. Jacob believes as I do that it's more important to finally "get it right" than to "always be right."

You've actually answered your own query. The authors of

Nutrition Desk Reference (as well as every other standard reference text) know that metabolism and "detoxification" of any sulfur-containing material usually results in a "final common end product," sulfate, which is nontoxic and ultimately excreted. The final step in making sulfate involves molybdenum, so it's an inescapable metabolic fact that the more sulfur-containing material we ingest (including sulfites found in many wines, which is also covered in the September 2000 letter), the more molybdenum we need to metabolize it. Since there's very little molybdenum in our food, and it's a bit hard to absorb anyway, many of us are marginal in our molybdenum nutrition.

This is why I've campaigned among companies supplying MSM and other sulfur-containing material to *add molybdenum* to their products, to prevent them from causing molybdenum deficiency with prolonged use.

If you read the above closely, you'll notice that glucosamine *sulfate* (or any other sulfate) is an exception to this rule, since the sulfur it contains is in the "fully detoxified" sulfate form already, not requiring any further molybdenum once it's formed.

To make an appointment with a Tahoma Clinic doctor, call the Tahoma Clinic; tel. (253)854-4900.

Macular degeneration: another link to digestion

Both *Nutrition & Healing* and the Tahoma Clinic say "thank you" to all the readers and their relatives and friends who called and wrote in concerning the December 2000 article "If your eyesight is going and your doctor can't help...it's time for a second opinion." This article is about stabilizing and/or reversing macular degeneration. I apologize if we haven't been able to respond to everyone individually.

Because of the great interest, I want to pass along a research observation that was published in a major eye journal called *Ophthalmology* 2000. (See the reference below.) The authors note that antacid use unexpectedly appeared as a positive risk factor for macular degeneration.¹ This might seem a minor point except that (as noted in the December article) it's been my observation that a very large majority of those suffering from macular degeneration have faulty digestion, most often including low stomach acidity. This low stomach acidity (hypochlorhydria) usually isn't a result of a specific disease but occurs as a part of "normal" aging. Of course, antacid use *creates* low stomach acidity if it doesn't already exist.

I've written before that macular degeneration in many cases may not be a primary disease of the eye but instead a secondary problem occurring in the eye as a result of the primary problem, digestive insufficiency. This recent small clue from a major research project (the Age Related Eye Disease Study, or AREDS) appears to confirm this impression.

¹Ophthalmology 2000; 107(12):2224-2232, 2000