the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

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IN THIS ISSUE:

Dr. Robert Mendelsohn

Hypoglycemia--a word that strikes terror in the minds of physicians. On one hand, it conjures up visions of rare, hard-to-treat endocrine tumors. On the other hand, it conjures up hordes of patients bent on identifying a disease state which they, the doctors, claim does not exist. Originally of concern to family practitioners and internists, hypoglycemia should be on the agenda of every pediatrician and obstetrician because of the possibility that sugar, now given routinely by intravenous injection to mothers in labor, may induce, paradoxically, a state of hypoglycemia in the baby right from the start.

This Newsletter is designed to help people map out a practical approach to hypoglycemia--without any sugar coating. I have also included information on ulcerative colitis in this same Newsletter because, while the two conditions are themselves unrelated, both respond to nutritional therapy.

Q Last April I had a "complete" physical examination. My doctor, who is an internist, sent me to a laboratory for a three-hour glucose and blood sugar test. He told me that the tests showed I COULD have hypoglycemia. He sent me a diet list that seems inadequate to me, and it conflicts with the ulcer diet I'm on.

I called and asked him about some of the specifics, but he refused to discuss my so-called condition, and he refused to have me come in for a periodic checkup.

I really don't understand how I could have hypoglycemia; a friend of mine has had it for years, and I don't seem to be suffering from any of the symptoms she describes. I am 67 years old and, since I have reduced my weight, I seem to be in excellent health.--M.C.

Diagnosing and treating hypoglycemia

A If you ever want to witness a first-class shouting match, try to collect a few M.D.'s, osteopaths, chiropractors, naprapaths and other members of the healing arts in the same room and ask them to discuss hypoglycemia (which literally means a lowering of glucose in the blood). Some will swear it is extremely rare, while others will claim it is almost universal.

Physicians tend to associate hypoglycemia with an overdose of insulin or a rare pancreatic tumor. Other practitioners who are more involved in the field of nutrition attribute a wide variety of conditions to hypoglycemia.

To further complicate matters, if you go to a health-food store that sells books, you are likely to find a number of references to this subject, almost all in sharp disagreement with one another. One of these is a most interesting, highly readable book called "Sugar Blues" by my friend, William Dufty (Chilton, $7.95).

I always am disturbed when a patient is told what he or she COULD have on the basis of a laboratory test. The delicate test for blood sugar is difficult to perform and depends on careful techniques of collection and storage of the sample. Even in tests that are much easier to carry out, such as hemoglobin levels for anemia, many laboratories have a high level of error. In fact, Dr. Morris Schaeffer, former general director of laboratories for New York City's Health Department, has said: "We say the quality of lab work has improved since 1967. It has changed from horrible to bad."

I'd advise you to be skeptical about this single test. If your doctor continues to be unresponsive, you may have to find one who will examine you thoroughly and then discuss with you whether you should allow this test result to interfere with what you describe as your excellent health.

I have hypoglycemia. My blood sugar is down to 45, and I am having difficulty controlling that as well as my weight--I am 5 feet 1 and weigh 150 pounds. I have received much conflicting advice on this subject, and I'm very confused. I've been told, "Eat every two to three hours," "Go on a low carbohydrate diet" and "Don't worry about it." I know I have to restrict sweets, but how much protein should I eat, and how much carbohydrate is safe? Is a low (or no) carbohydrate diet, such as the Atkins Diet, safe? Should I eat six small meals? I now eat too much, but I'm always hungry. My grandfather was diabetic, as was a great-grandmother. I gained so much weight in a short time because I was eating dormitory food which I soon will be eating again. I suffer from anxiety and depression, am seeing a psychologist and take Stelazine daily for anxiety.

Please help me. The hypoglycemia is contributing to my depression, and the weight is unsightly and causing upper back pain.--L.K.

Hypoglycemia and depression

Hypoglycemia is one of the most controversial issues in both orthodox and unorthodox medical circles, and has been ever since Dr. Seale Harris described it more than 50 years ago. A large variety of diets have been prescribed for this condition in which unexplainable low levels of sugar exist in the blood.

For help and knowledge about hypoglycemia, you might do well to shop for books, rather than for doctors. Out of the many references available, you might begin with "Low Blood Sugar and You" by Carleton Fredericks, Ph.D., (Grosset & Dunlap, $2.95) and "A Physician's Handbook on Orthomolecular Medicine" by Roger J. Williams and Dwight K. Kalita (Pergamon Press). In the latter, I would suggest especially Chapter 25, entitled "Hypoglycemia: The End of Your Sweet Life," a chapter written jointly by an M.D., a D.O. and a Ph.D.

Another of my favorite books on this controversial subject, "Hypoglycemia: A Better Approach" (Health Plus Publishers, P.O. Box 22001, Phoenix, Arizona 85028, $4.95), is written by Dr. Paavo Airola, introduced by J. P. Hutchins, M.D., with five other M.D.s as contributors. Later on, you might compare its approach with the approach of other

books that are available at health-food stores which, contrary to doctors' opinion, often serve as an excellent source of health information.

After you read such references, I would suggest you try to find a physician who has already read these books. (This may not be easy.)

While there may be considerable confusion about hypoglycemia, there is no disagreement that the Stelazine you are taking may produce some of the same symptoms for which it is prescribed. While the drug's indications include excessive anxiety, tension and agitation, its possible side effects include jitteriness, insomnia and (believe it or not) agitation. The prescribing information states: "At times these symptoms may be similar to the original neurotic or psychotic symptoms." Other "adverse reactions" range from grand mal convulsions, reactivation of psychotic processes and catatonic-like states to sometimes fatal conditions that include hypotension, cardiac arrest and sudden death.

I hope your psychologist (who should be familiar with the "Physicians' Desk Reference") will join you in your reading, and I hope he will challenge the physician who prescribed Stelazine for you.

I recently visited a dermatologist about a dark spot on my leg. A biopsy revealed what he called a "pre-diabetic lesion." The doctor explained this meant I show a potential for diabetes, but he explained that it might be years before I actually got diabetes. A week later, I took a glucose tolerance test at my family doctor's office. His nurse told me that the test showed me to be slightly hypoglycemic, a condition which she said is usually the prelude to diabetes. I was given a diet to follow for "spontaneous hypoglycemia," and I was told I could prevent diabetes if I followed this diet. No mention was made of any future tests to determine whether my sugar level shows any changes or whether it remains stable.

Shouldn't I be tested on some sort of regular schedule so that changes can be detected? Can I really prevent diabetes from happening, or will I just get it less suddenly? Will I have to take insulin daily, or will I have to stick to this diet for the rest of my life? Which is worse? Does diabetes cause heart disease and blindness in later life?

I know next to nothing about this disease, and I feel quite helpless. Please help.--Mrs. E.B.

Diabetes and hypoglycemia

No matter what our medical specialty, it seems all of us doctors specialize in frightening our patients. Thus, your dermatologist and your family doctor (apparently through his nurse) have labeled you as potentially diabetic. Obstetricians and pediatricians often test mothers who deliver large babies, and this sometimes leads to the labeling of these women as "latent diabetics," "subclinical diabetics," "chemical diabetics" and "symptomatic diabetics."

What does all this mean? Some physicians regard such findings with great seriousness, often requiring further testing and, sometimes, treatment. If you want to see the other side of the coin, you may wish to consult the seventh chapter of "Presymptomatic Detection and Early Diagnosis" by Drs. Sharp and Keen (Williams and Wilkins). Let me share a little of that chapter with you: "There is a strong body of opinion that holds that, for many cases of diabetes found in surveys, there is little justification in disturbing their peace of mind by making the diagnosis, and that treatment is an unnecessary burden...In a study of established patients attending two London diabetic clinics, vascular changes in the retina, proteinuria and cardiovascular disease were found no less fre-

quently among asymptomatic diabetics in whom diagnosis had been made by chance, than among those with a symptomatic onset...There is a dearth of satisfactory evidence, even in established diabetic patients, that those whose blood sugar levels are brought down by vigorous treatment do better in the long run than patients exposed to less energetic management."

There seems to be little question that diabetes can cause heart disease and blindness. Not so well known is some research reported at a meeting at UCLA sponsored by Research to Prevent Blindness, Inc., which demonstrated that insulin itself, through its production and sensitizing antibodies, may contribute to the development of diabetic eye disease.

Finally, even though diabetes-detection drives abound, you should be aware of the considerable dangers of overdiagnosis and overtreatment. Dr. Russell L. Poucher, who in 1975 was president of the Southern California region of the American Diabetes Association, has said, "One-third of the patients I see are not diabetic and never have been." And he proceeded to list the pitfalls of diagnosis, including drugs such as cortisone, birth control pills, diuretics, coffee and starvation diets which all may produce falsely positive glucose tolerance test results.

Dr. Arlen Rosenbloom of the University of Florida College of Medicine at Gainesville has stated that the most common error in the care of children and adolescent diabetics is insulin overtreatment.

Your questions are good ones, and I hope these references will provide a starting point for your self-education on diabetes which will enable you to properly evaluate the advice you receive from physicians.

Q About two years ago, I began having serious stomach pains with bloody diarrhea. My doctor sent me to the hospital for sigmoid and barium tests, and the diagnosis was colitis. Subsequently, I've been placed on all kinds of medication--Azulfidine, Valium, Prednisone, ACTH shots, Cortenema, Sinequan, Lomotil and Dyazide. I don't get any better, and a gastroenterologist has even been called in. Doctor, please tell me what this is all about.--M.M.

Q I have been told I have an irritated colon. Even though I have been reassured the problem won't kill me, I am uncomfortable most of the time. I often have severe pains in my right side below the rib cage.

These began about one year ago, approximately one month after I stopped taking tetracycline for acne. I had taken the antibiotic for a year, and during that time my skin cleared beautifully, and my general health improved. Can tetracycline be responsible for the colon condition?

A pharmacist friend told me that this drug often kills good bacteria that live in the intestinal tract, and loss of this bacteria makes the area vulnerable to infection. If that's true, will my colon return to normal?--Mrs. B.D.

A *No relief from colitis*

Your two letters indicate the problems both doctors and patients face when they treat a disease with chemicals. Tetracycline and other antibiotics long have been known to have effects on the normal intestinal tract, and within the last two years, tetracycline has been identified as having negative effects on tissue levels of Vitamin C.

As far as drugs used to treat colitis, a distinguished professor of medicine, Dr. Joseph B. Kirsner, who taught me gastroenterology in my student days at the University of Chicago, wrote an article in the August 1976 issue of Drug Therapy that addresses itself to this problem. Dr. Kirsner cites a Johns Hopkins study showing that drug-associated

disease was responsible for 5 per cent of all admissions to that hospital, and 30 per cent of those patients developed a second drug reaction during their hospitalizations. Most of these patients were being treated for gastrointestinal conditions that included ulcers and ulcerative colitis.

Almost all the drugs mentioned in your two letters are implicated in Dr. Kirsner's paper as producing symptoms that often cause the patient's condition to worsen. Also mentioned are Butazolidin alka, Dilantin, antihypertensives, Indocin, Atromid-S (which causes a tenfold increase in the incidence of gallstones), Elavil, Thorazine, antihistamines and aspirin (responsible for many cases of gastrointestinal bleeding).

I wish Dr. Kirsner's article could find its way into the hands of the many people who are plagued by gastrointestinal problems. He states that the aware physician can help prevent and eliminate many of these drug-induced diseases so that comments such as the following won't have their ironic significance:

Cured yesterday of my disease,
I died last night of my physician.
Matthew Prior (1664-1721)

I am writing this in response to your answer to the individual who was not responding to treatment for his colitis and the patient who developed an "irritated colon," possibly secondary to tetracycline.

Antibiotics such as Azulfidine, corticosteroids, Adrenocorticotropin and sedatives, as well as anti-diarrheal and anti-spasmodic agents, form the basis of the management of patients with ulcerative colitis. Unfortunately, we do not yet know the etiology or pathogenesis of ulcerative colitis or Crohn's disease; for this reason, all patients with inflammatory bowel disease do not respond to every type of medical management. This does not necessarily imply that physicians necessarily are doing a bad job because of management failures.

With regard to the patient who developed an "irritated colon" following use of tetracycline, it is true that a number of antibiotics including tetracycline, lincomycin, clindamycin and ampicillin can cause diarrhea and a colitis known as pseudomembranous colitis. The patient in the letter was prescribed tetracycline for a skin condition that I assume was acne, and there was good response. I have confidence that this patient's physician prescribed tetracycline in good faith and felt that the benefits of using the drug for the skin condition outweighed any possible risk. The fact that the patient developed side effects secondary to tetracycline does not imply that the physician was doing a disservice to his patient.--S.Y., M.D., Assistant Professor of Medicine, University of California, Davis

Management of diet and lifestyle in colitis

The letters from patients with ulcerative colitis continue to weigh down my mailman, just as I am sure that patients with this condition continue to fill up your waiting room.

Some patients seem to be helped by the drugs you mention. Others, who are not helped, face the prospect of having most of their gut removed and having a colostomy bag substituted.

The fact that doctors prescribe tetracycline in good faith does not help patients who are damaged by this potent antibiotic. The doctor gets an "A" for effort but a failing grade for results. The road to hell is paved with good intentions, Doctor. God only knows how many drugs physicians are now prescribing, with the best of intentions, that may have lethal results. Will we never learn?

Perhaps you and I should call attention to a book, "Triumph Over Disease by Fasting and Natural Diet" (Arco, $8.95), by Dr. Jack Goldstein, a podiatrist. Dr. Goldstein, a sufferer from ulcerative colitis, was treated by the highest-quality physicians. When medical management was exhausted, the doctors recommended total colectomy. Dr. Goldstein instead turned toward far-reaching changes in both diet and lifestyle, the results of which can be seen on the book's dust jacket--a healthy-looking Dr. Goldstein perched on a bicycle.

While this demanding kind of management does not apply to every patient, it certainly seems that you and I and all physicians treating ulcerative colitis patients should include this book on the reading list we recommend to them.

Potpourri

I just found out that having silver nitrate drops put into a baby's eyes directly following birth can have serious consequences.

I know nothing about this process, and I'd never even heard of it. But a friend who told me about it says it's done because the doctors assume the mother has V.D. She says an expectant mother should get in writing from her doctor that she is clean and pure and has absolutely no traces of V.D. Then the doctor wouldn't have to place the silver nitrate drops in the baby's eyes, and if he did, the mother could sue the doctor. Is my friend right?

Just what are silver nitrate drops, what do they do, what are they used for, how are they harmful, and what do they cause?--Mrs. B.P.

Why silver nitrate in baby's eyes?

Doctors in the United States routinely place silver nitrate drops--a caustic chemical agent--into the eyes of every newborn infant since they assume every mother has gonorrhea. They do not test the mother for gonorrhea, claiming that the test has a certain margin of error and therefore "just to be on the safe side" they behave as if every mother harbors this venereal disease.

Doctors have gone to every state legislature to make sure that this practice is mandated into law. In my book, "Confessions of a Medical Heretic" (Contemporary Books, $9.95), I refer to this ritual as the holy water of the religion of Modern Medicine. The practice poses several problems. First, it doesn't always work, since silver nitrate is far from being 100 per cent effective in preventing gonorrheal eye infection of the newborn. In the event that the baby does develop gonorrheal ophthalmia, he must then be treated with penicillin or another potent antibiotic. Second, silver nitrate causes a chemical conjunctivitis in 30 to 50 per cent of babies, so that their eyes fill up with thick pus, making it impossible for them to see for the first week or so of life.

During the first year of life, silver nitrate may produce blocked tear ducts which necessitate difficult surgical intervention. Finally, some believe that the high incidence of myopia and astigmatism in the United States may be related to the instillation of this caustic agent into the delicate, tender membranes of the eyes of the newborn.

Certainly the letter you propose to write should satisfy the doctor. If he is truly concerned about your baby, then he may be willing to defy a state law, thus opening up the possibility of a long-overdue court decision. Admittedly, this kind of action requires a certain amount of courage, an unusual commodity, on the part of the physician.

I have advised mothers, when the obstetrician comes near their baby with those drops, to look the doctor straight in the eye and say,

"Doctor, I didn't have gonorrhea when I came into your delivery room." (If a mother thinks she might have gonorrhea, then she should so inform the obstetrician, who can properly diagnose and treat the disease long before the time of delivery.) The father, present in the delivery room, can help protect his child by questioning and challenging the doctor. He should also be prepared to react to the physician as he would to any other male who insultingly implies that his wife has a venereal disease.

Now that modern medicine has abandoned the routine physical exam, the routine annual chest x-ray, the routine annual Pap smear, and the routine repeat Caesarean section, the routine use of silver nitrate drops should be the next to go. Attitudes such as you expressed in your letter will hasten that day.

Can anything be done to cure my husband's low sperm count? Our doctor suggests artificial insemination, and we need a second opinion desperately. We have no children.--Mrs. E.D.

Low sperm count and artificial insemination

First, it is important that your doctor determine whether your husband's low sperm count results from irreversible causes such as his mother having been prescribed DES during her pregnancy. Or perhaps his infertility derives from reversible causes, including prescription drugs. For example, SmithKline's Tagamet, a leading drug for peptic ulcer, can cause a drop in the sperm count in males.

Your first step is to carefully explore with your doctor all prescription drugs your husband recently may have taken which might be responsible for his infertility. Second, you and your husband should carefully investigate the known strategies for improving his fertility, including nutritional factors, exercise, clothing, temperature factors, and timing of sexual intercourse.

Artificial insemination should be considered only as a last resort, expecially if the semen specimen comes from someone other than your husband. If you decide to go this route, you must carefully question your doctor concerning the source of the specimen. Even though donor specimens usually come from medical students, those students (just like anyone else) may harbor hereditary and familial conditions which you should know about. Make sure the doctor uses the donor's specimen exclusively for you, rather than possibly sharing it with several other women in your age group who may live in the same general neighborhood.

As you can see, artificial insemination is a tricky medical procedure which deserves the most thoughtful deliberation by you, your husband, your doctor, and your clergyman.

(From Chicago Medicine, a publication of the Chicago Medical Society)

"A CMS [Chicago Medical Society] letter expressing displeasure was sent to Crain's Chicago Business concerning a cartoon and headline used with a recent article entitled, 'How MDs Set Fees That Make You Sick.' The CMS letter emphasized that both the headline and cartoon 'were inappropriate and in bad taste.' CMS particularly objected to the cartoon, which pictured an operating surgeon as a masked gunman."

Another View

by Marian Tompson
Executive Director, Alternative Birth Crisis Coalition

According to Laverne's description, Irene looked like a zombie: "She just lay in her hospital bed, hardly responding at all. She could barely function." Irene, Laverne's sister-in-law, had been confined to the psychiatric unit of a Chicago hospital for almost three months. She was admitted on the advice of a psychiatrist whom the family had consulted because of her deep depression. Since she had refused electric shock therapy, her treatment was limited to daily doses of tranquilizers and visits with the health team. But she was not getting any better, and the family was deeply concerned about what to do next.

Trying to elicit any information that might help with this decision, Laverne asked Irene to describe exactly what had been troubling her in the weeks before she was hospitalized. Surprisingly, Irene began listing many of the same symptoms Laverne had experienced years before, symptoms later diagnosed as having been caused by low blood sugar. Not only was Irene not feeling well and fainting frequently, she could not seem to convince anyone that something really was wrong with her. Her depression seemed to stem from feeling so sick and not being able to get any help. At this point, the family took her to the psychiatrist who suggested hospitalization.

Hearing this, Laverne decided on a course of action. First, she took Irene out of the hospital and into her own home. Then she set up an appointment for her with Chris Bytnar, a nutritional consultant. Chris works under the premise that the body will heal itself if we correct its imbalances. Using information gathered from Irene's medical history, diet history, and hair analysis and iridology reports, Chris recommended a program tailored to the patient's specific needs, including a balanced diet, some food supplements and exercise.

"For years people with hypoglycemia were put on a high protein diet," Chris explained, "but we know now that this was a big mistake." The diet Irene was placed on is based on research done at the University of Kentucky. It is basically a high complex carbohydrate fiber diet with 60 to 70 per cent of the calories coming from complex carbohydrates, 15 per cent from protein and 15 per cent from fat.

"It's how a food enters the bloodstream that makes the difference," Chris told me. "Brown rice, for example, enters the bloodstream slowly while sugar or refined foods enter fast, causing an extreme rise and fall in the blood sugar level. This may cause bothersome symptoms like dizziness, drowsiness or a craving for something sweet." So Irene's diet was changed to one which included lots of whole grains, brown rice, beans, raw and steamed vegetables, salads and small amounts of meat. Fruit juices, dried fruits and all refined foods were restricted.

After just a few weeks on this program, Irene was literally a new woman. The symptoms caused by her low blood sugar had disappeared. When I talked with her on the phone today, she sounded just fine. "Thanks to Laverne," she reminded me. "Without her help I would never have gotten well." (Anyone wishing more information on the high complex carbohydrate fiber diet can contact Dr. James Anderson, University of Kentucky Diabetes Foundation, University of Kentucky Medical Center, 800 Rose St., P.O. Box 811, Lexington, Kentucky 40536.)

Male Practice: How Doctors Manipulate Women, Dr. Mendelsohn's latest book, has just been published by Contemporary Books ($10.95).

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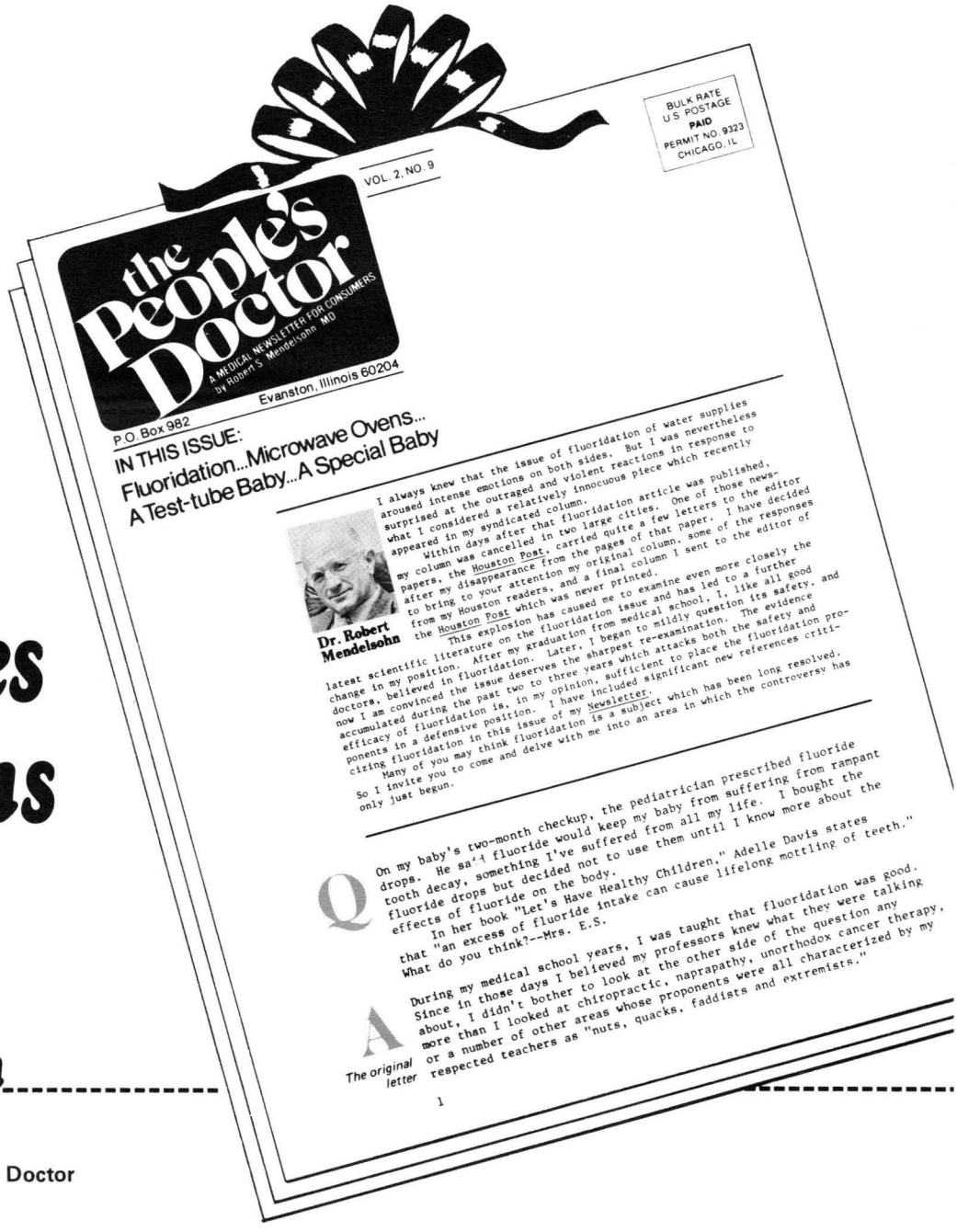

The original letter

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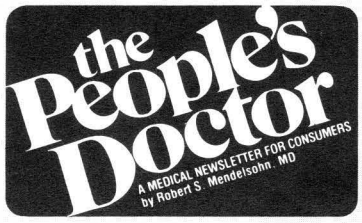

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