the People's Doctor

A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

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IN THIS ISSUE:

Diabetes

Dr. Robert Mendelsohn

Diabetes, according to conventional medical thought, is a condition which once acquired lasts a lifetime. It is by no means the only such condition in medicine. Doctors consider high blood pressure and arthritis as lifelong conditions which may have remissions and exacerbations, but which never disappear. Psychiatrists hardly ever label schizophrenic patients as cured, instead discharging them as "schizophrenia--in remission." Yet, if a hypertensive patient who was once on antihypertensive drugs loses weight and regains normal blood pressure, why shouldn't we state he is cured of high blood pressure? If an arthritic patient, through exercise and other changes in lifestyle, has a return to normal joint functioning, why shouldn't we state he no longer has arthritis? If a diabetic who once was on insulin returns to a normal condition (clinically as well as on blood tests) through proper attention to diet and abandons his insulin treatment, why shouldn't we state he once had diabetes. After all, even cancer patients are considered cured if they survive for five years.

What does it all mean? Is the terminology an attempt to make healthy people think that somewhere deep down inside their bodies lurks a continual threat? Is this a ploy to keep people forever dependent on doctors? In the case of cancer, is the use of the word "cure" an attempt to justify the enormous sums of money spent on research?

After reflecting on the implications of this kind of lifelong labeling, I think the best interests of my own patients will be served if I depart from conventional medical terminology and instead tell patients who have discovered the technique of living normally without medications good news--"You had hypertension. You had arthritis. You were schizophrenic. You had diabetes. But you're perfectly all right now."

Diabetes and oral antidiabetic drugs

Q My diabetes mellitus was controlled by Diabinase for about three years. Recently, my physician terminated the drug, and he now is experimenting with a 1,500-calorie diet. Is this sound? I am 47 years old and am otherwise in reasonably good health, although I do have hypertension.

Also, is there a way for a diabetic to have an occasional alcoholic drink? Most of what I've read and heard simply says "No alcohol."--C.P.

A Your doctor sounds like a good guy for two reasons. First, he took you off the oral antidiabetic drug; the evidence against these chemicals is growing year by year. Second, he used the word "experimenting" in relation to your 1,500-calorie diet, and if this particular diet does not prove optimal, presumably he will experiment further with both the quality and quantity of your food intake.

As for alcohol, I hope your doctor and I continue to agree. I usually advise diabetics (as well as everyone else) to restrict their intake of alcoholic beverages. If you pay careful attention to your diet, you may be able to enjoy an occasional glass of beer or wine. If you cannot limit yourself in this fashion, then refraining from alcohol completely may be the best course for you to follow.

Q I have a mild case of diabetes, so mild I can do without insulin. I was taking the oral antidiabetic drug Diabinase, but for the past three months I have deliberately given up the medication and have gone off my diet. Nothing has happened, and I feel fine. True, I spill sugar, but I feel great. So why should I continue doctoring for this disease? My doctor just smiles and says, "Follow your diet," but I see no reason why I should stick to a diet. No book on diabetes seems to answer this question for me. Maybe you can.--Mrs. M.K.

A *Diabetes and diet*

There are plenty of controversial issues in diabetes, one of them being the difference of opinion surrounding oral antidiabetics. Questions as to when to use insulin, how much to use and how close to normal the blood and urine levels of sugar should be are hotly debated.

Yet there is almost unanimous agreement among doctors that the usual diets recommended for diabetics today should contain those nutritive elements in quality and quantity that would be health-producing for most people, diabetic or otherwise.

One book that DOES deal with your question is "The Encyclopedia of Common Diseases" by the staff of Prevention magazine (Rodale, 1976). Chapter 102 is entitled "What Is a Diabetic Diet? Delicious!"

Q I want to learn how you feel about the use of water pills. I am a short, chubby woman who has had diabetes for approximately 20 years. I'd like to lose about 10 pounds to see if the diabetes would be easier to control (I'm 60 years old, 5 feet tall and weigh around 135 pounds). The doctors I've asked about using water pills tell me not to because they might cause kidney problems. I feel fine now, but I'd like to lose weight. What is your advice?--E.B.

A Your doctors are giving you good advice by cautioning you against the use of diuretics. For example, thiazide drugs such as Diuril may cause insulin requirements in diabetic patients to increase or decrease, and latent diabetes mellitus may manifest itself while a person takes this class of diuretic (and antihypertensive).

But you're also giving yourself good advice when you suggest that weight loss may help your condition. So why don't you and your doctors get together and come up with a diet that will help you reach your desired goal?

According to a five-year study at Chicago's Hines Veterans' Administration Hospital, adult diabetics who are of normal weight need not be confined to a rigid diet dictated by conventional medical standards. The study, reported in the Chicago Sun-Times (January 8, 1979), was conducted on 53 outpatients of normal weight, half of whom were allowed unmeasured diets while the remainder followed standard prescribed diets. The results of the study showed that those given their choice of food

picked almost the same foods as the men presumably controlled by standards established by the American Diabetes Association. The first group consumed the same amount of calories and their meals had the same composition of carbohydrates, fats and proteins as did those in the second group.

The doctor who headed the study, Carlos Abraira, M.D., warns, however, that "Under no circumstances should overweight diabetics be allowed an unmeasured diet."

Q After taking blood-sugar tests, my doctor told me I am a borderline diabetic. When I asked him what that means, he said, "It's nothing to fool around with." He advised me to lost 20 pounds (I am 5 feet 4 and weigh 150 pounds), and he put me on a diabetic diet.

Would you explain what "borderline diabetes" means? Does it mean that if I lose 20 pounds and stick to my diet, I will no longer be a diabetic?--Mrs. B.C.

A I wish I could say unequivocally that "diabetes is diabetes." But as your letter indicates, there is much confusion in terminology and understanding of this disease.

"Borderline" diabetes

Doctors talk about borderline diabetics, potential diabetics, latent diabetics, sub-clinical diabetics, chemical diabetics, pre-diabetics and asymptomatic diabetics. Different doctors often have different definitions and different kinds of management for each of these categories.

It is hard to argue with the generalization that a disease is more likely to be reversible in its early stages, but this rule may not apply to diabetes. There are great debates, even about established diabetic patients, as to whether vigorous treatment of blood-sugar levels produces any better results (preventing damage to the eyes, kidneys, vascular system and nerves) than does less energetic management. In their book "Presymptomatic Detection and Early Diagnosis" (Williams and Wilkins), Drs. C. L. Sharp and Harry Keen cite a study of established patients who attended two London diabetic clinics. In this study, changes in the retina, kidneys and cardiovascular system were found just as frequently in asymptomatic diabetics, in whom the diagnosis had been made by accident, as in patients with recognizable symptoms.

If this is true, then we doctors must be very careful about unnecessarily disturbing our patients' peace of mind by diagnosing "early cases." The implications of a positive diabetes test affect one's job and life insurance as well as one's confidence in the future.

In your case, regardless of whether borderline diabetes is or is not a problem, it is hard to quarrel with your doctor's advice to lose weight and cut back your intake of sweets. There is no way to remove the diagnostic label from your consciousness, but I do hope your physician will agree that it should not be used as a barrier to your future employment, admission to schools or purchase of insurance.

Q About six years ago, when my husband was 42 years old, he began to develop a tired, burning sensation in his feet and legs. This condition has gotten progressively worse, and this once-active, energetic man now leads a sedentary life because of constant pain.

My husband has been to many doctors and clinics. He has had complete workups at Stanford University Hospital, and he has tried acupuncture and chiropractic treatments for this condition known as "peripheral neuropathy."

In January, 1978, an internist discovered a mild case of diabetes. He thought the diabetes might be the cause of my husband's problems, but this doctor held out no hope for any relief, saying he has many patients with the same complaint.

My husband now is on a sugar-free, 2,000 calorie-per-day diet supplemented by vitamins and minerals. We read all of Adelle Davis' books as well as others on nutrition.

We recently read about a Navy doctor who was having success in treating patients suffering from diabetic neuropothy by using the tranquilizer Prolixin and the antidepressant Elavil. I took the article to my husband's doctor who, although he was skeptical, said he was willing to try the drugs one at a time. He prescribed 30 mgs. of Elavil daily, telling us not to look for any changes for at least three weeks. My husband took the drug for three weeks with no relief whatsoever. After five weeks, the doctor said we could increase the dosage to 50 mgs. daily, but he was not enthusiastic about it, and my husband quit taking Elavil altogether. I suppose Prolixin will be next.

Can you suggest where my husband can get help? The doctors feel he'll just have to live with the pain, but believe me, Dr. Mendelsohn, in his condition, he is barely living.--Mrs. L.C.

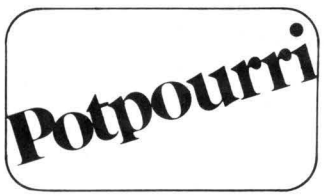
Diabetes and peripheral neuropathy

I am very impressed with the search you have made, using both conventional medicine and alternative approaches to find relief for a condition which modern medicine regards with pessimism.

Since every freshman medical student learns the basic principle "primum non nocere"--the first rule is to do no harm, I would be very careful about the drugs that Navy doctor is prescribing. Merck Sharp & Dohme's Elavil lists among its adverse reactions numbness, tingling, strange sensations of the extremities (paresthesias), and believe it or not, peripheral neuropathy! Squibb's Prolixin also lists a large variety of nervous system symptoms among its adverse reactions. Any patient for whom these drugs are prescribed should obtain the full information about their side effects as well as the possible interactions.

I applaud your exploring books on nutrition, but I hasten to add (and she would have been the first to agree) that Adelle Davis may not be the last word. In your readings on nutrition, have you considered Roger Williams, Paavo Airola, Mark Bricklin, and Michio Kushi? Finally, I believe a reasonable exercise program is a must. Because of your husband's constant pain, a physiotherapist or a physiatrist (an M.D. specialist in physical medicine and rehabilitation), should be consulted.

I will not give up hope on your husband, and neither should you or his doctors.



The U. S. Supreme Court has ruled that a teenager may have an abortion without her parents' consent. Regardless of one's moral views on abortion, it strikes me, speaking as a physician, rather strange that this is the only surgical procedure for which a minor need not obtain parental consent. What about a teenager's right to control her own tonsils?

I've long suffered from migraine headaches, and my doctor has now prescribed Inderal. I've heard of this drug being given for high blood pressure, but I don't know anything about its being given for headaches. Is it safe? What are the side effects?--C.V.

Migraine headaches and Inderal

For several months now, five page advertisements have appeared in the medical journals "Announcing Inderal for prophylaxis of migraine." Inderal, we are told by its manufacturer, Ayerst, "may provide a solution for many migraine sufferers."

As you point out, this is the same Inderal that's often prescribed for patients with high blood pressure. So naturally, the side effects are the same, regardless of the condition for which you're being treated. Here's the information you've requested:

The prescribing information on Inderal (propanolol) includes almost three full columns of contraindications, warnings, precautions and adverse reactions. There are seven contraindications (reasons NOT to take Inderal) ranging all the way from hay fever to heart failure. The warnings include problems of interaction with other drugs such as digitalis, with special warnings for patients with and without a history of heart failure or thyroid disease, patients undergoing surgery and anesthesia, and patients with bronchitis, emphysema or diabetes, as well as pregnant women. The precautions mention the need for certain laboratory tests "as with any new drug given over prolonged periods."

The long list of adverse reactions is divided by systems (cardiovascular, central nervous system, gastrointestinal, allergic, respiratory, hematologic) and a miscellaneous group which includes hair loss. A final section gives the expected changes in certain blood tests in patients on Inderal.

The dosage of this drug not only must be individualized to the patient, but is different for each indication. Dosage instructions take up almost a full column.

Of major concern is the black-bordered box right at the beginning of the prescribing information which states in capital letters: BEFORE USING INDERAL, THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA) AND THE PHARMACOLOGY OF THIS DRUG. Let's hope your doctor qualifies.

Q

My mother is taking the antihypertensive Hydrodiuril, which her doctor says she must stay on for the rest of her life. She is now complaining about extreme fatigue--she complains she's so tired in the mornings that she can barely get up and move about. I suggested she might consider going off the antihypertensive, but she says that she doesn't want to suffer a stroke which the doctor insists will happen if her blood pressure shoots up again. What is your advice?--Chicago Reader

A

Fatigue from antihypertensives

It is unfortunate that your mother's doctor has chosen to make your mother more frightened of the remote possibility of a stroke than of the real risks of her medication. It is equally unfortunate that she did not have access to the same prescribing information as did her doctor. Had she read this, she would have learned that one of the mechanisms by which Hydrodiuril acts is by increasing the excretion of sodium and chloride. Along with these electrolytes goes water. She would also have learned that, despite the omniscient attitude of some doctors, the prescribing information clearly reads: "The mechanism of the antihypertensive effect of thiazides (Hydrodiuril belongs to this class) is unknown." But even though doctors don't know why it works, they certainly should know what it can do to the patient. Under "precautions" in the prescribing information, the warning signs of electrolyte imbalance include weakness, lethargy, drowsiness, and muscle fatigue. (Sounds like your mother, doesn't it?) That is why "All patients receiving thiazide therapy should be observed for clinical

signs of fluid or electrolyte imbalance" and "Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals."

These few sentences are just a hint of the two columns of contra-indications, warnings, precautions, and adverse reactions of this widely used drug. It is time for your mother to return to her doctor, preferably having caught up on her reading beforehand, to find out what he intends to do about investigating the obvious possibility that his own prescription is causing her present symptoms.

A favorite cliche of doctors to patients with high blood pressure used to be, "You'll just have to learn to live with it." Since the advent of antihypertensives, this catchy phrase has been replaced by, "You'll have to take this medicine the rest of your life." Remind your mother's doctor that the prescribing information ends with the advice, "Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn."

My daughter suffered a traumatic experience about a year and a half ago, and because she had what was explained as "acute anxiety," she was put on three Valium (5 mg) daily.

She has tried to get off these tranquilizers, but each time she attempts this, she goes into a deep depression and is unable to function. She has cut down to two tablets twice a day, one in the morning and one at night. With this dosage, she is able to carry on a normal life and hold down a responsible job.

How can she be free of Valium without being admitted to a hospital? She doesn't even want anyone to know she takes this drug. Thank you for any help you can give.--Mrs. E.M.C.

Valium revisited

While Valium is one of the all-time best sellers in the tranquilizer field, controversy still exists about this medication's effectiveness.

Since your daughter has been taking Valium for a long time, I presume her doctor has been ordering periodic blood counts and liver function tests since a decrease in the white blood count and appearance of jaundice are listed among the drug's adverse reactions. Also of interest are changes in the electroencephalogram (EEG) patterns of patients during and after Valium therapy.

As I pointed out earlier, Valium's indications closely parallel the adverse reactions that may result from taking it.

I am particularly concerned about your daughter's episodes of depression since Valium acts as a depressant on the central nervous system. One begins to wonder how many of her present problems are a result of the condition and how many a result of the treatment.

Hospitalization certainly is not the ONLY alternative to Valium. Although you have not provided details of your daughter's traumatic experience, the doctor's diagnosis of acute anxiety should be reevaluated after so long a period of time. If the diagnosis changes, so can the treatment.

The July 6, 1979 issue of the Journal of the American Medical Association headlines its Medical News section, Side effects of cimetidine use coming under scrutiny. Reporting on this anti-ulcer drug which I have repeatedly warned about in this Newsletter, JAMA presents information from a recent FDA hearing conducted at the request of the drug's principal manufacturer, Smith Kline & French. Cimetidine

(Tagamet) therapy recently has been shown to be followed by substantial reductions in sperm counts and has been linked to gastric cancer.

In what the JAMA article referred to as a remark that was cryptic in nature, the FDA concluded that "a clear statement of the risk of cimetidine must appear (in the prescribing information)." Information presented at the hearing included "the well-known fact" that cimetidine can mask undiagnosed gastric carcinoma by easing the symptoms of malignancy. A common side effect of the drug was shown to be gynecomastia (swelling of the male breast).

Not surprisingly, Tom Davis, M.D., an SK&F vice president, made the following comment, "It is inconceivable that someone in his 40's or 50's with chronic ulcer disease is going to worry about a slight reduction in sperm count." ("Inconceivable" is exactly the right word.)

A California appellate judge has ruled that a patient's right to privacy outweighs the right of a state agency to examine hospital records. In a 17-page opinion, Justice Robert O. Staniforth of the Fourth District Court of Appeals overturned a lower court's order to release the records of five patients to the California Board of Medical Quality Assurance. Judge Staniforth wrote, "The state of a person's gastrointestinal tract is as much entitled to privacy from unauthorized public or bureaucratic snooping as is that person's bank account, the contents of his library, or his membership in the NAACP." (American Medical News, June 22, 1979)

Now, how about extending this concept of privacy to enable a patient to inspect his own private records and x-rays.

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Your questions about the medical problems that trouble you most will be answered by Dr. Mendelsohn. Please send your questions to: The People's Doctor, 664 N. Michigan Ave., Suite 720, Chicago, Ill. 60611.

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Another View

by Marian Tompson
President, La Leche League International

Bill discovered he had diabetes 18 years ago when a routine insurance exam revealed high sugar levels in his blood and urine. He was in his mid-30's at the time, and since he had no symptoms, he found it hard to believe he really had the disease. So he decided to do nothing about it. True, there was a history of diabetes in his family, but he had noticed that although all his relatives so afflicted were under a doctor's care, some of them did live to be old but others died young. "Laziness probably had something to do with my decision, too," he admitted.

Last year, Bill found himself losing weight and tiring easily. He experienced difficulty in passing urine and felt a need to urinate frequently. In a matter of weeks, he found himself hospitalized with an acute surgical emergency involving a prostate condition that flourished in the presence of diabetes. Tests revealed high blood sugar, and he was immediately placed on insulin.

Now that he was symptomatic, Bill decided it was time to be serious about his condition and turned to nutrition to correct it. He practically abandoned the use of white sugar, decreased his use of white flour and foods containing additives and preservatives, decreased his intake of dairy food and meat and ate more nuts, seeds, beans, and soybean products and rice. He also took insulin, in large doses at first, with gradual reductions as he recovered and the sugar levels in his blood and urine diminished. He had always enjoyed moderate sports activities and continued these as usual.

Over a period of four or five months, the needed dose of insulin became so low that he decided to discontinue it, a decision his doctor agreed with. He was particularly pleased because he had become a little leery of insulin, having read somewhere that eye trouble in diabetes was related to long-term administration of insulin to experimental animals, and findings on the dangers of oral anti-diabetic drugs were no more reassuring. He has stayed on his diet which has become a way of life for him, and he occasionally has his blood levels monitored.

Is the precept of "once a diabetic always a diabetic" any more valid than "once a Caesarean always a Caesarean"? If Bill stays on his diet, and if his blood sugar remains low, is there any good reason why he cannot, as Dr. Mendelsohn suggests in his introduction, consider himself cured? This seems to him a much more healthy attitude than living in fear that the demon of diabetes will strike again.

So this is how Bill handled his diabetes. It's certainly not the orthodox way. But knowing him as a warm and caring person whose enjoyment of life is contagious, I thought there might be some merit in sharing it with you.