



FABULOUS FRUIT: All these fruits are sources of vitamin C. PHOTOS.COM

Vitamin C helps prevent gout

By DR. JOHN BRIFFA

Gout is a condition caused by elevated levels of uric acid in the body. If levels are high enough, uric acid can end up crystallizing in one or more joint, which typically causes intense pain and inflammation.

Gout quite often affects the ball of the foot (the major joint of the big toe), but the condition can affect any joint. Conventional medical treatment is centered on painkillers for attacks of gout, as well as drugs that can lower uric acid levels by speeding its elimination from the body through the kidneys (known as having a uricosuric effect).

Conventional drugs are apparently not the only agents that have a uricosuric effect. Previous studies have found that vitamin C also does this [1-4]. Recently, we saw the publication of a study that assessed the relationship between vitamin C intake and risk of gout in almost 47,000 men [5]. All the men had no history of gout when they entered the study. Their intakes of vitamin C (via diet and supplements) were assessed every 4 years over a 20-year period.

Risk of gout was found to be lower in individuals with higher vitamin C intake. Compared to individuals with a total vitamin C intake of less than 250 mg per day, those with total intakes of 500-999 mg per day had a 17 percent reduced risk of gout. For intakes of 1,000-1,499 mg and 1,500 mg or more per day, the risk of getting gout was down by 34 and 45 percent, respectively.

The authors of this study also looked at the relationship between amounts of vitamin C ingested in supplement form only and risk of gout. Here again, higher supplemental levels were associated with a

reduced risk of gout. Compared to those who did not supplement with vitamin C, those supplementing with 1,000-1,499 mg and 1,500 mg or more of vitamin C per day were found to be at 34 and 45 percent reduced risk of gout, respectively.

These results suggest that vitamin C, either from diet or supplements, is associated with a reduced risk of gout. This study is epidemiological in nature and cannot be used to conclude that vitamin C reduced the risk of gout. However, the fact that vitamin C is known to be uricosuric does make a genuine protective effect likely.

Another piece of research, which provides supporting evidence for this, is a randomized controlled trial in which individuals were treated with 500 mg of uric acid or placebo over a two-month period [6]. Vitamin C, compared to placebo, led to a statistically significant reduction in uric acid levels (the average fall in uric acid levels in this study was 0.5 mg/dL, which is equivalent to about 30 micromoles/liter).

These results suggest that vitamin C has real potential to help prevent gout. My tendency in practice is to use doses of about 2,000 mg per day (as 1,000 mg taken twice a day).

Individuals who should consult their doctors before supplementing with vitamin C include those with the condition glucose-6-phosphate dehydrogenase deficiency, those suffering from conditions in which iron levels are elevated in the body, such as hemochromatosis or hemochromatosis (vitamin C enhances iron absorption), and those with a history of kidney stones or kidney failure.

References:
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Carbohydrates and infertility in women

By DR. JOHN BRIFFA

Infertility is estimated to affect up to 15 percent of couples. While the underlying issue here can be with either the woman or the man (or both), one relatively common cause of infertility relates to a problem with ovulation (the normal release of an egg from the ovary about every month).

Sometimes, problems with ovulation can relate to a condition known as polycystic ovarian syndrome (PCOS). Individuals with this condition often have problems with sugar and insulin regulation in the body. A mainstay of medical treatment for PCOS are drugs designed primarily for diabetes. Treating women with PCOS with these drugs has been found to improve ovulatory function.

Other evidence has linked higher levels of HbA1c (a measure of blood sugar control over the last two to three months) and reduced fertility.

These lines of evidence suggest that high levels of blood sugar-disruptive carbohydrates in the diet might be bad news for female fertility.

The extent to which a food raises blood sugar can be measured and is expressed as its glycemic index (GI). However, the extent to which a food disrupts blood sugar and insulin will depend not just on its GI, but how much we eat of it. One way to get an idea of the overall effect of a food is to take its GI and multiply it by the amount of carbohydrate found in a standard portion of food. Divide this by 100 and we have a measurement known as the glycemic load (GL).

In a recent study published in the European Journal of Clinical

Nutrition, researchers at Harvard Medical School and the Harvard School of Public Health assessed the relationship between intake of dietary carbohydrate in women's diets and their risk of fertility related to problems with ovulation (ovulatory infertility). [1]

The results of this study found that compared to women eating diets of lower GL values, those eating diets with the highest GL were 92 percent more likely to suffer from ovulatory infertility. Total carbohydrate intake was also associated with risk of ovulatory infertility, with highest intakes associated with a 91 percent increased risk compared to the lowest intakes. GI was also associated with enhanced risk, but only in women who had not had children.

One explanation put forward by the authors for their results is that a high-carb diet might displace certain fats in the diet that might have positive benefits for fertility (including saturated and mono-unsaturated fats).

Another explanation is that carbohydrates can induce biochemical and physiological effects that may directly hamper fertility.

This study adds yet another potential reason to be wary about over-consuming carbs, particularly those that tend to disrupt blood sugar and insulin levels.

References:
Chavarro JE, et al. A prospective study of dietary carbohydrate quantity and quality in relation to risk of ovulatory infertility, European Journal of Clinical Nutrition 2009; 63:78-86

Dr. John Briffa is a London-based physician author. His Web site is dbriffa.com

Prostate cancer: Seven points

By W. Gifford-Jones, M.D.

One. Benjamin Disraeli, Queen Victoria's Prime Minister, once remarked, "There are three kinds of lies: lies, damned lies, and statistics." If he had been a doctor, Disraeli could have been referring to the PSA test for prostate cancer. For instance, the New England Journal of Medicine has just reported a European study that showed that this blood test cut the death rate of this disease by 20 percent. But this impressive figure refers to a relative reduction in deaths.

There's another way to look at the reduction in the number of deaths. In the study, 162,000 men were followed for 10 years. Of those given the PSA test, 261 died, compared to 363 deaths of those who received routine care. A difference of 102 deaths out of 162,000 men isn't as impressive.

Another statistic helps patients decide about the value of the PSA test. To prevent one prostate cancer death, 1,410 men have to be screened by the PSA test and an additional 48 men treated. This means that a massive screening program would have only a modest effect on mortality, and some men would get treatment and complications they didn't need.

So statistics can be misleading, or as another wise sage said, "Statistics can be used as drunken men use lampposts—for support rather than for illumination."

Two. How many angels can dance on the head of a pin? I don't know the answer to this question. Nor do I, or others, know what is the best treatment for prostate cancer. One would need the wisdom of Solomon to answer this question.

A young man who is believed to have a rapidly growing malignancy may be advised that a radical prostatectomy is the best chance for survival. For others, external radiation, implanting radium seeds in



BENJAMIN DISRAELI: His comments regarding statistics are especially pertinent regarding prostate cancer diagnosis. PHOTOS.COM

the prostate gland, or freezing the prostate by cryosurgery are better options. But at the moment, there's no one ultimate treatment that is the best for everyone.

Three. The late Dr. Willett Whitmore, a world authority on prostate cancer at Memorial Hospital in New York City, remarked, "The survival rate has little to do with treatment. Rather it's related to the biological nature of the cancer."

In other words, how malignant is the cancer? So pathologists try

to grade cancers by how fast they grow. But it's still an inexact science. This presents the great dilemma: how to treat or even not to treat prostate cancer.

Four. Hippocrates, the father of medicine, always stressed when treating the patient, "First, do no harm." This is a huge problem facing doctors who treat patients with prostate cancer.

Five. Suppose you're about 70 years old and diagnosed with pros-

tate cancer. It's sometimes better to live with the devil you know than the one you've never met. The devil you know may be a slow-growing malignancy and not destined to end your life for many years.

In the meantime, there's a good chance you will die of something else. By age 70, autopsies show that about 50 percent of males have microscopic cancer cells in their prostate glands. So remember what a world-famous urologist once remarked, "Growing older is invariably fatal, cancer of the prostate, only sometimes."

Six. The devil you don't know may be horrible complications resulting from treatment, such as impotence or urinary incontinence. Radical prostatectomy is the most frequent cause. Studies show that urinary incontinence is often under-reported because the person who wets his pants is much more aware of and embarrassed by the annoyance than the surgeon who operated.

Many patients who have contacted me over the years mention how difficult it is to live with this problem and would have refused the surgery if they had known of this possible complication.

Seven. Another wise sage said, "If you're not confused about prostate cancer, you don't know what's going on." So my advice is to try as much as possible to be informed about this disease before submitting to treatment. Like Benjamin Disraeli, cast a wary eye at statistics.

One of Harvard's most distinguished professors often stated, "If something has to be proven by statistics, it's usually wrong." I say amen to that.

Dr. Gifford-Jones is a medical journalist with a private medical practice in Toronto.
His Web site is Mydoctor.ca/gifford-jones

No future in pharma for June grads

By MARTHA ROSENBERG

When college grads don their gowns and mortarboards this June, it's as close as they will get to a mortar and pestle. The pharmaceutical industry is fighting for its life just like Wall Street—and for the same reasons.

Toxic assets. Unsafe drugs. Ponzi schemes. Safety studies that were never conducted. Indecent profits footed by taxpayers. Medicaid fraud about patent drugs. Mayday mergers? Pfizer/Wyeth, Merck/Schering-Plough. New business models after investment-banking crashed? Hello biologics and vaccines!

While the nation gasps at AIG and Fannie Mae losses, pharma is running a strong second with Merck paying out \$4.85 billion for Vioxx, Pfizer paying \$2.3 billion for Bextra (and \$430 million for Neurontin), and Lilly paying \$1.4 billion for Zyprexa.

Nor will settlements cease after March's Wyeth vs. Levine Supreme Court ruling, which found that regulator approval doesn't trump personal injury lawsuits. Expect cases over fen-phen, Baycol, Vytorin, Ketek, Avandia, Bextra, Celebrex, Prempro, Premarin, Zyprexa, Risperdal, Seroquel, Lexapro, Celexa, Cymbalta, Fosamax, Boniva, Effexor, Lyrica, Geodon, (pant, pant), Ablify, Zolof, Paxil, Prozac, Chantix, Singulair, Ambien, and Trovan to reach the courts.

Of course you can blame the Bush Administration's FDA packed with industry vets who waved their buddies' new drugs through after six-week trials for the iffy drugs. You can blame ghostwriters, "bought" doc-



tors, and direct-to-consumer disease advertising for getting them in medicine cabinets and on formularies. But it's the public that asks itself, "Do I have restless legs syndrome, social phobia, fibromyalgia, and non-restful sleep?"

Still, the days when pharma reps would drive up to the state mental hospital and just ask for the order are clearly over. (In four years, Pfizer reps made over 200 visits to Western State Hospital in Tacoma, Wash., where 118 prescriptions of controversial Geodon are written a day.)

So are the days when reps could just slide by the nursing home to see how their Seroquel, Risperdal, and Zyprexa scripts were doing—elderly warning label notwithstanding—or

collect their post-traumatic-stress-disorder veteran "dividend" from psychoactive drugs for combat and post-combat.

Gone, too are the automatic antipsychotic and antidepressant prescriptions for the poor, mentally challenged, and children on Medicaid, now that the drugs are causing diabetes, and the states are suing. Antipsychotic drugs for children under 6 have dropped by 75 percent since the state of Florida began requiring physicians to receive prior approval, according to the St. Petersburg Times.

Few third-party payers and benefits managers are cooperating with the "patent drug two-step," in which once-a-week or time-release formulations are billed as breakthroughs.

And even pharma's continuing medical education courses at universities—which "teach" doctors a sales pitch—are under the ethical microscope.

Part of the problem is pharma can't stop shooting itself in the foot.

Just as the public forgets that Merck/Schering-Plough's miracle cholesterol drug Vytorin was worthless and even harmful; that Merck's bone drug Fosamax sometimes fractured the bones it was supposed to strengthen and causes esophageal cancer and osteonecrosis; just as people were forgetting that Wyeth's hormone drug Prempro causes breast cancer, new subterfuge surfaces.

In February, New York-based Forest Laboratories was charged in U.S. District Court in Boston with illegally marketing antidepressants Celexa and Lexapro, for burying a damning FDA study, and paying Dr. Jeffrey Bostic, director of school psychiatry at Massachusetts General Hospital, \$750,000 a year to promote illegal pediatric drug uses. (FDA approved Lexapro for adolescents in March—oblivious to the Justice Department complaint. Is the FDA bipolar?)

In March, London-based AstraZeneca was charged in U.S. District Court for the Middle District of Florida, in Orlando, with covering up the diabetic side effects of its atypical antipsychotic Seroquel. Its U.S. Medical Director for Seroquel, Dr. Wayne MacFadden, is accused of having affairs with two women responsible for Seroquel's "safety" studies.

But they're looking for jobs too.

Martha Rosenberg is a freelance writer.

Talk therapy eases anxiety in older adults

CHICAGO (Reuters)—Adding talk therapy to typical anxiety treatments that often include drugs helped older adults cope better, improved their quality of life, and lowered their risk for depression and other health problems, U.S. researchers said last week.

An increasingly popular type of therapy called cognitive behavior therapy, or CBT, which includes specific problem-solving strategies, significantly improved levels of worry, depression, and general mental health compared to those who got usual care such as antidepressants and anti-anxiety drugs, they said.

"This study is the first to suggest that CBT can be useful for managing worry and associated symptoms

among older patients in primary care," Melinda Stanley of the Baylor College of Medicine in Houston, whose study appears in the Journal of the American Medical Association, said in a statement.

The findings follow similar results in younger adults and suggest a new approach to treating anxiety in older adults.

About 11 percent of older adults see their primary care doctor for treatment of anxiety, which typically includes a variety of medications. But anti-anxiety drugs such as benzodiazepines, a type of tranquilizer, can worsen other problems common to older adults, such as falls, hip fractures, and memory problems.

"Often older adults don't want to

add another medication. They are worried about the side effects [and] the interactions with other medicines," Stanley said in a telephone interview.

She and colleagues wanted to see if CBT might help.

They studied 134 older adults with an average age of 67 who visited their primary care doctor for anxiety symptoms.

A 'tool kit'

In addition to what their doctors prescribed, about half of the patients also got three months of talk therapy, which included relaxation training, cognitive therapy, problem-solving skills training, and sleep management.

Stanley described it as a "tool kit" that patients can use when they start to feel anxious.

The other half got enhanced routine care, which included their doctor's treatment plan plus regular telephone calls from therapists to check on how they were doing.

Stanley said about 42 percent of the patients in both groups were taking antidepressants or anti-anxiety drugs.

At the end of the yearlong study, the people in the therapy group reported significantly improved symptoms on several common scales measuring anxiety.

In general, Stanley said she was confident that patients showed a benefit, and the benefit seemed to last over a period of several months. Generalized anxiety disorder is a disabling condition that can also cause muscle tension, insomnia, and fatigue.