

**SERVING YOUR PATIENTS WITH CARDIOVASCULAR DISEASE -----**  
**IF YOU DO NOTHING ELSE WITH NUTRI-SPEC, DO THIS ...**

What causes heart attacks and strokes?

- High triglycerides
- Low HDL cholesterol
- Dietary deficiency of saturated fat and cholesterol
- Excess dietary polyunsaturated fats
- Excess dietary carbohydrates (particularly fructose sugar)
- Electrolyte Stress Imbalance
- Anaerobic &/or Dysaerobic Imbalance
- Thyroid insufficiency
- Excess estrogen
- Testosterone insufficiency
- Excess catecholamines (Sympathetic or Glucogenic Imbalances)
- Excess cortisol (Anaerobic, Ketogenic, or Parasympathetic Imbalances)
- Excess insulin (or Insulin Resistance) (Anaerobic, Ketogenic, Glucogenic, Parasympathetic Imbalances)
- Oxidative stress to the heart
- Oxidative stress in the arteries
- Oxidation of LDL cholesterol (with release of metalloproteinase enzymes)
- Chronic inflammation of the arteries (Prostaglandin Imbalance)
- Excess proliferation of cells lining the arteries (Anaerobic Imbalance)
- Platelet aggregation and RBC Rouleux formation (Electrolyte Stress or Dysaerobic Imbalances)
- Excess Prostaglandins (particularly Thromboxane, PGD2, and PGE2)
- Excess vasoconstriction (Sympathetic Imbalance)
- Magnesium deficiency (Universal!!! --- Oxy A, Oxy K, Complex S, Formula ES, or MgCl2)
- Excess calcium (pushing out magnesium) in the heart, blood vessels, and vasomotor nerves (=== need Taurine, Oxy A, Oxy Tonic, Formula ES)
- Trace mineral deficiencies

Quite an exhaustive list, isn't it? (Note that elevated serum cholesterol is not on the list, and neither is excess dietary intake of cholesterol --- which is the point of this entire series of Articles on cholesterol, and the entire series of Articles on dietary fat.)

How do you possibly sort through all these causative factors to construct an effective clinical protocol to serve your patients at risk for cardiovascular disease (CVD)? It is quite simple --- do NUTRI-SPEC testing on your patients --- either complete Metabolic Testing, or the Sympathetic/Parasympathetic Support System --- or --- create for your patients their individualized Diphasic Nutrition Plan. On occasion you may want to back up your NUTRI-SPEC findings with selective use of blood work.

Here is a list of clinical indicators of CVD risk. In other words, this is a list of factors indicating the likelihood that one or more of the above listed causes of CVD are at work in a particular patient, and, why those causative factors are active in that particular patient.

- Electrolyte Stress Imbalance
- Anaerobic Imbalance
- Dysaerobic Imbalance
- Sympathetic Imbalance
- Ketogenic Imbalance
- Cardiac arrhythmia
- Elevated triglycerides (particularly elevated triglyceride to HDL cholesterol ratio)
- Elevated homocysteine
- Elevated C-reactive Protein
- Thyroid functional evaluation showing Thyroid Insufficiency (Low T3 Syndrome)

Do you appreciate the significance of the two lists you have just read? The knowledge you have in the first list puts you far above the vast majority of clinicians in your understanding of CVD causes. As unbelievable as it may seem, we have a condition that kills more than 50% of all people, yet most doctors are almost entirely ignorant of the causes of this condition. How unbelievably absurd is that? You (and your patients) can be quite pleased that you have risen above the mediocrity that characterizes the healing arts professions.

The real beauty is in the second list. Here, you have 10 clinical indicators that inform you completely about the 24 causative factors of CVD.

Do you see how valuable you are to your patients? You have the ability to define and monitor the 24 causes of cardiovascular disease with 10 clinical indicators. Now that you have developed a complete picture of the complexity of CVD, you should also begin to appreciate that you, as a NUTRI-SPEC practitioner, are uniquely in a position to actually do something about it. We have said repeatedly for more than 30 years now ...

**IF YOU DO ABSOLUTELY NOTHING ELSE  
WITH NUTRI-SPEC, TREAT PATIENTS WITH  
HYPERTENSION AND CVD.**

With NUTRI-SPEC you will save lives of patients at severe risk for heart attacks and strokes.

Imagine a patient coming to you who has already had one heart attack, has triglycerides over 400, blood pressure in the stratosphere, and a heart rate that

bounces up to over 100 at the slightest provocation. Imagine further that within a year you have the patient's triglycerides down below 200, the blood pressure is high normal and the pulse is steady and strong. Furthermore, the patient has been able to eliminate four of his six medications prescribed by the Cardiologist, and is feeling better than he has in years. How many cases like that does it take to build a booming Metabolic Therapy practice? These people will flood your office with referrals.

Just as gratifying as saving lives is enriching lives with NUTRI-SPEC. Do you see the magnificent prophetic capacity of your NUTRI-SPEC testing system? Your NUTRI-SPEC system allows you to identify the early stages of CVD 20 years or more before the typical physician will identify a pathology, and as much as 25-30 years before the heart attack or stroke. You will find patient after patient who has taken several giant steps down the road leading to death from CVD; patients you will rescue and redirect down the road to happy-ever-after.

With what you have learned about the true nature of the pathologies underlying CVD, you can clearly understand that the most direct and effective way to minimize CVD risk is to accompany your NUTRI-SPEC Fundamental Diet with NUTRI-SPEC supplementation --- particularly the Adaptogens --- Taurine, and the powerful Adapto-Max and Oxy-Max.

We have been singing the praises of Taurine. A tremendous amount of research for over 30 years has demonstrated its protective effect against heart attacks and strokes. Its benefits are largely the result of its control of calcium and magnesium metabolism. Taurine helps keep calcium out of the myocardium and the smooth musculature of the arterial intima, and allows magnesium to fully exercise its biological role. But beyond protecting against excess calcium and enhancing the effects of magnesium, taurine also facilitates the elimination of excess cholesterol, and promotes vasodilation, and best of all actually decreases the size of arteriosclerotic lesions.

Having celebrated the benefits of Taurine, we will now consider your other big guns against cardiovascular disease ...

You know that Oxy Tonic and Oxygenic D-plus, along with Diphasic AM and Diphasic PM, are the keys to preventing and reversing pathological hyperplasia and pathological disintegration. Pathological hyperplasia includes the anabolic, atherosclerotic phase of CVD; pathological disintegration, as it relates to the heart and blood vessels, includes the catabolic oxidative damage to the heart and vascular walls.

Your Diphasic AM and Diphasic PM contain the betaine to reverse the aberrant metabolic process that results in the buildup of homocysteine. The carnosine, the carnitine, the Co Q-10, and the whole family of tocotrienols and

tocopherols and lipoic acid also protect the heart and blood vessels against the degenerative changes of INFLAM-AGING.

As decreasing elevated triglycerides is one of your most important clinical goals, you must begin to appreciate lipoic acid. Nothing compares with lipoic acid as the means to lower triglycerides, and it does so by several mechanisms. When you combine the lipoic acid in your Diphasic AM and Diphasic PM with your NUTRI-SPEC Fundamental Diet (avoidance of excess carbohydrate in general, and fructose in particular) you will offer your patients by far the most effective means to lower deadly triglycerides. There have been many, many instances of NUTRI-SPEC practitioners lowering patients' triglycerides by more than 300 in a period of less than 6 months. You can do so as well. Doing so is as simple as either beginning to do NUTRI-SPEC testing on all your patients, or, implementing the Diphasic Nutrition Plan for your patients (and, by the way, giving up all your favorite herbal remedies, "adrenal support" supplements, and mega doses of this and that).

There seems to be no end to the flood of research highlighting the protective effects of Co Q-10. This nutrient is turning out to be one of the most valuable clinical tools you have for patients with a diversity of health problems, but particularly for those at risk for CVD.

A study published in Clinical Investigations, 1993; 71/8 Supplement: S140-4 entitled, "Isolated Diastolic Dysfunction of the Myocardium, and its Response to Co Q-10 Treatment," studied patients in the early stages of congestive heart failure and found that Coenzyme Q-10 resulted in a decrease in high blood pressure in 80% of hypertensives; an improvement in diastolic function in all patients based on endocardiograms; a reduction in myocardial thickness in 53% of hypertensives and in 36% of those with combined mitral valve and fatigue syndrome.

A study published in Clinical Investigations, 1993; 71(8 Supplement) S116-23, entitled, "Perspectives on Therapy of Cardiovascular Diseases with Co Q-10," showed that Co Q-10 myocardial tissue levels were significantly lower in patients with more advanced heart failure compared with those in the milder stages of heart failure. Administering Co Q-10 to these patients showed significant improvement in patients' capacity for physical activity and overall quality of life. The benefits were found to be far greater than those from treatment with traditional drugs such as angiotensin converting enzyme inhibitors.

A study published in The International Journal of Tissue Reactions, 1990; 12(3):163-8 entitled, "Pronounced Increase of Survival of Patients with Cardiomyopathy when Treated with Co Q-10," showed that patients with all classes of cardiomyopathy accompanied by low ejection fractions experienced dramatic improvement in ejection fractions and pronounced increase in

survival, which was attributed to Co Q-10's bioenergetic activity in regard to myocardial function.

Yes, your NUTRI-SPEC supplements plus your NUTRI-SPEC Fundamental Diet are beyond compare as a means to treat and prevent CVD.

Finally, another piece of evidence illustrating one of the primary causes of elevated serum cholesterol, particularly LDL (the "bad" cholesterol), comes from research published in Prostaglandins, Leukotrienes, and Essential Fatty Acids 2000:63(4):177-86). This research shows how eating too many sugars and carbohydrates accelerates the aging process because it results in the production of advanced glycosylation end products (AGEs). These AGEs so easily undergo the pathological oxidation that results in tissue damage and thus premature aging.

But note this research shows additionally that these AGEs are not just associated with accelerated aging in general, but in particular with the oxidation of LDL cholesterol in the vascular system and the elevation of LDL levels in the serum. What happens is the glucose from a diet high in carbohydrates and relatively low in fat and protein attaches to peptides (protein molecules) forming AGEs that end up circulating in the bloodstream and ultimately attaching themselves directly to LDL molecules. The body can no longer recognize this new LDL since it has extra molecules clinging to it, so the excess LDL is not removed by the liver, and thus continues to circulate --- resulting in elevated serum LDL.

So, the high carb, low protein and fat diet actually elevates LDL into the range that alarms most physicians, but also, since this LDL is glycated, it is more sensitive to oxidation damage than normal LDL (which is no threat whatsoever), thus contributing to atherogenesis, heart attacks, and strokes.

What truly causes heart attacks and strokes? May I be so bold as to suggest that ...

**YOUR UNDERSTANDING IS BROADER  
THAN MANY CARDIOLOGISTS' ...**

in answering that question.

Is there a way to discover and predict the risk of CVD years before the pathological process is evident to other clinicians? Yes, you have ten easily monitored prophetic indicators.

Can CVD be prevented? Yes, and no one can match your ability to do so.

Can CVD be reversed? Absolutely --- to some degree in all patients, and to a dramatic degree in many CVD patients. All it takes is your knowledge, and your NUTRI-SPEC products and procedures.

Now that you appreciate your power to prevent, control, and in many cases reverse cardiovascular disease --- dramatically reducing the risk of heart attack and strokes in your patients --- ask yourself ...

Question: How many of your patients go to a “Heart Specialist”?

Answer: One hundred percent of your patients go to a heart specialist.

What do I mean by that? One hundred percent of your patients go to you, and ...

### **YOU ARE THEIR HEART SPECIALIST.**

Your patients can be quite secure in knowing that you know the 24 causative factors of cardiovascular disease (CVD). Yet, I have no doubt that the typical cardiologist knows no more than you do about those 24 causative factors, and probably knows far less than you about many of them. Contemplate the absurdity: CVD kills 50% of all people, yet many cardiologists are almost entirely ignorant of many causes of this condition. So --- how valuable are you to your patients, considering that 50% of them are doomed (without your help) to die of CVD?

I'll tell you how valuable you are: You have the ability to sort through these 24 causative factors to construct an effective clinical protocol to serve every one of your patients at risk for CVD. You achieve your clinical power over CVD with your working knowledge of the 10 clinical indicators that inform you completely about the 24 causative factors of CVD. You have objective evidence of those 10 clinical indications of CVD risk, and, you have the means to use those clinical indicators to construct for each of your patients an effective CVD prevention plan.

Meanwhile, what does the conventional heart specialist offer his patients? Think about all your patients who employ the services of a cardiologist; those who have either already had their first heart attack, or those who experience attacks of atrial fibrillation, or those who suffer from congestive heart failure. After all the exams, the stress tests, the heart scans, the vascular studies, etc, etc, what have your patients actually obtained from their cardiologists? They have all come away from the cardiologist with nothing more than a bucket full of pills, and, (almost comically) they all have the same pills!

That's right! Regardless of the results of all their tests and scans, all these patients are (mindlessly) given the same handful of drugs --- the drugs that are

currently accepted as proper “standards of care” for CVD treatment. Partly out of ignorance of causative factors, and partly because of the fear of malpractice liability for failing to give a medication generally regarded as “effective” in CVD treatment to a patient who might die of CVD, a cardiologist is compelled to throw everything but the kitchen sink at every patient. So little thought goes into the pharmacological management of CVD patients that you could train a monkey to be a cardiologist.

Seriously, every one of your patients that sees a cardiologist has received the same cookie cutter pharmacological treatment. There are two (sometimes three) blood pressure medications. (Which two is determined almost entirely by trial and error, rather than by any objective interpretation of clinical tests.) There is also usually a drug to control heart rhythm, a Statin drug to destroy the liver’s ability to produce cholesterol, a diuretic, and often a blood thinner. If there is a perfect example of a “shot gun” approach to disease care, this is it. At least now your patient can die of a heart attack, and no one can ever doubt that his cardiologist did “everything possible”. After his death no one can go back to the cardiologist with the accusation, “What?! You had a heart patient for whom you did not prescribe a beta blocker?” --- or --- “What?! You had a patient at risk for heart disease for whom you did not prescribe a Statin drug?” Under this scenario, the cardiologist, the patient and the patient’s family all feel quite secure. The patient feels rotten, but at least secure. Very little has been done to actually decrease the patient’s risk of a heart attack or stroke --- but ignorance is bliss.

What are all the consequences of this monkey-brained, ignorance-and fear-based approach to CVD? Here is the short list:

- Many of these drugs are dangerous, with costs that outweigh the benefits (even the benefits imagined by the cardiologists are illusory).
- Calcium channel blockers are on the top of this list, for, as you know, they actually increase your patient’s chance of having a heart attack or stroke (while at the same time causing potentially suicidal depression, and decreasing mental acuity).
- The Statin Drugs are also on your list of Red Flag medications, certain to do more damage than good.
- Without the 10 clinical indicators of CVD risk that you work with, the cardiologist is almost completely in the dark as to whether his prescribed medications are doing any harm --- that is, until a crisis is precipitated. (Dijoxin is a drug on which physicians have largely given up --- because it needed to be monitored very closely, but very rarely was. The difference between the dose that was “beneficial”, and that which is damaging, was very small.)

- Your patient feels absolutely wretched. Fatigue, depression, and pain are common side effects of these drugs. The answer to these side effects? More drugs, of course. An anti-depressant will be prescribed without hesitation. (And this usually means an SSRI --- another devastating Red Flag medication.) Tylenol, (yet another Red Flag) is virtually always among the “try this” pain medications.
- Adding to the absurdity of the pharmacological approach to CVD is that both the beta blockers and calcium channel blockers actually weaken the heart. In a simplistic sense you can consider the heart a pump, and these drugs decrease the pumping ability of the heart. The heart beats more slowly and with less force (that is why these medications lower blood pressure.) So, your typical patient on these drugs has a pulse that is limping along in the 50s to low 60s, and has legs needing to be laboriously dragged around all day, feeling like they weigh a ton. Many of these patients experience dizziness upon arising (the orthostatic failure you test for with your NUTRI-SPEC procedures), since the heart can’t push the blood up to the brain on demand.
- Adding insult to injury, these drugs make it extremely difficult for you to analyze your patients’ results for NUTRI-SPEC Fundamental Imbalances. Calcium channel blockers, beta blockers, ACE inhibitors, Statin drugs, and the diuretic Lasix all cause the appearance of a strong Dysaerobic test pattern (high specific gravity, low urine pH, and high saliva pH). You have no way of knowing whether the patient is Anaerobic or Dysaerobic. Furthermore, the calcium channel blockers, and beta blockers can cause a false positive Parasympathetic test pattern. Again, you have no idea whether your patient is actually Sympathetic.

That brings us to our consideration of how you, a NUTRI-SPEC practitioner, can deal with the pharmacological nightmare you find in CVD patients. Just what do you do when a new patient presents with hypertension or a history of heart problems or stroke, and is taking seven different drugs?

Your first option is to go with the Diphasic Nutrition Plan. This plan will quite effectively protect your patient against the further development of CVD, and will reverse much of the pathological damage in most cases. That is far more than the patient is getting out of his seven different drugs. Your Diphasic Nutrition Plan for these patients looks like this:

- Activator = 2 AM and 2 PM
- Formula ES = 3 AM and 3 PM
- Taurine = 2 AM and 2 PM
- Diphasic AM = 3 AM
- Diphasic PM = 3 PM
- Oxy Tonic = (per Balancing Procedure)

- Oxy D-plus = (per Balancing Procedure)
- Electro Tonic = (per Balancing Procedure)
- Complex P = (per Symp/Parasymp Support System + Orthostatic Challenge)
- Complex S = (per Symp/Parasymp Support System + Orthostatic Challenge)

How do you determine the needs of CVD patients on the Diphasic Nutrition Plan? First, determine the Oxy Tonic, Oxy D-plus, and Electro Tonic based on the Diphasic Nutrition Plan BALANCING PROCEDURE. Now, consider the proper balance between Complex S and Complex P. If your patient shows a Sympathetic type blood pressure and pulse combination, i.e., with high systolic blood pressures, and with a somewhat rapid pulse, then you will definitely not use Complex P. You will use one or two Complex S in the PM. If the patient's orthostatic blood pressure response shows a big jump in both systolic and diastolic upon standing, then again, you will use no Complex P, and will use 2 Complex S in the PM. If the patient shows a close to normal pulse, and a normal rise in orthostatic blood pressure and clinostatic pulse despite the fact that he is taking either a calcium channel blocker or a beta blocker, then again you will not use Complex P and will use Complex S 2 in the PM. If the patient is taking a calcium channel blocker or a beta blocker and shows an extremely slow and non-reactive pulse, and shows blood pressures that are non-reactive to orthostatic challenge, then use neither Complex S or Complex P.

When can you use Complex P as part of the Diphasic Nutrition Plan for CVD patients? You may use it only when the patient has a slow, clinostatically unreactive pulse, and an orthostatic drop in either the systolic or diastolic blood pressures, and, you are absolutely certain the patient is not Ketogenic.

If you are not doing any NUTRI-SPEC testing at all, yet want to start your CVD patient on the Diphasic Nutrition Plan, you can begin with just the recommendation of Oxy Tonic and/or Oxygenic D-plus and/or Electro Tonic based on the Balancing Procedure. Using the Sympathetic/Parasympathetic Support System, you are best to omit the Complex P altogether and give Complex S if the patient shows a somewhat elevated resting pulse rate.

Whether you are doing NUTRI-SPEC testing or not, you must do two things to assure that your patient gets the full benefit of your DNP. You must get the patient off the Red Flag medications, and begin a slow withdrawal of certain other medications that you carefully select. You must also, within 3 weeks of instituting the Diphasic Nutrition Plan, begin the Oxy Tonic, Oxy D-plus, and Electro Tonic Balancing Procedure.

Which medications do you want to go after, and how? Here are some guidelines. The Statin drugs are a Red Flag that should be totally eliminated immediately. There is no need for gradual withdrawal.

Calcium channel blockers are another particularly pernicious red flag. If your patient is taking a calcium channel blocker to control blood pressure, then suggest that he switch to an ACE inhibitor. If the calcium channel blocker is designed to control cardiac rhythm as well as blood pressure, then suggest that the patient switch to a beta blocker.

If your patient is on a beta blocker, and shows a recumbent pulse one of 60 or less, or, of 68 or less with orthostatic blood pressure failure, then you know the patient is over-medicated. You need to gradually withdraw the beta blocker. The protocol is to delete one day of medication per week for two weeks, then delete two days (for instance, Monday and Friday) for two weeks, then delete Monday, Wednesday, and Friday for two weeks, and then re-evaluate. If the blood pressure is still reasonably well controlled and the pulse is still normal or below, then to go to the next step, which is to only take the medication Monday, Wednesday and Friday, followed after several weeks by a further reduction to taking it only on Monday and Friday, then a reduction to Monday only, then off it completely. If at any time along the way the blood pressure or pulse rate rises significantly above normal, then just stop at that level of medication.

If calcium channel blockers, cholesterol medications, and beta blockers have all been considered, then it is time to take a look at your patient's ACE inhibitor. If the ACE inhibitor is controlling the blood pressure quite effectively, yet the patient shows a Dysaerobic test pattern, then you should begin the same withdrawal procedure just described for a beta blocker. You may find that your patient only needs to take the ACE inhibitor a few days each week, or perhaps, eventually, not at all.

What you have just been given are the steps of analysis the NUTRI-SPEC staff uses to analyze the many CVD problem cases you send us. Now, you understand the rationale behind the way we analyze your drug-overloaded CVD patients. And now, you know how to manage these cases yourself (though you are still welcome to call us for advice --- anytime; every time).

The value of your expertise is incalculable --- you must use it fully in service of your patients. You are their only hope.