

The Hypoglycemic Health Association

NEWSLETTER

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Volume 18 Number 2

Registered Charity CFN 16689
ABN: 65-846-851-613

June 2002

<http://www.hypoglycemia.asn.au>

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The NEWSLETTER of the Hypoglycemic Health Association is distributed to members of the Association and to Health Professionals with an interest in nutritional medicine and clinical ecology.

There are alarming reports on the internet that the European Commission is considering legislation to ban over the counter sale of nutritional supplements. These are planned to be available only on prescription by doctors. If and when this legislation is ever passed, Australia will be the next target! (See: (<http://www.vitamins-for-all.org/english/default.html>)). This campaign, that has been going on for some years by international pharmaceutical corporations, no doubt aims at increasing their profits even further at the expense of our health. This is why charitable organisations like ours need your support in making the public and thereby governments aware that our freedom to purchase nutritional supplements is under attack.

A few of our members may have overlooked to send in their membership fees details of which are given on page 12 of this Newsletter. Please show this Newsletter to your friends and if they are interested ask them to join our Association. We aim to educate the medical profession and consumers on the benefits of complementary medicine.

Our Next Public Meeting will be at 2.00 PM

on Saturday, the 1 June, 2002

at **YWCA**

5-11 Wentworth Ave, SYDNEY

and our guest speaker is

Dr Elina Freidin

who will be speaking

on the subject of

***“Allergies among people
with hypoglycemia”***

Dr Elina Freidin was born in Estonia and attended medical school at the Academy of Medicine at Moscow. When arriving in Australia she was the only student selected out of 60 to be enrolled at the University of Sydney as an Overseas Trained Medical Undergraduate.

After she graduated in 1996 she completed several Postgraduate Courses in Nutritional and Environmental Medicine with the Australasian Academy of Nutritional and Environmental Medicine. She specialized in Chelation Therapy, Nutritional and Environmental Pathology Testing and Diagnostics, Biochemical Pathways and their Application to Nutritional Medicine. She is fluent in English, Estonian, Russian and Hebrew languages. She also has a great interest in music and is an accomplished pianist having won several competitions.

Previous Copies of the Hypoglycemic Newsletter

Back issues of the Hypoglycemic Newsletters are available at the NSW State Library, Macquarie Street, Sydney. They are filed under NQ616.466006/1 in the General Reference Library.

Other libraries holding copies are: Stanton Library, North Sydney; Leichhardt Municipal Library; The Tasmanian State Library; The Sydney University; The University of NSW and Newcastle University. The Association will provide free copies in PDF format to any library upon request to jurplesman@hotmail.com

The Association also has a web site at: www.hypoglycemia.asn.au where there are some Newsletters in PDF format, as well as articles on clinical nutrition and self-help psychotherapy.

Books for sale at the meeting

Sue Litchfield: **SUE'S COOKBOOK**
Dr George Samra's book

The Hypoglycemic Connection
(now out of print) is only available in public libraries).

Jurriaan Plesman: **GETTING OFF THE HOOK**

This book is also available in most public libraries (state and university). By buying this book at the meetings you are supporting

Any opinion expressed in this Newsletter does not necessarily reflect the views of the Association.

DISCLAIMER: The articles in this newsletter are not intended to replace a one-to-one relationship with a qualified health professional and they are not intended as medical advice. They are intended as a sharing of knowledge and information from research and experience in the scientific literature. The Association encourages you to make your own health care decisions based upon research and in partnership with a qualified health care professional.

the Hypoglycemic Health Association.

The Newcastle branch of the Association are still meeting with the assistance of Bev Cook. They now meet at ALL PURPOSE CENTRE, Thorn Street, TORONTO. Turn right before lights at Police Station, the Centre is on the right next to Ambulance Station. For meeting dates and information ring Mrs. Bev Cook at 02-4950-5876.

Entrance donations at meetings

Entry donation is tax deductible and for non-members will be \$5, for members \$3 and family \$5. People requiring a receipt for taxation purposes will be issued when asked for it.

Donations for raffle

One way of increasing our income is by way of raffles. If any member has anything to donate towards the raffle, please contact Dr

George Samra's surgery at 19 Princes Highway, Kogarah, Phone 9553-0084 or Sue Litchfield at (litch.grip@bigpond.com).

At the meeting on the 2 March 2002, Jack Simone won the lucky door prize and Graham Butt won the raffle.

Fund raising activities

We need money, ideas, donations, bequests (remember us in your will), donations over \$2 are tax deductible.

Raffles

Conducting raffles is an important source of additional revenue for the Association. Raffle tickets are available at \$2 each or \$5 for three tickets at Dr George Samra's surgery. Items to be raffled should be on display at the surgery and will be raffled at the next public meeting of the Association.

The Hypoglycemia support group meets every 3 months at 19 Princes Highway Kogarah (1st floor Dr. Samra's surgery) at 1.45 p.m. The members of this support group meet every second Saturday of the months of February, May, August and November. The cost is \$1. Afternoon tea provided - family and friends welcome. For further information please telephone - Lorraine on 02-95209887 or Jeanette on 02-95259178

The Tasmanian Hypoglycemic support group. For members in Tasmania if you want to form a group or meet people with hypoglycemia phone Alison on 040 9966 385 A/hours or for more info (altenann@bigpond.com).

REPORT FROM OUR KOGARAH SUPPORT GROUP

This group began in late 2000. It was established to help sufferers feel that they are not alone in their illness. In the early stages, trying to cope with the new lifestyle can be quite overwhelming. Some of our members have been on the diet for a number of years, others are just starting out and needing support. It helps just to talk to people who understand and care. Exchanging ideas is always helpful. Since symptoms can be diverse, there is always more we can all learn - from reading AND FROM EACH OTHER.

Our meetings are held on the 2nd Saturdays in February, May, August and November, so they do not clash with the meetings in the city.

Attendances average from 10 to 14. Several Diabetics and Coeliacs

are included in our numbers. Most recent members came after seeing our notice on Dr Samra's noticeboard and from the meetings in town.

Interest has been shown in acquiring Sue's Cookbook. Another place for recipes is on the Association's web site. A great many food allergies including Gluten are present within the group. Some future discussion on adapting recipes will be scheduled. Suggestions for meals and in-between "snacks" have been discussed to assist our newer members.

Fund-raising - Jeanette and Lorraine will be assisting in the sale of raffle tickets at the meetings in town, and will also be available to answer enquiries about the Support Group.

Publicity - We have designed a poster to go to Libraries, Health Food Shops, Chemists, Doctors' Surgeries and Community/Neighbour Aid Centres. It is our aim to promote public awareness of the

illness and the meetings in town, not just the Support Group. Everyone has heard of Diabetes, but very few have heard of Hypoglycemia.

Anyone who would like some posters for their area, please contact JEANETTE (02) 9525.9178 (rjbous@bigpond.com) or LORRAINE (02) 9520.9887 or

The next meeting of the Kogarah Support Group will be on Saturday 10th August at 1.45pm at Dr Samra's rooms (upstairs) at Kogarah.

PLEASE NOTE The Newcastle Branch also runs a Support Group where new members are always made welcome. Contact Bev Cook (02) 4950.5876.

HELP IS AVAILABLE FOR ALL WHO NEED IT. YOU JUST HAVE TO REACH OUT AND TAKE IT. DO IT NOW.

The New Hypoglycemic Connection: Including the Role of Hormones, Minerals, Vitamins and Microbiotics

By

Dr George Samra, M.B.,B.S.(Sydney) F.A.C.N.E.M.

My book "The Hypoglycemic Connection" was published in 1984 and there have been several reprints and it did very well at the time. Today the topic is about the "*New Hypoglycemic Connection*", the main title of my next book.

I am planning to rewrite the book and I would like to consider the various connections between hormones, candidiasis and add a special section dealing with *Chronic Fatigue Syndrome*.

The new book will summarize each chapter and then followed by an update of new information pertaining to the chapter.

I would like to refresh your minds of several passages from the book, the first one from chapter one of the book.

From the First Chapter

Hypoglycemic disease occurs in 3 to 4% of the general population. There is often a family history of diabetes or a history suggestive of hypoglycemic disease in close family members.

When hypoglycemic disease is suspected, Hypoglycemic Syndrome should be looked for. Hypoglycemic Syndrome is the presence of any 3 of the following 4 features - depression, lethargy, forgetfulness and sucrophilia. If present, other symptoms should be looked for - firstly adrenergic (epinephrinic) symptoms due to excessive autonomic stimulation and secondly chronic symptoms due mostly to hypothalamic dysfunction. Adrenergic symptoms

include nervousness, sweating, dry mouth and palpitations. Chronic symptoms include moodiness, depression, exhaustion and insomnia.

From Page 41

The Glucose Tolerance Test (G.T.T.) is historically the classical diagnostic test for diabetes but it is also the critical diagnostic test for Hypoglycemic Diseases - glucose intolerance is common to both conditions.

Rules must be followed when interpreting the G.T.T. Correct diagnosis is necessary for proper treatment. Based on the G.T.T. there are 6 classifications of Hypoglycemic Disease. These are

- Type 1. RELATIVE HYPOGLYCEMIA** - A fall in blood glucose of over 2.6mm/l (45mg per 100mls) in any one hour, or of over 1.6mm/l (30mg per 100mls) in any 1/2 hour.
- Type 2. ABSOLUTE HYPOGLYCEMIA** - Any blood glucose recorded below 3.4mm/l (62mg per 100mls).
- Type 3. COMBINED RELATIVE AND ABSOLUTE HYPOGLYCEMIA** - popularly referred to as "Reactive Hypoglycemia."
- Type 4. FLAT CURVE RESPONSE** - Where no blood glucose value is more than 1.3mm/l (24mg per 100mls) above the fasting level.
- Type 5. FASTING HYPOGLYCEMIA** - The fasting blood glucose level is below 3.4mm/l (62mg per 100mls). A substantial minority of patients falling within this category may have a serious illness such as insulinoma or pancreatic cancer.
- Type 6. CELLULAR LEVEL HYPOGLYCEMIA** - with a normal

G.T.T. but usually an abnormal zinc:copper ratio.

The underlying pathology is considered for each type of Hypoglycemic disease. The significance of zinc in glucose metabolism is considered. Patient cases are discussed paying particular regard to the Hypoglycemic disease typing based G.T.T. results.

The normal glucose load given in a G.T.T. is 70 grams. A can of coke is 65 grams of sucrose, these quantities are not unlike one another.

From Page 99. Hypoglycemic Generations

There is often a family history of diabetes or a history suggestive of hypoglycemic disease in close family members. Each child of a hypoglycemic patient has about a 50% chance of developing the disease.

In his play, 'As You Like It', Shakespeare cryptically describes the 'seven ages of man' in terms of urinary ailments at various ages. Perhaps less poetically there is a sequence of hypoglycemic disease suffering and at different ages.

'As a child he loved sweets. At Christmas he was good. He was showered with lollies and chocolates. When they were withheld he complained severely, misbehaved and carried on to the point of total frustration.

He seemed harder to manage if we took him anywhere. At times he would run around wildly, far

more than other children. Most of the time we thought he was good; he had a lovely nature, other times he was down-right naughty. At age 6 he seemed to be doing fairly well at school but he was always naughty after school. This continued for years. He would be mischievous, and annoyed his younger brother and sister. He seemed to settle down a lot after dinner. He never seemed to be keen at school and at High school all of his reports showed medium to low grades and carried the comments 'Is capable of doing much better' or 'Won't concentrate'. Anyone could see by just talking to him that he was much brighter than his school grades revealed.

At the age of 15, he seemed to have changed considerably - he had become a moody teenager. He seemed to behave differently compared to the other teenagers in the street - at times he was quite withdrawn.

He left school early and seemed somehow to be becoming slower and even depressive. This wouldn't stop him from having a good argument almost at any time. His poor old mum - nothing she would do, nothing his brother or sister would do seemed to please him.

He was different to other teenagers. Sure he was a little bit rebellious but seemed more withdrawn and even more argumentative.

He did get a job and to mum and dad's surprise, at age 18, a marijuana bong was found under his bed. When confronted with this, he claimed 'Quite rightly', that marijuana was less harmful than tobacco or alcohol and besides, Dad smokes and drinks too much anyway. If Mum continued to protest; he was quick to point out that the Valium she consumed was just as bad as his marijuana.

2 years later a hypodermic needle and syringe were found at the back of the bathroom cupboard. He had now progressed to heroin addiction. This was harder for Mum and Dad to cope with and again he

was confronted with the evidence.

'Yes, he was a heroine addict' he admitted, It made him feel even better than what marijuana could. Mum and Dad were bewildered. Their son had become a heroin addict and seemed to know all about drugs.

A few years later, having faced several judges and served short periods of time in jail, he had finally done well at the drug rehabilitation centre. He now avoided all drugs, he held a job fairly well and was now a 'social' drinker. He was in fact a very social drinker. When he did drink at a party he would seem to consume far more than his friends. By the end of the evening he could be found sleeping in a corner somewhere.

His sister was never quite as bad as he. She grew up, got married and had two or three kids. She seemed to be always taking some sort of sedative pill and two 'sleepers' at bedtime.

Her brother continued to drink heavily and at the age of 50 a routine urine sample collected by his doctor showed the presence of glucose. Testing confirmed that he was mildly diabetic and despite having an attempt to treat this with diet, he continued to consume large amounts of ice cream, soft drinks and sweets. Three or four years later his diabetes had progressed and because diet and tablets had failed; he was now back with his old friend, a syringe, giving himself insulin injections twice each day.'

The above story is full of cliches borrowed from genuine hypoglycemic patient cases. In many family cases all the above character roles in the story can often be seen to exist at once. The young housewife, the naughty children - she can only control them with sweets. They may be so hard to manage that she only copes by taking sedatives. Her husband may well be an

Appendix - Letter to Hospital

To The Treating Doctor,

Dear Doctor,

RE:

This patient has recently been diagnosed as having Reactive Hypoglycemia. This showed up on Glucose Tolerance Testing.

Dietary treatment was instituted and involved being on a strict Diabetic Diet, free of sugar, with 2 1/2 hourly food portions. The presenting symptoms of tiredness, confusion, and depression, disappeared after only a few weeks on this regime.

I am aware that this patient will soon be going into hospital. Considering the severity of presenting symptoms, I would ask you would ensure that whilst in hospital this patient is kept on a strict Diabetic Diet. I also seek your help in ensuring that Isotonic Saline with no Dextrose is used by the anaesthetist both during surgery and post-operatively.

Thank you sincerely for your co-operation. These simple measures should ensure the patients well-being.

Attending Physician

intolerable drinker. Her older daughter a moody teenager who has been mixing with the 'wrong crowd'. The poor old Grandad having been diagnosed as having diabetes in his late 50's.

The above story shows that dealing with hypoglycemia is not only dealing with numbers, but with people in the real world.

I would like to summarise some of the new chapters in the New Hypoglycemic Connection.

I have put some thought into nine new chapters ranked in alphabetical order as follows:

Chapter A

The Glycemic Index of Foods

The Glycemic Index compares the behaviour of different foods in particular their effect on glucose tolerance. It may be regarded as an index of how sugar-like or glucose-like different foods are. The higher the Glycemic Index, the more the foods act like sugar. The lower the Index the less the food acts like sugar.

This is a useful index for Diabetics and Hypoglycemics to choose foods. Generally the lower Glycemic Index foods are better suited to both Diabetics and Hypoglycemics.

Although I applaud the concept of Glycemic Index I believe I have detected a major flaw in the methodology and believe there is a need for a new Glycemic Index to be produced which compares **the height of the rise from fasting to peak level** for all foods, as they compare to glucose. The current Glycemic Index is based on an **area of rise under** the sugar curve in the first two hours. With this flawed methodology foods such as carrots, potatoes, rice and bread have Glycemic Indices that are wrongly higher than their actual impact on the patient.

CHAPTER B PRACTICAL TIPS

Going to hospital: A hospital

letter is included. (***See: Appendix Letter to Hospital***) This may be photocopied and copies given to the surgeon, the anaesthetist, the dietician and one kept at the bedside. It explains hypoglycemic symptoms, and asks the doctors involved to place the patient onto a diabetic diet whilst in hospital, and to ensure that Normal Saline with **no** Dextrose is given intravenously if fluids are required. The letter thanks the doctors for their co-operation.

Booking Food on Planes: Most patients do best requesting either Diabetic food or Asian Vegetarian food to be provided on the aeroplane. Airlines tend to provide sugar-free food and the patient is often fed first before other passengers. The food is specially prepared and is often nicer than the set menu otherwise provided.

Dining Out: Patients should avoid sauces or gravy, and try to stick to wholesome food, including meat, fish, chicken, seafood and wholesome vegetables and salad, removing as much sauce or gravy as possible helps. A good rule of dining out for Hypoglycemics is to be **protein greedy**. Eat more of whatever the meat is, practically no sauce or gravy, and little of the salads, vegetables, rice dishes etc.

Sugar-Cheating Advice: It is not realistic to expect patients to remain 100% free from sugar for the whole of their lifetime, especially when found in social settings. I have chosen to give some sugar-cheating advice, advice which helps ensure a minimum effect of sugar-cheating on blood sugars, and so minimises the symptoms that might have otherwise occurred.

Hypoglycemics are encouraged to cheat no more than once a week and preferably no more than once per fortnight. It is important never to sugar-cheat two days in a row, this could be the start of a very unhealthy pattern in which sugar addiction could occur.

The sugar cheating advice is as follows:-

If you eat a sweet food you must **within 15 minutes before or after the sweet food also consume meat, chicken, or fish** (minimum 75grams).

With this advice patients can enjoy an occasional sweet treat at birthdays and parties, even at restaurants with a minimum of subsequent side effects.

CHAPTER C PREVENTING DIABETES

Avoid obesity.

If overweight, lose weight.

Try to avoid over-eating.

Avoid sugar, honey and glucose.

The use of sweet – substitute is permitted.

Generally eat more of foods with a low Glycemic Index.

Avoid high Cholesterol and fatty foods.

Avoid excessive stress.

Have little or no caffeine.

Avoid smoking.

Limit red meat consumption to just one or two small serves per week.

Limit alcohol to one or two small serves a week also.

Exercise. Exercise need not be strenuous, thirty minutes per day four or five times a week is recommended, walking will do.

The following supplements are useful in helping to prevent Diabetes: -

Zinc, Chromium, and Selenium.

Vitamin C and E.

Multi-minerals and B complex are also useful, as are Magnesium and Manganese.

CHAPTER D INSULIN RESISTANCE AND IT'S RELATIONSHIP TO HYPOGLYCEMIC DISEASE

Over-eating and the consumption of excessive carbohydrates and saturated fats produces HyperInsulinism, which promotes more weight gain. Central obesity is known to induce peripheral tissue Insulin Resistance. Aero-

bic exercise and a controlled carbohydrate diet can reverse Insulin Resistance and help to undo this unfortunate cycle.

If there is a disturbance to the binding of Insulin to the Receptors there will be reduced Insulin activity or Insulin Resistance. There is a reduced glucose entry into cells, blood glucose levels rise and the pancreas responds by producing more Insulin i.e. Hyperinsulinaemia.

Insulin Resistance has been estimated to occur in 25% of adults in the USA, and one in six of these are likely to develop Mature-Onset Diabetes.

Insulin is an anabolic or building hormone. At the same time it inhibits catabolic processes. Insulin secretion generally is most responsive to rising levels of glucose, usually triggered by sugars and carbohydrates in the diet. Insulin is the hormone that binds to a Receptor on cell membranes allowing entry of glucose into the cells to form Glycogen, fatty acids into the cells to form Triglycerides, and amino acids into cells to form Proteins. These processes are inhibited when Insulin Resistance occurs.

Useful supplements for patients with Insulin Resistance include zinc, chromium, magnesium, and biotin.

CHAPTER E LOSING WEIGHT WITH HYPOGLYCEMIA

For the most part patients that adhere to the Hypoglycemic Diet will lose weight because they are avoiding sugars, and sugars are in fact addictive. By breaking the sugar cycle of addiction, one is consuming considerably less calories and weight should begin to come off. However it is a requirement for Hypoglycemics to also eat six meals per day. These should be small meals, as having large meals could undo any of the benefits of having overcome sugar addiction.

Hypoglycemics have an advantage in losing weight because they do have a controlled and structured diet. A good rule when weight management is becoming difficult is that one should limit lunch and dinner to physically fit onto a bread and butter plate, and all other meals should physically fit onto a saucer. These quantities are adequate for hypoglycemic management and maintaining blood glucose levels.

Useful tips are to develop a sensible exercise habit, with at least 30 minutes of exercise four to five times per week. If weight loss is still hard to achieve a gluten-free diet whereby rice-grain and rice products replace wheat, rye, oats and barley products almost always produces excellent results.

CHAPTER F HYPOGLYCEMIA AND YEAST DISEASE

Yeast disease is often referred to as Candidiasis since Candida Albicans is the main yeast or fungal germ inhabiting a normal human bowel.

There is a considerable overlap of symptoms in patients suffering with Functional Hypoglycemia and Candidiasis. However, although the vast majority (approximately 75%) of Candidiasis patients have Hypoglycemia, only about a third of Hypoglycemic patients have Candidiasis.

Functional Hypoglycemia affects approximately 4% of the population, whereas Candidiasis affects approximately 1.5% of the population. Many patients are intolerant to cow's milk. It is reasonable with yeast disease or Candidiasis to eat a Hypoglycemic diet, as well as avoid yeast foods, dairy and other allergic foods.

Anti-fungal medication such as Nystatin, Ketonazole, or Amphotericin maybe useful as part of the management of Candidiasis.

Candidiasis patients suffer with symptoms similar to Hypoglycemics. The major symptoms include fatigue, lethargy, poor

memory, depression, bloating, PMT, muscle aches, weakness, abdominal pains, constipation, numbness, vaginal discharge, burning or itching, skin rashes, impotence, and dysmenorrhoea. The symptoms of yeast disease are due to the patient's sensitivity to the toxins or poisons that yeast germs are producing and so yeast foods should be avoided.

CHAPTER G HYPOGLYCEMIA AND CHRONIC FATIGUE SYNDROME (C.F.S)

Chronic Fatigue Syndrome has two major diagnostic criteria (both are required for diagnosis):

Debilitating fatigue lasting over six months.

Exclusion of other conditions which could cause the patient's symptoms.

Of patients presenting to my practice who have previously been diagnosed by other doctors as having C.F.S, a majority have concurrent Reactive Hypoglycemia. At the very least, patients with Chronic Fatigue Syndrome should follow a diet free of sugar and follow other rules also for Reactive Hypoglycemia.

Useful supplements for Chronic Fatigue Syndrome patients include magnesium injections, as well as oral magnesium, DHEA, vitamin injections including Vitamin B12, Vitamin C infusions and high dose B complex injection, co-enzyme Q10, as well as various products including multivitamin and multi-mineral preparations.

CHAPTER H HORMONES AND HYPOGLYCEMIC DISEASE

Various hormones may impact on Hypoglycemic Disease and exacerbate suffering of patients.

Thyroid hormone - when this is low, it causes severe fatigue and may intensify the fatigue suffered by Hypoglycemic patients

Adrenal hormones - Excessive adrenalin is a part of the Type I

Hypoglycemic condition. The notion of adrenal exhaustion and adrenal lability are discussed.

Sex hormones - Estrogen is the main female hormone and can trigger multiple symptoms that both imitate and exacerbate hypoglycemic symptoms. Mechanisms for PMT due to tissue swelling are discussed; mechanisms of low Estrogen affecting menopausal women are discussed. The male hormone Testosterone is important to both men and women for strength, motivation, and various drives including libido. DHEA is an important hormone that makes all of the sex hormones and in its own right has an effect of metabolism, ageing, motivation, and drive.

CHAPTER I THE FOOD AND DISEASE PARADIGM

The notion that food and disease have an intimate relationship is nothing new to traditional Chinese medicine. The food and disease paradigm is a new way of thinking about chronic illness. There appears to be a pattern of food and disease symptoms which are common to sufferers.

The food and disease paradigm argues strongly that rather than using drugs as a first line of treatment, **a diet change based on common food triggers should be tried first** with or without other treatment modalities including lifestyle change and natural supplements. For example with migraine sufferers, patients should be taught to avoid chocolate, cola drinks, oranges, peanuts, cow's milk products, green beans and peas, and MSG (code 621). With Asthma, patients should be taught to avoid dust mite, cow's milk dairy, as well as beef and veal.

The food and disease paradigm argues strongly that this is a safe treatment modality, the patient has nothing to lose and that a reason-

able trial for one month should be considered. The food paradigm **aims to cure disease** by avoiding the cause, and argues when food avoidance has a positive effect on a chronic illness this is the preferred mode of treatment. Little is lost by waiting a month or so before commencing drug therapies. In chronic illness where drugs are used it is likely that they will be used for many years, so patients and doctors need not be in any hurry for the prescription approach.

This chapter lists and explains the foods that may be involved in various chronic conditions. Food substitutes are also recommended to replace the foods that are being avoided.

J. THE WEBSITE.

Visit the Hypoglycemic Health Association web site: www.hypoglycemia.asn.au

The web site shows contents as well as a brief history of the Association are discussed.

Hypoglycemic patients are encouraged to join the Association to help promote a better understanding of the condition by the medical profession and the community at large.

The Web site also contains some past copies of the Newsletter in PDF formats (Acrobat Reader required). There are special articles dealing with depression and drug addiction.

The web site offers a **SELF-HELP PSYCHOTHERAPY** course looking at Transactional Analysis. The Positive Ego Training Program ("How to Improve One's Self-Image"), Assertiveness Training, Values Clarification, Communication and Counselling.

This course aims at helping people overcome their lack of self-esteem and equip them with the social skills to ensure a more satisfactory life-style.

Recipes and tips

by Sue Litchfiled

How many times have I heard the Hypoglycemic diet is very bland well there is really no need to have bland diet as there are so many fresh herbs one can buy at the Supermarket. I grow quite a few in pots especially at the moment while I am living in a unit The herbs I really love to have is Rosemary, Basil Thyme Lemon grass (great for making tea) parsley, mint chives and oregano.

Their usage is up to one's imagination making up marinades, herb vinegar, chopped over pasta..added to casseroles and so the list goes on.

My Herbed Chicken

1/2 cup rosemary leaves
2 cloves garlic
1/3 cup olive oil
1 long red chilli seeded and chopped (optional)

Juice of 1 orange about 1/2 cup
Any juice will do apple is also quite nice as is lemon juice
6 chicken thighs

Finely chop rosemary and garlic in a bowl combine oil chilli if using juice and chopped rosemary/garlic and mix well. Add chicken to marinade cover and leave for at least 1 hour barbeque for about 15 minutes basting frequently .This can also be baked in a hot oven. When cooked pour over the dressing and serve with a salad and potato.

Dressing ;

1 tab Dijon mustard (I use Masterfoods)
juice of 1/2 orange or lemon
100 ml oil of choice
2 tabs fresh chopped mint
Mix all the ingredients together and whisk until well combined
Grilled fish

---> P.12

78 Ways Sugar Can Ruin Your Health

From: http://www.mercola.com/article/sugar/dangers_of_sugar.htm

The following list was contributed by Nancy Appleton, Ph.D. who has a web site at www.nancyappleton.com

She is also the author of the book [Lick The Sugar Habit](#)

In addition to throwing off the body's homeostasis, excess sugar may result in a number of other significant consequences. The following is a listing of some of sugar's metabolic consequences from a variety of medical journals and other scientific publications.

1. Sugar can suppress the immune system.
2. Sugar can upset the body's mineral balance.
3. Sugar can cause hyperactivity, anxiety, concentration difficulties, and crankiness in children.
4. Sugar can cause drowsiness and decreased activity in children.
5. Sugar can adversely affect children's school grades.
6. Sugar can produce a significant rise in triglycerides.
7. Sugar contributes to a weakened defense against bacterial infection.
8. Sugar can cause kidney damage.
9. Sugar can reduce helpful high density cholesterol (HDLs).
10. Sugar can promote an elevation of harmful cholesterol (LDLs).
11. Sugar may lead to chromium deficiency.
12. Sugar can cause copper deficiency.
13. Sugar interferes with absorption of calcium and magnesium.
14. Sugar may lead to cancer of the breast, ovaries, prostate, and rectum.
15. Sugar can cause colon cancer, with an increased risk in women.
16. Sugar can be a risk factor in gall bladder cancer.
17. Sugar can increase fasting levels of blood glucose.
18. Sugar can weaken eyesight.
19. Sugar raises the level of a neurotransmitter called serotonin, which can narrow blood vessels.
20. Sugar can cause hypoglycemia.
21. Sugar can produce an acidic stomach.
22. Sugar can raise adrenaline levels in children.
23. Sugar can increase the risk of coronary heart disease.
24. Sugar can speed the aging process, causing wrinkles and grey hair.
25. Sugar can lead to alcoholism.
26. Sugar can promote tooth decay.
27. Sugar can contribute to weight gain and obesity.
28. High intake of sugar increases the risk of Crohn's disease and ulcerative colitis.
29. Sugar can cause a raw, inflamed intestinal tract in persons with gastric or duodenal ulcers.
30. Sugar can cause arthritis
31. Sugar can cause asthma.
32. Sugar can cause candidiasis (yeast infection).
33. Sugar can lead to the formation of gallstones.
34. Sugar can lead to the formation of kidney stones.
35. Sugar can cause ischemic heart disease.
36. Sugar can cause appendicitis.
37. Sugar can exacerbate the symptoms of multiple sclerosis.
38. Sugar can indirectly cause hemorrhoids.
39. Sugar can cause varicose veins.
40. Sugar can elevate glucose and insulin responses in oral contraception users.
41. Sugar can lead to periodontal disease.
42. Sugar can contribute to osteoporosis.
43. Sugar contributes to saliva acidity.
44. Sugar can cause a decrease in insulin sensitivity.
45. Sugar leads to decreased glucose tolerance.
46. Sugar can decrease growth hormone.
47. Sugar can increase total cholesterol.
48. Sugar can increase systolic blood pressure.
49. Sugar can change the structure of protein causing interference with protein absorption.
50. Sugar causes food allergies.
51. Sugar can contribute to diabetes.
52. Sugar can cause toxemia during pregnancy.
53. Sugar can contribute to eczema in children.
54. Sugar can cause cardiovascular disease.
55. Sugar can impair the structure of DNA.
56. Sugar can cause cataracts.
57. Sugar can cause emphysema.
58. Sugar can cause atherosclerosis.
59. Sugar can cause free radical formation in the bloodstream.
60. Sugar lowers the enzymes' ability to function.
61. Sugar can cause loss of tissue elasticity and function.
62. Sugar can cause liver cells to divide, increasing the size of the liver.
63. Sugar can increase the amount of fat in the liver.
64. Sugar can increase kidney size and produce pathological changes in the kidney.
65. Sugar can overstress the pancreas, causing damage.
66. Sugar can increase the body's fluid retention.
67. Sugar can cause constipation.
68. Sugar can cause myopia (nearsightedness).
69. Sugar can compromise the lining of the capillaries.
70. Sugar can cause hypertension.
71. Sugar can cause headaches, including migraines.
72. Sugar can cause an increase in delta, alpha and theta brain waves, which can alter the mind's ability to think clearly.
73. Sugar can cause depression.
74. Sugar can increase insulin responses in those consuming high-sugar diets compared to low sugar diets.
75. Sugar increases bacterial fermentation in the colon.
76. Sugar can cause hormonal imbalance.
77. Sugar can increase blood platelet adhesiveness which increases risk of blood clots.
78. Sugar increases the risk of Alzheimer Disease.

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CHRONIC FATIGUE SYNDROME: NUTRITIONAL STRATEGIES

Studies by Dr. MR Werbach

It is most likely that chronic fatigue syndrome (CFS) has a multifactorial aetiology. No single aetiological agent and no consistent cellular or biochemical alteration has been found which can help differentiate CFS from other similar syndromes. It is diagnosed on the concurrent occurrence of fatigue, which results in a substantial reduction in previous levels of occupational, educational, social or personal activities, plus four or more of the following:

- 1) impairment in short-term memory or concentration
- 2) sore throat
- 3) tender cervical or axillary lymph nodes
- 4) muscle pain
- 5) multi-joint pain without joint swelling or redness
- 6) headaches
- 7) non-refreshing sleep
- 8) post-exertional malaise lasting more than 24 hours

The diagnosis of chronic fatigue is based on clinical symptomatology and not on an understanding

of the underlying mechanisms. Defining CFS thus may omit patients with milder or atypical presentations.

Several studies point to an infectious aetiology for a large proportion of patients. Patients may have chronic activation of the 2-5A pathway, an antiviral lymphocyte enzyme system, suggesting chronic viral infection. *Giardia lamblia*, the mycoplasma species and HHV-6 may be associated with the onset of CFS. Flu-like symptoms, muscle weakness, depression and gastrointestinal symptoms are very common, but mimic many viral symptoms.

Exposure to toxic agents such as organochlorines or lead may be part of the aetiology. Other evidence points to chronic low-dose exposure to organophosphates and/or carbon monoxide as causative agents.

CFS patients often exhibit some degree of sensitivity to foods and chemicals. Werbach comments that "patients with both chronic fatigue and multiple food intolerances are

more apt to have a lifetime of functional somatic symptoms and to fulfill the diagnostic criteria for somatization disorder. Assuming that this is also true for patients who meet the current diagnostic criteria for CFS, it is unclear whether the earlier history of somatic symptoms was a milder manifestation of the same disorder or evidence of a different aetiology of CFS for this group of patients".

Natural killer cell function is usually depressed on the one hand, but on the other immune activation may occur in CFS. It is not known, however, to what extent these immune abnormalities are secondary to the illness. There is also substantial evidence of central nervous system pathology with an attenuation of the activity of the corticotropin-releasing hormone and generally low activity in the whole hypothalamus-pituitary-adrenocortical axis. Adrenal atrophy has been found in some patients with CFS. The reported levels of stress in the 5 years prior to the onset of CFS has been found to be highly significant in the development of CFS. While depression is common in CFS, most evidence today suggests the depression is a

result of the underlying disease processes. CFS patients, may however, also suffer from psychiatric illness.

A detailed review of the literature suggests a number of marginal nutritional deficiencies which may have aetiological relevance. B vitamin deficiencies appear to be common and include folic acid, riboflavin, thiamine and vitamin B12. **Werbach states there is also some evidence for deficiencies of zinc, L-tryptophan, L-carnitine and coenzyme Q10. Specific essential fatty acid and amino acid levels may be abnormal.**

He comments that "nutrient deficiencies, while possibly promoting the development of the illness, do not appear to be due to dietary inadequacies, as the diets of CFS patients appear to be comparable to those of healthy volunteers".

A number of these deficiencies will cause some of the symptoms of CFS. Muscle pain for example

may be due to magnesium deficiency and fatigue to folic acid deficiency. Immunodepression may be caused by a deficiency of vitamin C and depression by low L-tryptophan levels. When feasible, objective testing needs to be carried out and the appropriate supplements recommended.

Double blind trials have shown the efficacy of Ginkgo biloba, Panax ginseng, licorice (the herb), bilberry, grapeseed and cranberry in the treatment of fatigue, CFS and fibromyalgia. Some evidence of efficacy exists for low doses of tricyclic antidepressants, the immune modulating drug Ampligen and also for hydrocortisone.

To conclude Werbach finds that it would be "rational to consider supplementing CFS patients with the nutrients (and herbs) discussed above, along with a general high-potency vitamin/mineral supplement, at least for a trial period".

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Editor's Comment:

Dr Werbach does not mention the role of hypoglycemia in Chronic Fatigue Syndrome and Dr George Samra's comment should be quoted here:

"Of patients presenting to my practice who have previously been diagnosed by other doctors as having C.F.S, a majority have concurrent Reactive Hypoglycemia. At the very least, patients with Chronic Fatigue Syndrome should follow a diet free of sugar and follow other rules also for Reactive Hypoglycemia."

from page 6 this Newsletter.

Great News

by Sue Litchfield

On 14 /02/02 we received the cheque of \$1000.00 from KPMG. Along with this grant will come a certain amount of publicity of which will be of great benefit to our great little association. This grant has been granted to us as a result of all the work Amittee Robinson done for us on a tirelessly and voluntary basis coordinating with Jur our great web page The page has been a great success and we have had inquiries from all over the world. How can we thank you Amittee enough?

Again I must thanks all those who have so generously given donations to us. As I have said over the years its is as a result of these donations that we have been able

to maintain our very high standards and keep our membership subs at an affordable price N.B. there are still some subs coming in without the GST included. PLEASE those who have not done so this year please do so next because it could mean a rise in the memberships as we have to pay for the GST out of our pocket.

Our financial state at the moment is looking quite healthy. The last raffle we sold at the meeting only sold \$20.00 worth which was not even the cost of the raffle. How ever the raffle before made \$ 107.00. If there is anyone would like to help by selling tickets besides it is a great way of helping out and it does give a feeling of satisfaction of knowing one has helped out!

The last meeting of which I could not attend was very well attended in fact it was the best attendance we have had for some-time. So is there anyone who knows somebody who may have an interesting story (e.g. travelling and coping with allergies) to tell at a meeting please come forward as is not always easy to get a guest speaker especially on a Saturday afternoon.

A big thanks to Lyn, Jeannette and Lorraine for all the work you have put in at the meeting. Is there anyone who may be able to help with the catering side of the meeting all that is required is a plate of something to eat and send me the recipe to include in the next newsletter. It would be nice to have a few new ideas come through.

----- Page 7

4 fillets fish e.g. ling or gemfish
 1 stalk lemon grass
 6 Kaffiir lime leaves
 2 tabs Soya sauce
 1 tab rice syrup
 2 cloves crushed garlic
 2 tabs finely chopped ginger
 1 long chilli finely chopped
 (optional)
 grated rind and juice of 1 lemon

2 tabs fresh chopped coriander 2 tabs oil

Place fish in a baking dish. Combine the remaining cover and marinate for about 1 hour heat and grease with the oil a grill barbeque or pan fry and cook for about 6 mins on each side or until cooked and tender.

Rack of Lamb

2 racks of lamb enough to serve 2 people

1/2 cup parsley 1/2 cup coriander

2 cloves crushed garlic

2 tabs mint leaves

1/2 teas ground cumin

1/2 teas ground coriander

1 tab lemon juice 2 tabs oil

Place all the herbs in a processor and process to a paste

Make a couple of incisions in the racks of lamb and rub all over and in the incisions allow to stand for about 1/2 -1 hour. Bake in a hot oven for about 30 mins on until the lamb is cooked as desired

NOTE ; this is also great cooked in a webber

Publicity Officer

The Association is looking for a person with a computer and internet access who is willing to become our Publicity Officer. The main job would be to advertise our meetings and prepare pamphlets for distribution to libraries, Universities, clubs and other organisations with the aim of attracting members of the public to our Association. It is not well known that many young people suffer from hypoglycemia, leading to depression and addiction. The person should be able to create a data base of editors of local newspapers and advertise our meetings under "Community Events" in local newspapers.

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INTERNATIONAL CLINICAL NUTRITION REVIEW

By Editor

Dr Robert Buist, Editor in Chief of the ICNR, has indexed the **International Clinical Nutrition Review** which will be updated in the last issue of each year.

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