



Hypoglycemic Health Association of Australia

working to prevent diabetes

HYPONEWS

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The Newsletter of the Hypoglycemic Health Association of Australia is distributed to members of the association and to health professionals with an interest in **nutritional medicine and clinical ecology**. Past newsletters are also available on the website.

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Our next Public Meeting and AGM will be at

12.30pm on Saturday 28 March 2015

**at Kogarah Library
O'Keefes Lane, Kogarah**

Our guest speaker will be Brent Daisley who will be speaking about:

“Nutrition”

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Brent Daisley

BSC, CMTA, FDN, HLC, CHEK

Holistic Health Practitioner, Author, Speaker and Practicing Consultant

Brent has studied under some of the most knowledgeable practitioners in the fields of disease prevention and correction. Brent specialises in metabolic diseases, hormone imbalances, immune system challenges, gland and organ dysfunction and other health challenges such as osteoporosis, arthritis and back pain. His studies encompass the fields of nutrition, corrective exercise, toxicity and diagnostic health. He shops and eats organic food and follows his own Metabolic Typing® diet. Brent's hobbies include functional training with Fitballs and free weights, cycling, swimming, reading and spending time with his partner Cheryl.

Can you please **RSVP to Kerrie or Linda on 9553 0084** to assist with the organisation of the catering. It would be good to bring your lunch with you or a plate to share with others.

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.

Treasurers Report

By Sue Litchfield

Another year has finished and it is also time for membership renewals. Those of you whose subscriptions are due to expire would have received a letter from me by now - no letter means no need to renew for at least another year.

Financially we are in good shape again this year, but with the interest rates so low, I have taken out a term deposit for 5 months investing \$7,799. In addition, we also have another \$2,000 in an interest bearing account plus \$2,300 in our cheque account. This is mostly thanks to the very generous donations we have received during the year, many of which have been the result of our web page

The meetings again have been a great success, with full house at all the meetings last year. The last meeting was very close to being in excess of room requirements! Thanks to all those who attend and make our meetings a great success! Lets keep it that way.

Again, is there anyone who can help with the afternoon teas? I am finding it increasingly difficult to continue doing them due to health issues. Looking forward to another year.....

General Information

- This year's Hypo members web page **password is: hhaa2014**
- **Stevia** - Members can receive a 15% discount for Stevia, Xylitol and other products. The discount applies over and above all discounts advertised on the following web page: <http://www.naturallysweet.com.au/our-products/xylitol/> . However, a minimum order of \$50.00 applies. At the checkout, make sure the discount code below is added: **Discount Code HC15D**
- **Pure Harvest** - Members receive 5% discount on all wholesale prices <http://gunguru.com.au/> Password: Hypo.
- **Glycerine in bulk** - <http://www.southerncrosssupplies.com.au/contact.php>
Telephone: 02 9572 7888 **Fax:** 02 9572 7822 **Street Address:** 6B Rich Street, Marrickville, NSW, 2204, Australia. **Postal Address:** PO Box 3113 Marrickville NSW 2204 Australia

Exploring the Mysteries of the Small Intestine

Article by Dr George Samra, MB.BS. FACNEM

The small intestine is the part of the gastrointestinal tract that follows the stomach, and is followed in turn by the large intestine. It is where much of the digestion and absorption of the food takes place. It is composed of three parts: the duodenum, jejunum and the ileum. It receives the gastric juices from the stomach, and bile and pancreatic juices through the common bile duct, into the duodenum.

What we don't know about the small intestine is greater than what we do know about it.

This is partly true, because the small intestine is hard to visualise with medical techniques. With gastroscopy and endoscopy, one sees to the duodenum and the colonoscopy only gets to see all the large intestine up to the caecum or appendix area. Our techniques, so extensively used these days, fail to visualise the small intestine.

The medical profession has failed to properly explore and understand the small intestine. This has to do with bowel and stools, and any topic remotely to do with "poo" seems to be shunned by doctors

and laboratory workers alike, thereby keeping us, for the most part, ignorant. So, the scopes that are used every day by our gastroenterologist fail to properly visualise the small intestine.

We humans are intrigued by the mysteries of **outer space** - yet the mysteries of **inner space** could have far more immediate consequences for most people. The small intestine has an average length of 7m, with a diameter of 2.5 to 3cms, and a surface area of the mucosa averaging about 30m², or the size of a double garage. The duodenum is about 20 to 25cms long, and is "C" shaped. The jejunum is about 2.5m long, and most of the products of digestion, sugar, amino acids and fatty acids are absorbed here. The ileum, or the last part of the bowel, is about 3m long and mostly absorbs vitamin B12, bile acids and other micronutrients.

Medical Arrogance.

It is medical arrogance to examine the stomach, duodenum and large intestine and reassure a patient with lots of symptoms **that there is nothing wrong**. The arrogance really emphasises our ignorance. Gut symptoms such as bloating, diarrhoea, constipation, abdomen pain, nausea, vomiting, wind or flatus, unexplained weight loss and unexplained anaemia are not explained away with routine gastro-colonoscopy.

The notion that just because we cannot visualise the small intestine, then nothing can be wrong, is at best naïve, and at worst, dangerously negligent. The assumptions with the small intestine that it can never get sick, it can never get cancer, that it does not get infections, have bacteria or Candida infestations or parasites, is part of the medical arrogance.

Diseases We Do Know About – Small Intestine

Coeliac disease is a disease in which people can't eat gluten grains as it causes damage to their small intestine. The typical gluten grains include wheat, rye, oats, barley and malt, and often gluten is used in medications, vitamins and even glues, and these should be avoided. The person can have symptoms in the gut, and might be minor or major, including diarrhoea, bloating, gut pain and often symptoms outside of the gut including malabsorption, features such as weight loss, irritability, fatigue, itchy rashes and depression.

The gold standard diagnostic test is a small bowel biopsy of the duodenum with samples taken when an endoscopy is performed while the patient is still ingesting gluten. The microscopy features show erosion of the "finger-like" villi that line the small intestine. Blood tests for gluten antibodies, gliadin antibodies and endomysial antibodies may at times help provide this diagnosis, possibly without the need of an endoscopy.

Even though this form of food allergy and disease is now well understood and documented by the medical profession, many doctors can still not come to terms with the notion that a food can cause disease. Indeed, coeliac disease is now considered to be an autoimmune disease, affecting many parts of the body, not just the intestine.

Crohn's Disease is an inflammatory bowel condition, and often occurs in the ileum, although it can occur in any part of the digestive tract, from mouth to anus. It is regarded as an autoimmune disease, with the body fighting its own tissues, and typically affects younger patients from about 12 to 30 years of age. Common features include gut pain, diarrhoea, bowel bleeds and weight loss. The pain is often excruciating. When it occurs in the small intestine which is not uncommon it often takes conventional medicine a long time to make such a diagnosis.

Advances in Visualising the Small Intestine

In days gone by, doing a Barium Meal, with a subsequent follow through, could provide useful pictures of the anatomy of the small intestine. For the most part, the x-ray pictures do not provide good visualization of the surface, or any chemical or germ information about the bowel whatsoever. ***Most labs are still stuck with this obsolete technology.***

The first major advancement was **capsule endoscopy**. This is an expensive test, since the capsule is actually a camera that transmits a picture, and is wasted at the end of the test, often flushed down the toilet. The procedure involves swallowing a small capsule that takes and transmits digital pictures as it passes through the small intestine. Up to 50,000 images are transmitted to a recording device worn on a belt around the waist. This recording device saves the pictures to be looked at and interpreted at a later time. Although this does provide direct vision of the lining of the bowel, it still does not allow any biopsying or sampling of material in the small intestine. It is a successful test for diagnosing Crohn's disease showing local bowel irritation, and can also detect polyps, ulcers and tumours in the small intestine.

More recent advances include **double balloon enteroscopy**. The technology involves the use of a balloon attachment on a scope which helps the scope move through the small intestine. The scope does allow for biopsy of tumours for surgical localisation using dyes, and for observing bleeding sites, and using laser to stop the bleeding. This procedure is not available to most people, and is in its infancy, being used mostly at several university hospitals in the USA. ***This is definitely a big step in the future of understanding the mysteries of the small intestine.***

There is more the medical profession doesn't know about the small intestine than what it actually does know. The small intestine has a massive amount of lymph or immune tissue surrounding the intestinal tissues, especially in the mesentery (the fold of tissue that anchors the small intestines to the back of the abdominal wall). With all this immune tissue or lymph glands, some of the mysteries of the small intestine could be brought to light. The small intestine has the job of absorbing nutrients, and filtering out disease, infected material and things that have been ingested and not wanted.

It obviously has a major role in many diseases throughout the human body, but these are barely understood - issues like the malabsorption of vitamin B12 which can cause pernicious anaemia. The role of the small intestine is critical in the forming of allergies, in particular food allergies and food sensitivities. On the whole, the medical profession has no clear notion on how this occurs, nor why it occurs, and remains blissfully ignorant.

The role of the small intestine in conditions like **irritable bowel syndrome** is obviously critical. But again, the profession has a problem coming to terms with this bowel condition, and for the most part, since it is not lethal, this sort of permits the medical arrogance. The role of the small intestine and glucose absorption in diabetes, in reactive hypoglycaemia, and in metabolic syndrome, is very critical. Again, the profession has no notion, and leaves it to dietitians and diabetic educators to try to sort out the mess.

The role of the small intestine in acid disease is extremely poorly understood. What we can't see can't hurt us. Well that is wrong! Our techniques allow us to see the duodenum, and obviously duodenal ulcers form a normal part of medical and surgical training. However, people producing too much acid will get typical symptoms in the upper half of the body including stomach pain, burning, and acid reflux symptoms which they often learn to recognise. Excessive acid will also necessarily

affect the lower bowel and particularly the small intestine. The fact that acid symptoms are not as pronounced, does not mean that acid damage is not being felt. Acid damage can include bloating symptoms, leaky gut disease and malabsorption states.

The role of the small intestine with **leaky gut syndrome** is in itself one massive topic. It is extremely poorly understood. Leaky gut syndrome refers to the **pore size** for particle absorption on the intestinal surface. When the pore size is increased due to various gut damaging issues including infections, infestations, viral disease or excessive stomach acids, then large molecules are absorbed into the blood stream, including large chains of the protein units known as amino acids. Leaky gut syndrome is the only credible explanation for food allergy, yet the profession has great difficulty coming to terms with both concepts that leaky gut syndrome actually exists, and also that food allergies are common, exist and can cause debilitating diseases – we still have a lot to learn about the mysteries of the small intestine.

Conclusion

The mysteries of the small intestine are extensive. They need to be explored. The profession has sat on its hands on this topic and only most recently with clever new techniques like double balloon enteroscopy does it seem that some of the mysteries will be solved. For an individual suffering with small intestinal disease, the symptoms triggered may be harrowing, with not only loss of quality of life, but loss of longevity also. I personally believe that medical research should develop a major focus on trying to solve the mysteries of the small intestine. These mysteries once solved are worthy of 100 Nobel Prizes in Medicine. If we continue to clumsy along at the current rate of ignorance, it may take mankind decades, or even centuries, to solve these important health issues.

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Coeliac Disease - Associated Conditions

Coeliac NSW & ACT website

There is a range of medical conditions associated with coeliac disease, and while it is important to keep in mind that many will not develop these conditions, awareness that these associations exist is essential to encourage screening, diagnosis and proper treatment. The reasons other medical conditions complicate coeliac disease are:

- **Genetics** - the inherited genes that make a person susceptible to coeliac disease also make them susceptible to a range of other immune conditions. Many people find that several autoimmune diseases are present in their immediate or extended family. Therefore, it is important to inform your doctor of the presence of other autoimmune conditions in yourself or your family. Screening should occur even if there are no obvious symptoms of coeliac disease. There is some evidence that early diagnosis and treatment of coeliac disease reduces the risk of other autoimmune disease developing.
- **Chronic inflammation** - the chronic inflammation caused by coeliac disease mainly affects the small bowel lining, but can also present in a variety of other organs in the body such as the skin, joints, bones, liver, pancreas, thyroid gland, nervous system, and reproductive tract.
- **Small bowel damage** - Chronic inflammation in the lining of the small bowel can result in poor absorption of nutrients – vitamins and minerals, e.g. calcium, vitamin D, iron, vitamin B12, leading to problems such as anaemia and vitamin deficiencies.

Conditions Associated with Coeliac Disease

Coeliac disease can affect most systems in the body. The following medical conditions occur at higher frequency in people with coeliac disease. These complications are thought to result from the abnormal immune response caused by gluten. You should speak to your doctor if you have any concerns or questions about these conditions for which there are specific treatments. Early diagnosis and treatment of coeliac disease can greatly reduce the risk of most of these problems ever occurring.

Glands (Endocrine system)

- Autoimmune thyroid disease
- Type 1 diabetes
- Addison's disease (insufficient adrenal hormones)
- Sjogren's syndrome (dry mouth and eyes)
- Amenorrhoea (absent menstrual periods)

Joints (Rheumatological)

- Polyarthritis (arthritis in 5 or more joints) and rheumatoid arthritis (inflammation of joints and other organs)
- Lupus (body attacks healthy tissue and organs)
- Sarcoidosis (inflamed nodules usually in lungs or lymph nodes)

Blood (Haematological)

- Anaemia (iron or B12 deficiency)
- Chronic thrombocytopenic purpura (low platelets)

Gastrointestinal

- Lactose intolerance
- Pernicious anaemia (inability to absorb B12)
- Pancreatic insufficiency (inability to properly digest food)

- Microscopic colitis (watery diarrhoea)
- Gastrointestinal cancers

Bone

- Premature osteopaenia (low bone mineral density) and osteoporosis
- Low trauma fracture
- Rickets or osteomalacia (caused by low vitamin D)

Liver

- Abnormal liver function tests
- Autoimmune hepatitis
- Primary biliary cirrhosis (blocked bile ducts)
- Primary sclerosing cholangitis (scarring of bile ducts)

Nervous system

- Multiple Sclerosis
- Neuropathy (breakdown of the nervous system)
- Epilepsy
- Depression

Skin and mouth

- Dermatitis herpetiformis (chronic, intensely itchy skin rash)
- Alopecia (hair loss)
- Dental enamel defects
- Mouth ulcers

Reproductive system

- Infertility
- Recurrent miscarriage

Other

- Lymphoma
- Pneumococcal pneumonia (pneumonia of upper respiratory tract)
- Down's syndrome
- Turner's syndrome (missing or abnormal X chromosome in women)

6 Pillars of Healthy Living™ (extracts from <http://www.drbradjacobs.com/>)

Modern life keeps us so busy that we are often overcommitted, juggling multiple priorities and feeling out of control. This lifestyle is exhausting, unsustainable, and can damage health. Research has shown that 70-90% of health conditions can be prevented, or adequately managed through lifestyle alone; therefore, a cornerstone of Dr. Brad's innovative solution includes his trademarked "Six Pillars of Healthy Living":

1. **Healthy Eating** - Is your caloric intake appropriate for the amount of energy you are expending? Are you eating the right types of foods? What is your relationship with food?
2. **Active Living** - How is your posture? What types of exercises, movement, and activity do you do on a daily basis? How do you feel about the level of vitality in your body?
3. **Restorative Sleep** - Is your sleep restful and sufficient?
4. **Stress Reduction and Awareness** - How well do you bounce back from adversity? How well do you manage a stressful lifestyle? Are you able to access the full potential of your mind?
5. **Connection** - How do you connect with yourself? With others? With nature?
6. **Finding Passion and Purpose** - Is your passion aligned with your values? How much time do you spend on those things that you are most passionate about?

The Possible Mix that makes up ME/CFS

By Dr Mark Donohue (speaker at the November 2014 meeting)

Dr Donohue spoke to the last meeting about a serious long term illness – Myalgic Encephalomyelitis or Chronic Fatigue Syndrome (ME/CFS). The following table, which he discussed in great detail at the meeting, illustrates just how complex this illness can be. It also highlights why many doctors just cannot help their patients to get better, because their medical training does not cover many of these areas:

<p>Genetics</p> <p>G</p>	<ul style="list-style-type: none"> • Our inheritance from our family history • Methylation (MTHFR gene) • Lewis Secretor • DQ2/DQ8 coeliac genes (also autoimmune genes) • HERVs (ancient virus imprinted on our DNA) • Epigenetics • Gene expression
<p>Environment</p> <p>E</p>	<ul style="list-style-type: none"> • External environment • Chemical insults – antiseptics, pesticides, phenols • Drug treatments • Moulds and mycotoxins • Simple sensory things – sleep, light, touch, noise
<p>Microbiome</p> <p>M</p>	<ul style="list-style-type: none"> • Our non-human organ essential to health (the bacteria that lives inside us) • Susceptible to pesticides and other poisons • Critical to detox and protect • Plays a big part in inflammation, obesity etc • Biofilms
<p>Inflammation</p> <p>I</p>	<ul style="list-style-type: none"> • Inflammation is a controlled process • Neuroinflammation and glutamate storm • External causes – trauma, moulds, microbes, food • Internal causes – biotoxins, LPS, autoimmunity • Protection and Resolution – address adrenal function and nutrition
<p>Nutrition</p> <p>N</p>	<ul style="list-style-type: none"> • Our most intimate relationship! • Loss of seasons, variability and winters • Terile food plus high carbohydrates all year round • Preservatives and pesticides change our Microbiome! • Restrictive diets can make nutrition worse
<p>I that is We</p> <p>I</p>	<ul style="list-style-type: none"> • We are part of the ecosystem • We need the external environment for life • We need the internal environment for health • We are sickening and “old foes” are arising • We need a broader view of health and life

Genetics - The first stage of my GEMINI diagnostic matrix is the identification of inherited and genetic risk. This will show any weak spots that provide opportunities for infection, inflammation and injury. The family history is the critical key to understanding inheritance, but an increasing number of genetic tests are proving useful for identifying methylation defects, predisposition to infection, gluten reactivity and autoimmunity and even adverse drug reactions and dosage requirements.

Irrespective of the genetics, epigenetic expression under the influence of diet, stress, and even the microbiome of the gut is the hot new area of research. A body of evidence for transgenerational inheritance of acquired epigenetic changes is growing. As if that weren't enough, we are now seeing the re-emergence of human endogenous retroviruses (HERV), ancient viruses copied into our DNA and thought to be fossils of past infections.

Research in the areas of autoimmunity and even chronic fatigue syndrome seem to be showing that these long "dead" DNA viral segments are resurrecting and inducing abnormal immune responses as we fight our old enemies. Knowing enough about genetics and epigenetic expression to keep away from some common trapdoors and reduce some of the risks is the first step of GEMINI.

Environment - After I graduated, my next training was in Environmental Medicine with the Australian Society of Environmental Medicine (ASEM) from 1985. I was working in a rural area on the Central Coast, and was repeatedly seeing farmers who should have been in excellent health suffering from persistent inflammatory and neurological conditions for which there was no clear explanation.

What tied these cases together was the use of a class of pesticides known as organochlorine insecticides, such as dieldrin, heptachlor, chlordane and DDT. Some colleagues and I got together in the late 80s to visit America and see Dr Rea's Dallas clinic and John Lasseter's laboratory, AccuChem. We were so impressed that on returning to Australia we established what we believe was Australia's first inpatient controlled-environment hospital unit in Sydney, the Special Environment Allergy Clinic (SEAC).

This Clinic opened its doors in 1989 and closed in 1994. During this time we saw and treated over 300 inpatients with a combination of chronic fatigue syndrome and chemical sensitivity or chemical toxicity. We carried out clinical research which was published in the [Medical Journal of Australia in 1995](#), identifying significantly higher levels of organochlorine pesticides in CFS subjects compared to controls.

The high proportion of agricultural workers, especially farmers, admitted to our clinic (before it was closed down under political pressure in 1994) seemed to confirm our suspicion that exposure to such pesticides was harmful despite the toxicological literature suggesting otherwise. Of course, we now know the impact of those pesticides on the bacteria in our gut and in epigenetic expression, and there is now general consensus that the type of harm that we described in 1995 as a result of pesticide exposure is most likely true and causative in nature.

What is absolutely clear is that humans depend for health upon a rich diverse external environment devoid of poisons and rich in nature. We depend on that environment for our breath, for the water we drink and for the food we eat. The contamination of our planet and the destruction of biodiversity weakens and impairs us. It makes us susceptible to illnesses that we have not previously encountered.

Protecting and cleaning up the environment that we have contaminated starts in the home, the school and the workplace, and spreads out from there to our back yards, our community, our parks, our beaches, and ultimately to the planet. Healthy, vibrant and natural surrounds, nature's noise and perfumes, the wind brushing our skin and sunlight waking us in the mornings to the marvellous beauty of our planet – this is the environment we were born for, the environment that sustains us and our health, and the cycle of life that shepherds us through our days and nights, and from birth to our eventual death. Rebuilding our relationship with nature can be really difficult, but small steps go a long way, and allow us to rediscover the healing magic can come from this sacred communion.

Microbiome - Despite what Wikipedia says, the microbiome is neither new nor recently discovered. It has, however, become *the* hot topic in medicine as the scientific community rediscovers the intimate relationship between ourselves and our "little masters" the gastrointestinal flora known as the microbiome.

Why the fuss? Yes, these bacteria outnumber us 10 to 1 if you just count the cells, and 150 to 1 if you count the genes. But there's less than a kilo of them and they're, well, kind of dirty. They make poo! How important can they be? The answer seems to be, "more important than we ever could have imagined". We depend upon them for nutrients that we cannot make or absorb from our diet.

They control energy harvesting and obesity, especially when provided with loads of sugar. They are very involved in inflammation, and our immune system is hugely influenced by their numbers and diversity. They manipulate our autonomic nervous system and affect mental functioning very profound ways. When the balance is distorted by antibiotics in drugs or foods the proportions change and they can turn feral very quickly. They were around before we were born, and if we are buried rather than cremated they will recycle us and continue on well beyond our death.

The microbes in your gut have never died. We can trace their lineage back over many billions of generations to the primitive bacteria and archaea. In many ways, we are just temporary housing for them, and there is a good case that we live healthily when we meet the needs of our microbiome optimally.

Managing gastrointestinal ecology and gut biodiversity requires a deep appreciation of the value of fresh organic food in season, avoidance of antiseptics and unnecessary antibiotics, a reduction in simple carbohydrates, and avoidance of preservatives and antiseptics in foods that blunt the genetic and species diversity within us. The art of managing digestion, nutrition and the gastrointestinal tract is arguably the most difficult task for a health-care practitioner. When it works, however, it is among the most rewarding outcomes, as food becomes the friend rather than the enemy and the microbes work to give us rewards and keep us healthy.

Inflammation - The control of inflammation is the holy grail of modern medicine. Inflammation underpins most of the degenerative disorders such as Parkinson's disease, arthritis and Alzheimer's disease, as well as the big killer, cardiovascular disease. It shows up as chronic infection and loss of organ function, it is disabling and painful, and it is managed poorly by most modern medications, and in fact by modern medicine itself.

The medications used to control inflammation such as steroids like cortisone and non-steroidal anti-inflammatory drugs like Celebrex and aspirin are all problematic because they are unsustainable in the long term without serious injury. If you gave most general practitioners the choice of one magic pill, I'm pretty convinced that pill would be one that eliminated inflammation without adverse effects.

Inflammation used to be considered to require four signs – rubor, calor, dolor and tumor (redness, heat, pain and swelling). This is not always true, especially in so-called neuritis with the nervous system or its surrounds are inflamed but have a different type of cell in place of the inflammatory peripheral immune cells.

Inflammation is not as disorganised as it may seem, however. Dietary agents derived from animals and plants, known collectively as omega-3 fatty acids, are metabolised to wonderfully powerful anti-inflammatory and protective agents known as protectins, resolvins and neuro-protectins. Plenty of omega threes seems to be an answer to reducing inflammation and protecting the most vulnerable organ of all – the brain – from the harms associated with inflammation. There are many other nutritional and supplemental agents, as well as the many drugs that can quench the fire of neuroinflammation, and many others that can help restore normal function after inflammatory damage.

Nutrition - We are very, very focused on diet and nutrition. My early training was in Nutritional Medicine, which is really the therapeutic application of nutrients in place of drug therapy. It is not the same as the nutrition learned by dietitians. What is very clear to any practitioner who was dealt with chronic fatigue syndrome or complex and chronic illnesses is that the gastrointestinal tract is almost always a player in the process, and the successful management of gut symptoms and restoration of normal gut function is one of the cornerstones of almost every successful treatment outcome.

Different people need different type of food, but almost everyone benefits when the diet consists of fresh organic foods in season with high variety and high nutritional content, especially the trace elements and omega-3 fats found in fish. Of course, this isn't the case for everyone, especially those requiring highly restrictive diets. One of the jobs natural healthcare practitioners do repeatedly and well is to restrict diets to improve the health of people affected by adverse food reactions. What is equally important, however, is to restrict only those foods with solid evidence of adverse reactions, and to reintroduce all the foods necessary for optimal nutrition and to restore the joy of eating and sharing meals with one's family.

I do restrict certain foods such as gluten and milk with the person's history or family history, or functional or genetic tests point to a food-related disorder. During this time, nutritional supplements are often helpful in maintaining a high quality of nutrition prior to the reintroduction of the foods. As described under Genetics previously some people carry genes that predispose them to fight prolamins in gluten-containing grains such as wheat, rye and barley. One rare outcome of this is coeliac disease, but the more common outcome is autoimmune disorders such as thyroiditis, type II diabetes and chronic inflammatory disorders.

I am not a fan of prolonged restricted diets especially severe restriction of healthy foods such as fruit and vegetables in low-salicylate diets. In most cases, if the diet needs to be restricted it is because the gut is abnormal, inflamed and possibly leaky. I use probiotics and cultured foods such as kefir, yoghurt, sauerkraut and others along with short-term, specific dietary restrictions to restore gut integrity, decrease gut permeability and return the sufferer to normal joyful eating and better nutrition.

The final "I" in "Gemini" is ... well ... I. Me. The sufferer - The individual affected. The person isolated by an unnamed, complex and unexplained illnesses. Treating the "disease" is useful but insufficient. The disease takes each sufferer on a very lonely journey into unnamed regions, and each path from that desperate isolation needs a transformation from "I" to "We". A transition from the lonely desperation to support, care, love and eventual recovery. Some, tragically, do not make it through.

This is not a question of the illness being in the body or in the mind. We are whole creatures. whole families. whole communities. and ultimately, a whole planet. We are tied to our external and internal ecosystems to the point that we have no clear divisions – we *are* what we eat, what we drink and what we breathe. Our internal environment is 90% microbes and 10% human.

We are constructs of our world and members of community. Our *health* depends upon relationships with others - with microbes, with food, with family and with nature. Health does not happen in isolation, and neither does recovery from illness and suffering. Certainly, we need to manage the physical aspects of the illness such as infection, inflammation, pain, and poisoning. But deep recovery and resilience needs acceptance and compassion, care and support from those surrounding the sickened person.

Sometimes, it's the simple shared activities of movement, mindfulness and meditation. Sometimes, it's the family sitting down to organic, wholesome meals consciously and joyfully. Or sleeping well and waking early to walk or run with the sun on our skin. Sometimes, it's a pet that brings joy. While the support of the family builds resilience and recovery, the understanding and support of friends and close community diminishes disability directly and indirectly. An employer offering reduced workload and hours, friends organising outside activities, neighbours helping with preparing meals – these make a huge difference to the sufferer, and maintain the touch and gossip so fundamental to feeling "normal"

What we doctors are slowly relearning is that complex and chronic illnesses are nothing like the acute diseases we handle so well. They do not bend to our technology. They require time, a willingness to stay with the patient – to deeply *understand* the patient - and to work through a dozen bad ideas to find the ones that will help rebuild health. Recovery is earned and precious. It is not cured by medical brilliance or miracle cure.

To treat the whole person, we have to go beyond the whole person. The "I" has to become "We". We are a collaboration of external and internal environments, and something of an invention of our own microbiome. We require an external environment supportive of health and recovery after illness. We need understanding, love and acceptance to return to a community from which we have become isolated when we are sick. And we need to relearn the skills, arts and traditions of humans throughout history to restore health and vigour and resilience after illness.

Why is this important? For more than 30 years I have watched and learned and helped people recover from chronic, debilitating and almost inexplicable illness. Some do well and some do poorly. Sometimes the illness is beyond the person's ability to recover (or their belief that they can recover), and we lose them forever. And sometimes, no amount of love and support can change

the outcome of the disease, but it always reduces the suffering and improves the quality of life for the person affected.

We are increasingly seeing these complex, chronic and difficult-to-define illnesses that will not submit to medical diagnosis and treatment. This does not make them untreatable, but treatment is only step one. Real recovery, or healing, needs more, and much can be gained from traditions of healing and the support of family and community. Mindfulness, meditation, relaxation, exercise, artistic expression, joyful food preparation and meals, living clean foods, good sleep, clean air and water and the simple touch of other humans all have profound influences on health and recovery.

Relearning life is not easy in the 21st-century, yet these are skills we need to recover to make our world fit for humans and humans fit for our world. Miracles regularly occur when we get this right, when we break the isolation and alone-ness, and rediscover the power of "We".

Thrown to the Wolves

(New Book by Ron Buckridge, member of our Association)

"THROWN TO THE WOLVES?" is a revised and updated edition of Ron's first book **"THE POLITICS OF DEMENTIA"**, a copy of which is available in the Association's library.

In February 2002, Ron began writing to federal ministers and senior departmental officers regarding alleged anomalies in the provision of Alzheimer's Disease (AD) medications on our PBS. These enquiries soon branched into most areas of aged care. It became self-evident that our planning and provision of resources for (AD) victims was totally inadequate; would our Ageing Population and its Dementia Epidemic component become our social and economic millstones? I labelled the replies from Canberra serial waffle and bureaucratic sophistry. Visiting Oxford Professor, Baroness Susan Greenfield in an authoritative address, filled with humorous anecdotes, told our National Press Club on 13th July 2011 that the cost of dementia by 2050 could be a prohibitive \$83 BILLION. Applying current data suggests the cost could be three times that number?

My investigations into (AD) produced numerous inconsistencies: (AD) was always considered to be a disease of ageing but now there are increasing (and officially underestimated) numbers of patients who were less than 30 years of age. Current 'planning' suggests these patients should not be housed with geriatrics? But where are the real resources and funds for any of this? In recent times the Productivity Commission produced two reports, the latter a 1,000 page effort. Between those two was a report by senior counsel. All three advocated a new bureaucracy. We have too many paper shufflers now. How can professional medical people attend to patients and fill in extraneous details on non-essential forms at the same time? I call this paralysis by analysis. The following ditty may explain:

*"A centipede was happy till one day a toad in fun said,
"Pray which leg moves after which?"*

*This raised her doubts to such a pitch
She fell exhausted in a ditch not knowing how to run.”*

It is true that a hospital formed a committee to reduce paperwork. The alleged result was that the number of forms increased by 250-300%! Over recent times, there were allegations of disgusting ‘service’ in some nursing homes. One internet case involved a report where a 90 year-old was raped, while staff looked on and nursing managers did not want to know. Finally, then Prime Minister John Howard and the relevant minister labelled this an isolated incident. However this opened a Pandora’s Box of alleged unacceptable treatment in some nursing homes. Despite a Senate enquiry nothing has really changed. Will it take a Royal Commission into all aspects of Aged Care and the provision of services to resolve these questions? If a 90-year-old citizen was raped in a public place, wouldn’t the media be all over such an incident? Should we delete the crime of rape from our laws or add a condition to allow it in nursing homes?

These young and old citizens deserve much better; they are not medical curiosities: they are someone’s grandparents, parents and children. People are paying huge amounts for their care. Are we rapidly approaching the situation where, if you can’t pay a \$250,000 – \$450,000 bond there won’t be a nursing home bed ‘available’? The government ‘solution’? Put your house up for sale. But what about the surviving spouse? The government’s \$60K lifetime payment solution for your high care didn’t last long. Did someone press the wrong key on the calculator and then announce that ‘policy’ before it was realised how little real time that covered for your care? Are we now back on the dreaded road to ‘death duties’, a policy which was eliminated in the later years of the last century? Those tactics were allegedly implemented in almost Gestapo-like fashion and universally condemned. Did we learn anything from that shameful period? Do we take real action now or just **THROW THEM TO THE WOLVES?**

Did the decline in some nursing home services start when the mandated number of nurses in nursing homes was deleted from federal law in 1997? It was estimated the cost of nurses in nursing homes was about 50% of running costs. Did someone fall for the “furphy” that you don’t need nurses to provide insulin or heart medication for nursing home patients? Did the desire for a few extra bucks from such alleged practices in reduced services mean some incontinent patients were only washed on every second day? Or those staff on certain shifts were given ‘impossible numbers’ of patients to service.

Are our public health/hospital/education/and higher education services sustainable given there are more patients/pupils each year and higher costs (at least CPI increases) but less resources as per the recent federal budget and earlier reductions in the 1996 budget? We haven’t enough money to sustain these and other essential, basic services. We allegedly haven’t enough money to repay our debt; we can’t pay for basic public health services; somehow these must be private/public ‘partnerships’; how many more ‘public’ assets **MUST we sell?**

Why are we allegedly selling off Australia so cheaply? Who really owns what? I especially fear for my grandchildren. What will the Australian economic picture portray when they reach the age of making important decisions?

Note from the Editor: A couple of Ron's new books have been donated to the HHAA and will be given out as lucky door prizes at the next meeting. This is quite an important topic as we are all "ageing" and expect that we will be looked after when we no longer can do this for ourselves. I know from experience with my father and father-in-law, both deceased, that the system seems to be a long way from adequate or fairly priced. There also seems to be a shortage of care facilities, which is a bit worrying considering the baby boomers will shortly be in that category, and that will certainly be "the straw that broke the camel's back".

Recipes

Unfortunately, Sue Litchfield has been unwell, and could not provide us with recipes for this Newsletter. If you have anything you would like to cook/prepare and require a recipe, please drop me a line on suebromwich@hotmail.com and I will ensure we have it in the next newsletter.