

Bend over, here it comes again...

The hidden, grisly dangers of “routine” colonoscopies

And two safe, time-tested alternatives that won't cost you a fortune (or your life!)

The U.S. is well-known for its massive expenditures on end-of-life care. On average, people here incur more medical costs during the last six months of life than during their entire life up until then. But it turns out the cost of ordinary care is nothing to sneeze at either.

“Routine” tests and exams add up to \$2.7 trillion per year (even more than the federal government’s annual deficit).¹ Colonoscopies are a case in point.

Colonoscopy is—by far—the most expensive screening test that Americans are exhorted to undergo. But there are several reasons you should think twice before “bending over,” when it comes again. In fact, skipping your next routine colonoscopy might actually save your life.

There are some serious dangers associated with this supposedly safe test you won’t hear about from the public health “experts.” Or the mainstream hype. There are also alternatives to colonoscopy that are just as effective—and much safer (not to mention less expensive). More on that in just a moment.

But first, let me tell you why some

real health experts are questioning whether it’s truly worth it to get a colonoscopy once you hit a certain age...

“Too old” for a colonoscopy?

The minute you hit 50, your doctor probably started encouraging you to get regular colonoscopies.

But at this point in life, is a colonoscopy really worth it?

You see, the major purpose of routine colonoscopies is to detect polyps growing from the mucosal surface of the colon. But it takes, on average, 15 years for cancer within a polyp to develop into full-blown colorectal cancer.²

Yes, some people have a specific genetic predisposition which can lead to multiple polyps and a higher risk of colorectal cancer. And these people should be followed and managed closely.

But anyone can potentially develop a colon polyp. And in light of that 15-year lag time, how old is “too old” to go through this uncomfortable procedure and be subjected to its risks? This question is important because “routine” colonoscopy can be quite dangerous—even fatal.

Horror-film injuries from a “routine” test

Colonoscopy is portrayed as a benign, safe procedure for everyone. But in my forensic medicine practice I have seen case after case of perforated intestines and peritonitis (a potentially fatal inflammation of the abdominal lining), lacerated and punctured livers with massive bleeding, and other fatal complications. All from “routine” colonoscopies.

I even had one case in which the

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Dr. Micozzi's *Insiders' Cures* is published monthly by OmniVista Health Media, L.L.C., 819 N. Charles St., Baltimore, MD 21201 for \$74 per year (\$6.16 an issue).

POSTMASTER: Send address changes to *Insiders' Cures*, 819 N. Charles St., Baltimore, MD 21201.

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 Publisher: Katherine Wheeler
 Executive Editor: Amanda Angelini

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For questions regarding your subscription, please call reader services at 443-353-4398 (8 a.m. to 8 p.m. EDT Mon.-Fri.)

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air pumped into the colon (to inflate it for easy examination) escaped into the patient's abdominal cavity. It put so much pressure on the liver that it cut off blood supply back to the heart. The patient died from shock.

To make matters worse, colonoscopies are often prescribed more frequently than medical guidelines recommend.

ACOG in the wheel

Ten years ago, apparently having run out of things to say on TV from one end, Katie Couric had her colonoscopy performed on the other end, live, on national TV. Patients began demanding them like the latest cosmetic procedure. Then, the American College of Gastroenterology (ACOG) successfully lobbied Congress to have the procedure covered by Medicare (in other words, us, the taxpayers).

So now, when you become eligible for Medicare at age 65, with the 15 year lag time for a polyp to become cancerous, this Medicare benefit can help you avoid coming down with colorectal cancer at age 80 years or older, on average. Just doing the math. But I digress...

The fact is, several much less expensive and less dangerous techniques are also effective. Yet specialist medical practitioners have (not surprisingly) picked the most expensive—and dangerous—option. Without any scientific data to support it. I know it sounds bizarre, given all the hype and increased recommendations for colonoscopy... but it's true.

In fact, according to a study published earlier this year in the *American Journal of Gastroenterology*, colonoscopy has never even been compared to other, much safer—and less expensive—screening methods head-to-head in randomized trials.³

This despite the continual call from mainstream medicine for ever more randomized, controlled, clinical trials—which are considered the “gold standard.”

Until the last 10-15 years, colonoscopies were only performed in doctor's offices. And only on patients at high risk for colorectal cancer or who were experiencing intestinal bleeding.

Then doctors reported they could detect early cancers even in people who are not at high risk and don't have bleeding. But, according to an article published in the *Journal of the National Cancer Institute*, there is no compelling evidence that colonoscopy offers any additional benefit over the older, cheaper, safer tests.⁴

And the bottom line is no study has shown that colonoscopy prevents colorectal cancer incidence or mortality any more than the other safer, less expensive screening methods.

And don't forget—colonoscopies can miss polyps that are present. In July, I sent out a *Daily Dispatch* reporting on a study which showed that with each passing hour of the day, gastroenterologists are nearly 5 percent *less likely* to detect a polyp during colonoscopy.

Nonetheless, the ACOG unilaterally declared colonoscopy as the “preferred” approach to colorectal cancer prevention. It certainly was preferred when it came to collecting membership dues, apparently.

Of course, colonoscopy has also become very lucrative. One analysis even reported colonoscopy is the reason the U.S. leads the world in health expenditures!

But some primary care doctors don't realize the costs of the tests and procedures they prescribe.

The most expensive hour you'll ever spend

A colleague of mine in Hartford, CT recently called the local hospital in order to price a colonoscopy. And even he couldn't get an answer.

Because this "routine" screening procedure can cost anywhere from \$6,000 to nearly \$20,000. For an outpatient procedure requiring less than an hour.

Again, they are the most expensive screening tests that otherwise healthy Americans undergo. In fact, colonoscopies in the U.S. often cost more than childbirth or an appendectomy in most other developed countries.⁵

But colonoscopies represent such a large financial burden because, unlike hip replacements, c-sections, or even nose spray, everybody gets them—or is supposed to, whether they need it or not.

The final "knock-out" blow

And on top of all this, there is the "wild west" of administering anesthesia during colonoscopies. Not only does anesthesia add to the procedure's risk, but this service is billed separately—and is all over the map.

For anesthesia during one surgical procedure, for the exact same service, one anesthesia group practice charges \$6,970 from a large private health insurer, \$5,208 from Blue Cross Blue Shield, \$1,605 from Medicare, and \$797 from Medicaid.⁵ *What* is the real cost of providing this service? Who knows!

A better question is: *Why* are anesthesiologists involved in colonoscopies at all?

Colonoscopy does not require general anesthesia. Moderate sedation—a drug like Valium, or another intravenous medicine that takes effect and wears off quickly—is all you really need. Both of which could technically be administered by any nurse in any doctor's office. There is no clinical benefit whatsoever from having anesthesiologists involved in this procedure. But it adds a further cost of \$1.1 billion per year.^{7,8}

So, who is keeping the anesthesiologists where they don't belong? Our "friends" at the FDA. They refuse to modify the drug labels advising that moderate sedation must be performed in the presence of an anesthesiologist (a policy that the American Society of

Anesthesiologists lobbies strongly to keep in place, of course).

So all of this leads us to the \$1 billion question...

What are the alternatives?

Here we have yet another situation where the most expensive, most dangerous screening procedure has simply never been proven to be better than less expensive, safer procedures.

Three proven alternatives to colonoscopy are:

- 1.) The long-established **hemoccult test** detects blood in the stool as a sign of intestinal bleeding. When there is bleeding in the lower intestinal tract it can be seen as bright red blood in the stool. But when the bleeding is higher up, the blood breaks down and becomes invisible, or "occult." Fecal occult blood testing can decrease the risk of death from colorectal cancer by 33 percent.⁹ Not bad for a test that is cheap, completely safe, non-invasive, and that you can administer yourself in the privacy of your own bathroom.
- 2.) To get an actual look inside the lower intestine, opt for a **sigmoidoscopy**. Unlike

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U.S. ranks as a world leader—in health care costs

It's not just colonoscopy that is too expensive. Americans pay more for almost everything we get from the healthcare system than people in other countries.

Hip replacements cost four times as much here as in Europe. Caesarian sections are three times more expensive than in Britain and New Zealand. A common nasal spray for allergies costs over five times more in the U.S. than in Europe. Hospital stays are three times more expensive in the U.S. compared to the rest of the developed world (even though they are being cut shorter and shorter by insurance companies).

We are prescribed more frequent, and more expensive, tests and procedures than in other countries—whether or not those countries have private or government health systems.

The International Federation of Health Plans compiled a list of drug treatments, scanning tests and other procedures which shows the U.S. is the most costly in all of their 21 categories—often by a huge margin.⁶

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colonoscopy, which examines the entire colon, sigmoidoscopy only enters the lower large intestine, which is where most cancers occur. Several recent studies have shown that this screening method is as effective as colonoscopy—if not more so.^{10,11} In fact, according to one of these studies, getting just ONE sigmoidoscopy between the ages of 55-64 can reduce incidence of colorectal cancer by 31 percent and colorectal cancer mortality by 38 percent.¹² A sigmoidoscopy can be done right in your doctor's office and doesn't require any sedation. Which makes it much less expensive—and also much safer—than colonoscopy.

3.) A relatively recent development has been **CT colonography**, which involves doing CT scans to detect colon polyps. In general, CT colonography is done every five years, but radiologists have worked


out several more specific guidelines for individual cases—including instances of positive fecal occult blood tests (FOBT), and to deal with the frequent problem of an “incomplete colonoscopy.”

Please don't misunderstand my intention. In no way am I downplaying the importance of colorectal cancer and effective screening for this potentially deadly disease. However, I—and many others—do take issue with the medical subspecialists' carte blanche recommendation of colonoscopy. The available science simply doesn't support it as the be-all, end-all of colorectal cancer screening. And, as always, when it comes to your health, it's absolutely critical to follow the science.

The fact is, there are serious risks associated with colonoscopy...and its superiority is unproven. But there ARE alternatives. Safer ones. That do a better (or, at the very least, safer)

job of reducing mortality from this disease.

If you have your doubts about getting a colonoscopy, make sure to consult with your primary care physician regarding your family history, personal medical history, and any current health problems or symptoms, to find out whether starting with safer, less expensive options—a hemoccult test, a sigmoidoscopy, or the new CT colonography scan—may be right for you for colorectal cancer screening and prevention.

And remember, you can lower your risk of colorectal cancer in the first place (and any other form of cancer, as well as many other chronic diseases, for that matter) by following the diet, exercise, and supplement recommendations you'll find throughout your issues of *Insiders' Cures*. 

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NEWS BRIEF

The South African secret to maintaining healthy blood sugar

In the March issue, I wrote about recent research showing that a compound in red bush (or rooibos) called aspalathin helps maintain healthy blood sugar in mice.¹ Now, some new research adds more insight into *how* red bush reduces blood sugar.

Red bush is a relatively recent discovery from South Africa, and I've explained before how it is your best option for healthy hydration. (To read more about it, refer back to my report *Miracle at Red Bush*, which you received when you subscribed to *Insiders' Cures*.) Now, this study shows that red bush also reduces insulin resistance in muscle cells.

Muscle cells make up the largest bulk of tissue in the body (after the skin). So, together with the liver, muscle activity has a profound effect on sugar metabolism. In fact, it's responsible for up to 80 percent of glucose uptake from the blood. That's why a short walk after eating dinner is so effective at driving blood sugar into muscles and avoiding obesity and diabetes (as I explained back in July in the *Daily Dispatch* “Short walks cut type-2 diabetes risk”)

Unfortunately, certain free fatty acids in the blood from the diet (such as palmitate) can interfere with glucose uptake by muscle, fat tissue and liver. But this new study showed aspalathin from red bush can reverse this effect.

In simple terms, as I've always said, red bush helps with healthy digestion after a meal as well as hydration between meals.

For a trusted source of red bush, I recommend the “Red Joe” brand, which I've helped develop. It's sold locally in Sarasota, FL but we are now making it available directly through my website, www.DrMicozzi.com.

Citations available online at www.DrMicozzi.com

WARNING: Cutting-edge macular degeneration therapy poses serious dangers

But new research shows you can cut your risk of vision loss IN HALF—without a single risky drug!

Age-related macular degeneration (AMD) is the leading cause of vision loss for men and women over 60 years. Yet, mainstream treatments are often ineffective. And expensive.

Now, some doctors have begun to use a cutting-edge cancer drug to treat AMD. Yes, it's less expensive. But it comes with serious risks.

I'll tell you more about this dangerous treatment in a moment. But first, let's consider why macular degeneration is such a big problem.

Bringing AMD into focus

Your retina is all-important for vision. It receives photons of colored light and codes them into electrical impulses. Then, it sends the impulses to the brain and central nervous system.

The center of your retina is called the macula. The macula contains highly specialized cells needed for sharp vision. Unfortunately, as we age, changes can occur to the macula. And these changes can lead to serious loss of vision.

The “dry” form of macular degeneration results from *drusen* deposits. (This word comes from the German word for “dregs,” as in dregs of wine). These deposits block the retina and cause blind spots.

The “wet” form results from the abnormal proliferation of blood vessels in your eye. These vessels leak blood and fluids that block the retina. Eventual scarring leads to serious loss of vision.

The dry form of AMD is more common. Although it may progress

to the wet form, most cases do not. About 10 percent of men and women with macular degeneration develop the wet form. But this percentage suffers the most severe vision loss.

Age-related macular degeneration (AMD) is the leading cause of vision loss for men and women over 60 years. Yet, mainstream treatments are often ineffective. And expensive.

Curiously, the abnormal proliferation of blood vessels in the wet form of AMD is very similar to angiogenesis seen in cancer growth.

The devastating cost of human error

Angiogenesis explains how cancer cells grow into tumors.

Cancer actually begins as a few abnormal cells. So how do these abnormal cells grow into a tumor mass? They deviously send out a message that redirects blood vessels to the cancer cells.

Then, the rogue blood vessels carry nutrients to the hungry cancer cells. Eventually, the cancer cells multiply and grow, forming a tumor.

As I presented in my special report *The one word battle plan to crushing cancer*, we now know that stopping angiogenesis helps slow or even stop cancer growth.

After decades of basic research proving the role of angiogenesis in cancer, Big Pharma has finally embarked on an all-out, multi-billion dollar effort to develop “anti-angiogenic” drugs.

These drugs block cancer growth by blocking the proliferation of new blood vessels. And unlike chemotherapy, this new treatment does not poison all the cells in your body.

Avastin is a new anti-angiogenic drug approved for the treatment of cancer by the FDA.

And some ophthalmologists recently began using Avastin “off-label” for the wet form of macular degeneration, in the hopes that it might stop the abnormal blood vessel proliferation in the eyes. (Once the FDA approves a drug, treating physicians can use it for any purpose they deem viable.)

This “off-label” use of Avastin appeals to AMD patients for one reason: its cost. A single injection of Avastin costs only \$50. By comparison, Lucentis—an FDA-approved drug specifically for AMD—costs \$2,000 per injection.

But, here's the catch. The manufacturer of Avastin, Genentech, does not make ophthalmic preparations of the drug. Compounding pharmacies must do it.

This process is cumbersome and potentially dangerous. The compounding pharmacies must divide a regular vial of Avastin many times to make doses small enough for treatment in the eye. Ophthalmologists inject it

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into the diseased eye using very fine syringes.

As I pointed out recently, preparing drugs for injections is a risky business. The extra handling and exposure greatly increases the risk of contamination.

Indeed, earlier this year, a compounding pharmacy in Georgia recalled 40 lots of vials. Turns out, several AMD patients developed bacterial endophthalmitis after receiving Avastin injections.

And that wasn't the first time Avastin caused problems.

In 2011, 16 people in Florida and Tennessee lost their eyesight following Avastin injections. In those cases, patients brought malpractice lawsuits against doctors, clinics and hospitals.

A study published last year in the *American Journal of Ophthalmology* investigated the problems with Avastin.¹ The researchers found that the drug itself wasn't the problem. But rather, the compounding procedures used to prepare the tiny ophthalmic syringes.

Essentially, this is the same kind of thing we saw back in 2012 with steroid injections for neck and back pain. As you'll recall, contaminated steroids caused dozens of deaths and hundreds of debilitating neurological illnesses.

Fortunately, you can skip the dangerous Avastin injections. And the pricey AMD drugs too. You don't need drugs at all to treat AMD.

"New" vision cure from age-old nutrients

Two new studies show that a few key nutrients may be all you need to save your vision.

The first study, published in May in the *American Journal of Clinical Nutrition* found that vitamin B12 and folate decrease the risk of macular degeneration.² These B vitamins help

maintain the peripheral nerves of the body. So it stands to reason they can benefit the highly specialized nervous tissues of the eye and retina.

Previous studies have noted statistical associations between serum homocysteine levels, vitamin B12, folate, and age-related macular

Fortunately, you can skip the dangerous injections and the pricey drugs too.

You don't need drugs at all to treat macular degeneration. Two new studies show that a few key nutrients may be all you need to save your vision.

degeneration (AMD). But this new study investigated how intake and blood levels of B12 and folate affect incidence of AMD over 10 years.

Blood levels were measured in samples drawn during 1997-1999 from a cohort of study participants 55 years and older. Dietary intake of B12 and folate were assessed using a food frequency questionnaire. And the presence of AMD was assessed by taking retinal photographs.

Higher homocysteine levels showed a linear, dose-response increased risk of AMD.

Patients with lower serum B12 had a 1.58 times higher risk of developing early AMD and a 2.56 times higher risk of later AMD.

Lower folate levels were associated with a 75 percent increased risk of early and 89 percent increased risk of later AMD.

Patients who took B12 supplements had a 47 percent reduced risk of AMD.³


A healthy dose of B12 (cyanocobalamin) is 20-40 mcgs per day, and 800-1,600 mcgs of folate per day. You can also ask your doctor about getting periodic B12 injections.

The second study, called LUTEGA, is evaluating the benefits of carotenoids, omega-3 fatty acids, and antioxidants for AMD.

One group of patients was given 10 mg of lutein, 1 mg of zeaxanthin, 100 mg of the omega-3 fatty acid DHA, and 30 mg of the omega-3 fatty acid EPA per day. A second group was given double these daily doses. And a third group didn't take any supplements.

After one year, researchers found that vision had improved among all the patients taking supplements. Improvements were the same with both the lower dose and higher dose of these supplements. However, vision deteriorated in the control group.

Lutein and zeaxanthin are two of the carotenoids my colleagues and I discovered during the 1980s when we examined the nutrient content of foods that protect against cancer. No one had ever heard of them before then. When I was interviewed on NIH Radio about our findings, the commentator said it was "too bad" these particular carotenoids were not (then) available in supplement form. I said not to worry because they are available in every grocery store—in leafy green, and yellow-orange fruits and vegetables.

Of course, these carotenoids are available in supplement form now—both alone and in combination. But even if you do choose a supplement, I always recommend following a diet high in fruits, vegetables, and fish. In addition to helping preserve your vision, eating in this healthy way has many other benefits as well. 

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The hidden costs of that “perfect” lawn

In the early 1980s, two British epidemiologists published a technical book on the causes of cancer. They concluded cancer was primarily due to factors that we, as individuals, can each control—such as tobacco, diet, body weight, physical activity, and sun exposure. They considered the contribution of “environmental” factors such as pesticides, pollution, food additives, etc., to be very small by comparison.

This was 10 years into the U.S.’s own flailing “war on cancer,” and the National Cancer Institute and the rest of the government largely went down this road mapped out by the British.

Unfortunately, it has turned out to be mostly a dead end.

Despite the general public’s collective efforts to quit smoking, improve their diets, lose weight, and slather themselves with sunblock, most cancer and chronic disease rates have continued to increase.

As I’ve written before, the government’s focus on smoking did not turn out to be the final solution for oral cancer, or even for lung cancer, for that matter. When it comes to dietary factors—saturated fats, eggs, meat, and other favorite government culprits—the evidence has been evaporating. Even being “overweight” isn’t the chronic disease and death sentence the “experts” have made it out to be (except when it comes to morbid obesity, which has now been declared the new disease of the month). And, of course, the crusade against sun exposure has actually contributed to a national and global epidemic of vitamin D deficiency which is now being seen to have wide-ranging negative health effects.

Meantime, evidence has been mounting that pesticides are strongly associated with increased cancer risk.

Pesticides fuel tumor growth

Some pesticides, such as lindane, propoxur, and endosulfan can mimic estrogen activity in the body. And they are prime suspects for increasing tumor incidence.

In fact, a new study in the journal *Anticancer Research* revealed how these pesticides can increase tumor growth (that all-important “mechanism of action” I keep mentioning).¹ As I explain in this issue’s lead article (and in my special report *The one word battle plan to crushing cancer*), the only way cancer cells can grow into tumors is by hijacking the body’s blood supply—a process called “angiogenesis.”

“Anti-angiogenesis” is well on its way to becoming the new watchword for targeted, non-toxic interventions against cancer. But it is important to remember that there is a “flip side” to this coin. Indeed, some chemicals cause angiogenesis. And, in turn, fuel cancer growth.

This new insight won’t just help us find effective ways to prevent and treat cancers. It will also help us identify what specific substances are really causing cancer in the first place.

And researchers have found that the particular pesticides I mentioned above do not damage DNA (thus they are not like “mutagens” that cause cancer “initiation”). So their cancer-causing effect is due to their ability to promote subsequent tumor growth, for example, through angiogenesis.

18 holes with a deadly “handicap”


We worry a lot about pesticides in our foods. And we should, since large crops are treated with a couple rounds of pesticides each cycle. But I have become more concerned about a source much closer to home. That is, all the chemicals that are poured onto lawns to keep them artificially green and weed- and “pest”-free. This is especially a problem on golf courses.

These large turfs require constant maintenance. Barely a day goes by, all year round, when workers aren’t spraying an herbicide, fungicide, insecticide or other “cide” onto these vast acreages—which then drain into our water supply.

Many of the chemicals used on golf courses have long been recognized as environmental carcinogens (causing cancer initiation). Now we are seeing others can act as cancer promoters (including through angiogenesis).

So it’s no surprise that studies around the world have been finding significantly higher rates of all types of cancers among golf course workers.

No one is really studying it yet, but I think the next problem we will find is increased cancer rates in avid golfers themselves—people who are on the golf courses for long periods almost every day, or several times per week. Not to mention all the people living on and around the high-end real estate that was built right on golf courses.

I, for one, wouldn’t recommend spending too much time hanging around on artificially green lawns or golf courses, waiting for the results to come in. There are a lot of other ways to get your exercise and your sun. 

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Building better bones—without more calcium

When it comes to the problem of osteoporosis (“brittle bones”) and hip fractures in elderly women, the focus has been on calcium in the diet. The government’s confusing and contradictory recommendations on dietary calcium have not helped.

But getting enough calcium from the diet or from supplements can be quite a challenge (see the article “Protect yourself from the government’s blatantly wrong ‘requirements’” in the September 2012 issue of *Insiders’ Cures* for more on this topic).

The good news is, there are other—better—options for protecting your bones.

In fact, new research shows that one of the best ways to prevent brittle bones and hip fractures is to get plenty of a nutrient I’ve covered in these pages quite a bit recently: omega-3 fatty acids.

Scientists analyzed blood cells from women with and without a history of broken hips as part of the large, long-term study known as the Women’s Health Initiative.¹ (I helped organize the forerunner of this study at the National Institutes of Health during the mid-1980’s.) They found higher levels of omega-3 fatty acids were associated with a lower risk of suffering a hip fracture.

Researchers also looked at omega-6 fatty acids (a prominent ingredient in the packaged, processed foods that are such a large part of the standard American diet). They found the higher ratio of omega-6 to omega-3 fatty acids, the higher the risk of hip fracture. Women with the highest levels had up to double the risk.

The researchers attributed the increased risk of bone loss and fractures to inflammation. This also helps explain the protective role of omega-3s. Omega-6 fatty acids promote inflammation, while omega-3s help reduce it.

In the February 2013 issue of *Insiders’ Cures*, I described how controlling inflammation is the key to controlling the damage and pain that occurs to joint cartilage in arthritis. And I also explained that to benefit the joint cartilage, it’s critical to support the underlying bone.

A complete approach to bone and joint health should control inflammation to prevent arthritis, osteoporosis, and fracture.

What to add—and what to cut

As usual, wholistic, natural approaches are the best options for protecting your bones.

Osteoporosis drugs have shown disastrous side effects. I consulted on one recent case where the drug given to strengthen the hip bone caused erosion of the jaw bone (mandible) leading to an abscess that was permanently disabling—and nearly fatal.

So here is yet another reason to make sure you get sufficient omega-3s from diet and/or supplements.

I recommend everyone take at least 1 to 2 grams per day of omega-3 fatty acids from fish oil. Ideally, you should be looking for dietary sources of omega-3s, such as salmon, sardines, and other fatty fish. Of course, if you don’t like fish, purified omega-3s and fish oil supplements are widely available.

It is very important to use a high-

quality fish oil supplement, which has been distilled to remove toxic metals like mercury, so you don’t get the wrong results—like the recent study on fish oil and prostate cancer from the statisticians in Seattle (see the August 5, 2013 *Daily Dispatch* “Something smells fishy—and it’s not the fish” for more on this debacle). Nordic Naturals makes some good quality products that I have personally tested over the years.

It’s worth noting that this study also suggests that plant sources of omega-3s were just as effective as fish sources. Good plant sources of omega-3s include flaxseeds, chia seeds, cauliflower, and walnuts. Flaxseed supplements are also widely available.

Of course, it’s not just about what to add to your diet, but about what to cut. Avoid omega-6 sources. Linolenic acid comprises 99 percent of the omega-6s in the U.S. diet. It’s found in corn, soybean, safflower and sunflower oils.

Between corn oil, corn syrup, and genetically mutated “sweet corn” itself (see my *Daily Dispatch* from June 17, 2013, “The curious case of corn”—available on my website, www.DrMicozzi.com), we have reached the point where this once great Native American food regrettably needs to be avoided altogether, in all its forms. The No. 2 crop grown by U.S. farmers today has simply become toxic (and that’s not even counting the pesticides—more on that topic on page 7 in this issue). And, unfortunately, our No. 1 crop—soy—is now no better.

Note to big agriculture: you have a growing problem. 

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