DR. MICOZZI'S
INSIDERS' CURES
FEBRUARY 2018 • VOLUME IX • ISSUE 2

What you REALLY need to know about your blood pressure

And why you'll be safer ignoring the new guidelines

While everyone was getting ready for the holidays, suddenly there were screaming headlines proclaiming, that "millions" more Americans will need blood pressure treatment.

The message was that blood pressure readings which had previously been considered safe—and essentially healthy—are now suddenly too high.

In fact, two large medical organizations I call the "delusional duo" have decreed that the new "normal" level should be less than 120/80. And "high" blood pressure starts at a reading of 130/80.

This means that a whopping 46%, or 103 million, American adults are now defined as having high blood pressure. And among people under age 45, the rate has *doubled* for women and *tripled* for men.[1]

The suspicious data behind the new guidelines

Since blood pressure is a serious risk factor for heart disease, we need to consider this new proclamation very seriously. Particularly because it flies in the face of real evidence I've long reported about healthy blood pressure levels—and how those benchmarks change as we age.

So I looked *past* the headlines—something many doctors don't do.

I found that this "new" evidence about healthy blood pressure readings came primarily from a clinical trial where researchers jumped to conclusions so fast, the study was never even *completed*. Plus, the researchers rushed to publicize the "results" in the media even *before* this incomplete study was published in a medical journal!

But the biggest mystery of all is that this faulty study was published two years ago—so why has it suddenly resurfaced? And why have the "delusional duo" of the American Heart Association (AHA) and American College of Cardiology (ACC) decided to issue new blood pressure recommendations now, based on this highly questionable study?

Today I'll reveal what you *really* need to know about high blood pressure. I'll also share my all-natural prescription for lowering blood pressure—and preventing heart disease—*without* drugs.

The lower the blood pressure, the more prescriptions written

In recent years, doctors were told to aim for a systolic blood pressure of less than 140 mm Hg for all adults, based on evidence from studies. Then in 2013, recommendations were relaxed to less than 150 mm Hg for people age 60 and older—again, based on evidence. In March 2017, the American College of Physicians and the American Academy of Family Physicians published clinical guidelines based on the 2013 recommendations.[2]

Why? Because as you get older, slightly higher blood pressure levels help support healthy circulation of blood and oxygen to the brain, heart, and other tissues—helping prevent cardiovascular disease and dementia. Higher levels also mean fewer blood pressure drugs are needed.

But because the AHA and ACC apparently couldn't leave "well enough" alone, the guidelines they released in November 2017 mean doctors will need to write millions more prescriptions to lower blood pressure even *further* than what has long been considered normal. This means not only more drugs for more people, but more drugs being taken by the *same* people.

In fact, to reduce blood pressure to the new, lower levels, patients in the study I mentioned above ended up taking three drugs on average, *or more*. As I report on page 6, this type of multiple drug use can cause

In this issue:

Marc S. Micozzi, M.D., Ph.D., is a worldwide leader in nutritional and complementary/alternative medicine. He has had a distinguished career as a researcher and physician executive at the National Institutes of Health and Walter Reed National Military Medical Center in Washington, DC, and the College of Physicians in Philadelphia PA. He has published over 30 medical and trade books, and founded and edited the first scientific journal, and the first textbook, on complementary/alternative and nutritional medicine, now going into a 6th edition (2018) and continuously in print since 1995.

Dr. Micozzi's *Insiders'* Cures is published monthly by OmniVista Health Media, L.L.C., 100 W. Monument St., Baltimore, MD 21201 for $74 per year ($6.16 an issue).

POSTMASTER: Send address changes to Insiders' Cures, 100 W. Monument St. Baltimore, MD 21201.

Author: Marc S. Micozzi, M.D., Ph.D.
Publisher: Katherine Wheeler
Executive Editor: Amanda Angelini

deadly side effects and interactions.

Are we heading for yet another big pharma boondoggle?

Unfortunately, there's *no real evidence* for this "new" proclamation about reducing blood pressure. In fact, it reminds me of all of the hoopla a couple decades ago about how lowering blood cholesterol would lower the risk of heart disease.

This "coincidentally" occurred just after statin drugs hit the market. Thanks to the "cholesterol boondoggle," big pharma was able to sell billions of new pills, for billions in profits, to millions of new patients who were perfectly healthy—but only at presumed risk of heart disease.

Unfortunately, it turns out these cholesterol "wonder" pills eventually led to *more* problems than they could ever hope to solve—including cases of cataracts, dementia, diabetes, kidney disease, muscle problems, and even heart disease itself.

Now, the lucrative patents for statin drugs are expiring, and big pharma needs a new fix. So, suddenly we have new, lower blood pressure guidelines. Coincidence? I think not.

One faulty study led to a nationwide mess

The study the AHA and ACC based their new guidelines on is called SPRINT (Systolic Blood Pressure Intervention Trial).[3] This study was designed to see if people who have a systolic blood pressure reading of 120 have less risk of heart disease, stroke, kidney disease, and memory and cognition loss compared with people with a 140 reading.

The study evaluated 9,361 men and women, age 50 or older, with a systolic blood pressure reading of 130 or higher, and at least one cardiovascular disease risk factor. The participants were divided into two groups—the intensive treatment group, which took medications to lower their BP reading to 120, and the comparison treatment group, which aimed for a reading of 140.

The study began in 2013 and was expected to last four to six years, but researchers shut it down after only two years. They attributed this to the "superior benefits of the more intensive blood pressure treatment intervention on the primary outcome and on total mortality."[4]

These results were hardly "superior." In fact, SPRINT is certainly an appropriate name for this study, considering the record-breaking speed the researchers set in jumping to these conclusions. But the sprint has now turned into a marathon, as they come around for another long lap—two years later.

The SPRINT findings were published in November 2015, but an article in the *New York Times* by Gina Bari Kolata (who I've known for many years) had already "scooped" the results two months earlier.[5]

I thought Gina's story was the last we'd hear of SPRINT. But now, she (and many other journalists) are once again reporting on it, thanks to the ACC and AHA's inexplicable resurrection of this faulty study and their subsequent new blood pressure guidelines.

The *real* numbers you need to know in the SPRINT study

As I mentioned above, the reason SPRINT was stopped prematurely was because the study participants in the most intensive treatment group (achieving 120 systolic blood pressure) had a lower incidence of cardiovascular complications compared to the standard treatment (140 systolic BP).

These results were heralded as earthshaking. But in reality, the intensive treatment group had a cardiovascular complication rate of 1.7% per year, while the standard treatment group had a rate of 2.2%. The actual risk reduction was just 0.5%. But because of the large number of study participants, this meager result was able to achieve statistical significance.

In other words, when the actual risk reduction is so small, the number of people who need to be treated to try to prevent just *one* bad outcome becomes very large. Of course, treating larger numbers of otherwise healthy people is just what big pharma wants, as we saw with cholesterol drugs.

Even the authors of the SPRINT study admitted that to prevent one death, 172 people would have to be intensively treated for *three years*. Meanwhile, the other 171 people would be subjected to multiple toxic, dangerous, and potentially deadly side effects from blood pressure drugs—with *no* benefit. A terrible model for medical practice and public health.

But that's not all that's wrong with the SPRINT study…

Five fundamental flaws that clouded results—and put YOU at risk

There are many reasons why this study should *never* have been used as the basis of new blood pressure guidelines. But here are the top five:

1.) The study was not blinded.
Instead, it was "open-label," meaning that the people who participated in the study, along with their physicians, knew *exactly* what treatment group they were in and which treatment they were getting. And that means their expectations could influence the study outcome.

Blinding is done to eliminate bias and the placebo effect—a very real phenomenon in which people respond to an intervention simply because they expect that they will, regardless of whether or not it has any true therapeutic value.

There's no physiologic measurement I can think of more subject to the placebo effect than blood pressure. It's an exceptionally volatile biologic variable, changing constantly in response to stress, activity, environment—*especially* being in a doctor's office or medical clinic.

In fact, bias and the placebo effect can account for the *entire* outcome of a study like this, especially when the treatment effect is small, as it was in the SPRINT study.

2.) The researchers didn't use realistic blood pressure measurements.
Participants' blood pressure levels were taken as an average of three measurements during an office visit, while the person was seated, and after five minutes of quiet rest. There were no staff members in the room.

All of these factors are indeed needed for an ideal measurement. But when is the last time *you* had your blood pressure measured that way in a busy medical office? A systolic blood pressure of 130 under the ideal circumstances of the SPRINT study probably translates to 140 or 150 in real-world circumstances.

So people who might have lower blood pressure when they're not in a stressful situation are in danger of being prescribed unnecessary blood pressure medications, based on the fantasy-world measurements used in the SPRINT study.

3.) The study measured too many different outcomes.
Another fundamental error was using a composite endpoint. Researchers are taught to assess one outcome, or endpoint, per clinical trial. But the SPRINT researchers used a laundry list of endpoints.

In other words, instead of conducting a study to see if lowering blood pressure reduces heart disease, the SPRINT researchers evaluated blood pressure's link to heart disease, kidney disease, stroke, and age-related declines in memory and cognition.

Composite-endpoint studies are often done to magnify the effect of a treatment (like blood pressure medication), particularly when the occurrence of individual outcomes is too low to observe anything. It's another statistical gimmick, employed to get a "significant" result.

4.) The monitoring committee didn't do its job.
All studies have data and safety monitoring committees. These committees *confidentially* monitor ongoing findings to observe whether a benefit becomes so obvious, there's no need to continue the study. They also observe whether any dangerous side effects arise that would cause the treatment to be discontinued.

When I was at the National Institutes of Health, confidential monitoring was a major component in conducting proper studies. And it's been a critical component of controlled, blinded clinical trials for decades.

Yet, the SPRINT study didn't bother with blinding, so the whole concept of confidential data monitoring was irrelevant—since everybody knew everything all along.

Nonetheless, the SPRINT data and safety monitoring committee stopped the study *years* ahead of schedule— when the intensive

treatment group was observed to achieve only a slight reduction in composite outcome (but only using the statistical gimmicks I already explained).

So you have to wonder what the *real* purpose of this otherwise useless committee really was?

Well, one thing that ending the study early *did* achieve was to downplay the dangerous side effects of the blood pressure medications the researchers used. These side effects would have typically increased over time if the study had been allowed to continue as originally designed and intended.

In fact, serious side effects had already been observed in the intensive treatment group when the study shut down.

We're talking about dangerously low blood pressure (hypotension) and fainting (resulting in bone fractures), along with potentially fatal electrolyte disturbances. Furthermore, the risk of acute kidney failure was *twice as high* in the intensive treatment group.

5.) People with diabetes were excluded from the study.
Of course, many people with high blood pressure also have diabetes, and there have been multiple studies on both conditions. One of the most significant is ACCORD (Action to Control Cardiovascular Risk in Diabetes).

This study of over 10,000 people found that not only was there *no benefit* to intensive blood pressure and blood sugar treatments, but lowering blood pressure and blood sugar too much was actually associated with *higher* mortality.[6]

But by refusing to include people with diabetes in their study, the SPRINT researchers made sure the ACCORD findings, from a real scientific study, didn't interfere with their rush to judgment.

And ironically, the new blood pressure standards that are based on the incomplete SPRINT "results" are meant to apply specifically to people *with diabetes*—and especially younger people.

So what can you do to avoid the pitfalls of the SPRINT trial?

The safest ways to manage your blood pressure

My advice is to stay with the sensible guidelines of 140 or 150 systolic blood pressure levels, especially if you are over 60. To achieve this goal, I recommend the following:

- **Manage stress and practice relaxation** by using mind-body techniques. You can discover which ones that will work best for you by taking my short quiz, "Find your boundary type" found on my website, www.DrMicozzi.com.
- **Get regular, moderate exercise,** preferably outdoors in sunshine and nature (see page 5 for specific recommendations).
- **Follow a healthy, balanced diet**, including plenty of fruits and vegetables. Fruits are fine, even if you have diabetes. Fructose (the natural sugar found in fruit) appears to bypass the body's insulin responses associated with metabolic syndrome and Type II diabetes. In fact, compared to sucrose (table sugar) and glucose (natural corn syrup), it invokes a much lower insulin response.
- **Supplement with vitamins B, C, and D.** Each of these powerhouse nutrients have been shown in studies to lower or maintain a healthy blood pressure. I recommend a high-quality B vitamin complex daily, along with 10,000 IU of vitamin D. And take 250 mg of vitamin C twice a day.
- **Don't forget the fish oil.** Research shows fish oil can lower blood pressure in people with hypertension. I recommend 1 to 2 grams of DHA/EPA fish oil a day.
- **Take magnesium.** In the October 2016 issue of *Insiders' Cures* ("The critical mineral that could save you from diabetes, depression, migraines—and more"), I discussed a review of 34 clinical trials (all double-blind, unlike the SPRINT study) showing that magnesium can lower blood pressure as well as drugs. I recommend 400 mg daily.
- **Embrace herbal medicine.** In a September 2017 *Daily Dispatch* ("Six herbs for high blood pressure management") I wrote how hawthorn, coleus, lily of the valley, olive leaves, roselle, and garlic can lower blood pressure and support heart health.

All in all, prescription medication should be a last resort, not the first line of treatment. As with most of my recommendations, use natural remedies, eat a healthy diet, practice common sense, and don't believe everything (or *anything*) you hear from the mainstream.

For more detailed, step-by-step instructions on the above recommendations—as well as even more drug-free, science-based recommendations for preventing heart disease—refer to my ***Heart Attack Prevention Repair and Protocol***. You can learn more about it or enroll today by **clicking here** or calling 1-866-747-9421 and asking for code EOV3U200. IC

Why breaking this one popular New Year's resolution is the best thing for your health

February is notorious in the exercise industry for the exodus of wannabe fitness buffs. All of the people who vowed to "get in shape" in the new year grow tired of their perpetually aching muscles and joints in January…and let their pricey new gym memberships lapse.

If you got caught up in the resolution hype last month and were determined to join a stinky, sweaty indoor exercise facility, hire a "fitness coach," or run a 5K every day, don't despair if you haven't reached these ambitious goals.

In fact, you should celebrate. Maybe during a walk around the park on a sunny day.

Why? Because new research shows that walking at a moderate pace for just 120 minutes a week can significantly lower your mortality risk.

And another new study found that people who exercise less than 150 minutes a week have almost *half* the incidence of coronary artery calcification—a major risk factor for heart attacks and stroke—than the fitness fanatics who work out *three times* as much.

The overall message is one I've been delivering for decades. When it comes to exercise, *moderation is key*—as it is for virtually everything else in life.

So while I'm all for New Year's resolutions that encourage a healthier lifestyle, I cringe every time I hear someone say this is the year they plan to "turbo charge" their workouts. Because that usually means they're *not* revving up their health.

When it comes to physical fitness, study after study shows that slow and steady wins the race for longevity.

The perils of overdoing your workouts

In the October 2017 issue of *Insiders' Cures* ("Why being a 'weekend warrior' may actually be optimal for your health"), I wrote about a large British study conducted on 63,000 men and women (with average age of 58). It showed that those who only exercised one hour a week had a 31% lower risk of mortality than people who didn't exercise at all.[1]

That makes perfect sense, because we all know that some exercise is better than none. But here's the part of the study that the exercise industry doesn't want you to know. These once-a-week exercisers fared almost as well in the longevity contest as people who worked out *nearly eight times* as much.

That's right. The researchers found that people who exercised about 7.5 hours a week had a 35% lower mortality rate than non-exercisers. So the "daily diehards" who worked out almost an hour *a day* only had a 4% lower mortality risk than the "weekend warriors" who exercised an hour *a week.*

Meanwhile, other studies show that people who exercise excessively eventually put more strain on their joints, kidneys, and gastrointestinal tract than moderate exercisers.

And now, a new study shows too much exercise may also lead to heart disease. Which is quite ironic considering fitness fanatics have long maintained the belief that more exercise is beneficial for the heart. Even though prior studies show that years of intensive exercise—like running marathons and cross-country endurance races—can harm the electrical conduction system of the heart, leading to heart strain and potentially fatal abnormal heartbeats.

How more exercise can lead to more heart disease

From personal trainers to medical doctors, many people maintain that boosting your workouts helps prevent the plaque buildup on arterial walls (atherosclerosis) that can lead to heart attacks, stroke, and peripheral vascular disease.

But the new Coronary Artery Risk Development in Young Adults (CARDIA) study of 3,175 people found that those who exercised the most had an 86% *higher* risk of coronary artery calcification (CAC), or plaque buildup, compared to those who exercised the least.[2]

The study participants were divided into three groups. The first group exercised less than the U.S. national guideline of 150 minutes per week. The second group met the guideline. And the third group exercised 450 minutes per week—the same 7.5 hours as the study I mentioned above.

The researchers said they were surprised to find the third group had nearly *double* the risk of CAC as the first group. But they didn't measure how likely the various groups were to have heart attacks or die. That's odd, because CAC is considered "dangerous" by virtually all doctors and researchers—and it's often used as an excuse for even more dangerous surgeries and stent procedures.

The researchers even attempted to make their own data disappear with mumbo jumbo about how the CAC caused by exercise is different than other types of coronary artery disease because it's "more stable" and "less likely to rupture and cause heart attack." Say what?

The researchers concluded that their study doesn't mean people should stop exercising. But people should stop exercising *excessively*, a detail the researchers unfortunately did not point out.

What's considered "moderate" exercise, exactly? Another new study addresses that topic.

Less than 20 minutes of walking a day boosts longevity

I've long maintained that walking, swimming, yard work, and house work are the best kind of activities because they involve moderate energy expenditures.

And most of them can be done outside, which helps your body generate vitamin D—not to mention lowering stress through the calming presence of nature.

And new research backs me up. Researchers reviewed data on more than 62,000 men (average age of 71) and 77,000 women (average age of 69) who participated in the Cancer Prevention Study II Nutrition Cohort. This study, which lasted from 1999-2013, was the first to analyze the health effects of walking on older adults.[3]

At the beginning of the study, only 6% of men and 7% of women reported that they didn't engage in any moderate or vigorous physical activity. Not surprisingly, the researchers found that this inactive group was 26% more likely to die over the next 15 years compared to those who walked "some."

So how much is "some?" The researchers defined it as walking a total of 120 minutes a week, at a pace of 20 minutes per mile.

This isn't "power walking" by any stretch. It's just a slight increase in exertion from a casual stroll. But it provides big benefits—the study found that people who walked at that pace for just two hours a week had a 20% reduced risk of death. And that's even taking into account chronic illnesses, obesity, smoking, and other risk factors.

Think about that. Just 17 minutes of walking per day can not only significantly increase your longevity, but it's also been linked to lower rates of diabetes, heart disease, and breast and colon cancers.

While I recommend walking outside in nature whenever you can, indoor shopping malls also provide ample room to amble—especially during cold or inclement winter weather.

The bottom line is it's not too late to make a sensible, attainable, and *healthy* exercise resolution this year. Vow to get about two hours of moderate physical activity a week.

That's probably plenty of time to walk to the nearest gym, turn around, and walk back home. Which is healthier not only for your wallet, but your entire body, as well.

A "medicine cabinet makeover" could save your life

Protect yourself from dangerous drug interactions with help from your pharmacist

You already know how dangerous most prescription drugs are for your health. But there's a disturbing medical trend called polypharmacy that's even more deadly.

Technically, polypharmacy is described as taking five or more prescription medications at the same time. And sadly, this isn't unusual—especially for older people. Each drug interacts with the others, multiplying their side effects.

Mainstream doctors may say this isn't a big deal since they understand the interactions of one drug with another drug. But as people take more and more drugs, the potential for complications skyrockets.

Not to mention, in this era of "specialized" medicine, many patients see numerous doctors, who may prescribe medications without checking to see what else the person is already taking.

Lack of communication between all of these sub-specialists, combined with rushed office visits where patients don't have time to fill doctors in on their complete medical history, multiplies the risk of adverse drug interactions exponentially. More on this in just a moment.

But first, have a closer look at just how dangerous it is to take numerous medications.

Chances of dangerous side effects increase dramatically with each extra drug

Let's say you take three drugs daily, which most mainstream doctors think is just fine. In fact, as I discuss

on page 1, the "delusional duo of heart disease," the American Heart Association and the American College of Cardiology, based their new blood pressure guidelines on a study in which patients were taking an average of three or more drugs just to lower their blood pressures.

The study actually found that the drugs caused *more* complications than the condition they were trying to treat (which is probably one reason why it was cut short)!

That's hardly surprising when you do the math. With three drugs, the number of possible individual drug interactions can be estimated by the mathematical expression 3-factorial (3 x 2 x 1), or 6. That means you could suffer from six possible different drug interactions.

That's bad enough, but a new study conducted by a trio of pharmacists reveals that 11% of Americans take *five or more* drugs a month.[1] And it's even worse the older you get.

Polypharmacy dangers increase as you get older

The researchers reported that a whopping 30% of people age 65 and older take *eight or more* prescription medications daily.

So let's do the math on that, using the 8-factorial equation. The number of interactions jumps dramatically. 8 x 7 x 6 x 5 x 4 x 3 x 2 x 1 equals a mind-boggling 40,320 possible drug interactions for someone who takes eight drugs a day.

That's not even taking into account potential drug interactions with dietary supplements. Sadly, the effects of widely used drugs on vitamin and mineral nutrients is a story rarely told. Mainly, because if there is a drug-dietary supplement interaction, doctors blame the supplement—*not* the drug.

Record numbers are hospitalized from drug reactions each year

Pharmacists, who are on the front lines, recognize that polypharmacy has become a "staggering" problem in the U.S., as cited by the researchers in the study mentioned above. Indeed, this over-prescription trend is resulting in increased deaths and hospitalizations—*especially* among older people.

In fact, the pharmacists noted that prescription drug problems are linked to an estimated 119,000 deaths every year. And more than 175,000 Americans over the age of 65 need to visit the hospital each year due to an adverse reaction from a commonly prescribed drug.

Why? Mainly because taking too many drugs causes disorientation and cognitive deficits, leading to increased falls—a major cause of disability and death in older Americans.

Why the "one drug fits all" approach is so perilous

So how did we get to this sad state of affairs?

Well, in our overspecialized, disintegrating healthcare system, many older patients visit several different specialists. Each of these specialists peers down his or her treatment silo, often without due regard to the patient's other medical problems or prescriptions.

After all, they reason, if one prescription drug causes side effects, they or another doctor can then prescribe a drug to address any complications caused by the first drug.

Of course, the "electronic medical record" pushed by the government (and now required of doctors) theoretically provides a record of all medications to all healthcare providers for coordination and monitoring. But what it's really done is create information overload and a lot of "white noise" in the system, according to the pharmacists.

Another problem is the "one drug for one disease" approach of modern medicine, which the mainstream touts as providing superior science and technology.

But the great irony is that this supposedly minimalist approach to healthcare has actually led to a lengthening list of drugs, interactions, and complications for many patients.

That's because while the drugs for diseases are treated individually, the patients are not. In other words, the "one size fits all" approach standardizes dosages of drugs for a single disease—rather than for the *person* who actually has the disease (and perhaps other health ailments).

Why dietary supplements flummox the mainstream

Meanwhile, natural approaches using nutrients and botanicals are derided by mainstream medicine for not fitting into this "one drug for one disease" category.

Why? Because each vitamin, mineral, or herbal remedy has *many* beneficial effects, both for preventing and for reversing virtually every chronic ailment.

You'd think that would be a good thing. But not if you're big pharma…

With drugs, some are now designed to prevent disease. Others are designed to treat disease. And still others are designed to simply manage various health conditions (if they even work at all).

But in natural medicine, a single nutrient or herb can have multiple

benefits for disease treatment, prevention, *and* management—not to mention quality of life and other health metrics.

The mainstream says that's "not specific" enough. But why should these wide-ranging benefits be seen as a problem—unless you're a mainstream doctor who doesn't understand how nutrients and botanicals actually work in the human body?

The simple step you can take to avoid polypharmacy

If you consult a pharmacist in Europe, he or she will review *all* of your treatment options—including natural approaches, as well as drugs. That's because European pharmacists are aware of the costs and complications of drugs, as well as the alternatives.

Fortunately, this trend is becoming more common in the U.S. as well. More and more pharmacists are educating themselves about multiple disease prevention and treatment options, and are willing to discuss them with patients.

That's why I recommend getting to know your local pharmacist. You'll quickly learn which ones can discuss dietary supplements intelligently.

Once you've found a pharmacist you like, ask them which hours are less busy for them. Then, stop in to discuss any drugs you may be taking and ask how they interact with each other—as well as with the dietary supplements you take.

Pharmacists are aware of the growing problem of polypharmacy, and are actually there to help. Don't be afraid to seek their advice when it comes to your medications. It could very well save your life. IC

Citations for all articles available online at www.DrMicozzi.com

NEWS BRIEF

Why your heart attack risk skyrockets in the winter

The REAL cold weather culprit and the simple solution you can start TODAY

It's well documented that more heart attacks occur during winter than summer.

These seasonal heart attacks have been blamed on everything from the cold to shoveling snow. But a compelling new study offers even more evidence for the real cause.

The researchers discovered that older adults with inadequate vitamin D levels are over 12 times more likely to suffer from heart failure than their D-sufficient peers.[1]

In fact, this study of 137 men and women over the age of 60 found that people with low levels of D had an even higher risk of heart failure than those who had heart arrhythmia or were obese.

The researchers suggested that the cardiovascular benefits of D could be related to the vitamin's ability to control chronic inflammation. This is backed up by studies in Scandinavia, Spain, and elsewhere that have linked the occurrence of heart attacks to low D levels.

So what does all of this have to do with the higher incidence of heart attacks in the winter?

Well, as I've reported before, just 20 minutes of full-body sun exposure during the summer can help your body make more than enough of its daily D requirements. But if you live north of Atlanta or Los Angeles, the sun isn't high enough in the sky from October through March to produce optimum levels of D.

The result? More heart attacks in winter cold when the snow flies.

How much D do you need?

The Brazilian study defined vitamin D deficiency as less than 30 ng/ml—which contrasts with the mainstream's 20 ng/ml threshold of deficiency.

Here is yet another study that begs the question regarding the mainstream's low recommended levels: How do you define "sufficient" vitamin consumption when it comes to human health and disease?

Of course, the mainstream only considers bone health when it comes to the Recommended Daily Allowances (RDA) for vitamin D—completely ignoring the dosage necessary to lower the risk of cancer, heart disease, and other killers.

And not only are higher levels of vitamin D key for preventing a host of chronic diseases, they can also increase survival... In fact, in the September 4, 2017 *Daily Dispatch* ("Breast cancer survival rates shoot up by 63% with one simple vitamin"), I reported on the ability of vitamin D to double survival in young women with difficult-to-treat premenopausal breast cancer.

So as the light stays low and the weather remains cold, help keep your heart, body, and brain healthy by supplementing with 10,000 IU of vitamin D per day.


20% OFF
20% OFF—ONE-TIME ONLY
Dr. Micozzi's
Heart Attack Prevention
& Repair Protocol
Click This Coupon
For one-time savings on this
natural, heart-healing pathway
to low blood pressure.
Must be redeemed by Wednesday, February 28, 2018
>> CLICK HERE TO REDEEM <<