

# Dr. Shari Lieberman

Dedicated to the Scientific Pursuit of Better Health

## April, 2004 Newsletter

### *Dr. Shari Lieberman's Nutritional & Integrative Therapy Review Newsletter*

Welcome to my newsletter. Each month I review the cutting-edge research in the field of nutritional and integrative medicine and give you my commentary. At the end of each newsletter, I give a specific nutritional protocol for a specific disorder. The newsletters and nutritional protocols can also be found on my website. You may also visit my website to view my numerous Powerpoint presentations given at medical conferences and visit my Q & A, library and more. As an ongoing commitment to excellence in product development, you can also view products I have developed and co-developed with leading experts all over the world.

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## **1. Constipation and its implications in the critically ill patient.**

*Mostafa SM, Bhandari S, Ritchie G, Gratton N, Wenstone R. Br J Anaesth. 2003 Dec;91(6):815-9.*

**Abstract:** Motility of the lower gut has been little studied in intensive care patients. Researchers prospectively studied constipation in an intensive care unit of a university hospital, and conducted a national survey to assess the generalizability of findings. Constipation occurred in 83% of the patients. More

constipated patients (42.5%) failed to wean from mechanical ventilation than non-constipated patients (0%),  $P < 0.05$ . The median length of stay in intensive care and the proportion of patients who failed to feed enterally were significantly greater in constipated than non-constipated patients. The survey found similar observations in other units. Delays in weaning from mechanical ventilation and enteral feeding were reported by 28% and 48% of the units surveyed, respectively. Constipation has implications for the critically ill.

**Commentary:** It is not unusual that you see a study involving constipation in a foreign journal. It's just something we don't pay any attention to here. Many physicians and other health providers think it's just fine if one is constipated and does not have regular bowel movements. The only time this is addressed is when it becomes severe. This study illustrates just how serious constipation can be in critically ill patients. If you are constipated you are re-absorbing toxic by-products of digestion and creating bowel dysbiosis. Those patients that remained constipated stayed in intensive care longer, failed to be weaned from mechanical ventilation and could not start to eat normally. I've never seen a hospital in the USA serve high fiber food (gee what a concept for constipation) or use any type of essential oils like flax or fish oil rather than mineral oil which would deplete nutrients. Sometimes enemas are used in a hospital setting as well. In German and Swiss clinics for example, bowel toxicity and constipation is addressed before any treatment is initiated for patients. Cancer patients will have colonics and saunas to detoxify themselves before initiating any treatment protocol. Colonic therapy is accepted in many countries as a recognized method of detoxification and as a therapeutic modality. In the USA colonic therapy is equivalent to voodoo. Well, maybe some practitioners just need to get out and travel more. Go ahead, see the world and learn something new!

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## **2. Weekly high-dose 5-fluorouracil as 24-hour infusion and folinic acid (AIO) plus irinotecan as second- and third-line treatment in patients with colorectal cancer pre-treated with AIO plus oxaliplatin.**

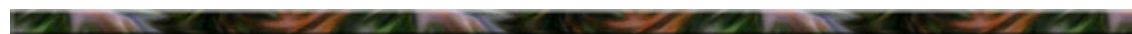
*Stickel F, Jungert B, Brueckl V, Schirner I, Brueckl WM, Mannlein G, Hegewald J, Muhlendorfer S, Bittorf B, Hohenberger W, Hahn EG, Wein A. Anticancer Drugs. 2003 Oct;14(9):745-9.*

**Abstract:** Our objective was to evaluate the efficacy and safety of high-dose 5-fluorouracil (5-FU) as a 24-hour infusion and folinic acid (FA) (AIO regimen) plus irinotecan (CPT-11) after pre-treatment with AIO plus oxaliplatin (L-OHP) in colorectal carcinoma (CRC). Twenty-six patients with non-resectable distant CRC metastases were analyzed for second- or third-line treatment with AIO plus CPT-11 after pre-treatment with AIO plus L-OHP. The main symptom of toxicity was diarrhea (NCI-CTC toxicity grade 3+4) occurring in five patients. Nausea and vomiting presented in two patients. The response rate of 26 patients can be

summarized as follows: partial remission: n=7 (27%); stable disease: n=9 (35%) and progressive disease: n=10 (38%). The median progression-free survival (n=26) was 5.8 months, the median survival time counted from the treatment start with the AIO plus CPT-11 regimen was 10 months and counted from the start of first-line treatment (n=26) was 23 months. We conclude that the AIO regimen plus CPT-11 is practicable in an outpatient setting and well tolerated by the patients. Tumor control was achieved in 62% of the patients. The median survival time was 10 months and the median survival time from the start of first-line treatment (n=26) was 23 months.

**Commentary:** In addition to the myth that antioxidants should not be given with chemotherapy (see my Powerpoint presentation in my library) another myth that has been perpetuated is that folic acid of any kind should not be given with chemotherapeutic drugs that essentially deplete this nutrient. This is simply not the case. This study confirms earlier studies that co-administration of folic acid with drugs such as 5-FU actually improves treatment and survival. Those patients that received the chemotherapy with the folic acid had a much longer progression-free survival time: 23 months or 10 months vs. almost 6 months without any folic acid at all. I am certainly not impressed with the results of this chemotherapeutic regimen in terms of survival. But this study clearly demonstrates that if one is to travel down this road of treatment it should be done along with folic acid.

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### **3. A randomized trial of two different doses of a SHR-5 Rhodiola rosea extract versus placebo and control of capacity for mental work.**

*Shevtsov VA, Zholus BI, Shervarly VI, Vol'skij VB, Korovin YP, Khristich MP, Roslyakova NA, Wikman G. Phytomedicine. 2003 Mar;10(2-3):95-105.*

**Abstract:** A randomized, double-blind, placebo-controlled, parallel-group clinical study with an extra non-treatment group was performed to measure the effect of a single dose of standardized SHR-5 Rhodiola rosea extract on capacity for mental work against a background of fatigue and stress. An additional objective was to investigate a possible difference between two doses, one dose being chosen as the standard mean dose in accordance with well-established medicinal use as a psychostimulant/adaptogen, the other dose being 50% higher. Some physiological parameters, e.g. pulse rate, systolic and diastolic blood pressure, were also measured. The study was carried out on a highly uniform population comprising 161 cadets aged from 19 to 21 years. The study showed a pronounced antifatigue effect reflected in an antifatigue index defined as a ratio called AFI in those taking the Rhodiola supplements only. The difference in AFI was statistically significant for both doses of the Rhodiola compared to the non-treatment group, while no significant difference between the two dosage groups was observed. There was a possible trend in favor of the lower dose in the psychometric tests. No such trend was found in the physiological tests.

**Commentary:** There is a wealth of scientific information showing Rhodiola is an excellent adaptogenic herb - right up there with Panax (Asian) ginseng and Eleutherococcus senticosus (formerly known as Siberian ginseng). All these herbs have a remarkable ability to buffer the body's response to stress. They all improve fatigue significantly, mental performance and mood. Other studies have shown that they may even improve sleep. Since stress is my middle name - I take a combination of all three of these herbs every day. There is also research that suggests each of these herbs may also improve sports performance and boost immune function. There is specific research on ginseng demonstrating that it may speed recovery from an illness and prevent degenerative diseases associated with aging such as diabetes and cancer.

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#### **4. Treating depression comorbid with anxiety- results of an open, practice-oriented study with St John's wort WS 5572 and valerian extract in high doses.**

*Muller D, Pfeil T, von den Driesch V. Phytomedicine. 2003;10 Suppl 4:25-30.*

**Abstract:** Depressive disorders in comorbidity with anxiety disorders represent a frequently diagnostic and therapeutic problem. A combination of 500 mg of valerian (Euvegal® Balance) and 600 mg of St John's wort (Neuroplant® or a higher dose of 1000 mg valerian and 600 mg of St John's wort were given to 500 patients with moderate to severe depression with generalized anxiety disorder. In general, doctors prescribed the higher dose treatment to those with more severe illness. Patients were evaluated before treatment, after 3 weeks on the treatment and after 6 weeks on the treatment. Symptoms were listed on a depression sheet with the ICD-10 list of symptoms plus a focal question from the Hamilton Anxiety Scale (HAMA) as well as a specific item assessing anxiety/nervousness and tension/dysphoria. Global Clinical Improvement (GCI) was also part of the assessment of treatment between the two groups. The doctors rated efficacy of treatment as "very good" or "good" in 87.2% of the cases and as "poor" in 1.6%. Tolerability was assessed as "very good" or "good" in 96.8% of the cases. In the comparison between the first and third examination, overall, 83.2% of the patients in the treatment groups rated the efficacy as markedly or very markedly improved. Only 3 patients reported mild adverse side effects. Drowsiness was not increased even with the higher dose valerian therapy. The combination of the two preparations for basic therapy for mild to moderate depression comorbid with anxiety is effective. In cases of severe depression and anxiety, treatment should be done with serotonin re-uptake inhibitors or serotonin/noradrenalin re-uptake inhibitors. From economic viewpoints, additional treatment with valerian is also recommended.

**Commentary:** The major problem with this study is the design. The study design could have been better. However, despite some of these pitfalls it appears that when patients were treated with a combination of 500 mg of

valerian and 600 mg of St. John's wort mild to moderate depression/anxiety symptoms dramatically improved. The more severe patients treated with 1000 mg of valerian and 600 mg of St. John's wort appeared to have marked improvement as well. Why they decided on a therapeutic dose of 600 mg when the therapeutic dose of St. John's wort in every study of mild to moderate depression is 900 mg per day is questionable. Studies that utilized very high dose St. John's wort (1800 mg/day) for severe depression demonstrated significant improvement. Given these previous studies, the researchers should have increased the St. John's wort dose to 1800 mg with the higher dose valerian in severe depression/anxiety. Also, these natural therapies should have been compared to conventional treatment. It would have given more power to the study. And the statistical evaluation should have been more precise and clear. What I find most bizarre are the authors' conclusion, "In cases of severe depression and anxiety treatment should be done with serotonin re-uptake inhibitors or serotonin/noradrenalin re-uptake inhibitors. From economic viewpoints, additional treatment with valerian is also recommended." Why they would say this after demonstrating that the higher dose combination did in fact work in severely depressed/anxious patients is a mystery. And the researchers recommend that valerian be given along with conventional treatment despite the fact that this study did not have an arm that looked at the interaction between valerian and conventional drugs. Despite these and other issues with the present study, it appears that St. John's wort given along with valerian may be a therapeutic modality for mild to moderate depression and anxiety and is certainly worth a try. The St. John's wort was standardized to provide 3%-6% hyperforin and 0.1%-0.3% hypericin. The valerian was an ethanolic extract.

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## 5. Reduced risk of Alzheimer disease in users of antioxidant vitamin supplements: the Cache County Study.

*Zandi PP, Anthony JC, Khachaturian AS, Stone SV, Gustafson D, Tschanz JT, Norton MC, Welsh-Bohmer KA, Breitner JC. Arch Neurol. 2004 Jan;61(1):82-8.*

**Abstract:** Antioxidants may protect the aging brain against oxidative damage associated with pathological changes of Alzheimer disease (AD). Elderly (65 years or older) Cache County, Utah residents were assessed from 1995 to 1997 for prevalent dementia and AD, and again in 1998 to 2000 for incident illness in this cross-sectional and prospective study. Supplement use was ascertained at the first contact. Among 4740 respondents (93%) with data sufficient to determine cognitive status at the initial assessment, we identified 200 prevalent cases of AD. Among 3227 survivors at risk, we identified 104 incident AD cases at follow-up. Analyses of prevalent and incident AD yielded similar results. Combined use of vitamin C and vitamin E was associated with a 78% reduced prevalence of AD in the cross-sectional analysis and a 64% reduced incidence of AD during follow-up. A trend toward lower AD risk was also evident in users

of vitamin E and multivitamins containing vitamin C, but we saw no evidence of a protective effect with use of vitamin E or vitamin C supplements alone, with multivitamins alone, or with vitamin B-complex supplements. The authors conclude that use of vitamin E and vitamin C supplements in combination is associated with a significantly reduced prevalence and incidence of AD. Antioxidant supplements merit further study as agents for the primary prevention of AD.

**Commentary:** Yes - let's study this further rather than recommending vitamin C and E to prevent Alzheimer's. Just think of all the harm that would be done giving this recommendation. I can't help but be sarcastic. There are so many studies now on antioxidants including combined use of vitamin C and E as well as with high dose alpha-lipoic acid and CoQ10 demonstrating a clear benefit in both preventing and treating AD - why wouldn't someone want to take these nutrients if they are at risk for Alzheimer's? Or even if they have AD? Heaven forbid someone would combine these antioxidants with Ginkgo biloba, vinpocetine, huperzine and phosphatidylserine for even greater prevention and treatment effect. There is no currently available drug that prevents or treats AD successfully. In fact, many of these supplements have been shown to delay and perhaps improve AD even better than many of the currently available drugs. You could even take these nutrients along with conventional drug treatment for AD if necessary.

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