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Artificial Sweeteners May Be Problematic

Stanley Hazen, MD is the director of the Center for Cardiovascular Diagnostics and Prevention at the Cleveland Clinic Lerner Research Institute in Euclid, Ohio. His research project, published in the February 27th issue of the *Journal of Natural Medicine*, involved finding substances in a person's blood that might predict the risk of a heart attack, stroke or death in the next three (3) years. By sheer accident, he discovered that an artificial sweetener called erythritol used in the sweetener Stevia, and monk fruit products, seemed to increase the stickiness of platelets resulting in increased cardiovascular and cerebrovascular events.

Dr. Hazen's researchers analyzed blood samples of almost 4,000 patients located in the USA and Europe. The higher the erythritol level the more likely the patient was to experience a heart attack or stroke or death within three years. To understand why this occurred, the researchers turned to animal studies. They found that the higher the blood level of erythritol, the more responsive or likely to form a clot the platelets became.

In a follow up study, the researchers served beverages with erythritol to eight healthy volunteers at a dosage commonly found in a U.S. diet drink. They then followed the blood levels and possibility of clotting and found that the beverage elevated the erythritol levels one thousand-fold and the level remained elevated for up to three days.

The authors and reviewers of the study cautioned that this study showed a correlation between erythritol and cardiovascular issues, not a direct cause and effect. Both agreed further research is necessary.

Erythritol is a sugar alcohol found naturally in some fruits and vegetables. It has 70% of the sweetness of natural sugar and zero calories. It is manufactured in large quantities for use in diabetic and diet products because it has no after taste and has far less of a laxative effect than other artificial sweeteners.

The authors of the study suggest that if you are diabetic, have known cardiovascular disease, or have major risk factors, you should read the labels and consider avoiding products that contain erythritol until more is known.

New Blood Pressure Treatments on the Horizon

Elevated blood pressure affects one in three adults worldwide but only 20% of those individuals have their blood pressure under control. Keith Ferdinand, MD, professor of clinical medicine at Tulane University School of Medicine, New Orleans, noted that effectively treating high blood pressure could prevent 76 million deaths, 120 million strokes, 79 million heart attacks and 17 million cases of heart failure over the next 25 years.

The reasons for poor blood pressure control include the cost of medicines, the need to remember to take multiple medicines to control blood pressure, lack of access to medical care with monitoring of blood pressure and many lifestyle issues including smoking, obesity, sedentary lifestyle. One of the ongoing research studies designed to combat this public health situation is the development of the "polypill." To control blood pressure, physicians usually have to prescribe three different classes of blood pressure medicines. This involves purchasing three products and remembering to take them all at the appropriate times of the day.

However, the polypill puts several different types of antihypertensive medicines (three or four) into one pill that you take once a day. Ongoing research shows great success with this strategy. The question remains whether pharmaceutical manufacturers will now actually produce such a pill and sell it in the United States after the medication goes through the vigorous FDA approval process?

In a presentation at a recent American Heart Association conference, George Bakris, MD from the University of Chicago School of Medicine presented his results on the Kardia-1 study which involved injecting patients with a medication that inhibited angiotensinogen which begins the chemical process of raising our blood pressure. The study examined the effects of injecting various dosages of this medication and found that it not only controlled blood pressure well over 3-6 months but had few adverse effects. This injectable will require additional human studies before it is available and of course we have no idea what the actual price to patients will be.

Despite this, the prospect of the polypill and an injectable that you can self-administer at home, and works for months at a time, is an exciting advancement in blood pressure control.

Please Go to the ER When I Advise You to Go!

On a daily basis, I receive phone calls from patients who are suddenly ill and either want to be seen in the office immediately or wish to speak to me immediately. We have an evaluation or “triage” protocol which teaches the staff when to immediately interrupt me and bring me to the phone after suggesting that you call 911. When I get on the phone, patients frequently say one of the following: *“I don’t want to go to the ER because the wait is too long.”* or, *“I don’t think the problem is serious enough to go to the ER can you please just order me an imaging study at an imaging center?”* or, *“Can I just go to a walk-in clinic?”*

I refer patients to the Emergency Department when their complaints and condition are such that I believe we do not have the equipment and/or trained staff to safely evaluate and treat you in an office setting. The last thing I want to do is bring you into the office, find that your condition requires a hospital emergency room and have to call EMS to the office to transport you safely to the Emergency Department. I do not enjoy going to the ER as a patient either, but sometimes it is a necessary evil.

We do not refer patients to the ER instead of the office because we don’t want to see you. We don’t refer patients to the ER because we don’t want to stay late to squeeze your visit in. We don’t refer patients to the ER because we want to keep our costs low and not pay overtime wages to our staff.

We refer patients to the ER because evaluation and treatment of your complaints safely requires the staff and equipment present in a hospital ER. This week alone a gentleman with recurrent chest discomfort over several days refused to go. When we finally got him to the hospital his studies revealed a life-threatening coronary artery blockage known in the non-medical press as a “widow maker.” A cardiac catheterization and stent placement saved this individual’s life. Another patient on an oral blood thinner plus a drug to inhibit his platelet function fell and hit his head. He had a terrible headache and also refused to go to the ER. When he finally did go, a large bleed and hematoma was found and surgically evacuated to save his life. A healthy woman developed chills and shakes two weeks after surgery on an inflamed internal abdominal organ. She refused to go to the ER. When she finally did the blood cultures drawn turned positive requiring several weeks of intravenous antibiotics to save her from an infection which was new and had nothing to do with her recent surgery.

I don’t like to refer my patients to the ER but sometimes that is the right thing to do. Nonetheless, I get flak and pushback from patients and family when I suggest it. However, I will continue to make that recommendation every time it is in your best interest to do so.

Proton Pump Inhibitors (PPIs) - Kidney Stones & Other Complications of Use

Medications to reduce acid in the stomach and duodenum are now available as prescription strength or over the counter at half the prescription strength. These are taken for heartburn, indigestion, gastroesophageal reflux

disease, gastritis, gastric erosions, ulcers and other gastric inflammatory conditions. They work by inhibiting a parietal cell (stomach cell) hydrogen potassium ATPase (an enzyme) thus reducing the production of acid.

These medications work well and patients who take them regularly at times cannot tolerate the symptoms that return after stopping their PPI. You know the commercial names of these drugs such as Nexium, Prilosec, Protonix, Dexilant. Their use has been hypothesized to improve GI symptoms but put you at risk for a long list of medical illnesses.

In a recent publication in the *British Medical Journal* online edition, PPIs increased the risk of developing kidney stones in over 27,000 patients followed while taking them. They increased the risk of an initial stone and for each year you continued the therapy they increased the risk by about 4%. PPIs do this by reducing the absorption of the minerals magnesium and citrate. Low citrate levels lead to more acidic urine (lower pH), and this leads to increased calcium crystallization in the urine and stones.

In the online journal *Primary Care* editorial is provided by David Rakel MD, FAAFP commenting on the original research of Timothy Overton, MD, MPH. Dr. Rakel notes that when he tries to wean his patients off PPI medications, and they just cannot tolerate the heartburn and gastric distress that returns, he will ask them to collect a 24-hour urine specimen and measure a citrate level. If the citrate level comes back “low” he restarts the PPI but supplements their diet with potassium citrate. The goal is to make the urine pH less acidic and greater than 7.0.

In Dr. Rakel’s review, he discusses all the illnesses that might increase in frequency and intensity by taking PPIs and reducing the acid level of the digestive juices in the stomach. The acidic digestive juices are an infection protector by destroying bacteria, viruses and parasites. Taking PPIs increases your risk of community acquired pneumonias, viral gastroenteritis, clostridia difficult colitis, small bowel intestinal bacterial overgrowth syndrome and the severity of Covid 19. These same medications can interfere with the absorption of iron, vitamin B12, calcium and magnesium. There is a loose evidence-based association with long term PPI use and chronic kidney disease, stroke and dementia.

It isn’t easy to just stop the PPI medications. If you do, the acid production often rebounds and produces more severe and prolonged symptoms.

Dr. Rakel presents a plan for gradually stopping PPIs. He gradually reduces the dosage every 10 days initially by 50% and then going to every other day. Prior to beginning the tapering of the drug, he requests that you taper your caffeine intake and consumption of acidic foods.

Instead of PPIs he prescribes sucralfate (carafate) one-gram tablets before meals and at bedtime for two weeks. Another option is substituting licorice (DGL) which coats and soothes the stomach. It is sold over the counter.

For nighttime symptoms he suggests using melatonin 1- 3 mg starting one half hour before going to bed. If that fails, he recommends a trial of acupuncture every 3 - 4 days for 3 weeks. Research has shown that acupuncture works better in symptom relief of heartburn and GERD than doubling the PPI dosage. His last resort for treating continuing symptoms is to add back an H2 receptor blocker such as Famotidine plus ordering a fiber optic endoscopy to inspect visually what exactly is causing the problem.

Proton Pump Inhibitors work very well in reducing symptomatic acid related GI illnesses. Like all medications, they come with potential side effects. Prior to starting them or stopping them please speak to your doctor about the pros and cons and make the best decision for your individual situation.

Walking Leads to Decreased Cardiovascular Events & Mortality Risk

I have often extolled the benefits of continuing to move. The arbitrary goal of 10,000 steps per day seems to resonate throughout the community but peer-reviewed published studies show that with far less walking you receive a strong positive benefit. Timothy Overton, MD MPH and associates published a study in the *Journal of the American College of Cardiology* that showed as little as 2,600 – 2,800 steps per day reduced your risk of a cardiovascular event and mortality risk. In their study, participants achieved additional benefits when walking up to 8,800 steps per day. Above that level, there was continued improvement in reducing cardiovascular events and reducing the risk of mortality, but the improvement numbers were not considered statistically significant.

Dr. Overton's study examined the data of 111,309 people from 12 different published studies examining the relationship between step counts and cardiovascular event rates. With 2517 steps per day there was an 8% reduction in all-cause mortality. This increased to an 11% reduction in all-cause mortality with 2,735 steps per day, an addition of just 200-300 steps. The reduction in mortality and cardiovascular events continued with increasing step counts to 7,126 steps.

Any additional benefit was not considered statistically significant. This did not necessarily mean more steps didn't help. It may very well have to do with the number of individuals in the study walking that far. That subject needs additional study.

The study did not define whether there was a benefit to accumulating your steps over the course of the day or all at once in one exercise period. Those studies will need to be done.

What is clear is that you don't have to hit 10K steps a day to benefit and walking just 2,600 steps per day reduces cardiovascular events and mortality risk. As the weather cools down, find a safe course to walk and get your steps in. It could save your life and certainly improve its quality.

Remote Patient Monitoring Available

I am currently advising you to try my remote patient monitoring (RPM) program which is covered by Medicare and many commercial health plans. The program, using Smart Watches from Apple and the Samsung 4S. The Watches have fall detection, feature emergency SOS, check for heart rhythm and rate and can record an EKG.

If you don't already own a compatible Apple or Samsung Smart Watch, you will be provided one at our expense by downloading the monitoring app and using it a minimum of 16 days out of the month. However, I recommend you use it every day. Note, you must own an Apple or Samsung Smart Phone to enroll in this program.

Same Day Cancellations Affect Others in Need

My daily schedule has been disrupted by a rash of same-day appointment cancellations even though my staff calls patients on their preferred number the business day prior to their next day's visit. In many cases, my staff also calls patients who chronically do this on the day of their appointment.

We do not mind coming in earlier or staying later to accommodate our patients' needs. We do find it inconsiderate to those patients needing to be seen who are delayed because of "no-show" or just decides at the last minute that a board game is a priority and misses their appointment (an actual reason given by a patient).

Reminder appointment cards will be offered when you complete an office visit and make your next appointment. We will continue to call you to confirm your next day's appointment. We will begin using text and email reminder messages in advance of that appointment.

This issue is being raised out of concern for patients who need to be seen in a timely fashion and to reduce the disruption it causes the practice. So please, be considerate and provide at least one day's cancellation notice whenever possible.