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Ken Baker column

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Statins' problems stimulate need for better answers

My incoming mail leaves no doubt, there is great interest in alternatives to statins for treatment of heart disease. Several nutritional combinations perform as well as the statins. In important respects they are superior. They are more effective and they treat symptoms for which statins have limited or no value.

The focus of orthodox doctors is on symptoms that respond to patented drugs. These include high levels of total cholesterol, the "bad" LDL cholesterol and triglycerides. Statins marginally raise low levels of the "good" HDL cholesterol. More recently, a long-ignored and serious risk factor was added to the orthodox repertoire after it was established statins lowered C-reactive protein ("CRP") levels.

Other signs of heart disease, even though more significant than cholesterol levels, are still in the closet. These include lipoprotein (a) ("Lp(a)") and to a lesser extent, homocysteine.

Elevated Lp(a) levels have been reported to be associated with a 70 percent increased risk of heart disease. Almost no doctors test Lp(a) levels and few if any mention it to their patients. CoQ10 has been found to reduce Lp(a). Because statins deplete CoQ10 it would appear that statin therapy, in effect, elevates this very serious risk factor.

Even those doctors who do test homocysteine levels, rarely provide nutritional therapy. Such therapy is simple, inexpensive and effective. Vitamin B-6, B-12 and folic acid show consistently good results for most patients. If the response is insufficient, Omega 3 or Trimethylglycine might be considered as add-ons.

Given that orthodox medicine treats only disease symptoms that respond to patented drugs, is it any wonder that half the sudden deaths from heart attacks are people with normal cholesterol?

Two core nutritional therapies for normalizing cholesterol and related conditions are Inositol Hexaniacinate and Policosanol.

Inositol Hexaniacinate, often referred to as "no flush niacin," is a combination of inositol and niacin. Niacin is the active agent for normalizing cholesterol. The combination is preferred, however, because niacin alone often causes flushing and itching, the result of harmless temporary release of histamines. Adding inositol

mediates the flush.

Niacin was first approved by the FDA for cholesterol normalization decades before statins were ever a gleam in any drug company's eye. In doses of 1,000 to 1,500 milligrams twice daily, on balance it has tested more effective than statins for most patients.

Although niacin only lowers LDL from 5 to 25 percent, while statins produce reductions up to 55 percent, it far outperforms statins in raising the good HDL and lowering triglycerides. Statins increase HDL from 5 to 15 percent, while niacin produces a 15 to 35 percent improvement. Although statins reduce triglycerides by 7 to 30 percent, niacin wins walking away with reductions ranging up to 50 percent.

Perhaps most importantly, niacin lowers the very significant Lp(a) levels as much as 26 percent. Statins do not lower Lp(a) at all. As noted, statins most likely increase Lp(a) levels.

While niacin has no recognized anti-inflammatory properties, CRP levels may be lowered by any of a dozen nutritional anti-inflammation nutrients, including Omega 3, and vitamins C, E or K. Doses of 1,200 IU of vitamin E alone have been found to reduce CRP levels up to 30 percent.

Professional guidance is important. Any patient already taking statins should not quit without consulting their physician. Although the risk is low, it is reported that the possibility of a cardiac event may increase for a short time following termination of statin therapy.

Starting Inositol Hexaniacinate therapy while tapering off statins should only be done under professional supervision. Testing at the 2-month and 6-month intervals is often recommended to measure liver enzymes, uric acid, homocysteine and blood glucose, as well as effects on cholesterol. The risks with niacin are very small; minimal when compared to statins. Reports from physicians who have treated more than 4,000 patients with high dose niacin, indicate no significant permanent adverse effects. There is, however, no one-size-fits-all answer and caution is prudent. It is also possible to have cholesterol levels too low.

Similarly, vitamin K and certain other nutrients should not be administered to those on coumadin except under a doctor's supervision. Those already taking medications to reduce clotting or platelet aggregation should be sensitive to the effects of various nutrients, especially vitamin E, on clotting rates.

Next I'll discuss Policosanol, other helpful nutrients, diet and exercise and what we might expect if cholesterol is too low.

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