

Healthy Ways Newsletter

The cutting edge source of information on coconut, fats and oils, diet, and nutrition.

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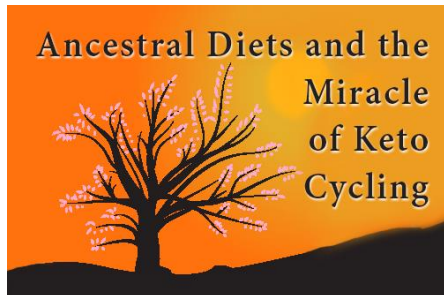
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Stories in this issue



Ancestral Diets and the Miracle of Keto Cycling

Ancestral diets are far healthier than our modern diet filled with sugar and other highly processed ingredients. Paleo, Weston A. Price, and other ancestral diets, despite how good they are, have one major flaw. Adding this missing element can make any basically healthy diet a highly effective therapeutic tool that can prevent or reverse most any chronic disease. [read more](#)



Which Oil is Best for Oil Pulling?

A variety of oils have been used for oil pulling. Some say you must use sesame oil and others proclaim sunflower oil is the best, while others say coconut, walnut, avocado, or some other oil gets the best results. Is there one oil that is better than the rest? [read more](#)



Scientific Fraud: Major Study on Alcohol Shut Down

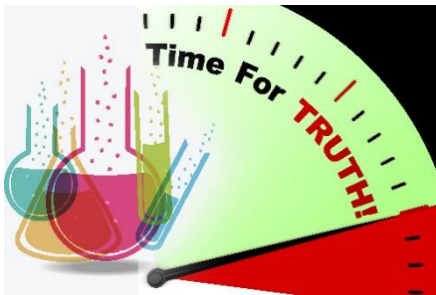
They wanted to call it the “CHEERS” study—a coordinated effort between scientists and the alcohol industry could have changed America’s drinking habits. [read more](#)



California Doctor is Punished for Exempting Vaccine-Damaged 2-Year-Old boy from Additional Immunizations

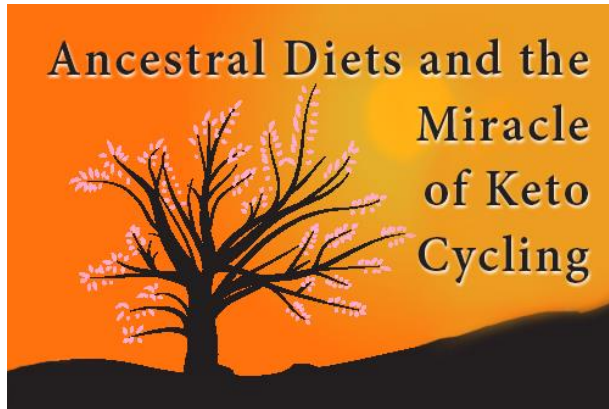
California's new vaccine laws essentially eliminates all vaccine exemptions even when children suffer adverse reactions. Doctors who try to protect their vaccine-damaged patients are punished even to the point of having their medical licenses

revoked. [read more](#)



How the Wrong Science is Making People Sick: The Truth About Saturated Fat, Animal Fat and Coconut Oil

The fourth part in a five-part series of articles by Dr. Fabian Dayrit demonstrating why the American Heart Association’s dietary recommendations are wrong and why saturated fats are essential for a healthy diet. [read more](#)



Ancestral Diets and the Miracle of Keto Cycling

In ages past, infections, starvation, and trauma were the major causes of ill health and death. Today it is chronic, degenerative disease, many of which were rare or unheard of among our ancestors. The first heart attack death was reported in the 1870s and remained a very rare

occurrence until the 1920s. By 1950 it had become the most common cause of death and remains our number one killer today. Obesity in the US has tripled over the past 50 years, diabetes has increased by 700 percent. Alzheimer's disease wasn't even recognized until 1906. The incidence of cancer, arthritis, glaucoma, asthma, and other chronic diseases have skyrocketed over the past 100 years. These diseases were rare among our primitive ancestors and are still generally unseen among modern primitive societies. These once uncommon chronic diseases are often referred to as diseases of modern civilization.

Doctors often blame our increased lifespan for these diseases, saying modern medicine and improved nutrition has allowed people to live longer so that we are now developing degenerative diseases more frequently than was seen in the past. However, chronic disease doesn't just affect the elderly, in fact, chronic disease is occurring at younger and younger ages. It is not unusual for cancer, arthritis, and other degenerative diseases to strike people in their 30s or younger. Degenerative disease is not confined to the elderly. Also, even a century or two ago people lived into their 90s. Most of these people continued to work in the fields and remained physically active and relatively healthy until they died—a far cry from today when people are confined to rest homes and care facilities where they can have constant medical care and supervision for the last several years of their lives.

To many, it appears obvious that the dramatic change in diet and lifestyle over the past century is the underlying cause of our declining in health. Modern food processing began around the turn of the 20th century. Before that time foods came primarily from local farms and were sold as is, with little or no processing. Bread was made from whole grains, butter and lard were the most commonly used fats, vegetable oils weren't used much until the invention of the hydraulic press, the process of hydrogenating vegetable oils for the manufacture of shortening and margarine first appeared in 1912. Sugar consumption has risen from about 15 pounds per person annually in 1800 to about 140 pounds today. This level of sugar consumption is actually down from what it was a decade or so ago because the use of artificial sweeteners has steadily increased.

In the late 1890s a man by the name of Weston A. Price graduated from dental school and began his dental career. He was a brilliant scientist and served for many years as the director of research for what is now known as the American Dental Association. In his clinical practice he was astonished by the gradual increase in dental diseases that he observed over his career. He was seeing more and

more dental diseases late in his career that he had rarely seen when he began dentistry. He wondered if the change in the diet that was occurring at the time was the reason. He decided to find out and in 1930 began a decade long study to see how different diets affect both dental and overall health. He traveled throughout the world studying how various diets affected people's health. He went to remote areas where people were still eating their traditional or ancestral diets and examined their teeth and overall health. He would then examine similar groups of people in the same region who had begun to adopt Western foods, primarily sugar, white flour, and processed vegetable oils.

He discovered that when people ate their traditional foods they had excellent dental, physical, and mental health. However, as soon as they started adding processed foods to their diet, their health declined sharply and dental disease became rampant. In every population he studied it was the same. It didn't matter where the people lived or what they ate, as long as they remained on their ancestral diets they were protected from the ravages of modern chronic and degenerative disease. Some populations, like the Alaskan Eskimo, had a diet that consisted almost entirely of meat and fat. Others, like the Pacific Islanders ate mostly vegetables and fruits and still others in isolated villages in the European Alps relied primarily on dairy. Dr. Price found that it was our modern processed foods, principally sugar, that was causing the decline in American's health.



Recognizing diet as a primary cause of chronic disease, many people have adopted a more natural diet. Some people have returned to eating the way people did in the past, consuming only foods that were eaten by our ancestors. Such diets are referred to as ancestral diets.

The most popular ancestral diet right now is the Paleo diet. Those following this diet try to eat only foods that were available to our Paleolithic ancestors that lived some 10,000 to 20,000 years ago. The Weston A. Price Foundation, an organization based on the discoveries of Dr. Price, promotes an ancestral diet, but does not go so far back in history. This diet encourages the consumption of organically produced whole, natural foods, much like the foods your great-grandmother would have eaten. A similar diet is the ethnic ancestral diet in which people eat the types of foods their direct ancestors ate. For example, there are native Hawaiians that eat only traditional Hawaiian foods such as poi, taro root, plantains, coconut, breadfruit, fish, and so forth.

While there are slight differences in the types of foods eaten between these ancestral diets, the one thing they all have in common is the avoidance of modern processed foods. They tend to avoid foods or food ingredients that would have been unrecognizable to our ancestors such as soda, candy, chips, processed lunch meats, and foods that contain artificial or chemical ingredients like

MSG or aspartame. Foods would be organically grown and definitely not contain any genetically modified ingredients. Processed sugars of all types are also avoided.

In essence, the foods they do eat are those that would be recognized by our ancestors or at least available to them in their day.

It is reasoned that if we can get back to eating more like people had in the past when they consumed only whole, natural foods, and eliminate sugar and other highly processed foods, health would improve. Indeed, this is what happens. This is why ancestral diets have become so popular in recent years. People lose unwanted weight and feel much better. Often, even longstanding health problems such as arthritis or inflammatory bowel disease disappear.

However, there are those who do not see the remarkable improvements reported by others. They may lose a little weight, find their arthritis pain a little less painful, or have less digestive troubles, but the problems still persist. They follow the diet as they are instructed, so why aren't they feeling better than they do?

There is one very important element that has been a part of all ancestral diets from the beginning of time that is missing from nearly all of our modern versions of these diets. Adding this missing element can make any ancestral diet ten times more effective in preventing and reversing chronic and degenerative disease. This missing element is periodic fasting.

Our ancestors did not have access to the abundance of foods that we enjoy today. They didn't have the luxury of eating three meals a day. Often, they were lucky to get one meal daily. They had to search and hunt for their food. When the hunt wasn't successful, they went hungry. Crops often failed or were devastated by droughts, insects, animals, and disease, and they went hungry. Our ancestors missed a lot of meals and went for days, weeks, and sometimes even months with little to eat. Adding periodic or intermittent fasting to an ancestral diet can more accurately mimic the eating patterns of our ancestors and provide the missing element that can stop and even reverse chronic and degenerative disease—the so-called diseases of modern civilization.

Fasting has long been used as a form of detoxification and rejuvenation. Fasting therapy rode a wave of popularity during the latter half of the 19th and early part of the 20th centuries. It was used to treat hard to treat conditions such as asthma, allergies, arthritis, cancer, and epilepsy. These conditions usually responded very well to fasting. For example, putting a patient with epilepsy on a water only fast for two to three weeks dramatically reduced seizure activity and severity with results lasting years.

Doctors noted that the longer they could keep a patient on a fast the better the outcome. A normal weight person could safely fast, consuming nothing but water, for at least 6 weeks; overweight people could fast much longer. However, fasting generally did not last more than about 4 or 5 weeks. In an attempt to extend the period that patients could benefit from a fast, researchers developed a diet that would mimic the metabolic and therapeutic effects of fasting but allow enough food to maintain good health for an indefinite period of time. This was called the ketogenic

diet. The ketogenic diet allowed patients to gain all of the health benefits of fasting while consuming enough food to satisfy hunger and maintain good health for an extended period of time.

The ketogenic diet was developed specifically to treat epilepsy and proved highly successful, bringing about complete lifelong cures to a large number of patients—a remarkable feat for an otherwise incurable disease. Over time, researchers began to wonder if the ketogenic diet could also be useful for other neurological disorders, so they tried it on patients with Alzheimer’s disease, Parkinson’s disease, multiple sclerosis (MS), ALS, traumatic brain injury, and stroke. In every case the ketogenic diet proved highly effective. It was later discovered that the ketogenic diet was also beneficial in treating a wide variety of health problems including obesity, diabetes, heart disease, cancer, allergies, arthritis, digestive problems, and essentially all the diseases that fasting had been used for. After all, the diet was designed specifically to mimic the metabolic effects of fasting so it only makes sense that it would have many of the same therapeutic effects as well.

The ketogenic diet is defined as a very-low carb, high-fat, moderate- to low-protein diet. Normally glucose serves as the primary fuel for all the cells in our body. We get glucose primarily from the carbohydrates in our diet. When we don’t eat for a period of time or if we don’t eat any carbohydrate-rich foods, our blood glucose level drops. Our cells, however, need a constant source of fuel 24 hours a day. So when blood glucose levels decline, our cells need another source of energy. That source comes from stored body fat. Our fat reserves are broken down and fatty acids are released. Our cells use fatty acids just as they do glucose to produce energy. Some of these fatty acids are converted into an alternative fuel called ketones or ketone bodies. When we are burning mostly fatty acids and ketones in place of glucose, we are said to be in a state of ketosis. Ketones can be remarkably therapeutic and produce much of the beneficial effects of fasting. When our ancestors went without food or only had access to a little food, they naturally went into a state of ketosis. They were cycling in and out of ketosis constantly throughout the year and throughout their lives. This keto cycling, combined with a healthy traditional diet, protected them from chronic, degenerative disease. Of course, if the periods of fasting or severe food deprivation lasted for too long it could lead to starvation, but as long as the periods of fasting were limited to just a few days to a few weeks at a time and were separated by periods of abundance, the people thrived and were healthy.

One of the primary benefits of fasting is autophagy—the cannibalization of body tissues for recycling. When fasting, blood glucose declines which triggers the body to cannibalize fat stores to supply the energy it needs. Most of the cells in our bodies do just fine using fatty acids and ketones as fuel, however, some cells absolutely require glucose. If you are fasting and not eating any sources of glucose, where does the glucose come from to feed these cells? It comes from body proteins. Protein is broken down and converted into glucose. Where does this protein come from? Our bodies have a keen sense of self preservation, so vital organs like your heart, liver, and kidneys are not touched. The first source of protein the body cannibalizes are those that are of the least importance to your survival; this would include all old, worn out or dysfunctional cells and abnormal growths. The body essentially goes into housecleaning mode and cleans out fat and all of the cells and tissues that serve no useful function. It is only when fasting begins to approach starvation that the body starts to dismantle more essential tissues like functional cells in our muscles and organs.

Our immune system is vitally important to our overall health. It is the immune system that protects us from disease-causing microorganisms, environmental and biological toxins, and from abnormal growths such as cancer. A malfunctioning immune system can lead to a host of health problems. Fasting can have a remarkable effect on immune health. There is some remarkable research being done right now in this area that is producing astounding results.

Most people would assume that during a fast, when we are depriving ourselves of food and nourishment, that we would become weak and be vulnerable to disease. However, just the opposite happens, we become stronger and more resistant to disease.



Valter Longo, PhD and his team at USC have been researching the effects of fasting on the immune system. He conducted a study using mice, splitting them into two groups. The first group was put on a 48 hour fast. The second group served as the control and received their normal scientifically designed, vitamin fortified chow supplying them with all the nutrients they need to maintain optimal health. The mice in both groups were then injected with a lethal dose of poison. The poison they chose to use was a chemotherapy drug, injecting the mice with an amount equivalent to about four times what a human cancer patient would receive. The mice receiving the nutritious diet immediately became deathly ill and lethargic; 65

percent of them died within a couple of days. The mice that were fasting, however, were running around as they normally do as if nothing happened. None of them died. The results were so shocking that Longo thought they may have done something wrong, so they repeated the experiment but ended up with the same outcome.

Longo observed that during a fast white blood cell numbers decline but as soon as refeeding begins the white blood cell count quickly returns to normal. He looked into what was happening and discovered it was due to autophagy. When fasting, the body removes all the old, worn out white blood cells (to be converted into glucose) and when food is eaten new white blood cells are produced to take their place. After a period of fasting, when food is reintroduced, stem cells in the bone marrow are activated and produce new white blood cells. Old, dysfunctional white blood cells are replaced with new, functional white blood cells. In essence, fasting regenerated a more robust immune system.

The treatment for cancer using chemotherapy is accompanied by many awful side effects including, hair loss, fatigue, weakness, nausea, diarrhea, mouth sores, memory loss, and numbness. One of the main problems with chemo is that it destroys the immune system. It kills the white blood cells and

the bone marrow where white blood cells are formed, and has long lasting effects that make the patient vulnerable to infections and other health problems.

Longo found that fasting immediately before and after undergoing chemotherapy maintains proper immune function and eliminates the side effects of chemo and even improves the effectiveness of the therapy. Fasting during chemotherapy has always been discouraged because it was believed to weaken the body and cancer patients are always encourage to eat more during chemotherapy. As Longo discovered, fasting doesn't weaken the body, it makes it stronger and protects the immune system from the damaging effects of chemo.

Since fasting can regenerate the immune system, it might be useful in treating people suffering from immune disorders, particularly those with autoimmune diseases such as multiple sclerosis (MS), type 1 diabetes, rheumatoid arthritis, celiac disease, Hashimoto's thyroiditis, and lupus. Autoimmune diseases are believed to be caused by a dysfunctional immune system that attacks its own body.

Longo decided to test the effects of fasting on MS—a common autoimmune disorder that affects the brain and spinal cord. With MS the immune system attacks the nerve cells destroying the protective myelin sheath that covers the nerve axon. His study consisted of two parts. The first part used three groups of mice that had the equivalent of MS. The first group of mice cycled in and out of a 3-day fast three times over a 30 day period. The second group was put on a mild ketogenic diet. The third group served as the control and ate a normal diet. At the end of 30 days the mice in both the fasting and ketogenic groups were showing significant improvement. Analysis of nerve tissue showed that the myelin covering on the nerves were being regenerated. The mice in these two groups, and especially the fasting group, had improved so much that 20 percent of them had completely recovered from MS—quite a remarkable feat since there is no medical cure for it.

The second part of the study involved humans with MS. The subjects were separated into three groups. The first group was put on a periodic fast separated by a high-fat Mediterranean type diet. The second group was put on a ketogenic diet and the third group ate a normal diet. After 6 months the first two groups of patients reported significant improvement in their MS symptoms. The third group showed no improvement. Again, the fasting and ketogenic diet groups proved beneficial.

Longo then examined the effects of fasting on another autoimmune disorder, type 1 diabetes. In this form of diabetes the insulin producing beta cells in the pancreas are attacked and destroyed by the immune system, leading to the diabetes. Mice with type 1 diabetes were used in this study. One group of mice was put on a four-day fasting cycle. Another group received their normal diet. The fasting mice had their immune systems regenerated. Old, dysfunctional white blood cells that had attacked the pancreas were replaced by new, healthy white blood cells. In addition, the damaged pancreatic beta cells were removed (recycled) and replaced with new, functional cells that produced insulin. These mice were now producing insulin with greatly improved blood sugar control. Again, Longo succeeded in reversing what was considered an irreversible condition.

In his studies, Longo didn't use a water fast but used what he calls a fasting mimicking diet—a diet that allows a limited amount of calories but mimics the metabolic and therapeutic effects of fasting. His fasting mimicking diet is a low-carb, low-protein, low-calorie, high-fat diet. Total calories are limited to about 800 per day. What does that sound like? It is basically a low-calorie ketogenic diet.

Longo's fasting mimicking diet is safe and easier than water fasting since it allows a limited amount of food. For those people who want to take advantage of the health benefits offered by his fasting mimicking diet, Longo recommends eating 800 calories or less for 5 consecutive days, once each month. It must be emphasized that in order for this diet to have the greatest therapeutic effect both carbohydrate and protein must be restricted. Carbohydrate must be limited in order to shift the body into ketosis. Protein must be restricted to activate the cannibalization of worn out cells. Most of the calories in the fasting mimicking diet come from fat. Although eating just steak and eggs is low-carb, and if you limit calories, it can be ketogenic, but it will not provide the therapeutic effects described by Longo.

Since the ketogenic diet emphasizes limiting total carbohydrate intake, some people mistakenly think of it as a high-protein diet. That is false, it is a high-fat diet. If you eat too much protein, the excess protein will just be converted into glucose and may even prevent you from getting into ketosis. That is why the ketogenic diet is defined as one with moderate- to low-protein intake. If you want to go a step further and stimulate autophagy to clean out old, dysfunctional cells and revive your immune system, you need to eat a low-protein ketogenic diet.

When people go on diets to improve their health and generally lose excess weight, they stay on the diet for a period of time and once they reach their goal weight (or tire of the diet), they go right back to eating the same foods that made them sick and fat in the first place. In time, the weight comes right back. They accomplish nothing.

In order to make a permanent change in your health, the diet chosen must be part of a lifestyle change. The diet must be one that could be maintained for life. Most low-fat, weight loss diets are not suitable for a lifetime because they are too restrictive, unsatisfying, unpalatable, and often unhealthy.

Many people will try a ketogenic diet for a few weeks or months and then, like any weight loss diet, go back to eating the poor quality foods they were eating before. In order to make the ketogenic diet powerful enough to achieve optimal health, the diet must be a part of a lifestyle change. A proper (traditional foods-based) ketogenic diet is nutritionally sound and can be adopted and maintained for life. However, this isn't the best way to incorporate the ketogenic diet into a lifestyle change. The best way is to mimic our ancestors and cycle in and out of ketosis just as they naturally did depending on food availability. Cycling in and out of ketosis has many advantages over staying in ketosis continually.

One of the main advantages is that you do not have to permanently give up all the higher carb foods you love and can't live without. You simply refrain from eating them for the periods of time you are actively in ketosis. This way you don't feel deprived and temptation is not as intense.

When you stay in ketosis for an extended period of time, your body begins to adapt to the elevated level of ketones and the therapeutic effects begin to decline. However, if you cycle in and out of ketosis your body does not have a chance to adapt and ketones maintain full therapeutic power regardless of how often you go into ketosis.

Also, long-term ketosis makes you more sensitive to the effects of sugar and starch. This is why the rates of diabetes were so high in traditional meat eating cultures, such as the Eskimos and the American Plains Indians, when they were fed high-carb processed foods. Their bodies could not adapt to the increased load of carbohydrate in their systems.

You can get into ketosis by eating full meals that completely satisfy your hunger, but restricting your total calorie intake for a time will also improve the effects of ketosis as demonstrated by Dr. Longo's research. Optimally, the ketogenic diet should include periods of semi-fasting, much like his fasting mimicking diet. His 5-day fast has proven highly effective. When you are in ketosis, hunger is naturally suppressed and shifting into a reduced calorie phase for a few days is relatively painless. So, not only should you cycle in and out of the ketogenic diet, but for some of that time you should also cycle in and out of a reduced-calorie ketogenic diet. For example, you can go on a ketogenic diet for two weeks and for the last five days of the diet go into a reduced calorie ketogenic phase. You can repeat this cycle every month or two. Of course, you could maintain the ketogenic diet for a month or longer, the length of time you are in and out of ketosis is up to you.

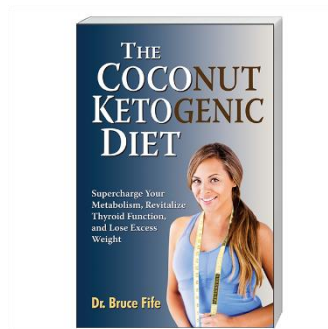
Keto cycling makes it possible for you to maintain the ketogenic lifestyle indefinitely. When you cycle out of ketosis your diet should be a healthy one—an ancestral diet, low-carb diet, or something similar. You definitely do not want to go back to feasting on sweets and junk foods. Often, when people adapt a ketogenic diet they feel deprived because they cannot have some of their favorite foods or enjoy a dessert on special occasions. With keto cycling this is no longer a problem. If you know that you will be in ketosis for only a limited period of time you can refrain from eating favorite foods temporarily without feeling deprived. When you come out of ketosis you know you will be able to enjoy these foods again. When I talk about favorite foods, let me stress I am not talking about candy and junk foods but healthy foods that may contain too much carbohydrate for a ketogenic diet, such as starchy vegetables and fruits.

When you cycle in and out of ketosis you can plan when you want to be eating a ketogenic diet, a calorie restricted ketogenic diet, or your normal healthy diet. This way you can plan to be out of ketosis when you know you will not be able to stay in ketosis easily, such as during the holidays like Thanksgiving and Christmas or your birthday when you want to a slice of birthday cake.

Keto cycling makes the ketogenic diet much for effective and much easier to follow. It allows the ketogenic diet to be part of your lifestyle change.

If you are new to the ketogenic diet and would like to learn the proper basics of the diet, I recommend reading my book [The Coconut Ketogenic Diet](#). If you would like a more in-depth discussion of the diet with an emphasis on its therapeutic aspects, I recommend my book [Ketone Therapy](#).

Dr. Bruce Fife's books referenced in this article are:

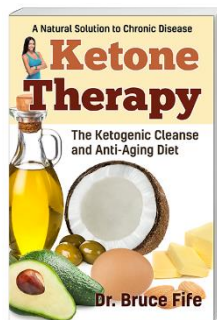


[The Coconut Ketogenic Diet](#)

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Which Oil Is Best For Oil Pulling?

A variety of oils have been successfully used for oil pulling. Sesame and sunflower oils are the most common traditional oils used but coconut, olive, rice bran, soybean, and other oils have also been used. In fact, any oil can be used for oil pulling; it can be cold pressed, virgin, organic, or refined—they all work. But do some oils work better than others? Sesame, sunflower, and coconut oils have

been studied the most extensively for their effect on oral health. While all of these oils work well for oil pulling, there is one that is clearly superior to all the rest and that is coconut oil.

Coconut oil has four major advantages over all other oils when used for oil pulling. Let me briefly discuss each one below.

Natural Antimicrobial Activity

Coconut oil is composed predominately of medium chain fatty acids (MCFAs) which possess potent antibacterial, antiviral, and antifungal properties. Studies have shown that these MCFAs kill *Streptococcus mutans*, *Candida albicans*, and other microorganism that are commonly associated with tooth decay and gum disease. [1-3]

Researchers at the Athlone Institute of Technology in Ireland have reported that coconut oil added to dental care products could be an effective way to prevent cavities. [4] The swishing action of coconut oil in the mouth, combined with fat-digesting enzymes begins to break the oil down into individual MCFAs, which gives the oil its potent antimicrobial action. The longer the oil can remain in the mouth before spitting it out, allows more time for the MCFAs to kill germs. This is one of the benefits of oil pulling for the recommended 15 to 20 minutes at a time. No other dietary oil can match the germ-killing potential of coconut oil.

Head-to-head comparisons have been made between oil pulling with coconut oil and chlorhexidine-based mouthwashes. These mouthwashes are available by prescription and are the most powerful antiplaque and antigingivitis rinses available. They are prescribed specifically to treat gum disease. Chlorhexidine-based mouthwashes are the gold standard on which all rinses are compared. Oil pulling studies have shown that coconut oil is highly effective in decreasing dental plaque and reducing gingivitis and is equally effective as chlorhexidine mouthwash, without the need for a doctor's prescription. [5-7]

Tissue Knitter

Coconut oil is known as a tissue knitter, meaning it stimulates the rapid healing and repair of damaged or injured skin and mucous membranes. The oil has a long tradition among tropical island populations as the go to treatment for wounds, burns, and abrasions. [8] Modern medical science has confirmed the wisdom of using coconut oil as a healing ointment.

A study published in the journal *Skin Pharmacology and Physiology* evaluated the effect of virgin coconut oil on wound healing in young rats. The rats all received identical wounds, followed by either no treatment or the topical application of coconut oil, then observed for 10 days. The progress of the healing skin in each group was evaluated by monitoring the time taken for new connective tissue and microscopic blood vessels to form on the wound and for new skin to completely replace the injured tissue. The researchers concluded that the coconut oil treated wounds “healed much faster, as indicated by a decreased time of complete epithelization and higher levels of various skin components.” The coconut oil also reduced the amount of destructive free radicals produced by the wounds, thus aiding in the healing process. [9]

In another study by a different group of researchers, rats were subjected to burn wounds and the healing effects of coconut oil were compared to sulfadiazine cream, a standard treatment for burns. After 16 days the controls, which had no treatment, showed only 34.9% complete epithelization, or regrowth of new skin. Those with topical coconut oil showed 84.7% epithelization, which was comparable to the sulfadiazine group. [10] Since coconut oil can be used both externally and internally, it has a clear advantage over sulfadiazine, which is limited to topical use only.

The MCFAs in coconut oil are physically smaller than the fatty acids in other oils. This allows them a greater ability to penetrate into the skin or mucous membranes, providing these tissues with nourishment that can stimulate cellular growth and repair. An interesting study was done comparing the effects of topically applied coconut oil to mineral oil and a placebo (powder) on premature newborn infants. Each infant was massaged with one of the three products four times daily for 31 days. At the end of the study the infants receiving the coconut oil showed significantly greater growth. [11] The growth was presumed to be the result of the improved nutrition delivered transdermally by the coconut oil. You can see the difference in oils yourself. Take 4-5 drops of coconut oil and message it onto the back of your hand, then take an equal amount of corn oil, or some other polyunsaturated vegetable oil, and rub it onto the back of your other hand. Without wiping it off, observe how long the oils remain noticeable on your skin. The coconut oil will absorb rather quickly. The corn oil will not penetrate well into the skin and will leave a greasy, sticky film that will last for hours. Injured skin has a greater need for energy and nourishment to facilitate healing. Coconut oil can accomplish that better than any other oil.

Whether an injury is on the skin or the mucous membranes of the mouth, coconut oil has proven useful for speeding recovery. The action of oil pulling, regardless of the type of oil used, draws out infection but it is coconut oil that can stimulate the rapid healing process that brings about the quickest recovery time possible.

Anti-inflammatory Action

Studies have shown that coconut oil has an antioxidant effect and can calm inflammation, ease pain, and reduce swelling, all of which typically accompanies infected gums. [12]

Most oils commonly used for oil pulling consist predominately of linoleic acid, the primary fatty acid found in polyunsaturated vegetable oils, including sesame and sunflower oils. Linoleic acid tends to generate destructive free radicals and promote inflammation, therefore, it might not be wise to use

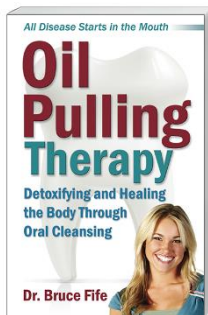
these oils for oil pulling when the gums are infected and already inflamed, as they might exacerbate the problem. [13]

Taste and Mouth Feel

Oil pulling is a practice that should become a habit and be done as a part of your normal daily oral hygiene routine. In order to accomplish this, the oil used must be palatable enough that it is not distasteful or burdensome. Some oils, like extra virgin olive oil and red palm oil, have strong flavors that make them undesirable for oil pulling. Coconut oil is one of the more pleasant tasting oils. Virgin coconut oil has a mild coconut flavor and if you don't like the taste of coconut you can use a refined coconut oil which is essentially tasteless.

Mouth feel is also important. When you swish the oil in your mouth, it combines with saliva forming an emulsified mixture that feels less oily and becomes easier to work in the mouth. This emulsification process occurs at different rates depending on the type of oil used. The MCFAs that make up the majority of coconut oil are more water soluble than other oils. This is important because it allows coconut oil to emulsify and mix with saliva much more quickly and easily than other oils, which tend to leave a greasy feel in the mouth and take longer to blend with saliva.

As you see, the advantages to using coconut oil are many. If coconut oil is available, it makes sense to choose it first for oil pulling. The only exception would be if coconut oil is not readily available, in which case most any other oil can be used as a temporary substitute.



[Oil Pulling Therapy](#)

by Dr. Bruce Fife

Available from Piccadilly Books, Ltd.

for more information or to order [click here](#)

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Scientific Fraud: Major Study On Alcohol Shut Down

They wanted to call it the “CHEERS” study—a coordinated effort between scientists and the alcohol industry could have changed America’s drinking habits.

In recent years a number of studies have been published suggesting that moderate alcohol consumption of between 1 to 2 drinks per day can provide protection from cardiovascular disease and thereby prolong life. The studies even indicated that moderate drinking was healthier than complete abstinence. These studies have stirred up controversy.



Drinking has long been associated with adverse health effects. Alcohol abuse is clearly detrimental to health leading to addiction, liver disease, cancer, mental decline, nutritional deficiencies, risky behavior, accidents, violence, and premature death. Alcohol is classified as a carcinogen. Even as little as one drink a day increases the risk of breast cancer. For this reason, The World Health Organization (WHO) contends that no level of alcohol consumption is safe. In addition, more recent studies have revealed that the positive effects of previous studies were in error because they lumped dry alcoholics and those people who have never taken a drink into the same non-drinkers category. Former alcoholics are more prone to cardiovascular disease and early death than moderate drinkers, which skewed the data in favor of moderate drinking.



Although the pro-drinking studies seemed to indicate benefits of moderated alcohol consumption, none of the studies actually proved moderate drinking to be healthful. For this reason, pro-alcohol scientists and officials at the National Institutes of Health (NIH) teamed up to design a large clinical trial to provide the medical evidence needed to recommend a daily alcoholic drink as part of a healthy lifestyle.

Dr. Kenneth J. Mukamal, an associate professor of medicine at Harvard Medical School and the lead investigator of the study, contends that moderate alcohol consumption is safe. He has published nearly a hundred scientific papers on the relationship between moderate drinking and cardiovascular disease, suggesting that moderate drinking is a good thing. A long-term randomized controlled trial could dispel many lingering doubts about the benefits of moderate daily drinking. “A definitive clinical trial represents a unique opportunity to show that moderate alcohol consumption is safe and lowers risk of common diseases,” he stated to alcohol industry executives in an effort to gain funding. “That level of evidence is necessary if alcohol is to be recommended as part of a healthy diet.”

The stated objective of the study was to test the hypothesis that one drink a day is better for the heart health than none. It would involve 7,800 participants. Half were to be told to abstain from alcohol. The other half would be instructed to have one serving of alcohol a day. No other long-term study has ever asked participants to drink, much less drink every day. The researchers would track the two groups for an average of six years over the 10-year study period to see if, as anticipated, daily drinkers would experience fewer heart attacks and strokes, and have a lower incidence of diabetes and death.

However, there were some major flaws in the study’s design. The trial would reveal possible benefits while missing the detrimental effects of alcohol. One of the biggest criticisms was that the study would not last long enough to detect cancers, which are slow-growing, among drinkers, and other problems such as heart failure linked to alcohol consumption. Also, two servings has long been considered moderate drinking for men. Limiting the drinkers to only one drink daily may not reflect

real-life habits and may reduce some of the consequences, such as falls, car accidents, and alcohol abuse among the subjects.

People whose health might be compromised by light drinking—anyone with a history of addiction, psychiatric concerns, liver or kidney problems, certain cancers, or family history of breast cancer—were not be allowed to participate. Those people who are most likely to experience harm were carefully excluded. However, if the study was to find even a modest cardiovascular benefit to light drinking, you can be sure that the general public would take it as a recommendation for everyone to start drinking, even those who are at high risk.

In addition, people who have never consumed alcohol were also excluded, so how could the study accurately compare drinkers to non-drinkers? As the study was designed, moderate drinkers (one drink per day) would be, for the most part, compared to former drinkers or former alcoholics, who quit for health reasons and are at increased risk of health problems to begin with. The study was not designed to accurately compare the health consequences of non-drinkers to moderate drinkers, but to promote the sale and consumption of alcohol in the guise of it being good for one's health—a complete fraud.

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**“Can I keep using alcohol and tobacco if
I blend them into my morning health shake?”**

By design, no form of alcohol—wine, beer, or liquor—would be identified as better than any other in the trial. This would appeal to the alcohol industry, who were courted to fund the study. Alcohol executives were assured that the outcome would be in their favor. The study was designed to focus on benefits and not to identify negative health effects such as an increase in cancers or heart failure associated with alcohol. Even if the study failed to find health benefits to moderate drinking but provided no evidence of harm, the results still would be a windfall for the beverage makers. Dr. Mukamal, the lead investigator of the study, was in close, frequent contact with beer and liquor executives while designing the study to make sure it conformed to their interests. Alcohol executives offered their own suggestions on how the study should be conducted. The study design was

approved and eventually five beer and liquor companies agreed to pick up most of the \$100 million cost for the 10-year study.

In order to hide the fact that the study was financed by the alcohol industry, donations were to be channeled through the Foundation for the NIH, a nongovernmental entity that raises money for HIN research and manages the partnerships established to direct private donations. This way the study would be viewed with more credibility than research funded directly by the alcohol industry.

The NIH awards most research funds on a competitive basis, and grant applications undergo a two-tier review of the scientific merit and public importance of a project, as well as the scientific integrity. Dr. Mukamal and his associates at the NIH were engaged in a deception with the agency. They denied that discussions with the alcohol industry were taking place. When questioned, Dr. Mukamal repeatedly denied communication with the alcohol industry during the planning stages of the study. He emphatically stated that he had “literally no contact with the alcohol industry.” He proclaimed that he and his colleagues “stand fully and forcefully behind the scientific integrity” of the trial.

Dr. Francis Collins, the director of the NIH, abruptly shut down the study as evidence of the improprieties came to light. An internal investigation revealed that the Dr. Mukamal and his colleagues waged a vigorous campaign to court the alcohol industry to sponsor the study and conceal the industry’s involvement. The report documented conference calls Dr. Mukamal held with alcohol beverage companies and lengthy memos written in response to their concerns, long before the NIH even announced it would sponsor the trial. Dr. Collins stated that Mukamal and the agency’s own staff had crossed “so many lines” in pursuit of alcohol industry funding that “people were frankly shocked.”

Memos revealed they wanted to call it the “CHEERS” study, short for “Cardiovascular Health Effects of Ethanol Research Study.” One NIH staffer stated somewhat in jest, “It will be a new drinking game. Every time you hear it you must assume its [sic] a toast, and so have a drink.” That idea was later abandoned in favor of the more sober acronym, MACH, which stands for “Moderate Alcohol and Cardiovascular Health.”

“Clearly, there was a sense that this trial was being set up in a way that would maximize the chances of showing a positive effect of alcohol,” said Dr. Collins

All along, the scientists were well aware the alcohol industry would use the study’s findings for marketing and promotion purposes. Dr. Michael Siegel, a professor of community health sciences at Boston University School of Public Health said the study “is not public health research—it’s

marketing.” He further stated, “This must have seemed like a dream come true for the [alcohol] industry. Of course they would pay for it. They’re admitting the trial is designed to provide a justification for moderate drinking. That’s not objective science.”

Fortunately, the study was shut down before it progressed too far and before it had the opportunity to be published. Unfortunately, many other similarly biased studies are published that affect the advice doctors give patients and the recommendations promoted by governmental and private health agencies. The American Heart Association (AHA) is notorious for quoting biased studies to order to support their contention that saturated fats promote heart disease and polyunsaturated fats can prevent it.

It is not always easy to tell the difference between a legitimate study and research produced as a marketing tool for industry. If you have a strong scientific background you may be able to spot problems with the design of a particular study. But that isn’t always enough to spot subtle design flaws that can seriously skew the study results.

Studies that are sponsored by certain industries that can benefit financially from the study results are clearly suspect. It doesn’t necessarily mean the study is invalid, but it must be viewed with some caution. The same thing applies when a study is produced by researchers who have financial ties with industries that could benefit from a study’s results. For these reasons, study authors must disclose who funded the study and if they have any conflict of interest. This helps to legitimize the study but is no guarantee as some authors hide their relationship to industries and donations can be channeled through third party nonprofit organizations to conceal the real financial backer.

Another way to help determine the legitimacy of study is to ask yourself if it makes sense. For example, a study proclaiming that drinking alcohol, even in moderation, is healthy doesn’t really make sense. There are too many detrimental aspects to even light drinking to suddenly accept it as a health food. Dr. Mukemal tried to overcome this obvious problem by spending years publishing numerous small studies suggesting that moderate drinking was beneficial and thus slowly prepare people for a more definitive study that would proclaim alcohol, in moderation, to be healthy despite its numerous drawbacks. You know the old saying: a lie told often enough over time is accepted as truth. Fortunately, in this case, it didn’t work. His lies were revealed before the study could be completed. Any study that goes contrary to common sense should be looked upon with some suspicion.

Finally, ask who would benefit from the results of a particular study? If the study could be used as a marketing tool for an industry, view it with some suspicion, regardless of who funded it. The results don’t always have to show positive effects, even negative results could be used as

marketing propaganda. Look what the soybean industry did to coconut oil in the 1980s. They painted coconut oil as an artery-clogging saturated fat in order to dissuade people from using it and use soybean oil as a healthier choice.

When you read a study, look at who funded it and what financial ties the author has. Does the conclusion of the study make sense? Who stands to benefit most from the results? Consider all these things before blindly accepting the study as fact.

Source: <https://www.nytimes.com/2018/03/17/health/nih-alcohol-study-liquor-industry.html?action=click&module=RelatedLinks&pgtype=Article>



California Doctor is Punished for Exempting Vaccine-Damaged 2-Year-Old boy from Additional Immunizations



Dr. Bob Sears is seen in his Capistrano Beach office. (Don Bartletti / Los Angeles Times)

Orange County pediatrician well-known for being sympathetic to parents concerned about vaccine safety.

In a decision that could signal how California's fierce vaccine debates will play out in the coming years, the Medical Board of California has ordered 35 months' probation for Dr. Bob Sears, an

The board threatened to revoke Sears' medical license for writing a doctor's note for a 2-year-old boy that exempted him from all childhood vaccinations because he experienced serious side effects to previous vaccinations. Eventually, the medical board settled on a lesser punishment, yet still severely limiting his ability to practice medicine.

Read the entire story here:

<http://www.latimes.com/local/california/la-me-ln-sears-license-20180629-story.html>



How The Wrong Science Is Making People Sick: The Truth About Saturated Fat, Animal Fat And Coconut Oil

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Abstract

The 2017 AHA Presidential Advisory attacked coconut oil using studies that did not involve coconut oil. A careful review of the fatty acid composition of coconut oil and animal fat shows that: first, coconut oil has a vastly different fatty acid profile from animal fats; second, coconut oil has negligible cholesterol content while animal fats are high in cholesterol; and third, animal fats are actually not saturated fats. This casts doubt on the basis of the almost 60-year anti-saturated fat campaign which was focused on animal fat. Although the AHA Presidential Advisory claimed that it had new studies to present, it actually just reanalyzed old papers and selected the studies, some dating from the 1960s and 1970s, which agreed with its position and labeled these as “high quality.” It then rejected the studies which gave contrary conclusions, such as studies on HDL as a beneficial cardiovascular marker and the Minnesota Coronary Survey (MCS). The MCS study is important because it is a research project which Ancel Keys himself undertook but which failed to support his saturated fat-heart disease hypothesis. In passing judgment that coconut oil has “no known offsetting favorable effects,” the AHA has ignored evidence from thousands of years of its use in the tropics and Pacific islands that demonstrate its healthful properties, and the repeated observation that people who shifted from a coconut diet to a Western diet have gotten sick. The AHA produced no evidence that coconut oil causes heart disease. The AHA attack against coconut oil is a repeat of previous negative campaigns that have made the Americans obese and sick.

Introduction

On June 15, 2017, the American Heart Association published its AHA Presidential Advisory entitled “Dietary Fats and Cardiovascular Disease.” [1] Although the title mentioned dietary fats, it was actually an attack on coconut oil. Although this Advisory tried to appear authoritative and objective, a detailed analysis shows that it is full of errors and biases.

1. AHA attacked coconut oil using studies that did not involve coconut oil.

Although the AHA Presidential Advisory claimed that it would present the “most recent studies, on the effects of dietary saturated fat intake,” it in fact just recycled old studies and reinterpreted them using statistical arguments. Four of the studies dated from the 1960s and 1970s [2] and had been previously criticized for being poorly executed. [3] But more to the point, all of these studies are irrelevant to coconut oil because none of them used coconut oil as a test material: these studies used animal fat and AHA just assumed that animal fat and coconut oil are the same. They are not!

Table 1 compares the fatty acid profiles and cholesterol content of coconut oil, butter, beef fat (tallow), and hog fat (lard). The following conclusions are clear:

- 1. Coconut oil has a vastly different fatty acid profile from animal fats and to assume a similarity is simply incorrect. Further, coconut oil is about 63% medium-chain fat while beef and hog fat do not contain any medium-chain fat (butter contains 9% medium-chain fat);
- 2. Coconut oil has negligible cholesterol content while animal fats are high in cholesterol; and
- 3. Animal fats are actually not saturated fats as Keys mistakenly assumed: in fact, animal fats contain comparable proportions of saturated fat and unsaturated fat.

Unfortunately, most studies, including those used by AHA, assume that animal fats are saturated fats and that coconut oil and animal fats are similar. In fact, animal fat is actually composed of long-chain saturated fat with lots of unsaturated fat. On this basis alone, we can say that the whole AHA campaign against saturated fat is based on the wrong definition of saturated fat and the warning against coconut oil is not valid. This represents over 50 years of defective dietary recommendations and false information!

The AHA provided an incomplete fatty acid profile of coconut oil in the table that it presented by not listing caproic acid (C6), caprylic acid (C8), and capric acid (C10) as components of coconut oil (Figure 1). These fatty acids, together with lauric acid (C12), are medium-chain fatty acids, and the AHA has consistently ignored medium-chain fatty acids as a distinct metabolic group from long-chain fatty acids. [4] The correct fatty acid profile of coconut oil is given in Table 1.

Table. Fatty Acid Composition of Fats and Oils

| | Saturated, g/100 g | | | Monounsaturated, g/100 g | | Polyunsaturated, g/100 g | | |
|-------------|--------------------|---|-------------------|--------------------------|-----------------|--------------------------|----------------------|----------------------------------|
| | Total | Lauric (12:0), Myristic (14:0), Palmitic (16:0) | Stearic (18:0) | Total | Oleic (18:1) | Total | Linoleic (18:n-6) | α -Linolenic (18:3n-3) |
| Coconut oil | 82 | 67 | 3 | 6 | 6 | 2 | 2 | 0 |

Figure 1. Reproduction of part of the fatty acid table from the AHA Presidential Advisory (AHA page e4). AHA excluded caproic acid (C6), caprylic acid (C8), and capric acid (C10) as components of coconut oil and lumped all saturated fats into one group.

Table 1. Fatty acid profile and cholesterol content of coconut oil and various animal fats.

| Fatty acid | Coconut Oil ¹ | Animal fat ² | | |
|--|--------------------------|-------------------------|-------------------|----------------|
| | | Butter | Beef fat (tallow) | Lard (hog fat) |
| C4:0, % butyric acid | | 3 | | |
| C6:0, % caproic acid | <0.7 | 2 | | |
| C8:0, % caprylic acid | 7 | | | |
| C10:0, % capric acid | 7 | 3 | | |
| C12:0, % lauric acid | 49 | 4 | | |
| Medium-chain fatty acids, % | 63 | 9 | 0 | 0 |
| C14:0, % myristic acid | 19 | 12 | 3 | 2 |
| C16:0, % palmitic acid | 9 | 26 | 27 | 27 |
| C18:0, % stearic acid | 3 | 11 | 7 | 11 |
| Long-chain saturated fatty acids, % | 31 | 49 | 37 | 40 |
| C16:1, % palmitoleic acid | | 3 | 11 | 4 |
| C18:1, % oleic acid | 7.5 | 28 | 48 | 44 |
| C18:2, % linoleic acid | 1.8 | 2 | 2 | 11 |
| C18:3, % linolenic acid | <0.2 | | | |
| Unsaturated fatty acids, % | 9 | 33 | 61 | 59 |
| Cholesterol, mg/kg | 0 to 3 | 2150 | 1090 | 950 |

¹ Codex Alimentarius 210-1999, amended 2015. Median values are calculated.

² USDA Food Composition Databases. <https://ndb.nal.usda.gov/>

The AHA Presidential Advisory is clearly full of errors.

2. The AHA ignored studies that were unfavorable to its position.

AHA selected information that was in favor of its agenda and ignored other facts that were unfavorable, in particular, those pertaining to LDL and HDL, and the Minnesota Coronary Survey. Regarding LDL, the AHA stated that “because coconut oil increases LDL cholesterol, a cause of CVD, and has no known offsetting favorable effects, we advise against the use of coconut oil.” (AHA page e13) This statement is scientifically unacceptable because the evidence of the link between LDL and CVD is only a correlation and its causality has not been proven. The AHA advisory cited two papers, neither of which presented convincing evidence that coconut oil was linked to CVD. In fact, one of the papers that AHA cited contradicted its position regarding coconut oil stating that: although coconut oil raised LDL cholesterol, “observational evidence suggests that consumption of coconut flesh or squeezed coconut in the context of traditional dietary patterns does not lead to adverse cardiovascular outcomes.” [5]

The AHA tried to further discredit coconut oil by ignoring the beneficial effects of coconut oil on HDL claiming that: “changes in HDL cholesterol caused by diet or drug treatments can no longer be directly linked to changes in CVD, and therefore, the LDL cholesterol-raising effect should be considered on its own.” (AHA page e13) The justification for this statement was based on a study that showed that a genetic variant rendered HDL as an unreliable marker for protection against heart disease. However, this genetic variant was found in only 2.6% of the population. [6] Similarly, a recent paper reported that extremely high HDL levels may increase the risk of death but this was found in only 0.4% of men and 0.3% of women. [7] Clearly, these examples represent a minority of the population and are outliers. Extremely high and low HDL (and LDL) levels are unhealthy but this does not negate the value of HDL as a beneficial cardioprotective marker for coconut oil.

The Minnesota Coronary Survey (MCS) was a study that Keys himself designed and implemented together with Ivan Frantz Jr. MCS was meant to finally prove Keys’s saturated fat-heart disease hypothesis using a large number of subjects (n=9,423), a long feeding period (4.5 years, from 1968-1973), a high level of dietary control, and double blind randomized design. [8] This study was conducted at the same time that Keys was coordinating the Seven Countries Study and would have provided powerful validation for his saturated fat-heart disease hypothesis.

In the end, Keys did not participate in the publication of the results of the MCS study. A partial report was made in a 1989 paper with Frantz as lead author but without Keys as co-author. [9] This work remained hidden until 2016 – forty-three years after its completion – when the raw data were unearthed and turned over to Ramsden and co-workers, who then analyzed the data. [10] The main conclusion from the MCS study was that a high omega-6 diet effectively lowered serum cholesterol, but also increased the risk of heart disease, a result that was the opposite of what Keys desired. [11]

The AHA eliminated the MCS study from its list of “high quality” core studies because of its “short duration, large percentage of withdrawals from the study, and intermittent treatment, which is not

relevant to clinical practice.” (AHA page e7) They conveniently ignored the fact that the MCS study was longer than some of the “high quality” studies that it cited and was likely better designed and implemented (by Keys himself). The AHA concern regarding subject withdrawals had already been adequately addressed previously by Broste [12] and Frantz. The AHA also critiqued the use of “lightly hydrogenated corn oil margarine in the polyunsaturated fat diet” which would have contained trans-fat, which is known to raise cholesterol. Ramsden and coworkers addressed this concern in their paper by pointing out that both Keys and Frantz were well aware of this problem and had already devised diets from previous studies which achieved reductions in cholesterol. The MCS study should remain an important study for consideration notwithstanding the AHA objection.

The AHA Presidential Advisory is clearly biased.

3. Coconut has always been part of a healthy traditional tropical and Pacific island diet.

The AHA Presidential Advisory complained that: “A recent survey reported that 72% of the American public rated coconut oil as a ‘healthy food’ compared with 37% of nutritionists. This disconnect between lay and expert opinion can be attributed to the marketing of coconut oil in the popular press.” (AHA page e13)

Obviously, the AHA is of the opinion that the perception of coconut oil as a health food is just a health fad and that, as previously mentioned, it has “no known offsetting favorable effects.” Coconut oil may be a fad in the US, but it has been part of a healthy traditional diet in the tropics and Pacific islands for thousands of years. [13] The AHA probably believes that a healthy diet can only be proven within the confines of its clinics and laboratories and not in the real world where people actually consume the food. The AHA does not realize that people cannot live on a tropical island and not consume coconut every day, and that despite this, do not suffer from heart disease. [14] The AHA is obviously unaware of the numerous published studies that document how Pacific island inhabitants who shifted from a coconut diet to a Western diet became more prone to heart disease and obesity. [15] The AHA wants us to miss the forest for the trees: There is no evidence that coconut oil causes heart disease; instead, they want to focus only on LDL.

At the same time that the AHA is attacking coconut oil, it has been promoting a high omega-6 diet. In 2009, AHA issued a science advisory which endorsed a minimum of 10% omega-6 in the diet, [16] contrary to the recommendations of international health agencies to limit total omega-6 + omega-3 fat consumption to about 8%, and to keep an omega-6 to omega-3 ratio of no more than 5:1. The excessive consumption of omega-6 fat and deficiency in omega-3 fat may be one of the major contributors to the epidemic of obesity and diabetes in the US. [17] It is soybean oil, an omega-6 fat, which has profited the most from the AHA support for a high omega-6 diet and warning against coconut oil.

In 1987, the American Soybean Association launched a “truth-in-labeling campaign” to demonize coconut oil to “increase market share for soybean oil.” [18] This campaign, which came to be known as the Tropical Oils War, severely damaged the coconut industry. Today, soybean oil accounts for 55% of the edible vegetable oil consumption in the US [19] and the soybean industry has been funding the AHA in the guise of supporting its health campaign [20] to further increase its market share. In exchange, AHA is once again using defective science that demonizes coconut oil and makes Americans obese and sick.

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