

For Doctors & Care Givers

LAST DAYS OF DIABETES

Consensus

Conspiracy

Cure



Dr. Biswaroop Roy Chowdhury



INDO-VIETNAM
MEDICAL BOARD

For Doctors & Care Givers

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LAST DAYS OF DIABETES - DR. BISWAROOP ROY CHOWDHURY

DEDICATION

Dedicated to my angel daughter Ivy,

loving wife Neerja

&

caring parents

Shri Bikash Roy Chowdhury

Shrimati Lila Roy Chowdhury.

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WHY SHOULD I READ THIS BOOK ?

To know why, attempt answering the following questions:

Q. 1) Which is correct ?

- a) High Blood Pressure leads to Heart Disease /Risk of Brain Stroke

- b) Risk of Brain Stroke/Heart Disease leads to High Blood Pressure

Q. 2) Is Mango good/ bad for diabetic patients?

- a) Bad
- b) Good

“Mango is
good for
Diabetic Patients”

CONSENSUS

Get ready to be pleasantly shocked! The first chapter has the potential for some amazing outcomes:

1. 100% of Diabetic patients will abandon their anti-diabetic pills... **permanently.**
2. Up to 70% of Diabetic patients will come to know that they are **no more diabetic....**

The Universal Consensus says that:

- The 10 year risk of cardiovascular diseases (CVD) in a Diabetic population is just 2% higher than in the non-diabetic population.

“**The 10 year risk of cardiovascular diseases in case of a person suffering from diabetes is 2% higher than in the non diabetic population**”

- Lifetime risk of Dialysis in case of a Diabetic patient is just 1.5% higher than the normal population.
- Lifetime risk of blindness is 4% higher in case of Diabetes patients¹.

It is clear from all the clinical studies specifically done on PIMA Indians (population with highest rate of Diabetes) that High Blood Sugar increases the risk of Cardio Vascular Disease (CVD), Retinopathy, Neuropathy and Nephropathy.

Higher Blood Sugar = Higher risk of Diseases.

in other words

Lower Blood Sugar = Lower risk of Diseases

but, does that automatically mean lowering blood sugar with medication = Lower risk of diseases!

It seems obvious. But the reality is just the opposite!

It is

Natural lowering of Blood Sugar = Lower risk of Diseases: **True**

and

Lowering Blood Sugar with Medication = Lower risk of Diseases:
False

Let me prove my point by considering each group of diabetes medication one by one, starting with Metformin the highest prescribed pill among all.

Given in the next page is the meta-analysis of 13 Randomized Control Trial (RCT) - 9500 Metformin cases / 3500 Placebo for 5 years (PLOS Medicine-2012). It can be clearly seen that the Risk Ratio Interpretation (RRI) for all the risk factors increase among patients on Metformin.

“Lowering blood sugar with medication does not lower the risk of heart failure or retinopathy”

Risk factor	RRI
Cardio Vascular disease mortality	1.05
Heart Failure	1.03
Amputation	1.04

PLOS Medicine 2012

Conclusively, it means being on Metformin, one can lower the blood sugar level. But our prime aim is not just to target a particular blood sugar range rather, our aim is to reduce the risk of suffering from heart disease and other complication because of increased sugar levels in the blood.

What about the other class of diabetes medication?

To find an answer, a large study called ADOPT (A Diabetes Outcome Progression Trial) blinded RCT (Randomized Controlled Trial) in which 4360 patients were followed up to 4 years to compare

the effects of Glyburide, Metformin and Rosiglitazone.

The result showed that Glyburide and Rosiglitazone performed worse than Metformin with more mortality rate, more edema and more weight gain.

Class of Drug	Mortality Rate %	Edema %	Weight Gain %
Glyburide	2.2	8.5	3.3
Metformin	2.1	7.2	1.2
Rosiglitazone	2.3	14.10	6.9

With these heart breaking results of the above class of glucose lowering agents, it is worthwhile to consider the performance of remaining class of anti-diabetic medications such as GLPS, Meglitinides and SGLT2.

Upon searching the entire medical database, I came across several research papers but the most relevant research paper is as follows:

“ Risk ratio interpretation (RRI) for all the risk factors increase among patients on Metformin ”

Diabetes Matab: 2014 Jan, 40(3):169-75 doi:10.1016/).diabet.2013.12.010. Epup 2014 Feb 3.

Effects of pharmacological treatments on micro and macro vascular complications of type 2 diabetes: what is the level of evidence?

BoussageonR1, GueyffierF2, Cornu C3.

Author Information

“In 2013, the level of evidence for the clinical efficacy of anti -diabetic drugs is disappointing and does not support the millions of prescriptions being written for them”.

All the above reports conclude that although high blood sugar may be bad for your health, reducing the high blood sugar with medication is worst for your health and also a loss of significant amount of wealth.

Here, we must understand that diabetes or high blood sugar itself is not a disease, but a risk factor for various diseases however, various developed countries (under the influence of medical industry) are irresponsibly propagating Diabetes as a dreaded disease (learn more in 3rd Chapter-Conspiracy).

"Type 2 Diabetes is a Lifelong (chronic) disease." - A service of the U S National Library of Medicine. National Institute of Health- USA

"Type 2 Diabetes is one of the fastest growing diseases in Canada." Government Of Canada

The fundamental question here is, **How high should the sugar level be, to be called Diabetes?** The universal consensus or a worldwide understanding is, 'if your Random Blood Glucose or Oral Glucose Tolerance Test (OGTT) is more than 200 mg/dl, then you are diagnosed as a diabetic patient. In simple words, if in each litre of your blood there is more than 2gm of sugar (after 2 hrs of eating food) then you are diagnosed as having diabetes or in other words you have 2% higher chances of suffering from CVD (Cardio Vascular Diseases) in next 10 years in comparison to the person with blood glucose less than 200mg/dl.

“Glyburide and Rosiglitazone performed worse than Metformin with more mortality rate , more edema and more weight gain”

Here, the important point of consideration is, from where this number **200mg/dl** arrived?

It all happened in 1979, when the expert committee of National Diabetes Data Group (NDDG) observed that the PIMA Indians (population with highest rate of diabetes) with higher blood sugar levels were at higher risk of retinopathy. Here, it is important to note that if you go through the original trial (learn more in 2nd Chapter-Calculation) you will find that it was never 200mg/dl.

All the trials which were conducted to establish a cutoff point for Diabetes arrived at same conclusion i.e. 250 mg/dl as a threshold beyond which the risk of retinopathy and CVD increases steeply.

Along with postprandial (PP/OGTT), other diagnostic parameters were also set such as:

- Fasting Plasma Glucose
- Intermediate Glucose Tolerance
- Impaired Fasting Glucose
- HbA1c

But the efficacy of these parameters were questioned from time to time and were considered only as a surrogate to PP/OGTT and not the main criteria to define or diagnose Diabetes.

My experience with more than 5000 Diabetic patients has shown that diabetic patients specially non-insulin dependent upon quitting their anti-diabetic medication are still able to maintain their blood sugar below 250 mg/dl. This means they were never diabetic patients but were falsely diagnosed as diabetic patients on the basis of the commercially promoted (learn more in 3rd Chapter -Conspiracy) fasting blood glucose $\geq 100\text{mg/dl}$ or HbA1c $\geq 5.6\%$ as a criteria to diagnose diabetes and had fallen in the trap of lifelong medication, diagnostics and doctors' visits and ultimately ending up being a drug induced diabetic or hypertension patient (learn more in 4th Chapter-Cure).

“What you have just read may not only be an eye opener but also shocking and a matter of disbelief”. At this point you may have

“Whole concept of prescribing Metformin is based on just one trial”

certain questions including, “if all kinds of anti-diabetes drugs do more harm and no good then why are millions of prescriptions being written for them?”

To answer your question let me start with Metformin, the first line of preferred drug for the newly diagnosed diabetes patients. The whole concept of prescribing Metformin is based on just one trial i.e. **UKPDS** (The United Kingdom Prospective Diabetes Study) where the number of patients on Metformin were followed up till the end of the trial were 136. Just 136! It is too small a number, to qualify for the world wide approval for prescription of Metformin as an anti-diabetic drug.

Here, it is important for us to understand that not all types of trials are same. Based on various factors, the trials are graded from highest to lowest level of importance. Refer to the table:

Hierarchy of Evidence²

- Highest** - Meta-analysis of randomized controlled trial
- Randomized Controlled trial
- Non Randomized Controlled Trial
- Cohort Studies
- Lowest** - Case Reports

What is Meta-analysis of Randomized Controlled Trial?

Meta-analysis is a statistical technique for combining the findings from independent studies. Meta-analysis is most often used to assess the clinical effectiveness of healthcare interventions; it does this by combining data from two or more randomized control trials.

What is Randomized Controlled Trial?

A Randomized Controlled Trial (RCT) is a type of scientific (often medical) experiment, where the people being studied are randomly allocated one or other of the different treatments under study. RCT is often considered the gold standard for a clinical trial.

What is Non-Randomized Controlled Trial?

A study where participants have been assigned to the treatment, procedure, or intervention alternatives by a method that is not random. The investigator defines and manages the alternatives.

“ All the trials to establish a cut-off point for diabetes arrived at 250 mg/dl as a threshold beyond which the risk of retinopathy and CVD increases steeply ”

What is Cohort Study?

Cohort Studies are a type of medical research used to investigate the causes of disease, establishing links between risk factors and health outcomes. Cohort studies are usually forward-looking - that is, they are "prospective" studies, or planned in advance and carried out over a period of time.

What is Case Report?

In medicine, a Case Report is a detailed report of the symptoms, signs, diagnosis, treatment, and follow-up of an individual patient. Case reports may contain a demographic profile of the patient, but usually describe an unusual or novel occurrence.

From here you can make out that the meta-analysis of RCT's are the best evidence to understand the efficiency and effectiveness of a particular treatment protocol. But the problem with meta-analysis is that it is possible only when there are few RCTs already available. Till that time the Medical Care has to rely on Cohort Studies or Case Reports, which can be misleading and even life threatening. Here is a classic example of it.

“Should Oxygen therapy be given for acute Myocardial Infarction (heart attack patients)?”

The general consensus on the basis of various Cohort Studies and Case Reports was that, “giving oxygen therapy to heart attack patients, increases the chances of survival,” till the meta-analysis of Cochrane Database 2013 was published and concluded that, ‘giving oxygen therapy to heart attack patients doubles the chances of death.’

Sometimes the consensus is based on a weak evidence and the public at large has to suffer.

Here is another example, “imagine all the cardiologists of the world vanish for 3 days from the world. What will happen to the heart patients and the patients who arrive in the emergency ward with heart attack?” General understanding would be, ‘the patients would suffer and certainly the mortality rate will drastically increase in the absence of cardiac doctors in emergency units.’

“ Up to 70% of people were falsely diagnosed as diabetic patients on the basis of the commercially promoted fasting blood glucose \geq 100mg/dl or HbA1c \geq 5.6% as a criteria to diagnose diabetes ”

Now, here is a jaw dropping surprise!

Every year **National Cardiology Meeting** is being organized by **American Heart Association (AHA)** and **American College of Cardiology (ACC)** in the month of March, where around 25000 Cardiologists participate in the conference leaving behind their hospitals for 3 days. In Dec 2014, a retrospective analysis was published in **JAMA Internal Medicine** with the objective to analyze the mortality rate among the high risk patients with heart failure. The outcome was about 8% reduction in mortality during the cardiology meeting dates.

Sometimes the general consensus and expected outcome may be far from truth. Here, it is important to understand how to distinguish between the low quality & biased medical report from a true medical outcome.

As a trained medical analyst (trained at **Penang Medical College, Malaysia**) I follow 3 rules to identify the true picture of expected medical outcomes, which has also become the basis of my writing this book:

1) If it is 'industry-funded' then '**scrap it**'.

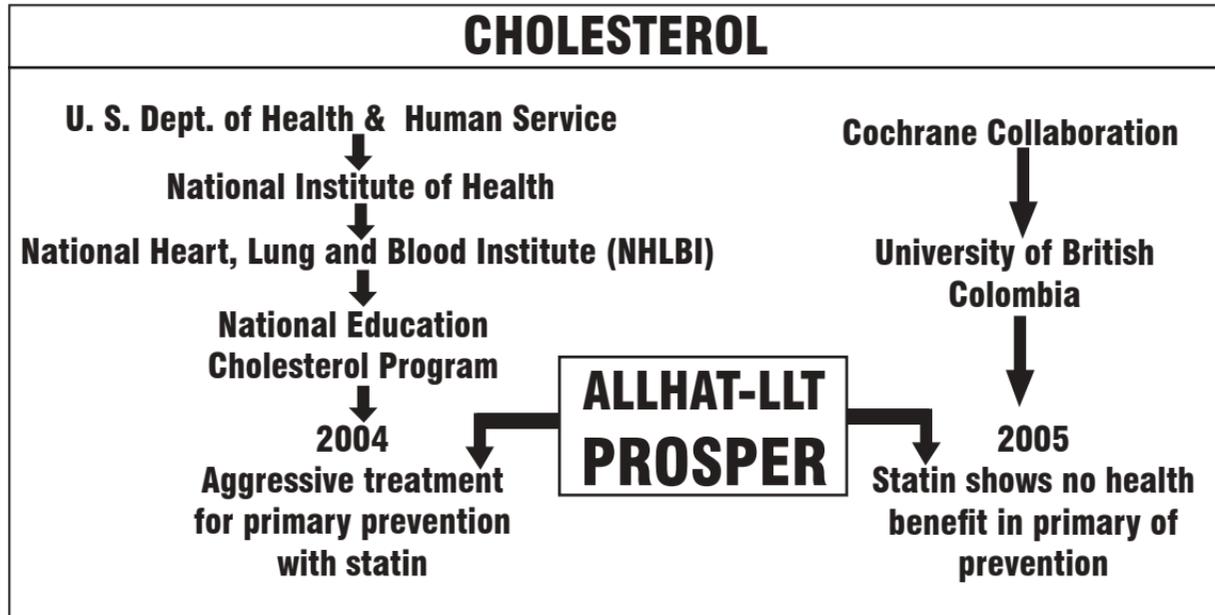
To understand it, read the full story of Cholesterol Guidelines.

DECODING MEDICAL GUIDELINES

U.S. Department Of Health and Human Services have projected themselves (successfully though) as a self-styled medical parameter and guidelines deciding authority for rest of the world. Under it is a department called **National Institute of Health**, under National Institute of Health sits **National Heart Lung and Blood Institute (NHLBI)** which runs '**National Cholesterol Education Program (NCEP)**'. An 8 member committee of NCEP decides the Cholesterol Guidelines (similarly there are other department in NIH, engaged in creating guidelines for diabetes, hypertension etc.) Now to decide the Cholesterol Guidelines they refer to some of the past trials related to cholesterol. In the present case they referred to two major past trials, 1) "ALLHAT-LLT" and 2) "PROSPER", and concluded for "aggressive treatment for primary prevention with

“**Meta-analysis of RCT's is considered as the highest level of evidence**”

Statin", in patients with cholesterol more than 200. Please refer below:



Please refer below for profile of the 8 Members of the Committee of NCEP.

Dr. Cleeman: (Chairman) has no financial relationships to disclose.

Dr. Grundy: has received honoraria from Merck, Pfizer, Sankyo, Bayer, Merck/Schering-Plough, Kos, Abbott, Bristol-Myers Squibb, and AstraZeneca; he has received research grants from Merck, Abbott, and Glaxo Smith Kline.

Dr. Bairey Merz: has received lecture honoraria from Pfizer, Merck, and Kos; she has served as a consultant for Pfizer, Bayer, and EHC (Merck); she has received unrestricted institutional grants for Continuing Medical Education from Pfizer, Procter & Gamble, Novartis, Wyeth, AstraZeneca, and Bristol-Myers Squibb Medical Imaging; she has received a research grant from Merck; she has stock in Boston Scientific, IVAX, Eli Lilly,

“ Giving oxygen therapy to heart attack patients doubles the chances of death ”

Medtronic, Johnson & Johnson, SCIE Insurance, ATS Medical, and Biosite.

Dr. Brewer: has received honoraria from AstraZeneca, Pfizer, Lipid Sciences, Merck, Merck/Schering-Plough, Fournier, Tularik, Esperion, and Novartis ; he has served as a consultant for AstraZeneca, Pfizer, Lipid Sciences, Merck, Merck/Schering-Plough, Fournier, Tularik, Sankyo, and Novartis.

Dr. Clark: has received honoraria for educational presentations from Abbott, AstraZeneca, Bristol-Myers Squibb, Merck, and Pfizer; he has received grant /research support from Abbott, AstraZeneca, Bristol-Myers Squibb, Merck, and Pfizer.

Dr. Pasternak: has served as a speaker for Pfizer, Merck, Merck/Schering-Plough, Takeda, Kos, BMS-Sanofi, and Novartis; he has served as a consultant for Merck, Merck/Schering-Plough, Sanofi, Pfizer Health Solutions, Johnson & Johnson -Merck, and. Johnson & Johnson.

Dr. Hunninghake: has received honoraria for consulting and speakers bureau from AstraZeneca, Merck, Merck/Schering-Plough, and Pfizer, and for consulting from Kos;

he has received research grants from AstraZeneca, Bristol-Myers Squibb, Kos, Merck, Merck/Schering-Plough, Novartis, and Pfizer. Dr Pasternak: has served as a speaker for Pfizer, Merck, Merck/Schering-Plough, Takeda, Kos, BMS-Sanofi, and Novartis; he has served as a consultant for Merck, Merck/Schering-Plough, Sanofi, Pfizer Health Solutions, Johnson & Johnson -Merck, and. Johnson & Johnson.

Dr. Stone: has received honoraria for educational lectures from Abbott, AstraZeneca, Bristol-Myers Squibb, Kos, Merck, Merck/Schering-Plough, Novartis, Pfizer, Reliant, and Sankyo; he has served as a consultant for Abbott, Merck, Merck/Schering-Plough.

It is now clear that these members can be greatly influenced by the drug companies from whom they receive regular grants /funding or have several monetary tie-ups. So to understand

“ **Mortality rate increases considerably by intensive blood glucose lowering among the ICU patients in comparison to the standard treatment** ”

the real picture of cholesterol guidelines it is important to draw your attention to **Cochrane Collaboration**, a highly regarded medical organization being recognized by and referred by all major medical agencies across the world. They have branches in more than 130 countries and are known for not accepting any sponsorship or any kind of grant from any pharmaceutical company. Under Cochrane Collaboration, is University of British Columbia who on the basis of same 'ALLHAT -LLT' and 'PROSPER' trial concluded that "Statin shows no health benefit in primary prevention." Even in the past, several medical agencies proved beyond doubts that lowering Cholesterol through drugs is not only worthless but also injurious to human health.

Consider the following reference:

**20 yrs (1960 to 1980) study by
World Health Organisation**

**Lowering Cholesterol with medication
increased overall risk of death by 47%.**

2010 British Medical Journal

**Observational study of more than
2 million people treated with statin.**

**Result: Significantly increased risk
of liver dysfunction, kidney failure
and cataract.**

Honolulu Heart Program

Low cholesterol had significant association with mortality, which was an increased risk of mortality by 64%.

The above conclusion was so clear that Pfizer, the largest manufacturer of Statin was forced to write a disclaimer for several years as below:

“Statins have not been shown to prevent heart disease or heart attack” -Pfizer

On the other hand, it was observed that the residents of Rural China and Central Africa were always found to have cholesterol levels which were considered dangerously high by the present medical standards, but these residents are known to rarely suffer from heart diseases and often live beyond 100 years.

2) For the final verdict of any expected medical outcome, a given medical care protocol and pharmacology also relies on meta-analysis of randomized controlled trial. For this, **‘the most preferred source is the Cochrane Database.’**

3) You should be able to '**read between the lines**'. Sometimes the final conclusion of a particular trial is too illusive and deceptive. It may mislead you in a direction which will in-fact harm the patients.

To understand further, consider the following RCT of 11,140 patients with Type 2 Diabetes to undergo either standard glucose control or intensive glucose control. This widely quoted trial **ADVANCE (Action in Diabetes and Vascular Disease: Preterax and Diamicron Modified Released Controlled Evaluation)** Collaborative Group was published in **New England Journal of Medicine- June 12, 2008 .**

The Final Conclusion of this trial is given below:

A strategy of intensive glucose control, involving gliclazide (modified release and other drugs as required), that lowered the glycated hemoglobin value to 6.5% yielded a 10% relative reduction in the combined outcome of major macro-vascular and micro-vascular events, primarily as a consequence of a 21% relative reduction in nephropathy. ClinicalTrials.gov number,NCT00145925

At the face of it, it is clear that the strategy of intensive glucose control is a wiser decision for the patients. However if you carefully read the complete 13 page report, you will find a contradictory (true) outcome.

Here in the box is given an extract from the ADVANCE trial:

Subgroup	Intensive Control (N-5571)	Standard Control (N-5569)
All Cerebrovascular Events	6.3%	5.9%
All Cardiovascular Events	22.1%	22.4%
Visual Deterioration	54.4%	54.1%
New or Worsening Neuropathy	42.2%	41.5%
Dementia	1.1%	0.9%

When you compare various medical events /risk factors of intensive control v/s standard control, you can clearly see that there is more

“ **Cochrane Collaboration 2013 defines the hypertension guidelines as having blood pressure more than 160/100 mmHg** ”

neuropathy, more dementia, more visual deterioration and more cerebrovascular events in intensive glucose control group in comparison to the standard group and only in cardiovascular event it is insignificantly better than the standard group.

Reading, interpreting and implementing the outcomes of a medical trial is far more important than understanding the pharmacology. Our modern doctors are not trained and are ill equipped to interpret the outcomes of the medical trials. As a result of this misinterpretation, sometimes the mass popular practice by the doctors becomes a harmful practice . For instance, it is a common practice to tightly control the blood sugar level of a patient, admitted in Medical ICU, whereas the truth is, the mortality rate increases considerably by intensive blood glucose lowering among the ICU patients in comparison to the standard treatment as reported in **New England of Journal of Medicines Feb 2, 2006**. The disparity in understanding of medical protocol and medical diagnostic guidelines were clearly demonstrated in **17th World Conference Of The Hypertension League Council** held in Montreal in 1997 where 27 National Hypertension Societies participated. Among them 14 used 140/90 mmHg as a threshold to diagnose hypertension and 13 used 160/95 mmHg. However, now 120/80 mmHg as a threshold is prevailing globally as hypertension cutoff point.

Here as a medical doctor, your ability to identify the right resources to find most reliable reference to diagnose hypertension will play an important role for the well being and safety of patients.

For that you can refer to the meta-analysis of **Cochrane Collaboration, 2013**, which defines the hypertension threshold as 160/100 mmHg specially in case of diabetic patients.

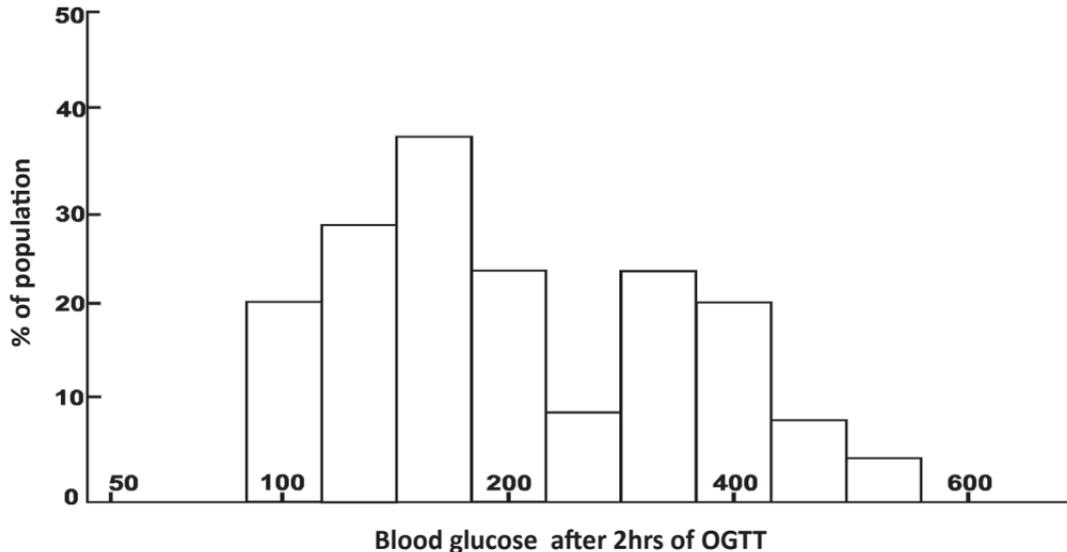
Besides your ability to find a reliable source to decide the protocol of your treatment and diagnostic parameter, one more factor will help patients to recover from the disease as it has helped me to reverse diabetes of thousands of my patients. And that is, 'your understanding of making of the diagnostic parameters.' In the present context of this book, let's try to understand the making of diagnostic parameter for diabetes.

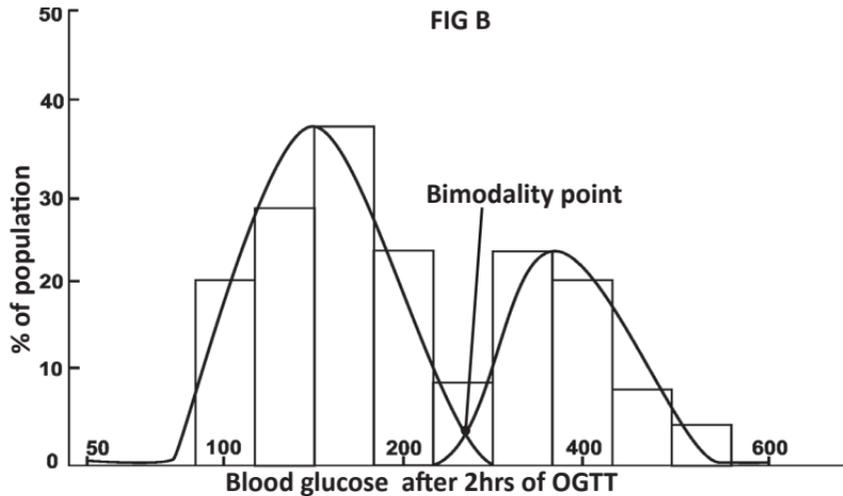
It was somewhere between year 1965 and 1978, an attempt was made to define the cutoff point for the diagnosis of high blood sugar

“There was about 8% reduction in mortality rates during National Cardiology meeting dates”

i.e. the amount of sugar in the blood beyond which there is a steep rise in the risk of retinopathy, nephropathy and cardio vascular disease. For that PIMA Indians, the population with highest prevalence of diabetes was chosen. After 75 gm of oral glucose load, blood sugar was measured after 2 hrs and the results were plotted in histogram form as shown below.

FIG A





In figure B, a superimposed composite curve has been drawn and there is a point where the 2 curves meet and cross one another. This is called Bimodality, which separates the two populations. Here the 2nd curve represents the diabetes population and cutoff point is a little above 200 mg/dl somewhere near 225 mg/dl which can be called as a threshold for the diagnosis of diabetes.

“ **Blood sample taken from finger tip (capillary blood) always has about 10% more sugar level than venous blood** ”

Here, we must note that the blood samples taken here were venous blood samples whereas in home set-up, the blood sample is taken from finger tip (capillary blood) which always has about 10% more sugar level.

In the light of the above factors, it is evident that the well being of the patients depends on the ability of the doctor to interpret the medical trial, treatment protocol and diagnostic parameter.

References:

1. *Cardiovascular risk factors and their effects on the decision to treat hypertension: Evidence Based Review. **BMJ-2001.***
2. *Chalmers TC, Celano P, Sacks HS, Smith H Jr. (1983) Bias in treatment assignment in controlled clinical trials. **New England Journal of Medicine.***

CALCULATION

Are you a Diabetic Patient? How do you know that you suffer from diabetes?

First of all we must remind ourselves that diabetes is not a disease but a condition in which, if sugar (glucose) concentration in the blood is below or above a certain level, then the chances of heart disease, kidney failure, blindness and even death may increase substantially (it may be noted that at any level of sugar, there still remains about 20% chances of heart disease and reasonable chances of blindness and kidney failure).

The basic question is how many grams of sugar per litre of your

“ **Retinopathy – a specific micro-vascular complication is a basis for deciding a cut-off point for diabetes** ”

blood is safe or will lead to risk of dying from previously mentioned causes. Prior to 1979, there were at least 6 different sets of criteria to diagnose diabetes,¹ all of them lacking evidence and standardization. In 1999, the **National Diabetes Data Group (NDDG)** attempted to resolve this issue by arriving at a clear cut value of sugar level in the blood above which the diabetes associated risk factors increased steeply².

Subsequently, the bimodal frequency distribution of sugar concentration in the blood was suggested which allowed a separation of the population in two groups- Normal and Diabetic. This provided a base for determining the degree of sugar level in the blood that could be regarded as diabetes^{3,4}.

Out of all the complications that high level of sugar may attract, they selected Retinopathy- a specific micro-vascular complication as a basis for deciding a cutoff point above which the chances of retinopathy increases sharply. Three major studies^{5,6,7} were available to the NDDG on which they based their decision. A total of 1213 patients were followed up for 3 to 8 yrs after **Oral Glucose Tolerance Test (OGTT)** and 77 of them developed retinopathy.

Oral Glucose Tolerance Test (OGTT) was conducted only at the beginning of the trial. It is very likely

that only these 77 patients with increased glycemia (high sugar) in the years between the **Oral Glucose Tolerance Test (OGTT)** and the Onset of Retinopathy were considered by **NDDG (National Diabetes Data Group)** to establish the cut off point /diagnostic criteria. So, on the basis of these 77 patients, the **NDDG (National Diabetes Data Group)** defined that anyone with blood glucose level above 200 mg/dl (or 2 gm sugar per litre of blood) should be recognized as diabetic. Thus, the gold standard of blood sugar ≥ 200 mg/dl after 2hr of consuming 75 gm of glucose (OGTT), as a cut off point for diagnosis of diabetes is actually based on results from less than 100 individuals⁸.

Adoption of similar guidelines by **World Health Organization (WHO)** attracted a lot of worldwide criticism and dissatisfaction as they seemed to be arbitrarily accepted as universal guidelines for diagnosing diabetes⁵. A Bimodal distribution method was applied on two civilizations - PIMA Indians and Nauruans (Micronesian

“On the basis of 77 people NDDG defined the blood glucose level above 200 mg/dl as threshold for Diabetes”

population). As a result, on the basis of the data of PIMA Indians, a new cut off level of approximately 250 mg/dl (after 2hr of OGTT) was found³. In Nauruans also the cut off level of blood sugar beyond which diabetes can be defined was found to be 250mg/dl⁴.

This above mentioned study was funded by **WHO (World Health Organization)** and **NIH (National Institute of Health-USA)** grant IRO AM 25446-02 and the report was published in 1983 in **TJEM (The Tohoku Journal of Experimental Medicine)**.

Around the same time (1982) another study on PIMA Indians (941 individuals without retinopathy or nephropathy at beginning of the study) conducted by **National Institute of Diabetes** gained importance. They followed the population for 4.5 years. The development of retinopathy or nephropathy during the follow-up was compared with the initial 2hr glucose concentration in the blood. The bimodal cut off point for 2hr glucose was found at 227 mg/dl.

This study gained much importance and got frequently cited in many medical journals⁹ for it being most complete in terms of evaluating the glycemic test from all dimensions¹⁰. This study was not available at the time of **NDDG (National Diabetes Data Group)** criteria for diagnosing diabetes and they used lower level (< 200 mg/dl) as a cut off point for 2hr OGTT.

In this present trial it was clearly established (as is evident from the table).

2hr Plasma Glucose

	< 227	≥ 227
Retinopathy	0%	17.5%

The chances of retinopathy is nearly nil below the blood sugar level of 227mg/dl. Here we must remember that among all the risk factors of Diabetes, retinopathy is considered as the basis for deciding the cut off point for diabetes in most research trials.

After the publication of the above trial and other relevant trials, around mid 1990's, the **American Diabetes Association (ADA)** convened an expert committee¹¹ to re-examine the diagnosis of Diabetes in light of the new information available. They considered the following trials:

“ **Bimodal distribution method was applied on two civilisations – PIMA Indians & Nauruans** ”

- 1) PIMA Indians trial of 960 individuals.
- 2) Egyptian trial of 1081 individuals.
- 3) The Third National Health And Nutrition Examination Survey (NHANES III) of 282 individuals.

The mid cut off point obtained (as reported in journal of **American Medical Association** - 1999) for 2hr OGTT of the above 3 trials were 298mg/dl, 252mg/dl and 292 mg/dl respectively.

Here also, development of retinopathy was taken as a basis to decide the cut off point above which the patients had substantially higher chances of developing retinopathy.

But instead of considering the above mentioned mean value of the bimodal threshold, which is the standard followed in such research analysis, they chose to adopt the lowest glycemic level of each of initial decile in which the prevalence of retinopathy increased which were 244mg/dl, 218mg/dl, 195 mg/dl respectively. Even the mean of the 3 values is 219 mg/dl but ADA decided to retain the initially proposed value of 2hr OGTT by NDDG i.e. 200 mg/dl which is misleading and has great potential of diagnosing false positive case of Diabetes.

Hence, to arrive at a sensible 2hr OGTT threshold, we must consider controlled trial on different population. Following is the table showing the cutoff point after 2hr 75gm of oral glucose consumption (OGTT).

Population	Year	Publication	2h Plasma Glucose
Samoa	1984	Diabetes Research	208
Mexican Americans	1985	Journal of Chronic Diseases	231
Kiribati	1993	Journal of Diabetes and its Complications	228
Wanigela	1994	Medical Journal of Australia	268

2hr Plasma Glucose distribution in different Population

The above mentioned 2hr glucose cut off point value is of the population in the age group between 35 years to 50 years. We may

“ **Bimodal cut-off point for 2hr glucose was found at 227 mg/dl** ”

here attempt to find the mean value of the cut off point in the above four populations so as to decide a reference point for ourselves as a doctor/health care practitioner which may represent a true cut off point for 2h OGTT or a Random Blood Sugar Value. The mean of the above 4 values is as follows:

$$208+231+228+268/4 = 935/4 = 233.75$$

233mg/dl, which is very close to the 2hr OGTT cutoff point as arrived by the high quality PIMA Indians Trial on 941 individuals i.e. 227mg/dl.

At this point, it may be appropriate for us to conclude that for an individual up to 50 years of age, the plasma random blood sugar or **2hr Oral Glucose Tolerance Test** value for being diagnosed as diabetic can be ≥ 230 mg/dl.

Here we must keep in mind that all the above results are from the blood samples taken from veins² whereas in a home setting, normally the blood is taken from capillary (finger prick) using a glucometer to measure the blood glucose level. It is universally accepted, as is accepted by WHO expert committee that the glucose concentration in the blood taken from capillary is around 10% higher.

It means you have to add 10% i.e. 23mg/dl to 230 mg/dl to arrive at the value of random blood sugar cut off point for the diagnosis of diabetes. This means capillary blood sugar level of $230+23\text{mg/dl} = 253\text{mg/dl}$ should be considered as cut off point for diabetes (for people up to 50 years of age).

It has been a trend in medical science to give a diagnostic figure adjusted and rounded off to nearest whole number (as in case of blood pressure 160/100mmHg, of total cholesterol 200mg/dl). Here we can round off the actual arrived value of 253 mg/dl to 250mg/dl as threshold for diagnosis of Diabetes for age group up to 50 years of age.

The above arrived cut off point of 250mg/dl will be of limited use if we don't consider some other factors which influence the blood glucose value substantially. The prominent one being the 'Age Adjustment'. Since the beginning of evidence based medicine, science has understood that various metabolic activities in the

“ **Mid cut-off points obtained for 2 hr OGTT from 3 trials were 298 mg/dl, 252 mg/dl and 292mg/dl** ”

body shows a dramatic change with age, which is a normal course of action in living beings. Blood glucose and blood pressure are two such metabolic activities which are greatly influenced by the age factor. So keeping a single cutoff point across a wide spectrum of age is too generic to be of much value in the real clinical diagnosis. One major trial on over 2900 PIMA Indians was conducted, to see the effect of age on the blood glucose level, two hours after a 75gm of carbohydrate load. The report along with the following table was published in **Nov. 1971 in Diabetes (Journal)**.

Plasma Glucose Levels (mg/dl) determined two hours after an oral 75gm carbohydrate load

Age Group	No. of examined Males	Mean 2h Plasma Glucose	No. of Examined Females	Mean 2h Plasma Glucose
5-14yrs	550	99.9mg/dl	606	104.89mg/dl
15-24 yrs	245	107.49mg/dl	314	112.19mg/dl
25-34 yrs	139	154.49mg/dl	186	226.29mg/dl
45-54 yrs	96	208.79mg/dl	112	256.69mg/dl
55-64 yrs	83	214.99mg/dl	106	293.19mg/dl
65-74 yrs	81	210.09mg/dl	52	229.49mg/dl
Total	1,340		1,571	

In the previous table if you observe both the male and female plasma glucose level, following conclusion can be derived:

1. Clear increase in blood glucose level with age.
2. After the age of 65 yrs the blood glucose level tends to drop a bit (as in the case of blood pressure).
3. There is no clear cut rate of increase of blood sugar in relation to the age.
4. In the 25 to 35 yrs age bracket, there is a trend of steep increase in blood glucose value i.e. more than 40mg/dl.

On the basis of above observation, it would be wise to include age adjustment factor to our arrived value of 250mg/dl of blood glucose for 2hr OGTT, so as to avoid the detection of false case of diabetes in individuals more than 50 years of age and false negative cases of diabetes in individuals aged 25 years .

“Blood Glucose level increases with age”

Conservatively, on the basis of the observation we can safely add 1 mg/dl for every added year after 50 years of age.

For example, for a 60 yr old individual, capillary plasma blood glucose after 2 hour of consuming 75 gm of glucose should be $250\text{mg/dl} + 10\text{mg/dl} = 260\text{mg/dl}$ to be diagnosed as a diabetic patient.

Similar approach can be applied to derive a more practical value of fasting blood glucose and HbA1c for more practical and error free diagnosis of diabetes. But these 2 criterias (fasting blood glucose and HbA1c) have much less predictive value to diagnose diabetes and are often misleading. They tend to give unacceptable number of false positive cases. I will explain about it in the next chapter.

But before we arrive at a conclusion to diagnose diabetes keeping in mind the above arrived cut off point, it would be interesting for you to know that the major trials specifically on PIMA Indians were done where the day temperature varied between 18°C to 38°C as Tucson, the habitat of PIMA Indians is a desert area with high day time temperature.

So the previous arrived cut off point is suitable for a place where the day temperature is not less than 10°C. This means the population that lives in a cold climate must add one more dimension to the above cut off point. i.e. 'Temperature Change' due to weather or climate change. Let me explain how?

It has been observed that in winters the blood sugar increases roughly by 10mg/dl in comparison to summer. So the figure for a 50 year old person during winter in capillary plasma blood glucose (2h PG) $\geq (250 + 10)$ mg/dl = 260mg/dl should be diagnosed as a diabetic patient. Diabetes is diagnosed more in winter season as the doctors are not taught to add the winter adjustment factor. Finally before diagnosing a person as diabetic on the basis of the above mentioned factors we must also check whether the person is suffering from any kind of viral infection/fever as it is very normal to have a 10% raised blood sugar during sickness and one should not be treated as diabetic.

“ **In 25-35yr age bracket, there is a trend of steep increase in blood glucose value** ”

Note: To avoid the false positive diagnosis of diabetes, the final value of the random blood glucose reading in your glucometer should be adjusted by:

1. Adding Age Adjustment Factor.
2. Adding Winter Adjustment Factor.
3. Adjusting for any temporary rise in blood sugar because of Fever/Viral Infection.
4. If you have eaten recently, the blood glucose level from blood obtained from a fingertip can be up to 70mg/dl higher than blood from a vein used for lab test.¹²

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CONSPIRACY

Not reading this chapter may increase your risk of falling into the trap laid by medical industry, leading to the loss of your health and wealth.

I am not talking about Modern Medicine or Modern Medical Science. I am talking about the Medical Industry. Let's start with differentiating between the two. Medical Science means evidence-based medical care whereas Medical Industry means profit-based medical care. To understand the magnitude of conspiracy by the medical industry often misunderstood as an evidence-based medicine, refer to the table.

“ Medical Science has never ever supported the idea of anti-hypertensive drug treatment at the threshold of 120/80mmHg as propagated by medical industry ”

	Diabetes		% of Diabetes in China
1	NDDG, 1979	>200mg/dl	3.5%
2	ADA 1997, WHO 1999	>126mg/dl	8%
3	ADA, 2003	>100mg/dl	27%
4	ADA, 2010	>140mg/dl (P.P) or >100mg/dl (Fasting) or > HbA1C > 5.6%	50.1% JAMA 2013

It is quite evident from the above table (survey on Chinese population) that from the beginning, when for the first time standard for diagnosis of diabetes was established (**National Diabetes Data Group NDDG 1979**) till present (**American Diabetes Association ADA 2010**), the threshold for diagnosis of diabetes has been narrowed to such an extent that nearly half of the population

on this earth can be tagged as a diabetes patient fit for lifelong medication. Similarly, the prevalence of diabetes increased two to five fold after the introduction of narrowed guidelines by **ADA-2010** report for the diagnosis of diabetes. Please refer to the table below:

Country	Increase in prevalence of pre-diabetes
Denmark	11.8% to 37.6%
France	15.9% to 45.2%
India	10.6% to 37.6%
USA	9.5% to 28.5%
Singapore	9.5% to 32.3%

The above data is extrapolated from the **National Health And Nutrition Examination Survey (NHANES)**.

Metaphorically, I can imagine a situation where the size of the goal-post is reduced to win a football match by hook or crook. In plain words it is cheating, a fraud!

“ **Lowering of the threshold for fasting glucose to 100mg/dl and HbA1c to 5.6% was criticised and rejected by World Health Organisation (WHO)** ”

In-fact lowering of the threshold for fasting glucose to 100mg/dl and HbA1c to 5.6%, was criticized and rejected by **World Health Organization (WHO)** and **European Diabetes Epidemiology Group (EDEG)**¹ as well. Just guess, who will benefit the most by labeling half of world's population as diabetes patients? The Medical Industry, of course!

To understand the modus-operandi of the Medical Industry, let's go back to the 'making of Cholesterol Guidelines' as given in the 1st chapter of the book. First of all, it should be clear that Diabetes and High Cholesterol are not diseases themselves but are the assumed risk factors for various vascular diseases. In fact cholesterol is not a bad guy (as propagated and labeled by the medical industry).

According to medical science, no metabolic activity in the body can be completed without the participation of cholesterol. In fact the membrane of each cell in the body is made up of cholesterol. Of course there is a much propagated concept of good cholesterol (HDL) and bad cholesterol (LDL) but the truth is, no type/amount of cholesterol is bad for the body as long as it is manufactured in the body itself. It is only the cholesterol that we take in as food (animal food) may cause some harm to our circulatory system. Here we must understand that God has not given this power to plant kingdom to manufacture cholesterol. This means you can take in

cholesterol only when you eat animal food including milk, eggs, chicken, fish, etc. It is this kind of cholesterol which may impose some threat to your body.

Lowering cholesterol levels by medication may not necessarily mean better health outcome or higher cholesterol may not imply higher risk of cardiovascular disease. This was also made clear by the **Cochrane Collaboration 2013** meta-analysis. In the example given in page- 24 of Chapter-1.

National Institute of Health (NIH) on the basis of 2 large scale trials **The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT-LLT) & The Prospective Study of Pravastatin in the Elderly at Risk (PROSPER)** recommended an aggressive treatment for the primary prevention of Cardio Vascular Diseases with Statins. Of course their 8 Member (except the Chairman) Cholesterol Guideline Committee was heavily linked to the pharmaceutical companies. Whereas the **Cochrane**

“**Metformin does an average business of more than Rs. 100 crore per month in India**”

Collaboration-2013 (that does not accept funding from drug industry) concluded that, statins shows no health benefits in primary prevention of Cardio Vascular Diseases, on the basis of the same two trials (**ALLHAT-LLT & PROSPER**). It is a clear case of Medical Industry v/s Medical Science!

Some other large scale medical trials such as Anglo-Scandinavian Cardiac Outcomes Trial- Lipid Lowering Arm (**ASCOT-LLA- 2003**) also concluded that, 'any apparent mortality or net health benefit of Statin for primary prevention is more likely from the trials where various biases may have arisen rather than a real effect'. The unacceptable fact about the Statins is (as reported in **Cochrane Database - September 2015**), it causes cancer, respiratory diseases & gastrointestinal diseases. In the present context of this book, it is important to know that, '**lowering cholesterol leads to diabetes**'.

Now read the following three facts and connect the dots-

Fact 1 : ADA Guidelines:- 'Over the age of 40 years everyone should consume cholesterol lowering drug irrespective of his/her cholesterol level'.

Fact 2: ADA is controlled, founded and funded by drug companies which include companies manufacturing cholesterol lowering drugs and anti-diabetes medication.

Fact 3: Cholesterol lowering drug causes diabetes.

What do you conclude?

ADA is conspiring to label most of us as sick and drug dependent for life (unfortunately I am one of the members of ADA), as more diabetes patients means more profit.

How big is the Diabetes Industry?

The scale of Diabetes business can be estimated from the fact that Metformin, one of the basic drug class of diabetes does an average business of more than Rs100 crore in one month, in India alone³.

This business of diabetes accelerated in 2003 when ADA introduced a term Pre-Diabetes. That virtually means, there is hardly any healthy individual left i.e. either you are diabetic or going to be a

“ **Because of change in parameter, nearly 78% more people in India are treated with anti-diabetic drugs** ”

diabetic (pre-diabetes). Earlier, anyone with fasting blood sugar $\leq 126\text{mg/dl}$ were considered healthy but are now classified as a pre-diabetic patient and there is no justification given by ADA for this lowering of threshold. In fact the ADA expert committee states “we do not yet know the total benefit or the total cost to an individual who is diagnosed by this criteria.” Here it may be noted that because of the above change in parameter, nearly 78% more people in India, 135% people in China and 193% people in USA are treated with anti-diabetic drugs as confirmed by **DETECT-2 study** (Diabetes Cardio Vascular Risk-Evaluation: Targets and Essential Data for Commitment of Treatment).

Clearly, it imposes a greater economic burden on the society and is also harming health outcome as reported by a large scale **DREAM Study**. (Diabetes Reduction Assessment with Ramipril and Rosiglitazone Medication).

Composite Primary Outcome	Rosiglitazone Group N= 2635	Placebo
Myocardial Infarction	0.6%	0.3%
Stroke	0.3%	0.2%
Cardio Vascular Death	0.5%	0.4%
Confirmed heart Failure	0.5%	0.1%
New Angina	0.9%	0.8%
Revascularisation	1.3%	1.0%
Myocardial infarction, stroke or cardio vascular death	1.2%	0.9%

DREAM-TRIAL

The above DREAM-Trial table clearly shows that the cardiovascular outcomes become worst in patients treated with rosiglitazone in comparison to the placebo group.

Similarly, another large scale study called **US Diabetes Prevention Program** results imply that you can give an otherwise healthy person labeled as pre-diabetic, a 100% chance of using metformin with a goal of reducing 31% of their risk of developing a condition that might require them to use metformin later (as published in **British Medical Journal 15 July 2014**).

Clearly on the basis of above findings we can conclude that pre-diabetes or fasting glucose $\geq 100\text{mg/dl}$, a diagnostic criteria laid down by ADA is a trap to label maximum people as sick and fit for anti-diabetic treatment.

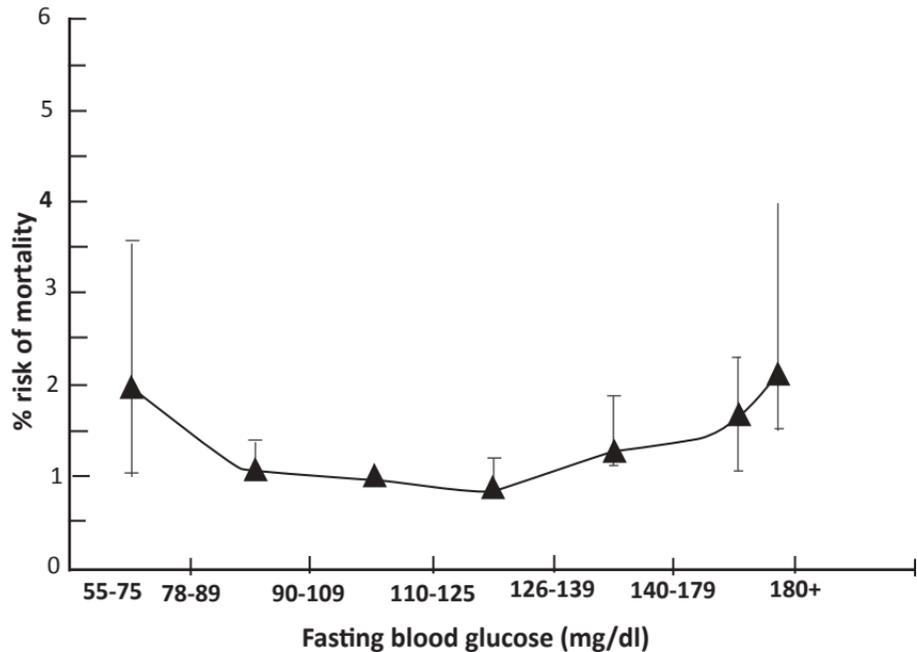
Does that mean people with fasting sugar levels below 100mg/dl are safe and healthy? Absolutely Not!

“ There is
2% risk of
mortality at
very low as
well as very
high fasting
blood sugar ”

It has been observed in the last 2 decades, in several large scale trials, that people with lesser fasting glucose ($\leq 100\text{mg/dl}$) are at a higher risk of cardiovascular diseases in comparison to people with higher fasting glucose ($>100\text{mg/dl}$), as is clear from the **DECODE study** (Diabetes Epidemiology: Collaborative analysis Of Diagnostic criteria in Europe) group report as given in the table below:

Center	No. of people studied	CVD (Normal Fasting Glucose) $\leq 100\text{mg/dl}$	CVD (Impaired Fasting Glucose) $\geq 100\text{mg/dl}$
MEN			
Monica Study- Finland	1813	4.1%	2.2%
Monica Study- Northern Sweden	923	0.9%	0.0%
Glostrup Study- Denmark	373	17.9%	10.3%
Pol Monica Study - Poland	133	7.5%	0.0%
WOMEN			
Monica Study- Northern Sweden	1027	0.1%	0.0%
Cremona Study- Italy	887	1.6%	0.0%
Pol Monica Study - Poland	171	0.6%	0.0%

The unreliability of diagnosis on the basis of fasting blood glucose was demonstrated in a study on 36,386 Taiwanese's gov. employees and school teachers who were followed up to an average 11 years⁴ which clearly shows that having a low fasting glucose (≤ 80 mg/dl) has the similar relative risk of mortality as very high fasting blood sugar (≥ 180 mg/dl), as can be seen in the graph.



The graph shows about 2% higher risk of mortality in very low as well as very high fasting blood sugar whereas at any level of fasting blood sugar there is still 1% risk of mortality in 10 years. So the diagnosis of diabetes on the basis of fasting blood sugar is not reliable as was indicated in the original study on PIMA Indians, as was reported in the **The Lancet - November 15, 1980**.

Another widely used parameter to diagnose diabetes is HbA1c. However it must be understood that the HbA1c value in two people with identical glycemic control may vary depending upon the life span of Red Blood Cells (RBC) in each of them. It has been assumed that the RBC life span fall within a narrow range in hematological normal individuals and thus have no significant affect on HbA1c^{6,7}. However normal RBC life span has been reported to have a wide range of values.

In a study published in **Blood 2008**, it was demonstrated clearly by **American Society of Hematology** that the mean RBC age ranges between 38.4 to 59.5 days in hematologically normal individuals. Let's assume 3 patients who have identical glucose control but different RBC ages, then accordingly their HbA1c will change significantly as shown in next page:

	Patient A	Patient B	Patient C
RBC Cell Age	38.4 days	47.9 days	59.5 days
HbA1c	7.5%	8.6%	9.9%

On the basis of above examples we can conclude that HbA1c value should not be used for the diagnosis of Diabetes but can only be used as an additional parameter to monitor the relative glycemic control over a period of months for an individual as is also indicated in the follow up report by the expert committee of **American Diabetes Association** (as published in **Diabetes Care** Volume 26, Nov. 2003)

As is understood, more people being identified as diabetic patients means more business for medical industry, which is notoriously achieved by propagating the much questionable diagnostic parameters as fasting glucose and HbA1c or lowering the value of post-prandial glucose. However their business of converting

“ **Mean RBC age ranges between 38.4 to 59.5 days in hematologically normal individuals** ”

healthy individuals into diabetes patients so as to give them a lifelong sentence of drug dependency with the help of manipulative diagnostic procedure, there are several mischievous tricks to achieve the same. One of them, what I call is “**The Hypertension Hoax**”.

Hypertension Standard	
Before 1993 (Till JNC-4)	160/100
1993 onwards (JNC-5)	140/90
Now (Drug Industry)	120/80
Within next few months	115/75

As you go through the history of diagnostic threshold of high blood pressure you could easily guess the intention of the medical industry to convert each one of us into a patient. To know which one of the above can be considered as a true value to diagnose hypertension, you may turn to medical science i.e. **Cochrane Collaboration- 2013** meta-analysis (unbiased & uninfluenced by the medical industry) which concludes 160/100 mmHg be the target blood pressure above which drug therapy may be introduced. Generally it is perceived that lower the blood pressure,

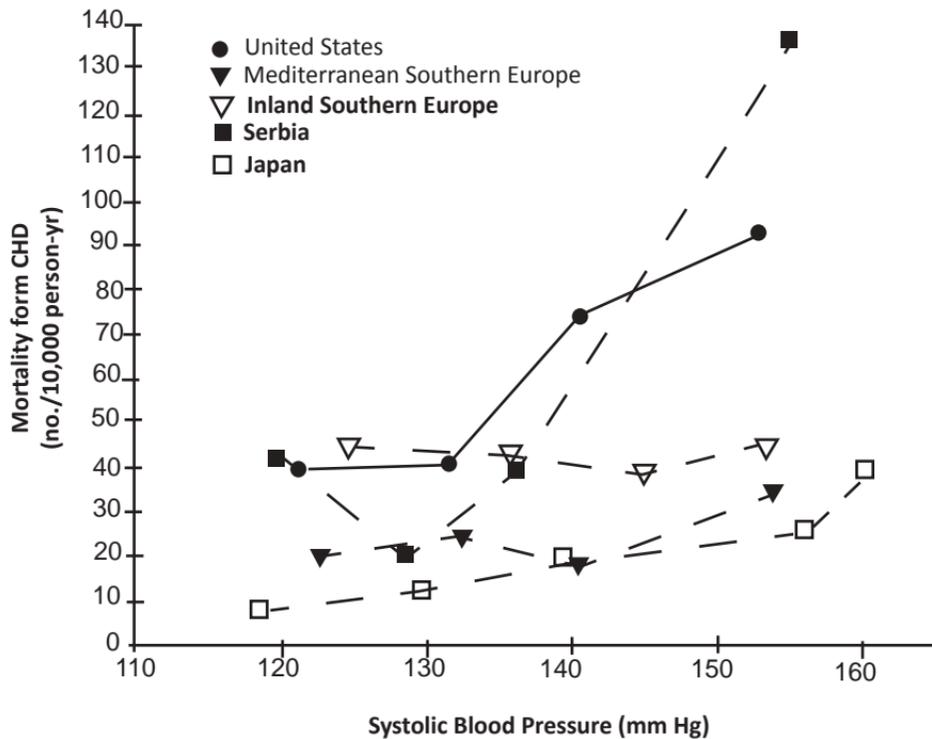


Figure: Mortality Due to Coronary Heart Disease per Quartile of Usual Systolic Blood Pressure.
 Values shown are 25-year rates of death due to coronary heart disease (CHD), adjusted for age, serum systolic blood pressure varied greatly among the populations.

better is the health. However, the relationship between blood pressure and health is not linear as was clinically demonstrated by the **Seven Country Study Research Group (New England Journal of Medicine January-2000)**. In this study 12,031, men were followed up for 25 years to see the effect of blood pressure on mortality. The result is presented in graph.

The above graph clearly shows:

1. Serbia:- The mortality rate decreases with the increase in blood pressure and then increases with increase in blood pressure.
2. Mediterranean Southern Europe :- The mortality rate increases with the increase in blood pressure and then decreases with the further increase in blood pressure.
- 3 Japan :- Mortality rate increases uniformly with the increase in blood pressure.
- 4 The mortality rate of USA at 120 is same as the mortality rate of Japan at 160 systolic blood pressure

5 Inland Southern Europe :- The mortality rate remains lowest at the systolic blood pressure of 148.

The above disparity in various geographical locations and also the Cochrane-2013 meta-analysis conclusively points that treating people with anti-hypertension drug at blood pressure as low as 120/80mmHg will do more harm than good. Further, it has been proved through various large scale randomized control trials (as given in the next page) that treating with anti-hypertensive drugs leads to diabetes.

Without much surprise we can say that, the reverse is also true i.e. people treated with anti-diabetes medication developed hypertension as concluded by **Diabetes Prevention Program Research Group**, which observed 3,234 individuals for an average 3.2 years. The full report was published in **Diabetes Care, April 2005**.

This means if you fall in either of the traps (Diabetes or Hypertension) chances are, that within 3 years you will be in other trap as well. Which means if you are a hypertension patient taking anti-hypertension medication, chances are, that within 3 years you will develop diabetes and if

Trial	Year	Primary treatment	Increase in new onset diabetes by primary treatment
SHEP	1985 - 1990	Placebo	5% ↓
CAPPP	1992-1998	Thiazide diuretic/BB	3% ↑
HOPE	2000	Placebo± BB/Thiazide diuretic	52% ↑
INSIGHT	2000	Thiazide diuretic	43% ↑
LIFE	1995-2001	BB±Thiazide diuretic	32% ↑
ALLHAT	1994-2002	Thiazide diuretic	16%/30% ↑
INVEST	1995-1996	Placebo± BB/Thiazide diuretic	52% ↑
INSIGHT	1997-2003	BB±Thiazide diuretic	17% ↑
CHARM	1999-2001	Placebo± BB/Thiazide diuretic	17% ↑
VALUE	1997-2004	DHP-CCB	25%
ASCOT	1998-2005	BB±Thiazide diuretic	32% ↑

Major Trails showing treating with anti-hypertensive drugs leads to Diabetes

you are a diabetic patient taking anti-diabetes medication, within 3 years you will be a hypertension patient too. As is clear from the fact that 73% of the adults with diabetes are on anti- hypertensive drug as well.

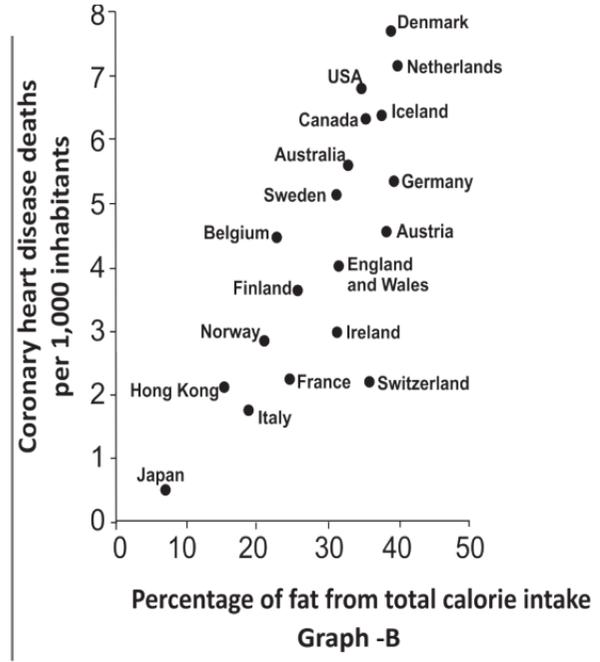
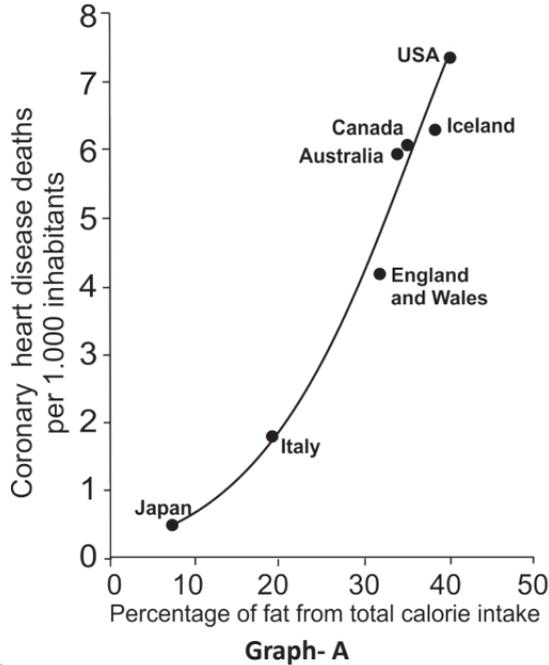
So the very fact that prevention or control of diabetes with anti-diabetic drugs as an attempt to reduce the cardiovascular risk factor is defeated as the very drug leads to hypertension which itself is an independent risk factor for cardiovascular disease.

In-fact to make the whole situation worse there is a third dimension to it. And that is, the propaganda of high cholesterol. As already made clear in Chapter 1 that the level of cholesterol has nothing to do with cardiovascular health outcome.

The story of cholesterol started in 1953, when the researchers of **University of Minnesota** purportedly proved that high cholesterol

“**The mortality rate of USA at 120mmHg is same as the mortality rate of Japan at 160mmHg of systolic blood pressure**”

leads to higher CVD mortality with the help of the following graph.



Graph-A clearly demonstrates that higher fat intake is connected with high mortality rate due to CVD.

Later upon investigating the findings of University of Minnesota, it was discovered that originally 22 countries' data was used at the beginning of the study (see the Graph-B).

But conveniently seven countries were selected which were falling in the straight line to prove the theory that high cholesterol leads to heart disease, as is published in the **Lancet 2002**.

As all medical studies do not support the high cholesterol theory, regular prescription of Statin is a clear triumph of Cholesterol industry over Medical Science. It is now evident that any one drug (high cholesterol/hypertension/diabetes) will lead to other two health conditions in an individual who is being prescribed these drugs. The table given below is testimony to the fact that there is a large scale global conspiracy to keep the **'High Cholesterol-**

“**People treated
with
anti-diabetes
medication
developed
hypertension**”

Hypertension-Diabetes theory' alive.

Year	Company	Fine	Violation(s)	Laws allegedly violated (if applicable)
2001	TAP Pharmaceutical Products	\$875 million	Medicare fraud/ kickbacks	False Claims Act/ Prescription Drug Marketing Act
2002	Schering-Plough	\$500 million	Poor manufacturing practices	FDA Current Good Manufacturing Practices
2003	AstraZeneca	\$355 million	Medicare fraud	Prescription Drug Marketing Act
2004	Pfizer	\$430 million	Off-label promotion	False Claims Act/FDCA
2004	Schering-Plough	\$345 million	Medicare fraud/ kickbacks	False Claims Act/ Anti-Kickback Statute
2005	Serono	\$704 million	Off-label promotion/ kickbacks / monopoly practices	False Claims Act

Year	Company	Fine	Violation(s)	Laws allegedly violated (if applicable)
2006	Schering-Plough	\$435 million	Off-label promotion/ kickbacks/Medicare fraud	False Claims Act/FDCA
2007	Bristol-Myers Squibb	\$515 million	Off-label promotion/ kickbacks / Medicare fraud	False Claims Act/FDCA
2007	Purdue Pharma	\$601 million	Off-label promotion	False Claims Act
2008	Cephalon	\$425 million	Off-label promotion	False Claims Act
2008	Merck	\$650 million	Medicare fraud/ kickbacks	False Claims Act/ Anti-Kickback Statute
2009	Eli Lilly	\$1.4 billion	Off-label promotion	False Claims Act/FDCA
2009	Pfizer	\$2.3 billion	Off-label promotion/ kickbacks	False Claims Act/FDCA

Year	Company	Fine	Violation(s)	Laws allegedly violated (if applicable)
2010	Allergan	\$600 million	Off-label promotion	False Claims Act/FDCA
2010	AstraZeneca	\$520 million	Off-label promotion/ kickbacks	False Claims Act
2010	GlaxoSmithKline	\$750 million	Poor manufacturing practices	False Claims Act/FDCA
2010	Novartis	\$423 million	Off-label promotion/ kickbacks	False Claims Act/FDCA
2012	Abbott Laboratories	\$1.5 billion	Off-label promotion	False Claims Act/FDCA
2012	Amgen	\$762 million	Off-label promotion/ kickbacks	False Claims Act/FDCA
2012	GlaxoSmithKline	\$3 billion (\$1B criminal, \$2B civil)	Criminal: Off-label promotion, failure to disclose safety data.	False Claims Act/FDCA

Year	Company	Fine	Violation(s)	Laws allegedly violated (if applicable)
2012	GlaxoSmithKline	\$3 billion (\$1B criminal, \$2B civil)	Civil: paying kickbacks to physicians, making false and misleading statements concerning the safety of Avandia, reporting false best prices and underpaying rebates owed under the Medicaid Drug Rebate Program	False Claims Act/FDCA
2013	Johnson & Johnson	\$2.2 billion	Off-label promotion/kickbacks	False Claims Act/FDCA

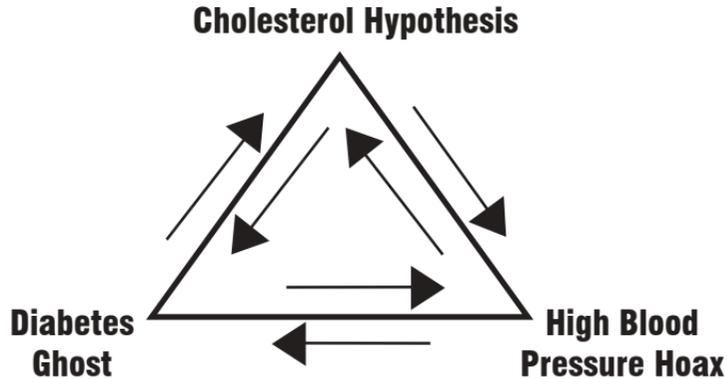
Companies convicted by various courts and the fine amount for various High Cholesterol - Hypertension - Diabetes related fraud.

Adding cholesterol lowering drugs in the **menu** of diabetes patients can be a sure shot recipe of Death as is demonstrated in prospective study of 1255 patients with Diabetes Type II. The study concludes as is given in the table below:

1. The risk of stroke doubles in the group treated by Statin in comparison to the placebo group.
2. Risk of Ischemia triples in Statin group.
3. There is an insignificant decrease in fatal myocardial infarction in statin group.

S.No.	Rates of Primary and Secondary end points	Placebo group	Statin group
1.	Fatal stroke	2%	4%
2.	Ischemia	1%	3%
3.	Fatal myocardial infarction	5%	4%

Metaphorically, I call it a "Triangle of Death".



Any Individual consuming one of the medicines will automatically be led to the other two. And to trap a healthy individual as a purportedly sick person suffering from any of the mentioned diseases, the diagnostic parameters are lowered (as you have understood already). In the present situation, modern medical industry is the worst threat to the very existence of humanity.

“People treated with anti-diabetes medication developed hypertension”

As alert and awakened citizens, it's our responsibility to end this slavery to modern medicine and it's my belief that with a collective effort, after 69 years of freedom, once again we will re-claim freedom this time from modern medicines and that will be a triumph for humanity.

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“ **73% adults with diabetes are also on anti-hypertensive drug** ”

NO CURE!

This is what you might have heard from your doctors. And further you might have been told that diabetes is like a life time sentence, it cannot be cured. However with medication, it can be controlled and progression towards worst can be slowed down with a timely and intensive drug & if required insulin therapy.

On the contrary, the truth is “Diabetes can be cured”. There is one major and well recognised study i.e. U.K Prospective Diabetes study-7 in which they have demonstrated how more than 50% of 2,597 diabetic patients were able to reverse diabetes with appropriate changes in diet alone.

In fact there have been several related studies, reports and findings published in journals from time to time. Some of them are listed as under:

1. *Type 2 diabetes in children and adolescents: American Diabetes Association. Pediatrics 2000.*
2. *Umpierrez GE, Woo W, Hagopian WA, Isaacs SD, Palmer JP, Gaur LK, Nepom GT, Clark WS, Mixon PS, Kitabchi AE: Immunogenetic analysis suggests different pathogenesis for obese and lean African-Americans with diabetic keto acidosis Diabetes Care 1999.*
3. *Umpierrez GE, Casals MM, Gebhart SP, Mixon PS, Clark WS, Phillips LS: Diabetic ketoacidosis in obese African-Americans. Diabetes 1995.*
4. *Mauvais-Darvis F, Sobngwi E, Porcher R, Ufveline JP, Kevorkian JP, Vaisse C, Charpentier G, Ullaussau PJ, Vexiau P, Gautier JF: Ketosis-prone type 2 diabetes in patients of Sub-Saharan African origin: clinical pathophysiology and natural history of β -cell dysfunction and insulin resistance. Diabetes 2004.*

“U.K Prospective Diabetes study-7 demonstrated that more than 50% of 2,597 diabetic patients were able to reverse diabetes with appropriate changes in diet alone”

5. *Umpierrez GE, Smiley D, Kitabchi AE: Narrative review: ketosis-prone type 2 diabetes mellitus. Ann Intern Med 2006.*
6. *Umpierrez GE, Clark WS, Steen MT: Sulphonylurea treatment prevents recurrence of hyperglycemia in obese African-American patients with a history of hyperglycemic crises Diabetes Care 1997.*
7. *Banerji MA, Chaiken RL, Lebovitz HE: Long-term normoglycemic remission in black newly diagnosed NIDDM subjects. Diabetes 1996.*
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12. Kitabchi AE; *Ketosis-prone diabetes a new subgroup of patients with atypical type 1 and type 2 diabetes. J Clin Endocrinal Metab* 2003.
13. Balasubramanyam A, Zern J W. Hyman DJ. Pavlik V: *New profiles of diabetic ketoacidosis type 1 vs type 2 diabetes and the effect of ethnicity. Arch Intern Med* 1999.

“ **The evidence of diabetes reversal has been so profound that the medical literature (for more details refer to the above listed reports) has referred them with many names such as Idiopathic Diabetes, Atypical Diabetes, Flatbush Diabetes.** ”

14. Yamada K. Nonaka K: *Diabetic ketoacidosis in young obese Japanese men (Letter). Diabetes cure 1996*
15. Balasubramanyam A, Garza G, Rodriguez LVN, Hampe CS, Gaur L, Lernmark Å, Maldonado MR: *Accuracy and predictive value of classification schemes for ketosis-prone diabetes. Diabetes Care 2006.*

The evidence of diabetes reversal has been so profound that the medical literature (for more details refer to the above listed reports) has referred them with many names such as **Idiopathic Diabetes**, **Atypical Diabetes**, **Flatbush Diabetes** and more recently **Ketosis Prone Type 2 Diabetes**.

Upon presenting the above proof of reversal, some of the doctors may adamantly argue that it may be true on rare occasions however in Diabetes Type 1, the patient would have to be insulin dependent for the rest of his life as β -cells are destroyed. Here also, the truth is, Diabetes type 1 which is also known to be an auto-immune disease, can be reversed as reported in **Diabetes Care- Volume 15 Jan 1991** (from **Diabetes Research Institute- Germany**) and subsequently such patients are termed as Diabetes Type 1½ instead of Diabetes Type 1 so as to create a difference between patients who are on life-long medications and the one who could reverse it completely.

Several of my Diabetes Type I patients could completely free themselves of insulin/drug dependency. The recent ones being-master Aditya Singh, a 15 year old son, Dr. V.P Singh, a senior scientist in Indian Council of Medical Research who had been on 50 units insulin for 6 months, could reverse diabetes within a week of following a specified high fruit diet (I will explain it at the end of this chapter).

Here, the obvious question could be, “Why did the doctors promote the idea of NO CURE even though there are substantial and un-ignorable evidences which proves it the other way.

My understanding could conclude at least 2 reasons for their thought process:

1. Most of the doctors are highly influenced by drug companies and acquire most of the recent medical updates through many glamorous medical conferences funded and organized by these

“ **Diabetes type 1
can be reversed
as reported in
Diabetes Care-
Volume
15 Jan 1991** ”

drug companies. These conferences are all about biased and commerce-driven medical presentations to boost the sale of one or the other product of the drug company which has sponsored the event (Please refer to chapter 3 about law suits against most of the major drug companies).

To prove my point let me ask a question. "What should be the blood pressure beyond which hypertension is diagnosed and is fit for drug intervention?" I asked this question in more than 1000 public health programs, in more than 100 cities of more than 10 countries in last 5 years.

The answer . . . you guessed is right! 120/80mmHg.

The truth is, when the standard blood pressure for human beings was established for the first time (Joint National Commission–1977), the blood pressure level of more than 160/100mmHg was considered for drug intervention and it did not change till JNC-4 (1988). Only in JNC-5 (1993) it was lowered to 140/90mmHg. However in 2013, meta-analysis published by Cochrane Collaboration confirmed that there is no evidence of benefit for treating high blood pressure below 160/100mmHg.

No-where in the medical literature, medical intervention above the threshold of 120/80mmHg is recommended. It is a false education being spread by the drug industry to convert healthy people into patients.

2. Misinterpretation of the medical evidence published in journals by the doctors who are already short of time and doctors who are over engrossed in the medicalization of the health care system. Let's understand it through the conclusion of UKPDS-38 report (**UK Prospective Diabetes Study**).

'Tight blood pressure control in patients with hypertension and Type 2 diabetes achieves a clinically important reduction in the risk of deaths related to diabetes, complications related to diabetes, progression of diabetic retinopathy, and deterioration in visual acuity.'

“ **The first time (Joint National Commission–1977), the blood pressure level of more than 160/100mmHg was considered for drug intervention** ”

At the prima facie, it appears as if we must maintain blood pressure close to B.P standard (120/80, as perceived and wrongly propagated by the doctors) whereas if you read the whole UKPDS report, tight blood pressure control means blood pressure near 150/85mmHg and less control ranges between 200/105 and 180/105 mmHg. Similarly there is a misinterpretation about fasting glucose. Majority of the doctors identify fasting blood sugar more than 100mg/dl as diabetes whereas it has never been defined in any literature as a diabetes diagnostic parameter. It is just a range of sugar level which is pre-diabetes, where it is assumed that the people having blood sugar more than 100mg/dl may become diabetic in near future. There is a great amount of ambiguity around fasting glucose as about 55%¹ of the population demonstrate higher fasting blood glucose (than post prandial).

An early morning raised blood sugar value (i.e. up to 200 mg/dl) is because of '**Dawn Phenomenon**'¹ and not because of any impairment of the glucose metabolism. It may be understood that in many of us, our Brain (as a background preparatory mechanism) may initiate a signal leading to release of glucose by the Liver just at the time you wake up in the morning so as to get sufficient energy to start the day (till you eat breakfast as a source of energy).

Contrary to the common belief, today's modern doctors have very limited knowledge of 'Food Combination Science' and its interaction with body to reverse a disease. Doctors are trained only in pharmacology which does more harm than good to mankind.

As a medical nutritionist I can tell you with my experience that if a patient is breathing and can eat, then he can surely reverse this critical and end-stage life style disease by just eating in accordance with food combination science. Although it seems to be too unrealistic to believe but I have proved it repeatedly with my patients. Here, I would like to share an instance which is very special to me as it included an iconic name in medical science, Dr. B.M Hegde who is my role model too. In the **32nd Social Science Congress** held in Mangalore University (1st to 5th Dec- 2015), I was given an opportunity to prove that diabetes can be reversed in 72 hours. Professor Som Shekharan, who himself was a diabetic patient taking 36 units of insulin every day, agreed to be the subject and a 5

“Modern doctors have very limited knowledge of food combination science and its interaction with the body to reverse a disease”

Member Committee was formed with Dr. B.M Hedge as Chairman and prominent personalities like C.K Raju (who gave India the first super computer) & Professor Anand (most reputed Professor of Jawaharlal Nehru University- Delhi) as members of the Committee. Prof. Som Shekharan agreed to follow my recommended diet for 72 hours (3 days). And to everyone's surprise he could fully withdraw insulin injections he had been taking and still maintained a healthy blood sugar within 72 hours of being on the recommended diet. Since then, till the time this book was published, he didn't ever return to insulin and could maintain a healthy blood sugar.

The whole thing about "Diabetes cure in 72 hours" is, it seems to be too magical to be true. But in actuality, it is a simple science that works! My recommended diet consists of a variety of fruits and vegetables minus animal food including dairy products. However, I am not the first person to show this profound effect

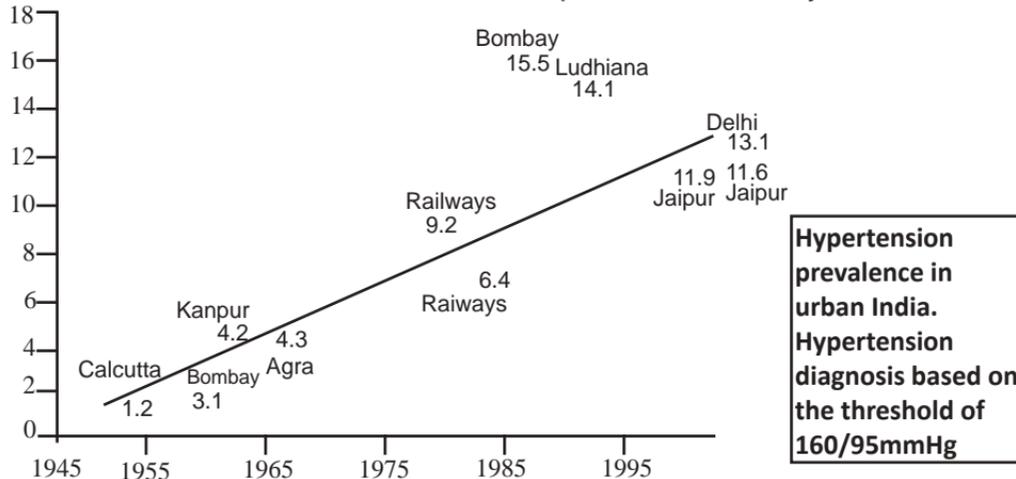


of vegetables and fruits, neither it is the first time when medical science has witnessed such a phenomenon. Bill Clinton, after 5 failed surgeries, adopted this strategy of food- based cure and then he never ever suffered from those life threatening conditions. He credits his remarkable recovery to Dr. T. Colin Campbell & Dr. Caldwell Esselstyn (I got a rare opportunity to get trained by them). Similar effect was seen on Sarajevan people during the Sarajevo War (April 1992 to February 1996) when the residents were deprived of milk, animal food, refined oil, cooking gas and were forced to survive mainly on local fruits and raw vegetables. The result was reversal of diabetes and heart disease among most of residents who otherwise were suffering from the above mentioned health conditions during peace time.²

Infact there are populations like the Jarawas in Andeman & Nicobar Island, Okinawas in Japan or Bama in China who have never suffered from diabetes or other associated health conditions.

“**An early morning raised blood sugar value is because of Dawn Phenomenon and not because of any impairment of the glucose metabolism**”

On the other hand it has been seen that among the population with the increase in consumption of man-made food/industrial food/packed food, there is a steady rise in the prevalence of life style diseases, in last one century. Refer to the graph below for better understanding of the relationship between the urbanisation and increase in the prevalence of life style diseases .



Clue To Cure :

To get to the cure of diabetes you have to find a common answer, which connects the following three questions:

1. Why, during Sarajevo War, its resident got cured of diabetes?
2. Why is there no diabetes among the Jarawas?
3. Why elephants (and other animals) do not suffer from diabetes and other lifestyle diseases?

A common thread which connects all of the above three is 'Man Made Food.'

Whenever man attempts to change the natural state of food by a series of industrial processes like refining and packaging, an unwanted by-product is also produced. It is a group of chemicals known as 'DLS' or 'Dioxin Like Substance'. By consuming this industrial food for a long period of time, modern man accumulates a significant amount of DLS in the body, which leads to a series of undesirable chemical activities in the body. This leads to the formation of 'AGE' (Advance Glycosylation End product) a kind of ash or waste in the body. AGE diminishes the body's ability to

“ Bill Clinton, after 5 failed surgeries, adopted this strategy of food-based cure and then he never ever suffered from those life threatening conditions. ”

produce a miracle molecule called Nitric Oxide (NO), which is known for its protective ability against Diabetes, Kidney Dysfunction and (Cancer by initiating the following regulatory functions of the endotheliums (the inner most layer of blood vessels):

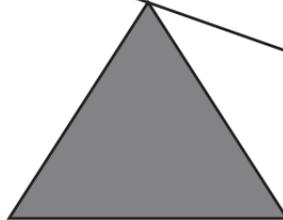
1. Vasodilation
2. Thrombolysis
3. Platelet Disaggregation
4. Anti-proliferation
5. Anti-inflammation
6. Anti-oxidation

The inability of endothelium cells to initiate the above functions lead to :

1. Vasoconstriction
2. Thrombosis
3. Platelet aggregation
4. Inflammation.
5. Oxidation

Vasodilation
Thrombolysis
Platelet disaggregation
Anti-proliferation
Anti-inflammation
Anti-oxidant

Vasoconstriction
Thrombosis
Adhesion molecules
Growth factors
Inflammation
Oxidant activity



Regulatory functions of the endothelium. Normal or antiatherogenic vs dysfunction or atherogenic properties.

“Diabetes reversed during Sarajevo War when the residents were deprived of milk, animal food, refined oil, cooking gas and were forced to survive mainly on local fruits and raw vegetables.”

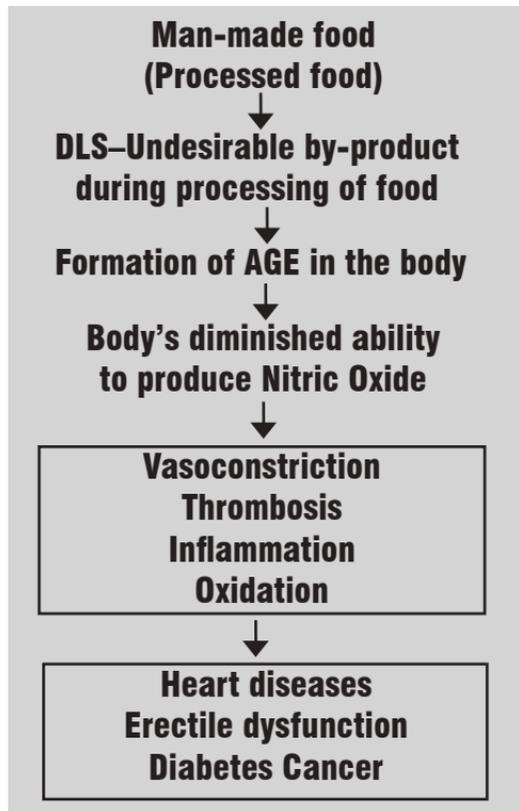
The above inactivity leads to initiation of :

1. Heart disease
2. Erectile dysfunction
3. Diabetes
4. Cancer

And other lifestyle diseases

Among lifestyle diseases, erectile dysfunction is the most under-reported. The percentage of prevalence of Erectile dysfunction is shown below

Condition	Prevalence (%)
Obesity	52.4%
Diabetes	50%
Hypertension	42.4%



The amount of damage caused by the otherwise seemingly harmless man-made food can be understood by conducting the following experiment.

Take a litre of Coke or Pepsi. Boil it for an hour. Once all the water evaporates observe what is left behind? Something very much unimaginable. Visually and chemically, a charcoal resembling residue.. That's what we eat!

Two years back I decided to make a small road beside my office by using this residue (by boiling gallon's of Coke). This road is still too strong to get damaged by rain or by traffic. That is what we eat and still we assume we are not being harmed by it.



Surely the first step towards cure is eliminating the cause i.e. man-made food. Stop consuming it.

What havoc DLS (by-product of man-made food) can cause to the body if ingested in a significant amount can be understood through the horrific story of 'Agent Orange', an American assault on Vietnam during war in Vietnam (1955-1975). In an attempt to expose the Vietnam soldiers from their hide-out, American soldiers sprayed a herbicide to destroy the entire vegetation of around 6 million acres of Vietnamese land. As a result, the Vietnamese population got exposed to a high level of DLS (a by-product of herbicide) causing irreversible and horrific genetic defects including



mental retardation and great amount of physical defects which was passed on to the 3rd generation of the affected population.



DLS induced war victims with various genetic defects

Unfortunately there are no medicines to give any kind of relief to the DLS war victims as medicine production itself leads to DLS production, as a usual by product, which is the primary cause of the disaster. So the road to cure starts with discontinuing consumption

“ **AGE diminishes the body’s ability to produce the miracle molecule called Nitric Oxide, which is known for its protective ability against Diabetes, Kidney Dysfunction and cancer** ”

of all man- made products, which includes drugs as well.

That's what we exactly do in our "Diabetes Cure in 72 Hours Residential Program". The very thought of discontinuing the drug abruptly which the patient might be taking for last several years comes with a great amount of fear. The fear of fatality in the body.

It is true that in last several years of dependence on drugs like anti-diabetic pills, pills for hypertension, thyroid and heart disease, etc. the body has become its slave and abrupt withdrawal may result in some unpleasant event. However, here in our '**3-Days Diabetes Cure Program**' we carefully design the Menu of the participants so that food plays the role of medicine and helps body to manage the blood pressure, blood sugar, etc. and replace the need of medicine that too without any side effect of the medicine.

Foods that help cure Diabetes:

Here to help you understand the concept of curing diabetes with the help of food let me introduce you to population of 2 extremes:

1. Kuwaiti Population: It is one of the richest country of the world and is also known for highest

prevalence (17.5%) of diabetes. I got an opportunity to live there and understand their lifestyle and eating habits.

2. Jarawas : Jarawas a hunter-gatherer civilization of Andaman & Nicobar is the population with no evidence of diabetes, heart disease, cancer or any other lifestyle disease. Since they are hunter-gatherers of paleolithic-era and had not yet learnt to domesticate animals or growing their own food through agriculture, the consumption of milk (except the mother's milk) was absolutely zero. Their major food consists of fruits & vegetables and occasionally fish and some other sea foods.

I got an opportunity to have a first hand experience of closely understanding both population one with the highest prevalence of diabetes (17.5%) and the other without any trace of diabetes. Upon close observation I could conclude the factor responsible for this extreme is the kind of food they are consuming. We can divide the food in 2 categories :

“ **Kuwaiti Population: It is one of the richest country of the world and is also known for highest prevalence (17.5%) of diabetes** ”

1. Food of Kuwaiti population : I call it **VIP diet**.

2. Food of Jarawas population : I call it **DIP diet**.

Food you are consuming can be divided in either of the two categories i.e. VIP or DIP depending on how the food behaves once it enters the stomach.

1. VIP Diet : It is a kind of food which on entering the stomach behaves like VIP. In India VIP (Very Important Person) like a politician or bureaucrat who can overlook and ignore or snub the laws that are otherwise applicable to every citizen of the nation. For e.g. A VIP can ignore the red light of the traffic signal and drive anyway, ignoring the risk and discomfort they may pose to others. Similarly, some food upon entering the stomach behaves like VIP and jumps into the blood stream without considering the level of sugar in the blood, the blood pressure and other parameters leading to great damage in the body.

2. DIP Diet : Here I call DIP as Disciplined and Intelligent People. People like the common citizens of our country who always try to follow the rules and law of the country. In the traffic signal they wait for the green light to cross the signal. Some foods, upon entering the body behave like DIP, they understand the signalling system of the liver and are able to understand the communication sign of traffic controller of the stomach i.e. incretin hormone and adds glucose

to the blood stream safely without putting unusual burden to the metabolic system of the body.

From my experience with more than 5,000 diabetes patients in more than 10 countries including Kuwaiti population, I found one thing was common in them, they were all consuming VIP food.

On the contrary the civilisations like Jarawas or Hunza or Okinawa, are people who never suffer from diabetes or other associated illnesses, are all on DIP kind of diet.

From the above observation, it is not difficult to conclude that by switching to DIP diet, a diabetic patient can reverse diabetes. That's what I do with my diabetic patient in our 72 hours diabetes cure residential program. Among those who stick to DIP diet the diabetes reversal rate is 100% in **Diabetes Type 2** patients whereas it is about 50% in case of **Diabetes Type1** patients.

“ **Jarawas a hunter-gatherer civilization of Andaman & Nicobar is the population with no evidence of diabetes** ”

How to identify VIP or DIP diet :

The Acronym **M.R.P** can help us identifying VIP diet.

M (of M.R.P) stands for milk, milk products & other animal foods. Consumption of milk and milk products is one of the major cause of diabetes specially in Diabetes Type 1. Humans are the only animals who consume milk lifelong and humans are the only animals to consume other animal's milk. The major factor here is the protein of the milk called **casein** that causes all the disturbances in the metabolic system and trigger the auto-immune self destructing mechanism of the body where the body's immunity attacks the β -cells (worker of pancreas responsible for the production of insulin). All over the world, the rate of increase of Diabetes Type I among children is alarming. According to a major report in the China Study it is observed that all the children diagnosed with Diabetes Type 1 were put on cow's milk or formula milk in their early childhood and just by stopping the consumption of animal milk much of the diabetes quietly disappeared. Milk and milk products is surely a VIP diet.

R (of M.R.P) stands for Refined Food. The prevalence of diabetes dramatically increased with the inclusion of refined food as a major diet in their lifestyle. All refined food including refined sugar, refined salt, refined oil are stripped off the necessary minerals before being supplied to the

consumer. In the absence of necessary minerals the food (refined food) behave like a VIP diet and causes unusual increase in the blood sugar.

P (of M.R.P) stands for packed food. One thing I observed common among all the urban diabetic patients is that more than 50% of their food comes in the form of packed food which includes biscuits, sauce, jam, bread, noodles, pasta, coffee, tea, etc. All packed foods can be equated to dead foods lacking the live-enzyme (which is responsible for understanding the signalling system of the body so as to successfully navigate the food and monitor the harmony and balance in the body).

To keep it simple, remember, if anything is in the box or a packet let it be in the packet, it is not fit for human consumption. It does not qualify as food.

On the basis of the above understanding of VIP diet, I have created a 4-step method to consume DIP diet to reverse diabetes. Following

“ **Any intervention with insulin is warranted only when the blood glucose exceeds 300 mg/dl after two hrs of eating food** ”

are the 4 steps which can help you to switch to DIP diet hence reverse diabetes.

STEP 1

**Discontinue anti-diabetes
& anti-hypertensive
drugs for 48hrs and check if
PP blood sugar $\leq 250\text{mg/dl}$
&**

Blood Pressure $\leq 160/100\text{mmHg}$

**Then you can safely
discontinue the drugs permanently**

STEP-2

Breakfast

**Diabetes Reversal
Fruit Breakfast (600 to 800gm)
(Mango, Papaya, Watermelon,
Banana and Musk Melon)**

STEP-3

Lunch/Dinner

**Diabetes Reversal Pre Lunch
Salad = 400 gm
[(Cucumber, Tomato, Capsicum
and Coconut
(chopped or grated)]**

STEP-4

Stop Eating

- 1. Packed food**
- 2. Refined food**
- 3. Dairy products**
- 4. Nutritional supplements**

Caution must be taken, while being on the above 4 steps of consuming DIP diet. The body will respond favourably by metabolizing sugar from the DIP diet and may not require an outside supplement of insulin or other hypoglycaemic drugs. So monitoring the blood sugar at least 3 different times of the day during the period when the patient is on the above 4 steps is important. While on DIP diet it is important to understand that any intervention with insulin is warranted only when the blood glucose exceeds 300 mg/dl after two hrs of eating the above food.

What is not a Cure:

The treatment of diabetes is based on a seemingly simple principle. Observational studies have shown that high blood sugar is a risk factor for excess mortality, cardiovascular events and microvascular complication. It therefore appears logical that the patient would benefit by reducing the hyperglycaemia and any drug with proven efficiency on lowering blood glucose may be considered effective

**“ Hence US
food and drug
administration
approves
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any drug if they
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blood sugar ”**

in lowering the risk factor as well. Hence US food and drug administration approves marketing authorisation for any drug if they reduce the blood sugar.

However, this should now be questioned as several randomised trials with high level of evidence refutes the idea that reducing the blood sugar with drugs may be beneficial for the patients.

The table given below primarily focuses on RCT's and meta-analysis evaluating the efficacy of the main anti diabetic drugs currently in the market.

Drug	Details of RCT's/ Meta-analysis	Outcome
Sulphonylurea	UGDP (University Group Diabetes Program)	Excess mortality in patients treated with tolbutamide compared with a placebo.
	Cochrane Meta-analysis (Hemmingsen B. Schroll JB, Lund SS, Wetterslev J. Glund C, Vaag A, et al. Oral Sulphonylurea monotherapy for patients with Type 2 Diabetes mellitus- 2013)	There is insufficient evidence from RCTs to support the decision as to whether to initiate sulphonylurea monotherapy. Data on patient-important outcomes are lacking.

Drug	Details of RCT's/ Meta-analysis	Outcome
Insulin Therapy	<p style="text-align: center;">UKPDS (UK Prospective Diabetes Study)</p>	<p>Insulin therapy failed to reduce either mortality or diabetes-related complications. In comparison, the risk of insulin-induced hypoglycaemia increased by 130%</p>
	<p style="text-align: center;">ACCORD (Action to Control Cardiovascular Risk in Diabetes)</p>	<p>It showed that insulin use frequently achieved glycemic targets. However, the study was not able to find any effect on patient-relevant outcomes and excess mortality was observed.</p>
	<p style="text-align: center;">VADT (Veteran's Affairs Diabetes Trial)</p>	<p>It showed that insulin use frequently achieved glycemic targets. However, the study was not able to find any effect on patient-relevant outcomes and excess mortality was observed</p>
	<p style="text-align: center;">ADVANCE (Action in Diabetes and Vascular Disease: Preterax and Diamicon MR Controlled Evaluation)</p>	<p>It showed that insulin use frequently achieved glycemic targets. However, the study was not able to find any effect on patient-relevant outcomes and excess mortality was observed</p>

Drug	Details of RCT's/ Meta-analysis	Outcome
Alpha-glucosidase inhibitors	(Cochrane Meta-analysis (Alpha-glucosidase inhibitor for type 2 Diabetes mellitus-2005)	There was no evidence of clinical efficacy with these inhibitors.
Incretin	SAVOR-TIMI (Saxagliptin Assessment of Vascular Outcomes Recorded in Patients with Diabetes Mellitus)	<ul style="list-style-type: none"> •There was no evidence of clinical efficacy with saxagliptin according to the main endpoints (cardiovascular death, myocardial infraction or stroke). •Saxagliptin failed to reduce total mortality, any other important criterion such as myocardial infarction or stroke However the risk of hospitalisation for congestive heart failure rose unexpectedly •There was also a statistically significant 14% increase in the risk of hypoglycaemia in patients taking saxagliptin.

Drug	Details of RCT's/ Meta-analysis	Outcome
Incretin	EXAMINE ("Examination of Cardiovascular Outcomes: Alogliptin vs. Standard of Care in Patients with Type 2 Diabetes Mellitus and Acute Coronary Syndrome.")	Study showed that Alogliptin had no better clinical efficacy on the main endpoint or on any other criteria.
GLP-1 Analogues	Meta-analysis (Glucagon like peptide-1 receptor agonists and cardiovascular events: a meta-analysis of randomised clinical trials. Exp Diabetes Res-2011)	<ul style="list-style-type: none"> •GLP Failed to demonstrate either positive or negative effects. •< 26 weeks excess risk of acute pancreatitis or pancreatic cancer.

The above evidence clearly suggests that lowering the blood glucose with anti-diabetic drugs may not necessarily lower the risk of heart disease or risk of mortality.

Mechanism which makes anti diabetic drug ineffective in lowering the risk factors:

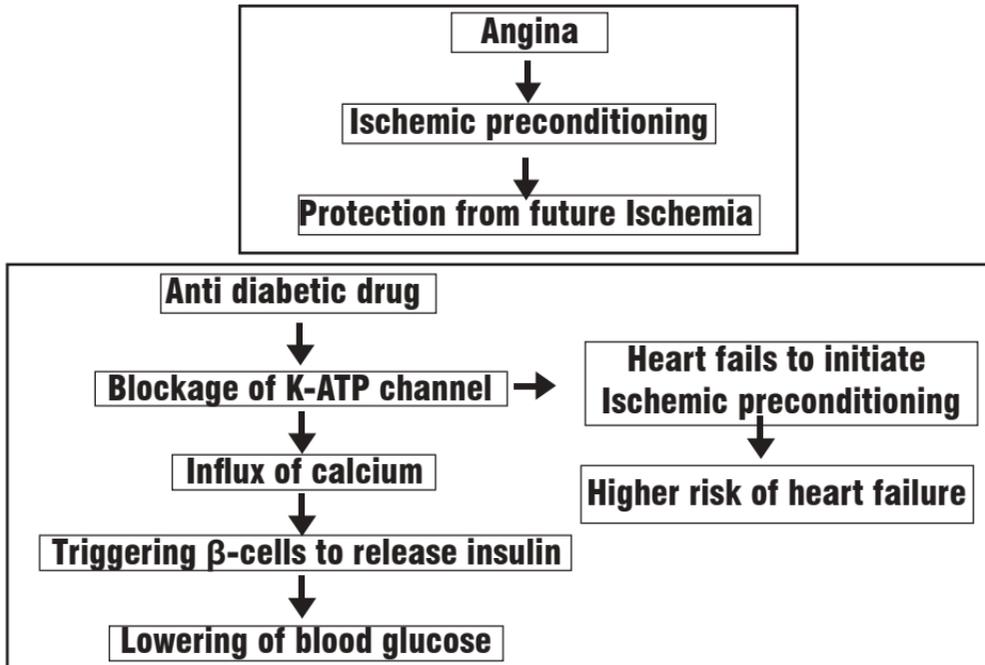
Here's a little understanding of the heart's protective mechanism called Ischemic preconditioning that may help you to conclude that anti-diabetic medication is not just a waste but also life threatening for the patients consuming it.

Ischemic preconditioning : As a result of blockage in the arteries which lead to the heart, the supply of oxygen is diminished resulting in a severe pain in the chest. This triggers the heart's protective mechanism so that in future episode of deprivation of oxygen, the effected heart cells are better prepared to survive. This is called Ischemic preconditioning. This complete protection mechanism is being initiated and mediated by the K-ATP channels.

Anti-diabetic Mechanism :Sulfonylurea a class of anti-diabetic drug blocks the K-ATP channels which results in influx of calcium triggering the β -cells of pancreas to release insulin which results in decrease in blood sugar. This entire anti-diabetic mechanism is based on blocking the K-ATP channel which itself means blocking the heart's ability to protect itself from heart attack.

The very purpose of anti-diabetic drugs is defeated as it is prescribed with the goals to reduce

the risk factor (such as heart disease) of diabetes by lowering the blood sugar. Instead it leads to increase in the risk of heart disease.



Conclusively, the first step towards getting rid of diabetes is by discontinuing all kinds of diabetes drugs and switching over to DIP diet.

Nutritional Fulfilment with DIP Diet

Before I end this chapter and the book as well, I must put an end to questions and confusions regarding nutritional fulfilment by being on DIP diet. Since the DIP diet is free of milk, milk product, animal food and has very little use of grains, some conventional nutrition expert may challenge the DIP diet saying that it may lead to the deficiency of various nutrients like Calcium, Vitamin B-12 or Carbohydrates.

Here to answer the questions, I will take the help of my experience when I was invited as Guest of Honour by the Govt. of Thailand in 'Festival of Elephants' on November 20th, 2015. As I was surrounded by more than 250 elephants, I was curious to know whether they ever suffer from diabetes or any other lifestyle disease. Dr. Pitara the Govt. appointed doctor for elephants informed me that there is no known case of diabetes or any other lifestyle disease in the history of elephants. While I was interacting with the doctor, a repeated announcement caught my ears



**Dr. Biswaroop Roy Chowdhury 4th, Dr. Pitara 5th
and Tanya Phonan (Chief Editor Thailand Book of Records) 6th from right**

"Ya-Leang-Chang-douy r-han-khong-kon. Chang-cha-puey"

Upon asking my friend and Chief Editor of Thailand Book of Records, it was translated for me. It

meant "Do-not offer human food to the elephants, elephants will become ill."

Elephant, the strongest & the biggest animal on the planet survives only on DIP kind of diet and never ever is deficient in any mineral/vitamin. Neither they fall sick of diseases like Diabetes as humans do.

Finally, Wish you a happy DIP Dieting.

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References:

1. *The Dawn Phenomenon Revisited, Endocrine Practice 2005.*
2. *The European National Nutrition Conference, Vienna 24-28 May,1998.*

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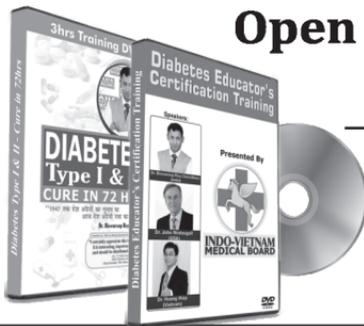
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- 8 Basil Leaves(Tulsi)
- 4 Green cardamom (Elaichi)
- 2 gm Cinnamon (Dalchini)
- 20 gm Ginger (Adrak)
- 20 gm Jaggery (Gur)

Instructions:

- Take 4 cups of water in a tea pan
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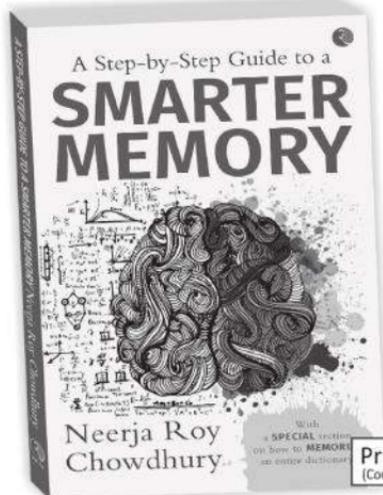
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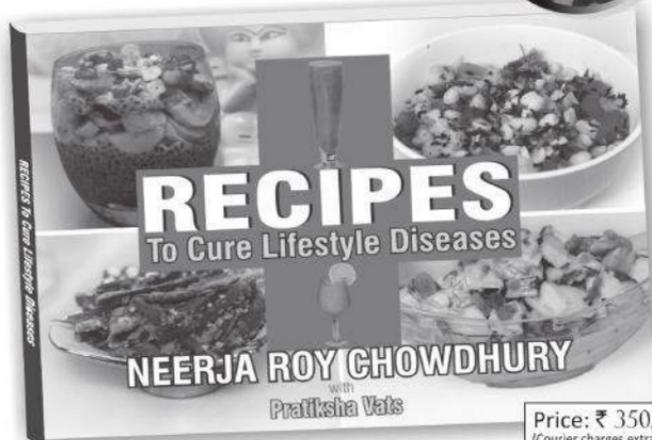
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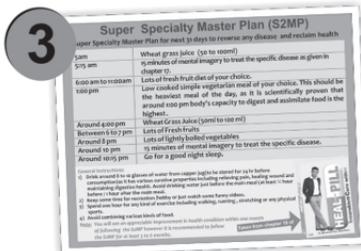
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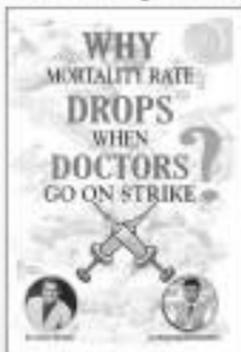
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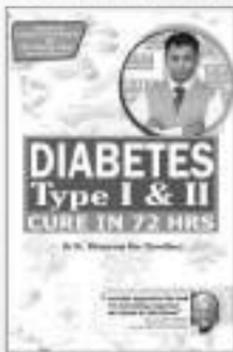
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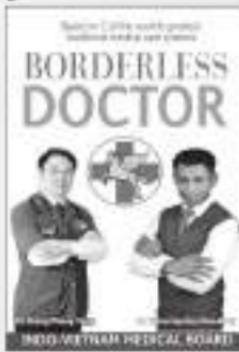
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Vinod Sharma

PROFILE

- National Record Holder
- Internationally awarded and recognized as Memory Expert.
- Many of his programs have been telecasted on National TV Channels and Radio.
- Has Served companies like IBS, Sports, Future Group and Max India as a Corporate Trainer.
- Has Addressed more than 3 lac trainees.
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Dr. Biswaroop Roy Chowdhury

- Two Guinness World Records (Mind & Body)
- Specialization in China Study, Cornell University (USA)
- Author of 25 books on Mind & Body
- Doctorate in Public Health (Vietnam)
- Paper published on 'Diabetes Cure in 72hrs' (Mangalore University)
- Certificate in Cochrane Guideline, Penang Medical College (Malaysia)
- Cardiovascular Life Support Instructor - American Heart Association
- Post Graduation in Diabetes Education- International Diabetes Federation
- Diploma in Echocardiography- Medical University of Vienna(Austria)

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