

Nutrition: Complementary And Alternative Choices

High Cholesterol

Note: to have optimal response, all protocols begin with Ultra-Vites and Ultra Omega-Linic

This information is intended for the use of health care professionals. It has not been evaluated by the FDA and is not intended to diagnose, treat, cure or prevent any disease. You should consult a qualified health care provider for advice before beginning any new health care program.

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Nutrient	Product	Quan
Multi Vitamin with High B Vitamins	Ultra-Vites*	2
	or Ultra Preventive (with Spirulina)	4
Essential Fatty Acids	Ultra Omega-Linic	8
Vitamin E (mixed tocopherols)	Vitamin E-400	1
Policosanol and Hesperidin	Loresterol	2
Calcium and Magnesium 2:1 or 1:1 ratio	Calcium D Chelate	1-2
	Ultra-Magnesium Chelate	1-2
Consider:		
Milk Thistle (silymarin)	Milk Thistle	1-3
Coenzyme Q10	Ultra-CoQ10 100	1-4
Yucca	Yucca	2-6

* Use a multi without iron unless there is a need for iron

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Cholesterol is necessary for life. It is a precursor for steroid hormones and is a precursor for parts of all cell membranes. We have been led to believe that too much of this good thing is a risk factor for Coronary Heart Disease (CHD); indeed many studies indicate that this is true. With recent NCEP-ATPIII (5/01) guideline changes, the number of patients with abnormal cholesterol levels has tripled. So has the use of expensive medication with serious side effects.

Cholesterol Facts. High density lipoprotein (HDL), "good" cholesterol, is protective. Low density lipoprotein (LDL) is the "bad" cholesterol and is a risk factor for CHD. Triglycerides make up most of the very low density lipoprotein (VLDL) and are also a risk factor for CHD. Very high elevated levels can be a risk factor for pancreatitis.

Current Guidelines for Optimal HDL, LDL and Triglycerides:

HDL levels over 40 mg/dl

LDL levels 100 mg/dl or less for patients with CHD or equivalent.

CHD equivalent is a patient with type II diabetes, Insulin resistance, symptomatic carotid artery disease, intermittent claudication, aortic aneurysm, and others.

LDL levels for patient with 2 or more risk factors 130 mg/dl

LDL levels for patient with no risk factors 160 mg/dl

Triglyceride Level

Normal less than 150 mg/d

Borderline 150 to 199 mg/dl

High 200 to 499 mg/dl

Very High 500 or greater

There is disagreement about using medication to lower cholesterol in patients who do not have CHD. In the patient below 65 years of age, treatment is associated with fewer coronary events and decreased overall mortality. However, without CHD, there are a few less coronary events with no decrease in overall mortality than non treated individuals. The British Medical Journal of Clinical Evidence states that “*reducing cholesterol in asymptomatic patients people lowers CAD events but not cardiovascular or overall mortality*”. They advise against treatment in asymptomatic people.

There have been recent studies suggesting caution in reducing cholesterol in patients over 65. One long term prospective study of Japanese-American men 45 to 65 yrs age reported the following: at 6 yrs, patients with total cholesterol 200-219 and LDL 120 - 129 mg/dl had the *fewest* incidences of CHD. Risks increase with levels below or above this range. Another study showed an increase in mortality of patients with congestive heart failure who were treated with statin drugs to lower cholesterol.

Another prospective study on aging and dementia looked at 4,309 patients 65 yrs of age and older. Mean age was 76.1, with mean duration of followup of 3 yrs. Low levels of cholesterol, non-high-density lipoprotein cholesterol, and LDL cholesterol were associated with a greater mortality risk. Patients with a cholesterol level or 175 or lower were twice as likely to die as those with cholesterol levels greater than 225. Lipid lowering drugs were used in the group with higher cholesterol, but it did not affect the increased mortality in the group with cholesterol lower than 175.

Each practitioner must decide whether to treat or not to treat; and if the decision is to attempt to lower the serum cholesterol, should one use drugs or nutrients, or both. Nutritional supplements can lower LDL raise HDL and decrease triglyceride levels with very minimal adverse events which are usually of no consequence. All of the drugs have very substantial, serious, and occasionally fatal adverse events.

Effective Nutritional alternatives for High Cholesterol:

- **Ultra-Vites** is a high potency, broad spectrum multi- vitamin, that is formulated to cover all the nutritional bases and optimizes liver function. In addition because of its high levels of Folic Acid, B 12 and B 6 it normalizes homocysteine levels.
- **Ultra Omega-Linic** These pre formed long chained polyunsaturated omega 6 and omega 3 essential fatty acids increase HDL, decrease inflammation, and decrease platelet stickiness. In addition, it reduces C-Reactive protein (CRP)
- **Loolesterol:** Policosanol and Hesperidin in Loolesterol have a long history of use for hyperlipidemia (high cholesterol).
- **Fiber** decreases bowel transit time so less bile acids are reabsorbed.
- **Yucca** It lowers total cholesterol, LDL, and normalizes elevated triglycerides..
- **Milk Thistle** can be added if it is felt that additional support of the liver is necessary or if there is active liver disease. It alters the outer cell membrane of the hepatocyte preventing the penetration of toxins into the cell. It also stimulates the regeneration of the hepatocytes by stimulating the action of nucleolar polymerase. It is a powerful antioxidant.
- **Ultra-CoQ10 100** if the patient is taking any of the statin drugs. Go to a high dose if the patient is in congestive heart failure. (200 to 400 mg).

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