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Water Fluoridation

The feature article on water fluoridation in the summer issue[1] is the best I have read on this subject. I have researched this subject and have most of the books the author references in the article. Dr. Kauffman does a superb job putting the history of water fluoridation into clear focus and in addressing its safety and efficacy. By showing how the anti-fluoridationists have weakened their case by an unjustified fear of all "chemicals" and "consulting with chemists," policy makers will, I believe, be better able to focus on fluoridation of water. This article may well play a pivotal role in ending water fluoridation in the United States and other English-speaking countries. Let's hope so.

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A recent review article on fluoridation published in your journal offered many interesting insights into the alleged benefits of water fluoridation.[1] However, there are a number of statements and conclusions with which we disagree.

Under the subheading, "How Anti-fluoridationists Have Weakened Their Case," the author alleges that groups, such as Parents for Fluoride Poisoned Children (PFPC), list any material that contains fluorine in any form as a danger by claiming that it contains "fluoride," which the author interprets as "fluoride ion." However, no such claim can be found anywhere on the PFPC websites, or in our publications.

I did provide information to the author that all fluoride compounds, whether inorganic or organic ones, were able to disturb thyroid hormone activity and that this effect did not depend on any "free fluoride." I also informed the author that pharmacological data has been around for many decades, and the appropriate historical evidence was provided. Statements made concerning the toxicity of Teflon and fluorinated drugs in the article were often not accurate and do not reflect thorough review of the source material.

Professor Kauffman's article also claims that Hodge's estimate of the amount of daily fluoride intake for 10-20 years that would not cause crippling skeletal fluorosis (CSF) was 20-80 mg/day. However, Hodge's data, irrespective of how faulty it was, indicated that in order to develop CSF, a person would have to ingest that amount. In 1979, Hodge corrected his dosages from 20-80 mg/day to 10-25 mg/day.[2] Likewise, the estimate attributed to Sherrell, that CSF might be avoided with intakes of no more than 10-25 mg/day, is inaccurate. In 1993, the NAS/NRC stated "Crippling skeletal fluorosis might occur in people who have ingested 10-20 mg of fluoride per day for 10-20 years."[3] Hodge and NAS ultimately arrived at the same dosage necessary to produce CSF (not *avoid* it): 10 mg/day for 10 years.

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1 Kauffman, JM. Water fluoridation: a review of recent research and actions. *J Am Phys Surg* 2005;10:38-44.
2 Hodge, HC. The safety of fluoride tablets or drops. In: Johansen E, Taves, DR, Olsen TO, eds. *Continuing Evaluation of the Use of Fluorides*. American Association for the Advancement of Science, Selected Symposium 11. Boulder, Colo.: Westview Press; 1979.
3 Subcommittee on Health Effects of Ingested Fluoride, Committee on Toxicology, Board of Environmental Studies and Toxicology, Commission on Life Sciences, National Research Council. *Health Effects of Ingested Fluoride*. Washington, D.C.: National Academy of Sciences Press; August 1993. Available at: www.nap.edu. Accessed Aug 8, 2005.

In Reply: To a chemist the suffix -ide in a chemical name indicates the presence of an anion such as fluoride. For more than 35 years the Chemical Abstracts Service of the American Chemical Society and the International Union of Pure and Applied Chemistry have recommended using the prefix fluoro- for covalently bonded compounds, especially those with carbon containing stable C-F bonds, as in Teflon, refrigerants, and many drugs.[1] Many of the misunderstandings would disappear if this clear nomenclature were used.

Andreas Schuld did not provide any new evidence on the toxicity of stable fluoro compounds in his letter, so my review stands as a balanced effort. The nerve gas sarin, containing a reactive P-F bond, is very toxic. Freon TF (CCl_2FCClF_2) has low toxicity with a threshold limit value for vapor of 1000 ppm v/v, the same as alcohol or acetone. One cannot generalize.

On the estimates of fluoride intake and risk of contracting skeletal fluorosis, we are

in complete agreement. It would have been better had I written "...that would *not* cause crippling skeletal fluorosis was *below* 20-80 mg/day."

I also regret not having listed the Fluoride Action Network as an effective antifluoridation organization.

Joel M. Kauffman, Ph.D.
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[1] Fletcher JH, Dermer OC, Fox RB. *Nomenclature of Organic Compounds*. Washington, D.C.: American Chemical Society; 1974:74-75 ff.

Recertification

In follow up to Dr. Tingey's letter referring to the decision of the American Board of Anesthesiologists to require periodic recertification for diplomates after 1999,[1] readers should know that unlike certification diplomas awarded before 2000, those diplomas subsequently issued have included a time limitation. Undoubtedly, the American Board of Anesthesiologists would have preferred to impose recertification on everyone!

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ABA Diplomate 1974
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[1] Tingey JB. Maintenance of certification (letter). *J Am Phys Surg* 2005;10:33.

Legal Implications of Abortion

An alternate title for Andrew Schlafly's article[1] might be "How Obstetricians Became Legal Risk-bearers for Abortionists." His article is required reading for obstetricians and insurance companies.

I would like to add a point about a group that experiences a disparate impact from the abortion-breast cancer link. In 1993 a significant study reported that for black American women diagnosed with breast cancer at age 50 or older, the odds ratio for induced abortion (IA) was 4.7.[2] In the United States, the IA rate for black women is about 3 times as high as for nonblacks. In 2000-2001, 43% of pregnancies in black American women ended in IA. During that period, there were 49 IAs per 1,000 black women and 13 IAs per 1,000 white women in the United States.[3]

Another major disparate impact on black women results from a higher risk of preterm birth, especially at less than 32 weeks gestation, which is associated with induced abortions.[4] Many of these early preterm births are of very low birth weight (VLBW), less than 1,500 grams. The U.S. rate of VLBW newborns is 2.6 times as high in black as whites (3.2% and 1.2%, respectively).[5] VLBW infants have 38 times the risk of cerebral palsy compared to the general population.[6]

As Schlafly states, obstetricians must protect themselves by obtaining a reliable history of induced abortions from their patients. Cerebral palsy is one of the most important sources of malpractice lawsuits.

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[1] Schlafly A. Legal implications of a link between abortion and breast cancer. *J Am Phys Surg* 2005;10:11-14.
[2] Laing AE, Demenais FM, Williams R, et al. Breast cancer risk factors in African-American women: the Howard University Registry Experience. *J Natl Med Assoc* 1993;85:931-939.
[3] Jones RK, Darroch JE, Henshaw S. Patterns in the socioeconomic characteristics of women obtaining abortions in 2000-2001. *Perspect Sex Reprod Health* 2003;34:226-235.
[4] Rooney B, Calhoun BC. Induced abortion and later risk of premature birth. *J Am Phys Surg* 2003;8:46-49.
[5] Martin JA, Hamilton BE, Sutton PD, et al. Final data for 2002. *National Vital Statistics Reports.* Vol 52, No 10. Hyattsville, Md.: National Center for Health Statistics; 2003.
[6] Escobar GJ, Littenberg B, Petitti DB. Outcome among surviving very low birthweight infants: a meta-analysis. *Arch Dis Child* 1991;66:204-211.

Caveats in Pain Treatment: Lamentations from a Convicted Physician

Since I have been convicted in a federal court under the Controlled Substances Act (CSA) in March of 2004, I have become much more informed and belatedly educated. The government has cleverly hidden from practicing physicians essential information required for the safe prescribing of any controlled medication regardless of schedule.

First is the mistaken belief that merely practicing good appropriate and empathetic medicine protects us from government onslaught and oppression. This is a wonderful naïve concept fit for sheep. The AMA continually reinforces this ideology. Unfortunately, this is a far cry from reality. Remember the DEA's unilateral removal of the FAQ just as soon as William Hurwitz's defense team tried to introduce this at his witch-hunt.

Excellent records are not CSA protective. Indeed, they become hugely self-incriminating. The prosecution used the **narcotic contract** to instill into the confused minds of the lay jurors that I must have known that these five patients were addicts. For why else would I have had them read and sign such a contract!

My insistence upon police reports for stolen medications was likewise used against me. Despite the fact that it is a crime to file a false report with authorities, the jury convicted me of the stolen pills and of the replacement prescription.

The DEA is commingling the civil and criminal standards during their federal CSA prosecutions. This is always done with the help of a physician witness who merely has to possess a medical license. Most of us are used to civil malpractice cases, in which an expert witness not only has to possess a valid license but must also have competence and familiarity within the medical realm of the plaintiff physician. In essence, the expert witness in the CSA prosecutions rewrites the CSA with each and every prosecution.

Any scheduled drug is now fair game. I was convicted for writing Xanax 0.25 to 0.5 mg in quantities of 30 pills per month to patients who carried the diagnoses of panic disorder established by psychiatrists. Needless to say, I was also convicted for writing Duragesic at 50 mcg or Oxycontin 20 mg every 12 hours for people with serious chronic pain generators.

Once convicted, I became acutely aware of the Draconian sentencing guidelines. Oxycodone, the active ingredient found in both Percocet and Oxycontin, carries a marijuana equivalent of 6,700 grams while heroin caries a marijuana equivalent of but 1,000 grams! In other words, a prescription of **Oxycontin carries a 6.7 times greater incarceration sentence than heroin**! Thank our lawmakers in Washington and the lack of dissemination of this serious fact from our staid channels of organized medicine.

Another misconception is that only filled prescriptions carry jail time. If a prescription for a controlled drug is written and then not filled within the required time frame, it becomes outdated and invalid. The prescription can be returned to the prescribing physician and a duplicate with the current date reissued. I was convicted for *both* prescriptions under the CSA! According to the government, it does not matter whether a prescription is a replacement for a voided one or not. By maintaining a photocopy of both prescriptions in my EMR, I was successfully prosecuted for both prescriptions regardless of whether they were filled.

"Why should I be concerned?" ask most physicians. Just look at me. I was not concerned, and I now I face 78 months without parole in a prison far removed from my home at a security level above maximum. We mature solo physicians all cautiously prescribe some controlled substances. We generally have some assets that are easily seized. The government is not required to keep records accounting for the seizures. The abusing addict has few or no assets to take; physicians' savings can be confiscated to fill the coffers of law enforcement agencies.

I am suggesting that each and every one of us give serious attention to the gravity of the problems that we now face with an out-of-control DEA. One needs to be extremely careful about the potential consequences before taking up a prescription pad or palm pilot and initiating any CSA prescription and thus becoming potential DEA fodder.

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