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Abortion and Breast Cancer

Professor Brind¹ identified significant inconsistencies in the Michels abortion-breast cancer study, which used Harvard nurses as subjects.² The Michels article expressed the hope that “an incomplete pregnancy of short duration might impart the benefits of a full-term pregnancy and thus reduce breast cancer risk.”² Although medical researchers all hope that this is true, the best evidence points in the opposite direction. Specifically, two published studies in peer-reviewed medical journals reported that a delivery under 32 weeks’ gestation was associated with double the maternal breast cancer risk relative to women who delivered full-term newborns.^{3,4} A former head of Harvard’s Department of Epidemiology, Dr. Brian MacMahon, expressed the accepted view that “[breast cancer] [p]rotection is exerted only by a full-term pregnancy.”⁵ MacMahon went on to write in January 1973, “Abortion and breast cancer risk were not associated in all study areas; where a relationship was observed, abortion was associated with increased, not decreased risk.”⁵ Thus, the best evidence strongly suggests that young healthy women should be informed that the length of pregnancy that offers the best odds of breast cancer risk reduction is one lasting full-term (i.e. at least 37 weeks’ gestation).

Brent Rooney, M.Sc.
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¹ Brind J. Induced abortion and breast cancer risk: a critical analysis of the report of the Harvard Nurses Study II. *J Am Phys Surg* 2007;12:38-39.

² Michels KB, Xue F, Colditz GA, Willett WC. Induced and spontaneous abortion and incidence of breast cancer among young women: a prospective cohort study. *Arch Intern Med* 2007;167:814-820.

³ Innes K, Byers T. Childbearing factors related to first pregnancy influence breast cancer risk. *Int J Cancer* 2004;112:306-311.

⁴ Melbye M, Wohlfahrt J, Andersen AM, Westergaard T, Andersen PK. Preterm delivery and risk of breast cancer. *Br J Cancer* 1999;80:609-613.

⁵ MacMahon B, Cole P, Brown J. Etiology of human breast cancer: a review. *JNCI* 1973;50:21-42.

Mortality and Statin Drugs

Professor Kauffman’s review article concerning papers on statin drugs¹ notes that

low-density lipoprotein (LDL-C) and total cholesterol (TC) were inversely associated with mortality in a Columbia University analysis of 2,277 non-demented elderly residents aged 65-98 (mean age 76) in northern Manhattan studied for 10 years (average length of followup was 3 years).²

Although results were similar for the subgroup of 469 participants who used statin drugs during the study period (mortality RRs of 1.5 and 1.9 for TC and LDL-C between the lowest and highest quartiles), it should be pointed out that the mortality RR for statin users compared to non-users of statins in this entire study group was 0.25 (95% CI, 0.2-0.4). This remarkable 75% difference in elder mortality with statins may be the largest ever noted; certainly it is to my knowledge.

The Columbia authors speculate that the inverse association of TC and LDL-C with elder mortality may indicate that low serum lipid levels are a “surrogate for comorbidity, frailty, or subclinical disease.” The participants most likely to have been treated with statins could have had higher TC and LDL-C initially compared to the whole group and thus conceivably were in better health (indication bias), or the ones most susceptible to coronary disease had already died at an earlier age (survival bias), or perhaps the statin users just received better medical care, yet a 75% difference of mortality in the elderly associated with statin treatment simply must not be ignored.

The pleiotropic actions of statins, separate from their LDL-C and TC reduction properties, have been reviewed previously in this journal by Anthony Colpo,³ and by other writers.^{4,5} These cholesterol-independent effects include impedance or reversal of atherosclerotic plaque formation, improvements in arterial function, anti-clotting effects, anti-inflammatory effects, antioxidant effects, inhibition of smooth muscle cell proliferation during plaque formation, prevention of plaque rupture, and prevention of cardiac hypertrophy. Simply because all the beneficial effects are attributed by most clinicians only to LDL-C reduction is no reason to abandon this statin umbrella of favorable heart/artery actions. Dosages should be carefully evaluated for each user to balance cardiovascular risk reduction against side-effect profile, which

can be substantial for this class of drug.⁶ Keep the baby; throw out the bath water.

Other means for reduction of cardiovascular risk factors include fish oils (source of n-3 fatty acids and natural phospholipid antioxidant furan fatty acids);⁷ telmisartan (Micardis), which is unique among angiotensin receptor blockers for its PPAR gamma partial activation at therapeutic levels;⁸ iron stores reduction by means of periodic blood donations or phlebotomies to hold serum ferritin in men and older women at a level similar to that of premenopausal females;⁹ and exercise, weight control, and dietary/supplement interventions too numerous to discuss in this letter.

Jay Caplan
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In reply: Mr. Caplan is probably correct in noting that the Columbia University study on the effect of TC and LDL-C on mortality was subject to survival bias, indication bias, and possibly better medical care in general for the statin users.

The reported lower mortality for statin users was ignored, not only for those reasons, but because it had not been supported by major clinical trials of statins. In a group of 11 large clinical trials, the mean reduction in mortality was a mere 0.28%/y (NNT = 357), clearly not clinically significant.¹⁰ The one trial among these 11 that involved elderly patients (aged 70–82 at baseline), the PROSPER Trial, showed a nonsignificant mortality reduction of 0.2%/y (NNT = 500).¹¹ Mark R. Goldstein noted the unchanged mortality and commented that a decrease in coronary heart disease death from 4% on pravastatin to 3% on placebo was balanced by an equal increase in cancer death (from 3% to 4%) and in cancer incidence.¹² The tendency of drug makers to publish the results of only the most positive trials has been noted.¹³ When the results of statins are as poor as shown above, the existence of “favorable heart/artery actions” in excess of adverse effects is unlikely.

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¹ Kauffman JM. Misleading recent papers on statin drugs in peer-reviewed medical journals. *J Am Phys Surg* 2007;12:7-9.

² Schupf N, Costa R, Luchsinger J, et al. Relationship between plasma lipids and all-cause mortality in non-demented elderly. *J Am Geriatrics Soc* 2005;53:219-226. Available at: <http://tinyurl.com/2o7uoy>. Accessed Jul 27, 2007.

³ Colpo A. LDL Cholesterol: bad cholesterol, or bad science? *J Am Phys Surg* 2005;3:83-89.

⁴ Lahera V, et al. Endothelial dysfunction, oxidative stress and inflammation in atherosclerosis: beneficial effects of statins. *Curr Med Chem* 2007;14(2):243-248. <http://tinyurl.com/yoaasf>. Accessed Jul 27, 2007.

⁵ Davignon J. Ongoing clinical trials of the pleiotropic effects of statins. *Vasc Health Risk Manag* 2005;1(1):29-40.

⁶ Ravnskov U. High cholesterol may protect against infections and atherosclerosis. *Q J Med* 2003;96:927-934. Available at: <http://qjmed.oxfordjournals.org/cgi/content/full/96/12/927>. Accessed Jul 27, 2007.

⁷ Spittler G. Furan fatty acids: occurrence, synthesis, and reactions. Are furan fatty acids responsible for the cardioprotective effects of a fish diet? *Lipids* 2005;40:755-771. Available at: <http://tinyurl.com/3djhlf>. Accessed Jul 27, 2007.

⁸ Pershadsingh HA. Treating the metabolic syndrome using angiotensin receptor antagonists that selectively modulate peroxisome proliferator-activated receptor-gamma. *Int J Biochem Cell Biol* 2006;38:766-781. Available at: <http://tinyurl.com/298jxz>. Accessed Jul 27, 2007.

⁹ Sullivan JL. Iron versus cholesterol—perspectives on the iron and heart disease debate. *J Clin Epidemiol* 1996;49:1345-1352. Available at: <http://tinyurl.com/33prn7>. Accessed Jul 27, 2007.

¹⁰ Kauffman JM. *Malignant Medical Myths*. West Conshohocken, Pa.: Infinity Publishing; 2006:9-10,88-90.

¹¹ Shepherd J, Blauw GJ, Murphy MB, et al. Pravastatin in elderly individuals at risk of vascular disease (PROSPER): a randomised controlled trial. *Lancet* 2002;360:1623-1630.

¹² Goldstein MR. Letter to editor. *Lancet* 2003;361:427-428.

¹³ Healy D. Lines of evidence on the risks of suicide with selective serotonin reuptake inhibitors. *Psychother Psychosom* 2003;72:71-79.

Correction in Review of *Vaccine*

In his book review,¹ Professor Kauffman states it was an error on the part of the author to refer to bacterial products from a New Jersey cranberry bog as “antibiotics.” He states that sulfonamides were the first antibiotics. In its broadest definition, “antibiotic” means destructive of life, but in the stricter sense sulfonamides are not antibiotics because they are not produced by a microorganism. Rather, they are a type of antimicrobial.

Gerald E. Sullivan, M.D.
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¹ Kauffman JM. Review of *Vaccine: the Controversial Story of Medicine's Greatest Lifesaver* by Arthur Allen. *J Am Phys Surg* 2007;12:58-59.

The Low-fat Diet

I read with excitement and admiration the article by Ottoboni and Ottoboni¹ concerning the colossal failure of the \$700 million study, the Women’s Health Initiative (WHI). Put in simplistic terms, the WHI set out with a preconceived paradigm that a life free of cancer and heart disease could be achieved simply by the time-worn admonition: “Eat your fruits and vegetables!” The established nutrition liturgy (definition: “a form and arrangement of public worship laid down by

a church or religion”) has been feeding us this vegan verisimilitude for 50 years. I am very weary of it, and I have been fighting this scientifically unsupportable admonition for 40 years.

Although the Ottobonis did a good job of debunking the study, the authors of the WHI report actually revealed their bias quite well through their complaints about unreliable patients and too short a study period (8 years), assertions without evidence (it’s a “proven healthy diet”), and fervent wishes (“we really hoped” that the dietary modification would produce a major health benefit). Hoping for an outcome, however, is not science. As a scientist, one is supposed to be seeking the truth, not engineering a preconceived hoped-for outcome.

The Ottobonis note that “[i]n order to retain the lipid hypothesis..., something that will excuse the failure of studies to confirm the concept, without lessening its validity is required.” They cite Walter Willett of Harvard Medical School, who apparently suggests applying restrictions only to saturated fats along with the trans fats of the vegetable kingdom. There is, however, nothing at all in the scientific literature to indicate that saturated fatty acids—in butter, animal fats in general, or the palm oils, are deleterious in any way to human health.

William Campbell Douglass II, M.D.
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¹ Ottoboni A, Ottoboni F. Low-fat diet and chronic disease prevention: the Women’s Health Initiative and its reception. *J Am Phys Surg* 2007;12:10-13.

In Further Appreciation of Dr. Bonham’s Case

Jeffrey White’s article on Dr. Bonham¹ brings our organic origins of law to life again for the benefit of a new generation of doctors and lawyers. The case is the foundation of multiple American constitutional precepts, including judicial review, the process due, and the rule of law.

Dr. Bonham’s case was one of the two major legal cases cited by the American Revolutionaries to justify their rebellion on constitutional principles. Founding Father John Adams was the foremost American scholar of Sir Edward Coke. Adams used Coke to write the Declaration of Rights and Form of Government of the Commonwealth of Massachusetts, a constitution that was copied by four other states. Three paragraphs of the original thirty are devoted to defining the executive, the judiciary, and the legislative, with the purpose of separating these powers. Coke thought that mixing the prosecutorial or executive power with the judicial power in an administrative court was void or unconstitutional. Adams, having watched the Admiralty Courts prior

to the American Revolution, had the Declaration of Independence state that all administrative courts should be banned.

Coke succeeded in identifying what is written on the hearts of man and translated that into natural law and American organic law, which are present in our first documents as a nation in 1776 through the 1791 Bill of Rights. Coke created the first English Petition of Rights in 1627, which foreshadowed the Anglo-American bills of rights. Massachusetts Governor John Winthrop, a former member of the Inner Temple, had the Body of Liberties, a 1649 Massachusetts Bill of Rights, passed by the legislature, defining the roles of the participants in civil and criminal courts. In England, John Winthrop's brother-in-law promoted the Agreement of the People, a Constitution for England, at the Putney House debates during the English Civil War.

Coke served in the executive branch as solicitor general and attorney general; in the legislature, where he was twice Speaker of the House of Parliament; and in the judiciary as chief justice. He wrote for posterity based on his own experience, as well as his reading and understanding of lessons of long ago collected by Antiquarians. Having already equated common law with the law of nature, Coke stated that common law was to be the perfection of reason.

Coke felt that both internal (natural) as well as external (past legal documents) were required to arrive at the meaning of the law. Also he believed that the law is not static but must stand the test of time.

Coke was speaking about monopoly power when he challenged the Royal College of Physicians. Royal monopolies were also challenged by Parliament and the City of London. The Royal College of Physicians of London used its power to limit the number of physicians. Coke shows a pre-Adam Smith economic liberalism.

Leonard Friedman, M.D.
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¹ White J. Dr. Bonham and due process for doctors: lessons from long ago. *J Am Phys Surg* 2007;12:25-27.

Homeland Security

In "Homeland Security for Physicians"¹ and a subsequent exchange of comments with Dr. Nathaniel Lehrman,² Dr. Orient reshapes more than two decades worth of tired arguments about nuclear civil defense. She takes the somewhat curious position, which we will not dispute, that Physicians for Social Responsibility (PSR) and International Physicians for the Prevention of Nuclear War (IPPNW) have won the argument that fallout shelters,

evacuation plans, and other proposals for civil defense in response to a nuclear war would be exercises in futility. She herself concedes that "the logistical problems of evacuating a large city are obvious," and can offer nothing more in defense of urban fallout shelters than assertions made in a 1990 article that was rejected by two major medical journals after careful peer review. Dr. Orient seems to attribute the success of PSR and IPPNW to our "influential physicians" and to the power of ridicule, rather than to the ridiculous nature of nuclear civil defense proposals themselves.

Her assertion that PSR and IPPNW have not revisited their arguments about preparedness in a world concerned about the possibility of nuclear terrorism, however, is baseless. In August 2006, PSR published "The US and Nuclear Terrorism: Still Dangerously Unprepared," and criticized the U.S. government at a Washington, D.C., press conference for remaining "dangerously unprepared to deal with the medical aftermath of a terrorist attack involving nuclear weapons, dirty bombs or explosions at nuclear power plants." The report, including a number of specific recommendations, has been available on PSR's website for almost 10 months. IPPNW offered a workshop based on the PSR report at its World Congress in Helsinki in September 2006.

Even in the context of nuclear terrorism, however, better preparedness would only marginally improve the capacity of physicians and other health care workers to treat the victims of a nuclear attack, would be enormously expensive, and would drain precious resources from other unmet public health priorities. Every effort must be made to prevent both nuclear terrorism and nuclear war. Toward this end, the principal and most essential preventive measure remains the global abolition of nuclear weapons.

Michael McCally, M.D.
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In reply: I'd like to thank Dr. McCally for substantiating my thesis that PSR and IPPNW have effectively obstructed civil defense and are proud of it. They support the flawed peer-review process of two "major medical journals" (*New England Journal of Medicine* and *JAMA*), which for decades have refused to correct an egregious misstatement with profound public policy consequences: that shelters were crematoria during the Hamburg firestorm, and hence all nuclear defense is futile. The source for this assertion was a popular book that was contradicted by the U.S. Strategic Bombing Survey, the British Home Office, and the Hamburg fire department. In any event, most

modern American cities probably do not have a high enough fuel loading to support a firestorm.³ Moreover, the allegation, even if it were true, is irrelevant to the issue of fallout shelters for citizens downwind from the blast zone. PSR and IPPNW stuck to it anyway, ignoring vast amounts of taxpayer-funded research, compiled, for example, in the recently reprinted classic work by Glasstone and Dolan.⁴

Yes, PSR and IPPNW now acknowledge the threat of nuclear terrorism. They say the U.S. is "still dangerously unprepared" (emphasis added)—obscuring the fact that preparedness was much better in 1960, before they started their anti-defense campaign. Their website revives their old "Bombing Runs," and recommends better planning, organization, and communication. But don't bother looking there for any useful facts on protection factors, suitable monitoring devices, or expedient shelter preparation—or any links to such information.

Perhaps PSR and IPPNW have upgraded their assessment of civil defense from "futile" (their characterization, never mine) to "marginal." But they still seem to prefer spending enormous "precious resources" on other "unmet public health priorities"—rather than launching minimum-cost civil defense efforts with enormous lifesaving potential. And they still apparently have faith that the nuclear genie can be globally disarmed.

Physicians had better not wait for the federal government to implement PSR's recommendations for centrally planned programs. The outcome for their family, neighbors, and patients depends on local efforts *now*. They could, for example, encourage their local officials to follow the lead of Huntsville, Ala., which is retrieving and updating the fallout shelter identification program last revised in 1992.^{5,6}

Jane M. Orient, M.D.
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¹ Orient JM. Homeland security for physicians. *J Am Phys Surg* 2006;11:75-79.

² Lehrman NS. Correspondence. *J Am Phys Surg* 2007;12:2.

³ Lucas KA, Orient JM, Robinson AB. Efficacy of bomb shelters: with lessons from the Hamburg firestorm. *South Med J* 1990;83:812-820.

⁴ Glasstone S, Dolan PJ. *The Effects of Nuclear Weapons*. 3rd ed. U.S. Dept. of Defense and the Energy Research and Development Administration; 1977. Available from: www.KnowledgePublications.com.

⁵ Paradise K. Revitalized civil defense program in Huntsville, Alabama, in Madison County; 2007. Available at: <http://www.physiciansforcivildefense.org/huntsville.php>. Accessed Jul 28, 2007.

⁶ Jones S. Interview with Kirk Paradise: a fallout shelter program for the 21st century. Available at www.physiciansforcivildefense.org. Accessed Jul 28, 2007.