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Lower Cholesterol Without Drugs

Reducing cholesterol levels saves lives. A recent report by a panel of experts from the American Heart Association and the government's National Cholesterol Education Program recommended more aggressive treatment of people with elevated cholesterol levels. I agree.

The diagnosis is right, but the prescription is incomplete. Millions more Americans will be prescribed cholesterol-lowering drugs that many, perhaps most, could have avoided by making bigger changes in diet and lifestyle than this panel recommended. Since about $20 billion was spent on these drugs in the United States last year (almost $10 billion on Lipitor alone), a lot is at stake.

Statin drugs such as Lipitor are effective ways of lowering cholesterol levels. I prescribe them for patients when indicated.

Several large-scale trials have demonstrated that these drugs can reduce heart attacks and premature death and that they may have additional benefits. Clearly, though, it would be better to accomplish the same goals by changing diet and lifestyle, since all drugs have costs and side effects, both known and unknown. As tens of millions of people begin taking these medications for decades, more long-term side effects are likely to become apparent; the statin drug Baycol was taken off the market in 2001 because of toxic side effects. In contrast, it costs nothing additional to eat a healthful diet, walk, meditate and quit smoking, and the only side effects of these behaviors are beneficial.

The panel recommended diet and lifestyle changes as a first step for some people. But the diet it recommended has little effect on cholesterol levels, because it doesn't go far enough; for most people, cholesterol levels decrease only 5 percent. In tacit acknowledgement of this, the authors advised that adults with LDL-cholesterol levels above 100 mg/dL (which includes most adults in the United States) or even above 70 mg/dL (high-risk patients) be treated with drugs right away before even finding out if diet and lifestyle changes are sufficient.

Why did the panel not give the option of making more intensive changes in diet and lifestyle, which, for most people, can be a safe and effective alternative to a lifetime of cholesterol-lowering drugs? Because they believe most people will not make them.

To assume this is often self-fulfilling: "Oh, I know you're not going to be able to change your diet very much—and why even bother when I can just prescribe you a statin drug?" Then, when patients don't change their diets, the doctor says, "I knew you couldn't do it."

For some, the moderate changes in diet that this panel recommended may be sufficient to avoid a lifetime of cholesterol-lowering drugs. For most, though, bigger changes are required. There is genetic variability in how efficiently people can metabolize dietary fat and cholesterol. The good news is that even if you're not very genetically efficient, reducing your consumption of saturated fat and cholesterol more than this panel recommended will lower your LDL much more. In Asia, where a very low-fat diet is the norm, the average LDL is less than 95.

In our studies, intensive diet and lifestyle changes reduced LDL by 40 percent (from an average of 144 to 87) after one year in people who were not taking cholesterol-lowering drugs. Also, most of them were able to reverse even severe coronary heart disease just by making changes in diet and lifestyle, usually avoiding bypass surgery and angioplasty. But the coronary heart disease of patients who followed the diet this panel recommended worsened.

Most doctors believe that taking a pill is easy but changing a lifestyle is virtually impossible. But most patients prescribed statin drugs are not taking them just a few months later. Why? Because they don't make them feel better.

In contrast, people are often able to make significant changes in diet and lifestyle because they feel so much better so quickly: sustained weight loss, improved sexual function, increased energy, decreased blood pressure, dramatic reductions in angina and better control of diabetes, none of which results from cholesterol-lowering drugs.

Joy of living is a more powerful motivator than fear of dying. My colleagues and I, in hospitals across the country, found that many people are willing to make and maintain intensive changes in diet and lifestyle when they are given support and when they understand and experience the powerful benefits. Most people were able to safely avoid bypass surgery and angioplasty. Medicare has been conducting a demonstration project of this program at multiple hospitals and is finding similar improvements.

The other reason these drugs are so appealing is that we physicians learn little, if anything, about nutrition in our medical training. Also, most insurance companies will reimburse the costs of these drugs, of bypass surgery and of angioplasty—but not the costs of teaching people how to change their diet and lifestyle.

We need a new model of medicine that provides Medicare and other insurance coverage for non-proprietary, scientifically proven diet and lifestyle programs as an alternative or adjunct to cholesterol-lowering drugs, bypass surgery and angioplasty. I appreciate that Medicare is going to consider a coverage decision so that programs like this can be available to many Americans who can benefit, as reimbursement is the primary determinant of medical practice and medical education. This approach gives Americans true freedom of choice. It addresses the underlying lifestyle causes of chronic diseases rather than literally or figuratively bypassing them with drugs and surgery. And it's cheaper than adding statins to the water supply.

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