Robert E. Shank Papers

Folder title:

Nutrition Committee, 1974.

Identifier:

FC034-S04-B018-F01

American
Heart
Association

NUTRITION COMMITTEE

Oct. 16 & 17, 1974
Oct. 16 - 9-5 P.M.
Oct. 17 - 8:30-1:00 P.M.
43rd St. & Mad. Ave.

Biltmore Hotel
Oct. 16 -Suite A
Oct. 17--Suite S
New York, N.Y.

NRC -

Atlanta hearing - Chamberlain

Talk to Ed. Brennan re cell culture +/or genetics

Brief statement for Risk Reduction Grants

a.) glucose - Albrink.
b.) uric acid. - Ed. Brennan.

Study in England in Nutr. Rev. -
early feeding.
Isobel.
Dr. Valadian - Dept.

Recommendations for diet - ? - carrying down thru adolescence

Na + K content of foods –

Handbook #456 – to be published

1500 foods. – (Revision of Handbook #72)

New table on spices – herbs –

minerals + vitamins.

Handbook #8 – will be revised. (Bernice Watt)

– in loose leaf.

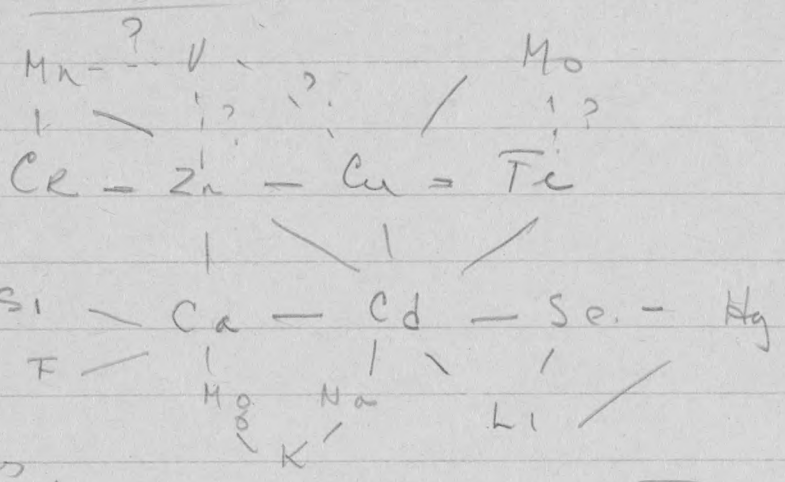
* Direct a letter to Harkins – data bank, food labeling, + the public

– ~~#~~ of ~~common~~ standards techniques describe

– AHA. –

Sandstead – Trace minerals, fiber + calcium

Trace Mineral Interactions



~~Efforgenous~~ Fiber factors – affecting absorption – Endogenous Factors

Lignins
Phytates
Inositol
amino-acids
(histidine)
Oxylates
Clay
Starch
Fat

Zn binding factor
Metallothioneins
AA
Glutathione factor

Changing Cu to Zn ratio influences serum cholesterol
– Low zn/cu (4) ratio – makes rats fat (750 gm)
– High zn/cu (14) ratio – rats lower in body wt. but serum chol are high

Human milk Zn/Cu – 6 Cows milk – 3.5

Believes Zn/Cu ratio may be influencing high serum chol. in US pop.

Osborne – in French lit. –

Plaques in coronary arteries of young persons (less than 20 yrs) dying of other causes – more frequent in children given cow's milk rather than breast milk in infancy

Phytate in presence of calcium – decrease Zn absorption

Fiber in diet – decreases Zn absorption

Herbivore birds Ca in large quantity.

Cd effect in hypertension

Mitchell – 1 p.m. of Cd in rat diet produces hypertension
– renin increased in rats + Cd hypertension

Mn + Zn – influences insulin activity and pancreas

Hard water –

↓ weakness + CV disease when water is soft

J.A.M.A. – Stops – re hard water

Ca + Mg in hard water

RES or CIN to Drs Harkey.

Motion passed.
60-75 copies -
People in field request info -
Could bring attention to recent publ.

Dietary Factors in Thrombosis -

14 RP

SENIOR STAFF RESPONSIBLE Mary Winston

COMMITTEE Nutrition Committee

DATE Oct. 16 & ½ day Oct. 17, 1974

SUBCOMMITTEE

TIME Oct. 16 - 9-5 p.m.
Oct. 17 - 8:30 -1:00 p.m.

PLACE Biltmore Hotel, Suite A (Oct. 16); Suite S (Oct.17) Luncheon, Suite

ROOM Oct. 16 - Suite A Lunch - B
Oct. 17 - Suite S

BUDGET 506-834

NAME	Will Attend	Will Not Attend	NAME	Will Attend	Will Not Attend
Chairman: Robert Shank, M.D.	X				
Margaret Albrink, M.D.	X				
Edwin Bierman, M.D.	X				
Sharon Borakove	X				
David Coursin, M.D.		X			
Ms. Ruthe Eshleman	X				
Fred Hatch, M.D.		X			
James Iacono, Ph.D.	X				
Mary Jane Jesse, M.D.		X			
Ezra Lamdin, M.D.	X				
Kenneth Lane, M.D.		X			
Richard Hurley, M.D.	X				
Mary McCann, M.D.	X	late arrival			
John Mueller, M.D.	X				
Harold Sandstead, M.D.	X				
Ms. Virginia Stucky	X				
J. Keith Thwaites	X				
Mrs. Mary Winston	X				

AGENDA

Ad Hoc Committee on Nutrition in the Young

September 25, 1974
American Heart Association

9:00 a.m. - 3:30 p.m.
6th Floor Conference Room

1. Introduction — Dr. Coursin

2. Special Reports:

Dr. Charles Glueck
Dr. Mary Jane Jesse
a. Available data on serum lipids in children
b. Diagnosis of hyperlipidemia in children and adolescents

Dr. Sheila Mitchell
Pathogenesis of atherosclerosis

Dr. Henry McGill
Epidemiological data relative to atherosclerosis in children and adolescents

Dr. Robert Shank
Nutrient requirements of children and adolescents

Virginia A. Beal - Dietitian Consultant
Dietary habits of children and adolescents

3. Other Business — Dr. Coursin

4. Next Meeting Date — Dr. Coursin

MW:yd:T/7

NUTRITION COMMITTEE CHARGE

Name of Committee	Nutrition Committee
Composition:	No more than seven members in addition to the Chairman. Consultants will be appointed as needed. Nominations will be solicited from the Council on Arteriolsclerosis, Epidemiology and Cardiovascular Disease in the Young.
Term of Office:	Chairman to be appointed for one year with reappointment up to three years. Members may serve three years. One-third of the membership rotates off of the committee every year.
Method of Selection:	Appointed by Chairman, Central Committee in consultation with Chairman, Nutrition Committee.
Frequency of Meetings:	Two a year; an additional meeting under exceptional circumstances.

AHA Nutrition Committee - Charges

1. To be fully informed concerning new scientific developments and the advances in knowledge concerning nutrition and/or diet as it relates to health and the occurrence or treatment of cardiovascular disease.

2. To provide a synthesis of pertinent nutritional knowledge for development of policy and position papers for consideration and use by the AHA, its Councils, Committees, and Affiliates.

3. To provide advisory and resource information in these areas for the officers, staff, Scientific Councils, and the Research or other committees of AHA.

4. To stimulate basic and applied research in nutrition, identifying areas of needed or expanded investigative effort and emphasis.

5. To promote in cooperation with the Scientific Councils and committees of AHA appropriate and well designed nutrition programs in the areas of:

    a. Hypertension and renal disease
    b. Coronary artery disease
    c. Cardiovascular disease in the young
    d. Cerebrovascular disease

(over)

6. To advise the Working Group in Public Policy and Government Affairs in matters concerning legislation and government regulation related to food, nutrition, health and cardiovascular disease.

7. To cooperate with and assist other scientific and health agencies in programs concerning nutrition and cardiovascular disease.

8. To disseminate information pertinent to nutrition and cardiovascular disease to health professionals through news and medical media and with the cooperation and assistance of affiliates.

9. To develop and promulgate programs of public education concerning diet, nutrition, health and cardiovascular disease, seeking assistance and cooperation of affiliates.

sdb
10/1/74

RENÉ BINE, JR., M. D.
1515 SCOTT STREET
SAN FRANCISCO, CALIFORNIA 94115
567-5581

October 8, 1974

Robert Shank, M.D.
Chairman, Nutrition Committee
American Heart Association,
44 East 23rd St., New York, N.Y. 10010

Dear Bob,

Mary Winston has forwarded to me your material concerning Health Care Feeding and Dietary Practices that you are going to consider at the Nutrition Committee meeting on October 16-17. This concerns the letter from Dr. Philip White with the Reports of the Task Forces on Fat-Modified Diets and Sodium Restricted Diets. I would like to make a few comments myself.

1- I think that it is great that there is now considerable information sharing and cooperation with the AMA.

2- The Fat Modified Diets.

I agree with the concept of making things more uniform and the terminology of the Fat Restricted vs. the Fat Controlled Diet makes sense to us but I wonder if it will be confusing th the general medical profession and the public (i.e. patients).

In line with the AHA Nutrition Committee recommendations which are based on percentage of total calories, the 65-80 grams of fat would be O.K. for a daily caloric intake of 1800-2000 calories, but what about those who eat a lower daily caloric amount? Or, for that matter, is it going to give proper proportions for those who take in 3000 or more calories/day?

Also, with that much fat (65-80 grams), carbohydrates have to be limited (not just in Types IV & V) unless the total calories are in the high brackets.

On page 3 it is stated why the "grams/day" is used instead of "% of calories" and these are valid but I wonder if there shouldn't be some range of total calories mentioned for different amounts of fat. I dont propose how to do this but merely think that some thought should be given to this by the Committee.

3- The Sodium Restricted Diets.

The last paragraph on page 1 in this section bothers me considerably. I do not believe that with the use of diuretics "no sodium restriction is ~~being~~ necessary" is being taught to patients. Some restriction must be practiced for a patient can counteract the diuretic effect by dietary indiscretions much too easily.

The statement that more information is needed by means of evaluations and/or surveys is a valid one but the difficulty is going to come in trying to get that information. Perhaps this would be an idea in which we could elicit the help of Heart Associations around the country or maybe there would be cooperations with the Society of Nutrition Education (since Dr. White is current President), and/or with the Dietetic Assocation.

On page 3, after talking in "milligrams of sodium" they suddenly switch to "milliequivalents".

I applaud the last paragraph on that page in hoping to get a 1 gram sodium diet/day!

The last item on page 5, referring to the fact that third party intermediaries will not pay for identified dietary consultations, hopefully will be changed in the not-to-distant future. If you remember, I believe it was Nanette Wenger who told us at that meeting in June in Seattle, that in Georgia they do pay a few, a very small one but "a fee". With the bills that two members of the California Legislature are trying to work up, such a thing may be passed ultimately in this state too. I think a more universal push for this, with the help of the AMA should be attempted.

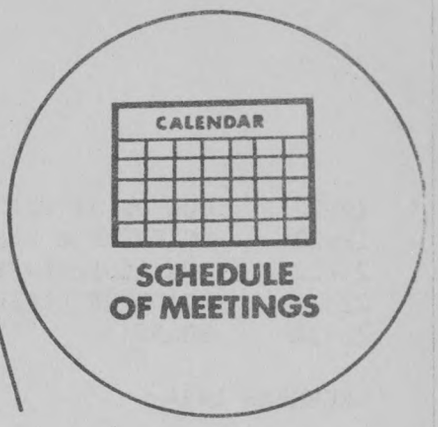
Expecting to see you all soon in Dallas.

Best to all,

Renée

Dr Shank

MEMO



AD 74-508-7

DATE	MEETING	LOCATION	EXT
OCTOBER 1974			
2	OHIO - NORTH CENTRAL REGIONAL FUND RAISING LEADERSHIP CONFERENCE	COLUMBUS OHIO	214
2- 4	ETHICS COMMITTEE	QUAIL ROOST NC	231
3	UPPER ATLANTIC REGIONAL AFFILIATE EXECUTIVES' MEETING	NYC	295
3- 4	NORTHWEST-ROCKY MOUNTAIN PROGRAM CONFERENCE	PORTLAND ORE	214
4	UPPER ATLANTIC REGIONAL HEART COMMITTEE	NYC	295
4- 5	NORTHWEST-ROCKY MOUNTAIN REGIONAL HEART COMMITTEE	PORTLAND ORE	214
10	COUNCIL ON HIGH BLOOD PRESSURE RESEARCH (HBPR) MEDICAL ADVISORY BOARD EXECUTIVE COMMITTEE	CLEVELAND OHIO	367
10	HEART FUND LEADERSHIP CONFERENCE NEW ENGLAND	TO BE ANNOUNCED	288
11	NORTH CENTRAL REGIONAL HEART	ST. LOUIS MO	295
10-11	SOUTHWEST REGIONAL PROGRAM AND FUND RAISING CONFERENCE	SAN FRANCISCO CA	214
11-12	SOUTHWEST REGIONAL HEART COMMITTEE	SAN FRANCISCO CA	214
11-12	COUNCIL ON HBPR - SCIENTIFIC SESSIONS	CLEVELAND OHIO	367
14	COUNCIL ON CLINICAL CARDIOLOGY EXECUTIVE MEETING	NYC BILTMORE	367
16-17	NUTRITION COMMITTEE	NYC BILTMORE	288-9
18	PUBLICATIONS COMMITTEE	NYC BILTMORE	351
20	COMMITTEE ON CRITERIA AND METHODS COUNCIL ON EPIDEMIOLOGY	NEW ORLEANS LA	292
21-23	3 DAYS OF CARDIOLOGY FOR NURSES - "HEART ATTACK" NURSING COUNTERATTACK 1974 AND FUTURE	HOLLENDEN HOUSE CLEVELAND OHIO	237
25-26	MIDDLE ATLANTIC REGIONAL HEART COMMITTEE	ARLINGTON VA	214
25-26	GREAT PLAINS ASSEMBLY	KANSAS CITY MO	214
26-27	GREAT PLAINS REGIONAL HEART COMMITTEE	KANSAS CITY MO	214
27-31	RESEARCH COMMITTEE	ST. THOMAS, U.S.V.I.	311
31	CVDY COUNCIL - COMMITTEE ON RHEUMATIC FEVER	NYC BILTMORE	371
NOVEMBER 1974			
1	CVDY COUNCIL - EXECUTIVE COMMITTEE	NYC BILTMORE	371
17	COUNCIL ON ARTERIOSCLEROSIS - EXECUTIVE COMMITTEE	DALLAS TEXAS	369
17	EXECUTIVE COMMITTEE COUNCIL ON EPIDEMIOLOGY	DALLAS TEXAS	292
17	COUNCIL ON CIRCULATION - EXECUTIVE COMMITTEE	DALLAS TEXAS	371
18-21	AHA 47TH SCIENTIFIC SESSIONS	DALLAS TEXAS	233

19-20	CCL ON ARTERIOSCLEROSIS ANNUAL MEETING	DALLAS TEXAS	233
19-20	SCIENTIFIC SESSIONS FOR NURSES	DALLAS TEXAS	232
21-22	AHA ASSEMBLY & ANNUAL MEETING	DALLAS TEXAS	214
22	BOARD OF DIRECTORS	DALLAS TEXAS	242
22-24	SHAPS	DALLAS TEXAS	208
DECEMBER 1974			
5	NEW ENGLAND REGIONAL HEART COMMITTEE	NASHUA NH	214
5-7	UPPER ATLANTIC REGIONAL PROGRAM CONFERENCE	WILMINGTON DE	295
6	CENTRAL COMMITTEE FOR MEDICAL AND COMMUNITY PROGRAM	NYC BILTMORE	218
9-13	AHA ORIENTATION COURSE	NYC BILTMORE	305
12-14	TOOLS & TECHNIQUES OF PRACTICING CARDIOLOGISTS	MIAMI FLA	237
JANUARY 1975			
8-10	CPR-ECC AFFILIATE FACULTY INSTRUCTOR TRAINING COURSE	MIAMI FLA	267
10-11	SOUTHWEST REGIONAL HEART COMMITTEE	SAN DIEGO CA	214
23	FUND RAISING ADVISORY & POLICY COMMITTEE	NYC BILTMORE	344
24-25	BOARD OF DIRECTORS	NYC BILTMORE	242
FEBRUARY 1975			
16-21	INTERNATIONAL SYMPOSIUM ON MYOCARDIAL INFARCTION & ANGINA PECTORIS	DAVOS SWITZERLAND	237
27-Mar 1	THROMBEOEMBOLISM: DIAGNOSIS AND TREATMENT	MIAMI BEACH FLA	237
MARCH 1975			
10-11	15TH ANNUAL CONFERENCE ON CVD EPIDEMIOLOGY - COUNCIL ON EPIDEMIOLOGY	TAMPA FLA	292
13-14	IMMUNOLOGICAL RENAL DISEASE	PORTLAND ORE	237
14-15	SOUTHERN REGIONAL HEART COMM	BIRMINGHAM ALA	214
19-22	SEVENTH TEACHING CONFERENCE IN CLINICAL CARDIOLOGY	MIAMI FLA	237
20	NEW ENGLNAD REGIONAL HEART COMMITTEE	NASHUA NH	214
21-22	NORTHWEST ROCKY-MOUNTAIN REGIONAL HEART COMMITTEE	DENVER CO	214
APRIL 1975			
4-5	SOUTHWEST REGIONAL HEART COMMITTEE	TO BE ANNOUNCED	214
18	CENTRAL COMMITTEE FOR MEDICAL AND COMMUNITY PROGRAM	NYC BILTMORE	218
18-19	NEW ENGLAND TRAINING	DURHAM NH	214
19	EXECUTIVE COMMITTEE	NYC BILTMORE	242
MAY 1975			
8	MANAGEMENT/FINANCE COMMITTEE	NYC BILTMORE	222
12-15	CARDIOLOGY FOR THE INTERNIST	ATLANTA GA	237
15-17	MASTER APPROACH TO CARDIOVASCULAR PROBLEMS	MIAMI FLA	237
16-18	MIDDLE ATLANTIC REGIONAL HEART COMMITTEE	TO BE ANNOUNCED	214

JUNE 1975

4- 6	ELECTRO PHYSIOLOGY & PHARMACOLOGY OF CARDIAC ARRHYTHMIAS	COLUMBIA UNIVERSITY NYC	237
5	FUND RAISING ADVISORY & POLICY COMM	NYC BILTMORE	344
5	NOMINATING AWARDS COMMITTEE	NYC BILTMORE	242
6- 7	BOARD OF DIRECTORS	NYC BILTMORE	242
10-12	CURRENT CONCEPTS IN THE RECOGNITION & MANAGEMENT OF CARDIAC EMERGENCIES	OKLAHOMA CITY OKLA	237
23-26	AFFILIATE/NATIONAL EXECUTIVE	TO BE ANNOUNCED	364

OCTOBER 1975

2- 4	NON-INVASIVE CARDIOLOGY	DETROIT MICH	237
24-26	MIDDLE ATLANTIC REGIONAL HEART COMMITTEE	TO BE ANNOUNCED	214

NOVEMBER 1975

17-20	ANNUAL SCIENTIFIC SESSIONS OF AHA	ANAHEIM CA	233
20-21	ANNUAL MEETING AHA ASSEMBLY	ANAHEIM CA	214
21-23	SHAPS	ANAHEIM CA	208

FEBRUARY 1976

27-28	16TH ANNUAL CONFERENCE ON CVD EPIDEMIOLOGY - COUNCIL ON EPIDEMIOLOGY	NEW ORLEANS LA	292

NOVEMBER 1976

15-18	ANNUAL SCIENTIFIC SESSIONS OF AHA	MIAMI FLA	233
18-19	ANNUAL MEETING AHA ASSEMBLY	MIAMI FLA	214
19-21	SHAPS	MIAMI FLA	208

UNLESS OTHERWISE INDICATED, MEETINGS IN NEW YORK WILL BE HELD AT THE AHA OFFICE

EXT EXTENSION OF PERSON TO CONTACT SHOULD A QUESTION ARISE REGARDING THIS MEETING

FG:yy
9/30/74

Many diseases of Western civilization have the same geographic distribution, says Dr. Burkitt, a surgeon and epidemiologist at the British Medical Research Council. He maintains the cause is decreased fiber in the diet—plus increased intake of fat, protein, and sugar and other refined carbohydrates.

ROUGHAGE IN THE DIET

Doctors explore its usefulness in preventing coronary and diverticular disease, colon cancer, and gallstones

Is insufficient vegetable fiber in the diet at the root of many so-called diseases of Western civilization—diseases that, until now, appeared to be unrelated?

The disorders in question include a broad spectrum of noninfectious conditions ranging from alimentary tract diseases such as diverticulosis, hiatus hernia, gallbladder disease, appendicitis, polyps, and colon cancer to cardiovascular conditions such as ischemic heart disease, occlusive vascular diseases, varicose veins, hemorrhoids, and deep vein thrombosis; and other conditions related to metabolism such as obesity and diabetes.

On first thought it would seem unreasonable that such a broad variety of conditions could have only one etiology—lack of dietary fiber—a prospect to be dismissed as the ravings of some food faddist. In this sophisticated age, a single agent, whether as cause or cure, is automatically suspect. Yet within the past decade or two, the role of dietary fiber—or roughage, to use the popular word—in disease has become a major topic of medical debate, not just among nutritionists but also among epidemiologists, pathologists, chemists, surgeons, gastroenterologists, and, indeed, physicians in general.

While the interest has certainly been aroused, in part, because of the missionary zeal of a few enthusiastic investigators who have developed the concept, mainly from epidemiological data, it is also due to the accumulation of clinical evidence that the lack of dietary fiber does in fact play a role in more than one of these diseases.

Clinically, dietary fiber has been shown to be an effective agent in the management of diverticular disease of the colon. There is some experimental evidence that dietary fiber plays a significant role in the prevention of cholesterol gallstones and in the control of obesity; and there is other evidence that rough-

continued

age lowers serum cholesterol with all that this may mean in occlusive and arteriosclerotic vascular disease, including ischemic heart disease.

Most exciting, and certainly in part because it comes from one of the more articulate spokesmen in today's medical world, Britain's Dr. Denis Burkitt, is the suggestion that a reduction in dietary fiber may be the cause of colon cancer, today one of the major cancers of man.

Fiber is of course the material that surrounds the cell walls of plants, providing both support and protection. But these fibers may have a variety of physiologic effects as they pass through the digestive tract, both direct or due to the action of the metabolites of the fiber.

There is really very little known about the complex interaction of dietary fiber, bile acids, and bacteria in the digestive tract. "We don't know which bacteria are adsorbed by fiber and how they are distributed in fiber," says Dr. Martin A. Eastwood of the department of clinical surgery at the Western General Hospital in Edinburgh, Scotland, speaking at a meeting at the University of Chicago last May on "Fiber Deficiency and Colonic Disorders."

Nevertheless, Dr. Eastwood thinks that fiber may perform a sieving function in the fecal stream. By using chemical tracers, he has measured the fecal flow patterns in normal persons and in patients with diverticular disease. He finds that in normal persons the solid portion of the stool is excreted more rapidly than the fluid part—that is the solid phase runs ahead of the fluid phase. But in patients with diverticular disease, the situation is reversed—the liquid phase runs ahead of the solid. Now, when bran—that is, fiber—is added to the diets of people with diverticular disease, the abnormal pattern is reversed. Thus, his study lends some support to the clinical studies that have shown that bran added to the diet of some patients with diverticular disease relieves their symptoms.

The general effects of bran on colonic activity, intestinal transit times, and stool bulk and consistency had been noted as far back as the 16th century. But probably the first modern study of the effects of a fiber-rich diet was done in the mid-1930s when two investigators noted the laxative effects of such a diet. They also noted a significant increase in stool weight of the subjects in their study when they were given whole wheat bran.

Since then a number of investigators have confirmed these findings. Just last year, for example, Edinburgh's Dr. Eastwood noted that both dry and wet stool weights were increased significantly and were considerably softer in consistency in bran-fed subjects as compared with those who were not. Dr. Eastwood came up with an interesting calculation: A man weighing 80 kg passing a daily stool of 100 gm would excrete feces equaling his total body weight every two years. But if he ate 16 gm of bran a day, he would double his daily stool weight and thus cut the fecal excretion-to-body-weight figure to 12 months.

Another effect of bran is to speed up the transit time through the alimentary canal. Studies using radiopaque pellets as markers that are eaten at the same time as the food and picked up by examination of the stool, show that individuals on high-fiber diets pass food through the gut almost three times faster than those on low-fiber diets.

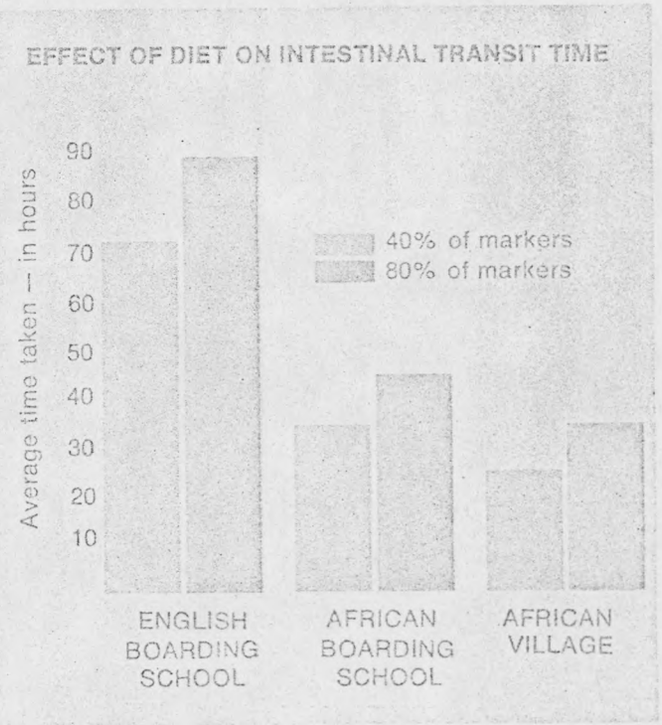
Two other effects of high-fiber diets have been identified. One involves the metabolism of bile salts, the other blood cholesterol. In prolonged transit times—a situation that prevails in the fiber-depleted diets of Western man—bacteria in the stool degrade greater quantities of bile salt. This reduction of the bile salt pool is, by one current concept, the basic abnormality involved in the genesis of gallstones that is, in turn, due to some factor inhibiting conversion of cholesterol to bile salts by the liver.

Dr. Kenneth W. Heaton of Bristol University in England postulates that the factor linking refined carbohydrates with inhibition of liver cholesterol metabolism is lithocholate, a toxic substance normally found in the feces as a product of degraded bile salt. In the liver, lithocholate is known to inhibit the conversion of cholesterol to bile salts and Dr. Heaton suggests that it may act on the liver microsomes—and one of the jobs of these microsomes is to synthesize bile salts.

Thus, the liver, rather than the gallbladder, as was pointed out in an editorial in the *New England Journal of Medicine* (July 9, 1970), may be the source of cholesterol gallstones. This is not merely a new concept but a revolutionary one, as the editorial said, and there is now considerable evidence, experimental and clinical, to support it.

While the significance of dietary fiber or its lack has mainly been thought of in connection with the elimination processes, it has become increasingly clear that dietary fiber also exercises metabolic effects; one of these is the effect of bran on blood lipid levels.

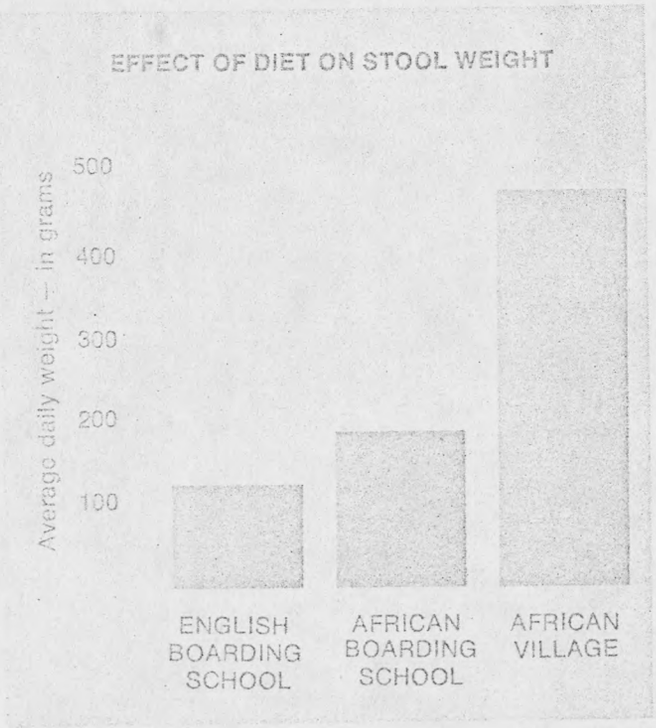
Ten years ago a clinical study by some Dutch investigators demonstrated that rolled oats had a serum choles-



terol-lowering effect. They showed that in 21 human subjects, feeding on rolled oats for seven days reduced their serum cholesterol from an average of about 250 mg% to 230 mg%. By the end of three weeks on this diet, the cholesterol fell to 223 mg%. When the subjects went back to eating ordinary bread, the serum cholesterol levels rose again, and by the end of two weeks it was virtually the same as it had been at the beginning of the study.

Other studies indicating a hypocholesterolemic effect of dietary fiber have since been done. Two of the most recent were discussed by Dr. Heaton at the Chicago conference. One, from a group at the Hammersmith Hospital in London, showed that gallstone patients fed chenodeoxycholate had a significant fall in serum triglycerides—from 118 mg% to 95 mg%. The second was by Dr. Heaton's group in Bristol who noted that plasma triglyceride levels fell significantly in 17 subjects given bran for five weeks. This was especially marked in those whose original levels of triglyceride were already above 100 mg%.

These observations, Dr. Heaton told the meeting, could be explained by the fact that plasma triglyceride levels correlate closely with the rate of synthesis of cholesterol in the liver. This is because most of the cholesterol passing through the bloodstream is carried in the triglyceride-rich pre-beta-lipoprotein which turns over much more rapidly than the cholesterol-rich beta-lipoprotein. "When chenodeoxycholate in bile is increased, as it is simply by ingesting the material, less cholesterol is secreted into the bile, and this is probably because the liver is synthesizing less cholesterol," Dr. Heaton said. Then he concluded: "If cholesterol synthesis is decreased, then the plasma level of triglycerides would be expected to fall too. This is exactly what does happen with chenodeoxycholate ingestion. Since bran has such similar effects to chenodeoxycholate, it is tempting to suggest that bran and perhaps other forms of dietary fiber act as natural regulators of cholesterol synthesis."



There is also the suggestion that fiber may play a role in controlling the level of glucose in the blood. The evidence here is based on comparisons between groups on high-fiber diets, such as rural Africans, and Europeans eating refined carbohydrates. Significantly lower values of fasting blood glucose, abnormal oral glucose tolerance curves, and serum insulin changes could be seen in those on high-fiber diets as compared with those on refined carbohydrate diets. Unfortunately, other dietary variables enter the picture and so the results are not conclusive.

As such studies as these implicating the lack of dietary fiber in the etiology of human disease were reported, they were eagerly snapped up as evidence in support of a major thesis that has its roots in epidemiological data. Most of the work along these lines, which really preceded many of the recent basic and clinical studies on dietary fiber, has come from the British.

Although the precise incidence over the years of many of these diseases in most parts of the world is not known, it is fairly well documented in some. Here are three examples, all from Great Britain:

- The death rate for ischemic heart disease in England and Wales climbed from about 250 per million in 1931 to about 2,000 per million population in 1971—40 years later;
- There has been a similar increase in deaths involving diverticular disease, although the figures are much smaller—from around five cases per million in 1931 to over 30 cases per million in 1971;
- Dr. Christopher D. Holland, a student of Dr. Heaton's at Bristol, documented the number of gallbladder operations in the Bristol area since 1933. It hovered at around 30 cases every 100,000 persons from the 1930s to the 1950s when it jumped to over 75 operations per 100,000 persons in the area.

Dr. Heaton goes on to point out that not only is gallbladder surgery increasing but the disease is beginning to affect increasing numbers of younger persons and is occurring among people in whom it was formerly very low, such as the Japanese and the Canadian Eskimos. There seems little doubt, Dr. Heaton says, that cholelithiasis is a disease that is spreading, not only in developing countries but also in Western society.

Seeking reasons for the increases in these diseases, a number of investigators have related them to a radical change in the intake of dietary fiber by the population dating from about 1850. In the past 100 years there has been a reduced consumption of fiber by the general population caused by a decrease in wheat flour consumption, a more highly refined milling of flour which today has reduced the fiber content of white bread to virtually nil, a reduction in potato consumption, and a replacement of wholemeal cereals—such as the oatmeal porridge—with ready-made breakfast cereals that are not only depleted of fiber but moreover are coated with sugar.

continued

It should be noted that, of course, a lot of other changes have taken place in the diet during the same period. But the major dietary alteration has been in a reduction of fiber. One piece of supportive evidence for the argument that dietary fiber is the culprit can be seen in the incidence of ischemic heart disease from 1930 to 1970—it decreased slightly during World War II. This was the period when the British were eating fairly high amounts of fiber in their flour in order to conserve wheat.

One of the investigators who early became impressed with the importance of dietary fiber and disease was a British naval surgeon, Capt. Thomas L. Cleave. Now living in retirement in Hampshire not far from Southampton, Dr. Cleave in his medical education and later in his travels around the world became impressed with the idea that a large number of noninfectious diseases had emerged in Western societies such as Europe and North America since the turn of the century and yet were still rare—in the 1940s at least—in underdeveloped and developing areas such as Africa.

Dr. Heaton of Bristol University in England postulates that the liver, not the gallbladder, may be the source of cholesterol gallstone because of the toxicity of lithocholate, a product of degraded bile salt.

He noted the increase in such conditions as ischemic heart disease, diabetes, peptic ulcer, and obesity and observed their historical and geographical distribution. He also noted that certain patients suffered from more than one of these diseases. This led him to the concept that a common factor might be involved in their etiology.

In a fascinating little book originally published in 1965 as *Diabetes, Coronary Thrombosis and the Saccharine Diseases* and more recently reissued as *The Saccharine Diseases*, Dr. Cleave identified the villain as refined carbohydrates, in particular sugar, and their overconsumption by Western man in combination with the removal of fiber from his diet.

In the introduction to his book, Dr. Cleave notes that since the main carbohydrate involved is sugar and since starch in white flour is converted in the body into sugar, he has made use of the term "saccharine disease." He warns that he means by saccharine "related to sugar" and that it should be pronounced to rhyme with rhine as opposed to the chemical sweetener of the same name (whose final syllable is usually pronounced rhin or rheen).

Dr. Cleave argues that overconsumption is inevitable when the diet contains highly refined carbohydrates, and that when dietary fiber is removed the problem is simply compounded. Removing fiber results not only in a low-residue diet with its potential for large-bowel disease ranging from constipation to cancer, he says, but also in a diet that is intrinsically fattening, a concept that has been taken up by Bristol's Dr. Heaton.

In an article in the *Lancet* (2:1418, '73), Dr. Heaton noted that dietary fiber provides three physiological obstacles to energy intake. First, it displaces available nutrients from the diet. Second, it requires chewing, which slows down intake especially of sugars. Chewing also limits its intake by promoting saliva and gastric juice production that distend the stomach and promote satiety. Third, fiber reduces the absorptive efficiency of the small intestine. Thus, he wrote, high-fiber diets help to control obesity, a condition that has been described as the commonest form of malnutrition in much of our society.

If one defines obesity as being more than 10% overweight, Dr. Heaton continued, then roughly half the adult population of England is obese. A Scottish study, involving students and using stricter criteria, estimated that more than 90% of these persons "carried more fat than the minimum which is probably the physiological optimum."

In addition, he continued, many people can eat extra calories without putting on weight, so the extent to which the population is overnourished is probably far higher than the figures for those who are overweight. Dr. Heaton suggests that this overnutrition may be involved in the etiology of such important diseases as diabetes, cholesterol gallstones, and coronary artery disease.

It is widely assumed that overnutrition is the result of taking an abnormally large amount of food. But perhaps, Dr.Heaton says, it is the result of taking an abnormal type of food.

The major sources of carbohydrate in today's Western diet are white flour and sucrose. Flour is very largely depleted of fiber, while sucrose is wholly stripped of it. Carbohydrates are widely regarded as fattening. Almost all weight-reducing diets restrict them. But Dr. Heaton points out that far more carbohydrates are eaten in primitive societies yet obesity among such peoples is rare. He cites the rural-living African Bantu who eats 580 gm of carbohydrates a day as compared with the Englishman's average of 220 gm of carbohydrate daily. He explains this paradox of high-carbohydrate diets without obesity by the fact that in underdeveloped societies the carbohydrate is eaten with most of its fiber intact.

Obesity was one of the starting points of another leader, Dr. Hubert C. Trowell, in the epidemiological and geographical studies involving fiber in the diet. Dr. Trow-

ell, like Dr. Burkitt with whom he is now associated at the British Medical Research Council, was a medical missionary for 30 years in Uganda. He returned home to England on his retirement and became a parson. He has since given up the church in favor of pursuing his studies on disease and the effects of diet fiber deficiency.

Some ten years after he had left Africa, he was invited to return to Uganda. The first thing that struck him when he got off the plane at Kampala was the sight of fat Africans. "Personal observation," Dr. Trowell has remarked, "can report that obesity was very rare in all East Africans in 1929 but became very common and often severe in upper socioeconomic groups in the decades from 1950 to 1970." In 1929, as he pointed out in a recent letter in the *Lancet*, "Africans ate a large amount of unprocessed carbohydrate foods, maize meal, millet meal, potatoes, plantains, and beans. No white wheat flour or white rice were eaten and very little, if any, sugar, for local production had just started."

Dr. Trowell is probably best known for the studies that led to the elucidation of the cause of the nutritional disease, kwashiorkor. He was honored with the C.B.E. (Commander of the British Empire) and there are some doctors in Britain who believe he ought to have been knighted.

Like Dr. Cleave, Dr. Trowell is the author of a stimulating book. In *Non-infective Disease in Africa*, he recounts the story of an African high court judge who had been eating a "Western" diet for a number of years. In 1956, this gentleman became a historic patient—the first clinical case of ischemic heart disease to be reported in East Africa. Pondering this and noting the rarity of ischemic heart disease as well as obesity, diabetes, and gallstones among Africans, Dr. Trowell suggested along with a South African investigator, Dr. Alexander R. P. Walker of the South African Institute for Medical Research in Johannesburg, that high consumption of dietary fiber might be the mechanism that protected Africans against these diseases.

During Dr. Trowell's more recent investigations of ischemic heart disease he has found that in urban areas serum cholesterol levels are on an average higher and ischemic heart disease is more common than it is in rural Africa. In a recent study done in association with Dr. Walker, Dr. Trowell notes that of 30 recorded cases of ischemic heart disease in Bantus seen in a single Johannesburg hospital in an 11-year period, the bulk of them were diagnosed in the two years 1971 and 1972. South African Bantus living in rural areas, he added, eat a daily average of over 24 gm of fiber. In Britain or the U.S. the figure is less than 6½ gm of fiber daily, while for Bantus living in urban areas, the intake is less than 6 gm of fiber daily.

Thus, argues Dr. Trowell, once one has established that there has been a significant change in fiber consumption and has related this to blood lipid levels and ischemic heart disease one can look for experimental evidence of the possible metabolic mechanisms involved.

In Dr. Trowell's view the mechanism is the accumulation of blood lipids from low-fiber diets that has already

continued

been noted. The case for adding fiber to the diet as a preventive of ischemic heart disease, however, is by no means proved. Indeed some investigators maintain that there is no evidence of any preventive effect. But Bristol's Dr. Heaton is not quite so skeptical.

Agreeing that the case for heart disease is the most difficult to prove, nevertheless he adds: "My personal view is that this is a disease of overnutrition and therefore refined carbohydrates are indeed the major factor."

Of all the diseases that have been associated with fiber-depleted diets, perhaps the one to receive the most popular attention has been colonic cancer. The prime expounder of this connection is Dr. Burkitt who, like Dr. Trowell, is a former medical missionary and an old Uganda hand.

It was an epidemiological investigation in the late 1950s into the malignant disease that he called African lymphoma that brought Dr. Burkitt's name into the public eye and not so incidentally managed to give cancer virologists a tremendous shot in the arm. And, 15 years later, in his latest crusade, it is epidemiology that has again provided him with the means to push open another door.

The argument is familiar and now widely reported (MWN, Jan. 29, '71, p. 14; Aug. 11, '72, p. 33). In essence it runs like this: Colon cancer is one of the diseases of Western civilization. Diverticular disease, heart disease, gallstones, polyps, hiatus hernia, colon cancer—all have the same geographical distribution. Where these diseases occur there is increased fat, protein, sugar, and other refined carbohydrates in the diet. Along with this there is a tremendous decrease in the amount of fiber in the diet.

In rural Africa, colon cancer is virtually unknown. In Western countries it is the commonest malignancy after lung cancer. There is an increase in appendicitis which always precedes by several decades an increase in large-bowel tumors.

With high-fiber diets, there is a shortened transit time. With low-fiber diets there are increased numbers of anaerobic bacteria in the stools. These bacteria degrade bile salts and the results are toxic. These toxic products, which Dr. Burkitt sees as carcinogenic when combined with slow fecal transit times and small feces, are thus held in the bowel for a prolonged period and in a more concentrated form than they would be if the stools were large and bulky. Thus the colonic mucosa is exposed to a higher concentration of toxic agents for a longer period of time when the diet lacks fiber. The argument is presented with flair and showmanship. The chairman of one session at which Dr. Burkitt spoke, commented: "The man's a treat."

Dr. Burkitt came to the Chicago meeting on colonic disorders to retell his story. As he expected, he stimulated a lively discussion. Dr. Albert I. Mendeloff of Sinai Hospital in Baltimore, for example, argued that appendicitis in the U.S. had decreased by 40% in the past 20 years. Also, he noted that although the incidence of colon cancer was high, it seemed to be holding steady rather than going up. He also pointed out that American Indians, who eat large amounts of fiber, had just about the same frequency of colon cancer as whites who eat small amounts.

Other speakers, commenting on the concept of prolonged exposure of the bowel mucosa to carcinogens by delayed transit times, noted that increasingly colon cancer was occurring above the sigmoid and descending colon and was affecting the right and transverse colon, an area that was higher in the gut than where the stasis is presumed to occur. Another speaker noted that there is a high incidence of colon cancer among Argentinians who eat a lot of fiber as well as a lot of beef.

Harvard's Dr. D. Mark Hegsted noted that the problem with epidemiological evidence is that changes in dietary practice tend to be the same wherever they occur. No matter where these changes take place—in the U.S. or in Japan or in Africa—there is an increased consumption of animal products, fat, sugar, and refined cereals and all of these happen at the same time. Obviously when alterations occur in two or more variables like this the epidemiological data cannot prove that either one or the other or several are causally related to the disease. They can't be separated out.

Dr. Painter, a London surgeon, originated the use of high-residue diets—especially unprocessed bran—to cure patients with diverticular disease. His clinical results have been confirmed recently in U.S.

Dr. Burkitt disagreed that the American Indian diet was high in fiber but he agreed that epidemiology did not provide definitive answers and that there must be multiple factors, including genetics, involved in the causes of colon cancer. He added that the effect of a low-fiber diet did not occur overnight; rather it took place over a lifetime of perhaps 30 to 40 years, so taking current diet histories of patients with colon cancer may not be very meaningful.

From the viewpoint of the practical clinician, the use of dietary roughage as specific treatment has been definitely proved in only two conditions. One is the relief of constipation; the other is in the management of diverticular disease (not diverticulitis). There is now firm clinical evidence that a high-residue, low-sugar diet including

continued

unprocessed bran relieves the symptoms of this latter condition, restores the bowel habit towards normal, and gives relief from the abdominal discomfort.

It has also been shown that giving bran to such patients avoids the need for surgery. And a recent study from Edinburgh, Scotland, has found that, among patients with diverticular disease who do come to surgery, those who receive bran postoperatively stood a significantly better chance of not relapsing (MWN, June 21, p. 26).

The idea of using high-residue diets in diverticular disease originated with a London surgeon, Dr. Neil S. Painter of the Manor House Hospital in Golders Green. Dr. Painter noted the increase in diverticular disease over the first half of this century: "It was a curiosity at the turn of the century. Then it became a clinical problem and has since increased in incidence to become the commonest affliction of the colon in Western nations," he wrote in his clinical report of the use of bran in diverticular disease (*Br Med J*, 2:137, '72)). He maintains that the disease is caused by a reduction in the amount of fiber in the diet

Dr. Kritchevsky of Philadelphia's Wistar Institute is controlling the types of roughage in a standard diet in order to measure changes in serum lipids and thus pinpoint the effect of fiber on cholesterol.

owing to the increased use of refined dietary carbohydrates, a process that takes about 40 years, he says.

This deficiency in dietary fiber alters the consistency of the fecal stream so that the sigmoid has to segment more vigorously to propel viscous feces. This generates high pressures in the colon that result in the herniation of the colonic mucosa.

Dr. Painter did intraluminal pressure studies in the colon that showed that when the lumen is narrowed, bladder-like formations occur along the colon. Within these "little bladders" high pressures can develop and it is this pressure, he believes, that causes the mucous membrane to extrude between the contracting rings of the colon and that makes up the typical pathologic picture of diverticular disease.

After eliminating other diseases and being particularly careful to check for the presence of cancer, Dr. Painter and his associates embarked on a long-term study giving bran to patients with diverticular disease. The amount of bran needed to prevent straining while defecating is adjusted to each patient. On average about two teaspoons three times a day resulted in soft stools and easy defecation. In addition, Dr. Painter put his patients on a high-residue diet, including porridge, whole meal bread, and fruit, and instructed them to cut down on refined sugar.

Unprocessed millers' bran is difficult to eat dry—it tastes a bit like sawdust—so most of the patients took it sprinkled on cereal, with milk or water, or in soup. Bran can cause flatulence, Dr. Painter warns, but this usually disappears within three weeks of starting the bran.

By the end of his study, Dr. Painter noted that his patients no longer strained to defecate. Their bowels became regular and their stools large and soft where previously they had been small and hard. The use of laxatives among the patients fell off dramatically.

In general the findings suggest that the widely held view that roughage irritates the gut is not founded on fact; indeed roughage when moist becomes "softage."

Dr. Painter's results have very recently been confirmed in the U.S. by Dr. Joseph L. Piepmeyer, a medical officer in the U.S. Naval Reserve stationed at Beaufort (N.C.) Naval Hospital. In a study of 30 patients with irritable bowel syndrome given eight to ten teaspoons of bran a day for three weeks, 23 reported improvement in their symptoms. Only three patients said they had not improved and four patients dropped out because they found the bran unpalatable. However, Dr. Piepmeyer cautions against the use of bran in patients with chronic renal disease because of its high phosphorus content.

Even with clinical results such as these, it is certain that factors other than dietary fiber are at work, for besides the reduction in consumption of fiber there are such things as excessive consumption of refined carbohydrates, animal fats, cigarettes, and alcohol, and insufficient physical exercises, just to list a few. Further, if one eats fiber, it may displace other items that would be eaten in its place.

The final word on the subject is perhaps best spoken by Dr. David Kritchevsky of the Wistar Institute in Philadelphia, who has spent many years studying the effects of nutritional factors on disease. "It may very well be that dietary roughage plays an important role in these diseases," he told MWN. "The trouble is that people like Drs. Trowell and Burkitt oversell the product. There's no question that it's important and it may be that it will turn out to be one of the most important factors in the control of cholesterol but it still interacts with everything else.

"What we are doing now," he says, "is to control the types of roughage in a standard diet and measure the slight changes in such factors as serum lipids when the types of fiber are altered. Very few people have done this. We hope that it will really pinpoint the effect of fiber on cholesterol. This work is now in progress. The rabbits are eating even as you and I speak." ■

EXHIBIT A

MINUTES

NUTRITION COMMITTEE

St. Louis Heart Association
St. Louis, Missouri

May 17, 1974
8:00 A.M. - 3:00 P.M.

PRESENT:

Members: Robert Shank, M.D., Chairman; Margaret Albrink, M.D.; Edwin Bierman, M.D.; David Coursin, M.D.; Ms. Ruthe Eshleman; James Iacono, Ph.D.; John Mueller, M.D.; Harold Sandstead, M.D.; Ms. Virginia Stucky.

Staff: Ezra Lamdin, M.D.; Ms. Mary Winston

Guests: Gaetano Bazzano, M.D.; Ruth Brennan, Sc.D.; Jerome Cohen, M.D.; Stephen Crespin, M.D.; Ms. Virginia Goldberg; Mr. Carl Marxer; Ms. Suzanne Switzer.

ABSENT:

Members: Fred Hatch, M.D.; Mary Jane Jesse, M.D.; Mary McCann, M.D.

Recorder: Ms. Sharon Borakove

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Action Items

1. That the Subcommittee of Dietitians and Nutritionists be charged with developing guidelines for preparing fat controlled menus for the NRA project.

2. That the Nutrition Committee write a letter to Dr. Hurley suggesting that the Nutrition Committee become a sustaining member of the Society for Nutrition Education at the rate of approximately $250.00 per year.

3. That copies of the AHA Weekly Report be sent to all the members of the Nutrition Committee when it contains information related to nutrition.

4. That publications containing other nutrition-related legislation be sent to the entire Nutrition Committee.

5. That the Nutrition Committee charge be revised, (with particular attention to strengthening statement number 1) and circulated to the Committee members for review and criticism.

6. That "Calcium, Minerals, and Fiber" should be discussed at our next Nutrition Committee meeting, and should appear on the agenda.

7. That a letter be written to Dr. Hurley requesting permission to publish a one page mimeographed nutrition letter tentatively called CIN - Communicator in Nutrition.

8. That Ruthe Eshleman, as Editor of CIN, should initiate work on this new publication as soon as possible.

9. That Dr. Shank contact Robert Harkins and Will Bartner of the National Grocers Association conveying to them the Nutrition Committee's concern that standard methodology for food analysis be established.

10. That another letter be written to Dr. Robert Levy at the National Heart and Lung Institute supporting his proposal that USDA provide more extensive analysis of food items.

11. That Mr. Dolph Chianchiano be kept informed about proposed legislation concerning food analysis.

12. That members of the Nutrition Committee submit their criticisms and comments on "Save Food Dollars and Help Your Heart" to Mary Winston within 3 weeks from the date of this meeting (June 7, 1974).

13. That Fred Mattson, and Norton Spritz may be contacted relative to the recent report on trans fatty acids in margarine.

14. That Dr. Fred Kummerow's paper be called to the attention of Dr. Kenneth Lane before the committee reviews abstracts of scientific papers for the AHA Annual Meeting.

15. That the Nutrition Committee or Dr. Shank prepare a written statement regarding Dr. Fred Kummerow's paper.

16. That a quick and practical mechanism be established whereby the Nutrition Committee members can reply to current issues or news releases related to Nutrition.

17. That copies of papers related to Dr. Oster's theory on xanthene oxidase be distributed to Dr. Shank and Ruthe Eshleman.

18. That Drs. Albrink and Bierman send their comments on "Nutritional Therapy in Acute Myocardial Infarction" to Dr. Shank.

19. That Dr. Schroeder's modified regular diet plan for hospitals be sent to the Subcommittee of Dietitians and Nutritionists for review and also to Dr. Shank, Ms. Eshleman, Dr. Mueller, Mrs. Stucky and Dr. Bazzano.

20. That a memo be written requesting the members of the Nutrition Committee to submit suggestions for the 1975 AHA Annual Meeting.

21. That suggestions for the Science Writer's Forum 1975 be submitted to Mary Winston, who will transmit them to Ben Patrusky.

22. That names of proposed Nutrition Committee members for 1974-75 be submitted to Mary Winston as soon as possible.

DISCUSSION

Dr. Shank, the Chairman, opened the meeting at 8:25 A.M. and proceeded to welcome the contingent of invited guests from St. Louis.

Review of Previous Minutes

The minutes of the October 12, 1973 meeting were reviewed, and the following corrections were made:

Page 8 - paragraph #3 - delete "AMA and change "Food and Nutrition Board" - line 4 to "National Board of Medical Examiners".

Page 5 - second paragraph from bottom of page, line 4 - change "30 per cent increase" to "a relatively large increase".

IT WAS MOVED, SECONDED, AND CARRIED THAT the minutes of the October 12, 1973 meeting of the Nutrition Committee be approved.

Report of the Subcommittee of Dietitians and Nutritionists

Virginia Stucky reported on the work of the Subcommittee.

1) Work is progressing on the "Guidelines for Nutrition Programming in the Community."

2) Nutrition/Cardiovascular Reviews 1970-1971, and 1972 has not sold well. Surpluses of both issues remain in the AHA warehouse. Mary Winston has made several attempts to distribute the remaining copies including writing to the Presidents of the State Dietetic Associations and the Society for Nutrition Education informing them of AHA's willingness to sell copies of Nutrition/Cardiovascular Reviews in bulk quantities. The 1973 issue is now in process and will be held in abeyance until a final decision as to its status has been reached.

The advisability of contacting the Society for Nutrition Education requesting them to work with the Subcommittee on writing future issues of the annotated bibliography was discussed.

3) A new working group of the Subcommittee has been formed, charged with the development of two AHA diet pamphlets on the fat-controlled diet:

a) One basic publication which could also be modified for calorie restriction

b) One publication for the professional (nutritionists and physicians) on the rationale of the fat-controlled diet.

4) The National Restaurant Association has agreed to assist the Subcommittee in the following ways:

a) By providing NRA consultants to work with the Subcommittee in developing guidelines for implementing fat and calorically controlled menus in restaurants.

b) By promoting any literature produced by AHA which is related to the project.

c) By sponsoring workshops concerned with this project.

d) Letters were sent to numerous hospital dietitians requesting tested quantity recipes which have been computer analyzed for nutrient content. In addition, the Subcommittee plans to include cards outlining instructions for restaurant personnel (cooks and waitresses) in preparing and serving low-calorie and fat-modified meals. To date, the responses received have been negative indicating that the hospital dietitians do not have the quantity recipes to give us.

e) Virginia Stucky suggested that the quest for recipe cards be dropped and, instead, guidelines for preparing menus be developed.

Dr. Iacono commented on the current poor nutritional quality of foods served in the fast food chains proliferating around the country.

Dr. Albrink questioned whether or not the fat-controlled menus featured in a restaurant can bear the words "endorsed by the AHA." This statement would appear to be in conflict with the AHA policy of non-endorsement.

It was agreed that the Subcommittee should be charged with developing guidelines for preparing fat-controlled menus for the NRA project.

5) The Society for Nutrition Education is seeking sustaining members. The Subcommittee recommended that the Nutrition Committee become a sustaining member of the Society of Nutrition Education at the current rate of approximately $250.00 a year.

Ruthe Eshleman stated that almost all of the Society's current support comes from private industry. Industry's role in the Society should be minimized.

When the Society was originally organized, AHA contributed funds to its establishment.

IT WAS MOVED, SECONDED, AND CARRIED THAT the Nutrition Committee write a letter to Dr. Hurley suggesting that the Nutrition Committee become a sustaining member of the Society for Nutrition Education at the approximate rate of $250.00 per year.

Nutrition Committee Structure

Dr. Shank reported on the new committee structure. The Nutrition Committee is a Committee of the Central Committee which is the parent Committee for the 14 scientific councils and various other committees. Dr. Lamdin further stated that the Central Committee is the most important medical and program activity group in the AHA.

It was agreed that the new charge for the Nutrition Committee should be written. The following revisions of the charge were presented:

1. Composition - delete "5" before members -- should be strengthened to reflect our responsibility to initiate action.

2. "To act as advisors and resource persons to the officers, staff, Scientific Councils and Research Committee and other Committees of AHA as well as in the Affiliates in matters related to Nutrition and Cardiovascular Disease."

3. "To act as advisors and resource persons to the working group on Public Policy and Government Affairs in those matters related to nutrition and cardiovascular disease and legislation and federal regulations."

4. Change "other regulatory" to "scientific."

5. "To engage in programs on professional education in nutrition and CVD and to disseminate information for the public.

   After the charge is written, copies will be distributed to the Committee membership.

In regard to legislative matters, the Committee felt that a communication mechanism is urgently needed to keep the members of the Nutrition Committee informed. Dr. Bierman suggested that twice a year a summary of legislative findings in the area of Nutrition be prepared.

It was agreed that copies of the AHA Weekly Report be sent to all the members of the Nutrition Committee when it contains a section on nutrition related information. It was also agreed that other publications containing nutrition-related legislation be sent to the Committee.

Dr. Lamdin urged that the Nutrition Committee be informed about the AMA Newsletter and other publications that focus on legislative activities.

Nutrition in the Young (Working Group)

An ad hoc committee on Nutrition in the Young has recently been formed. Dr. Coursin is the appointed Chairman, and the members are as follows:

Dr. Charles Glueck
Dr. Henry McGill
Dr. Mary Jane Jesse
Dr. Sheila Mitchell
Dr. Robert Shank

Dr. Coursin reported that there are 2 main areas of concern:

1. Nutrition education materials for teenagers with hyperlipidemia.

2. An AHA position paper on Nutrition in the Young as it relates to cardiovascular disease.

A lengthy discussion then ensued as to the extent of the pediatric population we should address ourselves to.

Special Reports

Liaison to Council on Arteriosclerosis -- Subcommittee on "Guidelines for Hyperlipidemia."

Dr. Albrink attended the November 7, 1973 and April 20, 1974 meetings of the Council on Arteriosclerosis. Dr. Albrink referred to Dr. Donald Fredrickson's outline on the four (4) main functions of the Council on Arteriosclerosis.

Dr. Albrink has also attended the Ad Hoc Committee on Recommendations for the Treatment of Hyperlipidemia, February 22, 1974, of which Dr. Eder is Chairman.

The following are comments on the draft (Exhibit E) presented by the Ad Hoc Committee. The following points should be considered in any screening program:

1. Preparation of the community
2. Development of local clinics, for patients who are identified as being at risk.
3. Physician education
4. Informing local medical community
5. Measurement of serum lipids
6. Decision must be made in regard to how much the local medical facilities can handle.

Dietary Treatment Recommended

1. Hypertriglyceridemia can be treated by focusing on weight loss (see page 3 - Exhibit E)
2. Low ~~polyun~~saturated diet for hypercholesterolemia

The Nutrition Committee offered Dr. Albrink several suggestions to transmit to the Council. They asked that she express their willingness to assist in this project in anyway she sees fit.

It was agreed that the topics of "Calcium, Minerals and Fiber" should be listed on the next agenda for the Nutrition Committee Meeting.

NRC-AHA Committee on Sodium Restricted Diets

Dr. Sandstead reported that the above-named Committee has not met recently. He will report on its progress at the next meeting.

Liaison to the American Diabetes Association

Dr. Albrink reported that the American Diabetes Association Nutrition Committee has not yet met, however, a meeting is scheduled for June, 1974. The intention of the ADA is that it become a working group comprised of nutritionists and physicians who will modify the diabetic diets in terms of fat content.

NUTRAH

Ruthe Eshleman, the Editor of NUTRAH, reported that the publication is currently at a standstill. The original purpose of NUTRAH was to function as a communicator between dietitians and nutritionists working in the area of heart disease. At the March 29, 1974 meeting of the Subcommittee of Dietitians and Nutritionists it was recommended that a one page bi-monthly letter be developed. One of the most important objectives of this communicator will be to assist nutritionists in sharing program plans, and in alerting them to important nutrition publications and scientific studies.

a) This letter would be edited by an appointed editor.

b) Produced on a bi-monthly basis.

c) About 1-5 pages in length.

d) Distribution would be approximately 100 copies to AHA Nutritionists, Subcommittee Members, MRFIT and SCORE Centers and LRC Personnel.

It was agreed that a letter be written to Dr. Hurley requesting permission to publish a one page mimeographed nutrition letter (CIN.) It was also agreed that Ruthe Eshleman, as Editor of CIN, should initiate work on this new publication as soon as possible.

Liaison with AMA Council on Foods and Nutrition

Dr. Shank reported that one of the objectives of the AMA Council on Foods and Nutrition, and the Nutrition Committee of AHA, is to work jointly on recommendations for standardizing data for the Food Data Bank.

The Consortium of Nutrition Societies has set up 2 panels dealing with nutrient labeling:

1. Meaning of nutrient labeling and how it is to be used.

2. Kinds of information on the label and how it can be used in planning the total diet.

It is the intent of the consortium that this information be used by other groups to get nutrient information to the public.

Once the guidelines are developed it may be appropriate to appoint a working group of the Nutrition Committee to determine the most effective use of them by AHA.

It was noted that as soon as the materials become available from the Nutrition Consortium, copies will be distributed to the members of the Nutrition Committee.

Work on National Data Bank is progressing very slowly.

It was noted that Dr. Shank should contact Robert Harkins of the National Grocers Association and Will Bartner and convey to them the Nutrition Committee's concern that standard methodology for analyzing foods be established. This is imperative if the data is to be meaningful.

It was agreed that a letter should be written to Dr. Robert Levy at the National Heart and Lung Institutes expressing our interest in this proposal that the USDA provide more extensive analysis of food items.

It was agreed that Dolph Chianchiano should be informed that there is money ($350,000.00) in the Office of Management and Budget earmarked for food analysis. A bill has been prepared supporting this expenditure. It is in the President's Office and will be sent to the House of Representatives for a vote.

Pamphlet - Food Cost

Mary Winston reported that the copy enclosed in the agenda booklet (Exhibit G) represents the 3rd editing.

It was agreed that the members of the Nutrition Committee should submit their criticisms and comments on "Save Food Dollars and Help Your Heart" to Mary Winston no later than 3 weeks from the date of this meeting (June 7, 1974).

Trans Fatty Acids

Dr. Iacono reported on Dr. Fred Kummerow's paper entitled "Swine as an Animal Model in Studies on Atherosclerosis - Influence of Various Dietary Sources of PUFA and of Cholesterol on Early Dietary Management."

Dr. Oster's Milk Hypothesis

Dr. Kurt Oster, a pathologist and Chief of Cardiology at Park City Hospital, Bridgeport, Connecticut asserts that consumption of homogenized milk may be the culprit of our high cardiac death rate in the U.S. and Finland.

However, currently there is no available scientific data to support Dr. Oster's hypothesis.

It was agreed that the Nutrition Committee must establish a quick and practical mechanism whereby the members can reply to current nutrition issues as they appear in the press.

Copies of Dr. Oster's papers on the theory of xanthene oxidase will be sent to Dr. Shank, and Ruthe Eshleman.

Nutritional Therapy in Acute Myocardial Infarction

It was agreed that Drs. Albrink and Bierman send their comments on the above named paper to Dr. Shank.

Dr. Schroeder's Diet Plan for Hospitals

Dr. John Schroeder at Stanford University Medical Center, Stanford, California has developed a modified fat regular diet plan for hospitalized patients. This program represents a vital means of getting medical nutrition information to the patient in the hospital.

Dr. Schroeder has requested the support of AHA (see letter to Dr. Ross of March 15, 1974) for his diet program.

The Nutrition Committee responded that the general hospital may very well be a good place to institute changes in a person's diet. Perhaps the hospital employee cafeteria would be an even more ideal place to institute change.

There may be a problem in implementation of these diets in hospitals; fat-modified foods tend to be higher priced than some energy-rich foods.

It was agreed that Dr. Schroeder's modified regular diet plan for hospitals be referred to the Subcommittee of Dietitians and Nutritionists for review and also to Drs. Shank, Mueller, Bazzano, and Ms. Eshleman and Ms. Stucky. The Nutrition Committee agreed that this diet plan should be included in the agenda for the next Subcommittee meeting.

AHA Annual Meeting - 1975

Nutrition Committee members were urged to submit suggestions for the AHA program for its 1975 meeting.

Other Business

It was agreed that suggestions for the Science Writers' Forum 1975 be submitted to Mary Winston who will transmit them to Ben Patrusky.

It was agreed that names of proposed Nutrition Committee members for 1974-75 be submitted to Mary Winston as soon as possible.

Next Nutrition Committee Meeting Date

October 17 and 18th were selected as the dates for the next Nutrition Committee Meeting. Dr. Shank adjourned the meeting at 3:15 P.M.

SB:lm
7/17/74

Nutrition Committee

October 16 & ½ day October 17, 1974
October 16 - 9:00 - 5:00 P.M.
October 17 - 8:30 - 1:00 P.M.

Oct. 16 - Suite A
Oct. 17 - Suite S
Biltmore Hotel
New York, New York

1.	Review of Nutrition Committee Minutes	Dr. Shank	Exhibit A
	Review of Action Items	Dr. Shank	
2.	Report of Subcommittee of Dietitians and Nutritionists	Virginia Stucky	Exhibit B
3.	Report of the Program Committee	Mary Winston	Exhibit C
4.	Special Reports:		
	a) ad hoc Committee on Nutrition in the Young	Dr. Coursin	Exhibit D
	b) Council on Arteriosclerosis	Dr. Albrink	
	c) Cardiovascular Disease in the Young (Nutrition Education Materials for Teenagers)	Dr. Jesse	
	d) National Research Council-Sodium Restricted Diets	Dr. Sandstead	
	e) American Diabetes Association	Dr. Albrink	
	f) Liaison with the AMA and National Grocers Association	Dr. Shank	
	g) AHA Cookbook	Ruthe Eshleman	
	h) Report of the Behavioral Science Conference	Dr. Shank	
5.	New Business:		
	a) Mechanism for Responding to Nutrition Related Items in News Media	Dr. Shank	Exhibit E
	b) Relationship of Calcium, Other Minerals ~~and Fiber~~ to Heart Disease	Dr. Sandstead	
	c) Materials distribution - publications, computer based.		
6.	Other Business	Dr. Shank	
7.	Meeting Date	Dr. Shank	

not available yet

Nutr. Consortium

Fiber, Trans fatty acids, ~~trace minerals~~. | Tony Gotto - Dick Havel

SB:jt

One page paper for Risk Reduction, Harris re glucose + uric acid

Report of Task Force
on
Sodium Restricted Diets

A need exists for standardized nomenclature; quantitative nomenclature is very desirable. Medical staff approval of the nomenclature would eliminate the use of vague terms such as "low sodium diet" and patient education would be simplified by standardized nomenclature.

Preferred terminology for sodium is "milligrams or grams" not "milliequivalents." The following diets, standardized by the American Heart Association are considered necessary:

~~1. 200-250 milligrams sodium~~ *

2. 500 milligrams (meq) sodium

3. 1000 milligrams sodium

4. 2-4 grams sodium

When sodium restriction and other dietary limitations are prescribed, the physician should consult with the dietitian.

In practice, sodium restriction is being superceded by the use of diuretics. Sufficient information is not available to determine whether sodium restriction is desirable in the treatment of most hypertensives on diuretics. Current medical practices are not known in this regard.

* (meq. in brackets)

* achieved by modification 2 500 mg Na in unusual situations as needed as in chronic renal failure, hepatic failure, etc

Recommendations on desirable sodium intake for hospital patients who do not require restrictions cannot be made until evaluations and/or surveys are initiated to obtain the following information:

A. Non-Hospitalized

1. The sodium intake for a person with no restrictions, preferably with a regional and ethnic breakdown.

2. The actual sodium intake of patients with restrictions.

B. Hospitalized

1. Sodium intake of persons without dietary restrictions, preferably with regional and ethnic breakdown, as well as percentage of sodium intake derived from convenience foods. The necessity for any degree of sodium restriction depends on the actual sodium intake of the hospitalized individual. Presently, there is inadequate information on which to base decisions. It is important to know how the Raw-to-Ready Scale affects sodium intake. One estimate suggests that a person on a R/R Scale of 8 would receive 23 grams of sodium chloride/day.

raw to ready

define

2. Analysis of actual sodium content of foods served on restricted sodium diets from a number of representative hospitals is necessary. Although food composition tables are available, it is often difficult to determine if the foods *per se* are within reasonable tolerance of the figures in the tables.

One method to determine the result of the physician's order and the hospital's adherence to sodium restriction is to study the 24 hour sodium excretion of patients on 70 milliequivalent sodium diets preparatory to plasma renin determination.

Because many patients are on diuretics, which frequently produce profound potassium depletion, there is a need for diets which would provide 4 to 4.5 grams potassium daily. This often would be in conjunction with sodium restriction. Drug replacement of potassium is expensive and unpalatable; thus, more palatable diets need to be devised and supplied. High potassium and low sodium foods should be starred or separately listed in sodium restricted diets.

The development of a wide variety of convenience foods that would provide a 1 gram sodium diet/day is needed. Figures for allowable milligrams of sodium in entrees for hospitals using tray-packs and other supplemental foods must

be provided. There is some apprehension concerning the adequacy of the diet of persons receiving pre-plates for an extended period of time. Once convenience foods are more palatable, hospitals will provide a large and growing market for sodium restricted diets. It is estimated that 20% of hospitalized patients will consume some convenience foods.

"Elemental" and/or tube feeding diets containing 500 milligrams sodium or less per day are needed. There is a ready market for the Spice Industry to increase the sale of herbs and spices that would enhance the palatability of sodium restricted diets if information disseminate on its usage with special attention to amounts needed.

Spices, packaged in individual containers that could be placed on patients trays, might be widely used in hospitals.

Information needed from the industry includes:

1. The sodium content of convenience foods.
2. If as suspected, it is quite high, is this because of: consumer demand; sodium as a preservative; sodium as a part of preservatives.

Miscellaneous Diets

A 200 mg calcium diet is indicated for the treatment of some renal stone patients. There is a trend in the American diet to increase phosphorus and lower calcium which may well result in osteoporosis later in life. It was agreed that the low iodine

diet could be eliminated and the low phosphorus diet was questioned as to being really "low". (There is very limited use for the 200 mg. sodium diet, primarily in cases of severe renal failure.)

The above report carries the implication for extensive dietary counseling and consultation with physicians. Problems identified that stand in the way of realizing these goals are:

1. The lack of interaction between the medical staff and dietary department.
2. The frequency with which the dietary department is used as the most convenient place to cut costs.
3. Since third party intermediaries will not pay for identified dietary consultation, dietary departments' ability to respond to these needs will always be limited.

Herbert Langford, M.D. - Chairman

Corinne Montandon, R.D. - Reporter

Program Committee
Membership List 1973-1974

Staff Representative:
Mrs. Mary Winston

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sdb
7/18/74

Report of Task Force
on
Fat Modified Diets

Fat Modified diets were discussed in respect to importance, frequency of use, and benefit to a basic diet manual of wide-spread applicability. There was general agreement that basically two types of diets are needed and that the names for these two diets should be descriptive and not related to previous names; they should be called Fat Restricted and Fat Controlled Diets. — change

Fat Restricted Diets would consist of 30-45 grams fat/day with the option of cholesterol restriction to 100-200 mg/day. The level of cholesterol could be stipulated when necessary.

Fat Controlled Diets would be similar to those suggested by the American Heart Association, American Medical Association, and the National Academy of Sciences. These diets are used in the Multiple Risk Factor Intervention Trials which were recently initiated and are consonant with the Prudent Diet which was instituted by Joliffe. The daily diet would consist of 65-80 grams fat; a limit of 200-300 mg cholesterol; and a polyunsaturated-saturated fatty acid-~~triglyceride~~ ratio in ~~triglycerides~~ fats greater than one to one.

35-40 gm Fat / 1,000 cal.

33-40 gm /

Indications for the Fat Restricted Diet might include gall bladder disease, pancreatitis and fat malabsorption. The diet could also be applicable to patients with hyperlipemia of the Types I and V (a correlation to exogenous triglycerides) and perhaps to patients with hereditary SEVERE hypercholesteremia Type IIa who have not responded to the more liberal Fat Controlled Diet.

Fat Controlled Diets would generally be used for the treatment of hypercholesteremia - LIPIDEMIA regardless of the Type Types II, III, IV, and V - especially in the latter two, if carbohydrate and alcohol were also limited in the diet. Fat Controlled Diets are compatable with other major these dietary restrictions, especially the carbo- colonically hydrate restricted diet. They could be useful in weight reduction diets where calorie restriction is important. These diets are not incompatible with a liquid diet or a mechanically soft diet, or with most religious dietary restrictions. Difficulty might arise in adopting ADAPTING fat-controlled to a low protein diet or bland diets. The only real incompatability exists with the ketogenic diet.

Fat Controlled Diets might also be considered as general diets if an institution followed the "prudent diet" plan of Joliffe. If used as a general diet, efforts should be made to make this a gourmet diet; in other words, more attention should be paid to the amenities of the diet than is often the case. Fat Controlled diets should be available to those institutions that might wish to pursue its broad use.

There was general agreement that the fat content should be stated as grams/day allowed rather than as % of calories. This would facilitate the use of these diets by patients and would simplify calculations by nutritionists. This also coincides with the new labelling regulations of the FDA which will require the gram allowance of fats in packaged materials.

Miscellaneous diets were categorized into three categories: those that are both frequently used and medically important; those that are important but infrequently used; and those used infrequently and of dubious importance. ~~Low~~ Calorie RESTRICTED diets and low protein diets were categorized as important and frequently used. Gluten restricted; lactose restricted; egg, wheat, milk free diets; diets for reactive hypoglycemia; and children's diets are important but infrequently used. All other diets under the miscellaneous list were considered to be infrequently used and of dubious importance.

It was agreed that reducing the number of therapeutic diets would have merit and would reduce the confusion in the minds of patients, doctors, and nutritionists. Multiple pieces of equipment used infrequently could be eliminated making the use of space and personnel more economical in the long run. Difficulty lies in the compromising of flexibility in meeting the unusual patient's needs. However, it was felt that this was not an insurmountable problem for most institutions.

The present multiplicity of diets allows for a greater possibility of error in fulfilling diet orders. A reduction in the number of special diets would better ensure that the patient received the proper diet. The physician and nutritionist would also have a more accurate method of ascertaining what the patient was receiving.

It was agreed that the use of ready made foods gives rise to a decrease in the space requirements and personnel cost of hospitals. The preparation area could be reduced, but the distribution area and service functions would probably require maintainance at the previous level. Distribution would be affected in the many divisions of the hospital decreasing control at the kitchen level. Loss of supervisory control over diets reaching the individual patient might result. Taking all things into account, the advantages probably outweighed this disadvantage in the use of ready made foods.

The physician's role is to specify the modified diet. Ideally, as therapeutic staff qualifications and medical attitudes permit, physicians will prescribe modified diets in consultation with the therapeutic dietetic staff. The dietitian should assume the responsibility for implementing the modified diet and training the patient for independent diet maintenance at home.

Richard Jones, M.D. - Chairman

Jerry Moore, Ph.D. - Reporter

Heart
Association

Dr. Shank

Memorandum

TO: Members of the Nutrition Committee 24 Sept 74

FROM: Robert Shank, M.D.
Chairman Robert Shank/ddb

SUBJECT: Health Care Feeding and Dietary Practices

The attached letter from Dr. Philip White is self-explanatory in regard to what he is asking us to do.

I will appreciate it if each of you will review the reports carefully and be prepared to discuss their contents at our meeting in October.

RS/ft/M2
Attachments: Dr. White's letter of Sept. 13, 1974
Report of Task Force on Fat-Modified Diets
Report of Task Force on Sodium Restricted Diets

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 751-6000 • TWX 910-221-0300

DIVISION OF
SCIENTIFIC ACTIVITIES

DEPARTMENT OF
FOODS AND NUTRITION

PHILIP L. WHITE, Sc.D.,
Director

September 13, 1974

William Moore
Executive Vice President
American Heart Association
44 East 23rd Street
New York, NY 10010

Dear Mr. Moore:

We need your help to modernize therapeutic dietary management of patients on fat modified and sodium restricted diets. The AMA's Council on Foods and Nutrition has undertaken a project entitled, HEALTH CARE FEEDING AND DIETARY PRACTICES. The objectives of the project are: (1) to try to determine if the number of therapeutic diets appearing in diet manuals can be reduced to a minimum and (2) to determine whether convenience foods are becoming more prevalent in hospital food service, and if so, how will this effect the therapeutic dietary management of patients.

Initial investigation and research has been completed. However, to implement new guidelines for improving the nutritional care of patients, support and input is needed from specialty organizations in the medical field.

Enclosed you will find summary reports on fat modified and sodium restricted diets which resulted from a resource conference held in April of 1974. The conference participants reviewed a survey of food service management and dietetic practices of 12 hospitals. The survey was conducted by our department. Current concepts of therapeutic dietary management were reviewed by four task forces. The task forces were assigned to one of the four diet categories: sodium restricted, fat modified, diets for gastrointestinal disorders, and diabetic diets. Miscellaneous diets were reviewed in all the task forces. Task force summary reports were submitted at the conclusion of the conference. Suggestions were made for simplifying specific diets, standardizing dietary concepts, and gaining support to implement dietetic guidelines on a national basis.

We are asking your organization to review the enclosed report and return it by November 15, 1974. Any data which would support or negate contents of the report, editorial comments, and endorsement for the need and value of our efforts will be appreciated. If your organization is not able to review the material we would be grateful if the material could be returned to us.

Thank you and we look forward to hearing from you in the near future.

Sincerely,

Philip L. White

Philip L. White, Sc.D.
Director

jc.

enclosure

Suggested titles:

"Eating Out - Frustration or Fun"
PR* in Nutrition
*Public Rights

We will publish 3 pamphlets (3½ x 6½) that will fit into a larger booklet (8½ x 5½). The material can be ordered as a unit or separately.

Overall objectives are:

General Objective: To make fat-modified and low calorie meals readily available to restaurant clientele.

Specific Objectives:
1. To develop a training guide for restaurant personnel.
2. To increase the public's knowledge in regard to the principles of the fat-controlled and low calorie meals.
3. To increase public awareness of availability of fat-modified and low-calorie meals in restaurants through educational and advertising campaigns.

The large booklet will be written for the manager. The small pamphlets can be carried in a pocket. (The appropriate one can be offered to patrons at the restaurant). The small pamphlets will be developed for the following:

1. Chef and cooks
2. Waiter and waitress
3. Patrons

For Managers

a) Guidelines for menu development for fat-modified and low calorie meals (to include item suggestions and terminology).
b) Guidelines for purchasing, preparation and service of fat modified and low calorie foods.

For Chefs

a) Guidelines for the development of standardized recipes for fat-controlled and low calorie menu items.
b) Guidelines for use of vegetable oils and margarines in food preparation.
c) Guidelines for fat modification and calorie restriction.

For Waitresses and Waiters

a) Basic principles of good nutrition.
b) Basic principles of fat-controlled and low calorie meals.
c) Guidelines for substituting one menu item for another within principles of the fat-controlled and low-calorie diets.

For Patron

a) Identify specific nutrients in foods on the menu.
b) Develop concise guidelines for restaurant clientele to aid them in selection of menu items appropriate for fat-controlled and low-calorie meals.

Example of Content:

What Can You Do for your Patrons?

Meet daily nutritional needs.

Control calories by -

a. reducing the calories in food preparation (see "Suggestions.")
b. serving low calorie foods (see "Planning" and "Purchasing.")
c. informing the patrons of the calorie content of foods.

Moderate food containing saturated fat and cholesterol by -

a. purchasing foods that contain less saturated fatty acids or cholesterol (see "Purchasing" and "Suggestions.')
b. inform the patron how to select foods lower in saturated fat and cholesterol

The material will incorporate AHA diet material that is being revised. Because they should be compatible it may be necessary to proceed slowly.

EXHIBIT B

MINUTES
THE SUBCOMMITTEE OF DIETITIANS AND NUTRITIONISTS

AHA National Office
3rd Floor Conference Room

June 28, 1974
9:00 A.M. - 4:00 P.M.

PRESENT:

Members: Virginia Stucky, Chairwoman; Mary Ellen Collins; Ruthe Eshleman; Marilyn Farrand; Mary McCann, M.D.; Janice Neville, Sc.D.; Jeanne Tillotson; Eleanor Williams, Ph.D.; Judy Wylie.

Staff: Mary Winston

Guest: Amelia Catakis

ABSENT: Reva Frankle

RECORDER: Sharon Borakove

ACTION ITEMS

1. That Jeanne Tillotson serve as Chairperson and Judy Wylie work with her on the newly formed Subcommittee's task force on Nutrition in the Young.

2. That the following people be contacted as possible sources of expertise for the task force on Nutrition in the Young:

   a) representative of the College Food Service

   b) representative of the School Lunch Program

   c) Mr. John Perryman - American School Food Services Association

   d) Mrs. Ostenso - USDA

   e) Joanne Styer - Food Service of Montgomery County, Maryland, and member of the American Food Service Association

   f) SCORE personnel

   g) Pat Hodgson and Diane Huse - Mayo Center

   h) Nancy Elmont - Brandeis University

   i) Staff in Dr. Jesse's group

3. That 2 separate dietary publications be developed by AHA -- one for use by hospitals and the other for use by restaurants.

4. That a letter be written to Dr. Schroeder concerning his hospital menus.

5. That a task force be formed to work on creating guidelines for implementing fat-controlled menus in hospitals with Mary Ellen Collins serving as Chairperson, and Dr. Mary McCann and Amelia Catakis as members of this Committee.

   a) That Mary Ellen Collins select additional members to the task force on guidelines for hospital menus as she sees fit.

6. That a letter to the AMA and the American Hospital Association be drafted, advising these organizations of our interest in working with them on developing guidelines for hospital menus.

7. That a revised edition of the Cookbook be completed by June 1975.

   a) Recipes are needed by August 15, 1974.

   b) The first draft to the publisher is due October 21, 1974.

8. That a memo be written to the following groups requesting their comments on the AHA Cookbook and additional recipes for the revised edition: Nutritionists in the Heart Associations, personnel from LRC, SCORE, and MRFIT and a letter to Nancy Hearns (at LRC).

   a) That Marilyn Farrand and Judy Wylie receive copies of this memo to forward to their respective staffs.

9. That Virginia Stucky's material on the NRA project be presented to the Nutrition Committee for review.

10. That Mary Winston send Jo-Ann Friedman the addresses of the Subcommittee membership in order that she will forward to them the order cards requesting a film showing of "Atherosclerosis."

11. That a memo be sent to all the Heart Associations suggesting that a nutritionist be present during the showing of the "Atherosicerosis" film.

12. That Mary Winston try to obtain the order cards from Medcom for the Subcommittee to request the film on "Iron."

13. That the possibility of holding the next Subcommittee meeting, tentatively scheduled for November 17 during the AHA Annual Meeting in Dallas, be investigated.

14. That meetings aimed at completing the Guidelines for Nutrition Programming in the Community be held tentatively as follows:

August 12 - Mary Ellen Collins and Judy Wylie
August 17 - Dr. Neville and Mary Ellen Collins
August 26 and 27 - Mary Ellen Collins and Reva Frankle

15. That the following people volunteered their assistance in staffing the AHA Exhibit Booth during the ADA 1974 Convention: Mary Ellen Collins, Judy Wylie, Marilyn Farrand, Dr. Williams, and Virginia Stucky.

16. That Amelia Catakis will hold a meeting with dietitians in the Washington, D.C. area for the purpose of reviewing and revising the NRA draft written by Virginia Stucky.

    a) This meeting will be followed up by a subsequent meeting with Virginia Stucky.

DISCUSSION

Virginia Stucky opened the meeting at 9:10 A.M.

Review of Minutes

The Minutes of the March 29, 1974 Subcommittee Meeting were approved with the following corrections:

Page 2 - Action Item #16 - line 2, insert "Computer" before quantity.

Page 6 - Pamphlet on Food Cost Cutters
#3 change to read "regrouping of Fruits and Vegetables"
#5 should be deleted
#9 this entire item should be reworded to clarify its meaning

Page 8 - National Restaurant Association Project - paragraph 2, end of line 6 - add "University of" Missouri.

New Committee Structure

Mary Winston reported to the Subcommittee on the new AHA reorganization. The Nutrition Committee is now officially a member of the Central Committee and shall maintain 8 or 9 committee members. The Subcommittee of Dietitians and Nutritionists is considered a working group of the Nutrition Committee.

Pamphlet on Food Cost Cutters

Mary Winston reported that the pamphlet previously entitled "Save Food Dollars and Help Your Heart" had undergone a change in title. The Nutrition Committee has made minimal comments on this pamphlet. The publication is at the printer. It should be ready by the 1st of October, 1974, in time to exhibit at the ADA Annual Meeting. This publication will be available to the public only through distribution by the Heart Associations.

Dr. Schroeder's Diet Plan for Hospitals

Virginia Stucky requested expressions of opinion from the Subcommittee membership regarding Dr. Schroeder's regular diet plan for hospitals.

It was noted that the food items required for a fat modified hospital menu such as Dr. Schroeder proposes would prove to be very costly. Obtaining the proper margarines to conform to the fat-modified diet plan may also pose a problem. The suggestion was made that the ideal place to institute dietary modification would be in the hospital cafeteria. Another suggestion made was to offer this diet plan as a selective menu rather than the "regular" hospital diet plan.

The importance of dietary counseling for the patient and the family was also cited. It was noted that we need to educate the public as to nutritious food choices. In this respect, it was agreed that the physician should take the initiative. It was further noted that the steps outlined by Dr. Schroeder for dietary modification may not be applicable nationwide.

The conclusion was reached that the diet plans produced for the hospitals and those for restaurant use must, of necessity, be 2 separate and distinct publications. The same diet pattern cannot be used by both. However, both diet plans could be based on the work of Judy Wylie's Ad Hoc Committee on revising AHA Diet Publications.

Amelia Catakis suggested that the Subcommittee contact Dr. Philip White since he is working on a project concerning diet modifications for hospital physicians. The proposed AHA Diet Publications will attempt to outline broad dietary principles for use by hospitals and restaurants.

IT WAS MOVED, SECONDED AND CARRIED THAT the Subcommittee appoint a task force to work on developing a publication which would be appropriate for hospital use. Mary Ellen Collins was selected as Chairperson, with Dr. Mary McCann and Amelia Catakis to serve as members of this Committee. It was also agreed that Mary Ellen Collins will have the option of selecting the other members of the task force. Suggestions were offered regarding people to contact requesting their services on our working group:

1) Representative of the Stanford University Hospital
2) Evelyn Berggren (AHA California Nutritionist) and Phyllis Ullman (California)
3) Grace Stumph
4) Dr. Lynn Howard
5) Representative of Veterans Administration Hospitals
6) Representative of Albany Hospital
7) American Hospital Association
8) American Medical Association

It was agreed that a letter be drafted to the AMA and the American Hospital Association advising these organizations of our interest in working with them on the project of developing guidelines for hospitals wishing to implement fat-modified menus.

Nutrition in the Young

Mary Winston reported to the Subcommittee on the status of the Ad Hoc Committee on Nutrition in the Young.

Jeanne Tillotson stated that the MRFIT program is currently researching data on the kind of fats used in the fast food chains spanning the U.S.

The point cannot be over-stated that there is no typical teenage diet since teenagers in the U.S. do not constitute a homogenous population in terms of eating patterns.

IT WAS MOVED, SECONDED AND CARRIED THAT a task force on Nutrition in the Young be created to work with Dr. Mary Jane Jesse's Committee with Jeanne Tillotson named as Chairperson and Judy Wylie working with her.

IT WAS MOVED, SECONDED AND CARRIED THAT the following people be contacted as possible sources of expertise to work with this newly formed task force:

1) A representative of the College Food Service

2) A representative in the School Lunch Program

3) Mr. John Perryman - American School Food Services Association

4) USDA representative - perhaps Mrs. Ostenso

5) Joanne Styer - Food Service of Montgomery County, Maryland and Member of the American Food Service Association

6) SCORE Program Staff

7) Pat Hodgson and Diane Huse - Mayo Center

8) Nancy Elmont - Brandeis University, Waltham, Massachusetts

9) Staff in Dr. Mary Jane Jesse's group

Ruthe Eshleman suggested that we should concentrate our efforts on working only with the teenagers motivated to change their eating habits and not focus on those who have no motivation to change.

Judy Wylie raised the question of designating the chronological age group of the "young" we are to work with. Should we focus in on only the adolescent--or should we also include the 5-year olds?

AHA Cookbook

Ruthe Eshleman reported that June 1975 has been selected as the deadline for completion of the first revision of the Cookbook. New recipes must be submitted to Ruthe Eshleman by August 15, 1974. Recipes with the following modifications are particularly needed:

> Increase the vegetarian meal section, decrease the amount of sugar in the recipes, include extended meat recipes, desserts without sugar, and recipes using a decreased amount of sodium.

Two graduate students will be employed to calculate the caloric content of each recipe.

The Cookbook will include statements on weight control and weight reduction. Other items expected to be incorporated into the revised edition are suggestions from our food budgeting pamphlet, and tips from Mary Winston's traveler's diet article.

Members of the Subcommittee were asked to send their comments on the Cookbook. The book will also include a statement emphasizing the fact that this Cookbook is not a sodium-restricted book. It was noted that the Cookbook has sold over 200,000 copies and is now in its 5th printing.

It was agreed that a memo should be written to the following groups requesting their comments on the AHA Cookbook:

> Nutritionists in the Heart Associations, LRC, SCORE, MRFIT personnel, and a letter to Nancy Hearns (at LRC).

It was suggested that perhaps Marilyn Farrand should be the person to contact the staff of the MRFIT program. Marilyn Farrand and Judy Wylie will receive copies of these memos to send to their staffs.

National Restaurant Association Project

Virginia Stucky prepared several sheets outlining guidelines for the restaurant project. She suggested that this material be presented to the Nutrition Committee for review.

Virginia Stucky stated that training the waitresses to serve fat-controlled meals proved to be one of the biggest stumbling blocks in her restaurant project in Wichita. She suggested the development of a small booklet of menus that can be carried in the waitresses' pocket and easily dispensed to the patrons. A packet of recipes should also be developed. The proposed title of the publication for the Manager is "Eating Out -- Frustration or Fun" or "P.R.* in Nutrition" *Patron Rights.

The materials could consist of four different publications - one for the manager, chefs (cooks), service personnel, and patron.

Recipe cards may also be used.

After the members have a chance to review Virginia Stucky's restaurant materials, they will discuss their criticisms with her later today. It was agreed that Amelia Catakis will hold a meeting with dietitians in the Washington D.C. area for the purpose of reviewing and revising Virginia Stucky's draft of materials for restaurants. Amelia Catakis will meet with Virginia Stucky at a later date to discuss the recommendations resulting from the Washington D.C. meeting.

Film on Atherosclerosis

At 11:30 A.M. the Subcommittee viewed the MEDCOM film "Atherosclerosis." Copies of the monograph accompanying the film were distributed to the members of the Subcommittee for review. The film was prepared with a grant from Best Foods, a subsidiary of CPC International.

Mary Winston stated that a film showing and free copies of the monographs can be arranged for upon request from MEDCOM. The address to order from is printed on the inside cover of the monograph.

Mary Winston stated that the intent of the film is to provide an over-all picture of the rationale and treatment of hyperlipidemia. The film is to be used in conjunction with the monograph. The order of presentation used by MEDCOM suggests that the film be shown before distributing the monograph. Marilyn Farrand said that we should commend MEDCOM for mentioning a nutritionist in the portion of the film showing the food. Mary Ellen Collins remarked that the film needs a reference to the complexities of changing food habits, rather than dictating the steps for modifying the diet as 1, 2, 3, 4, 5, etc. It must be stressed that food is a very personal thing and it takes persistence and determination to accomplish a modification in diet.

It was agreed that Mary Winston will send Jo-Ann Friedman the addresses of the Subcommittee membership so that she can forward to them the order cards which are to be used to request a film showing of "Atherosclerosis." A memo will be sent to all Heart Associations explaining to them how they can arrange to have the film shown in their area. Other audio-visual aids available from MEDCOM include: the film on "Iron" and the booklet "Three Times a Day." The Subcommittee expressed interest in obtaining the order cards for the film on "Iron." An effort will be made to obtain these.

It was noted that the TODAY Show will be broadcasting a special program on heart disease the week of July 8, 1974. Linda Barnhart our Washington D.C. nutritionist will appear on this show, as will Dr. Richard Ross, the President of the American Heart Association.

The Society for Nutrition Education

Ruthe Eshleman reported that Dr. Shank, the Chairman of the Nutrition Committee, has written a letter to Dr. Hurley suggesting that the AHA become a sustaining member of the Society for Nutrition Education (SNE). The issue is still pending since a response to this letter has not yet been received.

Firehouse Menus

California Heart will be producing a cookbook for firemen in the near future. The California State Compensation Insurance Fund is funding the project and will aid in distributing the material to the fire fighters in California. After completion of the Cookbook, the State Compensation Insurance Fund will consider funding the production of a film for fire fighters.

Revision of AHA Diet Pamphlets

Judy Wylie reported on the revision of AHA diet publications she and her "TAG" group are working on. Some of the suggestions offered include: changing the title "The Way to a Man's Heart" to emphasize that heart disease applies to both men and women and is not exclusively a male disease. Also, perhaps a change in the format of the diet publications is needed.

The committee members offered several suggestions for the revision. These have been passed on to the "TAG" group.

The suggestion was made that the new booklet should also include recommendations for using it as a teaching aid in conjunction with diet counseling and for using it alone. It is preferred that the booklet be used under the direction of a consulting nutritionist or dietitian.

The question and answer section will include information on reading labels and on low fat milk and cheese. It was noted that the term "skimmed or low fat milk" is the milk terminology to be followed throughout the pamphlet. In the milk section, substitutes for milk should be cited for the people who don't like milk but still need calcium.

Dr. Neville distributed copies of the AHA - Northeast Ohio Affiliate pamphlet entitled "Choosing Margarines and Oils" to the members of the Subcommittee.

Guidelines for Nutrition Programming in the Community

Comments were made concerning the guidelines prepared by Mary Ellen Collins. It was noted that page 1 needs to be reorganized. #4 Nutrition in the Young should be moved up to become no. 1. Weight control should be no. 2, with Fat Modification no. 3 and Sodium Restriction no. 4. Also, the risk factors should be emphasized. A bibliography should be included citing pertinent articles with up-to-date references for each year.

The Subcommittee was requested to review the draft of the guidelines this afternoon and evaluate them in terms of the document, "Evaluation of Program Guidelines" prepared by Barbara Henry, Consultant at AHA.

Dr. Neville and Mary Ellen Collins will incorporate the Subcommittee's suggestions and then review the guidelines with Mary Winston. Mary Ellen Collins has set up tentative meeting dates as follows to review the Guidelines for Nutrition Programming in the Community:

August 12 - Mary Ellen Collins and Judy Wylie
August 17 - Dr. Neville and Mary Ellen Collins
August 26 and 27 - Mary Ellen Collins and Reva Frankle

ADA Annual Meeting - 1974

Mary Winston reported that plans for AHA's exhibit at the October 1974 ADA Convention are presently under way. The following people volunteered their help in staffing the AHA Exhibit Booth at ADA: Mary Ellen Collins, Judy Wylie, Marilyn Farrand, Dr. Williams, and Virginia Stucky.

Communicator in Nutrition (CIN)

Ruthe Eshleman reported that work has not commenced on the proposed newsletter - Communicator in Nutrition, since its status has not yet been settled. However, it is hoped that permission will be granted to proceed with the project.

Next Chairwoman of the Subcommittee

Congratulations to Marilyn Farrand on being chosen the new Chairwoman of the Subcommittee of Dietitians and Nutritionists. Her appointment becomes effective November 25, 1974.

Future Meeting Dates

Sunday, November 17th was proposed as the tentative date for the next Subcommittee Meeting, to be held during the AHA Annual Meeting in Dallas. This date has been proposed since it would offer the AHA nutritionists throughout the country an opportunity to attend our Subcommittee meeting. The above proposal will be further investigated.

Virginia Stucky adjourned the Meeting at 3:15 P.M.

SB:yy

NCEN

NATIONAL COMMISSION ON EGG NUTRITION
205 TOUHY AVENUE • PARK RIDGE, ILLINOIS 60068 • (312) 696-1390

October 1, 1974

Richard S. Ross, M.D.
President, American Heart
Association
Professor
Chief of Cardiology
JOHNS HOPKINS UNIVERSITY
Baltimore, Maryland

Dear Dr. Ross:

Somewhat belatedly (because I have been traveling) I want to express to you and your associates at the AHA, our sincere appreciation for the courtesy you extended to us during our visit with you on September 12. I made a report about our visit to the National Commission on Egg Nutrition and it was gratifying for all of us to know that there really is not too much disparity of thought between NCEN and the American Heart Association.

We appreciate that you are willing to listen to us and we want to, on our part, express willingness to work with you and listen to you because only if we work together can we arrive at the truth and this, after all, is the only thing which is important.

NCEN will follow up on your offer to work together with Dr. Shank and his group to review the work that has been done and Mr. Fischer expects to contact Dr. Shank, in the near future, to make a start on this.

After these gentlemen have gotten together, hopefully, we can then again meet as a group for a further discussion of how we might cope with our differences, if there then still are differences, or how we might work together, if our disagreements have vanished or are down to manageable proportions.

Sincerely,

NATIONAL COMMISSION ON EGG NUTRITION

Hendrik Wentink
Chairman

HW:jms
cc: G. C. Bookey, NCEN
Norman Hecht, NCEN
Maurice Pickler, NCEN
Blanton Smith, NCEN
Robert V. Fischer,
HY-LINE INTERNATIONAL
Dolph Chianchiano, AHA
Richard E. Hurley, M.D.,AHA
William W. Moore, AHA
Elliot Rapaport, M.D., AHA
Ross Reid, Esq., AHA
Robert Shank, M.D., AHA ✓

American
Heart
Association

EXHIBIT E

Memorandum

Ad 74-516
September 18, 1974

TO: All Affiliates

FROM: Dolph Chianchiano
Chief, Public Policy and Government Affairs

SUBJECT: Meeting with Representatives of the National Commission on Egg Nutrition, September 12, 1974

AHA staff and volunteers had a constructive meeting with representatives of the National Commission on Egg Nutrition (NCEN) on September 12, 1974 in New York. Those who were present are indicated in the footnote.

It appears that NCEN's purpose in requesting this meeting was to explore whether AHA would re-examine its recommendation that the general public reduce its consumption of dietary cholesterol. This recommendation implies limiting intake of eggs in the diets to three per week. NCEN was suggesting that our diet prescription be directed only towards populations at risk. For its part, NCEN offered to re-examine the position of the egg industry on this issue.

While no substantive promises were made, all present agreed to a communique along the following lines:

> "The meeting was fruitful since both sides achieved a better understanding of each other's position on the relationship of dietary cholesterol and heart disease. As a result of the discussion, areas of agreement with respect to this issue were identified. It was obvious, however, that there are points of disagreement. In concluding the meeting, both AHA and NCEN agreed to re-examine the scientific evidence, to keep open lines of communication and to meet again in the future, as warranted."

cc: Area Services Offices

Attending for NCEN: Bob Fisher (Editor of Hy-Line World, Des Moines Iowa), Hendrik Wentink (Lancaster, Pennsyvlania; Chairman, NCEN), and L. A. Wilhelm, Ph.D. (Park Ridge, Illinois; Secretary, NCEN).

Attending for AHA: Richard S. Ross, M.D., Elliot Rapaport, M. D., Ross Reid, Robert E. Shank, M.D., William W. Moore, Richard E. Hurley, M.D. and Dolph Chianchiano.

Return to: Mary Winston
AHA-3rd floor

IMPORTANT
Please attach travel and other receipts. See other side.

AMERICAN HEART ASSOCIATION

44 East 23rd Street
New York, New York 10010

EXPENSE VOUCHER

For Meetings in New York

Meeting Nutrition Committee **Date** Oct. 16 & ½ day Oct. 17, 1974

Meeting _____ **Date** _____

Meeting _____ **Date** _____

Held at Biltmore Hotel, New York
(PLACE)

Your personal participation is vital to the success of the work of the American Heart Association and reimbursement is provided for your expenses. There are Board and Committee members who prefer to pay their expenses as part of their contribution to the Association. In those instances where expenses are not charged they are deductible for income tax purposes.

TRANSPORTATION: (See Note 1)
Railroad Fare $_____
Air Fare (Tourist) _____
Depot Bus or Limousine _____

Hotel (____days) (See Note 2) Charged to A.H.A.

SUBSISTENCE: (@ $15.00 max. allowance per day) _____
(See Note 3)

TOTAL EXPENSES _____ $_____

NAME Robert Shank, M.D.
(PLEASE PRINT)

ADDRESS Head, Dept. of Preventive Medicine
Washington Univ. - School of Medicine
4566 Scott Avenue
St. Louis, Missouri 63110

_____
(PERSONAL SIGNATURE)

DO NOT WRITE IN THIS SPACE

Approved by _____ **Budget Charge** 506-834

(over)

A

NOTE 1 **TRAVEL — AIR**

a. Cost of air travel by most direct route using "air coach" or "air tourist" (less than first class) unless it is clearly unreasonable or impracticable.

RAIL

b. Cost of rail travel by most direct route, first class with lower berth or nearest equivalent.

AUTOMOBILE

c. Cost of travel by privately owned automobile at the rate of $.12 per mile in lieu of actual costs. However, reimbursement for transportation by this means shall not exceed the cost of a. or b. above whichever is less.

NOTE 2

Arrangements have been made to house Board and Committee members at the Biltmore Hotel, when in New York on A.H.A. business.

Room rental costs at the rate of $20.00 per day can be charged to the Heart Association. **All other charges must be paid upon "checking out" of the Biltmore.**

NOTE 3

Maximum allowance of $15.00 per day for each scheduled day of a meeting.

— ACCIDENT INSURANCE

All board and Committee members are covered by the American Heart Association for any type of accident resulting in injury and/or death sustained while attending Board or Committee meetings of the Association. The limit of indemnity in the event of death is $100,000.

Since the Association carries this policy, no reimbursement will be made for any other travel or accident insurance.

Transportation and other receipts, should be attached to this expense account.

For budget control, Expense Vouchers must be submitted within 15 days after conclusion of the meeting in order to be honored.