Don't Skip The Dentist: Reversing Artery Disease With The Bale-Doneen Method Transcript

(Transcripts are generated by AI and may contain errors)

Introduction to Dr. Amy Doneen

– All right everybody really, really exciting interview. Really exciting guests. Please don't go anywhere reverse heart disease naturally. Summit is back for you but today we bring you Dr. Amy Doneen and you may know her, you may not know her but when we're done with this you're going to say, how did I possibly not know her? This is a reverse heart disease naturally Summit and Dr. Doneen in Spokane, Washington may have actually had hands on with more patients proven to reverse their heart and vascular disease.

Almost any clinician in the United States and I want to introduce her formally but she will tell us that the goal of reversing heart disease is real and it should be one we strive for but this pathetic anemic medical system just waits to have dead.

I'm going to stop editorializing. So I am reading Dr. Doneen's biography from an amazing book we're going to talk about but Dr. Amy Doneen, Doctor of nursing practice is an international leader and that's true in the prevention of heart attacks, strokes, diabetes and chronic diseases such as dementia.

She and Dr. Brad Bale co founded the Bale Doneen method in 2001 a medical approach proven to identify stabilizer, reverse arterial disease. She and Dr. Bale have been called disease detectives man that is so good checking for hidden signs of arterial disease. She has many academic appointments.

She was a beautiful new facility for her heart attack and stroke prevention center in Spokane, Washington people fly in from all over the place to see her and then of course a lot of us are doing telemedicine. She's also my mentor because I'm a graduate in 2015 of the Bale Doneen method. My certificate is proudly in my office lobby and waiting room that story your books, time flies when you're on on fire with desire to help people and also welcome so much Dr. Doneen.

– Thank you so much. Dr. Kahn I'm so happy to be here. Yes. And as I said it is not possible to have a summit called reverse heart disease naturally without having either you or your co founder and also awesome physician. He's just not available in the same city as you usually Dr. Brad Bale. You are the authentic you're like the like the rock that proves that the earth is billions of year old because you have seen it.

So let's start right there. I mean in 2001 you and Dr.

Proving Arterial Disease Can Be Reversed

Brad Bale set up a collaborative clinic and a method that bail donation method to demonstrate that arterial disease can be stabilized and reversed and are skeptics that say that's nonsense. So just just go on a riff and talk about 22 years of experience that it's real to stabilize and it's real to reverse arterial disease.

– Absolutely. Well yeah that's exactly how it happened when we started working together 20 plus years ago. It was a matter of realizing and you've talked about this over the years that that tools like coronary calcium scanning and then 2001 carrot and I. M. T. Started coming to play which are ways to find disease in the arterials bed before someone has a heart attack to prove that they have it.

So that concept in itself was was landmark. And so that's kind of where we started was we wanted to find out who had disease and and and who didn't and then look at the why they had disease and and amazingly treat the Y.

C. The disease stabilized. So fast forward to around 2008 where we started to collect our data and at the time we were working with Texas tech and we had data in 576 patients that we had been following for about eight years.

And we're at the time we were using carrots into the media thickness as our endpoint which can evaluate both the calcified or eco genic harder plaque and also the more unstable plaque. And so we wanted to see what was happening.

And so over that eight year time period and 576 patients, we saw a linear trend down of arterial thickness as documented by the current I. M. T. And we also saw stability of the plaque burden.

And then as we were continuing with our clinical practice, the data was pointing that it's really not the mean I. M. T. That we want to go for, we want to ask the question can we actually stabilize the plaque. And so we worked with Steve Jones at Johns Hopkins and we said, hey let's look at the fact can we actually stabilize the plaque? Can you treat somebody on an individual end of one and take plaque that soft and inflammatory and over time actually stabilize it.

And we had enough data and that data set 324 patients that over a five year time period in 100% of patients, the plaque became echo genic and stable and it was kind of this aha moment to say. And even Dr. Jones asked how are you doing that?

That's not normal, that's not normal. And our answer to that was pretty simple and yet pretty robust and that was it's bigger than just our cholesterol, our blood pressure. And if we're exposed to nicotine, it has to do with everything it has to do with lifestyle psychosocial stress.

It has to do with insulin resistance, vitamin deficiencies, genetically inherited lipid abnormalities like lipoprotein. A so many factors that aren't part of the guidelines. And so that's kind of how we got to where we are today. And the and the two books is to tell that story.

– A bunch of things just to follow up number one, you and Dr. Brad Bale. I have authored at least two incredible books. One called Beat the Heart attack Gene, I love it. It's out of my office.

It stresses particularly a genetic inheritance called N. P. 21. But it covers your comprehensive risk management program at the bailed onion method and your book your new book which is almost a year old when everybody's listening, healthy heart healthy brain, absolutely wonderful update. And expanded knowledge based thicker book.

These are must reads. But if you know people that were just listening to your eloquent, I mean you've had a whole day in the clinic and you're just like I am on fire because you know things that the average clinician doesn't really even think about.

What do you have plaque? What kind of plaque can we make your plaque friendlier and less dangerous to you? So you have a better life. I mean you're a better life doc. I'm a better life doc.

But it's cardiovascular disease that so often interrupts that. So you're talking about sophisticated. I just wanna make sure the audience gets it. Whether or not we make the plaque go away. Like some magical drain out, which is not so easy. We can take higher risk plaque.

And that's usually the non calcified plaque, whether it's in the carotid or the heart or other words we can make it stable, lower risk and largely calcified plaque and you're using Carotid internal medial thickness ultrasound, a really simple test.

But so under used and you document it and you see that, I think you said 100% of the academic series. You had you saw improvements in their carotid plaque characterization. – So yeah absolutely.

– And I want to warn people if you were to walk into your internist, your cardiologist, your preventive doc and said I want a carotid internal medial thickness ultrasound. It's simple.

They're usually going to hear the answer. It's not available. Which is so sad and so unfortunate. It's available in my clinic. And you guys have published, you know, on hundreds and hundreds.

It's basically as invaluable a tool as a stethoscope if you're into you know, precision medicine like you are and I am. And the audience is hungry to hear about.

I mean is it expanding and Spokane at least or it's still you're probably the only center in your city offering it. – Well it is expanding, its gaining more traction certainly.

But the the challenge we have is making sure the data is reproducible.

Imaging Plaque and the Need for Better Screening

And it is accessible in pretty much any city. If people know what to ask for and their service companies that come in and do that. But the interesting thing is that I want the audience to understand is that 99% of plaque in the artery wall, it doesn't grow in the area where blood flows where we can just wave at it and see it. It blocks the blood flow when there's a problem.

So using technology that actually looks at the wall of the artery such as carotid I. M. T. Or coronary calcium scan and other tools that are looking at imaging of the arteries is very acceptable and it's inexpensive.

That's the thing we're talking tests that are under $200. That can be life saving. And one of the things you mentioned that I think is important is when we set out to write the first book in 2014, we had a long pause to figure out who are we writing this for?

Because yeah, I mean yes, I've had a busy day but it's so exciting. We need to talk about this. We realize that we need I need to write it to the patient. We need to write it to the healthcare consumer because the healthcare consumer is going to demand change.

So while these scientific thoughts and topics seem complex, they're really not when we articulate them in a way and and use patient stories and really understand them all based in evidence. And the first book was really looking at ischemic stroke prevention. Heart attack prevention, you know the big guys right? The leading cause cause of death and disability.

And then that was in 2014. And then come 2017 we realize you know, I think the bigger benefit of what we're doing. Yes. Yes, preventing strokes and heart attacks. But you know what it is it's protecting all the tiny little arteries. The 30,000 little tiny capillaries that are no bigger than a human hair. And if we can protect those like the others which we're going to do by default by the way, we can we can prevent the disease, diseases of aging that claim our independence, like memory loss, vision, chronic kidney disease, peripheral vascular disease, erectile dysfunction, all the things that claim our our quality of life.

And so the second book was necessary to articulate what we have learned between the first book and the second book, leading to the fact that it's really about oxidative stress.

Looking at all the causes of oxidative stress treating the y and seeing the disease stabilized. And it's possible even on people that have had a tremendous cardiovascular history um with stents and bypass.

You can actually pause and say why did you have that first in And you know, Dr. Kahn sometimes it's perceived that it's so complicated and oftentimes I find clinically that the little things are missed, like the diagnosis of sleep apnea or periodontal disease or an endodontic tooth lesion or lifestyle, which you are so profoundly you have that covered hands down but and using genetics to be very precise in our drug selection if we need it in our lifestyle um suggestions and really looking at the end of one that individual wonderful patient. – Couldn't be more excited to hear that from you. So there's so many areas that you and your co partner Dr. Brad Bale have innovated in these two books and I just want to quote from your your most recent book and I love this.

And I would, you know, going to paint this in my lobby to find out which patients are in cardiovascular danger. You need to look at their arteries. Not just the risk factors you can steel is from me because I use the short firm called test not guests. I didn't create that.

I picked that up. It's not trademark. But you said it to your looking at arteries and for people listening that say, look at, you know, these screening companies or my local hospital will do a carotid ultrasound.

But you're talking about a specific test. Looking at their tear a wall. There's a difference from the typical insurance cover carotid ultrasound that an internist might order and what you and Dr. Bale are offering at your advanced heart attack stroke prevention clinic, right? – Yeah. Oh absolutely.

You know that like I said, the plat grows here and the quality of the plaque is assessed here. And so to use a test that just limits our vision at blood flow.

We're not going to see what's going on with the quality of the plaque itself. You know, um one thing going back to what you said on tests. Not guess. I love that you've had that.

And I think of that often because it's an expression, it's a statement that you've had for several years and it's really, really good.

Primary, Secondary, and Tertiary Prevention

But um we had a paper published last year that really challenged the current system of putting people into categories because that's what's done right now. Primary prevention means someone has not had a heart attack or stroke. Secondary prevention means they have and that's it.

So our call out is to say, let's put people in three camps. Primary prevention means we've looked we've looked at all the areas we can safely and effectively get to the crowd as the coronaries the aorta, the arteries at the top of the lake. We've looked and we don't find any plaque.

Well that we want our goal for a lifetime for that patient is to remain in primary prevention like you, Secondary prevention are people who we look and they've have plaque in their arteries. They probably don't know it because no one has come to me in 20 years and said Dr. Doneen, I think I'm growing fatty streaks in the wall of my artery. No, because you don't feel.

But if someone is secondary prevention, then what's our life goal to make sure they don't get in that third chair, which means they've had a heart attack.

They've had a stent, they've had a stroke to prove that they have plaque. And in that population, which we claim to be tertiary, we want to stop recidivism because the disease can be stopped. So if we simply say and ask ourselves if you're listening to this. Well, I wonder if I'm in the first chair or the second chair. I know I'm not the third chair because I've not had a heart attack or stroke. But the only way, you know, if your primary or secondary in the way we define it is you've got to, as you say, test not guess.

– And then again you guys have a method, you know that you've developed, you've published you've written about it the bailed owning method. You use this acronym called Ed Frog in both books.

And just so that everybody knows just tell us the bullet points of what that stands for. – Yeah. Absolutely. So it's an acronym that really kind of ties in what our method is. So um education is number one.

That's the e to educate ourselves and be evidence based and everything that we do and share the knowledge and educate our patients on what really causes a heart attack or a stroke.

And share that educational knowledge. Number one, number two is disease. That's what the D stands for. Look for disease. And if someone has plaque, monitor it on a regular basis so that we know the plaque is getting safer, it's healing and that's what we want.

So the F stands for fire or inflammation or more recently we've turned it oxidative stress that really is a key factor. So fire monitor the inflammatory labs on a regular basis. And then the R is huge. The R stands for root causes.

Looking at all the reasons may why someone might have plaque and like I said earlier, maybe it's sleep apnea. Maybe it's periodontal issues. Maybe it's psychosocial factors, maybe it's genetics, maybe it's lipoprotein a maybe it's air pollution, all of those root causes that have a cause and effect um look for them and lay all the cards on the table and treat them. The O stands for optimal goals and that means individualized, it's not aggressive, it means what's best for you might not be best for someone else and really be individualized in your care and the care that we give and that's possible. And then the G stands for genetics.

We use genetics for a lot of reasons. We use pharmacogenetics to understand how someone is going to metabolize treatment. And we use genetics to identify lifetime risk things like heart attack stroke aneurysms. And we set screening guidelines based on that.

So and we also use genes to look at how people might best um receive lifestyle advice even so yeah.

The ED FROG Method

It's really an acronym that we're an architecture that we put evidence based medicine into and use that directly in our clinical practices. – Yeah. And people that are listening will want to get one or both these books and study this method because you can understand it even if you're you know a lay member of the public concerned or known to have heart disease may be primary secondary tertiary as you just laid out a beautiful structure there.

But you do want to study this because it's very thoughtful and it's actually in the medical literature, they Dr. Doneen and Bale have taken the time to publish this so that doctors around the world can read, learn and put this into practice.

And they have huge training numbers that they've accomplished. We'll talk about that in a minute. So, another innovation that I give you guys credit for is really emphasizing what you guys call red flags.

And again, we can't go over everyone, but you specifically stress, you know, red flags for unknown heart and vascular disease in women. And just mention a few of them that you think the listening audience might not ever even have considered. – Oh, absolutely.

So thank you for asking that because February is women's heart month. So it's nice to specialize on that. But red flags are, they don't have a cause and effect. Here's an example.

So if a young woman experiences migraines, we know that she has a significant increased risk in her lifetime of also suffering a stroke. We don't know why though, exactly, is the pathology of the migraine? Is it the fact that it's affected her sleep pattern? But we know that migraines are a red flag and that individual needs to be treated and evaluated for cardiovascular risk.

Another one for women would be pretty glam CIA. You know, pregnancy is a wonderful time to it puts the body under stress, a wonderful stress, but it tells it's a story. So, if a woman has pre eclampsia, if a woman has hypertension or high blood pressure during pregnancy, if she has diabetes during her pregnancy, um those factors when the pregnancy is over are sometimes forgotten. But do you know any of those factors suggest increased risk throughout their lifetime of diabetes, sustained hypertension, blood clots in the legs and even strokes. And so it's using these red flags and the knowledge. And like you said in our books, both of them, they are written to the public. So, a whole chapter on all of these unique red flags. And it's just and people should not feel guilty if they have a red flag, maybe it's an autoimmune.

Maybe it's you know, any sort of arthritic condition that we need to recognize might place people on increased risk. So I think just knowing that is very helpful and recognizing and not being afraid to look in the mirror and realize that we all have risk.

And to get treated effectively. – Absolutely and you know, one of the ways you identify a red flag for silent atherosclerotic disease is you guys are focused on a couple of things most clinicians aren't and one is certainly insulin resistance and you still order an old old test called a two hour oral glucose tolerance test.

Shut the very thing we tell our patients not the pure sugar water and then monitor their blood sugar for two hours, maybe their blood sugar and insulin levels for two hours of blood?

I mean, tell us why you hold on to what many clinicians would call maybe even an out of date test. And what do you find in your clinic by doing that? – Yeah. Great question.

One thing I will say is insulin resistance is beyond a red flag. It's actually a root cause and one of the most common root causes that we see is missed when we see patients for the first time, especially those with known heart disease.

So how do we diagnose it? Well, we have options.

Womenu2019s Heart Disease Red Flags

We can look at a fasting blood sugar and if that's elevated but not in diabetic range, we say, God gosh, you probably have some prediabetes um if someone has an A one C or a three month average of blood sugar which is often advocated for um that can be a indication that they have prediabetes. But why do we put people through the agonizing test of drinking 75 g of glucose and then testing both the one hour and the to our blood sugar.

And like you say, insulin oftentimes as well. It really gives us an indication of not only how long someone has been insulin resistance, it really gives us a real life example of how an individual's body responds to that glucose load and really Dr. DeFranzo has done most of the work for this and way back even in 2010, he he looked at what is most predictive is it the fact casting the A. One C.

The one hour in the two hour and really the one hour, by the time it jumps up to 1 50 there is a 13 fold increased risk that that that individual is gonna be flat out diabetic over the next 7.5 years. And by the time the two hour glucose gets above 120 not 140 there's also a significant risk that there's beta cell decline.

And it really is a true fact that the sensitivity and specificity of A one C levels is about 50%. So someone could have a normal A one C. And that's a three month average, I should say, challenging that pancreas is the best way we can uncover this and make sure that they never, I consider it a personal clinical failure.

If one of my patients was ever to become diabetic, we have 20 years to identify it before someone before the beta cells get so wiped out that their type two diabetic.

So it we really have this wonderful window window of opportunity and it's so often not done. – Excellent. So we've talked about, you know, you go way beyond the usual approach to um looking at vessels.

You go way beyond approach, identifying root causes. You go way beyond the approach for these subtle red flags and sometimes testing for them. You really have taught probably more physicians about the oral cardiac connection the health of the gums the health of root canals, the health of cracked teeth. We did have the pleasure of interviewing Dr.

Doug Thompson dentist is a graduate of your bail donation program as well as uh starting up his own integrated dental network as you know. So we've talked about it but I mean very few clinicians have your experience and yours is greater than mine.

Insulin Resistance and Oral Glucose Testing

That patient with you know on fire with inflammation and really you can't get it under control. How often do you really say Aha Eureka? We found it by cone beam tomography by advanced periodontal evaluation.

I mean how often does that come up? Is it a fairly frequent event that the mouth is the source of the fire? – Yeah and they're they're all intertwined. So you know you look at periodontal disease and 70% of people over age 50 have some form of periodontal disease.

And if we equate periodontal disease and understand that it's really a chronic bacterial infection um that certain bacteria that live in the gum line.

And they have they have names A A. P. G. T. F. T. D. These dangerous bacteria actually have data to demonstrate that they can cause um plaque in the artery wall. And we had a paper published in 2017.

That really looked at that we used a model called the pathogenic triad to demonstrate this for the first time to show causality and it's not part of the problem.

And I'm sure Dr. Thompson mentioned this to the old way to diagnose. Periodontal disease is visually an exam which is important but it's if your gums depths are you know bleeding and over three centimeters or millimeters centimeters then you have periodontal disease. But if you shift gears and say well do I have any of these dangerous bacteria? Because those are the ones that we have the data to show the causality. And then to your question about an endodontic abscess Dr. Pesce was the first one to actually publish that.

And he looked at patients in the in the emergency room who for having a heart attack like having a heart attack 222 of them in fact and he asked them and got their permission to to analyze the clot the Rhombus that was blocking the flow of blood.

And he asked them and evaluated them while you know in the er do you have any mouth pain, do you have any teeth that hurt sensitive gold whatever? And the answer was no. So what he found is about 50% of these people who were in for acute m I had endodontic bacteria within the clot itself suggesting that an endodontic lesion could be the causal factor of a plaque rupture and subsequent rhombus. So I don't think any hospital that calls himself a heart hospital um is doing a good enough job unless they are partnering with an oral health specialist to evaluate and chronic lesions with three D.

Imagery so that we really can see those. And also working with an oral health specialist to understand the bacteria in the mouth. – Wow powerful statements. I want to circle back again.

You have a bail dunning method and obviously you're seeing uh important advances in arterial health cooling down the fire converting to more stable calcified plaque in heart and carotid arteries. Because you're intervening and your program does depend on pharmacologic agents, things like statins, things like blood pressure medication. You've got very tight goals for people at risk.

Now one of the unique things of the Bale Doneen method is that you still use a diabetic drug that many people have never heard of called pyro glitter zone in some patients.

And many people have heard of Metformin or everybody's going crazy right now about owes pick and the rest. Why do you hang on to pay a glitter zone and I know everything you do has a scientific basis but what have you seen in your patients by using that very inexpensive oral anti diabetic drug.

– Yeah. One thing I like to say is that all drugs are poisoned so we don't have to use them, We won't. But in some people that have insulin resistance to the degree that even an optimal lifestyle is not going to keep them safe. And there's still residual inflammation from the insulin resistance. What pilot zone does is it sensitize is the body to use the insulin insulin sensitizer. So um it reduces diabetes risk by 72%.

Oral Health and Cardiovascular Risk

And it also has data that it can stabilize the necrotic core of plaque and that was done by coronary angiography. And coronary imaging to show you can actually stabilize that plaque if you if insulin resistance is one of the root causes while we have and it's not it's not safe for everybody because you can get some fluid retention. So um if someone has a heart muscle that's in large, we're not going to use, it has to be properly selected um for sure.

But when we look at other technologies like the GLP ones which is the one you just mentioned those epic or we look at um Metformin which is a great drug as well.

We and we use that. We use we use that as well often times. But when we're talking about truly treating the insulin resistance pharmaceutically pious zone real has that ability to do so. And part of it is it can stop even the conversion of a secretary muscle cells to trap cholesterol within the artery wall.

So it has these plea a trophic benefits that are really, really powerful. – So just going back to really my first point, if anybody has any doubt that heart disease plaque and carotid disease plaque and sexual organ disease plaque and peripheral artery leg disease plaque can be at least stabilized the lower risk and maybe actually diminished.

You'd say not true. I've seen it hundreds if not thousands of times. Right? – Oh it's very true. I mean it's very true. We can identify plaque. We can understand why someone has plaque. We can monitor the plaque activity.

And if we treat the why we see the inflammation go down and we see the disease stabilize. Those are my expectations for my patients. And if I don't see that it's pausing together and say what do we miss? Have we looked at the bacteria in your mouth?

How's your stress? How's your sleep? Have you had a cone beam X ray? Do you have some inflammation from a tooth? Do you have got dysbiosis really taking the mystery out of this whole thing and identifying the why and that probably the biggest thing I would say is the standard of care is missing.

So many of the wise and they're not that complex and complicated. Yes lipids matter. Yes blood pressure matters yes. Don't expose your body to nicotine. All of those are important.

But there's so much more. – Tell us where one clinicians watching and says I want to sign up and take the bailed owning method course. What's the website for that?

– Oh thank you for asking. So it's just simple. It's baledoneen.com and it's B. A. L. E. Doneen, D O N E E N dot com. And you can. Yeah and we're starting since Covid taught us how to talk online, we're now doing hybrid so people can come if they want to come or they can watch.

Treatments, Training, and Clinic Policy

And it's a 17 hour cme and a C. E. Program because we invite all specialists to come at our last one. We just had in Houston last month we had a pediatrician. We had several dentists, hygienists, cardiologists, internal medicine, family practice, a doctor of nursing practices, ARNPs bringing to the table. Everyone comes with a different knowledge base and to think that one specialty or one backdrop is going to treat such a grand disease that affects 30,000 miles of vessels. We're gonna miss the boat.

So we welcome everyone to the table and we learn from one another. And I think that's important. – Actually. I believe the rarest job in America is to be a preventive medicine clinician. There is so much opportunity.

So I'm not worried that your training, my competition. I welcome it. It's such a need from all the specialties you mentioned and the fact that you integrate dentists and your audience is fantastic.

I want to come see you in Spokane. Number one do you do telemedicine in some states? – Oh absolutely yeah. – But I want to come visit you. What's the website for your clinic?

– So the website is the preventioncenter.com. – Okay. That's pretty simple. I am I gonna wait six months to get in to see you because you're such a big Kahuna.

– Well there is a waiting list but sign up because six months happens like that. – And I will say one of my colleagues, an interventional cardiologist jump ship.

Like I jump ship about eight years ago. And that interventional cardiologist is now your colleague in your clinic. And what a wonderful thing to see. I briefly owned the trademark prevent not stent and my hospital got so mad at me.

I didn't renew it. But Dr. Pierre is pretty much living the same path career that I took to. And I just got to finish up with the last you know, remarkable thing about your clinic um If it doesn't work, what's your policy that you almost never needed to activate?

But I want people to understand how confident you and Dr. Drad Bale are. So just tell everybody uh amazon like policy at your preventive clinic. – Yeah, so we are a fee for service clinic. And and so if someone was to have an afro robotic event a heart attack or an ischemic stroke on our watch.

We would give them back the money that they paid to us to prevent that during that year and it's not a legal issue. We do follow the standard of care.

We just don't think it's good enough. So, and it's a partnership. So working with patients and knowing that we've got skin in the game as well. It really increases that compliance and it also improves the care that they're getting because they deserve to be healthy and they, they work hard too to be here.

So I respect that. – And out of the thousands of patients you and Dr. Bale have taken care of. You've actually had to activate that policy like under five times, right? – Yeah. I think it's too actually and both people are fine. And one the one that I have was a very unique, interesting situation I won't go into but he never did cash his check.

He's a dentist and he hasn't framed on his wall. So, so that was one yeah. Elevation where I grew up in suburban Detroit. We called the policy like that chutzpah. So you know, you can't be any more confident in your ability to help people than to actually offer what you offer. So I know you've had a long day.

You probably got work to do. You got charts to do. I don't want to keep you any longer. But I think the audience has just been blown away that there is this force for over two decades to books, academic papers, thousands of patients and um they need to go out there and buy those books right now and study this up and I would say that it was very well invested.

Money. – Thank you. Thank you. Dr. Kahn. It's an honor to be here. Thanks for doing what you're doing. – Well. We fight the same fight in different parts of the country and God knows we need more soldiers on the ground with us.

– Absolutely. – Alright, Have a great day. – You, too, thank you so much.