Introduction and Background

Welcome, everyone once again to the Reverse Alzheimer's Summit. It's a great pleasure and honor today to welcome Doctor West Youngberg, our West. Congratulations on the fantastic work you're doing and all the wonderful success you've had.

And thanks for joining us today. Well, I had a great teacher, so I'm glad to be here. Good to hear that. And you know, everybody comes from a different background.

So one of the things that's been exciting to me about dealing with patients with cognitive decline is that each practitioner brings something different.

There are scientists, there are neuropsychologists. There are neurologists. There are internists. There are family practitioners, you know, on and on integrative physicians.

And you bring a, a background, really of, diabetes work, work with metabolism, work with nutrition. In your doctorate. So tell us a little bit about how you got to the field of cognitive decline.

Well, it's interesting, I, you know, I began my my passion, my interest, for lifestyle, nutritional medicine. When I was, when I was a child, my I found out my mother was dying of brain cancer at the age of nine.

I learned this, and it changed my life. It made me become very, very interested. And in health and medicine. But but preventive strategies. You know what? What?

You know, I remember as a teenager, I said to my dad, this is what what what can I do now so I can prevent what happened to mom in my life? And, without realizing it, that was the watershed moment that led me into just reading everything I could find about health.

And, later, I ended up at Loyola University and, and study, did a doctorate of public health in clinical preventive medicine, and basically lifestyle medicine.

And, along the way, I did a master's in clinical nutrition. And that's what, got me into all these areas. And of course, I first started tackling the question of diabetes.

Right. When, when Doctor James Anderson from the University of, Kentucky in Lexington, came to, Loma Linda University, and he was talking about how you can reverse diabetes.

And I go like, why is it more people are excited about this? You know, this was back in the early 80s, and I've been doing it since the early 70s. And, and so that's when I learned about insulin resistance and, and, and, the, the, underlying triggers that led to the diabetes in the first place.

And so it was when I read your 2014, I believe, study and the, you know, the novel approach to reverse cognitive decline that hooked me. And that's what got me into your training program, because in reading your your report, those ten individuals that had been able to reverse cognitive decline, it became very clear to me that insulin resistance was a key driver of cognitive decline.

And that was that's when I realized that I was going to become a sub specialist in reversing cognitive decline, because I already had the the most common driver of cognitive decline.

And as a subspecialty in my in my clinical work. Absolutely. And what percentage of your clinical practice is now devoted to cognition? You know, I, I take all comers.

Right. So I've always been that way. But the reality is I just saw three new patients today, that were interested in the British and protocol. And, so I have patients that are coming in at all levels of cognitive decline.

Some of them are are really wise. You know, they're they're recognizing that they have risk. You know, we all have risk, right? Absolutely. And they're recognizing at an early age that this is the time to tackle that risk and to develop a truly preventive protocol, that protects them against cognitive decline.

Practical Recode Approach and Patient Consults

And then other PMI had a patient today who she realized, after reading your book and they're reading my book, that that, you know, this, this word phishing.

Like. Like what? What's that word again? It is not just normal aging, right? I mean, it might be average age, but it's not the way it's supposed to be, right?

And so, and so she, decided to take a preemptive approach and, and, and address it now where it's in an area of subjective cognitive impairment moving into mild cognitive impairment.

And we're gaining her all set up, to address this and doing all the labs. And, you know, I tell them the more underlying risk factors that we discover from, from, you know, the recode approach here, where we're looking at as many risk factors as we can find, you know, I tell them the more we find, the better chances we're going to have of helping you, you know, not only prevent cognitive decline, but begin to reverse the aspects that have been troubling.

Use, to date. Absolutely. I think that's a really good point. And, you know, I think the whole term of mild cognitive impairment really concerns me because it is like saying to someone, don't worry, you only have mildly metastatic cancer.

It is a relatively late stage and it's the third of four phases as you get it's after Sci, it's after your pre-symptomatic phase. So I'm hoping that everybody will come in ultimately either for prevention or for, during CI, which lasts on average about ten years.

I still remember this is about, 1996 or so when the late Professor Leon Thall, who was at UC San Diego, told me about this thing that he called mild cognitive impairment, which, as he pointed out, about 5 to 10% of these patients would convert each year to full on, dementia.

And, of course, now we know we can see things of this coming much, much longer ahead than that. So, I think it really offers us, unparalleled opportunities to make Alzheimer's a rare disease, which is just what it should be.

So, if you could talk a little bit about your program, one of the. You know, I just got back from a couple of talks in Miami and in Tennessee, and one of the common issues that came up was, well, okay, we see what you're talking about, but it's too many different things.

How are we going to get these going? So, you know, in your practice you're dealing with, as you said, you've got to look for all the different things.

We know now that this is more of a coordinated system of neuroplasticity. There are synaptic elastic and synaptic plastic effects. You're looking for various toxins.

You're looking for energetic failure. You're looking for insulin resistance. You're looking for, oxygen desaturation and things like that. How do you address this in a very practical way with your patients?

Yeah, it's you know, I actually have now a blurb on the, the, the documents that I emailed back to patients after each visit that I have with them. I, I made a conscious decision early on in my practice that I would commit an entire hour, for the every consultation I do.

And I know not everybody can do that, but, because because I'm really specializing in this, I, I, I only take six patients a day, and I spend a whole hour or more with each patient at every phase of the protocol that I'm developing with them, because I need to really listen to them.

You know, it's, yeah, we've heard that the phrase, if we listened long enough to our patients, they'll tell us exactly what we need to do for them. Right? Right.

And sometimes I, I'm not actually figuring out what the real issues are until until the second or third visit, that I'm really talking to them. And they'll say something, you know, just in passing.

I go like, wait a minute, you didn't tell me that before. And so the more we interact with our patients and let them talk, let them express themselves and share their concerns, the more likely we are to pick up one additional risk factor that might be that risk factor that that brings us to that tipping point that will lead to, more significant improvements or or a decrease in the progression of that level of cognitive decline.

So I always tell patients, during the first visit, I say, first of all, you can fire me at any at any phase of this, program. I said, I'm here for you.

If this isn't working for you, then maybe you need to find somebody else. But, I always tell them said I'm going to do everything possible to to leave no stone unturned to figure out what it is, what the multiple factors are that are contributing to their cognitive decline, or or their cognitive, decline risk.

And so I say there's actually three goals. And, and of course, the third goal is the reversal of cognitive decline. I said, that's obviously we all have that goal.

But let me suggest that two other goals are even more important. At the beginning phases of what we're doing, the, the, the first of the third goals is to make sure that we're doing enough to slow down cognitive decline.

And I suggest to them that I believe, based on my experience and, and, and my, my reading and the field, that we can do that 100% of the time. We can slow it down at some level. Right.

And, and one, one x it's one, one example of this is, you know, some patients, especially family members, that might be caretakers or, you know, what I call health partners of that individual who has the concern might be thinking, wow, you know, it's just it's just a little bit, you know, memory issues.

It's not a big deal. I don't know if doing a comprehensive protocol and doing all these labs and and changing our diet, changing a lifestyle and taking these supplements, etc..

I'm not I'm not sure it's it's worth the energy and time to to in effort to put into this. Yeah. So I actually tell him a couple case studies that I've had recently because I get patients at all stages of cognitive decline, you know, from, from, you know, just I just want to prevent it from happening.

Don't even have a family history. I just, you know, want to be on top of it, all the way to. There's advanced Alzheimer's for already five years. So my book, you know, I had the case study of a patient who had already had advanced Alzheimer's for five years where a neurologist was saying, hey, you know, I know us.

I went to school with him. I've heard him lecture at, conference, and, man, I've never seen this happen, but, you know, hey, I don't know what else to tell you.

You know, give give Doctor Youngberg a call. And, and so I, I deal with patients at all stages of cognitive decline.

Goals of Treatment and Tracking Progress

And so the, the key here is that is that we we we there's no three goals. Number one, slow it down. Yeah okay. Number two let's try to stop it. Yeah okay.

And I believe that in many patients about 90% of the time we can actually stop it. We can stop it. And you know, the crude example that I use for these patients, they think it's not a big deal.

Potentially, I said I had a patient recently that, the, she went into the restroom in her home. The bathroom, and literally had forgotten how to have a bowel movement.

So that's a memory issue as well, obviously a cognitive issue. And so she's confused. She's in the restroom. She has the need to have a bowel movement.

So she has a bowel movement in her clothes. She then reaches back and grabs species and wipes it on the seat. And she doesn't know. She has forgotten how to have a bowel movement.

And and after two months of working her husband just doing everything possible to encourage her to get there, you know, all these foundational strategies.

Yeah. Keep the exercise, the diet, making sure, you know, because somebody at that level, they have no control, they're not going to they're not going to change.

Right. They're going to do all the wrong things if allowed to make all the choices. And so the caregiver or the husband in this case, was was the key change agent for his wife.

And within two months, she's now able to go into the bathroom and have a normal bowel movement and she knows what to do. Now, that's an example of reversal surgery, right?

Yeah, that's that's more critical in my mind. Yeah. Reversing a short term memory problem that somebody, you know, maybe forgot something that happened yesterday depending how, how important that information was.

And so individuals who have seen a family member go through this already have a much better understanding. You know why? It's worth every ounce of effort to put into it.

Now to number one, slow down that decline. Right. And if you slow it down enough, you know it. It's like like prostate cancer. The average prostate cancer in men. Right.

If you slow that down enough it's never going to be a problem. Right. And then number two stop in number three, begin to reverse that process. So I always explain it that way to my patients so that they know what to expect, and that even if they're not noticing any improvements.

And in the first couple months, I always explain to them, I said, listen, you know, you have to compare this to what otherwise would have been. Yeah. You know, of course we're dealing with a study of one at this point.

You know, we're about we're we're we're recognizing and helping them recognize that we're slowing down or potentially stopping progression. So that's why I have them on a weekly basis.

Keep a, a a journal of cognitive changes, good or bad. Yeah. You know, there's if there's one if there's one thing that would add that would, properly describe cognitive decline or cognitive cognition over time is there's undulations even while somebody is on, on this, this amazing rendition protocol.

There's got to be ups and downs. So, you know, life ends. Yeah. But they can learn from those up and downs and, and we see, we see the trend analysis where now we're improving over time, even though the ups and downs still occur at times, we're seeing an overall trend for improvement.

And that excites, patients when that happens. Yeah, it's a great point. Now, as we talked about, you are an expert in metabolism. But as you got going on this, you I know, became an expert also in dealing with bio toxicity, in part because that's such a common problem.

We have many people who are practicing, but they just avoid that part of it. Hey, you saw obviously, that a lot of people have this. What percentage ballpark of the people who come to you have some degree of bio toxicity?

Well, you know, my experience is most and the reason I say that, I'm not saying it's necessarily the most, important or critical part of their risk factor profile, but, you know, that's the whole point of, of of this protocol that you've developed is, is figuring out is making sure we're doing enough of it to get to that tipping point where the body's able to heal as opposed to gradually breaking down.

And so, I, I do toxicity analysis a second sometimes third tier, because there's so much to do. You know, with the metabolic analysis I began, I began not only looking at the hemoglobin A1, C and the fasting glucose, but I actually do a four hour glucose tolerance test with insulin and cortisol through those four hours on every patient.

And this is just my cognitive patient. I've been doing this for 30 years with all my patients, because I find what what I call this, this, perfect storm or where, where what happens is that you may have a perfect, you know, metabolic fasting glucose of, let's say, 70 to 85.

It's the optimal range, right? Oh, wait. Optimal range is much lower than the beginning of prediabetes. In fact, in my mind, prediabetes is actually stage three hypoglycemia.

Yeah. Okay, so there's two stages of high blood sugars that come even before prediabetes. And the most, sensitive way to to establish that this is a concern is by doing a glucose tolerance test that includes, one hour, a two hour, blood sugar to see how high the blood sugars go.

Yeah. Okay. And that can even get you into the pre-diabetic. Diabetic scenario, because there's a lot of diabetics that. Well, let's put it this way. If we just use an a1, C to diagnose diabetes, we're missing 73% of individuals that are diabetic based on their tolerance steps.

And so and so the glucose tolerance this gives us the but but this was a study done at the city of Hope. They have a whole endocrine section because of the relationship between insulin resistance, diabetes and cancer.

Right, right. And so and so, doing that, thorough evaluation of a glucose tolerance test picks up all kinds of hypoglycemia and hyperinsulinemia, especially with not only a fasting insulin, but a one hour insulin along with the one hour glucose after a 75 gram glucose load.

Right. Or 300 calories of your favorite sweets and or carbohydrates, if you prefer.

Metabolic Testing and Insulin Resistance

And and then the second hour, which of course, is is officially diagnostic for either prediabetes or diabetes. Prediabetes, 140 plus diabetes 200 plus. So, but the insulin levels at one and two hours are the most sensitive indicator.

I had patients you have perfect blood sugars, a perfect little curve of blood sugars. No elevation whatsoever. Not even into the the, first, your second phase of high blood sugar.

And and yet their insulin levels are sky high. In other words, they have insulin resistance, but their pancreas is hardly enough to produce enough insulin to compensate.

Okay. Where do you want it? Where do you want to see the insulin at that time? So. Well, okay, I, I say that, you know, ideal insulin is under five. I want wanted I want it at least under ten fasting.

Right. And then, and then the, you know, I and between the, you know, the the goal is under seven but ideally under five. So that's for fast. You know, of course when you look at insulin levels, you have to consider, what the blood sugar was at the same time.

Exactly. So you have, if you have a lot of, an insulin, for which normally we say that's great, but the fasting blood sugar is 100. Yeah. Which is the beginning of prediabetes.

There's a disconnect between the pancreatic output, the venous output, and, and and the blood sugars. And so, so clearly there is now apparently at least there is a beta cell defect okay.

Which which could be due to low grade infections could be due to toxins. You know, insulin resistance has more to do with toxicity than it does with excess weight.

Yeah, I just document that. So so so I and then I look at the third and the fourth hour, glucose and cortisol at those hours as well to see if that person has a drop off or what we call a reactive hypoglycemia mid crash.

Sure. So, so from a neurologic standpoint or from a hippocampal stress standpoint, we know that hypoglycemia is bad for the hippocampus. Okay. Hyperinsulinemia will well impair beta amyloid scrubbing or detoxification.

Right. Is the insulin degrading enzyme. Its main job is actually getting rid of, oxidized beta amyloid. Right. So so and and so, so too much insulin is really bad for the brain, because that that limits the amount of detox ification going on in the brain at any given day.

And then the hypoglycemic reaction is potentially even the worst of the three. But it's related to the three, because if the blood sugar goes up, the insulin goes up typically.

And then there is a reactive drop in blood sugars because of the access. So this is coming down. Yeah. So and so that low blood sugar we know basically blows up hippocampal memory cells.

And so you can lose hippocampal mass or volume with any one of those three in especially if all three are present. And I find a a significant number of my patients have both initial hypoglycemia initial hyper insulin MVA and then hypoglycemia an hour or two later.

Right. Followed, by by a roller coaster of cortisol. And that's equally bad for the brain as well. So so that's the the metabolic side actually. Then ties in to the evaluation of toxins.

Because I have I have quite a few patients that don't have the traditional insulin resistant or metabolic syndrome. They don't have. They're not significantly overweight size on a regular basis.

But when I do the glucose tolerance test, their insulin levels are through the rough. And, and it's going all over the place. And so and so I, I suspect in those cases that there is either some type of low grade infection that's persistent, that's driving inflammation and insulin resistance, or there is a toxicity issue, which of course is always the problem with infections.

It creates a toxicity issue. I could be mold or Michael toxins. It could be heavy metals, it could be industrial toxins, glyphosate. And so as some phase and once we get through the initial set of, the Recode labs, then I will add in evaluation for the hla d q for, for, for bone or bile toxin susceptibility.

I will add in, Michael metrics, test for, for, for mold in the home or the business. I will add in, I use the Great Plains laboratory to measure mycotoxins in the, in the urine, glyphosate, industrial toxins, etcetera.

And, and I find some level of toxins in everybody when I do all, all three of those toxin tests. Yeah. And, and, and I just consider it is one thing that, you know, if we're dealing with cognitive decline or cardiovascular disease or some other type of immunity, you know, if you just reasonable to include a thorough evaluation of toxins and then and then I appreciate your your work with Doctor Neil Nathan who who has really, made this clinically more reliable and clinically more, obtainable.

Yeah. And doable for the average patient so that we don't have to have a detox protocol that overwhelms the patient where they're having to do something 4 or 5 times a day.

They can. They can do it more. More, all at the same time, away from other supplements, medicines or food and and and begin a gradual but effective detox program.

Yeah. Great point. Now, what happens when you see the people who simply cannot make the insulin. So, you know, instead of having the high insulins, these are people that come in with a fasting glucose of 105, for example, and have a fasting insulin of, you know, 1.2, that sort of thing.

What do you do with those people? Yeah, yeah. So the first thing I do is, is I'll do that for our glucose tolerance test to see if that disconnect, that differential between insulin and glucose persists at one to, hours and so forth.

Sometimes I'll, I'll check insulin at three and four hours as well, depending on the situation. Then we'll look at, we'll look at is this we'll look at the C peptide.

Sometimes. That's not, not as important unless somebody is on insulin. Right. But but it's just another way to evaluate that the body's production of insulin under different stress scenarios.

The the the the key here, as I oftentimes will in those cases, if I confirm that the insulin response to glucose is, is way substandard at one and two hours, then clearly there's a beta cell defect there.

And and I will look for is there an other immune issue like like the Gad 65 antibody or the, the insulin? Autoantibody. Or there's, there's three different antibody tests that we can measure to pick up to see if there's any other immune driver of the beta cell, this function, and, and if so, then, of course, you know that I do.

Immunity in my mind, as I research about immunity is essentially strong. Only suggests that we need to evaluate for low grade infections. And and toxins.

Yeah, it's usually one of those two that is literally leading to that other immune exacerbation. And and so it all ties together right? It. Right. You really have to do the full protocol and, or the full assessment of the protocol before you fully understand any piece of it.

Absolutely. And I know you've had some excellent results. Tell us a little bit, for example, about, you know, you know, a patient, who's done well, and the sorts of things that you addressed for that patient keyword.

Well, I one example is, is the main case study that I put together in my book. Memory back over, How to prevent Alzheimer's and reverse cognitive decline.

Yeah. In that in that book, I basically tracked, a couple that I that was referred to be by a neurologist, who just, you know, was, was they didn't have anything else that he could do.

He, he'd done the, the, hippocampal volume metrics, and it was essentially, like, less than what, first percentile. This is a patient of his that it that he diagnosed with advanced Alzheimer's, over five years before.

And he was basically telling a hit her husband, that he was dealing with this. You know, you got to put her and, and, and, care home. There's really there's really you're going to burn yourself out.

There's nothing you can do. And he was just begging him out like, there's got to be something we can do. And you know the difference in these more advanced cases, where people would have in of themselves a, an inability to really understand how to do the protocol.

Toxicity, Genetics, and Immune Drivers

Right, it says is a spouse or a family member or an adult child really takes on this project and and, and makes sure that the protocol is being followed.

You know, that the fundamentals are there, that the diet, you know, the diet is a deal breaker if you don't follow the

diet, you're you're you're very unlikely to show success.

If you're if you're, you know, if if, if a family member is bringing, you know, lemon cake, you know, twice a week, yeah. You know, or whatever. You know, I love lemon cake, but I know that if somebody has problems with cognitive decline or they already have a, you know, a hippocampal volume, that's, that's, you know, under 50%, how they know they don't have a lot of reserves to work with.

Right? We have to we have to guard that as much as possible. You know with some the good news is that while it's true that many of these patients are losing over a thousand hippocampal cells a day, okay, the research shows that you can actually gain seven 800 or more new hippocampal cells a day if you remove the things that are holding it back, right.

The toxins, that's the high blood sugars or the low blood sugars or or the lack of, of optimal sleep. And, you know, all the things that, you know, you have so effectively outlined and, and the recode protocol, we need to take advantage of those bit.

By doing so, we can regain hippocampal volume, meaning we're gaining a thousand or so new new hippocampal cells every day. And so so this one case study I, I, I, I actually, you know, actually conversed with you several times about this case study because I was like, I didn't even know if I wanted to take it.

I, you know, it's like, wait a minute. You know, this is advanced Alzheimer's for five years. I didn't want to give this this, her husband, you know, I didn't want to give him false hope, but I also, I pointed out to myself that, you know, everybody does.

Deserves to be given some hope. Yeah. You know, because there's so much that we can do. There's so much available to us in this protocol that we can begin working on.

And so, making a long story short, I actually spent I spent an hour with them every month for 18 months. Now, I know that I don't usually do that. I usually say that most of my patients, I tell them I want to spend as few sessions with you as I can to get you up to a maintenance protocol, and we can follow up maybe, maybe once or twice a year, depending on what the risk factors are.

Making sure that we're making adjustments in your overall plan. But most people are going to take about 5 or 6 one hour consults to get them to that point.

So we'll take a lot more like this advanced case. Yeah. Now I'm only seeing them once a year now. So this is a patient advanced Alzheimer's for five years.

After four months the the doubt they Sundowning syndrome completely gone. I mean, this lady was packing their bags and and wanting to be with her mother, who'd been dead for 30 years and walking out of the house for 3 to 4 hours every evening.

And this had been going on for years. Yeah. Three years. Can you imagine the disruption in your life if you're spending four hours every evening, you know, just trying to keep your wife from from going outside and, and and getting lost with her, with her suitcase.

Well, within, within about three months of following the protocol, which, you know, to his credit, he figured out a way to get her to exercise, you know, so people say, oh, my, my, my spouse would never exercise.

And, you know, they they're not going to exercise. Well, hey, be creative right. Find a way to make it work. And he he he basically discovered that she'd love to go on a little drive.

You know, so he'd take her a little drive to the mall. They'd go walk around the mall or walk the walk inside the mall. So they they he took the time to figure out what it was going to take to get her to exercise every day, because without that, it probably wouldn't work very well. Right.

So a lot of these strategies are are dealbreakers. If they're not found, you need to follow multiple strategies. That was before you're going to get the results right.

So that I think some people don't get results, because they're they're two unit dimensional. They're saying, oh, I'm really good at dealing with this.

So I'm going to focus on this part. But to forget the other aspects of the Recode assessment, which are maybe equally or even more important than the one that we might be really good at.

I said, well, we have to we have to be willing to expand our horizons clinically, especially in this, in this area of cognitive, decline. So, so, so the Sundowning syndrome went away within three months, never came back.

Bring it back. And they did come back one time when she, accidentally fell off the bed rug. Had to go in for rehab. And during the rehab was a nightmare because of course they're not.

You know, they want to feed her the regular, you know, rehab, food and so forth. And so, so again, my, my, my friend, her husband, she, he figured out a way to sneak in the the smoothies with all the supplements in it.

Good luck. And and, you know, he learned you don't you don't ask permission to do that. Right? Right now. Because then that sets you up for medical legal issues.

And so the he figured it all out and he did it and it worked. Right. And that would reverse again. So so the good news was that after after a year and a half of doing the protocol, she, she had totally forgotten all family members, not not recognize anybody for years.

Went drove four hours, to visit, her sister, he drove her and she now was aware of where she was. She was spatially oriented. She said, hey, you're supposed to you're supposed to turn back there.

You know, he she actually started understanding. Yeah. Was in place in time. Was she had no understanding of time or place, and prior for, for at least three years prior to doing this protocol and then when she got out of the car at her sister's place in another city, she saw her sister and she ran to your sister and hugged her, called her by name.

Wow. Ride with her and had a wonderful discussion of of of them growing up together and so forth. None of that had happened for three years. So, you know, that was so rewarding to me.

And of course, you know, to him and to her and her sister, and and now, you know, I, I, you know, I said to him, because, you know, there's so many you know, you've heard many times say, well, you know, I there's just too many supplements to take.

This is just too much work, you know, let me know when it's only three things that I need to do, and then I'll do it kind of thing, right? Yeah. It's almost, I said to him, after all this and improved.

I said, hey, John, not his real name, but I said, hey, John, that's his book pseudonym. I said, hey, you know, you you're you're actually, you know, spending a lot of money on the supplements, for this protocol.

You want me to help you kind of, tone that down significantly? Save money? Not on your life. He said, like, oh, really? He said, I did. I did the math on what it would cost to have my wife in a memory care center.

Yeah. And what I'm spending on supplements is not even a fraction. Right. Well, I would have to spend. I would have had to mortgage my house. I would have lost my house.

And, and and they wouldn't have even done anything to really benefit her other than just take care of her. Yeah, it's a really good point. It's so I, I always remember that because, you know, as sometimes we get concerned about what the effort and the, the money we're spending on the actual program.

Right. That's nothing compared to the cost. If, if cognitive decline progresses. Not exactly. It's a it's a it's the best deal ever. So, so now now three years after the beginning of then starting the Radisson protocol, which was, which was managed by the husband, this his wife would have never been able to do this on her own.

He says to me, says says doc, I have my wife back. I've had my wife back for three years now. For the five years prior to that, I didn't have my wife.

She was in the house, but she was not present. Right now she's present. She'll come into the room and stick her tongue out at me and laugh. You know, like we did when we were young and, and, and, you know, I just feel so good to have her around.

She still technically has Alzheimer, right? But that doesn't matter. Right. So he has his wife back. You know, she is now functional. She's able to do things that she hadn't been able, that many things that I've been able to do for five years prior.

So. So that to me is, is is a great example, of somebody being at the end, you know, like, and, and, and they and they actually came back and, even though there's still an Alzheimer's, it's not no longer that advanced form of, of, of, of just being an invalid, not being able to do more of a, vegetative state.

Yeah, yeah. And now, now they have a, they have that connection together again. Yeah. It's a great point. So you brought up an important point, which is the cost.

And people ask about this all the time. The average cost for a person in the United States who goes through Alzheimer's disease is $350,000 spent. Of course, a lot of that in nursing homes.

And so I usually tell people, look, take, you know, one tenth of that, it'll probably last you for the rest of your life if you do the right things, you stay out of the nursing home.

What would be your ballpark estimate if you're going to the doctor, if you're, you know, taking appropriate supplements, you're doing, even health coaching, what would be your ballpark for?

What do you think this, what, you think someone would spend in a year? Again, if you go into a nursing home, it's going to be something like 90, 100, $110,000 per year.

What would be your ballpark for? What it would take to do the do the approach, the protocol personalized for you? Yeah. My my my experience is, is that it's roughly 10 to 15% of that costs.

So yeah. Yeah. Well so they're they're going to be I think, you know, it's reasonable to expect that they would spend maybe up to $15,000 a year. Now.

That's if they're doing a lot of stuff. Right. You know, and, and and, you know, I, I, I really, I, I feel bad when, when, patients, are being asked to pay out a lot of money upfront for big programs.

You know, I think, you know, the record program is, like, the best deal ever, because, you know, for just, you know, around $1,000 or less, they have access to so much information.

The best health risk appraisal I've ever seen. And I used to be the director of corporate wellness for Loma Linda University. I mean, wonderful health risk appraisal and, Yeah.

And, you know, it's detail. You know, it just gives you so much information. Right? And if you have access to a health coach and and to a, a reticent provider that understands how to apply the program overall, you know, that that and, you know, my experience, it's going to take, you know, a monthly visit for a period of, 6 to 8 months, right.

Case Study: Advanced Alzheimer's Improvement

To go through the toxicity, I spent about two full sessions on genomic analysis alone. Okay. Which which I know a lot of doctors don't do, but, you know, I, I did, a thorough review of 23 and me, you know, not using their interpretation, but using their raw data and and using, you know, other apps like of our support.

Right. You know, 50 page document and then, of course, I spent thousands of hours study genomics to figure out what to do. And so so I had like a 24 page narrative document I put together that I, that I look at the top hundred 50 genes and their mutation snips that, that give us clues of, of what to do.

And so here's what I say about genetics. See, we were all trained that genetics is a non modifiable risk factor. Right. That's really misleading. Yeah.

Because because while we can't change the gene itself we absolutely can change the expression of the gene. And we absolutely can change the downstream biochemical effect of that gene. Right.

Following where the mutation in. Yeah. So if it's if it's for 677 mutation, for instance, we know precisely the biochemistry of that, of that gene defect that leads to an enzymatic defect that leads to, biochemical defect downstream.

Right. And so we know that if we just appropriately supply the methylated, folate and the methyl B-12, etcetera, that, that by checking homocysteine and other in other related snips as well, we can figure out to how to undo or neutralize the negative downstream impact of that genetic mutation.

And so I, I, I find that it's extremely helpful to spend at least one full session, preferably two full sessions, because we get into clotting factors.

Doctor, is that I found out ten years ago when I did that for myself that I was factor five lighted mutant. Oh, so so, you know, and then I help my family figure this out.

I have I probably have 15 extended family members that are factor five. Mutant. Yeah. Which means that that even with the heterozygous single copy mutation, factor five, that's, about an 800% greater risk of, of having, blood clot.

Right? That's why it's really important to know. Yeah. Okay. So so do you take the age of Covid, right? Right. So, yeah, the genetics is, is a wonderful way to to help us understand what else we can do.

It is not. And even the April E4 mutation, it's not it's not fully penetrant. It's not fully deterministic. It gives us an understanding of what else we need to emphasize to do better and reach our goals.

So you talk a little bit about your immersion program. I know you've had immersion programs with your patients, and I realize with Covid things change.

But certainly even pre-COVID you were doing immersion programs. And what's your takeaway on these? Has there been success? Do you find this helpful? Do people share information?

Do they does this help with best outcomes? Yeah. So the immersion program I did, was basically a 15 hour program, where we literally I did I did presentations for, an average of five hours a day.

So it's actually over a four day, a four day week mark where patients and their family would fly in to, to San Diego. And, we had we we had this at a resort, at Coronado Island, the Marriott.

So it was it was a wonderful experience. You know, it got a little expensive, right? Sure. So I realized early on, and fortunately, I didn't I didn't know a pandemic was headed our way, but but I, I had it professionally videotaped.

And so I now have the entire program as, as a membership option on my website. Dr. youngberg.com. So that patience especially is there in between sessions with me.

And any family member can access that so that they all learn together the bigger, the bigger picture that you taught us years ago. And in your immersion program.

Right. That we did at, is there in, in San, in San Francisco. If so, at any rate, I find, now, since I have patients from all over the country, it's, and I do zoom a lot of the day, you know, I, I love it when somebody comes into my office these days.

But, you know, Covid kind of spoiled everybody. It's, Oh, they know they can just do a zoom, call it, even if they're even if there are ten miles away, they go like, to busy to drive over.

So I'll do a zoom call, which is fine. You know, it's it's very practical article. And they can get all the handouts online and, and go from there. Yeah.

And in your estimation with now with all the patients you've been seeing, what are the most critical variables that you find that are associated with cognitive decline.

And in, treating them seem to be associated with best outcomes? Versus what are the things that have led to the least good outcomes in your hands? Well, you know, I'm always asking the question, what else can we do?

Yeah. And so, so I'm not trying to cut, you know, and redefine even though I understand the potential need for that. It's with certain practices. Yeah. I'm.

I'm always asking a question. What am I missing? Is there something else that that we need to do? So that's why I have my checklist and and my spreadsheet.

All labs, along with the checklist to make sure I'm man, we then get that lipoprotein level, you know, I of a second phase lab. But, I, you know, I'm finding quite a few patients that may have perfect lipids, but they have, a very elevated lipoprotein.

A yeah, it's it's a totally different genetic issue. Then then lipids are themselves. Yeah. And so and so, I, the more, the more we throw out the net to look at other risk factors, the more likely we are to catch these outlier variables that previously we weren't picking up.

So, so, but to answer your question, as we discussed on the metabolic parameter, you know, insulin resistance is a critical, critical area. And, and so, I find it very important to, in addition to the importance of the fasting insulin and the importance of the fasting glucose and a chemical of an A1, see, measure that we need to go beyond that and, and look at, look at like this glucose tolerance test levels, because that picks up a metabolic defect that otherwise would we would tell the patient, you don't have any rest in that area, when in fact, they may have a considerable risk in that area.

So, so the but but another reason that such an important test, in my experience, is because almost every other strategy that we incorporate from the Recode report actually ties into that.

For instance, exercise in exercise is a powerful reversal of insulin resistance, especially the exercises that most people don't focus on, like strength training exercises or the the walking immediately after meals to block that rise of sugar and insulin that is such a powerful driver of it.

Basically, I call it transient dementia, you know, so that was go up with the insulin levels go up, and then the blood sugars crash. You know, I mean, I have patients who go through the test and they're reading a book while they're doing the test.

And about three hours into the test, they're going like, man, I had to read that page three times. Yeah. It's not it's not sticking with me. And that's because the blood sugars have dropped.

And now the cortisol levels are surging and and the brain is just not holding on to information anymore. Well, the

mental genic experience that's related to exercise and diet and snacking and, and, you know, all those very, toxins.

We as we mentioned, the, the sleep, you know, they're just just having one night of poor sleep. Yeah. More insulin, significantly more insulin resistance.

Costs, Immersion Training, and Key Outcome Factors

So, so in my mind, the emphasizing that metabolic evaluation ties in almost everything else that we do. And the Recode program. Interesting. And have you been seeing people with a Covid related brain fog.

Oh absolutely. Yeah. I'm, I'm, I actually am working with quite a few patients that have, long Covid. I'm dealing with patients that have, bad reactions to the vaccine, which, which is kind of a similar thing is long Covid, at different intensities.

And, and so, yeah. So the, you know, the, you know, this is interesting, the record program, you know, the British protocol is one of the best things that you can do to optimize your immune system.

Yeah. Because because it's really looking at all the parameters. Right. In order to do the required program properly, you have to optimize your immune system.

Yeah. You have to look at all the things that are trying to take your immune system down, the lack of vitamin D, the toxins and and and etc., etc., the lack of antioxidants in your system.

And and you know, the copper, copper zinc ratios, which pretty much everybody I saw when Covid began, pretty much all my patients had high carbon levels.

And just like what's going on here. And so optimizing zinc and optimizing several of plasm so that you have a low free copper level, those became important strategies to optimize your immune system as well.

Yeah. Fantastic. All right. Doctor Wes Youngberg, thank you so much. Always great to talk to you. And congratulations once again on the great outcomes you're getting through patients.

It's just so exciting to see and I look forward to future discussions. Thank you. And work for for me, being at the very beginning and teaching us and sharing your knowledge with us so that we can then share with others as well.

Thanks. You know, there's I think there's so much more for all of us to do to reduce the global burden of dementia and, of course, to continue to, as you said, just keep working on how to keep, tweak and keep optimizing things.

So this is fantastic. So thanks very much. And at this point I will stop the recording here. Let's stop that.