Welcome and Cardiovascular Health Overview

Hello, ladies. Welcome back to Mastering Your Menopause Transition Summit 2.0. I am your host, Dr. Sharon Stills and excited, as always, to be here with you today.

And we are going to talk about a very, very important topic. We're going to be talking about cardiovascular health, which women sometimes overlook. And after we have this conversation, you're going to understand why we're having a whole conversation on it and why it's such an important topic.

And I couldn't think of someone better to have the conversation with than a fellow doctor talk Summit host. So many of you may recognize him because he just hosted his summit on heart disease and heart health and he's going to be hosting another one.

So, Joel Kahn, Dr. Joel Kahn from Detroit, has a practicingcardiologist, has authored books. He's now a summit host. He's just you know, he's out there in the trenches like me seeing patients.

And very much appreciate you taking his time late at night to come join us on the summit. So welcome, Dr. Joel. It's great to have you here. Thank you so much. It's a pleasure.

And it's such an important topic, like I said, Dr. Stills. So let's help some people understand, you know, all this you're doing in this summit will translate to hopefully better quality of life, better youthfulness, and maybe a better longevity.

That's what we want to do. And is what we're all about. Change in the conversation and then living the outcome in living healthy and long. And we know that as women go through menopause, cardiovascular disease becomes an issue.

So before before we even go there, I just if you just tell us a little bit about yourself and how you got into cardiology. Sure. Very brief. Nobody cry.

I was born 64 years ago with a heart murmur. My poor mother got all nervous when the pediatrician said that, you know, very early in life, I'm fine. I've never needed a heart surgery.

But I ended up seeing a pediatric cardiologist all through my childhood. And if you were to ask me about age ten, I said, I want to do what Dr. GREENE does.

I want to put a stethoscope on my ears. I just like the whole process, and it did not alter my life other than setting me up a little bit for a comfort level.

And then medical setting, hospital setting, got into med school pretty darn early at age 18 at University of Michigan, Ann Arbor. They had an accelerator program, and I just knew I was in the right place.

And I've never looked back. I mean, I grew up in a family business. There were other things I thought about for a moment, but never once regretted becoming a heart doctor.

Along the way, I developed a passion for nutrition. I've been a vegan for 46 years.

Dr. Joel Kahnu2019s Background and Cardiology Journey

Not everybody can say that. Age 89, a healthy one. Yeah. All lentils and arugula and sweet potatoes. Not impossible burgers and beyond meat sausages. And it's been an interesting path.

Now I am a board registered integrative cardiologist, functional medicine cardiologist. I left the hospital scene. I left the cath lab scene about eight years ago.

So very busy practice in Detroit with licenses all over the United States and enjoyed trying to, you know, help people follow my path. You know, I wake up in the morning with tremendous energy.

I'd say at least half of my practice is women. And we have to talk about the topics that we're going to talk about today. And it's so important. I still think heart disease in women is largely ignored, largely unknown, and yet it's it's vicious and it's deadly.

So let's talk about that. Let's do it. I love your story. And it gives my my granddaughter comes over and I have got her play stethoscope. And I taught her how to listen to bowel sounds and the heart and the lungs.

She's three, so I hope she'll follow in your footsteps from the early stethoscope. Very cool. Mine is 15 months and I'll have to get a little doctor get.

Good idea. Yes, I highly recommend it. Okay, so let's let's stay on topic. So what is the number one reason for death in women? Yeah, it's crazy. But in the United States and if people are listening around the world, it's no different.

Since 1918, the number one cause of death has been cardiovascular disease, which is heart attack, which is stroke, which is high blood pressure, which is congestive heart failure, which is dropping dead suddenly.

It's just talk for 1/2. There's something called sudden cardiac death. You know, if Graham was 92 years old and the family's around the bed and grandma's in hospice and she's had advanced congestive heart failure, it's very sad.

But, you know, it's it's a rite of passage. But you know, if mom is 51 years old and is at the gym on a treadmill and drops dead and is not given a chance to say goodbye to spouse and children and other people in her life.

And I'm thinking of a particular person right now when I give this little case study, I mean, it just multiplies the tragedies. So not only is heart disease remaining the number one cause of death in the United States for 105 years since 1918.

But women share that title. Sadly, they share it on average a little later in life. Obviously, 51 years old is not late in life at all. On average, later in life.

But it's just as tragic and it's just as concerning and it's largely preventable. We've had so many advances and they're totally underutilized. So I may, you know, touchy feely arugula cardiologist, but I order high tech labs and high tech testing because I'm going to find your heart disease and I'm going to stamp it out, even if it's, you know, a little bit of effort to do that.

It's it's not just a giant hug. It's it's some serious technology. And, you know, it's such a good point because I've been in practice over 21 years now, and it's and a lot of my practice is women, not only but no one ever really they come in concerned about breast cancer, but no one really comes in concerned about cardiovascular disease.

It's very on the rarer side. And so there's a famous graph or meme, but it's actual data from 2016, what people were Googling for causes of death and what our actual causes of death.

And it was 33% was heart disease. The Googles were 2%. People were Googling kidnaping more than heart disease.

Why Heart Disease Is the Leading Cause of Death in Women

People were Googling air pollution as a closet more than heart disease. It's a completely disproportionate focus. You know, the pandemic and everybody's been worried about viral infections appropriately, maybe a little bit more

than we needed to.

But we've just never launched a war on heart disease. And we need to because it's it deserves our attention. And we'll win it. Well, win it with arugula and technology.

We will add a little hormone a little hormone therapy to perhaps. Is that the name of your new book or regular technology? I think we're on a good value.

Let's get going. So you talk about testing. And so I just want to jump into that real quick for the women listening, what should they expect? What kind of tests and what should they expect to happen when they go to the cardiologist?

Yeah, it's not expect. I'd say demand because they won't get it. Typically. And you have to be an educated consumer. So if you just pause for a minute and think about it, you know, women here at age 45 about mammography and all of a sudden we're talking about age 40.

Very recently, women hear about colonoscopy. At age 45, they get a gynecologic exam for potentially cervical endometrial cancer. Men get the added prostate cancer evaluation.

And that's pretty much the list. And it's the same at age 50 and 55 and 60. Like there's something missing in that list. And if you're over 45, you ask yourself, Did my doctors say anything about screening me for silent heart disease, silent blood vessel damage?

Whether I have a strong family history, like a father or mother that has a stroke, a heart attack, a bypass or died, or whether I'm just another American that's been eating a bit off and been stressed and sometimes not sleeping well, a wife I influence and the world news and all the rest.

There's no screening program for heart disease. It's abominable for two reasons. The lab tests are available. They're not the standard lab test. You have to go a little bit beyond what the GP and the gynecologist and the internist ordered.

You want to know about inflammation? Everybody's heard that word has been on the cover of Time magazine. Inflammation is a root cause of cancer and diabetes and dementia, but it's certainly a root cause, heart disease.

So you get a high sensitivity C-reactive protein blood test. It's often elevated and it just makes you examine the diet and the dental health and the sleep history and the fitness history and the food history and the vitamin levels and a whole lot of other things.

You get a genetic cholesterol called light bulb protein, little AA, 25% of people on the planet, women and men. But let's talk about women have the ability to make to cholesterol's not just LDL cholesterol.

Sometimes we call it L for lousy. It's not all lousy. But when you have too much of it, it can be lousy. But 25% of people have two factories in their liver, the LDL cholesterol factory, and another one called the light bulb protein little AA factory.

And they're totally separate. In fact, the number one best selling drugs in the world, the cholesterol lowering statin medications like Lipitor and Crestor, which can be useful in the appropriate setting.

They're not horrible drugs in everybody. They lower LDL cholesterol production in the liver, but they actually raise the other one. So do you want to take a drug with no knowledge, blind faith that improves one cholesterol and worsens another?

You should know all these things, of course. Vitamin D levels, blood sugar like hemoglobin, A1, C insulin levels. So you get a little extra lab work that characterizes you.

Usually these can be run through insurance. Some people order their own blood work from lifeextension.com or lifeforce.com or some other labsthat will do that for you.

And the second thing you do, you say, you know what? They look at my breasts, they look at my colon, they look at my cervix. Why don't they look at my arteries?

And the answer is, you can you can do an ultrasound of the arteries of the brain called carotid arteries, the lowest level entry is lifeline screening.

That kind of business that goes through churches and schools and public centers. You can do a more advanced one like we do in my clinic called a C AMT, carotid ultrasound.

Screening Tests Women Should Demand

But then last thing, final thing, $50, $75, $99 is a heart CT scan that would say every guy by early forties and every woman by late forties, maybe earlier should spend $99 and get as called a heart calcium CT scan.

It better be a zero as you're a woman in your forties and you're not a zero, you have rip roaring early at the rose sclerosis going on. It's going to be a problem in your sixties or late fifties, but you can get a clue just like a pile up on your goal and could be can be a clue that you might have a future colorectal cancer.

So you're going to make changes more fiber, less sugar, less processed food. Go back for another call and ask be if you don't have a calcium score of zero, you have to pay for it yourself before.

Except for the state of Texas. State of Texas has an insurance program. You get one free at age 50 and with those two things, a few extra blood tests and a heart calcium CT scan.

The good news about the heart calcium scan. There's no injection, there's no pain, there's no claustrophobia. It's very low radiation on par with the mammogram.

It is a C, D, but there's nothing injected. And you don't do it often if it's perfect, if it's a zero. And I'm proud to say at 64, I'm still maintaining a zero score.

You do it in about seven years. Again, it's you know, you do a mammogram more often than you do a hard CT scan because heart disease so slowly accumulates and all.

But, you know, I get emails every day from all over the country. Doc, I just had that test you talk about all the time and I'm 649 and I'm scared. And the answer is you should be there's a brand new study out this week just a little bit, that if you go for this CT scan and you feel fine, I play pickleball and I have grandkids, kids and everything's good.

But my calcium score came back. 312. You're basically at the same risk of dropping dead down the road as somebody who had a heart attack. But you've had no history.

You just went for this little test. It means a lot. And the other study that came out recently, if I recall correctly, it's from Denmark. They do some really good studies that on average a woman develops these CT scans, on average about 12 years later than a man.

They become abnormal. But the risk when they become abnormal can be two or three or four times more than a man. So if you're a 66 year old woman and you've been post-menopausal for ten or 12 years, and you go for this scan and it was zero in your fifties, and now it comes back 189 or 342.

It's a number that tells you approximately how much plaque is in the arteries. It's later than a man may develop it, but it's more lethal and it's more deadly.

And you need more love and attention. So women should be in the center of this heart prevention bull's eye starting about age 45 and maybe even age 40.

And how often do you recommend women who are postmenopausal get scanned, then get one? And if it's a zero, about 5 to 7 years later, unless there's a type one diabetic, a cholesterol of 350, this lipoprotein cholesterol, if it were sky high, I might move it up to every 4 to 5 years.

But it doesn't have to be done very often. Lab work, maybe once a year. I mean, I see women and I'd tell them everything came out perfect and three, four years, you know, that's good, too.

But everybody should get screened. And it isn't only for the ultra wealthy. I mean, most people can afford a 99 hertz CT scan. Most of the blood work can be intelligently bought through the insurance company appropriately.

Oh yeah, I run fibrinogen, homocysteine, theory, actor, put all of these through a patient has insurance. It will cover it absolutely correctly. And what about just I find and I agree with you like there's no screening.

I'm always sending my patients like, you know, it's time to just go see a cardiologist and get like, what about an echo, an EKG, an exam by a girl? I grew up as a standard cardiologist with a nutrition interest, but a whole lot of children of cardiology just went to Ivy League schools because of a nuclear stress test.

You get on the treadmill and you walk to your tired, but you've got an IV in your arm and you get injected. It used to be a medicine called thallium. Now it's a medicine called CAR-T light or my review takes about 3 hours.

You get a Band-Aid, you go home. You never see the heart arteries. I mean, you do a colonoscopy, you see the colon, but you never see the heart arteries and a nuclear stress test.

It has 15 times the radiation of the heart c.t. Scan. You can get a whole life worth of heart scans. 15 of them to equal one nuclear stress test. And you can walk around with 50% blocked heart arteries and have a normal nuclear stress test.

So I'm completely and utterly opposed to using that as your screening test. If you're going to get on a treadmill, ask for something called a stress echocardiogram.

It's the same setup. But he uses ultrasound, so it's zero radiation. It only takes 45 minutes and it's actually less expensive. So everybody wins, wins, wins.

An echocardiogram is not a good screening test for heart disease. It's appropriate if there's a heart murmur like I had, it's appropriate if there's high blood pressure, it's appropriate if there's palpitations or blackout spells.

And a lot of women suffer from those. But most of those are not serious disorders, although they can be very troubling and very scary, in fact. Great.

Thank you for clearing that up. So now you ladies know what you need to go. And I like what you said. Just say no to a stress nuclear scan. I, as a former board certified nuclear cardiologist with many publications in the field just say no to it.

I mean, I have to like, say mea culpa for all the ones I ordered 25 years ago. I hear you. So all right. So menopause. So let's talk about why are we talking about cardiovascular disease on a menopause summit?

What do you mean. Classic, you know, case study. Yesterday in my clinic, a 58 year old woman came to see me because her cholesterol's 260 LDL is 170. And we went through online from the hospital, her cholesterol history to 10 to 10 to 10 to 10.

Now, you know, it's up to 260 with it. LDL cholesterol, 170, pretty high. Yeah. I said to her, what's happened to you in the last two years since your last cholesterol level that your cholesterol shot up?

Did you gain weight? Have you had sleep changes? Have you changed your diet?

Menopause, Hormones, and Heart Disease Risk

Have you gone to the ketogenic diet that could do it if she suddenly went to a a beef butter cream in my coffee beans diet, often called the ketogenic diet, I got a B. S. diet because there's no science to it.

I'll be a little controversial. As a strongly known proponent of vegan nutrition, she said. Well, I've been through menopause. Is it bingo? Of course I knew that that would be about the right time.

We've gone through menopause, age 54 or so, and that's what happens. You know, you stop sleeping. Well, if you ever slept well, you gain ten, £12. You find it's not so easy to lose weight anymore, even if you try various fasting techniques.

I'm a very big fan of the five day prolonged fasting mimicking diet plan, but guys lose weight easier than women when their women are in their post-menopausal region.

But most importantly, there are women that get serious heart disease before menopause. Some of them, it's obvious they're smokers. They're type one or type two diabetics with obesity and hypertension.

Some of them have genetic input like that, light bulb protein a second cholesterol. I call it the silent killer in one of my books. But most of the time, women are pretty insulated from heart disease and they'll have a calcium score of zero if they go for the testing until menopause.

And then it doesn't happen overnight. But the wheels are turning the cholesterol has changed, the blood sugar changes, the sleep changes, the weight changes, the hormone levels obviously change dramatically.

And arterial disease can start to form. And there's been this giant controversy. In the 1990s, the American Heart Association recommended hormone replacement therapy for heart preventive therapy, and they didn't do it for no reason.

There were quite a few studies that suggested that at menopause, hormone replacement therapy could return a woman's sleep and or some of her blood sugar and cholesterol levels help her maintain her weight.

Good data, that hormone replacement therapy was generally artery friendly choices. But as many people know, in 2001 two studies came out, the HRC, hers study and the Women's Health Initiative study, and they seemed to report completely different findings that women placed on premarin and progestin two synthetic one the very famous Premarin derived from horse urine.

The estrogen form certainly not human forms, but that there was an increase in blood clots and cardiovascular events. And, you know, almost never has there been such a radical transition in the approach to a entity menopause as there was after those two studies where, you know, the rates of prescriptions of hormone therapy went down dramatically 80, 90% on average.

And there's been a lot of conversation. And what I point everybody listening to is a hardcover book. I wish it came out in paperback, but I just look today on Amazon, it's not a paperback.

It's called Estrogen Matters. I don't know if you've read it, Doc Stills, but Estrogen and made two eras incredible scientific review of what actually happened before 2001 what happened in 2001?

Why was the media before we talked about disinformation, pretty much just informing the public about the nature of those studies. Very rare because it actually harmed the pharma cynical industry.

And we know how powerful the pharmaceutical industry is with the media, but we're talking over 20 years ago and things are different now than they were then.

There may be a little more honesty back then, maybe. And Estrogen Matters lays out the fact that there was a lot of spin going on and women did not benefit from it because basically you still have the heart disease is still had the number one killer of men and women.

You still have the fact that after menopause, women's arteries were aging and silently and progressively and seriously, but we took away one of the therapies that at least in the 1990, seemed to be very beneficial and then came out a reevaluation and new studies.

And I point also to maybe a colleague of yours, Dr. Felice Gersh, great HMD, an obstetrician. Gynecologist, talking at a party. That wonderful. So, yeah, in Orange County, California, a dear friend of mine who really has joined hands with cardiology to write some very good actual medical scientific papers and really lays out something that women ought to know about called the timing hypothesis that the biggest flaw to those two studies in 2000, one, that the average woman enrolling in those studies was in her mid-sixties and had been postmenopausal well, more than a decade, maybe 51, 50 to 53 years old, period.

Stop advisories occurred, sleep got rocky, cholesterol levels went up, weight became a bit challenging, but they were not placed on what was used, particularly in the age II, the conjugated estrogen, premarin and these synthetic progestin until they're, you know, more than ten years after menopause, when there had been probably more than ten years of arterial damage, many of these women had serious, significant risk factors for heart attacks and strokes.

And then they used, you know, synthetic and maybe suboptimal pharmaceutical agents. And they did not see pretty findings. And even in the reevaluation of those studies, the women that were earlier from their onset of menopause when they started pharmaceutical agents, particularly less than ten years, and that's called the timing hypothesis.

We've seen this in other places. I can think of a nutrition example where what's good early in life isn't so good. Late in life, it's we're not identical when we're 66 and when we're 52.

But women that are 50 to 53 or 54, 55, 56 that went through menopause, you know, within the last ten years or less, the sooner the better that get on hormone replacement therapy.

And many of us in our field believe that the most natural approach and the most properly dosed approach, often called bioidentical hormone replacement therapy, is a whole different approach than what was done in the debate by Women's Health Initiative in the her study.

And so the pendulum is coming back, but it's not coming back all the way. If you talk to your typical gynecologist and they're good knowledge is they may give you a very mixed picture about the net benefit, but the net benefit for cardiovascular disease, speaking as a cardiologist, is something that, you know, I talk to my women patients as early as I can about, you know, either when menopause occurs or if you're in menopause now and it's fairly recent, we need to find you a good hormone replace one specialist.

You know, some people favor saliva testing. Other people do it by dried urine testing. Some people do it by blood testing. But somebody that's going to work with you and get you on a program and reevaluate and retest and adjust and balance and really do it with extreme care and I can tell you my own family and my own wife and others, there's no doubt it's a powerful youth supporting approach.

And I think cardiovascular supporting approach to I'll say one last thing. I've mentioned two or three times, this special cholesterol called light bulb protein, little egg.

And this is like a nasty cholesterol. In some women I see women that have really advanced silent heart disease based on c.t scanning or ultrasounds scanning.

And the only thing in their profile we determine is that they inherited from their parents the ability right from birth to make this second cholesterol.

And right now there is not a approved, FDA approved pharmaceutical agent to lower this second cholesterol because as I mentioned, Crestor and Lipitor and others don't work.

But bioidentical hormone replacement therapy does work. It does lower lipoprotein little AA. So it's maybe particularly important as you approach menopause to know if you're in the 25% that has this genetic risk factor for cardiovascular disease, heart attack and stroke.

And ask your gynecologist, are you aware that I may benefit more than average? Now, these studies haven't been done. It's a consideration and it's a discussion and it's a risk benefit.

But that they may benefit, particularly from HRT. Mm hmm. Yes, absolutely. And I just want to go back to testing of hormones, because it's part of why I run these summits, because I'm very passionate about women being tested.

The proper way. And so 24 hour urine testing, not dried urine, but actual collecting your urine for 24 hours is the gold standard way to have your hormones checked.

And so there are lots of things we can look at in the blood, but you can't see metabolites. So it needs to be a combination of bloodwork, looking at your DHT, looking at your fbg, looking at thyroid markers and things.

But you have to be getting 24 hour urine hormone testing. It is the best way, which is why women come from all over to see me, because we get really good results and we can really balance your hormones properly.

So I just have to say that because I see women come in, they're tested on saliva, they're testing the blood and they're totally misled.

Cholesterol, Inflammation, and Personalized Risk

They're either told they have too much and they have to lower their dose, and that's not true or vice versa. And so you just don't get the whole story.

And so you answered a bunch of questions. I was going to ask the one question I'd like to just ask before we wrap up is I'm just curious of your views on cholesterol, because we've been brainwashed that cholesterol is the enemy.

And I would like to hear what you have to say about that. And you may or may not disagree. I don't call LDL cholesterol, lousy cholesterol. There clearly is a need to support hormone synthetic production, vitamin D production, cortisol production.

But all you got to do is be a cardiologist for 33 years to see the impact. In some people. That's the oddity of heart disease. Give me two people with a cholesterol in 250 and the LDL cholesterol, 181 will be at risk for death, bypass and stents and one will have clean or nearly clean arteries.

It doesn't mean cholesterol doesn't have a role. It just it's not a perfect predictor. Smokers don't always get lung cancer and diabetics don't always have an amputation.

So you test you don't guess as I use a hashtag all the time test, I guess. But the fact that elevated LDL cholesterol can be a killer is indisputable.

That's certainly agreed upon by 99% of cardiologists worldwide. It's been called causal, not not associated that it is in the arteries that are narrowed and causing symptoms and causing air attacks.

You know, it is what's found under the lining of arteries, leading to inflammation, leading to oxidative stress, leading to scar tissue and plaque formation.

And all you got to do, as I did when I was a cardiology fellow, is take care of a child called Stormy Jones. Stormy Jones had a perfect body. With one exception.

She was missing a amino acid so that she could not make what are called LDL receptor was on her liver. So her cholesterol was 1100 from birth and she had bypass surgery by age nine.

All you have to do is take care of one child and the only thing wrong with them is they had an excessive cholesterol from birth. And you can see by, you know, late, late childhood and early teens, strokes, heart attacks, bypass and stents.

Now, thank goodness we have created amazing ways to deal with it and we still need better ways to deal with it, which is really true genetic engineering to shut off the gene disorder and replace with a more normal gene.

But yes, I believe that excessive LDL needs to be evaluated as a cause of heart disease in every person and on the other end, don't be so confident. My cholesterol is 130.

My doctor says my LDL of 60 is amazing because you might have that lipoprotein a or you might have a homocysteine problem. You still need the heart scan to figure out this very complex situation.

So I use a small amount of aggressive plus glowing therapy in my patients, but it's only those that have advanced heart disease. And I. I enjoy taking women off statins that we prove have healthy, youthful arteries, and maybe we'll do HRT instead of statins and maintain their healthy, youthful arteries.

So if someone has a high LDL but their inflammatory markers are normal, are you still concerned about that high LDL? And what do you consider a high LDL?

Yeah, well, a high LDL is an LDL in somebody that has a calcium score over zero and a high LDL is high LDL. And somebody that has plaque in their carotid because it's really correlated with their anatomy, because I'm not concerned about a high LDL and somebody who has wickedly clean arteries, you know, in a population of a thousand patients, it's clearly worse to have high inflammation numbers and high LDL cholesterol numbers.

The one two punch is dangerous, but on a one on one, I'm sitting with a patient. A lot of them have really nice inflammation markers and I get a lot of them and they still have plaque, so it doesn't work every time.

Maybe they had bad inflammation numbers a year ago before they came and saw me, and that's why they develop coronary disease and they've made lifestyle alterations and got good dental care and lost weight and practice fasting and do other things to lower their inflammation.

But you check it all. But it is it you know, if there is an inflammation, they get a pass, they can have a heart attack. It's simply, you know, not exactly what they described at Harvard in Dr.

Paul Richter's studies. A recent study said high C-reactive protein is more dangerous than high LDL cholesterol. The two together are the most dangerous.

When you, again, sit with one patient and talk about their risk, you got to get all the data. You can't just let them leave because their C-reactive protein is ideal.

Exactly. You are all individuals and need to be treated as such. So any last words of cardiovascular menopausal teachings, wisdom, knowledge that you would like to share with the listeners that we didn't already talk about?

Well, I just say, again, I think we're doing a really deficient job evaluating women, screening women, following up with women, talking about hormone replacement therapy.

Heart disease is a real deal. And even if you feel good, I can't tell you how many women in my practice are thin. Go to yoga, pilates, pickleball, eat, you know, arugula salads with avocado and walnuts with balsamic vinegar.

And they have silent heart disease that they're shocked by. So just get checked. Even if on the outside you feel like you're insulated from it, confirm it, make sure we're talking the number one risk to your health and don't assume

just because you're in your size six dress that you can't have heart disease.

Unfortunately, you can know it's it's a nice thing. Do we have good weight control and every other aspect of what we might call a healthy external lifestyle, but it's a wicked disease and treat it with respect.

So that's getting that calcium CT scan. And those additional labs if we can arrange them. And actually, I do have one more thing to ask you kind of alluded to before, but I would like to ask about your I know you're a vegan.

Right. And so I'm curious. Do do all your patients become vegan? I'm just curious to hear like what your your thoughts are because, you know, everyone's into Kido and Carnivore and you're a devout vegan.

Obviously, it works very well for you. So I'd love to just we have really talked about that on the summit yet. And so I love it. And again, since age 18, 46 years, it has worked very well for me and I do it pretty well.

I mean, it's whole food, organic with a fair amount of supplements. I like supplements. So my Omega three levels good and my vitamin D levels good and my vitamin K2 and iodine levels and various others.

These are actually very simple to provide kind of a nutritional support to a plant based diet. All my patients hear about it. They know when they're coming to see me, but I have paleo and keto, I have carnivore patients, I'm respectful, strong with them.

Diet, Prevention, and Where to Learn More

I mean, my most recent carnivore patient has a cholesterol of 480 and she seems not to care much about it. So I am not going to call her a fool, but I'm going to call her at risk.

They all have to do homework. They all have to watch forks over knives. They all have to watch what their health. They have to watch the Game Changers Movie three very popular health documentaries on the Internet that are easy to access.

And then we discuss it. And if they're sick, they're going to accept this very readily. I'm blown away when they come and see me the first time. And they've already made the changes.

They watched the documentary and they've lost £60 and they're off to medicine. This before I got to them and I just got to go, you know, I tell them I've been doing this so long personally that I don't see dramatic changes, just maintain very good high energy and good health, which I'm very grateful for.

And I do all the testing all the time, every test the world I do remember I used to see some that erratic. I just am kind of interested in the new age of, you know, advanced and artificial intelligence medicine.

But I'm also just blown away by people. One visit, six weeks later, they actually watched four eggs overnight and now they're having a green smoothie for breakfast and a giant salad with beans and ham for lunch with balsamic and olive oil.

And they tried a lentil stew and, you know, they're down £12 and their eczema is better and, you know, is it the perfect time for everybody? Of course, we don't know the answer to that question, but I think it's the most perfect diet of the choices that are out there as a heart focused doctor would say, because the most data for prevention and reversal of heart disease is plant based diets like 100 to 1 because there's none for carnivore and there's none for Paleo.

Even though my friend Jack Wolfson says there is, there isn't. And, you know, there's a nice amount of data for the Mediterranean diet, but there's a lot of data for disease reversal with plant based diets.

And so I that's what I think ethically, I have to teach patients. That, you know, and we we cover lots of different diets on the summit. And, you know, I just wanted to bring that up because.

Sure. Just to show there's like there's different viewpoints, there's different ways of doing things. And you have to find what works for you. And one of the things I see with vegans is often they're unhealthy vegan, so they just cut out meat, but they're eating pizza or like you said in the beginning, impossible burgers.

And so on. How you do something definitely has a big degree of how it works for you. So yeah, that's why we like that term of PB whole food plant based, you know, emphasize whole foods because the nature of the outside of the grocery store inexpensive and.

I'm not vegan I'm paleo and paleo works amazing. Yeah, no, it's a clean diet. You're not eating garbage. That's obvious. Step one Don't eat garbage steps to find the good foods.

There you go. So well, thank you. Thank you for taking time out of your busy practice and life and teachings and education and all that you do to help change people's health for coming here.

Because I really feel like if you listen to all these things and the summit and we've talked about so many amazing things that the test you talked about today, if you take nothing else but just go do that test, like then our job is done and we have helped contribute to you having a healthy life or preventing or knowing what's going on.

And so I really appreciate you being here and sharing with the audience. Thank you very much, doc. And for those who want to, I know you will have a summit coming up next year, but for those who can't wait, where can they find you?

To find out more? Yeah, I'm on the web everywhere. Instagram, LinkedIn, Facebook, Twitter, you know, so many times a day. It's ridiculous. Predominantly on my website.

drjoelkahn.com drjoelkahn.com links to my weekly podcast, link to my clinic, link to my books, blogs, and very high output of educational material every week.

Awesome. Look, go check him out. It just could save your life. Certainly will change it. So thanks everyone for being here. Heart, we love you. And we'll be back with another talk.