



Dr. Steve Sinatra: You feel tightness in your chest, shortness of breath or pain in your left arm. Your mind immediately pays more attention to that master organ pumping all day and night, but how much do you really understand about what helps it and what hurts it? For example, your doctor may be wrong about cholesterol, and you should know you're never too young to worry about heart disease.

Dr. Drew Sinatra: We're going to show you why your heart matters, how to really take care of it and why women need to pay as much attention to their heart as men.

Dr. Drew Sinatra: I'm Dr. Drew Sinatra.

Dr. Steve Sinatra: And I'm Dr. Steve Sinatra.

Dr. Drew Sinatra: And this is **Be HEALTHistic**.

Narrator: Welcome to **Be Healthistic**, the podcast that is more than just health and wellness information. It's here to help you explore your options across traditional and natural medicine, so that you can make informed decisions for you and your family. Health isn't a one-size-fits-all approach, everyone has their own needs to **Be Healthistic**. This podcast illuminates the whole story about holistic health by providing access to the expertise of Drs. Steve and Drew Sinatra, who together have decades of integrative health experience. They'll share with you the best that traditional and modern medicine has to offer, so that you could be more productive and more proactive in managing your overall health. **Be Healthistic** is powered by our friends at Healthy Directions. Now, let's join our hosts.

Dr. Drew Sinatra: Hi, folks. Before we launch into our discussion today, I wanted to encourage you to be a proactive member of our **Be Healthistic** community. If you like what you hear today and you want to listen to future conversations on all things integrative and holistic health, subscribe to our podcast on Apple Podcasts, or wherever you download your favorite podcasts. Also, check out and subscribe to our YouTube channel, which will feature video versions of our episodes, plus video extras you won't want to miss. And finally, we have more with me, Dr. Drew Sinatra, my dad, Dr. Stephen Sinatra, and other Healthy Directions experts, as well as a robust library of health and wellness content over on the Healthy Directions site. So visit **HealthyDirections.com** to explore our database of well-researched content and information. And of course, you can always follow us on our social media channels.

Dr. Drew Sinatra: Well, today's podcast is the heart of the matter. You are a cardiologist, you're a heart specialist, this is your wheelhouse, Dad. I think, as a culture, we think of heart disease as an older man's disease. But is that really true?



Dr. Steve Sinatra: Well, it was true when I was in medical school. I mean about 50 years ago. I mean, Drew, it's amazing. I was a senior in medical school, and I rotated through the coronary care unit and there wasn't one woman in the coronary care unit with a heart attack. We call it a myocardial infarction. So when I graduated medical school, I truly believed that women didn't get heart disease. I mean, I honestly believed it because I never saw it as a medical student. And then I had a baptism by fire. Over the years, I did an internship and medical residency, I did two years of cardiovascular fellowship.

Dr. Steve Sinatra: And then in the mid '90s about 20 years after medical school, I was chief of cardiology at my institution — and all of a sudden, the coronary care units were being filled with women. And I'm saying to myself, oh my gosh, this is a paradigm shift in this whole illness. And that's why I wrote the book *Heart Sense for Women* back in the year 2000, because the graphs actually crossed on heart disease. In the mid 90s, more women were dying of heart disease than men. That was a very pivotal milestone for me because again, I truly believed that women were protected. I don't know what the reason was. I mean, it could be women getting into the workplace, women becoming more like men, women not relying on intuition like they were, women maybe not crying. I mean, there's so many issues, but I think when a woman becomes more like a man, heart disease is placed in her path.

Dr. Drew Sinatra: Wow, that's incredible. So it's not just an old man's disease. It's happening to men in their 50s and 60s and 70s. I mean, now you're seeing women that are getting it even in their 40s and 50s.

Dr. Steve Sinatra: Oh yeah. In fact, in my book, the youngest woman I saw in the coronary care unit was 18 years old. She had a massive myocardial infarction. Thank God I admitted her that day, despite the fact that I was criticized by the head nurse, other doctors. I just finished my fellowship. But Drew, the most important thing about the diagnosis of heart disease is the story. In other words, what are the presenting symptoms? And this young woman had such classic symptoms, and her EKG was sort of subtle. It wasn't totally normal, it had what we call some high SD takeoffs. And my intuitive sense was she was on birth control pills. And back then, when I was a young doctor, birth control pills would sort of thicken the blood, and I just relied on my clinical acumen at the time and I admitted her.

Dr. Steve Sinatra: And thank God I did, because in the middle of the night my associate, Dr. Arthur Landry, had to put an emergency pacemaker in her, because she went into complete heart block and she had an extensive, what we call a myocardial infarction with a lot of heart damage. And if she wasn't admitted to the hospital, she would have passed. So, that was a wake-up call to me at a very early age, and I was only in my early 30s. I mean I just received my boards in cardiology. I



became an attending physician in cardiology — and heart disease can occur in anyone young, old, women or man.

Dr. Drew Sinatra: And we all associate heart disease with cholesterol. That's sort of the big thing in medical literature right now, and what doctors are prescribing to patients are statins, which are cholesterol-lowering drugs. Really, what's the whole story on cholesterol? Let's dig into that.

Dr. Steve Sinatra: Cholesterol plays a very small part in the overall picture of cardiovascular disease. The problem is that the conventional medical establishment sort of creates the scenario that this is the main problem with cardiovascular disease, and you must kill cholesterol or lower cholesterol or eliminate it. And in my opinion, as a heart specialist, nothing is farther from the truth.

Dr. Drew Sinatra: But there are certain patient populations such as age, sex. I think you've always spoken about men who have had a coronary event, or that had a stroke or something like that. They would benefit from taking a statin and lowering cholesterol. So there are some people that would benefit.

Dr. Steve Sinatra: Yes. And the reason why I developed experience, more expertise on this, one of the major medical journals about 20 years ago asked me to write an editorial about using statin drugs in the treatment of heart disease. Drew, it's amazing when you're asked to write an editorial by a journal, you really got to research the subject. So I went back and looked at all the clinical studies done on cholesterol, and there was one study that really caught my imagination. It was called the "West of Scotland study," and basically these Scots who were on statin drugs, they were high-risk men. They were two-pack-a-day smokers. When you're a cigarette smoker and you have other cardiovascular risk factors. I mean treating these patients with cholesterol lowering drugs — I thought high-risk men, it's not a bad idea.

Dr. Steve Sinatra: And here's what happened. The high-risk men treated with statin drugs did better than their counterparts who weren't treated. But when they analyzed all the data, and they looked at all the risk, what they found is this, and it blew me away. Statin drugs have an affinity of changing the shape of red blood cells as they go through the spleen, we call that rheology, basically. The statin drugs sort of made the blood thinner, and the statin drugs were acting like antioxidants, as well. So basically, statins do some good things — anti-inflammatories, antioxidants, thinning the blood somewhat or changing the shape of these red blood cells. So, in a vulnerable patient, like a cigarette smoker, a male with other coronary risk factors — could statins bring something to the table? And yes they can. So, I gave this a lot of thought.



- Dr. Steve Sinatra: After writing the editorial, spending 100 hours reading the literature, looking at my own clinical experience, I decided that statins did bring something to the table, but only in men — because I was using statins in women, and I wasn't seeing the same effect clinically. More women were getting side effects. And basically, I didn't use statins in older men because of the CNS effects. In other words, I was seeing older men on statins with more memory problems. So I just decided in my own little milieu of treating heart disease. And by the way, I was seeing 40, 50, 60 patients a day back then. I wasn't only treating a few patients, I mean I was in a sea of it. The bottom line was statins in any male under the age of 75 with proven heart disease, I use statins — and I still follow that reasoning today.
- Dr. Drew Sinatra: Okay. So what I'm hearing is that these statins have pleomorphic effects. So they have antioxidant, blood thinning effects that are affecting the red blood cells, etc. Perhaps that's one of the reasons why they're working to help people reduce their coronary risk over time, rather than lowering cholesterol. Because what I see in the clinic, my patients, is a male in his 40s, not overweight, but he's got a cholesterol of 240. Blood sugar is fine, eats a pretty clean diet, exercises — but he's got high cholesterol. So the doctors want to put him on statins. What's your thought on that scenario? Where generally, there's very few risk factors, but yet we're just treating a number. We're just treating cholesterol.
- Dr. Steve Sinatra: Well, you just said it. I mean a good doctor, a really good doctor, is not going to treat numbers. They're going to treat patients. So you've got to look at the patient's overall persona, his risk. I would say this, if you have a male who hasn't had a heart attack, remember any male under the age of 75 with a heart attack, I would put on a statin. But if that male had a positive what we call coronary calcium score of, let's say, over a couple of hundred. In other words, the male has coronary calcification by EBCT scanning. That's CT scanning of the heart. If they have that scenario and don't have a previous history of a heart attack, but he's in that risk where he can lay down calcification, I'll use statins. But here's the hook. Statins have been shown to create coronary calcification in arteries.
- Dr. Steve Sinatra: They appear to have an effect on MK7, which is one of my go-to supplements because MK7 takes calcium out of coronary arteries, but statins can adversely affect that as well. As well as CoQ10. And so, statins have so many biochemical effects that in any patient on a statin drug, male, female, older, younger. Any patient, the doctor needs to be very careful about working with that patient, listening to that patient and be able to change his or her focus and maybe alter the drug or the pharmaceutical usage in that patient. Because like I said, statins can have a downside.



- Dr. Drew Sinatra: So if you're a listener and you've got cholesterol 240, just like this gentleman we're talking about, what do you do?
- Dr. Steve Sinatra: Well, that gentleman had no other risk factors, correct?
- Dr. Drew Sinatra: No other risk factors.
- Dr. Steve Sinatra: Well, it sounds like you're talking about me. I had a cholesterol of 240 and I don't have risk factors, and basically I just treat myself with a lower carbohydrate diet. I eat more healthier fats. I take a ton of vitamin and mineral supplements that I believe have some really good effects on the body. I don't use statin drugs to treat numbers, like I mentioned before. I mean now if this gentleman had a cholesterol of 240, had a previous heart attack or has coronary calcification, situations like that, has active angina, has a positive exercise stress test with a thallium isotope, sure I would use a low dose statin — and I would also chase it with a lot of coenzyme Q10, as well.
- Dr. Drew Sinatra: So what I'm hearing is that there's a time and a place for our listeners to be on a statin — if there's risk factors present, if they've had a history of some kind of coronary event, age counts, all that sort of things count. So, what about a woman? Okay, we're talking about men. What about a woman who's got a cholesterol of 240, no risk factors. Does that change anything?
- Dr. Steve Sinatra: That's incredible that you're asking me this question, because this is what I would see in my office all the time. I'll never forget, I was in my office and a woman came in with a cholesterol of 250, and she was in her 30s, and I was the third cardiologist she saw. She saw two cardiologists at Yale who both recommended statin drugs. She saw me and I sat with her and I said, "No, I wouldn't recommend a statin drug at all, for these reasons." And she burst into tears. She was crying like a baby, and she hugs me and she says, "Thank you. Thank you, thank you." And again, why wouldn't I give a woman a cholesterol-lowering drug? Well look, Drew, women get more side effects than men. My colleagues have written about this. It's well written in the medical literature.
- Dr. Steve Sinatra: I mean, women for some reason are more sensitive to the side effect profile. In my own experience with women, I found that statins didn't bring a lot to the table. Now, if I had a young woman with bypass surgery, stents, for example, previous heart attack and she's going backwards, would I use a statin in that woman? Yes, I would. In other words, if this particular woman is not getting better, sure, I would use a statin. But in my experience with women, women get more side effects than men. So that's why I shy you off of statins. Even with women with coronary disease. Again, I'm not going to be dogmatic and say never, but let me say it this way. When a patient comes in to see you, they're all



different. There's not one size that fits all here, and that's the problem with a conventional medical establishment is we're too quick to write a prescription. Everybody has their own story. Everybody has their own risk factor profile. Everyone has their own different set of reasons of why we should use a drug or why we shouldn't.

Dr. Drew Sinatra: Well, you're mentioning the whole cookie-cutter approach in medicine, which is not working for treating heart disease, and cholesterol and statins and such. So I love the personalized medicine approach that you take there. That's really great.

Dr. Steve Sinatra: That's what it is. It's personalized medicine.

Dr. Drew Sinatra: Going back to side effects, let's say someone really does need to be on a statin, they're on a pretty high dose, but they've got some muscle pain, they're having some memory problems. Would you lower the dose? Would you change their statin medication? What would you do in that situation?

Dr. Steve Sinatra: I would do all of the above, and that's what I've done clinically. In high-risk patients that I believe a statin is useful. And remember, I'm using the statin not to lower cholesterol, Drew, I'm using the statin because of its pleiotropic effects, I'll repeat them again. The blood thinning, the antioxidant, the anti-inflammatory effects. That's why I like a statin. But in men if they have problems, will I lower the dose? Absolutely. Will I give coenzyme Q10? Absolutely. In other words, in men who have proven heart disease who have side effects, the combination of raising coenzyme Q10 and lowering the statin has been helpful in a lot of my patients, and I will continue to use a statin. Sometimes I had to switch from a fat-soluble statin to a water-soluble statin. So again, it's juggling the statin to fit the patient, and what we want is a patient without any side effect profile, and we want the drug to be working at the same time. That's good medicine.

Dr. Drew Sinatra: If anyone listening to this is on a statin medication, cholesterol-lowering medication, is there anything else that they can be doing for themselves to lessen the effects or the side effects of the statin?

Dr. Steve Sinatra: Geez, this feels like I'm in my office, having a conversation with a patient. Sure you can. I mean I've heard this from many of my patients. The patients come in taking statins. Some of them have fatigue, some a dreadful fatigue as well. Muscle aches and pains they can have, which are common. There are worse side effects, certainly liver side effects. But what patients come in with is — anything like males that have had some sexual difficulty on statins, for example. When patients come in with these side effects, my go-to nutritional supplement is



coenzyme Q10, because remember this Drew, statins are tremendous cholesterol killers, but remember that the CoQ10 pathway lies in that cholesterol pathway.

Dr. Steve Sinatra: So when you're knocking cholesterol down, you're knocking down the endogenous production of CoQ10 in the body. So what I've done with my patients is that I would administer a minimum of 100, sometimes you have to go to 200 milligrams of CoQ10, and I would use a high quality ubiquinone. There's a lot of controversy out there whether ubiquinol is better than ubiquinone. I mean, I can tell you this from my experience of using CoQ10 for almost four decades, a good, high-quality ubiquinone is as good as any ubiquinol out there. The only difference is the patient doesn't pay a lot more for the supplement, because ubiquinol is a trademarked situation. I just don't think it's necessary to spend extra dollars on a supplement. Because, Drew, one of the things I'm really sensitive about is I have patients that come in, they're on pharmaceutical drugs, they're taking supplements. We have to be very mindful of their budget. That's very, very important. So, a doctor needs to always think about what these patients have to do economically and financially to support a better health profile.

Dr. Drew Sinatra: Yeah, that's a great point about the cost effectiveness, and to make sure that our patients are not putting so much money into something that they don't necessarily need to be doing. What other nutrient deficiencies are there with statins? Anything else? Is CoQ10 really the main one that our listeners should be aware of?

Dr. Steve Sinatra: Yeah. CoQ10. I mean, I like patients on MK7. Again, I mean, I think MK7 is vital. I mean, I met the original researchers on MK7 years ago. I just feel this is one supplement that I personally take every day. I mean, who needs coronary calcification? I mean, nobody needs it. And I think a lot of women, for example, who want to support their bone health, MK7, remember it takes calcium out of blood vessels where it doesn't belong, and it puts it back in bones where it does belong. So I'm a big advocate of MK7.

Dr. Drew Sinatra: And what about fish oil and Omega-3s and EPA, DHA, what about those things? Do those help at all?

Dr. Steve Sinatra: Absolutely. I mean, I really like Omega-3s. I mean even the most recent medical studies are showing the benefits of Omega-3. And remember Omega-3s not only lower inflammation, but they do have a blood-thinning quality as well. And I'll tell you the sine qua non of coronary artery disease in this day and age of our computerized modern society, is ketchup-like blood, red ketchup-like blood. And I've talked about this many times, but basically when you use some of these



supplements in combination with pharmaceutical drugs, what you're really doing is you're improving the blood profile, and you're making the blood more slippery and thinner. And it's always been my belief that the more we make the blood freely flowing through blood vessels, the better our health is.

Dr. Drew Sinatra: Well, talking about drugs that thin the blood, when you're talking about ketchup consistency blood here, what about aspirin? A lot of our viewers are probably taking a baby aspirin to prevent a coronary event. What is your thought on primary prevention and also secondary prevention? Meaning someone has had a coronary event, let's say a heart attack or a stroke, and they're taking aspirin.

Dr. Steve Sinatra: Well, for secondary prevention, I like it. So in any patient with a bypass, a stent, an angioplasty, previous heart attack, I do like the low-dose baby aspirin a day. Now, primary prevention is another story. Remember this, Drew, about 19,000 people a year can die of GI bleeding from aspirin. I mean aspirin can have a horrific effect in a susceptible individual and cause bleeding in the abdomen. So when it comes to primary prevention, I don't agree with the use of aspirin. And recently, the conventional medical establishment has come to a similar opinion. So, for any our listeners out there that take aspirin as a preventive, and they don't have a history of coronary artery disease, take aspirin off the table.

Dr. Steve Sinatra: And I'll tell you another little story. There was an NIH researcher that came to my hospital who gave a lecture. He was a cardiologist. I had dinner with him in one of our local restaurants after the lecture. And he was limping a little bit, and I said to him, I go, "I noticed you were limping at the lecture today. And I see you have a little limp. What happened?" He pulls up his pants leg, and he shows me his knee and it's the swelling. He has a double knee. Similar to the time when you injured yourself in football, remember your knee was twice the size. Well, I got to tell you, I said, "Well, how'd you do that?" He goes, "Well, I was skiing." I go, "Oh."

Dr. Steve Sinatra: And then he says, "Oh, but I forgot to tell you, I was taking aspirin for prevention of heart disease, and I twisted my knee and I had this hemarthrosis, I had this bleeding into my knee." And I said, "Are you still taking aspirin?" He goes, "Heck no." He goes, "I won't take aspirin again ever." Because, you never know. You never know that, sure you get these blood-thinning aspects of aspirin — but if you're in an accident, God forbid an automobile accident, you're in a ski accident or anything like this, that's another downside of aspirin. So for primary prevention, using an aspirin — I'm out on. Secondary prevention, if you have a little bit to gain, I'm all in on.

Dr. Drew Sinatra: All right. That's a great tip for our listeners here. Now we talked about the thick blood. How do we know if we have thick blood? I mean in my practice I'll



typically run something like a homocysteine, a fibrinogen, an LP(a), an LPPLA2, maybe an MPO if we have access to it. CRP, ESR. Those are pretty good biomarkers, would you say, for looking at the consistency of the blood, the thickness?

Dr. Steve Sinatra: Well, these biomarkers don't actually measure the thickness of the blood. They measure the inflammatory potential of the blood, which then drives the blood into this red ketchup state. Now, there are specific tests. We call it blood rheology. In fact, Dr. Kenzie years ago developed this, and I thought he was years ahead of his time, so to speak. However, the conventional medical establishment has really not adopted it.

Dr. Drew Sinatra: What blood tests should our listeners be asking their doctor about?

Dr. Steve Sinatra: The easiest thing to do is to get a cholesterol fractionation. In other words, look at the cholesterol, look at the HDL, and remember there are dysfunctional forms of HDL now, and looking at the LDL — because I mean some of the numbers are important. But more importantly, I like other risk factors like LP(a), homocysteine, fibrinogen, I mean, to mention a few. And I think LP(a), Drew, is a real cholesterol story. This is a situation that can be inherited. Years ago, it was written up as a very, very severe coronary risk factor. When I was practicing cardiology on a day-to-day basis, I tested LP(a) on all my patients, and I was amazed that this was indeed a significant risk factor. And this is what it is, Drew, LP(a) is a very small cholesterol particle.

Dr. Steve Sinatra: It has a disulfide bridge. It is enormously blood clotting, and it has a very significant inflammatory component to it. So it causes thickening of the blood, inflammation of the blood. And this is one risk factor that I like to target. And the problem is, is that cholesterol-lowering drugs, like statins, can actually raise it. Now, there are no really decent pharmaceutical drugs that lower LP(a). Now what lowers it? Statins don't lower it. They can raise it. Niacin can have an effect on LP(a). Lumbrokinase, nattokinase — they can offset the ill effects of LP(a). CoQ10. There's an article about CoQ10 showing that it lowered LP(a), and I'll tell you, when I read this article in the medical literature, it was only a couple of years ago, I think it was 2017 or '18, where coenzyme Q10, which is my go-to nutrient for any cardiovascular situation, as well as a preventive.

Dr. Steve Sinatra: When I saw that it impacted LP(a), a major risk factor in young and old people for coronary disease, I felt an incredible joy in my body. You know as well as I do that when it comes to coenzyme Q10, I'm all in. I mean, this is one, I call it a miracle nutrient, and this is one nutrient that I have not only enormous clinical experience with, but I've written about it in multiple papers in the peer review medical literature. So I think over the next decade, CoQ10 is going to be used



more and more in cardiovascular situations, particularly by cardiologists, family practitioners and internists, as well.

Dr. Drew Sinatra: All right. Well look, we've talked about cholesterol. We've talked about statins, men, women. We talked about aspirin. We talked about different biomarkers that listeners can ask their doctor to run on them to learn about their inflammatory status and etc. Let's move on to hypertension. Because blood pressure is another big cardiovascular issue that people have. And a lot of people come to me to see me for their high blood pressure, and all sorts of alternatives that they can use besides pharmaceuticals. So let's delve into hypertension.

Dr. Steve Sinatra: Sure. And a point here about hypertension is that this affects women much more than men. And the reason why I say this is that not only have the degree of women in the workplace has increased and the stress on women has increased, but women as opposed to men take more what we call non-steroidals, Motrin-like derivatives. Certainly, these are aspirin-like derivatives, ibuprofens. There're various drugs that can render a woman more hypertensive. And this is very important for women to know, because one of the things about high blood pressure in a woman, and a reason why it's more of a significant risk factor than a male, is first her anatomy is different. She has smaller blood vessels, and high blood pressure in a woman renders a woman more than a man in developing what we call diastolic dysfunction of the heart.

Dr. Steve Sinatra: And I know these are terms that might be particularly — while there's some for the lay public to hear — but women need to hear this. This is very, very important. And this is cutting edge, leading edge information. So in any woman who is hypertensive, if they take these non-inflammatory drugs, they've got to be very, very careful, very careful. And any woman with high blood pressure is more at risk than a man. So we have to be aggressive in women, and the data shows us as well. Next to cigarette smoking, high blood pressure is the number one risk factor in women in provoking coronary artery disease.

Dr. Drew Sinatra: And when do you start to get concerned about blood pressure, in terms of a number? Because what we try to aim for is 120 over 80, systolic over diastolic. What do you see as a problem?

Dr. Steve Sinatra: Well, when I was in medical school it used to be 138 over 88. Anything over that. And now today it is 120 over 80. In fact, we even like 120 or 115 over 70 to 75. When it comes to blood pressure, the lower is better. And the same thing is true of blood sugar, Drew. We used to think a blood sugar of 100 was normal. Now we know that a fasting blood sugar of 70 is what we strive for. So this whole risk factor profile when we do look at numbers, whether it's



homocysteine, whether it's LP(a), whether it's fibrinogen. We want lower numbers. Every day blood sugar is equally as important. The lower the blood sugar this is important. And I should say this — 100 million diabetics in the USA, and there are tests out there to test for insulin resistance.

Dr. Steve Sinatra: They can test for early insulin resistance, and I think this is going to be a game changer. I really think, and this is new information for our listeners. These newer tests, where if you can find out if a person is more insulin resistant before it arises, oh my gosh, now you're making a dent in cardiovascular prevention. I see some good things on the horizon. I hope our listeners ask their doctors about some of these newer tests that are coming out, because if you can lower your blood sugar and lower your blood pressure numbers, to me, this is one of the greatest ways of preventing coronary artery disease.

Dr. Drew Sinatra: Well in regards to blood sugar, all we have today is really a fasting glucose. We can do a fasting C-peptide to learn about insulin production, and we can run a fasting insulin, and then we have hemoglobin A1C. Other than that, that's all we have for information. So I can't wait for these insulin resistance tests to come out.

Dr. Steve Sinatra: Oh yeah. These newer tests are coming out. This is the joy of medicine — when you can learn about prevention. Remember, prevention is easier than cure. So wouldn't this be great. I have a positive family history of diabetes. I mean my grandmother and my mother were both diabetic. That's why I always try to keep my weight down. I continuously check my hemoglobin A1C, at least once a year. But if you can render a person who is susceptible to insulin resistance or diabetes for that matter, and you can reverse that early on. Oh my gosh. Remember, inflammation is a key ingredient in ill health, whether it's Alzheimer's disease or heart disease, and insulin is the number one, provoking inflammatory hormone. So, if we can determine tests that can navigate around those insulin inflammatory relationships. Oh my gosh. We are doing a lot of good for humanity.

Dr. Drew Sinatra: Well, I think we're going to have a future podcast on blood sugar alone, so we'll come back to that. Going back to blood pressure, really quick. Exercise is something that all of our listeners can do.

Dr. Steve Sinatra: Walking.

Dr. Drew Sinatra: Simple as that. Just do that, right in the neighborhood. Get out in nature. Diet's an important piece, too. When we talked about inflammation and sugar and different foods that people may be eating, they may be creating more inflammation in the body. Getting rid of those foods and really cleaning up a



diet can really help. What else can people do to help lower their blood pressure?

Dr. Steve Sinatra: Well, there was an article that was just published, and I was part of that study in the *Journal of Alternative and Complimentary Medicine* about grounding. It was a small pilot study, and all 12 patients who are on multiple hypertensive drugs. All 12 patients were able to reduce their drugs by one or two, and everybody had a significant reduction in both systolic and diastolic blood pressure by simply sleeping grounded at night. So, this whole aspect of grounding, and thinning the blood and reducing blood pressure, and improving the autonomic nervous system. In other words, if you have an overcharged, sympathetic nervous system this creates higher blood pressure numbers. So when you balance out the autonomic nervous system through connecting with Mother Earth energy, again you are bringing these health benefits literally to the person.

Dr. Drew Sinatra: Now what about anything else? I mean in my practice I like to recommend something like magnesium. Magnesium can have a little bit of a blood pressure lowering effect.

Dr. Steve Sinatra: I am so glad you mentioned magnesium, because I think magnesium is the unsung hero. I mean, it is part of my awesome foursome. I like ribose carnitine, coenzyme Q10 and magnesium because of what they do to the heart. They support the production of ATP. They drive the energy of the heart in a preferential direction.

Dr. Drew Sinatra: And I think there's one thing that you and I disagree on that I want to talk about here, and that's Rauwolfia. It's an herb that I use extensively in my practice, all the time.

Dr. Steve Sinatra: As a vasodilator.

Dr. Drew Sinatra: And I have not seen an increase in depression from it, which is in the literature if you read about using higher doses of Rauwolfia, you may see depression settle in. I've never seen that. And I found it to be very effective with other things on board, whether it's magnesium, or CoQ10, or all the other things that we talked about, and grounding. But I do find Rauwolfia to be helpful.

Dr. Steve Sinatra: Hey, if it works, Drew, use it. I mean, I'm not a big fan of Rauwolfia, because I'm always afraid the person's going to eat the wrong form of cheese or something. And I'm sure you coach them about the diet. These tyramine cheeses or whatever it is, where you can get an adverse reaction. Being a doctor is sometimes...it's so hard. I mean, look at all these children, for example, who



were taking an antibiotic and had death because of eating certain foods. I mean, it's just amazing that certain foods or things we take in a diet can have an adverse effect. Whether you're taking an antibiotic or a blood pressure lowering medication. That's why I've always believed in more natural ways of healing. Hey, look, if you need a pharmaceutical drug, I'm all in. I mean, I'm all in. If you're having angina or refractory high blood pressure or arrhythmia, oh my gosh. But if we're treating situations with pain or discomfort, or moderate blood pressure or mild hyperglycemia, I like more natural ways of treating these patients.

Dr. Drew Sinatra: Well. I'm so happy you brought that up about the importance of using a pharmaceutical when needed. Because in my practice, if a patient comes in and it's 180 over 100, it could be due to stress. You got to take that into consideration. You got to do multiple draws, you got to make sure you're doing it at the right elevation of the left arm, etc., sitting. All these factors need to go into taking a correct blood pressure. But if it is sustained, and if it is elevated over time, I have no problem prescribing them a diuretic like HCTZ. Or doing an ACE inhibitor like less lisinopril, or maybe there'll be a beta blocker on board or something like that, while you're working on the other things in their life, working on stress, working on their diet, encouraging exercise, talking about grounding and getting nutraceuticals on board and magnesium, etc. So I think that that's a really important piece that you and I are talking about right now is hey, pharmaceuticals can be really, really helpful in a time like this when you need to get blood pressure down quickly, while you ramp up the other things.

Dr. Steve Sinatra: Well said, son. And I got to tell you, while you're using those alternative ways of methodologies in your patient, guess what? When, they come back you can cut the drug in half, and I'm sure you've done that, cut it in a quarter and then take them off it. And again, that's the joy of medicine. Where if you can get your patient on a more natural healing program, that's the way we want to go.

Dr. Drew Sinatra: Well, we covered a lot today, Dad. As a recap, we talked about how cholesterol is really not that big of an issue. More inflammation is what we should be worried about.

Dr. Steve Sinatra: Yeah, and remember that sugar is really the driver of coronary artery disease, because it sets the stage for inflammation.

Dr. Drew Sinatra: We also talked about how young people need to be more vigilant. Heart disease is not just something that's going to affect someone in their 60s and 70s, this could happen to someone in their 30s and 40s.

Dr. Steve Sinatra: Absolutely.



- Dr. Drew Sinatra: We also discussed how for women, there's a rise in cardiovascular disease that you're seeing. You saw this transition happen back in 2000. The shift that was happening in the graph, so women are just as susceptible to men to heart disease, and we'll have a future podcast I think about that because there's so much to talk about with women and heart disease.
- Dr. Steve Sinatra: Well, yes. And the truth is, is that women are getting heart disease more than men. I mean, like I said, the graphs have crossed. Now this is kind of scary.
- Dr. Drew Sinatra: Yeah, we'll dig into that in a future podcast. And lastly, we talked about different biomarkers. These different blood tests that patients, people listening to this podcast, can ask their doctor about.
- Dr. Steve Sinatra: Yeah. It's not just cholesterol. I mean, I would get a fasting blood sugar, a homocysteine, an LP(a), a fibrinogen. Fibrinogen is a marker of the thickness of the blood, particularly in post-menopausal women who smoke cigarettes. It goes sky-high. So yeah, I mean all these markers are important, and patients need to ask their doctor. If they want to check the cholesterol, they should ask, "Doctor, can you check my LP(a), my homocysteine, my C-reactive protein," which is an index of an inflammation of the blood. So if the doctor checks these entities, at least we have a firm grasp in the inflammatory nature of early heart disease.
- Dr. Drew Sinatra: Before we wrap up this episode of **Be HEALTHistic**, I wanted to share our **Wellness Wisdom** for the day. We've been talking about heart health, and given my dad's expertise in cardiology, he's been able to share a lot of really important information with you. But I think the most critical aspect from today's discussion that we wanted to reinforce for our listeners is about women's heart health. Specifically, the warning signs women need to be aware of if they're having a heart attack. Heart disease is the number one cause of death for women in the United States, and because the symptoms can be very subtle and totally different than the well-known, classic symptoms that men experience, many women completely miss the signs until it's too late. So in the spirit of awareness, we wanted to share the most common red flags for a heart attack in women.
- Dr. Drew Sinatra: Women's signs are far subtler than men's. Men often have dramatic onset, such as a numbness or a sharp pain in the middle, left or right side of the chest. For women, warning symptoms can often appear as anxiety, stress or indigestion — and for some, symptoms are so mild that they can be mistaken for the flu. Again, awareness is key. Pay attention to what your body is telling you, and if you feel that anything is off, don't hesitate to call 911 and reach out for medical help. Signs women should be aware of include: shortness of breath, back or



chest pressure, tightening of the throat, tingling or pain in your jaw, arm or elbow, lightheadedness with exercise, dizziness, nausea or indigestion, profuse sweating and sudden profound fatigue. These are facts that all women should know and share with all the other women they care about — it could save lives.

Dr. Drew Sinatra: Remember everyone, if you liked what you heard today and you want to be an active member of the **Be Healthistic** community, subscribe to our podcast on Apple Podcasts, or wherever you download your favorites, and subscribe to our YouTube channel. You can also find more great content and information from us and the Healthy Directions team at **HealthyDirections.com**, as well as on our social media channels. Check it out.

Dr. Drew Sinatra: All right, well that's it for the show today. I'm Dr. Drew Sinatra.

Dr. Steve Sinatra: And I'm Dr. Steve Sinatra, and see you next time.

Dr. Drew Sinatra: This is **Be HEALTHistic**.

Narrator: Thanks for listening to **Be Healthistic**, a health and wellness podcast powered by our friends at Healthy Directions, with Drs. Drew and Steve Sinatra. See you next time.