

IV Chelation Therapy- Is There Any Cardiovascular Benefit in Post Heart Attack Patients? Findings from the TACT Trial

An Interview With Gervasio A. Lamas, MD

May 8, 2013, By Kirkham R. Hamilton, PA-C
© copyright 2013, Prescription 2000, Inc.
www.prescription2000.com

KIRK HAMILTON: Hi, my name is Kirk Hamilton, your host of **Staying Healthy Today**. Our message is simple: To provide you credible usable health information from interviews and our educational resources to help you Stay and Be Well in the busy modern world. Please take a few moments before or after listening to this interview to browse through the **Prescription2000.com** website, the home of **Staying Healthy Today Radio**, for our free educational services.

Today's show topic is "**IV Chelation Therapy. Is There Any Cardiovascular Benefit in Post Heart Attack Patients? Findings from the TACT Trial.**"

Our guest today is Dr. Gervasio Lamas, M.D., Chairman of Medicine and Chief of the Columbia University Division of Cardiology at Mt. Sinai Medical Center in Miami Beach, Florida. Dr. Lamas recently coauthored a provocative paper in *JAMA* entitled "**Effect of Disodium EDTA Chelation Regimen on Cardiovascular Events in Patients with Previous Myocardial Infarction.**"

Welcome, Dr. Lamas. Thanks for coming on the show today.

DR. GERVASIO LAMAS: Thank you so much for having me.

KIRK HAMILTON: And, you know, I want to get my biases out. I know this is a – an interview on chelation therapy and vascular disease, but I'm kind of a lifestyle guy, so I'd prefer that everybody go on a plant-based diet, a la President Clinton and, see if they could reverse disease, but I also work in a clinic, an integrative medicine practice for the last 27 years, that has done chelation therapy.

DR. GERVASIO LAMAS: Oh, no kidding?

KIRK HAMILTON: Yes and really, you know, here's a typical scenario to kind of set the stage. So, we'd have a patient come in and they'd say, you know, my, my, my cardiac surgeon said, I need to do a bypass. They'd be having chest pain, angina, shortness of breath, and then they'd come in and do somewhere between 10 and 20 chelations, just like kind of the setup that you had here in the study. And somewhere between, you know, usually 10 and 20 treatments, something good would start to happen, from energy improving, to chest pain going away, to shortness of breath, in a good majority of patients. I'm not saying everybody, but in a good majority of patients. And then the classic scenario is, you know, they go back to their cardiologist, and they wouldn't have to have the bypass. Now, I've heard that story more than once, and so those people get hooked on chelation and they want to come back, you know, once a month forever to do it. So it's kind of in that light and I've always wondered myself, you know, what are the actual mechanisms and always wanted that wonderful study to be done, and they kind of started and stopped and never got done, and then finally you got the TACT trial done. So, I'm very

Staying Healthy Today Radio - ©2013 - Prescription 2000, Inc. - (916) 716-2295 - www.prescription2000.com

excited and pleased to – to be able to talk to and maybe get some clarification - maybe not, of what and what is not chelation therapy. At least in the study.

So, could you give a little bit first about your background and – and what you're doing right now and then how you got involved with this TACT Trial.

DR. GERVASIO LAMAS: Sure. I am a completely conventional cardiologist. Let me start with that. I've never used chelation therapy in my practice. I became interested in clinical trials many years ago when I was a cardiology fellow at the Brigham Women's Hospital in one of the Harvard hospitals in Boston. And participated as a coinvestigator for many years, and then eventually started doing NIH funded trials in 1995. And one day a patient asked me if he should have chelation therapy and I said of course not, that's baloney. That stuff doesn't work. But something clicked and I decided that I'd look into it a little bit and see if that was true – if what I had said was true. And I realized that I could not, I couldn't really say if that was true or not true. The information was not there to support it. I had no clinical information for sure, and I had no usable research or clinical trials information that I could believe or that had been done in a standardized way. And so that leads you to a question that you – that you can answer. Because by then I had the skills to be able to design a clinical trial to answer a simple question, which is, does an EDTA based chelation regimen reduce cardiovascular events in patients with coronary artery disease. And at around the same time, because what happens is that people always think of the – multiple people think of the same things at the same time. The National Center for Complementary and Alternative Medicine, and the National Heart, Lung and Blood Institute were in the process of developing an RFA, or "request for applications," for a clinical trial of chelation therapy. That means that they've set aside funds and that different groups would apply for it. We did a small pilot study to kind of figure out how we go about doing it. We applied for, with what our application was a "Trial to Assess Chelation Therapy" or TACT, and we received a grant award in 2002. It took us a year to get a FDA IND. An IND is an "investigational new drug," essentially a license to use a drug either that is really new or a drug for different indication, and that was the disodium EDTA that we used. And the first patient was randomized in 2003. The last follow-up, was, oh, gosh, about a year and a half ago, maybe a little bit longer. And the study was unblinded in August of 2012. And much to my surprise, the study was positive.

KIRK HAMILTON: What do you mean by positive?

DR. GERVASIO LAMAS: By positive I mean that an EDTA based chelation regimen reduced cardiovascular events by a statistically significant margin. And I can tell you that as a conventional cardiologist I was very surprised.

KIRK HAMILTON: Well, so from the moment – from the time that that patient put that question to the time that you –

DR. GERVASIO LAMAS: That was in 1999, in August.

KIRK HAMILTON: Alright. So that's –

DR. GERVASIO LAMAS: And it was unblinded in August of 2012.

KIRK HAMILTON: Tell me, was there much politics in getting this going?

DR. GERVASIO LAMAS: You know, not really in getting it going. I mean, there was – there were background politics in that, there had been some pressure from Congress I learned much later, or, really recently. There had been some pressure from Congress to have the, to have the NIH study chelation

therapy. Because – and I’m not – I’m not exactly sure why that pressure was applied but there was pressure from Congress to do that. My own pressure was internal. I decided that it was a worthwhile question to answer. And you know when you go into something you always have an idea, I think, as to what you think the answer is gonna be, and the reason you do research or the reason research is fun is to be surprised. And that’s – and I was surprised. During the study, there was a – there were a lot of politics involved. The application itself was pretty straightforward. You put together a lot of documents. And you do your very best to get a team together than can do this. You try to do a pilot study and that’s what really what carried us – and carried us over the finish line. Because it was a very complex, endeavor. We delivered 55,222 infusion to 134 sites throughout the U.S. and Canada so, you know, it was – it was – it was daunting. Once we started to get into the nitty-gritty of the practical aspects, not the science.

KIRK HAMILTON: Well, let me just jump into a fact there, and then we’ll get back to the flow. If you did 55,000 infusions, can you say chelation therapy irregardless of it works or not, is safe?

DR. GERVASIO LAMAS: Yes.

KIRK HAMILTON: Okay. I mean, that’s the obvious –

DR. GERVASIO LAMAS: I can tell you this. There were – we had all our adverse events were looked at, the serious adverse events were looked at by a blinded monitor, medical monitor at the Duke Clinical Research Institute. There were four unexpected serious adverse events. Two in the placebo group and two in the chelation group. There were, and in those four patients there were two deaths. There was one death in the placebo group and one death in the chelation group. This drug combination is so safe, it’s extraordinary.

KIRK HAMILTON: One other thing on the safety. I know I’m jumping in as the train is going, but kidney function. For years, you would hear a cardiologist come back to the patient, it’s gonna, mess with your kidneys and destroy your kidneys, or cause them to dysfunction. Can you comment on kidney function?

DR. GERVASIO LAMAS: Sure. We did not see any kidney failure that was caused by chelation. Now mind you, we had a very safe regimen. We gave no more than one infusion per week. We adjusted the content of EDTA based on the estimated glomerular filtration rate, prior to preparing, every fifth infusion it was looked at, just roughly. And it worked out to be about nine times during the infusion phase of the trial. And we only enrolled patients whose creatinine was 2 or better. So patients with severe renal dysfunction were certainly not enrolled in the study. And we watched the kidney function like a hawk because it’s a known potential problem. If you look into the literature, usually people who have severe kidney problems start out with very abnormal kidneys, or are receiving much higher doses. The maximum dose anyone could receive was 3 grams in a week.

KIRK HAMILTON: So let’s – let’s get into some of the, in my years, you know, never really knew how to explain how chelation therapy might work. First it was the “roto rooter” concept of, you know, pull all the plaque – the calcified plaque out of the arteries, then it’s maybe it enhances blood rheology, making blood thinner or improves energy production in the heart muscle, maybe nitric oxide secretion, reducing heavy metals. Do you have – did you have any premises on how chelation therapy might work?

DR. GERVASIO LAMAS: We had pretty much the same list of hypotheses that you just very nicely enumerated for me. The problem really is that when you do a large scale clinical trial, you commit all of your funds to the clinical trial. And when you try to ask for more funds, the reply is, well, if the study is

negative, who cares what the mechanism is, and if the study is positive, well then who cares what the mechanism is. It was positive.

KIRK HAMILTON: Yeah.

DR. GERVASIO LAMAS: So, along the way I made several efforts of getting additional funds so that it wouldn't just be a clinical trial. It would also be a mechanistic trial and we were unable to succeed in that. So at the present time, what I have in terms of potential mechanisms of action is just that. Potential mechanisms of action and my personal favorite, which is now we're talking opinion, is the heavy metal hypothesis that you just kind of listed at the end of your very complete list. In the sense that many patients have, we'll take lead as an example, levels of lead in their blood. And we know that heavy metals are associated with damage to the systems within – within the vasculature and within the blood that detoxify, reactive oxygen species. So that heavy metals are actually involved in oxidizing LDL and oxidizing a bunch of different proteins, none of which are a good idea to oxidize. And we also know that there are a lot of epidemiological studies that show, for example, that cadmium is associated with peripheral artery disease, that lead is associated with higher mortality, with higher rates of heart attack, hypertension, stroke, et cetera. We know that EDTA is an excellent chelator for lead and for cadmium. These are both divalent cations, so that they have two positive charges, and we – so we've used a medication that pulls out lead and cadmium and we've found out that it reduces cardiovascular events so are these – is the cause and effect – is this cause and effect, or is this just two different things that occurred and they're not linked. I don't know. I'd love to link them.

KIRK HAMILTON: Well, you know, aside from the extra funds you could have gotten, I mean, you know, in a real live clinical practice, we do post chelation challenges all the time and it's so simple, and you just have them collect six to twelve hours of urine and you test for those heavy metals, and you can do it before and after and see nothing before, and the metals after, and so that's an easy thing to show that metals come out and these patients have them.

Well, let me – let's get into the – the solution because this is – this is the thing that I've always thought. I've seen patient clinically improve. I have no idea sometimes why. But, you've got components besides EDTA that I believe if you gave magnesium, potassium, heparin, the B nutrients that you had, and some vitamin C, I believe that if you gave that IV without the EDTA that I think you'd see some clinical improvement in patients. I'm almost positive of it. So, you know it's interesting, you know when it said chelation you always think of EDTA, but I think of those six, seven other nutrients. You want to comment on that?

DR. GERVASIO LAMAS: Well, that's really why I have been calling it intermittently an EDTA based chelation regimen. Because it really had a lot of other things. There are ten components in it, and I'm not gonna list all ten because inevitably I leave one out. But the primary components are really 3 grams of EDTA, and 7 grams of vitamin C. People are receiving 7 grams of vitamin C intravenously, which is certainly has been demonstrated in the past to help restore endothelial function. There were some B vitamins, there was a little procaine, a small amount of unfractionated heparin 2500 units, then some electrolytes. So, it is certainly possible that all of these components contributed and that without the – this magical mix or the combination of say three or four or five of these ingredients, the infusion might have been inactive. I have no way of answering that. The reason that this infusion was selected is that, it was by and by the most prevalent solution used by chelation practitioners. Chelation practitioners are very individualistic and they always modify it. We went to, sort of the protocols for chelation therapy that had been written in the *Journal for, I believe, Advancement of Medicine*. And picked it from there, and one of the – and the author of that was one of our coinvestigators, Dr. Ted Rozema, and one of our coauthors.

KIRK HAMILTON: Well, someday when you have the money, you can do one with or without the EDTA. I just, I can say from this, though, that vitamin C probably doesn't have adverse effects if it's given intravenously at 7 grams. I'm saying this tongue in cheek, because we use intravenous therapies of vitamin C from, you know...

DR. GERVASIO LAMAS: Of course.

KIRK HAMILTON: ...30,000 to 70,000 milligrams. For different entities.

DR. GERVASIO LAMAS: Yeah.

KIRK HAMILTON: We are talking to Dr. Gervasio Lamas from Mt. Sinai Medical Center in Miami Beach Florida, who wrote a – who co-authored a very interesting paper “**Effect of Disodium EDTA Chelation Regimen on Cardiovascular Events in Patients With Previous Myocardial Infarction.**”

Were there any specific blood analytes that you did before we get into the study that you wanted to see changed with chelation therapy, like CRP, lipids, homocysteine, or any other markers?

DR. GERVASIO LAMAS: Not - not really. I mean, we did analyze lipids twice. We have not analyzed that as a substudy just yet. We really are still publishing primary results. We analyzed C-reactive protein. I'm not at liberty to say what those findings were. We have only preliminary findings at this point, and that will be appearing. But it really was not a study of surrogate markers. But rather a study of clinical events.

KIRK HAMILTON: Well, then just tell us about the basics of the study. I mean, you kind of did, but if you can review it for us.

DR. GERVASIO LAMAS: Sure. So, we enrolled 1708 patients in 134 clinical sites mostly physician offices and some university centers throughout the U.S. and Canada. Patients received – patients were randomized, randomized to receive 40 infusion, 30 weekly and then an additional 10 two to eight weeks apart of a – an EDTA based chelation regimen whose components we went throughout. And they were also randomized to receive either, sort of high dose oral vitamins and minerals versus placebo pills, so that generates four cells, if you will. What we published was the comparison of EDTA versus placebo infusions. Patients were followed for really quite a while. It was a lengthy study so the average follow-up was almost five years. That's just for – actually median follow-up was almost five years. The patients themselves were at least 50 years of age. They had – they could not have severe kidney failure, so the creatinine was 2 or better. And everyone had had an acute myocardial infarction at some point in the past that could be documented. It turned out that the median age was 65. There were mostly white men. They were either overweight or obese. The median BMI was 30. Patients were well treated with medications, so we had 73% were on statins, aspirin 85% were – I'm sorry 84% were on aspirin, and if you looked at either aspirin or some other type of anticoagulant, we were in the 90+% and beta blockers, over 70% were on beta blockers. So these are post MI patients that are treated well, and the median LDL when they started the study was 85. The median – I'm sorry 89. The median creatinine when they started the study was just over 1, about 1.08, 1.1. So these are stable post MI patients. 83% of them had had some sort of revascularization. Stable post MI patients. We followed the patients and we collected clinical events. And the events that we tabulated were death from any cause, another myocardial infarction, stroke, revascularization procedure, either coronary bypass or a coronary angioplasty, and hospitalization for unstable angina.

What we found at the end of the follow-up period when we unblinded the study was that *there was an 18% reduction in risk of having one of these recurrent cardiovascular events in the group overall with EDTA chelation* with a P value of .035 which was significant on prespecified characteristics of the statistical plan. So that was really something. And then we looked at prespecified subgroups. Now when you start a study, you always prespecify what subgroups you're going to be looking at. And you - you always want to look at women. You always want to look at different races. You want to look at different ages. And you want to look, say, at diabetics, you want to look at patients who had a large MI, etc. *We found that in diabetics there was nearly a 40% reduction in events with EDTA chelation therapy. And in patients with a large heart attack in the past in the anterior wall, which is a very important part of the heart, there was nearly a 40% reduction in clinical events.* Now, that was a surprise but potentially a surprise with a lot of benefit to our patients. Now, and again, the - this is an initial study. It's really the only large scale randomized trial of chelation therapy that's looking at cardiovascular events or anything else for that matter. It - it generates a lot of questions. Because these are potential mechanisms of benefit that our traditional drugs are not addressing. So there could be an entire line of research development of the treatment of cardiovascular disease with this kind of drug. And, you know and that's very exciting. It's very exciting to be on the cusp of a potentially exciting new therapy.

KIRK HAMILTON: So, I got a couple of questions as I was listening. So this didn't take any symptoms into account. For example, no - you wouldn't know if somebody improved their angina, intermittent claudication or, you know, shortness of breath. It was just those - the MI, the stroke, revascularization, etc., were the end points tested, correct?

DR. GERVASIO LAMAS: That is correct. That is correct. We - we did follow how much angina patients had. However, not many patients had angina to start with. These were very stable healthy, post MI patients.

KIRK HAMILTON: Right. Because they were on very appropriate medication, then you - then you can obviously say the chelation therapy filled in some of the blanks, so to speak, in the treatment. Is that kind of -

DR. GERVASIO LAMAS: Say that again. I'm sorry.

KIRK HAMILTON: Well, what I mean is that these people were on appropriate medical therapy.

DR. GERVASIO LAMAS: Yeah.

KIRK HAMILTON: And yet they had improvement. So chelation therapy filled in to where the medication wasn't benefitting, so to speak.

DR. GERVASIO LAMAS: Yes.

KIRK HAMILTON: Because you -

DR. GERVASIO LAMAS: I mean, I think that we're saying the same thing. I guess that the way that I would state that is that the improvement in their, in the rate of outcomes in the chelation group suggest that chelation is touching upon different mechanisms of benefit that are traditional drugs, either are statins, are ACE inhibitors, the aspirin, the beta blockers, are not - are not addressing.

KIRK HAMILTON: Could you say that chelation therapy, IV chelation therapy did not have an

adverse effect on the effective drugs? In other words, you know, did –

DR. GERVASIO LAMAS: Yes, I can say that.

KIRK HAMILTON: Okay. And so I – you don't think this was a waste of money? Because the way you...

DR. GERVASIO LAMAS: No. I think – I think that the naysayers who say that this is a – was a waste of money and that the results are not believable, etc., are starting out with a conclusion. So they made up their minds long ago that it was crazy to study chelation therapy.

KIRK HAMILTON: Right.

DR. GERVASIO LAMAS: Therefore, the results that we obtained after 10 years, hundreds of people working on this study, really superb colleagues. Duke Clinical Research Institute is the premier academic clinical research organization. Our lead statistician, Dr. Kerry Lee, is really an eminent respected biostatistician. And these are individuals who start out with a conclusion, and then at the end they say, okay, no matter what they did, no matter who was – who were these very respected scientists doing the study, it can't be true. And that's sloppy science. That's not how you do science. You do - you do research to be surprised, to find out the truth. And that's why we did this research. And that's why the *JAMA* editors who really were very tough on us, to analyze and reanalyze our data before they concluded that they would publish it. At the end of it all went ahead and published it. And they wrote a nice editorial about their process. They were really courageous scientists. They looked at the stuff and they said you know, it doesn't fit our bias, but these guys did it right. Let's put it out there. And that's – that's the kind of attitude that a scientist should have.

KIRK HAMILTON: So, I have a couple of questions. One is, when you said, I kept thinking that when you implied that there's some avenue for chelation therapy as a part of the complement of medications or stuff, that it would end up being a patented agent, made into a drug. Is that kind of what you're – would think?

DR. GERVASIO LAMAS: No. You know, the receiving IV chelation is such a daunting treatment for patients, that it's the – the ideal would be if a pharmaceutical company, develops an oral version of this that they can make some money on so that they will do the research, and that it would be yet another pill that post heart attack patients would take or diabetics would take. That would be ideal. None of that is in process to my knowledge, certainly not involving me. And, but that's really where ideally we would end up moving towards because it – it's pretty tough to receive all these infusions. You know it's very time consuming, it's expensive, etc.

KIRK HAMILTON: Well, where does Dr. Lamas go from here with all this research? Are you hanging it up and saying I did my part?

DR. GERVASIO LAMAS: No. No, not at all. I mean, I had expected to hang it up in terms of clinical trials with TACT. I did not expect to do – I've been doing clinical trials as I said since 1995. Large scale NIH funded trials without companies involved, you know, no particular profit motive. And I had expected that this would be my – my last clinical trial. But lo and behold it surprised me. So now I think we really do need to look very carefully at this therapy. We need to figure out mechanism and we need to figure out, for example, what does it do in peripheral artery disease. Can we prevent amputations for peripheral artery disease? My chelation practitioner colleagues say yes. So, I think that that has to be yet another target, but at the same time we need to work out mechanisms. A second study that has

positive results would put this particular therapy over the finish line I think.

KIRK HAMILTON: How long you think that would take to get going? (Laughter).

DR. GERVASIO LAMAS: Well, it depends how quickly I can find somebody who has 20 or 30 million to give me.

KIRK HAMILTON: (Laughter.) Well, I have to give you kudos – well, I have to give you kudos for a lot of things, but here's the one thing I give you kudos for. That you – you're able to call your chelation co-investigators colleagues –

DR. GERVASIO LAMAS: Absolutely. We've been working together for a decade.

KIRK HAMILTON: There's some that couldn't do that. So I want to ask you some, just a couple of vignettes on just cardiovascular disease in general. Alright. It's the number one still killer in the world.

DR. GERVASIO LAMAS: Yeah.

KIRK HAMILTON: So what is your diet? I mean, did you place any – do you think lifestyle can change this mess that we're in. Because, uh, you know, another therapy that's patented – okay, just keeps people in my opinion from working hard at their health, which is the bottom way we – the ultimate way we change things. So what do you think about lifestyle and diet in – in vascular disease and how would you change the heart disease epidemic?

DR. GERVASIO LAMAS: I spend my days as a clinical cardiologist asking people to change their lifestyle and they spend their days not changing their lifestyle. So I don't know what to tell you. I think it is like, the only way to address is the way that we as a society have addressed cigarette smoking. And while there's still a lot of cigarette smoking, kids have been so – are being taught that cigarette smoking is so noxious and so toxic that the smoking rate in this country has dropped significantly over the years. And these lifestyle changes are going to have to occur from early education so that schools, for example, cutting out gym, I think is outrageous. They probably should cut out advanced math because you need physical fitness a lot more than you need advanced math. You need to have a healthy – healthy eating habits more than you need, you know, medieval English. So, I think that we are making some strange choices in the way that we educate our children that are going to – these choices are going to perpetuate this epidemic of cardiovascular disease.

KIRK HAMILTON: Well, let me ask you another question then. If – here's my thoughts. If – I believe you can reverse vascular disease by aggressive diet, a la Bill Clinton, and that's just one example

–
DR. GERVASIO LAMAS: Yes. No, I agree with you.

KIRK HAMILTON: But here's the thing. If all the economic – and this is why I'm actually happy even though my – it might make my chelation colleagues upset, but I'm actually happy it doesn't get covered by insurance. And the reason is, is because when you make something easy for people, they do it versus working hard at their health. And if all the economic incentives for practitioners or even the patient is to – there – is when you get the disease you get reimbursed. Then, I just see cardiovascular disease keep going until we run out of money. I mean, you know, because it gets paid for. So I think there has to be some kinds of incentives to stay well. And I know that would be a little draconian, but I think it does. I think you have to have – and if you didn't reimburse, with all due respect to the very, very, very smart surgeons and cardiologists, but if they get reimbursed more than somebody, a primary care guy that's

supposed to prevent the disease, or could might have more of a chance of preventing disease, then I don't see it ever changing, truthfully, because I think it's economics personally and education.

DR. GERVASIO LAMAS: Yeah. You know, what you're saying is interesting. There have been a couple of studies published, smaller studies, where they pay patients to lose weight. And they have been relatively effective.

KIRK HAMILTON: Well, or penalized if you don't lose weight. I mean there's – in other words, when I get –

DR. GERVASIO LAMAS: Well, but that's a – that's a lot harder research environment.

KIRK HAMILTON: Well, I'm just saying, like if I get in a wreck in my car, my insurance goes up. One on one. My – I'm 56 years old. I'm – my insurance premium is the average 56-year-old that has, you know, vascular disease and four or five medications.

DR. GERVASIO LAMAS: Yeah, sure. Sure.

KIRK HAMILTON: And so to me that's the – the issue.

Well, I don't want to keep you any longer. I – I could go on for days. One other thing. What kind of – do you take any nutraceuticals?

DR. GERVASIO LAMAS: No, I don't.

KIRK HAMILTON: You don't. And so how is this – has this chelation trial changed anything in the way you approach your own cardiovascular prevention?

DR. GERVASIO LAMAS: No, I'm actually pretty healthy. I exercise every day. I'm going to a yoga class as soon as we – as we stop this interview. And it will be a very vigorous power yoga class. And you know, yesterday I was at the gym. I try to eat very healthy. And I think that that's the best thing that you can do for your cardiovascular health. But the truth is that it is a daily battle to try to stay thin, not eat horrendous food or not eat large quantities of horrendous food which is much more likely. And there are many of my, really, many of my patients lose that battle. And, you know that's really why I spend a lot of time asking people to do things that they're not gonna do.

KIRK HAMILTON: One last question very quick. If your brother – if you had a brother, I don't know if you do or not. And he was, you know, the exact opposite of you. Didn't go to power yoga class, sat on the couch, ate, drank his beer, you know x, y and z, had bad vascular disease and he wasn't going to do anything. Would you might – might you say, go see a chelation practitioner as part of your total approach?

DR. GERVASIO LAMAS: I don't have any data to say that that would be the right thing for him to do. If you change the clinical characteristics of my hypothetical brother, make him an overweight diabetic who had a heart attack –

KIRK HAMILTON: Okay. Fair enough.

DR. GERVASIO LAMAS: - coronary bypass, and you know, we're kind of concerned about him, then that changes it. That makes it probably yes.

KIRK HAMILTON: Okay. Fair enough. Fair enough. Any last thoughts you want to say?

DR. GERVASIO LAMAS: No, it's really just my colleagues that I would want to say that you do research in order to be surprised, and that we have to look at new mechanisms of treating atherosclerosis with an open mind.

KIRK HAMILTON: Gosh, I can't thank you enough. So Dr. Lamas, thank you very much for coming on the show today, and I want to thank you, the audience for listening to this edition of Staying Healthy Today Radio. And until next, time, Stay and Be Well.

No part of this interview may be copied or reprinted in any form,
electronic or print, without written permission from Prescription 2000, Inc..

© copyright 2013, Prescription 2000, Inc.
www.prescription2000.com