Mentoring the Mentor

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Mentor goals:

- To declare what is possible and establish a commitment to that possibility
- Address personal and professional barriers limiting the ability to serve
- Evolution of vision/mission/ethics that drive success
- Create immediate action steps to apply learning and growth
- Construct the round table of applied trophologists

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Mentoring the mentor:

- Who are the mentors? – Practitioners
- Who are we mentoring? – Patients and GAP
- What's the purpose? – Optimized life
- How does it work? – Whatever you learn you teach someone else (anyone else)
- Who's is included? – Self selection, you pick yourself

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Mentoring the mentor:

- Each participant attends monthly teleconferences (1 hour in duration, 4th Thursday of month) creating a round table discussion/exploration of the dynamics and details of a nutrition-based wholistic practice
- Each participant chooses how to convey the notes and information to their world and community – no information squandering
- Issues/problems/questions are considered a learning process for everyone, although individual's remain anonymous
- All questions, comments, case studies to be directed through email to SP rep who will compile and include in next teleconference (must be submitted 10 days prior)

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Our healing mission

Every person, all the events of your life are there because you have drawn them there.
What you choose to do with them is up to you.

Richard Bach

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Reviewing Part I,II & III - Dyslipidemia

- Part I considered:
  - Structure of lipid molecule and various ways to influence
  - Consideration of traditional and less traditional risk factors involved in coronary artery disease (CAD)
  - Review of fractionated lipid studies by Spectrocell Labs for the assessment of risk effacement of biochemical individuality
  - Vitamin C chronic deficiency and resultant Lipoprotein a increased production speculatively due to genetic activation
  - Demonstration of mechanisms to reduce lipid profile using low glycemic dietary lifestyle
- Part II considered:
  - Many nutritional ways to influence lipid profiles
  - Finally a sequential formula for intervention to achieve lipid management
- Part III considered:
  - Review of Part I and II
  - Further elaboration of research compilation of nutrient impact on dyslipidemia, including new speculations on dietary fiber and berberine as ways to reduce lipids

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Managing Lipoprotein Dyslipidemia

- For decades the primary blood marker associated with cardiovascular disease has been cholesterol – total cholesterol at first then LDL and HDL, deemed 'bad and good' cholesterol
- Additional risk factors have emerged including c-reactive protein as an indication of inflammation and homocysteine as measuring the attachment potential to the wall of the artery
- Although lifetime coronary heart disease mortality can be correlated to cholesterol, it does not predict CHD events in individuals as well as could be hoped

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The Lipid Players

- LDL – total amount of cholesterol found in low-density lipoprotein particles – currently specialists seek to limit under 70 with high risk individuals – large clinical trials have confirmed that LDL reduction decreases the risk for future events
- HDL – total cholesterol found in high density lipoprotein particles – these particles ar thought to assist in transporting cholesterol from the tissue to the liver for removal – In general a 1 mg/dl increase in HDL results in a 2-4% decrease in risk (most seen in women)
- Non-HDL cholesterol – total amount minus HDL – easily derived form simple lab test make this useful in cost prohibitive cases – high risk <130 mg/dl, moderate risk <160, low risk <190

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The Lipid Players

- Triglycerides – a form of fat in the blood is elevated in insulin resistant dyslipidemia – fasting TG above 150 is a criteria of metabolic syndrome, below 150 is normal, 150-199 borderline high, 200-499 high, over 500 very high, less than 80 is optimal
- Apolipoprotein B – a protein found in the outer shell of all lipoproteins – each VLDL, IDL and LDL particle contain I molecule of apo B so it is an estimate of the atherogenic character of the lipid particles – guidelines say high risk <90, moderate risk <110, low risk <130
- Apolipoprotein A – found within HDL only – A ratio > 1 of Apo B to Apo A is considered atherogenic
- VLDL – becoming a key constituent of atherogenic profile related to insulin resistance and diabetes
- Lipoprotein a – essentially same structure as LDL except it has apo (a) covalently attached to the surface of LDL particles which make it promote coagulation and increase oxidative inflammatory activity – Niacin is only reliable way to lower Lp(a)

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Ratios of the players -

- Apolipoprotein A1 = HDL (good guy) – the more you have the better you are – promoted with Tuna Omega (4)
- Apolipoprotein B + lipoprotein a = LDL (bad guy) – reduced with soluble fiber like Gastrofiber (4) or Prebiotic Inulin
- Apo B/ Apo A1 ratio is best predictor of CAD – ratio over 1 is best indicator of atherogenic propensity
- lipoprotein a - hereditary marker for CAD, carotid atherosclerosis, cerebral infarction risk – niacin (3-4 g/day reduces up to 38%) – use Niacinamide/B6 (4) and Gingko Forte (4) to reduce

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Anatomy of Lipoproteins -

- Cholesterol and triglycerides are transported through the blood in particles called lipoproteins, that are classified by their relative densities
- Lipoproteins have a shell derived from phosolipids, free cholesterol and apolipoproteins – and a central core of triglycerides and cholesterol esthers
- The number and size of the various particles and corresponding lipoprotein levels and the more accurate markers of atherogenic potential

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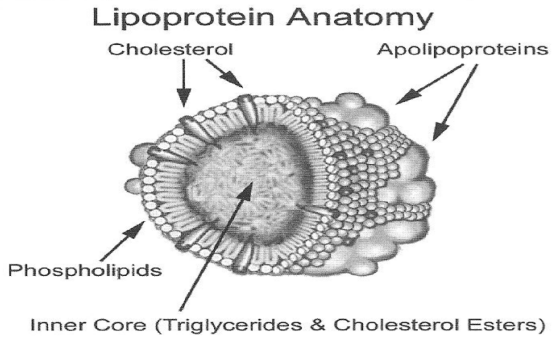
Lipid Structure -



The Cholesterol Game -

- Traditional risk factors of CAD are total cholesterol, HDL, LDL, Triglycerides, ratios (only 50-60% accurate)
- Individualized risk factors fill in the blank:
  - Genetics – Lipoprotein a
  - Nutrition – Homocysteine
  - Inflammation – C-Reactive protein
  - Viscosity – Fibrinogen
- With the current model the practitioner's challenge is to find where the risk effacement is and reinforce that pathway to reduce the likelihood of an event
- The fractionated lipid lab studies are approaches to this endeavor

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The greatest use of your time

Creating the world we want is subtle, but more powerful than destroying the one we don't want.

Marianne Williamson

Product Alert – Read All About It!

- Niacinamide/B6 first introduced in 1949 is a unique combination of factors to reduce the physiologic decline known as aging, possibly based on the work of Kaufman and the larger nutritional community in teat era. This is a cocktail of called a proprietary blend, leaving us to speculate what was in Royal Lee's mind as he formulated this product. It is an inexpensive and impressive influence upon neurological decline and aging that is only recently being elaborated in scientific literature. This product takes the assessment out of the picture for the clinician and addresses the common background issues at work universally in every person. Known to promote nervous system function, RNA/DNA synthesis at cellular levels, and facilitates metabolism and utilization of fats and proteins through support of HCl production.

- Niacinamide/B6:
  - Niacin 50 mg per 2 capsules (250% RDA)
  - B6 9 mg (450%)
  - Proprietary blend of bovine liver, porcine stomach, calcium lactate, soybean, bovine spleen, ovine spleen, defatted wheat germ, para-aminobezoate, porcine brain, and ascorbic acid

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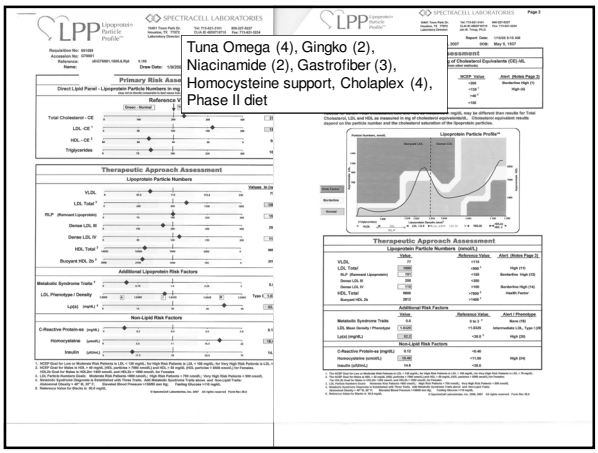
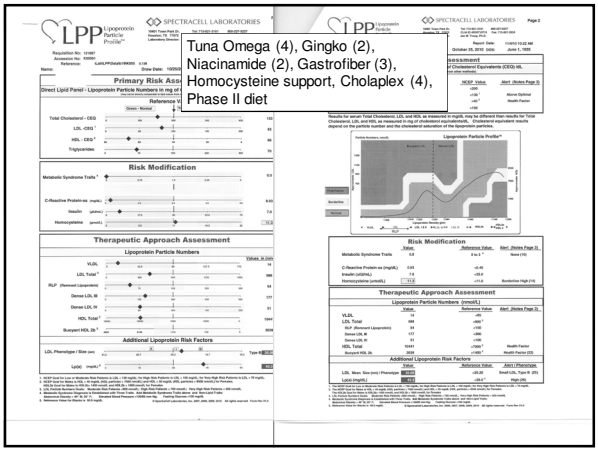

Tuna Omega (4), Gingko (2), Niacinamide (2), Gastrofiber (3), Homocysteine support, Cholaplex (4), Phase II diet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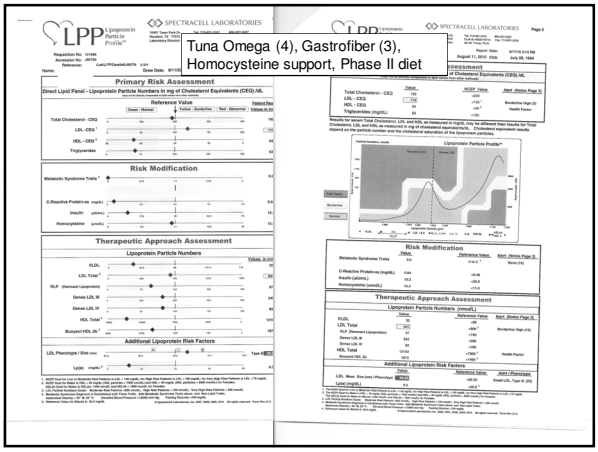
Tuna Omega (4), Gastrofiber (3), Homocysteine support, Phase II diet

Nutrient Benefits in Dyslipidemia

- Low fat diets
- Low Glycemic diets
- Niacin (Nicotinic Acid)
- Pantethine (Pantothenic Acid)
- Policosanol
- Phytosterols
- Omega-3 Fatty Acids
- Tocotrienols (Vitamin E)
- Red Yeast Rice (RYR)
- Berberine
- Guggulipids
- Artichoke
- Garlic

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Nutrients Benefits in Dyslipidemia

- Fenugreek
- Walnuts
- Carnitine
- Taurine
- Red Wine
- Green Tea
- Pomegranate
- Conjugated Linoleic Acid CLA

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Nutrient Benefits in Dyslipidemia

- Low fat diets – Much debate has occurred in the past 2 decades over influence of low fat diets on lipids – One central truth emerged that required label warnings for content of hydrogenated trans fatty acids. Intake of hydrogenated polyunsaturated oils in place of saturated fats increases both total cholesterol and LDL-C, and more recently has been shown to reduce LDL particle size and Apo A levels, while increasing both Apo B and Lp(a) further promoting atherogenesis
- Low Glycemic diets – Dumesnil et al (2001) showed that a reduced glycemic index diet out performed the American Heart Association Step I diet in reducing caloric intake, Apo B, triglycerides and insulin, while increasing LDL particle size

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Soluble Fiber to support weight

- Much attention lately has come to the idea of increasing soluble fiber to reduce appetite, increase insulin sensitivity and address metabolic syndrome traits, as well as address lipid irregularities
- Also promotes toxin elimination and thus reduction of body fluid and weight
- Multiple studies reveal that those who ingest more than 21 grams of fiber per day gained 8 pounds less over a 10 year period that others who ate less – high dietary fiber is associated with lower body weight
- Some suggest to maximize weight loss increase dietary fiber to between 35-45 grams daily

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Nutrient Benefits in Dyslipidemia

- Dietary Fiber – Increased consumption of both soluble and insoluble fiber (especially researched are sources of oats, psyllium and flax) have shown numerous health benefits including reducing CVD risk by increasing the LDL particle size and reducing the number – recent studies have shown fiber supplementation has outperformed statin use. Gastrofiber (3 at bedtime or Whole Food Fiber can be used to supplement the diet)
- Niacin (Nicotinic Acid) – First reports of lowering lipids were in 1955, and numerous studies since then. It is understood to inhibit free fatty acid mobilization from peripheral adipose tissue to the liver, thus decreasing synthesis of triglycerides, VLDL, and the synthesis of LDL from VLDL. I t also appears niacin reduces the breakdown of Apo A-1, which elevates Apo A-1 and leads to enhanced HDL production. Niacin supplementation is available in three forms - Immediate release (IR), extended release (ER), Sustained release (SR). The rate of absorption is crucial in how the liver metabolizes niacin thus effecting efficacy, safety and side effects. Principle side effects include flushing and the SR & ER may induce liver inflammation. Niacin doses range from 250 mg to 3000mg/day, although 2000 mg/day is the maximum dose for effecting HDL and triglycerides. Niacinamide/B12 (2/day) is excellent low dose niacin to achieve these benefits

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Nutrient Benefits in Dyslipidemia

- Guggul – From the resins of the mukul myrrh tree (Commiphora mukul) guggulipids have been used in India for centuries for obesity and lipid disorders. The active ingredients are guggulstreones that have been reported to lower total cholesterol, TG, LDL-C and raise HDL-C. It's primary role seems to be to increase bile secretion and decrease cholesterol synthesis due to its ability to increase the number of hepatic LDL receptors. Some controversy exists over the efficacy of guggul for lipid improvement due to study published in 2003 that actually showed increased LDL-C over 8 weeks in guggul using subjects compared to a control group.
- Garlic – (Allium Sativum L.) Has long been used for medicinal purposes with over 50 studies over the last 40 years showing various results. Meta-analysis suggests have modest effects on lipid profiles but this fails to consider the mechanisms of action. Instead of decreasing lipids garlic acts to prevent LDL oxidation reducing profoundly the atherosclerotic activity, while also improving fibrinolytic activity, inhibiting platelet aggregation and act as an anti-hypertensive agent. Processing techniques and tabletting protocols, such as enteric coating or de-odorizing, can effect outcomes. Garlic 5000 from MediHerb is an excellent way to achieve the benefits of properly prepared garlic because it is enteric coated to protect the allinase enzyme from being destroyed by stomach acid and thius ensuring that it will be present to convert alliin to allicin (2/day).As well it has been shown to have immune supporting qualities and reduces gut dysbiosis.

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Nutrient Benefits in Dyslipidemia

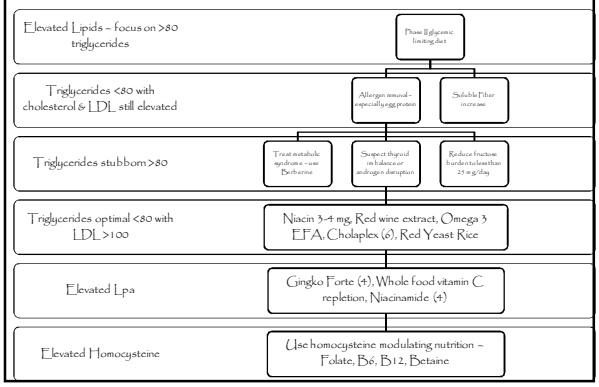
- Berberine – Found in numerous plant including Golden Seal and Phillodendron, it is most noted as antimicrobial, antifungal, and immune enhancing. Through genetic screening it was found to up-regulate LDL receptor gene mRNA subsequently showing novel cholesterol-lowering influence. It was shown that it significantly lowered cholesterol (29%), TG (35%), and LDL-C (25%) as well as useful in congestive heart failure and hypertension. No increase in HDL-C was noted. It is also hepato-protective and improves liver enzymes whole recent studies reveal that it may have insulin receptor sensitization making it useful in insulin resistance and dyslipidemias found in metabolic syndromes. Found in Gut Flora Complex and future to be released products – stay tuned with Berberine)
- Artichoke – have been popular in managing dyspepsia, liver support and hypercholesterolemia thought to increase bile synthesis and output. Not widely used as a monotherapy, but in conjunction with bile-sequestering soluble fiber can effectively move cholesterol out of the body. In vitro studies in rat hepatocytes also reveal an inhibitory action against the HMG-CoA reductase enzyme which limits the production of cholesterol (similar to the target of statin compounds). Recently it has been shown to have antioxidant properties and increase nitric oxide formation improved endothelial function in patients with atherosclerosis and cardiovascular disease. It should be used with soluble fiber to maximize benefits and can be found in Livton (2 bid) which is a general liver cholagogue.

New Thinking …

People become really remarkable when they start thinking that they can do things. When they believe in themselves they have the first scret of success.

Norman Vincent Peale

Algorhythms to sequentialize



Phase II Diet

Phase II diet for balancing blood chemistry (edited from Melvin Page's work)
Removing Starches will control your blood sugar, which will remove THE major stress on your body-Hypoglycemia
The 1st and most important step is to remove, pasta, bread, white potatoes and rice
The 2nd step is consume protein 3x/day
The 3rd step is to dilute all juice 50% with water & be cautious not at drink too much fluid with meals, reducing digestive capacity

Animal Protein 3x/day
MEAT
FISH
FOWL
EGGS
Animal protein requirements are calculated by taking your weight in pounds and divide by 15 to get min. ounces per day ie. 150lbs/15=10oz per day
10oz/3 meals = 3.3 oz per meal
Vegetables (see guidelines to right)
FRUIT as a MEAL
Unlimited amount of ANY fruit as a meal
FRUIT between meals as a snack
Max 2 times per day
Best snack fruits (low glycemic) are:
Apple
Berries / Cherries
Grapes
Peach
Pear
Plum

UNLIMITED AMOUNTS	
VEGETABLES 3% or less carbs	**VEGETABLES 6% or less carbs**
Asparagus	Bell Peppers
Bamboo Shoots	Bok Choy Stems
Bean Sprouts	Chives
Beet Greens	Eggplant
Bok Choy Greens	Green Beans
Broccoli	Green Onions
Cabbages	Okra
Cauliflower	Olives
Celery	Pickles
Chards	Pimento
Chicory	Rhubarb
Collard Greens	Sweet Potatoes
Cucumber	Tomatoes
Endive	Water Chestnuts
Escarole	Yams
Garlic	**VEGETABLES 7-9% carbs**
Kale	Acorn Squash
Kohlrabi	Artichokes
Lettuces	Avocado
Mushrooms	Beets
Mustard Greens	Brussels Sprouts
Parsley	Butternut Squash
Radishes	Carrots
Raw Cob Corn	Jicama
Salad Greens	Leeks
Sauerkraut	Onion
Spinach	Pumpkin
Yellow Squash	Rutabagas
Zucchini Squash	Turnips
	Winter Squashes

2-3 times per wk max
VEGETABES 12 - 21%carbs
Celeriac (celery root)
Chickpeas
Cooked Corn
Horseradish
Kidney Beans
Lima Beans
Lentils
Parsnips
Peas
Popcorn
~~**Potatoes-white**~~
Sprouted Seeds
Soy (fermented is best)
Sunflower Seeds

2-3 times per wk max
Low Glycemic Grains
Buckwheat
Quinoa
Sprouted Grains (from original diet)
Wild Rice (actually a grass)
Avoid higher glycemic grains:
~~Amaranth~~
~~Barley~~
~~Rice-brown or white~~
~~Millet~~
~~Wheat~~

MISCELLANEOUS
Slightly Restricted
Butter
Caviar
Cottage Cheese
Coconut Oil
Jerky
Kefir (liquid yogurt)
Cheese or Milk, Raw
Nuts (except Peanuts)
Olive Oil, Sesame Seed Oil, Walnut Oil
Dressing-Above Oil & Apple Cider Vinegar
BEVERAGES
Spring or Filtered Water
Herbal (NON-caffeinated) teas
Broth-Chicken or Beef
Red Wine only (3 glasses max/day)

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The Low Glycemic Lifestyle

America has been accustomed to a high carbohydrate diet. Today there is controversy around the high carbohydrate vs. a low carbohydrate diet. Oftentimes the low carbohydrate diet is misnamed the no carbohydrate diet, but that is not accurate. The reality is that the standard American diet should be called high carbohydrate and a low carbohydrate should be called the normal diet.

Some experts speculate that approximately 90 percent of illness results from carbohydrate metabolism and difficulty. When archeologists wander in the wilderness and discover the skull of an aboriginal people the first thing they do is open the jaw to view whether or not the teeth are still there. If the teeth are in the jaw the skeleton is classified as a hunter/gatherer, and if the teeth are missing the remains are classified as aggregarian (eating cultivated grains). Even this simple classification describes carbohydrate difficulty, wherein primitive people eating a higher carbohydrate grain diet lose their teeth due to the damaging effects of sugar on the body.

Most people intend to control sugar in their diet because of weight gain, although they never seen to succeed in overcoming the sugar cravings. This is because there is more unseen and untasted sugar in the starches from grains than there is from simple sugars that are sweet. It has always been difficult to encourage people to reduce their sugar consumption while leaving them on a high starch diet. Now simply by eliminating pasta, bread, potatoes and rice, and all forms of starch sugar cravings go away. This is because the starches are powder kegs of sugar requiring huge releases of insulin to manage leading to irregular blood sugar level management and subsequent sugar cravings.

Because of our past attitudes towards dietting and sugar control many people believe that low glycemic diets would be difficult. It is quite the opposite, by eating more protein, healthy fats and oils, and the low carbohydrate composition of vegetables and fruits within days there is an elimination of sugar cravings and the beginning of glycemic balance. The results of this are more energy, less inflammation and aching, and less food cravings, sugar especially. The other results are lower triglycerides and cholesterol, reduced body fat percentage and therefore shape loss and weight loss, increased concentration and attention, and increased repair of the protein structures of the body.

Of the three major diseases facing modern-day America, namely heart disease, diabetes and cancer, a low glycemic diet would be preventative and reparative in each case. Indeed when the deeper cause of these three major diseases is addressed it follows to say that longevity is served. Strategically perhaps the low glycemic diet is the most important aspect of an effort to word longevity and vitality.

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Controlling Cholesterol

Cholesterol has become the focus of a great deal of attention in the modern medical world. Many people have thought that cholesterol is something that signifies a tendency towards coronary artery disease and heart disease, and it is generally assumed that is very difficult to bring cholesterol levels down if elevated and that a statin drug would need to be employed to accomplish the reduction. There are a number of factors that should be considered when it comes to considering cholesterol balance.

The original study of cholesterol done in the 1960s on approximately 240,000 subjects found that cholesterol levels above 300 directly associated itself with an increased risk of heart disease. What was also reported in the same study also was that cholesterol less than 130 directly associated itself with an increased risk of cancer. At first it was thought that cholesterol came from animal foods and fats that were consumed in the diet, although it was later discovered that two-thirds of the body's cholesterol is actually fabricated in the liver. Today with our new understanding around healthy fats and the impact of carbohydrates and high glycemic diets it is revealed that elevated triglyceride levels result in a downstream elevation of cholesterol. Chemically when triglycerides are high they automatically cascade downstream into high cholesterol. While the triglycerides lab values for the common American are said to be normal under 200 or 150 (depending on the lab), the truth is that any triglyceride level above 90 will result in unnecessary elevation of cholesterol. Oftentimes simply by limiting the glycemic intake in the diet the triglycerides fall to under 90 and the cholesterol naturally follows into range, optimally to be between 160 and 180.

If the triglycerides are under 90 and the cholesterol continues to be elevated it oftentimes suggests the possibility of some food allergy congesting and slowing the digestive process thus resulting in elevated cholesterol resorption from the gut. The most common allergy in this situation is eggs, and an estimated 30 percent of the population is allergic to eggs (lactalbumin). By eliminating eggs, if one is allergic to them and limiting the glycemic intake, the cholesterol naturally comes to an optimal level. It used to be expected that these changes in cholesterol take months or even years and that therefore legitimizes the employment of certain statin drugs to lower cholesterol. These triglyceride and cholesterol imbalances can actually be corrected profoundly within 7-10 days demonstrated by lab work. It is so simple to limit the glycemic index in the diet and see the triglycerides fall and subsequently the cholesterol normalize. It also is rewarding to discover that we can control our own chemical imbalances without having to use drugs to achieve this.

HDL cholesterol (high-density lipoprotein) is another consideration. HDL's are able to help transport cholesterol through the blood and keep it from plaquing onto the arterial wall. HDL's can be increased through exercise and through certain nutrients including red wine. Recently another factor has become a consideration as the level of Homocysteine protein in the blood acts as Velcro to attach the plaque to the arterial wall. Although normal levels allow up to 12-15, it is optimally recommended that Homocysteine be kept under 7. Interestingly enough Homocysteine is a purely nutritional event and if elevated simply adding vitamins B6, B12, folate and folic acid usually will return it to an optimal level. This is very good predictor of heart risk. Another influence to arterial wall plaquing is C-reactive protein (CRP). CRP represents the state of inflammation in the body and therefore the subsequent stickiness of the arterial wall. By keeping our body free of chronic infection and immune burdens, especially allergies, the C-reactive protein will fall to less than .04 where there is very little likelihood that plaquing will occur.

There are multiple factors that influence the lipid profile of our blood. A few of them have been outlined above so that a person can begin to explore their own capability of controlling their own cholesterol levels. It is a most exciting thing to find that you are in control of your chemistry rather than the genes you inherited determining your destiny. Many people have been skeptical to believe how quickly the lipid profile could be optimized, and many have chosen not to try. When it is possible to see profound change within seven days there is every reason to be encouraged to try experimenting with your own lipid levels.

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Assessing Fructose Burden -Fruit Fructose Content

Fruit	Serving	Grams Fructose
Limes	One	0
Lemons	One	0.6
Cranberries	1 cup	0.7
Passion Fruit	One	0.9
Prune	One	1.2
Apricot	One	1.3
Guava	Two	2.2
Dates (Deglet)	One	2.6
Cataloupe	1/8	2.8
Raspberries	1 cup	3.0
Kiwi	One	3.4
Blackberries	1 cup	3.5
Star fruit	One	3.6
Cherries	10	3.8
Strawberries	1 cup	3.8
Pineapple	1 Slice	4.3
Boysenberries	1 cup	4.6
Tangerine/Mandarin	One	4.8
Nectarine	One	5.4
Peach	One	5.9
Orange	One	6.1
Papaya	Half	6.3
Honeydew	1/8	6.7
Banana	One	7.1
Blueberries	1 cup	7.4
Date (Medjool)	One	7.7
Apple	One	9.5
Persimmon	One	10.6
Watermelon	1/16	11.3
Pear	One	11.8
Raisins	¾ cup	12.3
Grapes (green or red)	1 cup	12.4
Mango	Half	16.2
Apricots (dried)	1 cup	16.4
Figs (dried)	1 cup	23.0

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Seek to limit daily consumption of fructose to 25 grams per day to avoid fatty degeneration

Sequential Intervention

- When lipid profiles are elevated and abnormal sequential nutrient and botanical measures may be employed to assist in achieving balance
  - 1 Use Phase II diet lifestyle as discussed reducing obesity and improving TG and total cholesterol while increasing HDL
    - TG under 80 means diet is normal, otherwise suspect egg allergy or other food
  - 2 Use Gastrofiber (2 bid) or Whole Food Fiber to bind to cholesterol and reduce re-absorption this reducing lipidemia
  - 3 Employ Livton (2 bid) to increase artichoke benefits
  - 4 Increase Tuna Omega (2 bid) and omega 3 oils
  - 5 Consider Garlic 5000 (1 bid) to support atherosclerotic mechanisms and reduce events
  - 6 Use Cholaplex as liver health supporting product
  - 7 Consider liver cleansing support with numerous products especially A F Betafood (5 bid)
  - 8 Gingko Forte (1 bid) may assist in lower Lpa
  - 9 Consider Cyruta (3 bid) as a way to cleanse the cardiovascular system of atherosclerotic buildup through solubization influence
  - 10 Niacinamide (2 bid) to reduce abnormal lipid events
  - 11 Red Yeast Rice to reduce cholesterol formation in the liver

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