

June 1999 Issue | Dan Labriola, ND

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Welcome to *Functional Medicine Update*[™] for June 1999. This is an auspicious issue for us. I was reminiscing with Jay Johnson, the audio technician who produces *FMU*. This is our 18th year of producing *FMU*. It started as *Metabolic Update*[™] in the early 1980s, became *Preventive Medicine Update*[™]; and recently evolved to become *Functional Medicine Update*[™]. A few subscribers have been with us the whole time, and we thank them. We look forward to watching what happens in this field as it continues to unfold in the new millenium.

We have been fortunate over the years to have many extraordinary Clinicians of the Month. Through their voices we have heard about the emergence of this field, its evolution, and the changes that have occurred. We have also watched the literature unfold, going from isolated articles to a real tsunami of functional medicine literature. With great pleasure and privilege we push on with *FMU* toward the year 2000.

The best way to define functional medicine and functional health is through a person we would hail as a success story in functional lifestyle. Dr. George M. Shambaugh, Jr., an otolaryngologist and surgeon, is such a person. He developed many surgical procedures for the neck, throat, and nose. Later he became a strong advocate of the work in environmental medicine by Dr. Theron Randolph. Dr. Shambaugh was an academic at the Northwestern University Medical School in the Department of Otolaryngology. He increasingly emphasized environmental medicine in practice. His clinic in Hinsdale, Illinois, was a premier center of excellence in this area. At the Fourth International Symposium on Functional Medicine we honored Dr. Shambaugh for his extraordinary contributions over many years.

Born on June 30, 1903, Dr. Shambaugh was still seeing patients up to the day of his death on February 7, 1999. His life is a fine example of rectangularizing the survival curve, making contributions up until the last moment when one undergoes a natural death. We celebrate Dr. Shambaugh and mourn his loss. We will miss seeing Dr. Shambaugh at the many meetings he participated in. He was a model for all of us.

It is difficult to arrive at a specific diagnosis for many walking-wounded symptoms that appear in members of society. Some are diffuse symptoms like abdominal pain, fatigue, muscle weakness, anorexia, chills, headaches, malaise, nausea, general weakness and myalgia. How do we characterize those conditions in terms of a differential diagnosis if they are clustered as symptoms?

Our colleagues Scott Rigden, MD, recently called my attention to a bit of literature. In this paper, which appeared in *Biological Psychiatry*, the authors explain that many of the symptoms I just listed apply to patients who have abruptly discontinued serotonin reuptake-inhibiting drugs, SSRIs.¹ People who take SSRIs develop a physiological dependency, so to speak, and abrupt discontinuation of the drugs can

create adverse rebound effects. Many people take these medications, and the reported rebound symptoms from rapid discontinuation of the drugs can affect as many as 50 percent of the people taking them. Since non-compliance with prescribed treatment regimen is reported to be as high as 82 percent, the possibility of periodic withdrawal is a significant risk. Many people may be walking around with these symptoms of chronic, diffuse physiological dysfunction who may be suffering from rebound effects that have occurred as a consequence of abruptly discontinuing SSRIs.

INTERVIEW TRANSCRIPT

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JB: One topic that many subscribers have requested over the last few years is drug/nutrient interactions in oncology, and the role of nutrition during cancer treatment. This area is fraught with misinformation, confusion, and controversy. We are fortunate to have with us today Dr. Dan Labriola, Director of the Northwest Natural Health Specialty Care Clinic in Seattle, Washington. Dan was trained as a naturopathic physician, and is a graduate of Bastyr University. He has spent more than a decade ferreting out the wheat from the chaff, knowing that while it is an imperfect science, it is still a clinical field. Dr. Labriola will help us gain some perspective in this area.

Dr. Labriola, we appreciate your being with us on *FMU*. Please tell us about Northwest Natural Health Specialty Care Clinic and its relationship to adjuvant and adjunctive therapies.

DL: Northwest Natural Health Specialty Care Clinic has been treating, in an adjunctive setting, for over 15 years. We treat many patients who are receiving conventional therapy. Our treatment objectives generally are centered around providing good, solid, anti-cancer activity, about which we are learning a great deal in natural and functional medicine. We spend a lot of time reducing morbidity and improving patient tolerance for conventional treatments. In addition, new studies now suggest we can actually develop some synergism, carefully using natural medicine concurrently with conventional treatments.

Dr. Sherman, Dr. Collins and myself, who are the three doctors at the clinic, spend a lot of time assisting functional medicine providers, literally all over the world, develop treatment protocols that are safe, effective, and usable in a conventional medical setting. Interestingly, we find that an important part of this recipe is providing protocols that are understandable, at least in principle, by conventional providers so they have something they can base their understanding on and are more comfortable with. In fact, I'll put in a plug for my book, *Complementary Cancer Therapies*, to be published by Prima Publishing within the next month. It's over 100,000 words and is a patient-oriented text, but it's pretty large and it describes many of these protocols.

JB: It will be of tremendous value to patients and practitioners alike. I've been impressed, not only with the quality of thought that has gone into your work, but also the clinical attention to detail. It has been received well in the local Seattle and greater Washington State medical services. Have you been pleased with the response from your colleagues?

DL: I have, very much so. We work with a lot of natural medicine providers, and more than 80 percent of our referrals come from conventional medical oncologists. We are now consultants to most of the area hospitals, including the Fred Hutchinson Cancer Research Center. We have been very pleased. Our effort has been to inject good, solid science into this controversy and into the general discussion. It has been very well received.

JB: Tell us about the whole area of drug/nutrient interactions in oncology. That is a very specific area of pharmacology, and it requires one to consider many things.

DL: It's unique. One reason it's unique is it is not always intuitive. If we utilize conventional wisdom and look for immediate responses, in terms of determining where there are interactions, those responses often are not obvious. In fact, they often don't show up in the short term at all. Many conventional treatments that occur are done for long-term objectives—avoiding a recurrence, whether it's a local recurrence or a systemic recurrence. So in many cases, you're looking for a non-event, which makes the science and the study a little more difficult.

If you look carefully at the basic science, it generally predicts in the short term that even with an improper drug/nutrient interaction, you can end up with short-term improvements. But they unfortunately belie poorer long-term results. We can actually reduce short-term morbidity, because we're effectively reducing the dosage of the conventional therapy. In the process of doing that, we're also reducing non-target tissue damage so that the tissue we didn't want to be damaged as a result of toxicity of these cytotoxic drugs actually does better. The patient does better; and feels better in the short term. But unfortunately, that same reduction in dosage that occurs because of poor interaction planning will have a poorer long-term result because we haven't prevented a recurrence based on the pharmacology that we understand right now.

Bibliography

1. Rosenbaum JF, Fava M, Hoog SL, Ascroft RC, Krebs WB. Selective serotonin reuptake inhibitor discontinuation syndrome: a randomized clinical trial. *Biol Psychiatry*. 1998;44:77-87.
2. Pre-symptomatic detection of Parkinsons. *Parkinson's Disease Update*. 1999;96:645-646.
3. Low-dose clozapine for the treatment of drug-induced psychosis in Parkinson's disease. *N Engl J Med*. 1999;340(10):757-763.
4. Cummings JL. Managing psychosis in patients with Parkinson's disease. *N Engl J Med*. 1999;340(10):801-803.
5. Gern JE, Yang E, Evrard HM, Sampson HA. Allergic reactions to milk-contaminated "nondairy" products. *N Engl J Med*. 1991;321(14):976-979.
6. Sampson HA, Mendelson L, Rosen JP. Fatal and near-fatal anaphylactic reactions to food in children and adolescents. *N Engl J Med*. 1991;327(6):380-384.

7. Legendre C, Caillat-Zucman S, Samuel D, et al. Transfer of symptomatic peanut allergy to the recipient of a combined liver-and-kidney transplant. *N Engl J Med.* 1997;337(12):822-824.
8. Gura T. *Chlamydia* protein linked to heart disease. *Science.* 1999;283:1238-1239.
9. Meier CR, Derby LE, Jick SS, Vasilakis C, Jick H. Antibiotics and risk of subsequent first-time acute myocardial infarction. *JAMA.* 1999;281(5):427-431.
10. Bachmaier K, Neu N, de la Maza LM, Pal S, Hessel A, Penninger JM. *Chlamydia* infections and heart disease linked through antigenic mimicry. 1999;283:1335-1339.
11. Kapahi P, Boulton ME, Kirkwood TB. Positive correlation between mammalian life span and cellular resistance to stress. *Free Rad Biol Med.* 1999;26(5/6):495-500.
12. Chen L, Bowen PE, Berzy D, Aryee F, Stacewicz-Sapuntzakis M, Riley RE. Diet modification affects DNA oxidative damage in healthy humans. *Free Rad Biol Med.* 1999;26(5/6):695-703.
13. Ballard-Barbash R, Forman MR, Kipnis V. Dietary fat, serum estrogen levels, and breast cancer risk: a multifaceted story. *J Natl Cancer Inst.* 1999;91(6):492-493.
14. Wu AH, Pike MC, Stram DO. Meta-analysis: dietary fat intake, serum estrogen levels, and the risk of breast cancer. *J Natl Cancer Inst.* 1999;91:529-534.
15. Foy MR, Xu J, Xie X, Brinton RD, Thompson RF, Berger TW. 17beta-estradiol enhances NMDA receptor-mediated EPSPs and long-term potentiation. *J Neurophysiol.* 1999;81(2):925-929.
16. Bosland MC, Oakley-Girvan I, Whittemore AS. Dietary fat, calories, and prostate cancer risk. *J Natl Cancer Inst.* 1999;91(6):489-490.
17. Mukherjee P, Sotnikov AV, Mangian HJ, Zhou JR, Visek WJ, Clinton SK. Energy intake and prostate tumor growth, angiogenesis, and vascular endothelial growth factor expression. *J Natl Cancer Inst.* 1999;91(6):512-523.
18. Stolzenberg-Solomon RZ, Albanes D, Nieto FJ, et al. Pancreatic cancer risk and nutrition-related methyl-group availability indicators in male smokers. *J Natl Cancer Inst.* 1999;91(6):535-541.
19. Heimbarger DC, Alexander CB, Birch R, Butterworth CE Jr, Bailey WC, Krumdieck CL. Improvement in bronchial squamous metaplasia in smokers treated with folate and vitamin B12. Report of a preliminary randomized, double-blind intervention trial. *JAMA.* 1988;259(10):1525-1530.
20. Kim JH, Brown S, Walker E. The use of high dose vitamins as an adjunct to conventional cancer treatment. In: Prasad KN, Cole WC, (eds.) *Cancer and Nutrition.* IOS Press;1998:205-212.
21. Prasad KN, Kumar A, Kochupillai V, Cole WC. High doses of multiple antioxidant vitamins: essential ingredients in improving the efficacy of standard cancer therapy. *J Am Coll Nutr.* 1999;18(1):13-25.

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