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## THE PHYSICIAN'S CONCISE GUIDE TO:

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# FAILURE of Statin Crestor® (Rosuvastatin) in the "Justification for the Use of Statins In Prevention & Intervention Trial Evaluating Rosuvastatin" (JUPITER) Study

Brian Scott Peskin, B.S.E.E., *Founder: Life-Systems* Engineering Science

*Dedicated to advancing and publicizing the science and discoveries of Prof. Brian Peskin.*

**There is simply no one better in the 21st century** at developing practical health-related solutions based on the world's leading medical and nutritional science. **"Science — Not opinion" is Brian's trademark.** When Brian is through explaining a topic it is "case closed!" When he says it, you "can take the information to the bank!"

Unlike most of his peers' recommendations, Brian's health and nutritional recommendations have stood the test of time. **Brian has never had to reverse or significantly alter any of his medical reports—reports that have tackled everything from the dangers of soy, to the wrongly popularized need for fiber in the diet, to his warning about the potential harm of supplementing with copious amounts of omega-3**. In 1995 he published the report "Fiber Fiction" and finally, eleven years later, others in research are acknowledging the silliness of recommending fiber in the diet of a human being. Brian's latest crusade is to warn of the dangers of excess omega-3 (in particular, fish oil) and how it will lead to increased cases of skin cancer. The list goes on and on…

Brian received an appointment as an Adjunct Professor at Texas Southern University in the Department of Pharmacy and Health Sciences (1998-1999). **The former president of the University said of his discoveries: "...His nutritional discoveries and practical applications through *Life-Systems* Engineering are unprecedented."** Brian earned his Bachelor of Science degree in Electrical Engineering from Massachusetts Institute of Technology (MIT) in 1979. Brian founded the field of *Life-Systems* Engineering Science in 1995. This field is defined as *The New Science of Maximizing Desired Results by Working Cooperatively with the Natural Processes of Living Systems*. To many, Brian is THE MOST TRUSTED AUTHORITY ON HEALTH AND NUTRITION IN THE WORLD.

Brian continues to be a featured guest on hundreds of radio and television shows both nationally and internationally. His sheer number of accomplishments during the last decade of the 20th century and into the 21st century are unprecedented and uniquely designate him as the #1 authority in the world of what really works and why. Forget listening to the popular press or most popular so-called health magazines. Their editors simply don't understand the complicated science that they write about — they merely "parrot" what everyone else says without independent scientific verification. Their recommendations often have no basis in reality of how the body works, based on its physiology.

Brian has dedicated his life to provide the truth — which is almost always opposite to what everyone says. Here's why Brian is the #1 man in America to listen to when it comes to your health.

## Why Today's Medical "Breakthroughs" Often Become Tomorrow's Discredited Science

*Discover* Magazine published an exceptional article regarding a Yale School of Medicine emergency physician's horrendous experience with giving a stroke patient a drug meant to save his life, which instead killed him. Marketing hype is misleading both physicians and their patients. Here is the information from this article that you need to know[1]:

· "Drug manufacturers are **spending more to promote their products** while being subject to tighter regulation and **greater pressure for financial returns**.

· "John P.A. Ioannidis, an epidemiologist at Tufts University School of Medicine in Boston, analyzing published clinical (drug) studies between 1990 and 2000, found that "**key claims of nearly one-third (14 out of 49) of the original *research studies* he examined were either *false* or *exaggerated***.

· "A 2006 analysis published in the *American Journal of Psychiatry* found that **90 percent of manufacture-sponsored** studies of antipsychotic drugs **led to claims that the study drug was as good as, or superior to, every other drug in its class**. [Note: If they didn't say this then no one would use their new drug — why would they?]

· "Marcia Angel [MD], the former editor-in-chief of *The New England Journal of Medicine (NEJM)*, says that **most doctors are ill equipped to critically access the conclusions of researchers**." [Note: physicians typically don't have backgrounds in statistical analysis, nor do they have time for these analyses — they should not have to! They rely (and should be able to rely) on drug companies not to mislead them. Tragically, this is often a big mistake.] Dr. Angel goes on to say…

· "Let me tell you the dirty secret of medical journals: **It is very hard to find enough articles to publish**. With a rejection rate of 90% for original research, we were hard pressed to find 10% that were worth publishing. So you **end up publishing weak studies** because there is so much bad work out there. **Doctors, Angell says, are not skeptical**

1. "Medicine's Magic Bullets," Jeanne Lenzer, July 2008, pages 46- 52.

**enough about what they read in top journals**. They should say, 'I don't believe this; prove it to me.'

· "One way to **make drugs look better or safer** is to **report only successful studies while ignoring those with bad results**. [Note: This routinely happens in the medical journals and so physicians are misled.]

· "John Abramson [MD], a clinical instructor at Harvard Medical School and author of *Overdosed in America: The Broken Promise of American Medicine* states '**You can lower cholesterol levels with a drug, yet provide no health benefits whatsoever**.'

· "'…**Dying [from heart attack] with corrected cholesterol is not a successful outcome**'…." (Emphasis added.)

## ◗ *Life-Systems* Engineering Science Commentary

Is it any wonder physicians either don't believe much of what they read in the medical journals or are misled by them? No, it isn't. You can see from the above that drug manufacturers have been forced to become superb marketers — likely the best marketers in the world. Because so many drugs have horrific side-effects and so few drugs can be brought to the marketplace at all, the pharmaceutical companies are forced to make these few drugs "blockbusters" with little regard to each drug's actual performance. The perfect example of this masterful marketing is the use of statins as the following article details.

## FAILURE of Statin Crestor® (Rosuvastatin) in the "Justification for the Use of Statins In Prevention and Intervention Trial Evaluating Rosuvastatin" (JUPITER) Study*

**Brian Scott Peskin, B.S.E.E., Founder: Life-Systems Engineering Science**

That's right, FAILURE. The JUPITER study as reported in *The New England Journal of Medicine* (Ridker PM, et al, 2008;359:2195-207, published November 20) clearly showed another statin failure when the study is analyzed using science instead of emotion.

My review flies in the face of reactions from the American Heart Association and every news organization that has recently reported on this very carefully conceived and constructed study. There is an enormous difference between "carefully constructed" and first-rate science.

First, this study applies to a **sample population that is virtually nonexistent**—meaning that even if the drug did work (which it doesn't), it wouldn't likely help you. **In fact, the researchers had to conduct the trial at 1315 different locations** to find "special" people meeting the study "requirements." That's right. **On average, 4 out of every 5 potential subjects were rejected, so that each location only contributed on average 13 patients to the grand total of 17,802 patients**—a ridiculously small number, making the process extremely costly and raising the question of why these scientists would go to such extreme lengths.

If the JUPITER trial was such a failure—all statin studies have to fail when measured based on science and not marketing—then why are so many physicians raving about JUPITER's success? The short answer is that when you are desperate to find anything that might work, you make mistakes—*big* mistakes. Rosuvastatin clearly doesn't work according to the pharmaceutical company's own measure for success of a drug, which is called the NNT (number needed to treat). The NNT for the Jupiter trial (prevention of a major cardiovascular event) was 95, meaning that for every 95 patients given the drug, it was a failure for 94 patients or a failure rate of 99%! (Note that this failure rate does not include additional patients who

* I wish to thank Uffe Ravnskov, M.D., Ph.D., Marissa Carter, Ph.D., Sandy Szware's "Junkfood Science" column, Michael Eades, M.D., and distinguished cardiologist David Sim, M.D.

suffered harmful side effects.). Contrast this with an antibiotic or insulin reducing blood sugars that have NNTs of 1, meaning that for every 100 patients treated, 99 patients are cured. The higher the NNT, the *worse* the drug's performance.

In this trial, LDL cholesterol was lowered an average of 50% and C-reactive protein (CRP) was decreased 37%. These changes, however, are not significant because they do not focus on or impact the metabolic pathways that are truly causal and predictive for prevention of cardiovascular disease.

Physicians are grasping at straws, desperate to have something to give patients, even if it works poorly. Desperate people do desperate things, such as failing to ask critical questions and taking pharmaceutically-paid studies at face value without looking too deeply, asking insightful questions, or even using common sense. Add this to the pharmaceutical companies' enormous physician advertising budget dedicated to statins and it is no wonder that physicians are on the statin bandwagon.

My article is not an indictment of physicians; it is an attack on pharmaceutical companies. Understand that most drugs do not make it successfully into human trials. After a pharmaceutical company spends hundreds of millions of dollars and close to a decade in time, most new drug trials are disallowed. Whenever the pharmaceutical company finds a drug that doesn't kill too many people or cause too many serious side effects (there are very few drugs that meet those criteria) they have to put all of their hopes of staying in business on that drug. Never forget that pharmaceutical companies started marketing statins in 1986 and it has taken them over 20 years and an enormous amount of money to achieve the result of having persuaded almost everyone, mistakenly, to believe the simplistic "cholesterol theory." (Please refer to the Special Medical Report "The Failure of Vytorin and Statins to Improve Cardiovascular Health: Bad Cholesterol or Bad Theory" at www.brianpeskin.com or in the peer-reviewed *Journal of American Physicians and Surgeons* at *http://www.jpands.org/jpands1303.htm*.)

As discussed in this article, the correct anti-inflammatory answer is consumption of the parent essential oil omega-6 (EFA) for its $PGE_1$ (the body's most potent natural anti-inflammatory) effect. The anti-thrombosis answer is in the PEO (parent omega-6) derivative arachadonic acid's prostacyclin

production — which is the body's potent natural anti-aggretory/anti-platelet adhesion weapon.

Because pharmaceutical companies already understood that statins did not alleviate heart disease and caused horrific side effects in too many people, they needed to create a problem that statins actually helped.

It is most important to understand that the gross failure of the Vytorin study in the ENHANCE trial a few years back was withheld by the pharmaceutical company for about 2 years while another study was "developed." They knew they would have to address the fact that despite a 50% reduction in LDL cholesterol, arterial clogging in patients' lumen (vessel interior) was *not reduced*, intima-media thickness was *not reduced*, and atherosclerosis was *not lessened*. This was a major embarrassment and the pharmaceutical company said nothing about the ENHANCE trial for close to 2 years. Their admission of the ENHANCE debacle coincided with their "discovery" that statins aided a new, more important health concern. What good fortune for the pharmaceutical industry!

## Here's what you need to know:

• The JUPITER study enrolled only men OVER 50 and women OVER 60, with average ages of 66. No results should be allowed to be generalized to other untested populations.

• Patients were "pre-screened" for a month and patients with any history of inflammatory disorders like any history or evidence of heart disease, high blood pressure, diabetes, and arthritis, were eliminated or excluded. You simply can't do this and expect to generalize the results to most physicians' practices.

• These selected people had elevated C-reactive protein levels. C-reactive protein is MERELY a GENERALIZED, nonspecific marker of inflammation that can be caused by a common cold, emotional stress, or even a sprained ankle.

• The patient population was decidedly atypical, with "normal" LDL cholesterol AND elevated C-reactive protein. Patients had no history of any inflammatory disorders. The study authors were

trying to claim that the inflammation came from cardiovascular inflammation exclusively. I applaud their effort. Nice try, but wrong. I will discuss why in detail shortly.

Critical Issue #1: The pharmaceutical companies use the "double-edged" method of misleading both physicians and their patients. When the drug side effect is harmful, they tell physicians that it only occurred in a "small" group. In the example above, the pharmaceutical companies reported great success in the drug's effectiveness with that same "small group." However, in reporting harmful side effects, they then call the exact same results "minor." This is exactly what they did to minimize the increased cases of diabetes in the Crestor patients. *Medical News Today* (Nov. 10, 2008) reported "…[B]ut there was a slight **increase in diabetes incidence in the statin group**, [although the magnitude of that increase was the same as those supposedly helped by the drug.] **which is usual in most statin trials**."

Critical Issue #2: Medical journals and the pharmaceutical companies repeatedly report inflated drug effectiveness when there isn't any. Both physicians and patients are misled with such inflated reports of drug effectiveness. Furthermore, harmful side effects are often under-reported. This is done by allowing very large probability values (allowing errors often in excess of 20%) instead of the more reasonable 5% error value. Everyone therefore is misled with a double-whammy: a drug that doesn't work, and which also delivers horrific side effects (like a rise in diabetes)—and neither shortcoming is revealed.

- Out of nearly 18,000 subjects, there were less than 450 deaths in both groups over the years of the study—a relatively small number given the large sample size and age of the patient population. There were 22.24 deaths per 1,000 in the treatment arm and 27.75 deaths per 1,000 in the placebo group. The ABSOLUTE RISK reduction (this concept is key) in death due to rosuvastatin compared to placebo was a difference of only 5.51 per 1,000 patients and for heart attack, stroke, or confirmed death from cardiovascular causes, a difference of 8.28 per 1,000 patients annually. **This so-called "success" translates to an *NNT of 120 (99.2% FAILURE)***. Thus, to prevent a single stroke or heart attack event, or death from cardiovascular causes, 120 patients would have to be treated for 1.9 years! (This number was also reported in an accompanying editorial to the study by Mark

Hlatky, MD, Stanford University School of Medicine. His major interests are in outcomes research, *evidence-based medicine*, and *cost-effectiveness analysis*. He introduced data collection about economic and quality-of-life endpoints in several randomized trials, principally trials of therapies for cardiovascular disease.) Once again, we are at the statins' "magical" 100 NNT (99% FAILURE). Statins don't work no matter how you try to "massage" results. Remember, antibiotics and insulin have NNTs of close to 1—they work for everyone—yet most drugs don't work at all, and that's why they need thousands of people in clinical trials to show a few positive results. Translation: The drug is an utter FAILURE. A 99% failure rate simply cannot, under any circumstances, be called "successful."

The NNT is fundamental in measuring any drug's effectiveness. It is the sole measure of the drugs significance and effectiveness. Remember, we never want to use "relative risk." We want to use "absolute risk." Here's why. What is the true difference between 2 out of 1,000,000 and 1 out of 1,000,000? Is it the same as the difference between 2 out of 10 and 1 out of 10? Of course not; no research scientist or person with any schooling in mathematics would even attempt to say it is. Yet, the pharmaceutical industry would have you believe the difference is the same 50% — (2-1) / 2 = 50%. The problem with that method is that it totally *disregards sample size and the entire field of statistical analysis*. The real answer in the first case is next to 0 (as in most drug studies). In the second case it is 1 out of 10 or 10%.

• The placebo (untreated) group had 51 more patients with a family history of premature cardiovascular disease than the treated group, giving an unfair advantage to the drug-treated group. We see how this study is already slanted toward the pharmaceutical company. We already know there is nothing genetic about the majority of cardiovascular issues. The problem is in the adulterated parent omega-6 oils so prevalent in U.S. diets. (See Special Medical Report "The Scientific Calculation of the Optimum Omega 6/3 Ratio.")

• RED FLAG #1: Note that this screening showed only 1% for diabetes (from the supplementary data). That is extremely odd since the national (reported) incidence of type 1 + type 2 diabetics is about 8-9%. Therefore, the "eligible trial population" used in this clinical

trial was NOT a normal population, which tells a lot. There were 270 new cases of diabetes for the drug group compared to 216 cases for the placebo group. Diabetes is a very strong factor in increased heart disease. If the study had been allowed to run to completion instead of being terminated early when the results were favorable to the pharmaceutical company, would the drug group have had more heart disease? We will never know because they didn't want anyone to learn of such a bad outcome.

• RED FLAG #2: When the study terminated, 25% had stopped taking treatments. **This fact alone invalidates the trial**. How any physician can tolerate this failure of the necessary conditions of the trial and go on to say the drug works mystifies me. This is an absurd study condition and completely invalidates its conclusions, because all patients were initially screened for 30 days using the drug before they were included in the trial. Most "problem patients" would have been eliminated during that time. This strongly suggests that the statin caused enough negative patient side effects long-term that a huge number of patients decided to quit. The authors reported the same amount of side effects in both groups. We aren't told how this measure of equal side effects was accessed and it doesn't make sense because *statins are known to cause significant harmful side effects*, such as muscle pain, decreased cognitive ability, chronic exhaustion, and impotence. A "must read" book detailing the significant, wide-spread, harmful effects of statins is *Statin Drug Side Effects* by Duane Graveline, M.D., a personal victim of their ubiquitous cognitive impairment. This book details the biochemistry of how statins *negatively impact every patient's* delicate cellular machinery to some degree.

• This is another "red-flag" warning that something is amiss with the conditions and results of this study. Furthermore, "adverse events" do not include exhaustion or impotence, which are significant negative side-effects of statins normally counted in statin studies. In addition, the increased harmful trends reported in kidney, liver, and gastrointestinal disorders are not good for the statin group, either.

• RED FLAG #3: The trial lasted a median of about just 2 years while results were still "reasonable" for the pharmaceutical

company. Many patients had taken the statin for less than 1 year. What would happen if patients continued to take the drug over the next 2-3 years? This should be a mandatory requirement because patients placed on statins are often on them for life. Another "red-flag" warning should be raised for this serious study deficiency. Furthermore, in an elderly population, typically on a drug like this, the incidence of serious adverse events is not likely to be linear over a long period of time; more complications, especially liver/kidney related, will occur with increasing age. This is another reason why the study should have been allowed to continue for at least 2 more years, as it was originally designed.

• RED FLAG #4: This trial reported patient benefits quickly, contradicting studies of high-risk patients over many years. If a drug works, it should work well in a high-risk population. **The 3-year CORONA study with the same drug, Crestor, FAILED miserably in preventing heart disease even while significantly lowering CRP (an absolute 37% decrease)!** (*Medscape Medical News*, Nov. 6, 2007). Statins don't work because they focus on the wrong metabolic pathway to produce the results desired. If this drug worked, results would be both similar and more significant with NNTs <10 — at least a 10% success rate.

• RED FLAG #5: A major "overlooked" event was that newly diagnosed diabetics occurred at a rate of 0.6% with Crestor compared to placebo. The increased incidence of contracting diabetes occurred at only a slightly lower percentage than the reported lessening of the incidence of heart disease and cardiovascular-related mortality. The increase in the incidence of diabetes in the drug group was higher than the percentage of patients helped as evidenced in decreased nonfatal heart attacks. **TRANSLATION: Taking Crestor means you risk contracting diabetes in exchange for the possible decrease in nonfatal cardiovascular events**. Adverse drug side effects are common with statins, including increased incidence of cancer (see Peskin, *Townsend Letter* article February/March 2008 "Statins and Increased Cancer: The Hidden Story and New Solution.") Now you can add a higher chance of diabetes, too. Another "red-flag" warning about this study—and statins—should be raised.

• RED FLAG #6: Good science mandates that the results of a study or experiment be independently verified and replicated before recommending

that asymptomatic people should be placed on a drug for life. Not so in this case. Another "red-flag" warning should be raised.

• RED FLAG #7: Lastly, JUPITER is touted as showing that statins are a treatment for levels of C-reactive protein above 2.0 mg/liter, a known marker of inflammation. This is NOT the case at all. The trial did not compare patients taking Crestor with high and low C-reactive protein values. The next section will discuss the C-reactive protein marker in detail.

## WARNING: C-Reactive Protein Conclusively Does NOT Cause Heart Disease

CRP is only a generalized marker of inflammation. The following finding was just published in the Oct. 30, 2008 issue of the *New England Journal of Medicine*, in a study authored by Borge Nordestgaard, MD, et al. Here's what their experiment showed in the *NJM*, as reported in *Scientific American* on October 29, 2008:

> "**Since people with different genetic make-up are naturally predisposed to have different levels of CRP**, the researchers did genetic testing on 50,000 people in Denmark to see if people with naturally high CRP levels had higher heart risks.
>
> "We simply looked at those with lifelong high levels [of CRP] due to C-reactive protein genetic variation versus those with medium and low levels," Nordestgaard said in a telephone interview.

Newsflash October 2008:
**"It turned out that even if you have genetically high levels, you have exactly the same risk of heart disease or stroke as if you have genetically low levels,"** he said.

"And because the study was so big, it has enough statistical power to answer the question about CRP.

"'Atherosclerosis is an inflammatory disease. So, **C-reactive protein is simply measuring how inflamed is the atherosclerosis** you have,' he said.

Nordestgaard said the **findings are likely bad news for companies developing compounds that lower levels of CRP**.

"'I think they [pharmaceutical companies] should seriously consider whether it's a good idea to spend money developing these drugs,' he said, noting **CRP is one of the body's natural defenses against disease**." [Emphasis added]

In theory, people whose genetic profile gave them high levels of CRP should demonstrate an increased incidence of ischemic diseases such as heart attack and stroke—if the causal theory is true. But no such relationship was found. By contrast, a study of the genes for apolipoprotein E—a protein that governs blood levels of cholesterol's apo (B) in which the parent omega-6 resides—did find such an association for people in the study. People genetically destined to have high levels of cholesterol [not supplemented with correct PEO ratios] did have a higher risk of heart disease and stroke, the study found. Therefore, CRP is a risk factor, but not causal to cardiovascular disease.

The University of Maryland Medical School study of more than 15,000 adults concluded that CRP appears to be closely linked to traditional heart disease risk factors, but is ***not an independent risk factor***. The findings appear in the Oct. 10, 2008 issue of the *Archives of Internal Medicine*.

CRP is a protein that can rise with short-term infections, injuries, or inflammatory process anywhere in the body. Elevated levels are associated with injury from anywhere and include even anger and stress.

The failure of "the cholesterol theory" is reaching grand proportions so anything new that changes the focus is gobbled up by the medical profession. Here's what was recently stated at the American Heart Association's Scientific Sessions 2008 (reported by Medscape and accessed November 18, 2008) by Dr. Robert Rosenson, who focuses research on LDL particle size, not amounts: "**LDL particles are a much stronger predictor of risk than LDL cholesterol… The questions is, why are we still relying on a marker that is not a predictor of severity of disease?**"

Shockingly, Dr. Rosen points out that although statins lower total LDL cholesterol amounts, the particle concentration (lower particle size) typically increases, making risk of a heart attack worse, not better.

## Newsflash 2008: A New Focus—LDL-Cholesterol NOW called Meaningless!

Dr. James Stein (University of Wisconsin Medical School, Madison) and Dr. Steven Nissen (Cleveland Clinic) praised the JUPITER investigators and the study sponsor for **EXPOSING the current *LDL-cholesterol thresholds for lipid lowering therapy as arbitrary*… "Many patients with heart attacks have normal LDL-cholesterol values…."***

Dr. Steven Nissen pointed out that there has been **a lot of recent pushback against the cholesterol hypothesis**, with many speculating that **lowering LDL-cholesterol levels had no impact on the reduction of cardiovascular risk**…. (Emphasis added.)

* *Medscape Medical News*: AHA 2008: JUPITER Hits New Orleans: Landmark Study Shows Statins Benefit Healthy Individuals With High CRP Levels. (CME/CE release date: Nov. 10, 2008)

The medical journal article, "Socioeconomic and racial/ethnic differentials of C-reactive protein levels: a systematic review of population-based studies," published online by *BMC Public Health* (2007, 7:212, doi:10.1186/1471-2458-7-212, available at: www.biomedcentral.com/1471-2458/7/212) authored by by A. Nazmi and C. Victora, stated:

> Researchers utilizing Mendelian randomization techniques have found that certain genotypes are associated with higher CRP levels but that individuals with ***these genotypes are not necessarily at increased risk for cardiovascular events*** **[26-29].**[1] **This calls into question the assumption that CRP levels are, per se, causally associated with risk for CHD**….

1 (References 26-29 in that article are: Davey Smith G, et al., Association of C-Reactive protein with blood pressure and hypertension: Life course confounding and Mendelian randomization tests of causality, *Arterioscler Thromb Vasc Biol* 2005,25:1051-6;Timpson NJ, et al., C-reactive protein and its role in metabolic syndrome: mendelian randomisation study, *Lancet* 2005;366:1954-59; Casas JP, et al., Insight into the nature of the CRP coronary event association using Mendelian randomization, *Int J Epidemiol* 2006;35:922-31.

In 2005, *Clinical Chemistry* published the paper titled "Novel protein markers of acute coronary syndrome complications in low-risk outpatients: A systematic review of potential use in the emergency department" (51;11:2005-12). Mitchell AM, et al., state in their conclusions:

> The most important observation of this review is that **there are very few studies that address the prognostic value of these markers** in the low-risk general emergency department population… Only **C-reactive** protein has been sufficiently studied to allow aggregation of the data, and these **results demonstrate no better test performance than would be expected by random allocation of diagnosis**. The threshold for a positive C-reactive protein remains unknown. (Emphasis added)

Back in 2004, the *New England Journal of Medicine* published "C-reactive protein and other circulating markers of inflammation in the prediction of coronary heart disease," authored by John Danesh et al. (350:1387-97). The conclusion states:

> **C-reactive protein** is a relatively ***moderate predictor*** of coronary heart disease and **added only marginally to the predictive value** of established risk factors for coronary heart disease. These findings suggest **that recent recommendations regarding the use of measurements of C-reactive protein in the prediction of coronary heart disease may need to be reviewed if one wants to actually make a recommendation based on science rather than wishful thinking**.

Note: The fluctuations (standard deviations) were huge for C-reactive protein in the treated group (1.75 ± 5.3) and in the controls (1.28 ± 5.2).

## ◗ *Life-Systems* Engineering Science Commentary

Here's why the reporting of the JUPITER Study in the medical press is misleading.

1. Taking results of a study applied to an aging population and automatically applying it to everyone is irresponsible and hazardous.

Next, are the pharmaceutical companies going to try to apply these results to children, too?

2. A 30-day "trial" was given in which patients with adverse reactions to medication were immediately thrown out and not included in the study. **This is unprecedented in a clinical study and COMPLETELY invalidates any generalization of findings whatsoever (only 1 out of every 5 patients screened were enrolled—an 80% study rejection rate)**. You can't then go back and say this same excluded group, which most physicians will see in their practices, will benefit—because they had bad reactions to the drug and quickly stopped taking it.

3. This study has no independent verification.

4. This study's result shows the same kind of unremarkable results as other statin studies. They clearly showed statins don't work as demonstrated by extremely high NNTs (100+).

5. This study still had an NNT of over 100 - 99% failure. In sharp contrast, both antibiotics and insulin have NNTs close to or equal to 1—100% SUCCESS.

6. The results of this study are counter to numerous C-reactive protein experiments as detailed above.

7. Your risk of contracting diabetes increases with the drug.

8. The horrific side-effects of all statins, including Crestor, will often include, in addition to raised likelihood of diabetes: muscle pain, erectile dysfunction, and cognitive problems. With the drug, you will lower your cholesterol and also become weak, stupid and impotent as *Statin Drug Side Effects* by Duane Graveline, M.D. so aptly describes. You must give the pharmaceutical companies some credit for making these side effects seem acceptable.

9. The entire "cholesterol hypothesis," while unsupported by medical physiology, was propagated by the pharmaceutical companies (who manufacture statins) in order to convince physicians

to lower LDL cholesterol levels in all Americans. This wrong hypothesis was instigated by the pharmaceutical companies only because they had a drug to lower cholesterol. Although their method failed miserably and continues to fail, physicians were getting upset and their patients frustrated, so something new had to be "cooked-up." The new "answer" was C-reactive protein, even though this is not the cause of heart disease as proven by Dr. Nordestgaard (see above).

**If physicians and cardiologists are forced to laud these horrific statin-prescribed results as spectacular, America and those nations around the world following us are to be pitied. The correct answer is all in the PEOs (parental essential oils) because aside from giving each of your body's 100 trillion cells the unadulterated parent omega-6 it requires, your body's most potent anti-inflammatory $PGE_1$ is made from the parent omega-6 derivative GLA. Your body's natural thrombosis inhibitor and anti-aggretory $PGI_2$ (prostacyclin) is made from the parent omega-6 derivative arachadonic acid. A cellular parent omega-3 component is required but it must be noted that this is significantly less important than the unadulterated parent omega-6. The omega-3 derivatives predominate in fish oil, are even less important. When you connect the dots, the world's leading medical textbooks confirm the heart-health power of the correct PEO formulation.**