

True expert in cardiac imaging, William Blanchett and Ivor Cummins talk about an enormous experience in scanning people to look for signs of inherent heart disease which could cause them risk and then aiming to resolve it. Find out more @ [ihda.ie](http://ihda.ie) and [TheFatEmperor.com](http://TheFatEmperor.com)

[00:00:00](#)

*“And so we need to readdress these issues and look at them through fresh lenses and find such fabulous outcomes. It makes this job awarding. It makes me glad that I'm doing what I'm doing. And I feel sorry for my colleagues who are stuck in these, you know, “Follow the protocols, click-click-click, low fat. Here's more medicines for your low fat. Here's more medicines for you. Oh, I'm sorry. You had that stroke. I'm sorry you had that heart attack.”*

Ivor Cummins

[00:00:27](#)

Welcome to the Fat Emperor podcast. I'm your host, Ivor Cummins. We're supported by the Irish Heart Disease Awareness charity ([www.IHDA.ie](http://www.IHDA.ie)), which advocates a simple CT Scan to reveal your CAC score. So know your score, and take action to prevent that premature heart attack. Everything you need to know we'll be right here.

Ivor:

[00:00:49](#)

Today I'm with a true expert in cardiac imaging, William Blanchett, who has several CT scanner machines, an enormous experience in scanning people to look for signs of inherent heart disease which could cause them risk in the future and then aiming to resolve it. So delighted to meet you Bill here, well electronically.

Bill Blanchett:

[00:01:12](#)

It's so good to be here, I appreciate that. Now, I want to modify your... although I will take credit as being an expert in cardiac imaging, I think that my greater expertise is an internist and dealing with patients who have cardiac disease and how we modify risk factors and prevent heart attacks from happening, which at the end of the day is the bottom line.

Ivor:

[00:01:33](#)

Exactly!

Bill:

[00:01:35](#)

Imaging is a tool, it's a powerful tool, it's a necessary tool in order to accomplish our goal of stopping heart attacks. But my greater experience is in the latter, is in actually stopping heart attacks. Imaging, yes; stopping heart attacks is where the payoff is.

Ivor:

[00:01:54](#)

Yeah, I couldn't agree more because there's no point knowing about the level of disease, knowing if there's a huge risk present if you don't actually intervene to change the future. So absolutely, that's what it's all about.

[00:02:06](#)

So, we're going to actually talk about both I'd say in the coming hour or so. And I'll probably preface things by certainly mentioning David Bobbett and the Irish Heart Disease

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Awareness Studies [Inaudible 00:02:19]. That's the only reason I'm able to actually create these podcasts and do all the other work I do for awareness. And as you well know, and we'll talk about it, David had in 2012, a calcium scan, actually by fluke or coincidence, and found out he had a 900 score and three blocked arteries after essentially passing a series of executive medicals and treadmills over the previous five, six years and being told he was bulletproof. And of course, he's interested in the fixes, as you rightly say that's huge, and he applied them and stopped his calcification progressing. But, he's also very much passionate about getting awareness out there on this technology that can let people know they're at risk. So, do you reckon Bill, I suppose there's millions of David Bobbett's out there who are harboring enormous disease and really without a calcium scan or a proper diagnostic, they may not be aware at all.

Bill: [00:03:24](#) Almost every day we find David Bobbett's, who think they're healthy; they're vegan, they exercise, they're 10, they get a heart scan to find out they're at the ninth percentile. So, yes, I have a great debt to David Bobbett for what he has done to try to promote this message. And on my bucket list is the opportunity to meet David one day. That hasn't happened yet, but I had a chance to meet his cardiologist but I have not met him yet.

[00:03:52](#) So yes, David Bobbett's are everywhere. I see them all the time. I live in Boulder, Colorado where everyone is healthy. Everyone thinks they're immune to heart disease. Yet heart disease is still a major killer in Boulder, Colorado. And so, the heart scan has told me which patients have disease, which patients don't have disease, which patients need to be doing more to change their disease process, and through serial calcium imaging, and then able to tell who has mitigated their risk.

[00:04:23](#) So in David Bobbett circumstance, he has a very high calcium score. But since he has been able to modify his risk factors, his calcium score is now stable and his risk is very, very low. It never reaches to zero, but very, very low. He has reduced his risk forty-fold by treating his risk factors sufficiently. His plaque burden is now stable.

[00:04:49](#) The reality is, everyone can do this. There's no one who can't take their disease and make it go away. They just need to have the data, need to have the information, how much disease that

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they have, and then over time, is that disease stable? It's very simple, it's very straightforward.

[00:05:08](#) You mentioned before the talk that we're going to do this not a too complex a level, that you don't have to be a scientist to understand. But I've always said that when I get old and addled, I'm going to limit my practice to stopping heart attacks because that's the easy stuff. You know, the 35-year-old female with belly pain, that's the hard stuff. Stopping heart disease, stopping heart attacks, that's the easy stuff. And the fact that we're not doing it is a tragedy and an outrage and an embarrassment.

[00:05:36](#) We continue to practice medicine using expensive, invasive procedures that actually at the end of the day have been shown to do no value. And we're ignoring inexpensive, incredibly low radiation diagnostics, and nutritional advice and exercise advice and lifestyle advice that's easy, that's inexpensive, that works that serves to stop heart attacks. And that's really, really cheap. That's important. So why we can't do that, why we're not doing that?

[00:06:09](#) Sadly, it probably comes down to the economics of it. I know a lot of people who've made a lot of money treating heart disease the wrong way. I know a handful of people who went nearly bankrupt, trying to prevent the heart attacks the way that David Bobbett's heart attack has been prevented. And so when you can't make a living preventive heart attacks and you can make a fortune treating heart attacks in appropriately, sadly the economics rule and that's where we are.

Ivor: [00:06:36](#) Yeah Bill, and I guess that's just the way it is. And again, it's not a conspiracy theory, it's simply how business and economics works, that there's the profit motive which generates any positive things in the world. In this case, ironically, the profit motive just kind of drives the wrong behaviors.

Bill: [00:06:58](#) Yes. I often have to perceive my statement on heart disease with the fact that I'm not a conspiracy theorist. I think it's possible that Lee Harvey Oswald acted alone. I have to be careful who you say that too because you might get a 30-minute conference you didn't need. But I'm not a conspiracy theorist. The simple reality is, do we stress test missus over 80% of heart attacks and over 63% of coronary deaths? We have the studies. They are in, they're documented, they're signed off on.

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Nuclear stress test will miss over 63% of people who will die from heart attacks and will miss over 80% of people who have heart attacks, whether they survived them or not. If we do a nuclear stress and we find an obstruction, we now have nine randomized perspective studies showing that fixing that obstruction reduces heart attacks by 0% and coronary death by 0%. Nine studies showing no benefit and no studies showing benefit. Do the math on that. It's not hard.

[00:08:05](#)

What we currently do, 10 million nuclear stress tests in the United States alone every year that do 1.2 million steps that reduces heart attacks by 0%. And yet, we don't feel that we have the resources to do an inexpensive coronary calcium score and based on that determine adequate therapies. And then based on the next calcium score, determine if the therapies are working - or do we need to try harder.

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That simple technology, we push aside and don't use. Well, I have been using that technology for 18 years now. I've been using it extensively for the last 15 years. The last patient of mine who died from a heart attack, died 13 years ago. The last heart attack that I've seen in my practice of the patients whom I directly care for was over six years ago. Well the average age of my patient is 67 years old. The average calcium score puts them in the 57th percentile. So my patients have more heart disease than the average American.

[00:09:16](#)

However, it's been six years since I've seen a heart attack, and 13, over 13 since I've seen a fatal heart attack. And so just from my experience alone, I feel comfortable in saying this can be done. This must be done. These tragedies need to stop. This enormous expense needs to stop. We spend probably around \$200 billion a year in the United States treating heart disease mostly the wrong way. The non-medical economic costs are currently over \$400 billion per year. They start talking in terms of \$400 billion per year. Those are game changing numbers. You know, looking at the budget and take \$13 million dollars out of Special Olympics. But we're continuing to lose \$400 billion dollars into the economic expense of heart disease in the United States.

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So, why aren't we doing this? Why aren't people responding? And the answer is, you get back to it, doctors need to make a living. Now if the doctors were doing it wrong by making \$300,000 to \$700,000 per year, and the doctors who are doing it right are going out of business because they're going broke,

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will continue to do it wrong. Unless people like you educate the general population and the general population goes to their doctor and insist that their doctor do it correctly, things might change.

Ivor: [00:10:48](#) I'll do a little I can? [Inaudible 00:10:49] and again, it's I guess, David has been the one who sets this whole thing in motion and it is largely as you say, to go to the grassroots to go to the people because, the medical profession, you know there's criticisms, but at the end of the day, influencing the medical profession is nearly impossible. So of course you had the strategy, it has to be to go to the people, explain this problem that you so well described in simple terms and have them demand to know whether they have extensive heart disease. But you there, that's incredible statistics you've given even though they are just for your own practice, that what your people are experiencing is so out of whack with the average experience of Americans at an average age in their 60s with high calcification. It's quite incredible. And I think William Davis, M.D., who's also a strong proponent of the calcium scan, he also saw the same thing. When he began to treat people with the right medications, not stance, and with the right dietary advice, he basically freed up his whole practice and didn't really have to deal with repeat heart attacks again.

[00:11:59](#) So the tragedy that's out there, it's just so enormous because the solutions are largely here. I mean, a recent study that I was fascinated by, and I know there's a lot of arguments about statins, but we know that statins reduce events. And a recent study showed that people with high calcification on stuff and versus not, there was a very big reduction. But then in the people from not calcium up to 100, there was almost no reduction. So it very eloquently demonstrated that, well, okay, the drugs maybe don't appear to be overly effective, but one of the reasons is that huge amounts of people who don't have enough disease to benefit are taking the drugs and they're watering down all the data. What do you think of that one?

Bill: [00:12:50](#) I think that's absolutely the case. They looked in the MESA Heart Study, the Multi-Ethnic Study on Atherosclerosis. It's a large NIH sponsored study in the United States. And what they looked at was of people who qualify for statin therapy, they found out that half of them, their calcium score is zero. When you have a calcium score of zero, your annual risk for heart attack is less than 1/10<sup>th</sup> of 1%. If you take a statin and let's say that reduces the heart attack risk by 20%, let's take a 1/10<sup>th</sup> of

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1% risk and reduce it by 20%. We have a number that asymptotically approaches zero. We're not going to see a value in treating those people with statin.

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However, if your calcium score is over 300 in the MESA Heart Study, your risk of a coronary event is 10 times greater than your risk factors would have predicted. And the higher the calcium score, the divergence between what your risk factors predicted and what your actual risk is. And so if we can select who we treat with statins based on the calcium score, we're treating the right people. [Inaudible 00:14:04] to a fairly recent study on aspirin. You may have read to your alert reader couple of months ago, study comes out saying, "Aspirin has no value in the primary prevention group." Well, the fact of the matter is, in that study, the people that were studying the annual risk of heart attack was 7/10<sup>th</sup> of a percent. Aspirin reduces risk by 20%. But once again, reduce 7/10<sup>th</sup> of percent risk by 20%. You have a pretty darn small number.

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However, if you did a calcium score, and once the calcium score is above 100, or if the individual is in the top quartile for risk, even with the calcium score of less than 100, you put that group on aspirin, and suddenly we have a profound benefit in taking aspirin. And the higher the calcium score, the more people will avoid a heart attack simply by taking an aspirin.

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Another reason with the study that just came out see saying an aspirin doesn't work is a recent study that predated that study, showed that very low dose aspirin, the 81-100 mg aspirin is not enough in people who weigh more than 70 kilograms. What any study done today, over the half of that population will weigh more than 70 kilograms. And so in that study that showed no value from aspirin, half the people were taking so low dose of aspirin based on their weight, that it wasn't going to work. And so if once again you do the calcium score, and then you dose the aspirin based on weight. Now, if you're under 70 kilograms, take 81 milligrams. If you're over 70 kilograms, take at least 160 if not 325 milligrams, and we will see a profound benefit from taking aspirin. But instead based on a crappy study, we throw aspirin all the way because it's cheap, it's no big deal. And they don't even think about it, they don't even process it. The people who read these studies have lost the ability to analyze and process the data and reach reasonable conclusions. They just take whatever conclusion the study is, and that becomes the will of God suddenly. I kind of disagree.

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Ivor: [00:16:24](#) Yeah, and I've seen this so much in the last six or seven years of research that reading the abstract and taking the conclusion is absolutely not; you must go and find the data tables. And I also find sometimes you have to get the supplemental data tables that are only available online from any studies, to actually get to the data and verify yourself what the reality is. But this is a huge challenge we have in science and nutritional science and medical science. The devil is in the details, the nuances, that's where you've got to go.

[00:16:58](#) But you're right. The vast majority of doctors and medical professionals who are actually deploying these guidelines are completely up to their ears busy running a business and trying to stay effective and deal with all the patients in the system. Well, hopefully people who have the bandwidth to do the analysis like yourself, myself, hopefully, and many others, can kind of help clarify these matters.

Bill: [00:17:25](#) Another similar study that came out about the same time was the fish oil omega 3 trial. I'm sure everyone's heard of that. It's really frustrating, because I had patients who will also get a cardiologist and invasive cardiologists and have on their side. And this invasive cardiologist say, "Fish oils have been proven not to work, stop that." But when you look at this study, this study that claims to prove the fish oil doesn't work, across the board, that was greater than a 26% reduction in heart attacks. That's better than we get from Lipitor, a 26% reduction in heart attacks. Among the subjects not eating fish twice a week, there was a 40% reduction in heart attacks, twice what we see from Lipitor. Among the block subset in that population, which is about 10% of the study, there was a 70% reduction in heart attacks.

[00:18:17](#) So the two things that are most remarkable about that study was, 1) how effective fish oil actually is in reducing heart attacks, and 2) how in God's name that they come to the conclusion that fish oil doesn't work when it works better than Lipitor. So the same authors who write the conclusions that fish oil doesn't work with a 26% reduction heat attacks, write the conclusions that PCSK9 inhibitors, the expensive new drug that has come to the market in the last couple of years is a great addition when it has a 15% reduction in heart attacks.

[00:18:57](#) And so it's remarkable how this is interpreted, how this is treated. And it requires people who are not myopic to look at the big picture and say, "Wait a minute, as you say, let's read

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the abstract. Let's look at the populations." The problem with that study they used to combine the endpoint and used a large combined endpoint that had too many factors in it. And, and with large combined endpoints reaches statistical significance and be very difficult. But you just looked at the endpoint of heart attacks and you're taking fish oil to prevent heart attacks, that seems like a good endpoint to look at. When you look at the endpoint of heart attack, there was a very significant reduction in heart attacks from taking what is really an inadequate dose of fish oil. They only had the votes on 1000 milligrams, that's not enough. And still they saw a robust reduction in heart attacks.

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The same thing happens in the vitamin D study. The study had a vitamin D wing. In the Vitamin D wing, the conclusion was vitamin D has no value. Except that in two years, there's 25% reduction in death from cancer. So in this study, the people with low vitamin D levels were placed on 2000 international units of vitamin D and inadequate dose to make a difference in most people. In my business, in my practice, 2000 units, usually does not budge the vitamin D level. I have a low vitamin D level as on 2000 units per year, my vitamin D level went from 34 to 32, taking 2000 units a day for a year. So 2000 is usually inadequate for most people. Despite that, at two years is a 25% reduction in death from cancer. Put that in perspective.

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We believe that everyone should get colonoscopy screening for colon cancer. I believe that it's a good thing. Colon cancers bad with [Inaudible 00:20:58]. If everyone gets screened for colon cancer, we will reduce cancer death by 5%. If we treat people with vitamin D deficiency, according to the study, we would reduce cancer death by four times greater than by colonoscopy screening. So, yes, let's promote colonoscopy screening. But do we really want to tell people, "Don't worry about your vitamin D level?" when it's five times better at preventing cancer death, even when it's under dosed? That's mind-boggling how we can reach those solutions.

Ivor:

[00:21:34](#)

And I've seen those various trials of many supplements and minerals and they're often underpowered, under dosed; all what you described. The vitamin D, I always say to people because you know, if you get vitamin D from ultraviolet and from the sun, you also get nitric oxide release, you got other photo chemicals produced and you've got Nitric Oxide and blood vessel dilation. So I always say, well more ideal to get it

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from the sun; get your vitamin D and get many other benefits. But your point is well taken

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On the fish oil, yeah. I mean, there's now interestingly a kind of patented fish oil trials recently. And they are absolutely gushing about a 20% improvement or 25%. But by under dosing in the non-patented fish oil and all the other clarifications you gave there, they managed to say, "Don't bother guys." So, again, no conspiracy but let's be honest. If there's no profit driver, there seems to be a general antipathy or a general distrust and dislike of supplements, vitamins and minerals relative to patented medicines. And I think again, that's just the way the business works. But fish oil, Davis as well, Wheat Belly Davis, calcification is on the record in the [\[Inaudible 00:22:54\]](#) and other studies that it is both inevitable progress of an even mathematically predictable. In other words, when you've got a high score, the medical profession is largely happy that you will inevitably continue to your demise. And yet, Davis is the only published author that has demonstrated to my knowledge, a regression in a third of his patients, a flat lining in another third and a very slow progression like Davis in the other third, which as you rightly say, is almost as safe as going back, regressing to a low score in terms of statistics.

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But that's the only published paper I'm aware off. In general, this belief system is that calcifications just going to keep going so we're not too interested in the scan. Is that you're kind of experience?

Bill:

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Well, here's how that came to pass. When the calcium score came out, there were studies done using the calcium score and statins and found that statins alone did not stabilize coronary calcium very well over time. And so the conclusion was since statin is the only and best treatment we have, and statins do not stabilize serial calcium measurements, therefore, there's no reason to do serial calcium measurements. And then some people like [Steve Nissen](#), who basically is a bad thinking person... [Steve Nissen](#) is a bad thinking person. I invite you to watch the Widowmaker and see the interview with [Steve Nissen](#).

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Let me tell you, that is just scratching the surface of how bad a person Steve Nissen is. He has come up with intravascular ultrasound studies that he's used... to say the coronary calcium studies don't work. He didn't even use a coronary calcium study;

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he used an intravascular ultrasound study to reach to conclusion the coronary calcium doesn't work.

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So, the thing to remember is that gifted researchers see what they're looking at, **sub-par** researchers see what they're looking for. And so many people in that market are looking for a reason to not use serial coronary calcium. Because, you know, stands alone, don't do it. In my practice, yes, we expect to see a stable plaque. We oftentimes see regression of plaque. And the beauty of the coronary calcium score, is it the serial calcium is such a strong predictor of events versus nonevents that we can say, "Let's try this and see if it works." And if over time this works, this is something we may be ought to be adopting.

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And I have several examples of that. One is a patient that I have who has a fairly high calcium score, 600 calcium score. He comes and his plaque burden had just gone up to 32%. It's just bad. He's at a very high risk of an event. But at that time I said, "Let's increase your fish oil, and let's start Niacin. Come back and see me in six weeks and we'll see how it's going." Like, take care of a lot of alpha monkeys, executive types. And so he doesn't come back in six weeks; he comes back in a year when he gets a second calcium score and announces that, "I didn't take your niacin, it made me flush. I did increase the fish oil by one pill. But my dental hygienist shamed me into flossing. I've flossed my teeth 365 times since the last time we visited." So based on one additional fish oil pill plus flossing every day for a year, his plaque went from going up to 34% per year going down 4%.

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So armed with that information, I start flossing every day. And I love every day for two years. And all those two years my calcium score went down to 18%. So I'm now promoting dental floss to all my patients and I tell them, "It's important to floss because your gums, healthy gums are really an integral part of having a healthy heart." And I also encourage them to floss every day. Because we have some old literature that's still accurate – just because it's old doesn't mean it's not accurate – surely that if you rarely floss... when you floss, you'll create bacteria, bacteria in your bloodstream. If you never floss, you'll get gingivitis which will put bacteria into your bloodstream periodically. If you floss every day, and flossing no longer puts bacteria into the bloodstream. So flossing every day is part of the solution. Not just flossing occasionally.

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I used to floss the day before I went to my dentist and he would say, "One day's worth of effort does not make up for a lifetime's worth of neglect." Now I floss every day that dental hygienist is effusive about how healthy my teeth and gums are. So for people who are not flossing, keep in mind, your dental hygienist is judging you harshly. He's keeping it to himself, but start flossing and see how effusive the compliments start coming back from the dental hygienist. So something as simple as dental floss, I'm absolutely convinced is part of maintaining a healthy heart.

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How do I know that? Because I've seen it stabilized plaque on multiple occasions. Furthermore, because... I've been taking care of this group of patients for a while and their plaque is stable, that window for plaque will go up on occasion. When that happens, I will send them to the dentist for x rays. Seven times out of 10 will find an asymptomatic dental lab tests. They get that treated, get that gone. The next year their plaque burden is stable again.

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So, these are things that I learned from having a tool as powerful as serial calcium. That everything's fine, nothing's changed. Last year, your plaque burden went down 1%. This year, it's gone up 18%. What's that about? Seven times out of 10 will find an asymptomatic dental abscess.

Ivor:

[00:29:05](#)

You know, that's fascinating, Bill because yeah, I get asked this question all the time. Generally speaking, when people switch to medications as appropriate, and a lower carb diet and get their insulin down, their glucose down, they fix a lot of issues, maybe some of them go keto because they've got diabetic physiology very powerfully and weight issues so they go harder core. And they added magnesium, potassium, and maybe some iodine and the good things, and they do quite a bit. And most of them then kind of level off their calcification regression or reduce it greatly. But there are people who occasionally even do that for a year or two and then they go up just as you describe, and I always say to them, that it's such a multifactorial disease that simply low carb, **so meds?? [Inaudible 00:29:56]** and getting decent nutrition is not going to be magic. It's going to help the majority of the population, it's going to overwhelmingly reduce our levels of disease; but it's not magic. And there will be people, what I call "an engineering special causes" you know, less common causes.

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Now, that one you mentioned is interesting because we had this argument a couple of years ago, myself and people on Twitter. And I always maintained that the dental health is strongly linked cardiovascular issues and other issues. We know root canal and abscesses and sub clinical infections have a strong linkage to these diseases. And there are theories about microbial ultra-nano bacterial slime layers on arteries that can harbor disease that drives atherosclerosis and all this stuff. But on the other hand, the people as a group who have dental issues tend to be eating the wrong foods because our ancestors didn't have the issues because they only ate real foods. So there was some confounding there, that is it that the dental issue is directly causal? Or is it that the person with dental issues tends to be eating other causes of heart disease? And I always stayed in the middle and said, "I think it's a combination of both, depending on the person. Best fix both." That's what I always said.

Bill:

[00:31:19](#)

Give me an [Inaudible 00:31:19] with that one if you don't mind. First off, I think that you're right. Your dietary choices contribute to whether or not you have dental issues. Absolutely hands down. But when you look at how does plaque get into coronary arteries? What's the mechanism by which cholesterol enters the coronary arteries, then you can understand fairly clearly where teeth and dental health may become involved.

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Within the wall of the blood vessels, we have something called tissue macrophages, which are white blood cells that police the wall of the blood vessel to look for invading bacteria. A bacterium tries to cross the wall of blood vessel, this tissue macrophage, [Inaudible 00:32:02] it doubles it up and destroys it. But when it does, it goes on to high alert. Intruder or their bacteria in the system, everybody get on high alert; released cytokines as the matrix so the other regional macrophages are on high alert. And that's when our inflammatory markers start coming up a little bit in blood work.

[00:32:24](#)

Well, now that high alert macrophage, these are lipid particle coming across the wall of blood vessel, it must take that lipid particle for invading bacteria and then the next one and the next one. And that white blood cell becomes something we call a "foam cell." A foam cell is a lipid [Inaudible 00:32:46] white blood cell well. To well describe, you can Google and see pictures of bone cells. It's not a theoretical thing; it's a thing. And so as these foam cells then dies, and when it does, it again releases cytokines into the matrix, they track other white cells to that location, presumably to take care of the bacteria that

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killed the foam cell, but actually the lipid particles that's on the foam cell.

[00:33:10](#) Well these other macrophages have been subjected to the same forces. They are also foam cells. They aggregate. They die. Now you have a puddle of lipid particles which coalesce and form plaque. That is a well described mechanism for plaque formation. Well, here's the ticker, when they do carotid endarterectomy and take the plaque out of the clot artery in a sterile fashion, if they grind it up and culture it, it's not uncommon to be able to culture all bacteria from Atherosclerotic plaque. So the circle is complete.

Ivor: [00:33:46](#) Wow!

Bill: [00:33:46](#) If you have tangible disease, oral bacteria into your bloodstream, when they're crossing the blood vessels, they trigger the macrophages, they gobble them up as well as gobble up other particles. That form as a plaque and then the plaque does what we know plaque does.

[00:34:03](#) So, getting the teeth healthy. So it's not simply the same risk factors that caused dental disease also cause plaque. Risk factors caused dental disease and the dental disease itself contributes to plaque. Because when my plaque burden went down 18%, the only delta I did that year was I added floss. I didn't change my diet. My patient whose plaque burden went from going up to 44%, going down 4%, yet he increase one fish oil per day. He did not change his diet. He started flossing. He got his gums healthy. So yes, you're right. They're both in play, but don't accept dental disease as a unimportant sidebar. Gum disease, dental disease, very important integral part of what creates heart disease. And we need to address that. And you know, I own no stock in the floss company. I floss every day. Makes a huge difference.

Ivor: [00:35:05](#) Yeah, that's a great summary. And you know Bill, it also resonates powerfully. I did a podcast a few weeks ago with [Gabar Erdosi](#) a molecular biologist in Hungary. He's basically a brilliant microbiologist and problem solver. He's gone through thousands of papers. But what we discussed and [\[Inaudible 00:35:26\]](#) release is the autoimmune aspect of cardiovascular disease. And one of his proposals is that, in some ways, cardiovascular disease is largely an autoimmune disease. And we talked through, for instance, arthritic conditions where the immune system is highly activated, there's much higher risk

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ratios for cardiovascular disease, psoriasis, lupus. All of these autoimmune inflammatory conditions have vastly bigger risk factors for future atherosclerosis than high cholesterol or any of the other things, but we don't talk about them. So everything that activates your immune system and creates an inflammatory environment is inherently deeply connected to the causal pathways of atherosclerotic disease. But mostly we don't talk about them. We talk about cholesterol and you know, not drinking Coca Cola, but this whole world.

Bill:

[00:36:29](#)

So I want to, I want to call you out on saying, there's a much greater risk than high cholesterol. Because cholesterol is such a miniscule risk. It's laughable, that on Heart Month, in February, we tell everyone to get their cholesterol check. There are so many studies out there, demonstrating that people who have heart attacks and people who don't have heart attacks actually have the same cholesterol levels. And so to screen your cholesterol to look for heart attack risk is patently absurd.

[00:37:00](#)

Now that said, yes, having inflammation, having an autoimmune disease is equivalent to having Type 2 diabetes or worse as far as the incremental risk for heart attacks. And so a heart disease is much more a disease of our immune system and a disease of inflammation than it is a disease of cholesterol. And call it a disease of cholesterol is just, we still do it. And it turns out, medications to lower your cholesterol, had deck of million dollars' worth of sales for a few years there is that you have an industry that's selling \$30 billion worth of drugs. They can market to us this concept that, "Cholesterol is the problem, here's our solution," when cholesterol is barely the problem, and treating them with cholesterol lowering drugs is 20% of solution but it's not the solution. The solution is much more involved **taming? [Inaudible 00:38:01]** our immune system, modulating our immune system. And there's so many things we can do easily, comfortably, enjoyably that does that. The fact that we're not understanding that, not doing that is criminal. It's terrible.

[00:38:16](#)

In the Widowmaker, in the movie, David Bobbett has been interviewed. And he comments how vigorously, how brutally he changed his life to modulate the risk factors. My position David is that you don't have to be brutal. Foods that modulate the risk factors are delicious. You can eat wonderful things and modulate your risk factors. You don't have to do a heroic amount of exercise to modulate your risk factors. In fact, a study out of **[Inaudible 00:38:48]** shows that people who were

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doing a 20-minute daily walk at three miles an hour reduce their heart attack risk by 50%. And so we kind of get this concept that you have to be an elite?? [Inaudible 00:39:02] athlete and take a jog and then climb mountains in order to modulate your heart risk. When the reality is a 20-minute, daily walk. Get a dog. A 20 minute daily walk, reduce the heart attacks greater than a statin does.

[00:39:19](#)

So, you know about diet with... when I have a patient has a calcium score, "Here's the diet that I want you to do." And here's why. If you go on the internet and look at heart healthy diet, you'll get every results you want. You'll get some people saying don't let a drop of fat cross your lips. Don't let anything that has eyes or nose or mother enter your mouth. The flip side of the coin is you'll have people who say 70% of the covers of your diet should come from fats. And so how do I compare those and say this one's wrong, this one's right, etc? So I go back to the literature and say what can I glean from legitimate studies, not necessarily the conclusions of the studies but the body of the studies that will make some sense? And the INTERHEART trial and major multinational trial looking at risk factors for coronary disease. And in the INTERHEART trial, they found that for every incremental serving of any fruit or vegetable, there's a 4% reduction heart attacks.

[00:40:23](#)

Nurses' Health Survey (NHS), found the nurses even the large amount of pigmented berries at 34% in your heart attacks and the nurses even the smallest amount of pigmented berries – blueberries, strawberries, raspberries. A 34% reduction heart attacks as an incremental independent variable is monumental. Let's say here's the foundation of a heart healthy diet. Try to get eight servings of fruits and vegetables per day and make two of them pigmented berries. The reason I picked eight, is eight servings is eminently doable, but you have to try. It's not just going to happen, you have to try. And then those servings of blueberries, strawberries, raspberries, dark cherries, dark grapes, any kind of a berry with a colored skin contained this so called berry anthocyanin with powerful antioxidants that modulate your immune system. Put this together as the first layer of what I refer to [Inaudible 00:41:23] of the heart healthy diet.

[00:41:25](#)

The second layer of the party [Inaudible 00:41:26] of the heart healthy diet is adequate amounts of the good fats. And the more the merrier. And the good fats are extra virgin olive oil, fish oil, tree nuts, particularly almonds and walnuts, and

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avocado. And there's good supporting data are in the literature that these oils tend to be anti-inflammatory. It can be beneficial. However, despite what we've been taught for the last 60 years, that rate of fats are not poison. There's no data showing that saturated fats do harm to our hearts. Furthermore, the recent trial in Europe demonstrated that... they had 148,000 people fill out dietary histories and follow them prospectively. And across the board for every incremental increase in dietary fat, there's an incremental reduction in death and coronary death, and it never reach the level of dietary fat as associated with anything, but a further reduction in death and coronary death. And so this so called "pure trial" should have ended our discussion about low-fat-high-carb being the way to go. But somehow it didn't.

[00:42:42](#)

And, at the most recent American College of Physicians annual meeting, I went to a diet and health promotion, and they were still promoting high carb. "Be sure you get your whole grains, get lots of whole grains." No one thinks of whole grains aren't anything but good. I think it's something, because I think we need to limit our grains, whole or otherwise. So basically get fruits, vegetables, pigmented berries, get adequate amounts of the good fats and don't run away from what we've historically referred to as bad fats. And then the next level is reduce the carbs. This logical say, "Don't eat sugar; sugar is bad for you." But most people don't realize that a white potato, or rice, or wheat is converted to sugar in our bodies, just about the fastest, sometimes faster than table sugar is converted into sugar in our bodies. And so, a big part of heart healthy diet is bringing down the highly available starches. They're just the same as eating sugar.

[00:43:50](#)

I remember 20 years ago, we used to think that a baked potato with no sour cream or butter on was the ultimate heart healthy food. It has a couple of vitamins in it. You know, I can't argue with that, but from a heart healthy perspective, it's probably equally healthy with an equal number of calories of table sugar. It's in that same perspective. Its Glycemic Index (GI) is actually higher than table sugars.

[00:44:13](#)

So, get the starches down. And so, that's my message. Fruits, vegetables, pigmented berries, lots of the good fats. The only bad fats are hydrogenated vegetable oils, the margarines and things that were taught back in the 60s and 70s. "This is the healthy butter, eat this and throw that nasty stuff the cows make." It turns out that stuff the cows make is the good stuff,

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and we ought to be eating more of that. That's the healthy diet that I promote.

[00:44:43](#)

And it's always in flux because I have my ear of the rail, and when I find something new, it's going to be incorporated in what I recommend. With the Paleo folks, I think they're on the right track. I think they can go a little too far down that rabbit hole if they tell people that a blueberry has too much sugar. And I've heard people tell me that blueberries have too much sugar. The blueberries, you know, the berry anthocyanin in the blueberry I feel firmly overcomes amount of sugar in a blueberry. Turns out there's not that much carbon **[Inaudible 00:45:16]** with, but the anthocyanin are immense in a blueberry. So on the net, blueberries aren't good.

Ivor:

[00:45:21](#)

Hey guys, just a quick break to remind you that this podcast is only possible due to funding from the Irish Heart Disease Awareness charity and its founder David Bobbett. David discovered he had massive heart disease in 2012, and could only do so by getting a five minute calcification scan and CAC score. It enabled him to take action to stop the disease process and to save his own life. Now, he is spending millions to help others do likewise. All we ask is to help get the message out in the power of CAC. Watch the Widowmaker movie linked at the end of this podcast and share it as widely as you can. Thank you. And now we return to the conversation.

[00:45:57](#)

So essentially Bill, there are.... well, fruit, I think what's acknowledged in the low carb community largely, it would be meat, fish, eggs and all the healthy fats and meat and two veg you know, with above ground, non-starchy vegetables, not the tubers, and then berry fruits like blueberries, strawberries, raspberries for potential benefits as you described, and they really are low sugar. Probably the aversion is to the modern bred for sugar fruits, where if you're eating oranges and apples that have gone through hundreds of years of competitive breeding to get them sweeter and sweeter, they're kind of glucose and fructose bombs. But yeah, meat and two veg and berry fruits and you could go on a healthy low carb diet, which is particularly appropriate when the majority of your adult population are now to some degree diabetic. It's kind of a no brainer to lower those carbs and starches. If they were all athletes, you know, amazingly insulin sensitive, maybe it's okay to have quite a few potatoes. But let's be honest, that's not the population we have. The reason our population is racked with cardiovascular disease is because there's a massive amount of

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diabetes and autoimmune, and we got to take down this carb to deal with the challenge. I agree.

Bill: [00:47:19](#) One of the hidden values of fruits and vegetables that is oftentimes lost in the general population is the value of soluble fiber. So the fiber contained in any fruit or vegetables of soluble fiber, and it has value at several different levels. First off, soluble fiber tends to bind to bile acids in the gut. The bile acid or bile salts are made out of cholesterol. So if these soluble fiber binds the cholesterol bombs and stays in the gut instead of being reabsorbed in the terminal ileum, you will not necessarily lower the cholesterol levels but you will lower the age of a cholesterol particles in your body. And these younger non recycled cholesterol particles are not iatrogenic. The white cells don't think they're invading bacteria. And so they have that value.

[00:48:13](#) The second value is these soluble fiber particles, probably do also adhere to other bio toxins and inflammatory mediators and can reduce our inflammatory [\[Inaudible 00:48:25\]](#) simply by having adequate amounts of soluble fiber in our gut. And the final thing is there's good studies showing that the bacteria in our colon and to cleave the soluble fiber particles into short chain fatty acids that are very anti-inflammatory and add a value to our system for anti-inflammation. And so we really do need to get a volume of best soluble vegetable fiber in our diets in order to harness that additional value. It also requires we have a bio floor? [\[Inaudible 00:48:58\]](#) that's working and also requires we have a reason we have that diet, they were squeezing the bile into our intestines to help digest the fats so that we spread it more of the bile salts with soluble fibers.

Ivor: [00:49:09](#) So it's complimentary to a healthy, low carb, higher healthy fats diet in a sense. I think the real arguments nowadays actually based on human studies is the insoluble kind of wheat [host/hoops? \[Inaudible 00:49:23\]](#) fibers and the classic breakfast cereal fibers, arguably, they can create bulk and water retention and irritation, very different than the soluble fiber I think you're describing there. So a lot of the industry and business pushes kind of insoluble fiber, like it somehow scrubs out your intestines, largely it probably scours your intestines and causes challenges.

Bill: [00:49:50](#) Well, I like to hearten back to the old DART trial. The DART trial is a diet and reinfraction trials, it's back in the 80s, long time ago. In that study, they took a group of men who had heart

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attacks and randomize them to three overlapping subsets. They had a low fat subset, a high fiber subset, and a high oily fish subset. So the third subset, they were asked to eat six ounces of salmon every day. Well, at the end of the study, the low fat diet had no effect on reducing subsequent heart attacks. The high fiber diet had no effect on reducing sudden heart attacks. But back in the 80s, high fiber was exclusively wheat bran and psyllium. We didn't think of high fiber as being vegetables. And the high oily fish subset of diet had a fairly profound reduction in heart attacks. Within that high oily fish subset, some people couldn't handle six ounces of salmon every day. But for those folks, they [Inaudible 00:50:56] the fat out of the salmon, abet to them as a supplement. That group had an even greater reduction in heart attacks as the group eating a six ounce of salmon, probably because of compliance. You can take fish oil every day. But some people's hard to eat six ounces of salmon every day for two years. That's a challenge.

[00:51:14](#) And so, the old rough fibers we're referring to, if your biggest problem is constipation, yeah, it'll help. But if your goal is overall health, I think you want to go for the vegetable fibers, the soluble fibers, that's where the value is.

Ivor: [00:51:30](#) Yeah.

Bill: [00:51:31](#) Within the world of pharmaceuticals, we have a class of drugs that functions as a soluble fiber. They're called bile acid sequestrants – cholestyramine, colesevelam, colestipol, are these bile acid sequestrants.

[00:51:45](#) I had a group of patients in my practice who are on statins to lower their cholesterol. And we're not tolerating the statins. So we move them from statins to bile acid sequestrant. They all had a pretty substantial burden of plaque. And so, on the statin, their average LDL cholesterol was 55 on the statin. But their plaque progression on average was going up to 32% per year and a robust plaque progression despite the fact that their LDL cholesterol is 55. Switch them from the statin, the bile acid sequestrant, their cholesterol went from 55 up to 95, but their annualized plaque progression went from 32% per year down to 12% per year.

[00:52:31](#) So, by using this bile acid sequestrant, even though I was using it from a pharmacologic perspective, I saw a robust reduction in plaque progression. The reality is adequate amounts of fruits and vegetables, it mitigate the need for using the

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pharmaceutical type of bile acid sequestrants. And I talked to my naturopathic friends. They find bile acid sequestrants usually beneficial in stopping the inflammatory cascade that's seen with Chronic Lyme disease, [toxic mold exposure?? 00:53:04] or other diseases that conventional doctors know nothing about and naturopathic physicians are all about. In their world, bile acid sequestrants are very, very effective. And so, bile acid sequestrants from soluble fiber, fruits and vegetables, I think is absolutely an integral part of a heart healthy diet, and in everything else healthy diet.

[00:53:29](#)

They did a great study UCLA, when they had a pool of patients who had had repeat calcium scores, referred by outside physicians. And they looked at the outcome of all-cause mortality. And they found that no other studies have shown a dramatic reduction in heart attacks based on plaque stability versus plaque progression. This particular study found a threefold difference in all-cause mortality based on plaque stability versus plaque progression. Threefold difference in all-cause mortality. If you had prevented every heart attack death, you could not reach a threefold difference in all-cause mortality.

[00:54:09](#)

One thing, the things we need to do, keep our hearts healthy, also keep our heads healthy, and keep our bodies healthy and keep us on this planet a longer period of time. So we're not just stopping heart disease by stopping heart disease. We're stopping other reasons for premature mortality by stopping heart disease.

Ivor:

[00:54:28](#)

That's a very important point to make. And I often show graphics like the iceberg of insulin resistance and above the water I put cardiovascular disease, depression, diabetes, some cancers like endometrial and breast cancers, [Inaudible 00:54:45] insulin resistance, and a host of other fatty liver and Polycystic Ovarian. So there's all this misery above the surface in the iceberg, the primary problem, [hyperinsulinimia?? 00:54:57], insulin resistance underneath and the beauty is when you tackle the big killer (cardiovascular disease) by lowering insulin, lowering glucose and fixing auto immune and many other factors, you're kind of attacking all the root causes of many other diseases too. So it's an important point. Your overall health really takes a bounce.

Bill:

[00:55:18](#)

Yes. And the observation that a modicum of exercise is beneficial for heart disease was also beneficial for arthritis and osteoporosis. And so we're hoping to prevent heart disease at

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the same time helping to prevent us from getting broken hips and broken backs. We'll get into the older ages. We're doing a lot of good. It's really kind of fun.

[00:55:41](#)

But I've been in practice since '86. It's been a couple years now. And I've had patients who followed me for this whole time and kind of fun to see how healthy these people are in their 90s. Now, they drive in, they come at the office, the guy's 90 years old, and you would not guess that he was over 75. It's just amazing. And so it's like, you're not going to be any younger than your blood vessels. It may be, you're not going to get any older than your blood vessels, and if we keep our blood vessels young, we can keep the rest of our bodies young. That's a compelling message, that people prefer being young given a choice. People prefer being young. And with the calcium score, we can tell if we're winning or not.

[00:56:32](#)

I can think of a particular patient who is a retired professor. And when he first came to see me, (he had recently retired from university) and he had diabetes, he had massive heart disease. We do a calcium score. His calcium score was like 4000, somewhere in that range. And so I feel like I'm going to throw the [Inaudible 00:56:52]. We're going to have to stabilize his plaque burden. So he changed his diet. And although I told him several times that he needs to eat a higher fat diet, his concept of low fat diet was so ingrained in him that he couldn't change it until I actually gave him some books. I had to reference the books, "Read these books and get the message."

[00:57:17](#)

And so he is now in his late 80s. He looks younger than he did when I got him as a new patient 15 years ago. He had no symptoms, he's very active, his plaque burden has been stable. He's at a 4000 plaque burden but is in stable the entire time. And, to talk to one of his fellow professors who told me when he retired, he was so old and so sick. Now look, he's 80 something year old guy who's healthy and vigorous and vital. It's a wonderful thing. Does he hadn't had heart disease, he wouldn't have made these change, if you know a guy now. He was lucky enough to have heart disease. He made the changes to treat his heart disease that ended up treatments in his entire physiology. Finally, on a high fat, low carb diet, his Hemoglobin A1c is sliding back down. We're not having to increase his diabetic medications, were able to reduce diabetic medications. It's a remarkable thing.

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[00:58:16](#)

I was talking with Type 2 diabetes, it's a gradual march to the [Inaudible 00:58:20]. Diabetes gets worse and worse. Eventually they need insulin, eventually need high dose insulin, blah blah, blah. No. If you do a modicum of exercise and get on a low carb, higher fat diet, the diabetes does not progress. The diabetes can actually get better. And you know, we talked about some people say that 70% of your calories coming up from fats. If you do that, the diabetes almost always goes away. It's a hard diet to maintain, but the diabetes almost always goes away.

[00:58:48](#)

And so we need to readdress these issues and look at them through fresh lenses and find such fabulous outcomes. It makes this job awarding. It makes me glad that I'm doing what I'm doing. And I feel sorry for my colleagues who are stuck in these, you know, "Follow the protocols, click-click-click, low fat. Here's more medicines for your low fat. Here's more medicines for you. Oh, I'm sorry. You had that stroke. I'm sorry you had that heart attack." It shouldn't be that way. There's a better way of doing this. And once again, their job is about it.

Ivor:

[00:59:24](#)

Well, personal responsibility. Yeah, for sure. And to that point about, you know, David, having putting huge effort, which we mentioned a while back, most people it's true, do not need to put in enormous efforts. I think he is such a driven man and he was so outraged at finding out there was a scan that could save people's lives in the way we've discussed. And he only got it by coincidence that he was absolutely driven to do everything. A 110%. So I think that was the sentiment. He was not taking any chances. But he has mentioned before to me that, you know, he takes a moderate dose statin because he's belt and braces. He's going to take everything for someone with huge disease. He will do huge exercise, but he acknowledges, you know, everyone doesn't have to do that. That's his choice because he's so driven. But he agrees that low carb, low carb, low carb for him, especially with his diabetic physiology is just huge. So the low carb, the nutrition, magnesium, the vitamin D, sun, and all these things are kind of 95%. And he also takes the medication belt and braces because it stabilizes plaque and they give him the extra. He's going for gold. He's doing everything and he's going to take away his risk, his enormous risk of death that existed when he first got the scan. But he is so passionate about... he is furious that people are dying all over the world in huge numbers. And ignoring a technology that's 40 years old, it's not even like it's just out, no one knows about us. And it's not being used in the way that it could deliver such enormous value, as

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you've described. It's actually quite horrifying in many ways, isn't it?

Bill: [01:01:18](#) It really, really is. It's a huge tragedy. You know, I like to hold out certain examples. A number of years ago, we had [this \[chalet 01:01:28\]](#) and mining accident where these miners were trapped on the ground, and the world stopped and watched the rest of these miners that pull the last guy out. Everybody was in tears and cheering. That was a wonderful thing. And so we save 40 miners lives and watched it intensively. And what we didn't realize that during that same period of time, 60,000 Americans died from heart attacks. It could have been prevented, had we done anything like the calcium score to find out who had disease and treat them appropriately.

[01:01:58](#) So the highest calcium scoring among my patient populations, a fellow who has a score of over 10,000, 10,000 and change. And he was referred to me because he was failing his stress test every other year and getting more procedures and more procedures. A friend of mine said, "Would you see him as a new patient?" And I did. And so we changed things around and we stabilize his plaque. Three years later, he does a stress test, but he had just failed before he saw me. Three years later, he passed the stress test. And he's doing fine. Six years, he's doing fine. He's climbing mountains, he's hiking across Alaska. He's doing great. And then he gets the Harvard Heart Letter. And the Harvard Heart Letter says, "Niacin doesn't work. Fish Oil doesn't work." And he stops his niacin and fish oil. And he comes in to see me, and I bust him. I say, "What are you taking?" He said, "I stopped my fish oil because of the Harvard Heart Letter." And I just [\[Inaudible 01:02:57\]](#), but my God, it's Harvard; they say it's got to be true.

[01:03:00](#) So then, later on, I noticed he's following up with one of my partners and not seeing me. And he had again, read another Harvard Heart Letter that said, this doesn't work [and \[stop it 01:03:11\]](#). Six months later he's in the hospital and got a 4 vessel bypass. So we had doctors disease, we've changed the course of his future. And based on the Harvard freaking Heart Letter, he stopped what we were doing and he ends up with a 4 vessel [\[Inaudible 01:03:28\]](#).

[01:03:29](#) So we are pushing back not only against ignorance, we're pushing back for the antiphysis of what we should be doing. The people are still saying, "Eat lots of grains, that's good for you." The people are still saying, "Niacin doesn't work. Fish oil

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doesn't work. Vitamin D doesn't work. Aspirin doesn't work. The only things that work are things that we are going to make hundreds of millions of dollars studying. So use these pharmaceuticals who are going to pay us hundreds of millions of dollars to study them. Stay away from all this confusing stuff that doesn't work."

[01:04:03](#)

I started medical school in '76, and it has always been the theme that supplements don't work. We've always assumed that supplements don't work. And it's been a transition for me to go from a person who was taught by people whom I respect that supplements don't work. As someone who feels that supplements have a real role in preventing heart attack. And there are a handful of supplements that I think this data out there is almost irrefutable. Fish oil, I was talking about that already. Niacin, basically the [Inaudible 01:04:44]; the niacin doesn't work, according to my experts at Harvard. Until you look at the studies.

[01:04:53](#)

There are two studies that the Harvard experts rely on to say niacin doesn't work despite previous studies showing that niacin regresses plaque on serial angiograms and niacin reduces heart attacks by a much greater percentage than statins do. But there are two studies have proven niacin doesn't work. One of the so called AIM-HIGH Study, and the AIM-HIGH study a randomized patients to 2000 milligrams of niacin versus placebo. In this particular study, the placebo they chose was a drug called niacin. The placebo was actually niacin. And of the people taking the 2000 milligrams of niacin, over a quarter of them couldn't take it and stopped. But were still treated as though they were taking niacin.

[01:05:42](#)

There's probably only study in history where there were more people taking the study drug in the placebo group than in the treatment group. Before the study, if I asked an endocrinologist, "What's the minimal effective dose of niacin?" They never had an answer. My personal experience is I put a patient on niacin, the most you could power, it was 250 milligrams, and that stabilize your calcium score. So the placebo is 200 milligrams of niacin. Follow along with the 400 people taking the high dose stuff and taking it. The mathematician said, "We're not going to reach the statistical significance. Stop the study." What the mathematicians did not know that it takes nine months for niacin to reach steady state. And so they stopped the study without that reality that they didn't give us a nine month washing period to reach steady state.

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[01:06:33](#) Now, the European Society for Lipidology and the American Lipidology Society both said, "We should not change prescribing patterns based on this study." Harvard said, "We've proven that niacin doesn't work." Then comes along the HPS2-THRIVE trial. The HPS2-THRIVE trial, they took a group of people taking Simvastatin and randomized them to Simvastatin alone, which is statins, it's like Lipitor, versus Simvastatin plus niacin, plus **[Inaudible 01:07:10]. [Inaudible 01:07:11]** is an antiprostaglandin, designed to block the flushing from niacin. Even mind every other antiprostaglandin on the market has been shown to increase heart attacks by anywhere from 30 to 100%. So put a drug that's similar to the drugs that they've shown to increase heart attacks in this study.

[01:07:33](#) The other thing we do is over half the population study are Asian. Asians have a higher toxicity, genetically have higher toxicity statins and niacin. And in this study for the first time, we found an increase in liver disease and an ulcer disease and kidney disease in the niacin group that are exceeded any toxicities any previous studies had shown. What turns out every other antiprostaglandin on the market like **[Inaudible 01:08:05]** increases all sorts of disease, increases tendencies and increases liver disease. But we ascribe all of this increase to the niacin, even though no previous studies have shown this. And there was a small benefit, but it didn't reach statistical significance. The conclusion was last nail in the coffin are niacin.

[01:08:27](#) Same month that that conclusion was reached, **[Inaudible 01:08:32]** printed a meta-analysis of every niacin study ever done including the AIM-HIGH Study which diluted the results and showed the 35% reduction heart attacks, significantly better than we've seen from statins. But yet it's been repeated so many times and we've proven niacin doesn't work, and take the niacin off the list.

[01:08:52](#) I've done two studies in my database, "Are you taking niacin or are you not taking niacin?" People who are taking niacin are probably the people whose plaque burdens were going up and we had to add niacin. You know, both studies that were separated by time, in both studies, the people taking niacin had better improved plot progression than people not taking niacin.

[01:09:17](#) We have the FATS Trial. The FATS Trial are all these studies designed... it wasn't big enough to look outcomes. That was a serial angiograph study. It showed a regression of plaque on serial angiography among people taking niacin. We did a 20-

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year follow up study on the FAST Trial and found a 71% reduction in coronary death and a 46% reduction in non-coronary death among those taking niacin. Despite that, the Harvard Heart Letter still says, "Niacin doesn't work." The niacin is one of the supplements that work. It has a very small toxicity.

[01:10:00](#)

Over the last 20 years, I've probably stopped niacin on three patients because of toxicities. Stopped and they did fine. I probably stopped a 100 patients from statins in the same timeframe because of toxicity. We stopped it, they've done fine. So I'm not saying statins are terrible. Statins work. Statins reduced heart attacks by an amount. They seem to work best in younger people. They seem to work best for the first few years of taking it.

[01:10:25](#)

The ASCOT-LLA Trial found that a 3.4 years there's a 30% reduction in heart attacks among those randomized Lipitor. We did 13 year follow up on the ASCOT-LLA Trial and found no reduction got from coronary disease at 13 years. Although there's a small reduction in death from pneumonia among those taking the statin. The nice thing is the statin didn't kill people, and the ASCOT-LLA Trial [\[Inaudible 01:10:52\]](#) follow up, but it also didn't prevent coronary death at year 13.

[01:10:57](#)

So, this is a complicated mix of data that we have. And it takes a nerd like myself who sits around, read it all and process it and try to put them together to understand it. But at the end of the day, it is so easy to stop heart disease. Getting back to a brutal exercise program; I worry a little bit about a brutal exercise program. There's a couple studies in Germany, showing that marathon runners have twice as much coronary plaque as non-marathon runners who have the same risk factors. The health safety trial and exercise for the couch potatoes had the highest risk of coronary events based on risk factors. As you start to exercise, that risk drops fairly precipitously. They got down to 30 minutes, three times a week of exercise the equivalent of a brisk walk or slow jog, you got about 85% of benefit that anyone got. When you got to five hours a week of vigorous exercise, the [\[Inaudible 01:11:58\]](#) starts going the other direction. When you get up to 20 hours a week or 21 hours a week of vigorous exercise, a triathlete marathon runners program, their risk approximated that a couch potato. And so in Boulder, because I'm dealing with such driven people here, the tough job of mine to tell people, "Stop exercising so damn much. [\[Inaudible 01:12:20\]](#) a little bit. You're not doing yourself good by working out three hours every day. Bring it in, bring it in. And, eventually

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they hear it. I mean, it's a challenge to get a Boulder athlete to stop being a Boulder athlete. But eventually they hear it. And when they ray it down, they actually do better in their triathlete competitions, because they're not destroying their muscles and they're not [Inaudible 01:12:44] in their heart with their [Inaudible 01:12:47]

[01:12:47](#) I feel stupid I didn't mean to say that. [Inaudible 01:12:51] So anyhow, I'm digressing, I'm bouncing around a little bit here.

Ivor: [01:12:55](#) No, the exercise one is interesting for sure. And, you know, I think it has been seen just as you described many studies, there are some that suggest, okay, higher calcification with a lot of exercise, but not necessarily the higher expected rate commensurate with that calcification. So it's like you win some, you lose some. And then I think, yeah, athletes who do more resistance training and less intense long term aerobic and combine those two can perform even better. But that whole area of athletics is kind of so specialized.

[01:13:28](#) But I think in general, yeah. If you have the calcification score and you get the heads up, you have big disease, some people say, "Oh well, if I'm doing low carb and I'm living fairly healthy, well, I don't really need it because what will I do different?" But what I always say is, "Well, if you get a high score and you find out you have a major issue, which only the scan will really tell you, you can sit down and say, "Okay, I'm doing low carb and I'm doing this good stuff, but now I got a very big risk, a lot of disease. What more do I need to do?" And then you get to searching. "I need to do everything!" "I need to look at the dental health." "I need to look at possible subclinical inflammatory conditions."

[01:14:10](#) I mean I had two guys came to at a fascinating thing. They both had high gamma glutamyl transferase, the liver enzyme which indicates inflammatory issues, glutathione depletion in your body (your primary antioxidant), high GGT, the [Inaudible 01:14:26] for mortality. It's a huge problem. But I had two guys that have high GGT, and for years tried to get it down with healthy living. They didn't drink too much alcohol. And both of them then, by fixing small intestinal bacterial overgrowth, they've done inflammatory bowel and they fixed it with antibiotics. And for the first time in literally years or decades, their GGT went from a high 60 or 70 down to the 20s. And that was it. It's a bit like your dental hygiene. It's not common knowledge, but there are many things. And if you get a high

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score and you've got very high risk, you can search and search deeper, like David did, go further and save your own life. So it's all upside.

Bill:

[01:15:13](#)

But I'd like to just reflect on a couple of other things that not everyone's going to be doing that my patients with plaque burdens do and we've seen it bring their plaque burdens down. And one of them is K2. A lot of people have never heard of Vitamin K2. But Vitamin K2 is a reasonably recently described vitamin by reason that we recently like 80 years ago, we've described vitamin K2, which is associated to improve bone mineral density, approved metabolism of calcium. And we have studies showing that serial coronary calcium is attenuated, the progressions attenuated among people randomized to K2. Populations whose diets are high in K2 have significantly fewer heart attacks than populations whose diets are low in K2.

[01:15:59](#)

And a Japanese population being the best example of that. Japan has significantly less coronary disease. About 1/3 of the coronary disease as United States. Japanese-Americans have about 30% more coronary disease than Caucasian Americans. It's not a function being genetically Japanese. Something goes on in Japan. What do they do in Japan that they don't do in the United States? Well, first off, they eat a lot less wheat. That may be playing a role. They eat a lot more rice. I bet that isn't playing a role because I'm from the state of Louisiana where we eat nothing but rice. There's a lot of heart disease in Louisiana. They eat a lot more oily fish. They eat more seaweed. There may be a value there. But they eat a lot of nacho. And nacho is [\[chock of 01:16:44\]](#) block full of K2. The dietary K2 consumption in Japan is much higher than United States.

[01:16:50](#)

We like to look at the French paradox. French eat what we used to think was bad things. They eat these rich, saucy things and the bread and all those kind of stuff and yet they have significant definitely less heart disease than United States. What was said is because they drink white wine, or red wine, rather. They drink red wine. And they do. But red wine probably doesn't account for 10% of the difference. However... well, first of all, they're eating fewer carbs, they're eating more fats, that's part of it. But the other thing is, while they're drinking their red wine, they're oftentimes eating brie or Gouda cheese, which both are very high in K2. So maybe the K2 in the brie, not the resveratrol in the wine is making more difference from the French paradox.

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[01:17:35](#) So I'll have my patients take K2. And based on hundreds of a lecture, worst case scenario, we're giving them healthier bones. We're making their plaque progression reduced, and we're almost certainly reducing heart attacks, although that has not yet been proven.

[01:17:55](#) The other thing I'll have my patients take is something called aged garlic extract. Aged garlic extract, how weird is this? Well, basically exactly what it sounds like. It's garlic, it's been aged, the powerful aromatics evaporated off and you're left with this powder that smells a little bit like garlic but not a lot like garlic. Can you think a lot of that without seeing a garlic?

[01:18:18](#) And we have several studies showing that individuals randomized the aged garlic extract have more stable calcified plaque over time. And that booted off at UCLA a couple of years ago did a study on patients who had had a CT angiogram. On CT angiogram you can see soft plaque. I had a group of patients with CT angiogram who randomized the usual care versus usual care plus 600 milligrams of aged garlic extract twice a day. Those on the aged garlic extract had net regression, regression of their soft plaque. But for \$12 a month, I can have my patients plaque regress, all of these be equal by adding aged garlic extract. So K2, aged garlic extract, B3, and fish oil, are my special sauce, is for patients who have plaque or whose plaque is progressing, these are things that I pull out.

[01:19:16](#) And we absolutely do the other things. We do the dietary things, we do the [\[Inaudible 01:19:20\]](#) things, we do the exercise things. Sometimes you put it all together and that doesn't work. These things added to that do work. And so the person who says, "I'm already eating well and exercising, there's no value of a heart scan," there's a lots of other things we do to stabilize plaque and yes we need a heart scan.

Ivor: [01:19:42](#) And of course the serial nature which you, and I know we have to we have to end shortly, but the serial utility. So if you get a scan with a high score and let's say six months ago you started eating more healthy, well okay, that scan result is your historical build up. But you can go back in a year or two with are healthy regime, with a high score, you can also apply yourself even more fruitfully. For instance, I take [\[Inaudible 01:20:10\]](#) of K2 just as you say Bill, but if I got a high score or progressing score, I'd push that vector much harder. I'd much more regularly take magnesium and potassium. Currently, I'm quite casual.

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[01:20:23](#) There's so many things you do differently if you had a high score or progressing score, even beyond what I do as someone who's quite knowledgeable in all these things. So it's the power of tracking yourself and taking extra actions to ensure that you protect yourself from that heart attack, which is huge.

Bill: [01:20:43](#) Knowledge is a good thing and knowing the [Inaudible 01:20:46] needs to happen can be a huge motivator for you to do it. We can share anecdotal stories all day but they have a study in the literature, looking at people who should be taking a statin. Normally if you should be taking a statin, compliance at six months is less than 50%. In this study, patients in the top quartile of coronary calcium at a 93% compliance with statins at three and four years. And so yes, it's a huge motivator to do what you know you should be doing.

Ivor: [01:21:18](#) Yeah.

Bill: [01:21:19](#) The other thing is that you get a calcium score and say you're 48 years old and you got a calcium score of 50. So that's a low score, I'm not so worried. But that 50 score at a 48 year old puts him above the 75th percentile. When that 40 year old becomes a 60 year old, he can have a score of a 1000. And so that 40 year old was able to intervene, stabilize that score now and not have a high score later. Badly not all 40 year olds hear that message that say, "I've got a good score, I'm not worried." "I'm low; I'm less than a 100. Yay!" Know you're in the top quartile for risk. Follow the curve. It is a logarithmic, you're going to have a big score the next 5 to 10 years.

[01:22:03](#) And so the first score should be a great motivator. The only thing more important than your first score is your second score because that tells you if you've met your needs, have you mitigated your risk? The answer is yes, keep doing what you're doing. The answer is no. Find somebody knows what they're doing and find out what they're doing and do the same thing. And you can try something, see if it works.

[01:22:26](#) I love the fact that when I fail, my failure is based on number going up too fast. My failure is not based on one of my patients being in the ER with chest pain. I hate going to the ER 2:00 o'clock in the morning to meet people with chest pain. I actually did that Monday night, but it was for someone whose chest pain was not from his heart. The patient was massive heart disease. Used to be in heart failure. He is now 83 years old. He no longer has angina, no longer has heart failure, and when I

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saw him at 2:00 o'clock in the emergency room on Monday is because he has esophageal reflux; not because he had coronary pain.

[01:23:04](#)

I love that. I love the fact that my people are having so few coronary symptoms. It makes my job easier. It really does.

Ivor:

[01:23:14](#)

Well Bill, it's a huge testament to you. You've clearly described how... you are root cause expert and imaging expert and a resolution expert which as you said at the very start is the key thing. You got to resolve these things. It requires a huge amount of observation, reading off the literature, so many different vectors to be able to do what you've done. So, I can't commend you enough for it. And I know that the Widowmaker movie which you have done several screenings off as well which is superb. We've got it available in the short version at the end of this podcast will be a link to be able to watch it. So I just ask people you know, share as widely as possible with your friends because to David's point, if you get to know about the scan and you get the result, okay, the movie might not tell you all the fixes that we've talked about. But once you know where you stand, you can go and find those fixes. Like you said, you can search, you can discover, you can basically take responsibility to save your own life by going out and finding out what all the facts are. And that's all the people really need.

[01:24:21](#)

My introduction to coronary disease was 55 years ago, when age nine my grandfather suddenly died from a heart attack. And so at age nine, I started wondering what is this heart attack thing? What took grandpa [\[Inaudible 01:24:37\]](#) away from me? What happened there? Is this going to happen to my father's? Is my father's going to suddenly be gone? And so what we're looking at here is 55 years of research in heart disease. And it's kind of nice to know, yes, there is an answer. Yes, it can be resolved. Nine year olds don't have to have their grandpa die while they're still an active 70 year old who's taking them fishing, taking them to the beach. That grandpa could still be taking them to the beach for another 10 or 15 years. If we could have had the technology back then that we have now. We have it now, the fact that we're not using it is criminal. It's just insane that people are dying who don't have to die every day in those [\[Inaudible 01:25:23\]](#). It's just insane.

Ivor:

[01:25:26](#)

Absolutely, Bill. Well, hopefully this gets out. And again, if people can share and reach more people, we can overturn that criminal negligence, if not downright maliciousness from certain

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people in the medical community to stop us using this technology to save lives.

[01:25:43](#) So I think that's a great way to wrap it up. I know you got to get back to your stuff this evening, and me too, and great conversation. Any last brief comment or we'd wrap it up?

Bill: [01:25:55](#) Well, you know, I'm delighted to be here. I appreciate the opportunity and we just need to get this message out, and we can make a difference. But we cannot rely on Harvard and Cleveland Clinic to lead us to make a difference. Because there are too many confounding factors, too many financial factors that motivate these so called "thought leaders" in the wrong directions. It's time for grassroots event to bring people to realization. Heart disease should be stopped. Heart disease can be stopped. It's not expensive. It doesn't require nuclear stress test. It does not require coronary angiogram. It does not require steps. It requires some fairly inexpensive simple interventions that are not painful or not problematic or not hard to do.

[01:26:45](#) Fat people can avoid heart attacks, skinny people can avoid heart attacks. Everyone doesn't have to get skinny to avoid a heart attack, if they can be avoided. I'm overweight. My plaque burden went down 57% last year. It can happen.

Ivor: [01:26:57](#) Yeah, and again, we don't have time to get into other topics. But, that is another thing. I've discussed another podcast that there is healthy subcutaneous fat even in large amounts without inflammation, without visceral fat. And it's not... we have so much data that it's not the actual obesity, it's always the GGT level, or it's almost the inflammatory markers. It's never really the obesity. That only had correlates with the real problems. So, absolutely!

[01:27:27](#) So listen, thanks a lot Bill. It was delightful to talk to you here this evening. You know, we'll have a chat again I'd say. I'll be circling back in coming months on other topics.

Bill: [01:27:38](#) Thank you so much.

Ivor: [01:27:40](#) Thanks a lot, Bill. Best luck! Good evening.

Thanks for tuning in, guys. If you're watching on YouTube, you can see my subscribe button in the middle of the screen. A free viewing of the Widowmaker movie on the far right. And myself

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