

Recommending plant-based diets

The physician community has started to acknowledge the health benefits of a plant-based diet; the next step is to start recommending it to our patients.

Dr Grant's commentary "Time for change. Benefits of a plant-based diet"¹ is remarkable for a number of reasons. It highlights the broad and impressive health benefits of a plant-based diet, all backed by scientific evidence. Vegetarians, and especially vegans, are much less likely to be overweight, have high cholesterol levels, or have diabetes. The exposure to carcinogens and microbes (that can cause food poisoning) in certain meat products is nearly eliminated by eating only plants. If a new pill were discovered that had all these health benefits, it would constitute a groundbreaking discovery!

It is a step forward that these health benefits are being clearly acknowledged in medical journals such as *Canadian Family Physician*. No longer is it acceptable to view a plant-based diet as a fringe or quirky activity.

The general public and popular media are becoming increasingly aware of the health benefits of a plant-based diet. As physicians, we should not lag behind them. We should acknowledge the health benefits of a plant-based diet, but we should go further, too, and actually recommend its use to our patients.

Here are some selected resources for patients considering more plant-based meals:

- Physicians Committee for Responsible Medicine: *21-Day Vegan Kickstart* (website)²
- Forks Over Knives: *Getting Started on a Plant-Based Diet* (website based on the documentary of the same name)³
- *The Oh She Glows Cookbook* by Angela Liddon (vegan cookbook)⁴
- *Plant-Powered Families* by Dreena Burton (vegan cookbook)⁵
- *Becoming Vegetarian* by Vesanto Melina and Brenda Davis (information and cookbook)⁶

Doctors should consider advising patients that if they move toward a plant-based diet they will be healthier, need to take fewer pills, improve and possibly reverse the courses of chronic diseases such as diabetes, and increase their longevity.

When put this way, why wouldn't we recommend a plant-based diet to our patients?

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Competing interests
None declared

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Evidence for benefit of low-dose alcohol

While there is almost no doubt that excessive alcohol use is invariably harmful to health and communities, I believe the study cited¹ by Dr Ladouceur in his editorial in the October issue² does not provide enough evidence to counter the mountain of high-quality evidence that suggests drinking alcohol in moderation is overall beneficial for health. Low alcohol consumption does improve all-cause mortality, diabetes, and cardiovascular disease despite it being a known carcinogen in higher doses.³⁻⁵

Although the Whitehall II study does appear to show a correlation between moderate alcohol use and changes on neuroimaging, the cognitive decline outcomes were not consistent.¹ However, I believe the main flaw with the study was that magnetic resonance imaging was only performed once during the study. This is effectively a snapshot at one moment in these patients' lives where self-reported alcohol use was described as moderate. The authors admit that the moderate-to-light drinkers in the study could possibly have been heavier drinkers in the past or even at the time of the study. The Rosenthal effect (the idea that being a study participant makes one behave differently because one is being studied) might have decreased self-reported alcohol use. No amount of statistical wizardry can account for these subtleties of human behaviour.

The so-called J-shaped mortality curve has been discussed in the medical literature for decades and, time after time, large-scale prospective cohort studies and meta-analyses have shown that there is mortality protection from low-dose alcohol consumption. It could be argued that if low-dose alcohol were a pharmaceutical drug, such as thrombolytic agents for acute myocardial infarction, it would be considered unethical to perform further studies.⁴ Like all drugs, there are contraindications

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and adverse effects but at the right dose and in the right population, some will benefit.

We often ask our patients to adopt a Mediterranean diet but perhaps we should encourage them to adopt the Mediterranean lifestyle, too. As anyone who has visited Italy would know, this includes a healthy relationship with alcohol where it is enjoyed in moderation, something that we in Canada and the United Kingdom need to practise.

—Michael Fernando MD
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Competing interests

None declared

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Cyclical hypervirulent *S aureus* clones and community-acquired MRSA infection

The review by Loewen et al on community-acquired methicillin-resistant *Staphylococcus aureus* (CA-MRSA) is a solid reminder for general practitioners and the general medical community.¹ The important contemporary concerns about CA-MRSA began more than a decade ago with the proliferation of strains that were capable of being modestly invasive and often produced deep soft-tissue infections such as boils.² The clinical scenario now is much different, and although methicillin-resistant *S aureus* is, and will continue to be, a microbial hazard in both communities and institutions, we have seen a considerable decline in the absolute numbers of CA-MRSA infections. This noticeable reduction occurred early in this decade. There remain foci of endemicity, but the absolute number of such infections is markedly reduced.

The pandemic of CA-MRSA did, however, stir the medical community to action. There had been complacency, certainly in Canada, that the status quo would remain.³ As for any outbreak, careful attention to rational preventive measures would have had a role in maintaining control.^{4,5} Overcoming a “counterculture” in the medical populace was also a critical feature of controlling outbreaks.^{6,7}

If one were to ascribe the reduction in CA-MRSA infection entirely to medical interventions, whether they be for infection control or treatment, it would be quite an honour. The valid postulate remains, however, that the wave of CA-MRSA infection was ready to happen, given historical

patterns of community outbreaks of *S aureus*. Indeed, the genesis of hypervirulent clones with hyperendemicity and antibiotic pressure was inevitable and predictable.⁸ Both the microbiology and the dermatology communities recognized that abscess-causing *S aureus* commonly returns to the general populace in cycles.⁹ Methicillin resistance does not necessarily confer greater pathogenicity.⁹ Rather, the CA-MRSA outbreaks of the past decade likely combined the features of a cycling *S aureus* strain with enhanced virulence and the complicating trait of being methicillin resistant. Effectively, the reduction in the infectious cycle would be both a function of purposeful control and treatment efforts and the evolution of immunity in the population to those virulence factors. Future relapses of the same in cyclical fashion are also now quite predictable.

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Competing interests

None declared

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