The Polymeal: a more natural, safer, and probably tastier (than the Polypill) strategy to reduce cardiovascular disease by more than 75%

Oscar H Franco, Luc Bonneux, Chris de Laet, Anna Peeters, Ewout W Steyerberg and Johan P Mackenbach

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The Polymeal: a more natural, safer, and probably tastier (than the Polypill) strategy to reduce cardiovascular disease by more than 75%

Oscar H Franco, Luc Bonneux, Chris de Laet, Anna Peeters, Ewout W Steyerberg, Johan P Mackenbach

Abstract

Objective Although the Polypill concept (proposed in 2003) is promising in terms of benefits for cardiovascular risk management, the potential costs and adverse effects are its main pitfalls. The objective of this study was to identify a tastier and safer alternative to the Polypill: the Polymeal.

Methods Data on the ingredients of the Polymeal were taken from the literature. The evidence based recipe included wine, fish, dark chocolate, fruits, vegetables, garlic, and almonds. Data from the Framingham heart study and the Framingham offspring study were used to build life tables to model the benefits of the Polymeal in the general population from age 50, assuming multiplicative correlations.

Results Combining the ingredients of the Polymeal would reduce cardiovascular disease events by 76%. For men, taking the Polymeal daily represented an increase in total life expectancy of 6.6 years, an increase in life expectancy free from cardiovascular disease of 9.0 years, and a decrease in life expectancy with cardiovascular disease of 2.4 years. The corresponding differences for women were 4.8, 8.1, and 3.3 years.

Conclusion The Polymeal promises to be an effective, non-pharmacological, safe, cheap, and tasty alternative to reduce cardiovascular morbidity and increase life expectancy in the general population.

Introduction

Cardiovascular disease continues to be the leading cause of mortality and morbidity in Western populations. Although several risk factors for cardiovascular disease have been identified, its prevention is still suboptimal owing to high costs, low compliance, and side effects of treatment. In 2003 Wald and Law introduced the concept of the Polypill. The advocates of the Polypill selected six pharmacological components that by modifying different risk factors of cardiovascular disease multiplicatively might reduce the levels of cardiovascular disease in the population by more than 80%. In general, the medical community has welcomed the concept but questioned the potential adverse effects and costs of such an intervention.

Our objective was to define a safer, non-pharmacological, and tastier alternative to the Polypill in the general population: the Polymeal. We also wanted to calculate the potential effects of the Polymeal in terms of total life expectancy and life expectancy with and without cardiovascular disease.

Methods

The recipe

To optimise the Polymeal ingredients we used an evidence based diet conceptual framework, which follows similar principles to evidence based medicine. The constituting elements of a meal or recipe are selected on the basis of the best available evidence; the evidence available for each ingredient is graded according to the level of evidence. We searched PubMed, informed by expert advice, for non-pharmacological ingredients with evidence levels 1 or 2: randomised controlled trials, meta-analyses of randomised controlled trials, and meta-analyses of observational studies. To be included in the Polymeal, the ingredient had to have individually reported effects (not as an element of a diet) on reduction in cardiovascular disease events or modification of risk factors for cardiovascular disease. We checked papers retrieved for further possible ingredients. The following dietary elements met the inclusion criteria to be ingredients of the Polymeal: wine, fish, dark chocolate, fruits and vegetables, almonds, and garlic (Allium sativum).

Efficacy of the Polymeal

We obtained information from the literature on the benefits of the interventions (table 1). Daily consumption of 150 ml of wine reduces cardiovascular disease by 32% (95% confidence interval 33% to 41%). Fish (114 g) consumed four times a week reduces cardiovascular disease by 14% (8% to 19%). For chocolate, fruits and vegetables, almonds, and garlic, we found data on modification of risk factors for cardiovascular disease. One hundred grams of dark chocolate consumed daily reduces systolic blood pressure by 5.1 mm Hg and diastolic blood pressure by 1.8 mm Hg; similar reductions in blood pressure correspond to a reduction in cardiovascular disease events of 21% (14% to 27%). A total of 400 g of fruit and vegetables consumed daily produced a reduction in blood pressure similar to that observed with chocolate (4.0 mm Hg systolic blood pressure and 1.5 mm Hg diastolic blood pressure), so we decided to assume

<table>
<thead>
<tr>
<th>Ingredient</th>
<th>Percentage reduction (95% CI) in risk of CVD</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wine (150 ml/day)</td>
<td>32 (23 to 41)</td>
<td>Castelnuovo et al (MA)</td>
</tr>
<tr>
<td>Fish (114 g four times/week)</td>
<td>14 (8 to 19)</td>
<td>Wheat et al (MA)</td>
</tr>
<tr>
<td>Dark chocolate (100 g/day)</td>
<td>21 (14 to 27)</td>
<td>Taubert et al (RCT)</td>
</tr>
<tr>
<td>Fruit and vegetables (400 g/day)</td>
<td>21 (14 to 27)</td>
<td>John et al (RCT)</td>
</tr>
<tr>
<td>Garlic (2.7 g/day)</td>
<td>25 (21 to 27)</td>
<td>Ackermann et al (MA)</td>
</tr>
<tr>
<td>Almonds (68 g/day)</td>
<td>12.5 (10.5 to 13.5)</td>
<td>Jenkins et al (RCT)</td>
</tr>
</tbody>
</table>

Table 1 Effect of ingredients of Polymale in reducing risk of cardiovascular disease

CVD=cardiovascular disease; MA=meta-analysis; RCT=randomised controlled trial.

Department of Public Health, Erasmus MC University Medical Centre Rotterdam, PO Box 1738, 3000 DR Rotterdam, Netherlands
Oscar H Franco scientific researcher
Chris de Laet senior researcher
Ewout W Steyerberg associate professor
Johan P Mackenbach professor
Belgian Health Care Knowledge Centre (KCE), Oostzaan 133, B-1040, Brussels, Belgium
Luc Bonneux senior researcher
Department of Epidemiology and Preventive Medicine, Monash University Central and Eastern Clinical School, Melbourne, Australia
Anna Peeters senior researcher
Correspondence to: O H Franco o.franco@erasmusmc.nl

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Table 2 Lifetime effect (years) of Polymeal at age 50, stratified by sex

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Men</th>
<th>None (overall)</th>
<th>Polymeal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>28.7 Ref 21.0 Ref</td>
<td>39.0 4.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>34.2 Ref 26.9 Ref</td>
<td>39.0 4.8</td>
</tr>
</tbody>
</table>

The limits of medicine

Effects of the Polymeal on life expectancy and time with cardiovascular disease

To translate the effects of the Polymeal on reduction of cardiovascular disease events (table 1) in terms of differences in life expectancy and life expectancy with and without cardiovascular disease, we created multi-state life tables starting at age 50 years and closing at 100 years of age. We stratified the multi-state life tables by sex and created them separately for the general population with and without the Polymeal. The multi-state life tables included three different states: “free from cardiovascular disease,” “history of cardiovascular disease,” and “death.” The possible transitions were from “free from cardiovascular disease” to “history of cardiovascular disease” or “death” and from “history of cardiovascular disease” to “death.” We used the estimated risk reduction associated with the Polymeal. We used Excel spreadsheets for all analyses.

Results

Effects of the Polymeal

Combining all the ingredients of the Polymeal resulted in cardiovascular disease being reduced by 76% (95% confidence interval 63% to 84%) (table 1). Whether increasing the amount of each ingredient would increase the effect of the Polymeal is uncertain. On the other hand, decreasing the quantities could be expected to reduce the effects of the Polymeal. Omitting wine from the Polymeal had the strongest effect on the risk reduction of cardiovascular disease (from 76% to 65%). Excluding any of the other ingredients had a lesser effect: 73% reduction without fish, 70% without chocolate or fruits and vegetables, 68% without garlic, and 73% without almonds.

Lifetime effects of the Polymeal

The effect of the Polymeal represented a large increase in total life expectancy and life expectancy free from cardiovascular disease and a decrease in life expectancy with cardiovascular disease for both men and women (table 2). For men, taking the Polymeal would result in increases of 6.6 years in total life expectancy and 9.0 years in life expectancy free from cardiovascular disease. The decrease in life expectancy with cardiovascular disease attributable to the Polymeal was 2.4 years. The reductions were similar for women, although the magnitudes were lower (table 2).

Adverse effects

No proved serious adverse effects were reported in any of the papers selected. For garlic, in addition to body weight, a few adverse effects were reported. These included allergic reactions, and bleeding. Some unproved adverse effects were mentioned: flatulence, oesophageal and abdominal pain, allergic reactions, and bleeding. Fish consumed in larger amounts than recommended as part of the Polymeal is known to result in raised blood mercury concentrations, especially with large fish such as shark and swordfish. No association between wine consumption and any of the adverse effects was reported in any of the papers included in our analyses.

The same reduction in cardiovascular disease effect as assigned for chocolate (21%).

Daily consumption of garlic reduced total cholesterol concentrations by 0.44 mmol/l (17.1 mg/dl), corresponding to 66% of the reduction (0.66 mmol/l) that was found to be associated with a 38% reduction in cardiovascular disease at age 50. Therefore, we considered 66% of the effect previously reported and assumed a reduction of 25% (21.7% to 27.7%) in cardiovascular disease events for garlic. Most of the randomised controlled trials included in the meta-analysis used 600-900 mg/day of dried garlic powder preparations, equivalent to 1.8-2.7 g/day of fresh garlic. We selected 2.7 g/day of fresh garlic for the Polymeal. Consuming 68 g/day of almonds produced half the reduction in total cholesterol (10 mg/dl) observed with garlic, so we assumed a reduction in cardiovascular disease half the one assigned to garlic.

We calculated the combined effect of the ingredients of the evidence based diet Polymeal by multiplying their correspondent relative risk estimates. This is the same method that was used for the Polypill.

Study population

We applied the effects of the Polymeal to a life table built using the Framingham study population. The original Framingham heart study cohort consisted of 5209 respondents (2336 men) residing in Framingham, Massachusetts, between 1948 and 1951. Participants have been examined biannually, and the cohort has followed up for 46 years. We used follow up data from participants attending study examinations 4 (1956-8), 11 if present or otherwise 12 (1969-73), and 19 if present or otherwise 20 (1985-9). Follow up started at the date of the chosen baseline examination. Each participant could therefore be included more than once but for different follow up periods of no more than 12 years in order to avoid overlapping periods. A total of 9181 participant-periods of follow up were available for the analysis.

We used three endpoints in this study: the composite endpoint of incident non-fatal cardiovascular disease (angina, coronary insufficiency, myocardial infarction, congestive heart failure, stroke, transient ischaemic attack, and intermittent claudication), fatal cardiovascular disease, and other causes of death. In the Framingham heart study, a panel of three physicians evaluated all events (fatal and non-fatal); agreement of all three was needed. We selected total cardiovascular disease as the outcome and not coronary heart disease and stroke separately on the basis of current recommendations in the European guidelines on cardiovascular disease prevention.
Discussion

The Polymeal is an effective, natural, probably safer, and tastier alternative to the Polypill to reduce cardio-
vascular disease and increase life expectancy in the
general population. The effect was consistent in both
men and women at age 50. Adverse effects reported for
garlic include malodorous breath and body odour. As
garlic is destined for mass treatment, few people will
still notice this after a while. No additional adverse
effects should be expected from the other ingredients
of the Polymeal (in the quantities recommended here)
except in people who are allergic to the components.
Another advantage of the Polymeal is that its
ingredients can be taken combined as a meal or
individually at different times of the day. Taking the
Polymeal on a daily basis (fish two to four times a week)
should be feasible, considering that the ingredients are
generally well tolerated and appreciated among the
general population. The development and distribution
of specific recipes combining the Polymeal ingredients
could enhance the compliance of the population.

Costs and precautions

Although the exact price of the Polymeal is unknown
and will be country specific, it could be expected to be
similar to or perhaps higher than that of the Polypill.
By checking a local supermarket in Rotterdam, the
Netherlands, we estimated a total price for the
Polymeal of €21.60 ($15.20; £28.10) a week (€5.50 for
the wine, €6.25 for fruit and vegetables, €2.80 for
almonds, €4.34 for dark chocolate, €6.14 for garlic,
and €4.60 for fish). Although we do not recommend
particular brands, spending more—for example, on
your favourite bottle of wine or brand of chocolate—
might also be rewarded by an improved quality of life.

The Polymeal should not be combined with
additional consumption of alcohol, in order to avoid
intoxication and conflicts with friends, relatives, and
authorities; furthermore, additional alcohol consump-
tion could attenuate the effects of the Polymeal and
negatively influence other health measures. Driving
motor vehicles or performing activities that require
high levels of attention shortly after the consumption
of the Polymeal should be avoided. Moreover,
considering the disturbing adverse effects of garlic, we
do not recommend taking the Polymeal before a
romantic rendezvous, unless the partner also complies
with the Polymeal.

We believe our search was comprehensive and
although we looked for additional ingredients to
include in the Polymeal, we found no other potential
components with a sufficient level of evidence or with
clearly reported effects on cardiovascular disease
events or on modification of risk factors of cardiovas-
cular disease. Some other ingredients could be added
to the Polymeal (olive oil, echium oil, soya oil, soya
beans, tomatoes, oat bran, cereals, nuts, tea, chickpeas,
and so on), but this will only improve its effect on car-
diovascular disease risk reduction.

Concerns might be raised about the validity of the
source evidence and the multiplicative model used to
calculate effects of the ingredients of the Polymeal.
However, these are shared by the Polypill analyses, as
we used a similar approach. None the less, a greater
possibility of interaction exists between dietary factors
as less information is available about underlying
mechanisms of action. This might result in an overesti-
mation of the effect of the Polymeal.

Another potential limitation of our study is that no
back flows are allowed in the multi-state life tables, and
only the first entry into a state is considered. This is not
always seen in real patterns of morbidity and mortality.

No contraindications to combining the Polymeal
with additional interventions seem to exist. After the
daily consumption of the Polymeal, for example, half
an hour of walking could prevent further cardiovascu-
lar disease events. For those people earnestly seeking
to prevent cardiovascular disease, the Polypill can be
combined with the Polymeal. The fortification of flour
with Polypill ingredients (a statin, two antihypertensive
drugs instead of three, folic acid, and aspirin) certainly
merits further study. Redundant cardiologists could be
retrained as Polymeal chefs and wine advisers.

Conclusions

The preventive strategy outlined here is radical. But the
“healthy person” is an outdated concept from the era
before scientific prevention. We should recognise that
in Western society we all have cardiovascular risk
factors, so everyone is at risk, and the diseases they
cause are common and often fatal. It may be argued that
the Polypill is even more effective, but the
Polymeal promises to be an effective, non-
pharmacological, safe, and tasty alternative for
reducing cardiovascular morbidity and increasing life
expectancy in the general population.

We thank the Framingham Heart Study Coordinators for access
to the original dataset. The Framingham study is conducted and
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Investigators. This manuscript has been reviewed by the NHLBI
for scientific content and consistency of data interpretation with
previous Framingham publications. We also thank M E
Kruipshaar and L J Veerman for their valuable comments and A
Randomised controlled trial of magnetic bracelets for relieving pain in osteoarthritis of the hip and knee

Tim Harlow, Colin Greaves, Adrian White, Liz Brown, Anna Hart, Edzard Ernst

Abstract

Objective To determine the effectiveness of commercially available magnetic bracelets for pain control in osteoarthritis of the hip and knee.

Design Randomised, placebo controlled trial with three parallel groups.

Setting Five rural general practices.

Participants 194 men and women aged 45-80 years with osteoarthritis of the hip or knee.

Intervention Wearing a standard strength static bipolar magnetic bracelet, a weak magnetic bracelet, or a non-magnetic (dummy) bracelet for 12 weeks.

Main outcome measures Change in the Western Ontario and McMaster Universities osteoarthritis lower limb pain scale (WOMAC A) after 12 weeks, with the primary comparison between the standard and dummy groups. Secondary outcomes included changes in WOMAC B and C scales and a visual analogue scale for pain.

Results Mean pain scores were reduced more in the standard magnetic group than in the dummy group (mean difference 1.3 points, 95% confidence interval 0.05 to 2.55). Self reported blinding status did not affect the results. The scores for secondary outcome measures were consistent with the WOMAC A scores.

Conclusion Pain from osteoarthritis of the hip and knee decreases when wearing magnetic bracelets. It is uncertain whether this response is due to specific or non-specific (placebo) effects.

Manufacturers of permanent static magnet devices claim that they reduce pain in various conditions, including osteoarthritis.1 Worldwide sales were estimated at $5bn ($2.6bn, €3.8bn) in 1999.2 Osteoarthritis affects around 760 000 people in the United Kingdom, producing an estimated 3.02 million general practice consultations in 2000.3 If magnets were effective they would offer a cheap and probably safe treatment option.

Some studies of permanent static magnets have found significant pain reduction,1 4 whereas others reported no effect.5-11 Major differences exist in the type and strength of magnets used, the conditions