


**ANNUAL
HEART
HEALTH CHECK**

Dr Ross Walker



UnstressHEALTH



**Unstress
HEALTH**

with Dr Ron Ehrlich

Podcast Transcript

Dr Ron Ehrlich: [00:00:00] Hello and welcome to Unstress. My name is Dr. Ron Ehrlich. I'd like to acknowledge the traditional custodians of the land I am recording this podcast on the Gadigal people of Eora Nation and pay my respects to their elders, past, present and emerging and acknowledge that we have much to learn from our First Nations people.

Dr Ron Ehrlich: [00:00:23] Well, this is your annual heart health check-up with the legendary Dr Ross Walker. Now, Ross is Australia's leading integrated cardiologist. He is so far ahead of the game. He's written books, he has a regular Sunday night top-rating program, Healthy Living on 2GB, where he covers a wide range of topics and we cover a wide range of topics today. I hope you enjoy this conversation I had with Dr Ross Walker. Welcome back, Ross.

Dr Ross Walker: [00:00:57] Ron, it's always a great pleasure to talk with you, my friend.

Dr Ron Ehrlich: [00:00:59] It is indeed and I always feel like an obligation to my listeners because cardiovascular disease is still an issue and I have to get you back on every year just to remind them about that. I wondered if we might... We're going to talk about a few things today, but I thought we might just start with what's the current state of cardiovascular disease?

Dr Ross Walker: [00:01:22] Well, it's still the biggest killer around the world. Kills close to 18 million people per year. In Australia alone, one person dies every 20 minutes from some form of cardiovascular disease, and the commonest form of cardiovascular disease is what we call atherosclerotic heart disease. So basically, if you imagine a doughnut with a hole in the middle, that's where the blood is going. But all the fat sitting there in the wall for decades before eventually that big fatty plaque ruptures internally. A clot forms, blocks the hole. Then you typically have what we call an acute coronary syndrome, heart attack, angina, or even sudden cardiac death. So this is the most common condition, and it has been made worse by COVID and all the aspects of it around COVID, including the vaccination.

I really want to get into a conversation too much about vaccination, but it's more... COVID is the problem. And COVID has really made cardiovascular disease worse for so many reasons that we can get into we as we keep talking.

Dr Ron Ehrlich: [00:02:25] Hmm. And age range, where is the risky range? You know, is there a risky range?

Dr Ross Walker: [00:02:32] Yeah, there is a risky range. And the greatest risk for all conditions is getting older. So whether we're talking about heart disease, whether it's cancer, obviously Alzheimer's, diabetes, osteoporosis, all of our autoimmune disease, all of that, common killers occur as we get older. But for cardiovascular disease, really, once a male hits 50, a female hits 60, that's when the risk typically starts but there's always the outliers. We often hear about somebody who's had a major heart attack in their forties and let me make the point here, and I think this is a really key point for all of these discussions. All disease is genetic. It's all genetic now and a lot of people think all that means if my dad had heart disease, then I'm going to have heart disease or there's no one in my family with heart disease, therefore I won't get it. That's too simplistic and a lot of... People don't realise we are all 99% identical in our DNA makeup, but one DNA molecule is 3 billion chemical pairs. It's about two metres long. When you string it out, it's got to be bent, turn and twist into a little dot you can't see with the naked eye. So 1% of 3 billion, which is the difference we all are, unless we're all identical twins, is a hell of a lot. And so therefore, as far as cardiovascular disease goes, we've already mapped over 300 different genes for cardiac function, cardiac disease, etc... So for example, if you inherited 200 out of 300 lousy genes, you'll probably get cardiovascular disease in your fifties with the right environmental stimulus. But if you only inherited 50 of those 300 genes, you might never get cardiovascular disease or well into your eighties or nineties. So I've got families where say there's five siblings, three have vicious heart disease and two don't because of the coin toss. So those different individual genes that have set some people up for vicious disease, some people up without it. So I always say it's your genes that loads the gun, it's your environment that pulls the trigger and nothing is more certain when we're talking about cardiovascular disease, cancer or any of the other diseases.

Dr Ron Ehrlich: [00:04:45] Yes. And that actually is an interesting throw. Well, it's not a throwaway line, but a line which often people don't go on to... Doctors often don't go on to make that second statement, oh, it's genetic. It's often that is the explanation that is given. Oh, it's genetic. Yeah. To your point, there's this wonderful thing called epigenetics, and that is how our genes express themselves.

Dr Ross Walker: [00:05:10] Absolutely. And this is a game where people don't understand genetics. When you talk about genetics, people think this is a fixed thing that you can't control. Nonsense. Yes, less than 5% of our genes are fixed. So what makes Ron Ehrlich the incredibly handsome man that he is? What...

Dr Ron Ehrlich: [00:05:26] That's why I love to have you on, Ross. I need this once a year.

Dr Ross Walker: [00:05:30] And me, make look like me.

Dr Ron Ehrlich: [00:05:32] Also handsome... No doubt, but there we go.

Dr Ross Walker: [00:05:35] That we can do nothing about that. But the 95% of genes are either activated or inactivated by environmental stimuli. And this is another thing. When your gene is activated to do something or suppressed to stop it from doing something, those effects typically hang around for two or three months. So, for example, if you have an enormous period of stress in your life, then you will activate a set of stress genes which hang around for two or three months. So to go away for a week in the middle of that is not really going to fix the stress problem up at all. It will take a few months for it to work out and a lot of people have a time when they get more symptoms, or they get more issues for a few months, then they seem to improve and that's typical of how genes work. And when we talk about genes lighting the gun environment, pulling the trigger, I give two incredibly good examples. One with coronary calcium scoring, which is basically a CT scan that takes a snapshot of your arteries, measures how much muck you've got. So zero is what you want. 1 to 10 is trivial, 10 to 100 is mild, 100 to 400 is moderate. And above 400, I always say rather flippantly is don't read Tolstoy.

Dr Ron Ehrlich: [00:06:49] I repeat that so many times, Ross and it's haunted me since you said at ten... You told me that he is and he's got... Give us the scores again. Zero is fine. 1 to 10 insignificant.

Dr Ross Walker: [00:06:59] Yeah. And 10 to 100 is mild. 100 to 400 is moderate and above 400 serious. Based on your age so, for example, if you're an eighty-year-old, the average calcium... Coronary Calcium Score eighty-year-old is about five or 600. But if you're a 50-year-old, you want it to be zero. And 50% of 50-year-old males have zero scores, but 50% don't. And let me tell you two anecdotes. These are not clinical trials, they're stories. The worst Coronary Calcium Score I have is in a 68-year-old man in the fitness industry, doesn't have an ounce of body fat, normal cholesterol, blood pressure, never smoke, not diabetic, no family history. So on Framingham Risk, which is the standard risk calculator we use, or the American Coronary risk calculator, etc., etc. There's so many of them. But all those risk factors where you just use standard risk factors, that man is at very low risk for disease. His Coronary Calcium Score was eight and a half thousand.

Dr Ron Ehrlich: [00:07:58] Wow.

Dr Ross Walker: [00:07:59] Now why? Because he had an elevated Lipoprotein Lipase, which you know all about.

Dr Ron Ehrlich: [00:08:05] Well I do, I do but hang on let's not assume everybody listening to this does.

Dr Ross Walker: [00:08:10] Okay, so Lipoprotein Lipase is the cause of one in five cases of heart disease and it doesn't care how you look after yourself. If you follow 100 people through their lives who have elevated Lipoprotein Lipase, the number doesn't matter. It's either just above normal or below normal. So if you follow people with above-normal Lipoprotein Lipase levels, they have about a 70% chance of having a vascular event throughout their life. So 70 will have an event. 30 what? Now the reason for that is... lack of Lipoprotein Lipase is an LDL molecule hooked up to a thing called an apolipoprotein, lipo A protein. Which of these four for what we call kringles, that can thicken your blood, so the LDL puts fat in your arteries, the kringles

thicken the blood, but some people have large LDL in their head and it's my hypothesis that some people have large LDL in the head of their lipase A that don't have much in the way of vascular disease. If you've got small LDL in the head of the Lipoprotein Lipase A molecule they're the people who go on to have significant vascular disease. So anyhow, back to my man, 68-year-old man with the eight and a half thousand score he presented with angina, we did a stress echo quite abnormal, severe coronary disease, needed bypass surgery about ten years ago. A few years ago, he sent me an email with a picture of him and his mates winning their latest basketball grand final. But had he been a profligate self-abuser, he probably would have died in his forties because he had such lousy genetics. Story number one.

Dr Ross Walker: *[00:09:21]* Story number two is one of my best mates who's a brilliant surgeon, but he has no discipline outside the operating field. He's diabetic, he's hypertensive, he's significantly obese. He's on 20 pharmaceutical pills for his diabetes and hypertension. He hits himself with insulin a couple of times a day. He's nearly 70 and he's... At the age of 70 his Coronary Calcium Score is zero.

Dr Ron Ehrlich: *[00:10:10]* Wow.

Dr Ross Walker: *[00:10:12]* Because he has rock-solid genetics as far as his cardiovascular system goes, that doesn't justify his obesity because his body's a wreck from obesity. And he's a human vacuum cleaner in the way he eats. He just loves to eat foods. But that aside, he has... He probably won't have a heart attack. Now, you'll have some people in the cardiology world say, I know, but if you've had a CT angiogram, you could still have a blockage. So CT angiography is better than coronary calcium scoring. No, it's not. A CT coronary angiogram, you squib someone full of dye. The difference is that the Coronary Calcium Score costs around \$200 not covered by Medicare. The CT coronary angiogram, if you have no symptoms, is not covered by Medicare. It's about \$1,000. \$800 to \$1000. It's a much higher radiation dose for most machines. It's an intravenous injection. You can have an anaphylactic reaction to or can even damage your kidneys. And you typically need a beta blocker before the test to slow your heart down. So it's a much greater field. It's a much greater imposition.

And a big study in 2006 in the journal the American College of Cardiology showed that the Coronary Calcium Score was actually a better long-term predictor than the intravenous CT coronary angiogram. So the question I asked to all of my colleagues, why on earth are you doing this at the moment as a screening test for heart disease when you could just be doing the simpler, cheaper, a safer coronary, calcium score? And of course, one in 500 people might have a blockage with a zero score. That doesn't justify the other 499 with the extra expense, the radiation, the potential reaction to the dye. So the Coronary Calcium Score is the way to go. So every case is individual. You can't look at anyone run and say, you look terrific. So therefore your arteries are going to be great. It just doesn't work like that. And in my professional talks, I have a picture of Winston Churchill and Jim Fix. Winston Churchill smoked, drank, was overweight and depressed, died at 91. Jim Fix, read the complete book of running and he dropped dead in a race at 53. Didn't have an ounce of body fat. But again, Jim Fixx had a heart attack at 32. Really bad genetics. So it's how we manage our genetics is a real, real key here. Genes loads the gun, environment pulls the trigger.

Dr Ron Ehrlich: [00:12:33] You've said so much there. And I should add for my listener that you have been talking about coronary calcium CT score is the gold standard in cardiology for 20 years?

Dr Ross Walker: [00:12:45] We introduce that... The Sydney Adventist Hospital. Dr David Gratton myself introduce this test into Australia, went for this in 1999, So I started investigating this in 1997.

Dr Ron Ehrlich: [00:12:58] Yes.

Dr Ross Walker: [00:12:59] And it's... I saw a patient the other day who said to me, my general practitioner hasn't heard of Coronary Calcium Score. Yes. Another patient said to me the other day, a different patient said, My general practitioner doesn't believe in Coronary Calcium Score. How much arrogance is that? A general practitioner demeaning a test that they have no understanding of where there's there's thousands of papers now in the peer-reviewed literature showing the benefits of this test, and a GP says to a patient, I don't believe in that I'm in... Sir, or I've never heard of that.

Dr Ron Ehrlich: [00:13:32] Yes, yes. Well, they're probably the ones that also say it's all genetic. Don't worry, there's nothing you can do about it anyway. And that is not a common, uncommon statement to be made. Listen, you know, how do you measure Lipoprotein Lipase A? Is it a part of a standard blood test?

Dr Ross Walker: [00:13:49] It's not a standard blood test. It has to be asked for. And at the moment, the government is not give you any Medicare compensation for it. So you still have to pay. I think it's anywhere between \$40 to \$70 depending on the laboratory for the test. But here's the interesting thing from the medical profession have just started to show some interest. I've been measuring Lipoprotein Lipase A for even longer than I've been doing coronary calcium scoring, so I've been doing for the last 25, 30 years, measuring lipase A . And no one has been speaking about it until the last two years. Now, come on, be cynical. Why are doctors starting to show some interest in this Ron?

Dr Ron Ehrlich: [00:14:26] Go on. Is there a medication for it?

Dr Ross Walker: [00:14:28] Yes. How did you know that? Oh, yes, I've been using for the last 25, 30 years the combination of vitamin C, vitamin E and lysine, which doesn't change the level at all, but coats the molecule and stops it getting into arteries. Now, I can't give you any randomised controlled clinical trial of this because it hasn't been done, But a fellow called Linus Pauling, a fellow that he puts in the history of the world, has won two unshared Nobel prizes, was speaking about Lipoprotein Lipase A like 30, 40 years ago and talking about the benefits of C, E and lysine and even uses prolin. But I've been using a standard dose a couple of grams a day of vitamin C, 500 initial units of either natural vitamin E or even now better we have the tocotrienols and also just 1000 milligrams of lysine, which is a harmless amino acid. And I use nicotinic acid, which is an interesting thing. Because nicotinic acid, I've actually started taking it myself and I've got it... I'm nearly 67, I've got a zero calcium score and that's just pure genetics and not boasting about it. But I've started taking nicotinic acid myself as an anti-ageing drug because we all know about the wonderful work of David Sinclair, who talks about the NAD plus derivatives, of which nicotinic acid is one of them.

So I've had a lot of my patients with a high lipase A I who I've had on nicotinic acid for many years, and they just keep on keeping on and still look very young.

Dr Ross Walker: [00:15:53] And I tell another... This is another interesting anecdote about Lipoprotein Lipase A. One of my best friends is a Jesuit priest, and I'm not even Catholic. I'm married to a Catholic, but I'm not a Catholic. And he taught my sons at Riverview. His brother died at 48, his father died at 48. Both had a high Lipoprotein Lipase A. I've been looking out for this man now for about 26, 27 years, and I study on nicotinic acid 26 years ago. He has a high calcium score. He's never had a vascular event. And he's... We recently celebrated his 90th birthday. I take him out for lunch once a month and he waltzes into the car, sits down, waltz in the restaurant. We have an engaging conversation and you look at the guy and you say, he's not 90, but he's 90 years old friend. And I'm not saying it's only because of nicotinic acid. That's one part of it and this is the... To put it on... This whole thing in perspective, 80% of anyone's management is how they look after themselves. As I said, my God, the 8 and a half thousand score, had he been a profligate self-abuser, he wouldn't be alive. So all of us need to practice the five keys, which you and I have spoken about. No addictions, good sleep, good eating, and less of it. 3 to 5 hours of exercise. Most importantly, happiness. That's 80% of all of our managements. So I said in my patients don't come in to see me with the big fat gap or the fag hanging out of your mouth and expect that the crystal is going to do anything to your health. So 80% lifestyle, 10% is the appropriate use of pharmaceuticals, which I'm not against at all, and 10% is the appropriate use of evidence-based supplements that just getting back to Lipoprotein Lipase A. Like in the last couple of years there have been two different types of drugs. There's a thing called an anti-sense oligonucleotide that works on the production of LP that lie in the liver, which is where clearly it's produced. And this is a monthly injection that Pulverises Lipoprotein Lipase A. And then one of the Australian experts on cholesterol, Professor David Sullivan from Prince Alfred Hospital in Sydney, has been involved in a worldwide trial of a different type of drug called a small interfering RNA molecule. That's a six-monthly injection that Pulverises LP lipase A down by about 70 to 80%. Now those drugs are not available on the market yet, but over the next few years will emerge and may be a game changer for LP lipase A but may not.

You see, the point is just by lowering LP lipase A doesn't mean that you affect the long-term clinical output. So I'll give you one example is a new drug called Repatha, which is a monoclonal antibody that's used to lower LDL cholesterol. Now that that powerfully lowers LDL cholesterol but when you look at the relative risk reduction in these... In the people who are given Repatha, the relative risk reduction is 15%. So when you look at the trials, just say there's a 30% ten-year risk, that 30% ten-year risk is lowered to 28.5%, which is a 15% relative risk reduction. When you think about it, that's not that powerful. But if you're a 30% ten-year risk is reduced with lifestyle, the five lifestyle case, that's an 80% reduction, say you're taking your 30% down to about 3 to 5%, I mean seriously. So you're prepared to inject yourself once a month to get your relative or your absolute risk down 1.5%, but you're not prepared to put in the lifestyle. Yeah. So I just don't get it.

Dr Ron Ehrlich: [00:19:28] Well, you've raised something there, which is a really interesting one. The difference between not just in this drug but in general, the difference between a relative risk and an absolute risk, because I know, for example, that Lipitor has a relative risk reduction of 36%, which is very, very impressive.

Dr Ross Walker: [00:19:49] Yep.

Dr Ron Ehrlich: [00:19:49] You know, except when you see what that... I wonder if you could just give us relative absolute risks 101 so people might understand what the difference is.

Dr Ross Walker: [00:19:59] What's very simple. It just really depends on the population you're looking at. So, I'll give you an example that if you look at, say, the drug Nexium, which is a PPI to control acid production in the stomach, it just switches off as a production. But it's been shown in studies that people who take Nexium have a 40% higher risk of dementia. But the reality is that if you look at the risk of a 65-year-old getting dementia, it's probably about over a ten-year period around 10%. So if you increase that by 40%, you take it from 10% to 40%. So it puts it in perspective. Now I'll give you another great example. The lifetime risk for bowel cancer is six per 100 people per year. If you then have a piece of delicatessen meat or a bacon every day of your life, you increase your risk for bowel cancer by 17%,

But the absolute figures are you take your risk from six per 100 people per lifetime to seven per 100 people per lifetime. So the risk you can make things sound really bad or really good. So for example, there was a wonderful study done by a professor of Valin's from Philadelphia looking at the stent and benefits when you look at it based on coronary calcium scoring. So if you have a Coronary Calcium Score of zero, there is zero benefit from being on a statin. If your Coronary Calcium Score's below a 100, there is no statistically significant benefit. So rather than saying there's a 20% reduction or whatever, they look at the number needed to treat. So the number needed to treat, if you've got a calcium score below 100, you've got to treat 100 people for five years to prevent one heart attack with no difference in death rate. So the person might have a minor heart attack. So the stent and benefits, there are not that good. Once you get above 100, then the number needed to treat is only 12. That and that's highly statistically significant. A p-value less than .00001 so a number of nutrients... So this whole thing about somebody goes into a doctor in their fifties and their cholesterol seven their HDL is 2.5. They triglycerides 0.7. That's a very balanced profile. They've got a zero Coronary Calcium Score. And the scaremongering doctor says to them, if you don't take Lipitor, you're going to die. Really, there's no evidence you might lower their risk for cardiovascular disease. Well, if it's a zero score, you won't lower it at all. But even if this score was 60 or 70, which is in the mild range, you're taking the risk from maybe a predicted risk of 5% over ten years, which we consider in the low-risk range down to 4%. So who in their right mind would take a strong synthetic metabolic regulator like a statin for ten years to reduce the absolute risk for a vascular event by 1%, whereas when your doctor says, Oh, we can reduce your risk 20, 30% that sounds really dramatic, but even if your ten-year risk then is, say 50%, just say yeah, all the balls are stacked against you, you have a lousy lifestyle, you've got every risk factor in the book. Your father died at 50. Your Coronary Calcium Score's 500. Your cholesterol's through the roof, You smoke. So your ten-year risk for a heart attack is about 50% so going on to an average Joe statin will take you down by about 20%. A high dose of Lipitor or Crestor might take you down 30, 40%, but just say it's 20%. So if you're starting risk is 50%, reducing that by 20% is only 10% because 20% of 50%. So you take your risk from 50% to 40% it's not that good.

Dr Ron Ehrlich: [00:24:06] No. No.

Dr Ross Walker: [00:24:07] Throw lifestyle in there, then it becomes powerful.

Dr Ron Ehrlich: [00:24:10] Yeah, well this is again what you were... Oh and just before I forget because I want to ask the Lipoprotein Lipase A is something you would fill out on your... On the path... Pathologies when you're getting your LDL, HDL cholesterol, you ask for little and you will end up having to pay extra for it.

Dr Ross Walker: [00:24:27] Yeah, yeah, yeah.

Dr Ron Ehrlich: [00:24:28] But it's there. It doesn't really need...

Dr Ross Walker: [00:24:29] You only need it done once.

Dr Ron Ehrlich: [00:24:30] Once, okay.

Dr Ross Walker: [00:24:32] Unless... Until these new drugs come out where we want to see the reduction, you just want to know whether it's high or low. If it's low, forget about it. It's not a risk factor. You don't need the CCA in lysine.

Dr Ron Ehrlich: [00:24:41] Yeah. And the other thing was, you mentioned nicotinic acid, which is B3?

Dr Ross Walker: [00:24:46] Yep.

Dr Ron Ehrlich: [00:24:47] Nic... What's the difference between nicotinic acid and nicotinamide?

Dr Ross Walker: [00:24:50] Well, nicotinamide is pretty weak. And there's a study that at a Sydney university a few years ago showing 5 to 10 milligrams Bd of nicotinamide reduced non-melanoma skin cancers by about 30%, but it doesn't have a profound systemic effect, whereas nicotinic acid is a pain in the butt to take. So if you... So, I took mine this morning, went

up for a coffee and by the time I'd got to the coffee shop my face was bright red, lasted for 5 minutes, went away. I couldn't care less. I want to get the anti-ageing benefits. So it is difficult to take. So I say to my patients who got cardiovascular disease, I like to get them on to a gram a day. I'm only taking 250 milligrams a day per gram. A gram a day is the good dose but it's short-acting. Flushing is the big issue of flushing and maybe a bit itchy, depending on your response to it. But I've got patients with a high LP lipase A have been on this for 20 years... Oh, I have one guy and he loves taking it. He says I take four twice a day because I've read the evidence and he just keeps on keeping on. He had a Coronary Calcium Score 23 years ago of 1500. He's never had a vascular event. So again, I attribute a lot of that to his lifestyle. A bit of it to nicotinic acid. So nicotinamide, I wouldn't use it all. Nicotinic acid is a powerful... It's a pharmaceutical drug. Nicotinamide is a supplement. Different.

Dr Ron Ehrlich: [00:26:16] Right. Right. And nicotinic acid needs prescription?

Dr Ross Walker: [00:26:20] Sort of.

Dr Ross Walker: [00:26:21] Yeah. I mean I give my patients a prescription for it but you can actually buy it over the counter if you want to. So it's... And I say to all people, if you go to buy supplements or you go to buy medications, get them in Australia, don't order them on the Internet, you don't know what you're getting, especially American supplements. A lot of them are contaminated and what it says on the bottles, not off in the bottle, whereas Australian stuff is made to pharmaceutical grade.

Dr Ron Ehrlich: [00:26:46] Hmm.

Dr Ron Ehrlich: [00:26:46] And, and does that flushing reduce with time? Or is that something? Kind of...

Dr Ross Walker: [00:26:51] It's weird. It does to some extent, but I know myself that all have the same breakfast and swallow the pill at the same time. Somedays I don't flush. Other days I do and I have no idea why. But it doesn't matter if it lasts for five or 10 minutes and it goes away. Your face goes red, I mean, you'd see now my face isn't red.

Dr Ron Ehrlich: [00:27:09] No.

Dr Ron Ehrlich: [00:27:10] And when you talk about... And I think this is worth mentioning and I know you went through those five... Those five things that I love you relating... When you say genetics loads the gun environment pulls the trigger. What we're talking about environment is nutrition the way we think, the exercise, the whole thing. It's not just the chemicals, the air out in the environment. We need to be very clear about that.

Dr Ross Walker: [00:27:34] But you write, you wrote a wonderful book about this a few years ago. What's the name of the book Ron?

Dr Ron Ehrlich: [00:27:38] A Life Less Stress, The Five Pillars of Health and Wellness.

Dr Ross Walker: [00:27:42] Absolutely. And it's very, very similar to that stuff. But let me make the point. I've been practising medicine now for 40 years and I've not seen one person in 40 years who had a heart attack, stent bypass or a stroke who wasn't under some form of stress at the time it happened. But it's not just... Everyone thinks stress is just "I'm upset. I've just broken up with my partner or whatever.". None of that. There are five categories of stress. Let's go through those because they are really important.

Dr Ron Ehrlich: [00:28:11] Mm-hmm.

Dr Ross Walker: [00:28:12] Within 2 hours of you getting acutely angry or anxious about anything, you increase your risk for a cardiac event by eight times. So any emotional stress can do it. You're under the pump at work. Mental stress. So was a thing called the Whitehall study, which is a long term study. Links 23,000 British civil servants have been monitored for the last 30 years and it found there's a thing called job strain, which is high demand, low control. So the bosses didn't cope with it. The middle managers did. And so when you're under the pump at work, when there are holiday deadlines or you're feeling stressed by the mental aspects of your

job. That's number two. Number three is physical stress. Now, I talk about exercise as being the second-best drug in the planet, and the evidence shows clearly that it is after happiness. But excessive physical stress, especially under excessive extremes of temperature, can be a problem. So I'll give you an example. I had a guy in his late seventies who thought it was a good idea on a 45-degree Celsius day to play singles tennis, ended up with a stent in his arteries. And I had a woman who in May thought she'd go for a jump in the ocean. Freezing cold water, jumped in, had a heart attack. Now, cold water, swimming is incredibly good for you, but not if you're not used to it. So again, extremes of exercise. So, for example, there are people run wide for those who run marathons. Now, I tell them there's a perfectly good bus service. Why anyone would do that is beyond me. But they did a study at the end of the Boston Marathon where they measured troponin levels, indications of cardiac damage, and also did echocardiography on people throughout the Boston Marathon and found that a third of people had evidence of heart damage after running a marathon. So you don't push yourself too hard. But also it's extremes of pain or an operation can do it all. You mentioned nutrition, even a heavy meal for some people can be enough just to tip them over the edge.

Now it's not going to happen to all of us, but if someone's got a huge big fatty box sitting the wall, their arteries and they go out and overindulge one night with too much grog or too much whatever. That can rupture a plaque and cause an issue. So number three is physical stress. Number four is pharmacologic stress. So I'll give you a couple of good examples. I had a guy in his mid-thirties. We thought it was a good idea to have three double-shot cappuccinos in an hour sends his heart into overdrive. I'd another guy in his thirties with a strong family history of heart disease went out in a buck's night one night, had a few lines of coke. Major heart attack wiped out half his heart. So any legal or illegal stimulant to do it. People think, "Oh, marijuana's safe. We should legalise marijuana." No, we shouldn't. Now I'm on the board of a company called MGC Pharmaceuticals who are developing and researching medical cannabis around the world. Different issue. But within 2 hours of you smoking a joint, you increase your risk for a heart attack five times. So when people tell me marijuana is harmless, it's okay to do it. No, it's not. You should not smoke anything. The lungs are meant for two things. Run them in for asthma sprays if you've got asthma.

And for another interesting thing called breathing. Not to put a stick in your mouth and smoke this... The stuff in your lungs, that's just ridiculous. And then finally, in this pandemic era, infective stress. So you might be going along. Okay, Then you get COVID when you've got a few plaques in your arteries. And the COVID can inflame your arteries, as can influenza. As of getting back to your especially as can a tooth abscess or even just bad periodontal disease, urinary tract infection. All of these things can inflame the arteries and set you up for heart disease.

So those five categories of stress, emotional, mental, physical, pharmacologic and infective stress are the precipitants of acute events. So, I have always seen a precipitant of acute event. I've never seen someone know... I'm sure there's an occasional case out there, but I've personally never seen someone in 40 years of practising medicine who was feeling happy and contented at the time and not under any stress, who went on to have a heart attack. There's got to be something that... Imagine that big fatty plaque in the wall, something that squeezes the pimple and makes it go "pshh" there's your heart attack.

Dr Ron Ehrlich: [00:32:31] I've often thought of a stressor because most people just think of stress as an emotional stress as anything that compromises immune function and promotes chronic inflammation. Is that a fair statement, do you think?

Dr Ross Walker: [00:32:44] Well, I think there's two... That's a pretty good definition. But there's two components to stress. There's well, as a few copays, but there's biochemically there's the release of adrenaline, which is the acute response to stress, and that constricts arteries and impairs blood flow. And also... It also puts pressure around a plaque. But the other component is, of course, the long-term release of excessive cortisol and cortisol weakens the lining of blood vessels and as you so rightly say, weakens the immune system. But then also when people are stressed, they're less inclined to practice the five keys are being healthy. I mean, if you are incredibly stressed, who's going to come home and sit in their exercise bike for a half an hour? Or who's going to say, Look, I'm feeling really stressed, but I'm not going to have that extra drink tonight because I know it's not good for me.

So they're the two components, it's the physiological pathophysiologic effects of stress in the body. But it's also the fact that when you are stressed, you're not really maintaining a good, healthy lifestyle.

Dr Ron Ehrlich: [00:33:47] Mm-hmm.

Dr Ron Ehrlich: [00:33:48] You mentioned, infect., an infective stress and this brings us to something that we've all been dealing with over the last two or three years, and that's COVID. Tell us how you are seeing that, you know, infection impacting on our health.

Dr Ross Walker: [00:34:05] Well, I think it's impacted profoundly on our lives and on our health as well. I have a lot of an armchair criticism for how the pandemic was managed by the authorities. I think there's been a lot of nonsense put out there and also a lot of health commentators, and I won't mention any particular names who are just ridiculous scaremongers who want people to be fearful about COVID. And there's just this horrible condition. There's no doubt in my mind. Again, I usually typically use five because it's a simple way of thinking.

Dr Ron Ehrlich: [00:34:36] And we've got five fingers.

Dr Ross Walker: [00:34:38] Five, we've got five digits, five senses, five seasons, if you count Frankie Valli. So everything's five. So with that, with the five category of people who get severe COVID, the very old, the very sick with other conditions, the very overweight, people with severe insulin resistance. So for example, in the US, the Latinos and the African Americans had three times the death rate compared with the Caucasians and I think part of the reason is that was severely insulin resistant, allowing the ice receptors. So when you're insulin resistance, you have more ice receptors in the body's ice2 receptors, which is how COVID gets to the body. And finally, occasional, people who have rare genetic abnormalities. So, for example, two brothers in Holland developed severe COVID in their thirties. One of them died. Another one became very ill and had to go on a ventilator in their thirties. So they met their entire genome and they found that both these brothers had a defect in a thing called TLR seven, which is toll-like receptor seven, which is a vital immune checkpoint for how we

respond to viral illnesses. So they didn't have that ability.

Dr Ross Walker: [00:35:51] So in my own personal example, I had COVID... I had four vaccinations and then I had COVID last July and I had a minor illness with COVID and got over it. But my body loves influenza, absolutely loves it. I hate it. And I probably in my life had ten really bad episodes of influenza also to the point where I had an anaesthetic for a ruptured Achilles tendon about 15 years ago. A week later, developed influenza A and was close to death with that, I had such a bad illness because my body doesn't respond well to influenza. So if I don't get the flu vaccine every year, I come down like a ton of bricks with influenza. But the 90-year-old Jesuit priest I was telling you about told me that he's never had influenza in his life and he's never had a flu vaccine. Much to my disgust but that aside, it's just we're all different and so... We found with COVID, it is having a profound effect on the heart. A study out of the US of 150,000 war veterans found that 50% of the war veterans say they were certainly in the older group had some cardiovascular complication in the 12 months after COVID, so not during COVID. Some of them did, of course, but it might be three, six, 12 months later. But there was a higher incidence of cardiovascular disease versus people who didn't have a history of COVID exposure. And I must say, however, on that subject of COVID exposure, in a country of 25 million people, I suspect we've all been exposed to COVID, and I think probably about 80% of the population have had COVID, whereas it's only been reported, I think about 14 million Australians have actually reported having had COVID. So I think most of us have been exposed and there are some people that just have a really great immune system that just blocks out the disease and don't get sick from it, but other people do.

Dr Ron Ehrlich: [00:37:42] Hmm. You know, it's interesting because when the pandemic struck in 20, early 2020 and all the vulnerable people were identified, you've identified them old, sick, overweight, insulin resistance. Let's just focus on those four, because genetics is not much you can do about it. I thought this was just such an incredible opportunity to engage with the population about preventive health. I mean, you have all of these diseases which have a long timeline. And so you can talk about, you know, diabetes, not good for you. But if you're going to die in the next week or two, you better get on top of your health. What a great time to do that. What a missed opportunity.

Dr Ross Walker: [00:38:26] Yet you have just made a beautiful point and I think this needs to be made about COVID. I think what COVID has done is just you've got the car balanced precariously on the cliff and COVID just pushed it over.

Dr Ron Ehrlich: [00:38:40] Yes.

Dr Ross Walker: [00:38:41] And it's the same thing with people's health and the authorities didn't want this message to get out there. But I'll say what happened at a certain hospital in Sydney, I won't mention the hospital. Two young men in their twenties died from COVID. One was 280 kilos, the other was 230 kilos. That's a huge commitment to eating and they didn't want the message to get out there because they didn't want people to think, Oh, what happens in fat people's cells? It can happen to me. So therefore they'd think, Oh, people weren't going to be vaccinated. People won't wear their masks or they won't, they won't keep isolated. They'll think it's only other people who get the condition. But you see as many people who mightn't be grossly obese but are still eating poorly and they're still smoking and they're still not doing all the right things. A great opportunity, as you say, to get the message out there. But people, human beings, have the attention span of a gnat. What happened yesterday was forgotten because I don't know what happened yesterday. It says. And so this is the problem with COVID. We did waste the opportunity but whether it was going to happen, that people are going to take it on board anyhow, who knows? And in my patients... I have in my practice, I've got two groups of patients. I got people to listen to my advice and people who doubt the people who listen to my advice, nothing ever happens to them they just become long-term mates among. The people who don't listen to me, whittle away bits of their heart to the premature death. And you know what? But it is a personal decision. It's a decision you make. You say, okay, and I'm just over my shoulder here. I've got my exercise bike. I've broken three exercise bikes in 16 years since I gave up sport because of a crappy knee. But most people buy an exercise bike and it sits in the storeroom never, never being used. Now, I'm not saying I'm wonderful because I use it, but it's just called discipline. Napoleon Hill wrote a book about 100 years ago called Think and Grow Rich, and he wasn't talking about money. He was talking about growing rich in your life. And two success principles, discipline, perseverance.

That's it. I don't believe in 12-week programs. I believe in doing something for the rest of your life and getting into a habit of doing things and that's the way to be successful in your... Not just in your working life, but in your personal life and in your health as well. And again, COVID was a wasted opportunity because many people, apart from the very elderly and obviously there's nothing to do about being very elderly apart from accepting it, but people were very sick or insulin resistant or whatever. And a third of Caucasians are insulin resistant. 50% of Asians and close to 100% of people with dark or olive skin are insulin resistant. But you can still do something about it. It's not as if, oh, I'm insulin resistant. That's why I'm overweight. No, you can eat less food, you can eat better quality food, you can do more exercise and you can take certain supplements that can help. So there are so many things you can do, but many people didn't do them. I'm talking about COVID there's the whole discussion of vitamin D.

Dr Ron Ehrlich: [00:41:27] Hmm.

Dr Ross Walker: [00:41:27] Now, vitamin D is something that a third of Australians, as you know, have low levels of vitamin D, And a number of the studies have said that people with the best levels of vitamin D had lower rates of COVID, COVID complications, COVID death. So what did they do? People go to hospital with COVID. They give them big dose of vitamin D. How stupid is that? Because you've missed the boat and it would take a few months for that vitamin D to ingrain into the genetic system to start improving the immune system. So all of us should be having at least 2000 units daily of vitamin D. Study came out last year. 25,000 people followed for five years. Those who took this is a placebo-controlled trial, two vitamin D a day, 2000 units. A 25% reduction in autoimmune disease. Other studies have said you get your vitamin D level around 100. Low rates of COVID, COVID complication, COVID death. So the evidence is all there.

Dr Ron Ehrlich: [00:42:45] But Ross, you know, this is what's so frustrating. I mean, I was president of the Australasian College of Nutritional and Environmental Medicine in 2020, and together with Ian Brighthope, we wrote letters to the TGA, the AMA, the NHMRC, sending them so many articles. I mean one that comes to mind is from the Journal of Endocrinology, which showed that 70% of people in ICU in intensive care

units were found to be severely deficient in vitamin D, So so the evidence was there and we said as a simple measure, just even in aged care and those that are vulnerable give them vitamin D, You know, you mentioned C, I also mentioned zinc, which I think has a place in viral as well. And as I said, just as a simple measure, do that as a preventive measure. I'm sorry, Doctor Ehrlich, there's no evidence to support any of that having an effect on COVID. And yet, when the antivirals from Merck Molnupiravir and Pax lovid from Pfizer, came out with two studies, immediately rushed through TGA. Yes, let's put it out there. Five or 600, \$700 for a five-day course. I mean, you know, this was part of I mean, the issue of myocarditis is one that has come up as a response to both COVID and in terms of adverse reaction to the novel, novel experimental mRNA vaccines. What are your thoughts about that?

Dr Ross Walker: [00:44:14] Okay. Well, can I make an analogy here with measles? If you put measles through a group of children, one in a thousand will get a complication known as subacute sclerosing panencephalitis, which is as bad as it sounds. And that child is often left intellectually disabled for the rest of their life. If you then vaccinate a group of children, one in 10,000 will get the same thing. So the reality is that measles is ten times worse than the vaccine, but the vaccine is not harmless. And this is where I think people need to put this in perspective. The rates of myocarditis are ten times worse with COVID than they are with the RNA... the experimental, as you say, RNA vaccines. And you can even get myocarditis with AstraZeneca or with Novavax. You just don't get it as often as you do get with Pfizer or Moderna. But I've got to say in my own practice, so a private cardiologist seeing a number of people every day over the past three years, I've probably seen well over the past two years since the vaccines have been out, I've probably seen about 100 people who've developed cardiac symptoms after getting the RNA vaccines. I've not personally seen one case of full-blown myocarditis. Now, what's the difference? You see, everyone thinks I've got the disease or I don't have the disease. Now it's a spectrum from normal to severe disease. So in severe myocarditis, your heart instead of pumping like that is pumping like that. So we have a measure called ejection fraction, which is the efficiency of heart function. A normal ejection fraction is about 60% severe myocarditis. You might get down to below 20%, below 15%, getting close to needing a heart transplant.

I've never seen that with the RNA vaccines and it's the reported incidents, there's probably about four per million people vaccinated get that degree of myocarditis. But I've seen a number of people, probably around 100 who get chest pain, shortness of breath, palpitations, dizziness, very soon after being vaccinated. And they occasionally have what we call a troponin rise. So elevation of cardiac damage. But when you look at their heart on an echo, it's working fine. So the heart's still working okay. But I still think there is a degree of subtle damage to the heart, which most people in my experience, recover from.

Dr Ross Walker: [00:46:39] So, yes, I think there's a concern about the RNA vaccines. Let's look at the numbers. 64 million doses of all sorts of vaccines given to Australians alone. So 25 million people, 64 million doses of vaccines, the rate of serious adverse events with the vaccination is about 0.2%, that's still 138,000 people. It's more people than fit in the Melbourne Cricket Ground. So it's a lot of people. But the reaction to COVID in terms of death and disability is much worse. So I still think we needed vaccination. I said from the start of the pandemic and I said from the start of the vaccination program, reading all the evidence in the New England Journal of Medicine, not on damn Facebook with people, put all this nonsense up. But in the New England Journal of Medicine, the evidence, in my view, still showed that the AstraZeneca was a safer and more viable vaccine than the RNA vaccines. And I had all these other people say, Oh, no, Pfizer is much better. Much you ought to give AstraZeneca to all people. You don't give it to younger people. But I thought the AstraZeneca was a safer vaccine. But still, I've seen people who've had problems with AstraZeneca as well. People have had occasional problems with Novavax, but I've seen more people with Pfizer. But much more people with COVID getting serious problems. And I've seen full-blown myocarditis with COVID. Haven't seen it with the RNA vaccines. So that's my perspective on that.

Dr Ron Ehrlich: [00:48:04] Mm-hmm. Okay. The... And long COVID. What are your thoughts on long COVID?

Dr Ross Walker: [00:48:11] Well, the thoughts are that the evidence is showing pretty clearly that about 10% of people who with a proven diagnosis of COVID, whether it's mild or not, get

long COVID. If you are hospitalised with this, it is about a 30% risk of getting long COVID. So if you've been in hospital with COVID, you've been on a ventilator. 30 to 50% of people will get long COVID symptoms. So what are the common symptoms are fatigue, shortness of breath and brain fog, they're the three classic ones. But even the taste problems, the smell problems, all of those issues that some people get the aches and pains in their joints and the gastrointestinal issues. So my thoughts are what? What is long COVID? What's the cause of long COVID? I think there's two things leading to the third thing. So firstly, and this is something you and I have spoken about for years is gut dysbiosis, and it's felt that the COVID virus pulverises healthy gut bacteria and it allows the overgrowth of abnormal gut bacteria. And I don't think that's being shown in a number of studies now that there's a huge link between long COVID and gut dysbiosis, because if you don't have healthy gut bacteria, you're not making those healthy post-biotics, which are the short chain fatty acids like butyrate, acetate, propionate they're the three common once putting these healthy chemicals into our bloodstream and also the end healthy chemical, which is coenzyme Q10 in the form of ubiquitin.

So gut dysbiosis, number one. So firstly, and you said it before beautifully about preventative health. Most people have lousy gut microbiota biota because they eat crappy food. So if you want to ruin your gut, bacteria feed it rubbish. This processed package, muck masquerading as food, something in a box or a container, rather than people who have two or three pieces of fruit per day, 3 to 5 servings of vegetables per day and you say, well, that's pretty doable. Sounds doable to have that. Less than 10% of people do that, Ron. And those who do have the lowest rates of heart disease, cancer, COVID complications just by having the fruits and vegetables. So we've got to get people back to eating healthy foods. And also taking healthy, high-quality probiotics and possibly now. Is these clever companies that are making try biotics so prebiotic, probiotics with post biotics as well so we're moving into that space to getting the high-quality stuff and there are some integrative GP's around who are now doing proper stool assessments for gut microbiota, not microbiome. So the difference is the microbiome is just mapping which bugs are in the bowel.

Dr Ross Walker: [00:50:49] The microbiota is looking at the function of the

bacteria in the bowel, how it's affecting the bowel, etc. and then directing therapies at that. But again, if you speak to conservative people in the medical field that this is nonsense, why would you bother with that? But, people are getting help from fixing up the gut microbiome, number one. Number two, the second theory for Long-covid is it's a reactivation of dormant viruses. So all of us as adults have been exposed to either Epstein-Barr virus. A variety of different herpes viruses one of the big ones that have been mentioned is this thing called HSV six. So when you think about cold sores and genital herpes, the herpes virus is one and two, but HSV six is a very common herpes virus that almost all children have had just as a minor viral illness, as children not even checked for it. And then what happens? They get COVID or they get infectious mono and they're in their twenties and it really activates stuff. Send them on to long COVID, because here's the interesting thing Ron, long COVID is very similar to chronic fatigue syndrome, Fibromyalgia, Myalgic Encephalomyelitis and hoon... And that could be this rare reactivation of the dormant DNA viruses, or it could be gut microbiota problems, all ending up with problems with your energy so people pulverising their Coenzyme Q10 stores. So what I'm doing for long COVID is I'm trying to get people back on to the fruit and vegetables on prescribing a really high-quality probiotic, which I'm not allowed to mention in these sort of forums. I'm also saying if people aren't getting better, they can possibly have their stool checked and sent off to a particular lab in Melbourne that checks the gut microbiota rather than just going to your local pathology and giving a stool spat...

Dr Ron Ehrlich: [00:52:41] I think that's... Is that are we talking about bio screen?

Dr Ross Walker: [00:52:44] Bio screen? Exactly.

Dr Ron Ehrlich: [00:52:45] Professor... Professor Henry Butt?

Dr Ross Walker: [00:52:46] Yeah, very appropriate last name Professor Henry Butt so that... So Henry's looking at the microbiota so I tell people to do that but also after getting people to try and improve their lifestyle, I give people typically, especially for the first month or so of long COVID, high doses of vitamin C, at least two grams a day. Some people push it even

further. At least 2000 units of vitamin D, possibly even more, warning to... Aiming to get their vitamin D levels at about 100. I give them a krill because I think it's a good natural omega-three anti-inflammatory and Kirkman and Boswellia. So my company, MGC Pharmaceuticals, the Medical cannabis company, we've done trials of a combination of Kirkman and Boswellia are showing some significant benefits with COVID and long COVID so, I get people on to that and of course, Ubiquinol all so I give them 300 milligrams of Ubiquinol all for the first month. And if they're feeling better, pull it back to 150 milligrams. And I'm a great believer in good ol Magnesium Orotate because the Orotate lifts the Q10 up in the Mitochondria as long as it doesn't upset people's guts is about ten... There's the thing about magnesium, it's a great supplement, but about 10% of people do get a gastrointestinal disturbance with it, so you got to make sure they don't get that. But if they don't get that, those things altogether, I think improve your immune system, get you gut healthier. There's not much we can do at the moment about fixing up the reactivated DNA viruses, although there's a woman in Germany called Dr Ursula Jakob that I have a peripheral association with, and she's doing some seminal work, on a very intensive program to try and kill the Epstein-Barr virus by really improving B and T cell immunity. But it's very expensive and it means a trip to Germany.

Dr Ron Ehrlich: [00:54:39] Hmm. Wow Ross we've covered some territory there. The future of medicine. Do you want to talk... It?

Dr Ross Walker: [00:54:44] Yeah. Well, look, I'm really excited about the future of medicine, because I think medicine is changing so much. And one of the lectures I give in... The circuit now is talking about the future. I think the big one is anti-ageing. So Professor David Sinclair, who actually just grew up in the north shore of Sydney, is now the world anti-ageing guru. He's a professor of anti-ageing at Harvard University. And I think his book, Lifespan, is one of the great health books of the time apart from yours, of course.

Dr Ron Ehrlich: [00:55:14] And yours...

Dr Ross Walker: [00:55:20] But. No, but I think the whole thing about anti-ageing is really

important. But again, the best anti-ageing thing anyone can do is follow the five keys of being healthy. That's no doubt but then there's all this work about the NAD derivatives Nicotinic Acid in him. And I do Riboside, Dave has done a lot of work on Metformin, the diabetic drug which some people are using as well, and there's some newer things coming through. So looking at the hallmarks of ageing and working on that. So anti-ageing is number one. Number two is the whole thing about gene manipulation and gene therapy. And some people are very worried about the whole eugenics sort of stuff. But I'll give you an example. One of my best mates is Professor Ian Alexander, who's the Professor of Genetics Westmead Hospital. Now he's using gene therapy to change the destiny of little babies with spinal muscular atrophy who could hope to live if are very lucky to ten now because of Ian's gene therapy, they can expect to have a normal life. And we're talking about these single gene manipulations now with gene therapy, but also gene screening as well. What's the potential of for a few hundred dollars having your genome screened to see what your risk is for different diseases so you can start doing something about it now because we all know that the best treatment of any disease is not to get it in the first place. And so the best way to know about that is to know what your risk is and to do something about the risk. So I think all of the genetic therapies are really very, very exciting. And then we're moving on from there to just looking at the new therapeutics. And the new therapeutics are not just vaccines for infectious disease. They're now talking about vaccines for cancer, vaccines for heart disease. Going to put me out of a job, a vaccine for heart disease. But there's a trial on at the moment of a vaccine for heart disease, as one example. And there's some incredible work about different vaccines taking people had terminal cancer and giving them a normal life and things like that. The glioma, they're talking about manipulating a... The Poliomyelitis gene, the virus, and injecting it straight into a glioma, because, as you know, Poliomyelitis damages nerves and this just damages the nerves within the tumour. So you've got all these new therapeutics and the new therapeutics of gut bacteria, all the things we've just been speaking about. I find that really exciting as well. Then then you talk about regenerative medicine.

Dr Ron Ehrlich: [00:57:43] Hmm.

Dr Ross Walker: [00:57:44] Regenerative medicine with stem cell therapy, with bionics, with all

of these sort of things. I mean, that's very, very exciting stuff. And then I think another thing about the future of medicine is just total assessments. So talking about having little biosensors in your body, wait for these biosensors are monitoring real-time all the chemicals running through your system, whether it's sugar level, whether it's indications of heart damage, whether a chemical is being released to tell you, you're about to have a heart attack or whether you're whether you've got a cancer brewing somewhere. And then they're talking about these biosensors delivering therapeutics to get rid of the problem. So I mean, who knows what's going to happen over the next ten, 20, 30, 40, 50 years. But the world's changing dramatically. So I think the future of medicine is incredibly exciting.

Dr Ron Ehrlich: [00:58:33] Hmm. I'd be I hope the future of health is as exciting because, I mean, you know, I think one of the exciting parts is there's so many commercial possibilities there. And with for an industry that's already at \$1.5 trillion a year, one can only imagine where the limit is there. I just hope it translates into good health. But listen, always so wonderful to have you on, Ross, and to hear and to remind our listener about what an integrative approach to cardiology is all about. And so thank you so much for joining me.

Dr Ross Walker: [00:59:07] Thanks, mate. And can I say it, the reason I do this is because I genuinely believe that we can all have a better life, but we realise that that responsibility for that is not your doctor's responsibility or in your naturopaths or your dentist. It's your responsibility. And if people don't put effort into practising those five keys or say them again because they are so important from the least important to the most important.

Dr Ron Ehrlich: [00:59:31] Say them slowly, Ross. Say them slowly.

Dr Ross Walker: [00:59:34] You cannot be healthy and smoke, drink too much grog or snort cocaine. So no addictions. Number two 7 to 8 hours every night of good quality sleep is as good for your body as not smoking. Number three, nutrition. Very simple. Eat less food. Eat more natural food. Number four, second best drug on the planet. 3 to 5 hours every week of moderate exertion should be two-thirds cardio, a third resistance training. And number five, easily the best drug on the planet to think or happiness. So I'll leave you with the IDEA trial from Harvard

University showed the one key to health and happiness is to have someone else in your life who loves and cares for you, who you love and care for. It's much more important than your damn cholesterol levels. So doing those five things will reduce your risk for all diseases somewhere between 70 to 80%. And I think we I don't believe in lifespan or I believe in health span. So health span to me is being as healthy as you can for as long as you can. And getting every moment out of life being alive is a privilege. Being healthy is a privilege. Don't abuse the privilege.

Dr Ron Ehrlich: [01:00:43] Ross, thank you so much.

Dr Ross Walker: [01:00:45] Thanks, man.

Dr Ron Ehrlich: [01:00:45] Well, there it is. I mean, it doesn't really matter what disease you're talking about. I think lifestyle, the five stresses, the five pillars, if you like, are a great structure by which to approach health. And the way health problems manifest themselves is very much a genetic issue. And we do need to respect our genes, but it's how our genes express themselves that what we do have... Some control, a great deal of control over. And Ross's five elements that he always quotes, and I don't think we can ever hear them often enough reduce your risk of of getting a chronic degenerative disease by 70 or 80%. Now, you know, medications come in, reducing your risk by 20 or 30 or 40%, but nothing beats the 70 or 80% that you actually have control of yourself and look. It's a personal decision, and I hope this program is stimulating enough to you to keep tapping that hoop along the hoop being health and the game being life. And let's play the long game, which is life, hopefully. And that's why we constantly and we all in on myself included, the constant reminders of how important it is. So I hope this find you well. Until next time. This is Dr. Ron Erlich. Be well.

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