



The Bill Edwards Heart Beat

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FDA Uncovers Additional Tainted Weight Loss Products

Agency alerts consumers to the finding of new undeclared drug ingredients

The U.S. Food and Drug Administration is expanding, for the second time, its [nationwide alert](#) to consumers about tainted weight loss products containing undeclared, active pharmaceutical ingredients.

The FDA has identified additional weight loss products (Herbal Xenicol, Slimbionic, and Xsvelten) and new undeclared active pharmaceutical ingredients (fenproporex, fluoxetine, furosemide, and cetilistat). The current list now includes the following 72 products:

2 Day Diet	7 Days Diet	BioEmagrecim
Fatloss Slimming	Meizitang	Powerful Slim
Slim 3 in 1 M18 Royal Diet	Slim Waist Formula	Superslim
2 Day Diet Slim Advance	7 Diet	Body Creator
GMP	Miaozi MeiMaoQianZi JiaoNang	ProSlim Plus
Slim 3 in 1 Slim Formula	Slim Waistline	Super Slimming
2x Powerful Slimming	7 Diet Day/ Night Formula	Body Shaping
Herbal Xenicol	Miaozi Slim Capsules	Reduce Weihgt
Slim Burn	Slimbionic	Trim 2 Plus

3 Day Diet	8 Factor Diet	Body Slimming
Imelda Fat Reducer	Natural Model	Royal Slimming Formula
Slim Express 4 in 1	Sliminate	Triple Slim
3 Days Fit	Eight Factor Diet	Cosmo Slim
Imelda Perfect Slim	Perfect Slim	Sana Plus
Slim Express 360	Slimming Formula	Venom Hyperdrive 3.0
3x Slimming Power	21 Double Slim	Extrim Plus
JM Fat Reducer	Perfect Slim 5x	Slim 3 in 1
Slim Fast*	Somotrim	Waist Strength Formula
5x Imelda Perfect Slimming	24 Hours Diet	Extrim Plus 24 Hour Reburn
Lida DaiDaihua	Perfect Slim Up	Slim 3 in 1 Extra Slim Formula
Slim Tech	Starcaps	Xsvelten
7 Day Herbal Slim	999 Fitness Essence	Fasting Diet
Meili	Phyto Shape	Slim 3 in 1 Extra Slim Waist Formula
Slim Up	Super Fat Burner	Zhen de Shou

* This product should not be confused with the line of meal replacement and related products

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that are marketed as conventional foods under the brand name “Slim-Fast®”. The manufacturer of Slim-Fast®, Unilever United States, Inc., maintains that the Slim Fast product which appears on this list is not in any way associated with, sponsored or approved by, or otherwise related in any way to the Slim-Fast® brand of meal replacement and related products.

“These tainted weight loss products pose a great risk to public health because they contain undeclared ingredients and, in some cases, contain prescription drugs in amounts that greatly exceed maximum recommended dosages,” said Janet Woodcock, M.D., director of the FDA’s Center for Drug Evaluation and Research. “Consumers have no way of knowing that these products contain dangerous drugs that could cause serious consequences to their health.”

On Dec. 22, 2008, the FDA warned consumers not to purchase or consume 28 different products marketed for weight loss. On Jan. 8, 2009, the FDA expanded the list of tainted weight loss products to include 41 additional tainted products. The FDA will continue to update this list as warranted.

The products listed above, some of which are marketed as dietary supplements, are promoted and sold on various Web sites and in some retail stores and beauty salons. Some of the products claim to be “natural” or to contain only “herbal” ingredients, but actually contain potentially harmful ingredients not listed on the products’ labels or in promotional advertisements. These products have not been approved by the FDA, are illegal, and include the following undeclared active pharmaceutical ingredients:

- fenproporex – a controlled substance not approved for marketing in the United States;
- fluoxetine – an antidepressant available by prescription only;
- bumetanide – a potent diuretic available by prescription only;
- furosemide – a potent diuretic available by prescription only;
- rimonabant – a drug not approved

for marketing in the United States;

- cetilistat – an experimental obesity drug not approved for marketing in the United States;
- phenytoin – an anti-seizure medication available by prescription only; and
- phenolphthalein – a solution used in chemical experiments and a suspected cancer-causing agent that is not approved for marketing in the United States.

The FDA has inspected a number of companies associated with the sale of these illegal products and is currently seeking product recalls. Based on the FDA’s inspections and the companies’ inadequate responses to recall requests, the FDA may take additional enforcement steps, such as issuing warning letters or initiating seizures, injunctions, or criminal charges.

The FDA advises consumers who have used any products containing these ingredients to stop taking them and consult their health care professional immediately. The FDA also encourages consumers to seek guidance from a health care professional before purchasing weight loss products.

The health risks posed by these products can be very serious and include high blood pressure, seizures, tachycardia (rapid heartbeat), palpitations, heart attack, and stroke. Sibutramine, a controlled substance, was found in many of these products at levels much higher than the maximum daily dosage for Meridia, the only FDA-approved drug product containing sibutramine. These higher levels of sibutramine can increase the incidence and severity of these health risks. Fenproporex, another controlled substance, can cause arrhythmia and possible sudden death.

Health care professionals and consumers should report serious adverse events (side effects) or product quality problems to the FDA’s MedWatch Adverse Event Reporting program either online, by regular mail, fax or phone.

- Online: www.fda.gov/MedWatch/report.htm
- Regular Mail: use postage-paid

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FDA form 3500 available at: www.fda.gov/MedWatch/getforms.htm and mail to MedWatch, 5600 Fishers Lane, Rockville, MD 20852-9787

- Fax: 800- FDA-0178
- Phone: 800- FDA-1088

Information on these products for consumers and health care professionals can be found at: http://www.fda.gov/cder/consumerinfo/weight_loss_products.htm

<http://www.fda.gov/bbs/topics/NEWS/2009/NEW01977.html>

Heart Disease: Combined Treatment Is Best

Heart Patients Fare Better When They Fix Both Blood Pressure and Cholesterol, Study Shows

By [Salynn Boyles](#) WebMD Health News March 23, 2009 -- [Heart disease](#) patients who achieve normal [blood pressure](#) and very low [cholesterol levels](#) with aggressive drug therapy do better than patients who achieve only one of these goals, new research suggests. Using [ultrasound](#) to identify plaque buildup within the artery walls as a measure of disease progression, Cleveland Clinic researchers found that patients who were able to get their low-density lipoprotein (LDL) [cholesterol](#) below 70 mg/dL and their systolic blood pressure (the top number in a blood pressure reading) below 120 with medication had less plaque buildup over the course of the study than patients who reached just one or neither of these targets. The findings highlight the importance of treating all risk factors for heart disease progression, rather than targeting just one, study co-author Stephen J. Nicholls, PhD, tells WebMD. "I think sometimes we aggressively try to manage one risk factor and lose sight of the fact that we need to manage all of them," Nicholls

says. "If we want to get the greatest bang for our buck in terms of treatment, we need to focus on all risk factors.

Lower Is Better' for LDL,

Earlier research by Nicholls and Cleveland Clinic colleagues helped establish the "lower is better" strategy for controlling LDL cholesterol with statin drugs like [Lipitor](#), [Crestor](#), and Zocor in patients at high risk for having [heart attacks](#), strokes, or other cardiovascular events. As a result of their work and the work of others, national treatment goals for LDL were recently lowered to less than 100 for patients with established heart disease and less than 70 for the highest-risk patients. Current guidelines identify a resting systolic blood pressure of 120 or below as normal; a reading of 140 or above is high. A reading of between 120 and 140 is considered "prehypertension." There are no widely accepted guidelines for treating patients who fall into this category, but the new research suggests that maybe there should be, Nicholls says. "We know that (heart attack and [stroke](#)) risk starts to increase at about 115," he says. "This study suggests that treating to lower blood pressure levels is probably beneficial, but we need clinical trials to test this." The Cleveland Clinic study included 3,437 heart disease patients whose [arterial plaque](#) progression was monitored with intravascular ultrasound. The monitoring revealed that:

- Patients who achieved LDL levels below 70 and systolic blood pressures of below 120 had the slowest progression, as measured by increase in plaque volume.
- Those with LDL levels below 70 and systolic blood pressures above 120 had more rapid plaque buildup, but these patients fared slightly better than patients with LDL levels above 70 and systolic blood pressures over 120.
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Patients with LDL levels above 70 and systolic blood pressures above 120 had the most rapid increase in plaque volume. "With the powerful statin drugs we have today, we see a lot of patients who reach their cholesterol goals but not their blood pressure goals," study co-author Steven E. Nissen, MD, tells WebMD. "This suggests that we need to aggressively target blood pressure and cholesterol to stop disease progression and even reverse it."

More Study Needed

The study appears in the March 31 issue of the Journal of the American College of Cardiology.

In an accompanying editorial, UCLA heart disease researchers Jonathan Tobis, MD, and Alice Perlowski, MD, urged caution in interpreting the study.

The researchers note that a direct relationship between plaque progression as measured by the ultrasound technique used in the study and hard clinical events like heart attack and stroke has not been established.

They write that clinical trials examining these hard endpoints are needed to confirm that very aggressive treatment of cholesterol and blood pressure is beneficial for patients with established heart disease. Cardiologist James T. Dove, MD, agrees. Dove is a clinical professor of medicine at Southern Illinois School of Medicine and the immediate past president of the American College of Cardiology.

"In high-risk patients, very aggressive treatment might well be the best approach, but the operative phrase is 'might well be,'" he tells WebMD. "There is a downside to very aggressive treatment that needs to be considered, especially

with blood pressure."

Very [low blood pressure](#) can result in [dizziness](#) that can increase a patient's risk for falls.

Dove says clinical trials are definitely needed to determine if the "lower is better" treatment strategy results in better clinical outcomes for patients with established heart disease. "The 'lower is better' approach may be the way to go, but we need more information to be sure about that," he says.

<http://www.webmd.com/>

Men and Women Get Different Benefits from Daily Aspirin

By Peggy Peck, Executive Editor, MedPage Today
Published: March 16, 2009

Reviewed by [Robert Jasmer, MD](#); Associate Clinical Professor of Medicine, University of California, San Francisco

DENVER, March 16 -- The benefit of daily aspirin appears to differ by gender -- for men it means fewer heart attacks, but in women it reduces the risk of stroke, according to the U.S. Preventive Services Task Force.

The gender disparity emerged in studies reported after 2002 and the new information led the guideline agency to tweak its recommendation on aspirin, recommending a daily dose for men ages 45 to 79 to prevent myocardial infarction and for women ages 55 to 79 to reduce risk of ischemic strokes.

The new recommendation, published in the March 17 issue of *Annals of Internal Medicine*, addresses primary prevention in men and women who have no history of coronary heart disease or stroke.

And in both cases the potential benefit -- reducing heart attacks in men and strokes in

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women -- should be weighed against the risk of gastrointestinal hemorrhage, the guideline writers said.

“The USPSTF recommends against the use of aspirin for stroke prevention in women younger than 55 years and for myocardial infarction prevention in men younger than 45 years,” wrote Ned Calonge, M.D., M.P.H., of the Colorado Department of Public Health and Environment. Dr. Calonge chaired the task force.

The panel said there was “insufficient evidence” to make a recommendation for aspirin use in men and women 80 or older.

Although 81 mg daily -- the so-called baby aspirin -- is a commonly recommended dose, the new USPSTF guideline does not name an optimum dose noting that primary prevention trials “have demonstrated benefits with various regimens, including doses of 75 mg and 100 mg/d and 100 and 325 mg every other day.”

It does, however, state that the risk of GI bleeding increases as the dose increases and that a “dose of approximately 75 mg/d seems as effective as higher doses.”

Filling in some of the blanks on the precise dose, a second paper in *Annals* -- a post-hoc analysis from the CHARISMA investigators -- found that aspirin doses of 100 mg or higher did no good by themselves in patients with established cardiovascular disease.

And when patients were given dual antiplatelet therapy with 75 mg of clopidogrel (Plavix) and 100 mg or more of aspirin, there was a decrease in the efficacy of clopidogrel and a slight increase in bleeding risk, although the differences were not statistically significant.

Steven R. Steinhubl, M.D., of the Medicines Company in Balsburg, Switzerland, and the CHARISMA co-investigators, concluded that “daily aspirin doses of 100 mg or greater are not associated with clear benefit and may cause

harm, and that daily aspirin doses of 75 to 81 mg may provide the optimal balance between efficacy and safety in patients with known cardiovascular events or those who are at risk for events but require aspirin therapy.”

Dr. Steinhubl pointed out that the aspirin dose in CHARISMA was not randomly assigned or blinded, a limitation of the analysis, which was also limited by its post-hoc design and the analysis was based on baseline aspirin use.

He noted that aspirin dose tended to change over time, especially among persons using higher doses at baseline.

CHARISMA randomized 15,595 patients with cardiovascular disease to clopidogrel or placebo plus aspirin. The primary endpoint was myocardial infarction, stroke, or cardiovascular death.

After a median follow up of 28 months, clopidogrel plus aspirin was not superior to aspirin alone.

In an editorial that accompanied both papers, Shamir R. Mehta, M.D., M.P.H., of McMaster University and Hamilton General Hospital in Hamilton, Ontario, wrote that a key concern for physicians is “when to recommend against taking aspirin.”

One approach is straightforward: when the rate of harm -- bleeding events -- exceeds the rate of benefit -- reduction in risk of heart attacks or strokes -- recommend against taking aspirin.

But that approach, he warned, “assumes that patients place the same value on avoiding a bleeding event as they do on avoiding a stroke or MI. Depending on the site of the bleeding, some patients would rather avoid a stroke than avoid a bleeding event and would prefer to take aspirin.”

Dr. Mehta said that a “valuable feature” of the USPSTF recommendation is an emphasis on shared decision-making. That means not

only discussing risks and benefits, but also individualizing that discussion to the specific patient or situation.

www.medpagetoday.com

Know the Signs of a Mini-Stroke

February 2009

A transient ischemic attack (TIA) can mean that you have an increased chance of having a full-fledged stroke, but there are steps you can take.

A transient ischemic attack (TIA), or “mini-stroke,” occurs when a blood clot temporarily clogs an artery and blood flow to the brain is restricted. Symptoms of a TIA can occur rapidly and last for a short period of time (usually less than one hour). Fortunately, TIAs do not cause lasting damage to the brain, but they could be a warning that you may have a stroke in the future. According to the National Institute of Neurological Disorders and Stroke, about 33 percent of the approximately 50,000 people who have mini-strokes every year will later have a more severe stroke.

“The difference between a stroke and a TIA is based on the duration of the patient’s symptoms,” says Leslie Cho, MD, FACC, editor-in-chief of Heart Advisor. Symptoms of both conditions can include numbness or weakness of the face or extremities, confusion, sudden vision loss, and dizziness. Researchers have identified three bedside clinical features that should help distinguish between TIAs and other disorders with similar symptoms. The features include: speed of onset; vague symptoms; and a history of similar events that were not shown to be TIAs. If you think you’ve experienced a TIA, it’s important to seek medical treatment immediately. A doctor can assess your symptoms and

determine if a TIA or stroke has occurred or if the symptoms were caused by something else such as a seizure, migraine headache, or a problem involving the heart or the brain.

Reducing Your Stroke Risk

Some factors that affect your stroke risk include age, family history, smoking, hypertension, diabetes, and high cholesterol. While factors like age cannot be modified, controlling co-morbid medical conditions can significantly reduce your stroke risk. “Ideally, blood pressure should be less than 120/70,” says Dr. Cho. “For diabetics, their hemoglobin A1C should be less than 6.5. In older adults, LDL cholesterol should be less than 100, HDL cholesterol should be greater than 45, and triglycerides should be less than 150.”

There is no established treatment for a TIA, but depending upon your medical history, medication or surgery may be suggested to reduce your risk of having a full-blown stroke. Drug treatment could include antiplatelet medications, especially aspirin, or warfarin (Coumadin) if you have atrial fibrillation. Dr. Cho recommends visiting the American Heart Association’s website for more information (www.heart.org) or call 1-888-4-STROKE (121659) to learn more.

Exercise Can Reduce a Stroke’s Severity and Improve Recovery

March 2009

New research shows older adults who were physically active before having a stroke can often endure it with fewer complications.

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Your doctor has been telling you that exercise will help keep your heart healthy and your blood flowing, and you're hoping that all those miles you and your sneakers have covered are also lowering your odds of a stroke, too. But what if you do suffer a stroke—an event in which a blood vessel supplying blood to the brain becomes blocked or bursts?

What will all that exercise have done for you then?

According to recent research, the more physically active you are prior to a stroke, the less severe the stroke is likely to be and the faster and more complete your recovery is expected to be, also. A study of 265 stroke patients, average age 68, published in the October 21 issue of *Neurology*, found that those who exercised regularly were two and a half times more likely to have a less-severe stroke than more sedentary individuals. The more active patients also had a much better chance of a faster and more thorough recovery, researchers found.

Cleveland Clinic neurologist Gwendolyn Lynch, MD, explains that exercise helps protect you against stroke via several mechanisms, and they all start with the improved blood flow that results from regular physical activity.

“The increased blood flow acts to promote healthy blood vessel walls, which means that the walls will have fewer or no cracks, and little or no fatty plaque build-up,” Dr. Lynch says. “Exercise also improves the response of blood vessels to the brain’s demand for extra blood flow, and this means that if the brain needs more blood flow, the vessels will open up better and faster to meet the demand.”

After The Stroke

Dr. Lynch adds that after a stroke, when brain tissue is starved for the oxygen it receives from blood, a healthy circulatory system can help meet

the demand by essentially creating or expanding new blood pathways.

“Exercise encourages the formation of new capillaries and new arteries, so that tissue has better blood supply and will get the oxygen it needs to survive,” Dr. Lynch says. “This also means that if, for some reason, a brain artery is plugged off, the newer capillaries and arteries can take over to provide some of the blood supply that would have been lost.”

Dr. Lynch echoes the findings of the study researchers, who noted that the brains of physically active stroke patients seem to be better able to revive damaged brain cells and call on other brain cells to begin to replace the functions of cells destroyed by the oxygen deprivation during a stroke.

“Exercise decreases the inflammation in the brain that happens after a stroke,” Dr. Lynch says. “This can lead to less scarring and better recovery of brain cells that have not died, but are simply ‘sick’ after a stroke. Exercise can also stimulate the brain to form new connections that will allow unaffected parts of the brain to take over responsibilities of the parts of the brain that died due to a stroke.”

Understanding Your Stroke Risk

You might wonder if a person exercises regularly and manages other risk factors, such as weight and blood pressure, why would he or she have a stroke at all. Unfortunately, even seemingly heart-healthy individuals can be at risk of a stroke. Common risk factors include family history, diabetes, atrial fibrillation, prior stroke, heart attack or transient ischemic attack (TIA), and, of course, smoking.

And along with exercise, there are other steps you can take to reduce your odds of having a stroke and give yourself the best chance at a good recovery if one strikes. Dr. Lynch

recommends a healthy diet that is low in fat and simple sugars, low in sodium and high in fiber and potassium. She urges patients to maintain a healthy body weight and body mass index (BMI), limit alcohol use to no more than one drink per day for a woman and two for a man, and to keep blood pressure, serum lipids and blood sugar levels under control. You should discuss all those numbers with your doctor and discuss methods to help manage them.

“Stroke prevention and recovery should be viewed as a lifelong process which is best managed by working regularly with your physician and other healthcare providers to get to and maintain optimal management of your stroke risk factors,” Dr. Lynch says. “In doing so, you can substantially reduce the chance of suffering a stroke and improve your chances of a good recovery after a stroke.”

The Cleveland Clinic, Heart Advisor, March 2009

LIONS GATE HOSPITAL CARDIAC REHAB – CARDIO METABOLIC PROGRAM

Education Schedule--2009

Monday May 4th

CARDIAC REHAB CHAMPIONS
Jennifer, Monique and Guest Speakers

Monday May 18th

Heart Physiology and Heart Disease
Dr. Kevin McLeod, Internal Medicine Specialist

Monday June 8th

Risk Factors – How to reduce them and live longer
Dr. Kevin McLeod, Internal Medicine Specialist

Monday June 22nd

Exercise and Heart Health
Min van Velzen, Exercise Specialist

Classes Held in the Lions Gate Hospital Auditorium
(ground Floor) at 7:00 PM

PLEASE NOTE: Nutrition education and counseling is available through Lions Gate Hospital. Please let us know if you would like to be directly referred to this program.

North Shore Rotary Seawalk Run

Sunday May 31, 2009

7:30 AM

Entry Fee \$37 which includes a T-shirt and breakfast.
Entry information available from your site walk co-ordinator.

Burnaby Lake Rhythm of Life Walk

Under the auspices of Cardiac Health Foundation of Canada

Sunday May 24, 2009

Burnaby Lake

More details coming.

Coming Events

Vancouver Coastal Health Diabetes Drop-In Information Series

Topic	Time
Is An Insulin Pump For You?	Tuesday, May 21st, 7:00 PM

All sessions will be held in the Diabetes Education Center, Classroom 2, Lions Gate Hospital.

For more information please call:
604-984-5752

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Recipes

Garlic-Rosemary Mushrooms

These simple sautéed mushrooms work as a quick, weeknight side dish. To turn them into a main course, toss with cooked pasta and a generous handful of Parmesan cheese or fold into an omelet with Gruyère, fontina or Swiss cheese.

Makes 4 servings, about 3/4 cup each

1 ounce bacon (about 1 1/2 slices), chopped
1 1/2 pounds mixed mushrooms, such as cremini, shiitake (stemmed) and portobello, cut into 1/4-inch slices
2 medium cloves garlic, finely chopped
1 1/2 teaspoons chopped fresh rosemary or 1/2 teaspoon dried
1/4 teaspoon salt
Freshly ground pepper to taste
1/4 cup dry white wine

Cook bacon in a large skillet over medium heat until just beginning to brown, about 4 minutes. Add mushrooms, garlic, rosemary, salt and pepper and cook, stirring occasionally, until almost dry, 8 to 10 minutes. Pour in wine and cook until most of the liquid has evaporated, 30 seconds to 1 minute.

NUTRITION INFORMATION: Per serving: 95 calories; 3 g fat (1 g sat, 1 g mono); 8 mg cholesterol; 8 g carbohydrate; 7 g protein; 1 g fiber; 316 mg sodium; 795 mg potassium. Nutrition bonus: Potassium (23% daily value).
1/2 Carbohydrate Serving
Exchanges: 1 vegetable, 1 fat
From EatingWell Magazine January/February 2007

Honey-Soy Broiled Salmon

A sweet, tangy and salty mixture of soy sauce, rice vinegar and honey does double-duty as marinade and sauce. Toasted sesame seeds provide a nutty and attractive accent. Make it a meal: Serve with brown rice and sautéed red peppers and zucchini slices.

Makes 4 servings

1 scallion, minced
2 tablespoons reduced-sodium soy sauce
1 tablespoon rice vinegar
1 tablespoon honey
1 teaspoon minced fresh ginger
1 pound center-cut salmon fillet, skinned (see Tip) and cut into 4 portions
1 teaspoon toasted sesame seeds (see Tip)
1. Whisk scallion, soy sauce, vinegar, honey and ginger in a medium bowl until the honey is dissolved. Place salmon in a sealable plastic bag, add 3 tablespoons of the sauce and refrigerate; let marinate for 15 minutes. Reserve the remaining sauce.

2. Preheat broiler. Line a small baking pan with foil and coat with cooking spray.
3. Transfer the salmon to the pan, skinned-side down. (Discard the marinade.) Broil the salmon 4 to 6 inches from the heat source until cooked through, 6 to 10 minutes. Drizzle with the reserved sauce and garnish with sesame seeds.

NUTRITION INFORMATION: Per serving: 234 calories; 13 g fat (3 g sat, 5 g mono); 67 mg cholesterol; 6 g carbohydrate; 23 g protein; 0 g fiber; 335 mg sodium; 444 mg potassium. Nutrition bonus: Selenium (60% daily value), excellent source of omega-3s.

1/2 Carbohydrate Servings

Exchanges: 3 lean meat, 1/2 other carbohydrate
TIP: Tips: How to skin a salmon fillet: Place skin-side down. Starting at the tail end, slip a long knife between the fish flesh and the skin, holding down firmly with your other hand. Gently push the blade along at a 30° angle, separating the fillet from the skin without cutting through either.

To toast sesame seeds, heat a small dry skillet over low heat. Add seeds and stir constantly, until golden and fragrant, about 2 minutes. Transfer to a small bowl and let cool.

From EatingWell Magazine August/September 2006

Edamame Succotash with Shrimp

We give succotash—traditionally a Southern dish made with corn, lima beans and peppers—an

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update using edamame instead of limas and turn it into a main dish by adding shrimp. To get it on the table even faster, purchase peeled, deveined shrimp from the fish counter instead of doing it yourself. Make it a meal: All you need is a warm piece of cornbread to go with this complete meal. Makes 4 servings, about 1 1/2 cups each

2 slices bacon

1 tablespoon extra-virgin olive oil

1 bunch scallions, sliced, or 1 medium onion, diced

1 red bell pepper, diced

2 cloves garlic, minced

1 1/2 teaspoons chopped fresh thyme

1 10-ounce package frozen shelled edamame (see Tip), thawed

1 10-ounce package frozen corn (about 2 cups), thawed

1/2 cup reduced-sodium chicken broth or vegetable broth

1 tablespoon cider vinegar

1/4 teaspoon salt

1 pound raw shrimp (26-30 per pound), peeled and deveined

1/4 teaspoon lemon pepper

1. Cook bacon in a large nonstick skillet over medium heat until crisp, about 5 minutes. Leaving the drippings in the pan, use tongs to transfer the bacon to a plate lined with paper towels; let cool.

2. Add oil to the pan. Add scallions (or onion), bell pepper, garlic and thyme and cook, stirring, until softened, about 3 minutes. Stir in edamame, corn, broth, vinegar and salt. Bring to a simmer; reduce heat to medium-low and cook for 5 minutes.

3. Meanwhile, sprinkle shrimp on both sides with lemon pepper. Scatter the shrimp on top of the vegetables, cover and cook until the shrimp are cooked through, about 5 minutes. Crumble the bacon and sprinkle it on top.

NUTRITION INFORMATION: Per serving: 307 calories; 9 g fat (1 g sat, 4 g mono); 172 mg cholesterol; 26 g carbohydrate; 30 g protein; 7 g fiber; 491 mg sodium; 476 mg potassium.

Nutrition bonus: Vitamin C (120% daily value), Selenium (53% dv), Vitamin A (40% dv), Iron (30% dv).

1 Carbohydrate Serving

Exchanges: 1 1/2 starch, 1 vegetable, 3 lean meat

TIP: Tip: Edamame are found in the natural-foods freezer section of large supermarkets and natural-foods stores, sold both in and out of the "pods." For this recipe, you'll need the shelled edamame. One 10-ounce bag contains about 2 cups of shelled beans.

From EatingWell Magazine January/February 2007

Spinach Salad with Japanese Ginger Dressing

This spinach salad tossed with spunky ginger dressing was inspired by the iceberg salads served at Japanese steakhouses across the U.S. Add shrimp for lunch or a light supper.

Makes 4 servings, about 1 1/2 cups each

3 tablespoons minced onion

3 tablespoons peanut or canola oil

2 tablespoons distilled white vinegar

1 1/2 tablespoons finely grated fresh ginger

1 tablespoon ketchup

1 tablespoon reduced-sodium soy sauce

1/4 teaspoon minced garlic

1/4 teaspoon salt

Freshly ground pepper to taste

10 ounces fresh spinach (see Note)

1 large carrot, grated

1 medium red bell pepper, very thinly sliced

1. Combine onion, oil, vinegar, ginger, ketchup, soy sauce, garlic, salt and pepper in a blender. Process until combined.

2. Toss spinach, carrot and bell pepper with the dressing in a large bowl until evenly coated.

NUTRITION INFORMATION: Per serving: 135 calories; 11 g fat (2 g sat, 5 g mono); 0 mg cholesterol; 9 g carbohydrate; 3 g protein; 3 g fiber; 407 mg sodium; 559 mg potassium.

From EatingWell Magazine September/October 2008

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