

## Chair's Report

Robert H. Eckel, MD, Chair

The NPAM Council Leadership Committee meeting was held on Saturday evening November 8, 2003, at the AHA annual Scientific Sessions in Orlando. Attendance among the leadership members was excellent, and updates on all aspects of Council activity were reviewed. Following a presentation of the many AHA materials related to nutrition, physical activity and metabolism by Jane Ruehl of the AHA, AHA President Dr. Augustus Grant discussed selected aspects of the AHA Strategic Plan, activities of the AHA Board, the Paid Advertising Campaign, the upcoming joint meeting on Ethics in June 2004 with the American College of Cardiology, and the AHA spring Lobby Day in Washington, DC with the Council leadership.

NPAM committee reports were given by Drs. Xavier Pi-Sunyer for *Obesity*, Barry Franklin for *Physical Activity*, Daniel Porte for *Diabetes*, Barbara Howard for *Nutrition*, Ron Krauss for *Nominations*, Penny Kris-Etherton for *Clinical Affairs*, Beatriz Rodriguez for *Annual Sessions Program*, Robert Eckel for *Membership*, Scott Grundy for *Budget*, Sylvia Rowe for *Communications* and Sue Borra for *INAP*.

Highlights of the activities of these NPAM committees included:

1. Nine Scientific Statements for the NPAM Council that are in progress.
2. Plans and discussion for the next AHA Dietary Guidelines by the *Nutrition Committee* to include the science behind recommendations for physical activity as a joint effort with the *Physical Activity Committee*.
3. Joint efforts on behalf of the *Nutrition/Obesity* committees to establish a conference on Obesity/Portion Size were presented.
4. The development of a questionnaire that would provide information about the practice of physicians in the area of lifestyle related to cardiovascular disease, i.e., gathering dietary and physical activity data. The value of this approach was discussed at length, and steps to modify are ongoing.
5. Nominations for NPAM Council Leadership are Drs. Scott Grundy for Council

Chair, Barbara Howard for Council Vice Chair, Neil Stone and Barbara Hansen for At-Large Members, Alice Lichtenstein for Chair of the *Nutrition Committee*, Larry Appel for Vice Chair of the *Nutrition Committee*, Michael Jensen for Vice Chair of the *Obesity Committee*, and Henry Ginsberg for Vice Chair of the *Diabetes Committee*. AHA Nominations included Robert Eckel for President-Elect, Ronald Krauss for At-Large Board Member, Barry Franklin for the *Advisory Committee*, Sylvia Rowe for another term on the *Membership Marketing Committee*, Alan Chait and Larry Rudel for the *Research Committee*, Trudy Forte for the *Scientific Publishing Committee*, Kathy Berra for the *Women/Minorities Committee*, and Paul Thompson for the *Science Advisory/Coordinating Committee (SACC)*. These AHA nominations were discussed at SACC in February 2004.

6. A working group was formed to examine the potential role of NPAM in participation/sponsorship of the spring meeting on *Lipoprotein Kinetics* put on by Dr. Ernie Schaefer.
7. Dr. Scott Grundy reviewed the Metabolic Syndrome conferences co-sponsored with NHLBI and the American Diabetes Association in April and September 2003. Conference reports were published in *Circulation* on January 27 and February 3, 2004.
8. As of September 2003, the NPAM budget was at \$84,337 with expected expenditures to follow. The opportunity for NPAM to support more travel awards, scientific conferences, and efforts in the direction of the *Clinical Affairs Committee*, and membership was discussed.

Speaking of membership, as of September 2003 we had 915 members (including 86 Fellows), with 835 from the USA and 80 from abroad. With the change in the structure of AHA membership, i.e. a primary and secondary council for all, it is expected that some growth in NPAM will come from within. However, the challenge remains for each of our members to probe the interest level of colleagues in the field and energize their interest in the science and goals of the Council. If every member would recruit just

one more NPAM member this year, within a few years our directory and budget would bring additional opportunities that at present are not possible. We also need to elevate some of our membership to the level of Fellowship, an acknowledgment of excellence, innovation, and leadership in the fields within NPAM's interest. Self-nominations are acceptable with sponsorship by a Council Fellow.

AHA meetings jointly sponsored by NPAM include the 44th Annual Conference on Cardiovascular Disease Epidemiology and Prevention featuring the L.J. Filer Symposium on Prevention of Overweight and Its Consequences Beginning in Youth, on March 3–6, 2004, in San Francisco; the 5th Annual Conference of Arteriosclerosis, Thrombosis and Vascular Biology (ATVB) also in San Francisco on May 6–8, 2004; and the 2nd Scientific Conference on Compliance in Healthcare and Research primarily supported by the Cardiovascular Nursing Council in Washington, DC on May 17–19, 2004. Abstract deadlines have already passed for the joint conferences with Epidemiology/Prevention and ATVB; however, let me encourage our membership to attend one or more of these meetings if time permits. Expected in 2005 is a joint conference between Epidemiology/Prevention, ATVB and NPAM. Again, the timing of our own meeting must await the necessary growth in membership and resources to support this independence. Until then, we very much appreciate the opportunity to share our scientific interests with our colleagues from other AHA councils.

Finally I'd like to acknowledge NPAM's 2003 Robert I Levy Endowed Lecture in Lipid Metabolism that was given by Dr. Scott Grundy on "Benefit Beyond LDL Lowering: The Metabolic Syndrome as a Target for Clinical Intervention" and the 1st NPAM Young Investigator's Award (sponsored by INAP) that was received by Dr. Marie-Pierre St-Onge from Columbia University for her abstract "Prevalence of Metabolic Syndrome and Metabolic Syndrome Risk Factors in Normal Weight Individuals." Congratulations to both, and much thanks to INAP for their support!

# How Can We Practically Include 10 to 25 Grams of Soluble Fiber in the Diet?

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Scientific data demonstrates a strong association between certain types of dietary fiber and reduced risk of coronary heart disease (CHD). Fiber traditionally has been classified into two groups based on solubility in water. Soluble or viscous fiber is commonly found in oats, barley, legumes and fruits. The National Cholesterol Education Program (NCEP) guidelines list soluble fiber (10–25 g/day) as a therapeutic option for lowering LDL-C. Studies indicate that this amount will reduce LDL-C by 5–10%.

Consumption of whole grains, many of which provide fiber in addition to other beneficial nutrients, has an even stronger inverse association with CHD. The American Heart Association Dietary Guidelines therefore recommend consumption of a variety of grain products, including whole grains (three or more is suggested by some groups) for a minimum of six servings a day. The guidelines also recommend five or more servings of fruits and vegetables, which also provide fiber. Rather than setting a goal for fiber in numerical terms, the AHA guidelines note that adhering to these whole food recommendations (which include the regular consumption of legumes and nuts) can result in a total fiber intake of  $\geq 25$  g/day. These food-based recommendations will also provide 10 g of soluble fiber if a variety of foods are chosen.

Intakes of soluble fiber up to 25 grams per day as suggested by the NCEP are not practical solely from whole foods. Supplements of extracted fibers or functional foods with added fiber would be necessary to help patients achieve this goal (e.g., Metamucil® provides 2.4 g soluble fiber/rounded tsp). However, it is extremely unlikely that simply adding fiber supplements to a poorly chosen diet (lacking in whole grains, fruits and vegetables, nuts and legumes) would confer the protective benefit provided by a diet rich in fiber from adequate consumption of plant foods. Many of the phytochemicals that exist in plant foods are found in the fiber matrix. These substances appear to function synergistically within the context of the whole food to provide antioxidant and anti-carcinogenic properties.

Our message to patients and consumers should focus, first of all, on choosing a strong base of plant foods for their diet. Concepts that need to be communicated include:

- The importance of variety. A diet in which fruit juices and lettuce salads are the only sources of fruits and vegetables is unlikely to provide adequate fiber or protective phytochemicals. The concept of color variety can be helpful for patients to use in selecting fruits and vegetables. Exploring a variety of grains such as barley, oats, and rye that are richer in soluble fiber than wheat products can also be useful.
- How to identify whole grain products (e.g., looking for “whole” wheat or grain instead of “wheat” flour or “enriched wheat” as the first ingredient on a product label). Once this skill is mastered patients will be more confident in searching for and trying new products among the large variety of cereals, breads, and other grain products.
- Dispelling misconceptions regarding cost, selection, storage and preparation of fruits and vegetables; reassurance that frozen and canned produce may be used and in some cases may actually confer greater nutritional advantage than their fresh counterparts (e.g., enhanced availability of certain phytochemicals).
- Nuts are a healthy food. Instructing moderation in serving size (2 tablespoons to 1/4 cup each day), and how nuts can be incorporated into salads, grains and main dishes to add texture and flavor.
- Recognition of legumes (beans, lentils, peas) and how to include them daily in soups, salads, marinated as an appetizer served on crackers or bread, or as a dip for fresh vegetables. Canned beans (rinsed and drained to reduce sodium) can be used as a quick and inexpensive main course.

The following table provides approximate fiber amounts for each of the food groups likely to provide fiber in the diet:

## Approximate Fiber Amounts for Food Groups

Fiber content of plant foods	Total dietary fiber, g/serving	Examples: (Serving sizes based on 2003 exchange list for meal planning except nuts)
Whole grains	2.4	1/2 c oatmeal or bulgur cooked, 1 sl whole wheat bread, 3 c air-popped corn, 1/3 c cooked brown rice
Fruits (not including juices)	2.3	1 apple unpeeled, 1 c cantaloupe, 17 small grapes, 1 orange, 1/2 c canned pineapple or pears, 2 plums, 1 c fresh raspberries
Vegetables, starchy	3.0	1/2 c cooked corn, 1/2 c green peas, 1/2 c mashed potato, 1/2 c cooked yam
Vegetables, non-starchy	1.6	1/2 c cooked vegetable, 1 c raw vegetable, eg, carrots, romaine lettuce
Nuts and seeds	1.3	2 tablespoons nuts, 1 tablespoon nut butter or about 1/2 oz nuts (approx. 2 fat exchange servings)
Legumes	6.1	1/2 c cooked beans, lentils or split peas