

SLEEP APNOEA: A CAUSE OF HEART DISEASE AND CANCER

Sleep apnoea may affect one in four adults. If left untreated, it can play a role in causing heart attack, brain fog, hypertension, chronic fatigue, pain syndromes, stroke and cancer. It may be the result of underlying problems including hiatal hernia and chemical or EMF sensitivity.

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Disordered breathing, including the temporary cessation of breathing, during sleep or attempted sleep is called *sleep apnoea* (or *apnea*). We will see that as many as one out of four adults may have this usually undiagnosed but life-threatening condition. The seriousness of untreated sleep apnoea is indicated by its linkage to accidents, hypertension and heart disease, and in 2012 it was even linked to increased likelihood of cancer. It is also a probable causative factor in the pandemic of chronic fatigue syndrome (CFS), fibromyalgia and myalgic encephalomyelitis (ME). Thus, many people who seek out alternative practitioners may have sleep apnoea. It's not likely to be corrected by supplements. I have found it to be linked to other problems I have written about in NEXUS—including the hiatal hernia/vagus nerve imbalance syndrome, multiple chemical sensitivity (MCS) and electromagnetic field sensitivity (EMFS). This article explains the different types of sleep apnoea, how they are tested for, and mainstream and holistic types of treatment for it.

The Nature, Causes, Prevalence and Dangers of Sleep Apnoea

Possible symptoms of sleep apnoea include trouble going to or staying asleep, or being tired and unrefreshed upon awakening. Being tired or sleepy during the day—including having full-blown narcolepsy—snoring, and waking up gasping are other possible symptoms. It is a mistake to think that sleep apnoea only affects the elderly or middle aged or the obese.

There are two main types of sleep apnoea: *obstructive sleep apnoea* (OSA) and *central sleep apnoea* (CSA). A third type is their combination, called *mixed sleep apnoea* (MSD). Obstructive sleep apnoea refers to the closing off of part of the airways in the throat. Snoring is usually heard in sufferers of OSA. Snoring does not always occur, but a close-by snorer can have a decibel level exceeding that of a jet flying 100 feet overhead. The snorer will almost never be able to hear his/her own snoring, but the partner sure can! Many a marriage may have been prevented or terminated due to the decibel levels emitted by the snoring sleep apnoea sufferer and the partner's own ensuing inability to sleep. So, saving a marriage can be another reason to be tested and treated.

Central sleep apnoea refers to the brain not sufficiently innervating the muscles of respiration, which include the diaphragm and the abdominal and rib muscles. CSA may be caused by cardiac conditions, including the usually hidden PFO—the patent foramen ovale or hole in the heart that I have written about in NEXUS [see 18/03]. The PFO or other cardiovascular problem can lead to hypoperfusion of the brain. It is thought that many people with just OSA eventually also develop the central form.

Obstructive sleep apnoea can be treated with devices (CPAP or BiPAP) which breathe into sufferers, and with surgery, dental appliances and other methods. These other methods can include tongue muscle exercises and advanced energy balancing. Central sleep apnoea is treated via the breathing devices,

especially BiPAP. Sudden infant death syndrome (SIDS) may be a manifestation of sleep apnoea—perhaps, more likely, CSA.

Sleep apnoea—by virtue of the low oxygen states induced by obstructive or central sleep apnoea—stresses the heart, raises the blood pressure, ages the heart more rapidly and can cause a heart attack at any time if the apnoeic event lasts long enough. Diminished sleep, especially the rapid eye movement (REM) fraction, leads to a suboptimally functioning brain, which can cause narcolepsy, fatigue, accidents, "mental illness" and other problems.

A 2002 study reported: "On the basis of the average of prevalence estimates from these studies of predominantly white men and women with mean BMI [body mass index] of 25 to 28, we estimate that roughly 1 of every 5 adults has at least mild OSA and 1 of every 15 has at least moderate OSA."¹ This presumably refers to people in the USA.

A poll taken in the USA in 2005 by David M. Hiestand, MD, PhD, *et al.* led to the following results: "Of the 1,506 respondents, 26% (31% of men and 21% of women) met the Berlin questionnaire criteria indicating a high risk of OSA. The risk of OSA increased up to age 65 years. A significant number of obese individuals (57%) were at high risk for OSA. Those whose Berlin questionnaire scores indicated a high risk for OSA were more likely to report subjective sleep problems, a negative impact of sleep on quality of life, and a chronic medical condition than those who were at lower risk. Conclusions: As many as one in four American adults could benefit from evaluation for OSA. Considering the serious adverse health and quality-of-life consequences of OSA, efforts to expedite diagnosis and treatment are indicated."²

In 2012, a groundbreaking article noted that hypoxia (an inadequate supply of oxygen), which occurs in sleep apnoea, promotes angiogenesis. This is an increase in the vascularity that is associated with tumour growth. The article stated that a 4.8 times higher incidence of cancer mortality may thus be associated with sleep apnoea.³ Sleep apnoea also entails increased risk for stroke and diabetes.⁴

Note that it appears that most studies or polls only looked for obstructive sleep apnoea and not central sleep apnoea. So the percentage, at least in the USA, may be even higher, and the physician-authors are probably being conservative as well. Thus the prevalence of all forms of sleep apnoea may be 25 per cent or more of adults in some countries.

So, sleep apnoea is pandemic in western society. It is a

leading cause of fatigue, brain fatigue and rapid ageing.

Predisposing factors for sleep apnoea include sinus disease, tonsillectomy, obesity, smoking, alcohol consumption and, as noted and in my opinion, the hiatal hernia syndrome and also MCS and EMFS. It is important to note that many quite thin people also can have sleep apnoea. I believe that additional factors can be causative as well, and they include hypothyroidism and infection with micro-organisms—such as the very small spirochetes that cause Lyme disease and other diseases. These may get into the brain or otherwise play a role here. A tendency towards having trigger points can play a role here as well. Sleeping on a memory foam mattress or overlay may help (after it has outgassed, for those with MCS). Of course, this works both ways. Sleep apnoea contributes to causing fibromyalgia and other pain syndromes.

The more problematic central sleep apnoea usually does not entail snoring. CSA may be more problematic

because there may be less likelihood of the person's waking up during an apnoeic event, as the brain's signals are diminished with CSA—as opposed to OSA where a throat blockage occurs and the person usually awakens, sometimes gasping.

It sounds innocuous to say "she died peacefully in her sleep". But what if "she" had undiagnosed sleep apnoea and could have lived several more

years? So if the testing or treatment seems problematic, or if you just don't envision this as a serious problem, imagine this. Someone is coming into your room up to 100 times an hour, and he goes towards you and places his hands on your throat and chokes you for 30 seconds or longer. Many people who undergo the sleep test are shocked to find that they have had serious apnoeic events up to 100 times an hour. What you feel as an inability to go to sleep is revealed during the test as numerous apnoeic events. So, envision ridding yourself of someone choking you many times each night.

What took place some eight years ago with a client can be instructive. The person had MCS and EMFS. She also reported strange feelings and difficulty during the night, awakening with great distress. I told her that this could well be sleep apnoea and that she should immediately schedule a test and get treatment if she had sleep apnoea. Her husband replied that she did not snore. To this, I replied that this could mean that she had the even more problematic central sleep apnoea, and again I implored her to get tested as soon as possible. She replied that she had MCS and EMFS, and it was too difficult. I nonetheless implored her again. She did not schedule any type of testing, and she died in her sleep

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just a few weeks later. She was in her forties.

Yes, both the testing and treatment can be difficult for someone with MCS and/or EMFS. Indeed, sensitivity to chemicals or EMF can be part of the cause of sleep apnoea. As far as chemicals are concerned, you may be reacting to fragrance, formaldehyde, mould or other things in the room or bed—both at home or at the sleep centre. Regarding EMF, you may be reacting to the AC current in the room or from nearby towers, Wi-Fi or even the coils in your mattress that can absorb and re-radiate radiowaves or microwaves.

The kindling effect may play a large role in sleep problems. Just looking at TV or computer monitor screens can lead to hyper brain states. Indeed, I have had clients report back, after I had tested them, that not only was their sleep better but their asthma or hypoglycaemia was better when they avoided TV and the Internet. Some people also have hyperacusis and must avoid sounds to feel and sleep better. Again, the PFO or other cardiovascular problem may be causing hypoperfusion in the brain. Also, allergic or porphyric reactions to foods such as wheat, sugar, caffeine or others can also cause hyper states in many people.

Testing for Sleep Apnoea

The testing of sleep apnoea is called *polysomnography*. The person reports to a sleep centre for 10 to 12 hours. After a briefing and orientation to the room, the subject is "wired up" with sensors. These sensors may be placed on the chest, legs (looking for restless leg syndrome), face and throat. Sensors on the head will be part of an electroencephalogram (EEG) to measure brain waves, and there will also be an electrocardiogram (ECG) run throughout the test. Real-time monitoring and video recording also take place. Because of the cost, the distance from and the different environment of the sleep centres, various types of home testing are now available. Here, the various types of sensors and recording devices may monitor REM/deep sleep or chest or body movement. None of these devices can duplicate a full polysomnography nor include its immediate testing of the air machines and nasal or nasal/mouth cannulae, but they have home, cost, quickness and reusability advantages.

During the test, if the sleep technician sees—or the sensors indicate—significant sleep apnoea and/or concomitant medical problems, he or she may come into the room and put the subject on an air pressure machine.

**Regarding EMF,
you may be
reacting to the
AC current in
the room or from
nearby towers,
Wi-Fi or even the
coils in your
mattress that
can absorb and
re-radiate
radiowaves or
microwaves.**

When this occurs, the optimum settings for inhalation and exhalation can be gauged. Different types of nasal or nasal/mouth attachments can also be tested for efficacy. Sometimes, due to insufficient sleep during the test, a second test may be desired.

If both a sleep centre and home testing are not available to you in your region or country, the following can be used to help determine the possibility of your having sleep apnoea. Medical oxygen suppliers often can provide a recorded-pulse oximetry kit for home use. This test entails a pulse oximeter placed overnight on a fingertip and attached to a recorder. Episodes of hypoxia may be evidence of apnoeic events—especially if other heart and lung diseases have been ruled out. Pulse rate is also recorded this way. It may be a good idea for sufferers of any chronic illness to purchase their own pulse oximeter, as these now sell for under \$50—about one-tenth of what they were a dozen years ago when I first bought one for myself and my clients. The oximeter shines an LED light through the fingernail and detects the oxygen level on the haemoglobin of red blood cells. Overnight pulse oximetry, of course, cannot detect such things as insufficient REM sleep.

Air Pressure Devices

There is a very significant difference between the two types of air pressure machines available: CPAP and BiPAP.

CPAP denotes *continuous positive airway pressure*. CPAP devices have one continuous level, or one maximum level, of air pressure—presumably optimally determined from analysing the polysomnography data. CPAP was invented in 1980 by Dr Colin Sullivan, a physician and SIDS researcher from Sydney, Australia. Prior to

that, tracheotomy was actually employed for (severe) sleep apnoea.

BiPAP refers to *bi-level positive airway pressure*. The "bi-level" means that two different settings are used with these devices. The higher level refers to the maximum pressure that the machine can emit when it senses you are—or should be—breathing in, and the lower level is the device's maximum pressure when it senses that you are breathing out. The higher air pressure is needed to force air past blocked airways.

Some of these devices can sense if they need to emit their maximal pressures during inspiration and expiration, and they may emit a pressure less than their maxima if it is not needed at that moment.

Even in patients without sleep apnoea, BiPAP machines are now being used for treating chronic obstructive pulmonary disease (COPD), pneumonia, asthma and heart failure.

The difference between CPAP and BiPAP devices is evident during the exhalation phase. With BiPAP, this pressure is significantly less than the pressure during inhalation, so the person does not have to breathe out against the higher pressure when it is not necessary to do so. The CPAP device has only the one level, though more recent CPAP devices may have some (sensor-controlled) variability capability. The point is that, for some or many, it can be an unnecessary struggle to breathe out against the machine. The elderly, asthmatics, the obese and people with other conditions can have great difficulty with CPAP.

Indeed, it is hoped here that CPAP will eventually be eliminated and that everyone who tries these devices uses a BiPAP. It is estimated that about 50 per cent of people who try CPAP discontinue its use. Many of these people do not get other treatments and so are at great risk. Perhaps if only BiPAP were used, the 50 per cent figure would go down.

If you get a CPAP or BiPAP device, make sure it has a heated humidifier. With this, the air first passes over a container of water, which itself can be heated. This prevents dry and/or cold air from entering your lungs, which could cause problems. People with asthma or reactive airways disease (RAD) or other medical conditions will not do well with dry or cold air. Inexpensive bacterial and viral filters can also be added to the air hose line.

The CPAP or BiPAP machines themselves can be problematic for sufferers of MCS or EMFS. To lessen the sound level, there is foam in the machines but it needs to outgas for the chemically sensitive. Likewise, the full mouth and nose coverings can contain numerous chemicals. If just a nasal cannula can be used, there are silicone cannulae available that are usually well tolerated by those with MCS. Timely outgassing of the full-mouth cannulae and the machines themselves should help. The machines, of course, emit their own EMF, but the intensity falls off with the square of distance and a longer hose can be used. The machines could also be shielded and surrounded by metal foil for the very EMF sensitive.

Some people who reported correcting the chemical or electromagnetic problems with their sleep room ameliorated their "insomnia".

Dental Appliances and Surgical Options

Another possible treatment for OSA is the fitting of an oral appliance. Specially trained dentists can make a moulding and create a dental appliance that facilitates keeping the airway in the back of the throat open during sleep, thus preventing or reducing apnoeic events. However, this does not help with central sleep apnoea.

People with significant sinus disease may not be able to use CPAP or BiPAP devices.

I knew someone who had nasal surgery, and because of this, when she tried to use CPAP, the air went into her stomach, not her lungs, and she had a dental appliance fitted.

Advocates of the Buteyko system report that just taping the lips closed during sleep, to prevent low CO₂ status (hypocapnia), can improve sleep.

Surgery for OSD is also available, and there are at least three variations: traditional (scalpel) surgery, radio wave surgery and laser surgery. The first is probably performed most often. The last, laser surgery, is probably the most expensive but is said to yield the best results and quickest recoveries—though insurance companies often only reimburse for the first option, and then only if the pressure devices cannot be used or tolerated. With the second and third options, radio waves and laser beams burn away some of the throat tissue.

Note that with all three types of throat surgery, some people have reported that their throat tissue grew back. I know that those who do neural therapy injections would not advise the massive creation of scar tissue, but I do know people who did well with laser surgery.

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Hiatal Hernia and Hypoglycaemia Connections

There is clearly a hiatal hernia connection with sleep apnoea. I have had clients tell me that upon following my advice and elevating the top of their bed and/or sleeping on a wedge, their "insomnia" vanished or improved. Obviously, all the diet and lifestyle changes I noted in my NEXUS article would be a good idea here [see 18/04], as would doing the simple self-help corrections for the hernia, diaphragm and vagus nerve depicted in my book.⁵ A good time to do these corrections is before going to bed.

Now, one of the mainstays of hiatal hernia treatment is not to eat for several hours before going to sleep, but this can be problematic for those with reactive hypoglycaemia or porphyria.

Hypoglycaemics and/or porphyrics might crash in a few hours and so will tend to want to eat just before going to sleep. This may then cause apnoeic events because of the hiatal hernia. People who get up a few hours after going to sleep and can't go back to sleep, and may also be hungry or agitated at this time, may be hypoglycaemic and/or porphyric. Taking vitamin B6 before sleep can also cause some people to wake up a few hours later and be unable to go back to sleep.

Eeman and Lindemann Screens and FIR Pads

Here are three additional items that may improve sleep and also ameliorate chronic pain syndromes.

First I will describe the little-known *Eeman screens*. Leon Ernest Eeman was a British World War I pilot who crashed shortly after a flight take-off and was left in a disabled state. He suffered from constant, severe pain which also prevented him from sleeping. His doctors told him that his condition was hopeless. So Eeman began to study everything available to try to help himself. He created a system of copper plates which, when placed in certain positions on or under his body, cured his pain and sleep problems.

The underlying basis for this can variously be called "polarity", or maybe "Tibetan energy flow" or "figure-eight energy flow". So perhaps Eeman came across some ancient eastern wisdom. Kinesiologists also put the body into a figure-eight position to facilitate this energy flow. Eeman's copper screens

apparently significantly increase the body's proper energy flow—whatever that may be.

Some people have reported a duplication of Eeman's results of pain or insomnia cessation. You can search online for companies that make copper Eeman screens. These involve a copper screen attached to a tubular copper rod that is held in the hand. A screen, placed under the head, is attached to a copper rod which is held in the left hand. At the same time, a second copper screen is placed under the base of the spine (coccyx) and is attached to a copper rod which is held in the right hand. The feet must be positioned such that the left foot is on top of the right foot. This can be problematic for those with arthritis or obesity.

A variation of the Eeman circuit is the *Lindemann symmetrical circuit*, and it may be a powerful improvement. Three sets of copper screens are used. One set is for the head and the coccyx (screens on both ends), and the other two sets are for each foot with the other end being held by the opposite hand. The feet can be kept apart with this set-up. The feet screens, at least, should come with attached straps. Note that one acupuncture method

for people with poor circulation in the extremities is to needle certain points on the feet and hands simultaneously. This may work similarly. But here there are no needles and there is no electricity—only the body's own energies apparently being properly directed or redirected.

Another method that may afford improved sleep and/or pain reduction is the use of a far-infrared (FIR) heating pad. This does involve AC current and so may not be suitable for those with certain problems such as EMFS, mast cell disease and others. As with the Eeman screens, some people report a deep calm coming over them in minutes which helps reduce pain and/or leads to sleep. I have tried both of these methods (I have no connections to any of the devices' manufacturers) and can attest that they can quickly afford deep relaxation, but they were not curative of anything for me. Again, these methods are not substitutes for a sleep study or other treatment if the problem is moderate or severe.

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Drugs, Vitamins, Cold Packs

Drug treatment for insomnia can be very dangerous if sleep apnoea is what is really occurring. This is because the drugs may artificially "knock out" the sufferer to the extent that he or she may not wake up during an apnoeic event.

Supplements for insomnia have been very popular for decades. These supplements have included tryptophan, 5-hydroxytryptophan (5-HTP) and melatonin. For some people

these work fine, but people with asthma or porphyria may not tolerate any of these. Often better tolerated—even for (hidden) porphyrics—can be GABA (*gamma-aminobutyric acid*) or the newer form, PharmaGABA. GABA is an amino acid and inhibitory neurotransmitter found in the brain, and the PharmaGABA form better crosses the blood-brain barrier and is taken in smaller amounts. It can provide a very natural calmness and sometimes sleepiness. For chronic pain sufferers, I also note that D-phenylalanine has become available recently—not the DL form, but pure D-phenylalanine. This appears to be far more effective for pain and can also aid sleep. Again, no supplement should be a substitute for having polysomnography if sleep apnoea is suspected. In addition, all supplements should ideally first be tested kinesiologically. Also be advised that in some people with fragile thyroid function, supplements that can aid pain reduction, insomnia or anxiety may cause hypothyroid-like reactions.

Sleep may also be facilitated by placing a cold gel pack on top of the head and/or by cooling down the room. The gel pack should be stored in your freezer for use when you

have anxiety, insomnia or similar problems. This treatment may also help with pain, flushing and even respiratory and circulatory problems. The ancient Greeks knew some things better than do most physicians today. They coined the term "hothead" and sought ways to cool down the hot head in people with hyperactivity or anxiety. If mild insomnia is present, try this.

According to oriental medicine, flushing may occur because some aspects of *chi* may not be flowing to the extremities and can build up and overheat the head and face. Western medicine might say or find that blood and/or lymph flow are reduced to the extremities, and again flushing can result. There may be underlying cardiac problems and/or such things as ongoing reaction to monosodium glutamate (MSG) or certain foods.

While the head may be overheated, the extremities may be too cold. Some people will sleep better while wearing socks and gloves. Organic cotton may be best for the chemically sensitive. If tolerated, FIR socks and FIR gloves are now available, as are FIR blankets and FIR mattress covers. These reflect the body's heat back to the wearer. On the other hand, some people when ill or agitated have very irritable skin and may prefer to sleep totally nude. They may not want to wear any clothes at all during the day as well.

Having irritable skin while being agitated is unfortunately considered by some to be a psychiatric disorder—as depicted by the Billy Chenowith character in *Six Feet Under*—but is understood by this author to be a manifestation of mast cell disease (MCD) [see NEXUS 19/02]. MCD, in my opinion, is another hidden cause of the present explosion in sleep disorders.

Basic and Advanced Muscle and Kinesiology Help

There are mouth/throat/tongue exercises that may reduce obstructive sleep apnoea by strengthening the airway muscles. Over time, OSA should diminish.

1. Press your tongue flat against the floor of the mouth, and brush the top and sides with a toothbrush. Repeat brushing five times. Perform several times a day.
2. Press the length of your tongue to the roof of your mouth, and hold for 2–3 minutes once daily.
3. Place a finger into one side of mouth. Hold the finger against the cheek while pulling the cheek muscle in at the same time. Repeat eight times, then rest and alternate sides. Repeat three times.
4. Purse your lips as if to kiss. Hold your lips tightly together and move them up and to the right, then up and to the left, 10 times. Repeat 2–3 times during the day.

Advanced kinesiology methods that I have devised are far too involved to present here, but are in line with the

methods I describe in my article on applied kinesiology [see 18/06]. I have created a mode or test for sleep apnoea and then use the advanced method to balance as much as possible for it, if it tests positive. All the kinesiological modes I have devised—including for sleep problems, PFO, porphyria and other imbalances—are correlated with positive medical test results.

Every person's advanced balance is different, and the word "cure" is never used here. I still advise everyone who suspects they might have sleep apnoea to utilise the overnight sleep study, or the overnight pulse oximetry, or other recently devised home testing devices, and to undergo one of the treatments if significant apnoea is found.

Having a CPAP, or the better BiPAP, around is a good idea. BiPAP machines, as we saw above, are even being used for respiratory and cardiac emergency or failure. A prescription for a device will list its parameters. For example, a BiPAP might be written up with the make and model of the device desired for the patient and the diagnosis, and say something like "17/12". This would refer to its two main settings. The higher number is the setting for inspiration, or IPAP, and the lower number is the setting for exhalation, or EPAP. (The pressure units are in "millimetres of mercury".) A CPAP device has just the one parameter, and might say "14 mm".

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Conclusion

All too many of both orthodox and holistic practitioners act as if they believe their role is confined to dispensing pills, and many do not consider testing for and treating many causative factors including possible underlying sleep apnoea which is pandemic now. If one out of four adults in general has sleep apnoea, this may imply that a significantly higher percentage of people who go to holistic practitioners have some form of sleep apnoea—considering the type of complaints often presented. Yet many holistic physicians, I have found, do not even know how to write a prescription for the test, or how to read the simple report conclusions, or how to prescribe a CPAP or BiPAP device.

Untreated sleep apnoea plays a role in causing or exacerbating accidents, chronic fatigue, brain fog, fibromyalgia and other pain syndromes, hypertension, heart disease, more rapid ageing and even cancer, as we have seen recently. Of course, death can occur at any time as well. Common signs are trouble going to or staying asleep, snoring, tiredness during the day and others. The polysomnography test was described, as was

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the overnight pulse oximetry test if the former test is not readily obtainable in your area. The air pressure devices as well as numerous other types of orthodox and holistic treatments were also described. Get tested now if you have any of the possible complaints.

If you have sleep apnoea, get some form of treatment for it soon. Due to the seriousness of this condition, the decision to undergo a sleep study—if you have the symptoms—should be made immediately. Clearly it should not be a decision...to sleep on.

With a nod to the Bard, I say that one of our goals might be this: "To sleep, perchance to dream... Better still to wake up anew and with vitality." ∞

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past 32 years he has researched chronic and environmental illnesses and taught his seminars across the world. His unique system incorporates breakthroughs in energy kinesiology, nutrition and human ecology. Dr Rochlitz is the author of 10 books. This article is partially extracted from his breakthrough book *Porphyria: The Ultimate Cause of Common, Chronic, and Environmental Illnesses*.

Further research is at the website <http://www.wellatlast.com>. Dr Rochlitz can be contacted by email at info@wellatlast.com.

Endnotes

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