Diet Doctor Podcast
with Dr. Ana Lorenzo
Episode 66

Dr. Bret Scher: Welcome back to the Diet Doctor podcast. I'm your host, Dr. Bret Scher. Today I'm joined by Dr. Ana Lorenzo. Now, as you'll hear us discuss, Ana's a little unlike any other doctors we've had on this podcast. She's an ophthalmologist. And what's interesting is this metabolic disease we talk so much about, whether it's insulin resistance, it's type 2 diabetes...

So much of the focus is on the heart, the kidneys, the blood vessels, sort of the overall metabolic condition, but it also affects the eyes and it can affect it quite severely. So, as we're going to hear, Dr. Lorenzo specializes in what's called anterior segment surgery or cataracts. And people with type 2 diabetes are more likely to get cataracts.

But when she looks into someone's eyes and can examine and see the back of their eyes, she can already see changes from diabetes called diabetic retinopathy and through her own personal experience and her family experience, she came across low-carb lifestyle as a way to dramatically improve and treat blood sugar control for people with type 2 diabetes and now she's able to apply that to her patients who she sees for eye problems but then can make the diagnosis of type 2 diabetes or can help treat their type 2 diabetes with low-carb lifestyle.

So it's a wonderful example of, you know the old saying of "stay in your lane"... Well, she didn't stay in her lane and thank goodness, because she's helping so many people. You might say eye doctors just need to stay in their lane and treat the eyes... But, no, she took it into her own hands to help her family and now she's using that to help her patients.

And I think it's a wonderful example. And you can see she's a very kind and caring person, so she definitely wants to help people and this is a great way that she can do it. So, I hope you enjoy this interview with Dr. Ana Lorenzo. Dr. Ana Lorenzo, thank you so much for joining me on the Diet Doctor podcast.

Dr. Ana Lorenzo: Thank you, Dr. Bret, I'm very happy to be here. For me it's an honor. You are one of my long-distance teachers, so I'm so excited. And Diet Doctor it's been a great tool for me and my patients. So, I can't be happier. Thank you so much.

Bret: Thank you for that, I appreciate it. We've had quite a few doctors on the Diet Doctor podcast, but most of them deal with sort of the internals of the body. The metabolism, the heart, the kidneys, the endocrine system.

But now you are an eye specialist and I'm sure a lot of people are thinking what does have the eye have to do with glucose and insulin metabolism and overall health? But interestingly it does.

And I definitely want to get into that. But first, tell us a little bit about your background and how you got into being an ophthalmologist and specifically a cataract specialist.

Ana: Well, I studied medicine at Anáhuac University. It's a very prestigious university here in Mexico City. And I like all specialties, I wanted to be a cardiologist, a neurologist, an internal medicine doctor, but at the end I decided I wanted to do a surgical specialty.

So I wanted to make a difference in the world so I just thought that ophthalmology would be a high-impact specialty because the sight is valuable for a lot of patients. And also for the lifestyle that I wanted to be able to... to manage my own time. So that's why I chose ophthalmology among other reasons.

Bret: Yeah, that's a good description. It's important to feel like you're really making an impact and seeing that impact. And with ophthalmology you certainly can see that. I mean, people walk out of your operating room completely different in terms of their ability to see. And that's pretty remarkable. But one of the things that I always really took in with awe, amazed about this, is how much you can learn by looking into somebody's eyes.

And it's one of the hardest physical exams to get used to. You know, putting the stethoscope on someone chest and listening to their heart is pretty easy. But taking the special magnifier, looking into someone's eyes, getting real close and actually seeing the back of the eye can tell you so much about a person's overall health. So, the eye is the window to the soul, but the eye is also sort of the window to the health. So, tell us about some of the things you can learn just by looking into somebody's eyes.

Ana: Yeah, at least here in Mexico you don't get to know a lot about ophthalmology until you enter the residency. Because it's a very different to look through the ophtalmoscope, than to look at it from the slit lamp. It's very different. You can see a lot of things, a lot of signs. For example people don't even know that they're diabetic and I find out some signs into their eyes when I do the retinal exam with the dilated pupil and I can see macular aneurysms or hemorrhage or other stuff.

And I tell them, "You are diabetic", and they didn't even know that they had diabetes or hypertension or some other problems that you can directly see into their retinas. So, we tend to have a lot of patients with undiagnosed diabetes, but with our medical exam we can diagnose them.

Bret: So, that's pretty remarkable that they walk into your office because of an eye problem, but then you can make the diagnosis of the systemic metabolic disease of type 2 diabetes, or hypertension, or metabolic syndrome that they had no idea they even had. I mean that's a pretty powerful diagnostic tool. No blood test needed, no special scans needed, just looking in the back of somebody's eyes.

So you mentioned some fancy terms there, but basically, if you were to simplify what those terms mean it's an abnormality of the blood vessels in the back of the eye, which can then affect the retina itself and the vision itself. Is that sort of an accurate way of saying it?

Ana: Yes. The problem with diabetes is that it affects the small vessels in the retina. Sometimes they can dilate and form micro aneurysms. And these blood vessels are tiny blood vessels, they can leak, they can cause macular edema. They start leaking and is like an accumulation of fluid between the layers of the retina.

But on the other side they can close up and then you have macular ischemia because the blood can't reach the retina, the layers of the retina, and then you have ischemia. So it can go both ways, but you can see the changes, early changes, even if the patient has a vision of 20/20, you can look at the signs and know that they have some sort of a disease.

Bret: That's interesting. So there could be zero vision changes. Their vision is perfect, as far as they can tell but they could be having already manifestations of this. So, if they were to develop symptoms of diabetic retinopathy or the eye disease from diabetes what type of symptoms would they start to present with?

Ana: At the beginning most patients are asymptomatic. They don't see any changes, that's why it's very important for patients to check their eyes at least once a year, even if you think you're healthy. But here, in Mexico at least our people don't go to preventive medicine. They only go to the doctor when they have some symptoms, they can't see very well or they want to change their glasses prescription.

And that's not very good. Or maybe they come, but when they start having this vision loss and their diabetic retinopathy is already advanced and there's not so much that we can do about it or it's harder to treat. So, it's advisable for all patients, even if they think they are healthy, even if they think they have very good eyesight, to check their eyes at least once a year. Because there are silent diseases like diabetic retinopathy, but there are others like glaucoma. So, it's advisable that people check their eyesight once a year.

Bret: Yeah, that certainly makes sense. Then if they have symptoms like floaters, like little dark spots floating across the vision or black spots where they sort of can't see. If it's part of their vision, obviously that's sort of a red flag that they need to get their eyes checked right away as well.

Ana: Yeah, and a very early sign of for example diabetes is that they can have changes in their eyesight even in the same day. For example, they say in the morning, my eyesight is better, but in the afternoon, evening, it's getting worse and then come back again. So, that's an early sign and that means that their glucose levels are changing.

That's a very early sign. It's important for example to know if your glucose level is high, you can't get a prescription for glasses, because it's not going to help you. It's going to change and then when your glucose levels go down again, then your glasses prescription is going to change again. But it's important to have like a stable blood glucose before you have a prescription.

And that's because the crystal indents get swollen and then your prescription for your eyesight changes a lot. So, that's a very early sign and that's when you start suspecting that something is off when people tell you that their vision is changing a lot during the same day or maybe in a day or two it's changing a lot, that's like a red flag for me.

Bret: Okay, interesting. Now, I'm sure you see a high percentage of patients with diabetes, because type 2 diabetes is also a precursor to developing cataracts, which is your specialty, but that's something that you can sort of treat.

You can remove the disease lens and put new lens in and they are basically good to go. You sort of fix their cataracts. It's the same true for diabetic retinopathy? Is that something you can fix or reverse? Or is just something you just sort of try and manage with surgery?

Ana: It depends on what stage of diabetic retinopathy the patient is. For example if it's very ear-

ly or it's very recent macular edema, then it's completely reversible. And this is the early stages when they can have a perfect vision, so it's important to check them and to manage their diabetes.

But, for example, if it's chronic macular edema, that means more than three months, then it's harder to reverse it. There's basically two different stages when it's non-proliferative diabetic retinopathy and that usually is reversible. Or at least manageable. But when this progresses to proliferative diabetic retinopathy, then it's harder to treat and also sometimes it's nonreversible.

The difference is when you have a proliferative diabetic retinopathy there are new blood vessels that form, but these new blood vessels are really thin, and they break and then you have a vitreous hemorrhage or hemorrhage in between the layers of the retina and then it progresses, you can have retinal detachment or other irreversible consequences. So, it's very important to check them in early stages, so that it can be reversed. For examples if it's macular edema, it's reversible, but only when it's not chronic.

Bret: And now I'm sure, when you entry your ophthalmology training, you learn all about the photo coagulation and vitrectomy and the different surgical approaches to addressing diabetic retinopathy. But did you learn anything about treating diabetes and trying to manage diabetes with lifestyle potentially to help reverse or stop the progression of diabetic retinopathy?

Ana: Not at all. In medical school we learned that diabetes is a chronic condition, non-reversible, progressive, basically is a life sentence. I also learned at residency that the only thing you could do is to have a close follow-up of patients so that you manage their symptoms with either photo coagulation, that's laser, or with antiangiogenic drugs, that's injections into their eyes, but unfortunately these injections for macular edema or trying to prevent the proliferation of new blood vessels, that only lasts for about a month.

So, patients have to come back, have those injections every month, so that's not a very good quality of life. So, that's what I learned and that you can only manage the complications as they present. Bu now I know better.

Bret: But now you know better, exactly. So, now you've been a vocal supporter of using lifestyle, specifically nutrition and specifically low-carb lifestyle to help treat the underlying diabetes and thereby also treating the diabetic retinopathy.

So, before we get into sort of the specifics of how that works, tell us about your personal journey and how you came to learn about low-carb lifestyles and the effect they can have for health, because, like you said, you didn't learn in your medical training, so how did you learn it?

Ana: My journey started about five years ago and it all started because of my dad. I remember it was New Year's eve, I was at the beach with my now husband and my sisters called me worried about my dad, because he had been losing weight and he had a bad flu. I think he'd lost around ten kilos.

That's about 20 pounds in about 15 days. And he wasn't getting any better from the flu he had. So, the first thing we thought was that he had cancer. And I ordered some blood work and it was a surprise to know that his blood glucose was around 300 ml/dL, that's about 18 mM/L.

Bret: Very high.

Ana: Yeah, very high. So, he was diagnosed with diabetes. So he was referred to an endocrinol-

ogist and he started as every other diabetic patient with medications and with low fat and high carb, whole grains and orange juice for breakfast and all this crazy diet and crazy treatment.

At the beginning the endocrinologist managed his blood glucose, but he started feeling not so well. For example he loves to take long walks in the park, but two times he just lost consciousness, because he had a hypoglycemia.

And they called my mom... it was really bad. So, I talked to his endocrinologist and asked him to lower his medication. But he was reluctant to do so because he thought his glucose was well-managed while he didn't exercise. So, just told him to not exercise. And he was like really sad. He was disappointed. And I started doing my own research because I knew what that path could be.

As a doctor, I knew that he would only be put on more medication and then insulin and then three types of insulin and maybe he would go blind or start with nephropathy. So I just started doing my own research and that's how I came across the low-carb world and the ketogenic diet and Diet Doctor and Dr. Jason Fung and everything changed for me. I started questioning everything I've learned about nutrition and the way we treat diseases and to ask myself if this is the best way or the best treatment especially for diabetes.

I talked to my dad about all that I was learning, but first I started doing myself the ketogenic diet, because I wasn't going to put my dad or any other patient through something that I wasn't... Hadn't gone through. So, I did it myself and for me it was amazing because I've lost like 5 kg. Like 10 pounds in about two weeks. I didn't have like a lot of weight to lose, but I started feeling amazing.

My focus, my energy, even my exercise performance, everything was better, I was feeling so great. So I started talking to my dad about this new treatment I'd just discovered. But at the beginning he didn't want to-- He wasn't sure about this new way of eating because it was exactly the opposite of what the endocrinologist was prescribing him. So I reached out to Dr. Jason Fung and I went to Toronto to do a clinical rotation and that's also when my life changed because I learned that diabetes is reversible.

I knew a lot of patients who could reverse their 20+ years diabetes; they were in high doses of insulin. And all of that was reversible. So, I came back and within one month my dad lost... Well, he just went off medication and his blood glucose was at normal levels.

Bret: I'm dying to know how did this doctor react to that. The doctor who said you just can't exercise and stay on your high doses of medication. How did he react when your father responded so well to a low-carb diet?

Ana: He didn't respond very well. He was actually mad at me. Because he thought that I was hurting my own father. But he saw the results. He had had a lot of gastrointestinal upset and when he stopped taking the medications, everything changed for him. I was very closely monitoring him, I called him every day.

And one day I called him, "Dad, how are you doing?" "Oh, I'm all right. I'll have to call you back because I'm at the gym now." So, he went back to exercise... I mean his whole life changed.

Bret: That's remarkable.

Ana: Yeah, and he definitely stopped seeing that doctor because he thought he was going to hurt himself and he didn't want to get involved in--

Bret: Yeah, it's such an interesting way to how to think about a doctor like that. Because it was not like the doctor was trying to hurt your dad. It's not like the doctor was trying to be mean or controlling necessarily. But that's just the way the doctor was taught. And let's face it, as physicians, we're not really taught to question guidelines.

We're not taught to question authority, which is a big problem I think in medical education. So anything outside of what the guidelines say was completely foreign and a threat. So on the one hand you can sort of understand why the doctor would react that way, but when he just comes out of the common sense and hearing stories like this... It's like how could anybody react that way.

We really need to be more open-minded as doctors. So, stories like yours are incredible, because you have the personal experience of trying it yourself, trying it with a family member, seeing the life-changing potential. And then you go forth and you can apply it to your hundreds if not thousands of patients that you see.

So, how did you then make the transition to treating your patients who come to you for a different problem? I mean, they're not coming to you for diabetes. They're coming to you for cataracts and for eye problems. So, how did you make that transition into trying to help them understand the importance of nutrition, and lifestyle, and carbohydrates and so forth?

Ana: Yes, Bret, first of all I'll have to say that I don't blame this particular doctor or any other doctor, because I was one of them. When I was in training I used to look up at all my teachers and I thought that they were doing a great job and I learned from them.

And I think it's just the system. It's what you learn but it's important to... to raise your voice and to see if there's something that's not working... look for something else. So, I want to tell you a story. When I finished my residency and I started seeing patients, a lot of them would complain that when they started insulin that their eyesight was even worse.

And they were telling me about thinking... about not taking the insulin any more. And I would tell them, "No, don't do that. The insulin is helping you, so don't stop it. You're going to hurt yourself." But right now, with the knowledge I have right now I understand. Now I believe them.

And I think it's exactly because the insulin, the only thing that it's doing, it's pushing the glucose into the cells, including their retina and... All the cells in the body. So, it's logical that's getting worse. That their vision is getting worse. So, I now believe them and I try to take them off insulin and I encourage them and tell them that it's possible.

Bret: Yeah, and they must look at you a little crazy saying, what's and eye doctor doing telling me about nutrition, especially when my regular doctor is not teaching me about nutrition. So, do you get some resistance in some people thinking like, she doesn't know what she's talking about? Or people seem to be more accepting of nutritional advice from you, especially low-carb nutrition advice?

Ana: Well, I'm lucky enough to have some examples. For example when I tell patients about my dad, I don't try to push the low-carb diet, but I always tell this story of my dad or of my husband who also... He had a hypertriglyceridemia. He was like in the high 700s. And only with diet in one month he went from 700 to 150 mg/dL.

So I tried to tell these stories to my patients. And they trust me, they don't think like this is just a fad diet or some experiment that the doctor is trying on me. This is something that I tell them

the story of how my dad reversed his diabetes or my husband... So, they trust me even more, because I try to explain them that way.

So, they just say, I'll give it a try. And I try to... Well, I direct them to my social media or my webpage, because sometimes I don't have like a lot of time at that moment to explain them. And when they do their own research, they come back to me to help them with the diet and the... And all the other, sleep and... I try to incorporate a lot of other stuff. Other than diet in their lifestyle.

Bret: Yeah, definitely a multifaceted ophthalmologist, looking at far more than just the vision and the eyes. That's wonderful. Certainly it seems like you've got a nice sort of protocol figured out. I mean just by who you are and clearly caring for your patients and being interested and wanting to help them. Plus with your own personal stories and your family stories and your patients stories.

You can really connect with them and having another avenue to send them to with videos. But it seems like you probably have another hurdle. So being in Mexico City... I mean let's be honest... The Mexican culture is very involved with food and specifically carbohydrate rich food with beans and rice and tortillas and chips.

And that's a hurdle in and of itself. So, tell us a little bit about what you encountered from that standpoint and what some of your strategies are to help people kind of get over that?

Ana: Well, in Mexico food is delicious. And I think since you are a little kid, your mom and your grandma they are demonstrating their love with food. So, people here are used to use food as a comfort. So, it's very hard... And people love their beans and they love their tortillas and sometimes they are reluctant to change.

But I use a lot from the Diet Doctor website to show them that they can switch... And some very easy like swap things to make them delicious. And for example for tortillas, we have here, many people don't know them, but we have nopal tortillas. That's a cactus that it's very prevalent here in Mexico and it's really high in fiber and very low in carbs, in net carbs.

So, we usually do the little switch to tortillas, to nopal tortillas. Or, for example, if they go to eat tacos that it's... everyone eats tacos in here... I just ask them to wrap them in lettuce instead of tortilla. Or cheese, like hardened cheese. So, it's not so hard for them. Also for hamburgers, I also ask them to have them like between two lettuce wraps.

So, small changes that they can do to improve. Other things that I do is for example instead of rice I teach them how to make cauliflower rice. So it tastes exactly the same. Or very similar. So, when they notice that they can eat almost as before, just with little tweaks, then they get motivated because they see results and they start making these changes.

Another tool that I use a lot is the continuous glucose monitor. For example a couple of years ago when I came back from Toronto, there was none in Mexico. So, I tried to bring here as much as I could and that was, for example for my dad was a very helpful tool.

Because he didn't want to leave rice for example. I always... The first step always in the treatment or in the protocol is to switch from processed foods to natural foods. So, my dad was, oh, but beans are natural, they're not processed. So I don't think they are bad for me.

But when he got the continuous glucose monitor he started to see how his blood glucose would spike and then go down even at low levels at the beginning. So, when you have a visual clue of what's happening with each type of food, then they get it and they start changing and that's when

they get the importance of the carbs and everything else.

Bret: I'm thrilled to hear that you're using glucose monitors, CGMs. We had a whole episode of the podcast with Dr. Casey Means talking about CGMs. And they are so valuable for patient learning experience, both, you know, how their actions and what they're eating, how it affects their blood sugar and that immediate feedback is so important.

So, I'm glad to hear that you're doing that. And I mean substitutes are so important, because, you know, at Diet Doctor we have these tortillas that you can make with eggs and psyllium husk so you don't have to give up tortillas.

And if you're using cauliflower rice, you can still season it with similar seasoning to get a similar taste, but I'm sure there's a sort of a resistance at first or a hesitancy especially in families that have like multi-generations living together, because older generation might have zero interest in making any changes. And younger generations too, if the taste is different they might not be interested. So, someone making a change for themselves is one thing.

Someone making a change that involves other members, the family, can also be challenging. Is that something you see in Mexico with maybe like multigenerational living situations and difficulty or barriers from that standpoint?

Ana: Well, I usually have the mom or the spouse of the patients coming to the consultation, because they're the ones who cook. So, if they understand how is the diet, what changes they have to do, then the whole family will do the changes. The most extraordinary case that I've had up until now it's been a patient who was born with a genetic condition, called Prader-Willi syndrome. So, she was a 39-year-old female patient.

So, she came here with obesity since childhood and she had short stature and small legs, small arms. And these patients usually they have obesity since childhood and they're always hungry. So it has been until recently that it was discovered that they have leptin resistance. They have very high levels of leptin, so, for them it's sad, they're always hungry.

So, this patient came with her mom and so I explained to her mom and we made a protocol for her. She started eating only three times a day, tried to avoid snacks, only natural foods, nothing processed. And it was a slow progress with ups and downs, but finally, after like six months, she could lose about 25 kg, that's about 50 pounds.

And also she could leave a lot of the medications was taking. For example she was on three different types of insulin, she was taking oral hypoglycemic agents, she was even taking SSRI for anxiety and agitation. So we could start taping her off and now she's doing great and I think she is an example because if someone with those levels of leptin resistance and being always hungry could improve that much, I think anyone can do it.

Also, her mom told me how it has changed her life and how she's happier now than ever before. So, I think involving the whole family, especially the moms, can be really helpful.

Bret: Yeah, that's a great example of something that's so important. People don't have to and shouldn't do it alone, but engaging the entire family as assistants and educating them on the importance of the change. It's wonderful, that's great.

So now that you've been doing this for years now, helping people change their diet and promoting low-carb, have you started to see patients come back so you can re-examine their eyes and

see any changes, either any improvement or certainly lack of progression?

I guess my question is twofold... Have you seen that? And then is there any studies or evidence or science to support that nutritional intervention can halt or reverse the progression of diabetic retinopathy?

Ana: In the ophthalmological medical literature is clear that the number one factor for developing or the progression of diabetic retinopathy is to control of the blood glucose levels. So, with this intervention we can see that people really stop-- I usually operate on patients, but then I have them come back at least every six months, or earlier if their disease is more advanced.

People notice that they see better, that they're not progressing, that they are losing weight, so I can definitely see especially not progression and improvement in their eyesight if their diabetic retinopathy is not in late stages. But yes, there's evidence, and I think that low-carb diets and ketogenic diets and fasting, all of them have shown to help with the control of the glucose levels more than anything else.

Bret: Yeah, and I have seen some research about ketogenic diets for glaucoma and for optic nerve disease. You know, they're small studies and I don't think a lot have been done. I tried to do a search and didn't come up with a whole lot, but I would hope that this is a field that's going to get more and more attention, because just like we are worried about the vessels elsewhere in the body and metabolic health elsewhere in the body, it affects the eyes as well.

And let's face it, there aren't a lot of great treatments to reverse it, to reverse that problem, especially if it's late on, like you said. So, if something as simple as nutrition can make the difference, that's something I'd like to know about and certainly hope more people are studying it. Have you started to see any trends in the ophthalmology community? Like in conferences or just other colleagues talking about it that people are starting to get more interested in lifestyle interventions for eye disease?

Ana: Not very much, at least not here in Mexico. Unfortunately, they are more focused on the new antiagiogenic drugs or the new types of laser to photo-coagulate their retina but not so much in this intervention like lifestyle interventions.

But I think... well, we're spreading the word, so I hope that-- Especially if we can tell the patients, then the patients tell their primary care doctors and I think that slowly we're going to spread the word. And for me is very important that patients know that this is not a chronic condition... Well, it's chronic, but it's not a life sentence.

That they can reverse it. Most patients think they can't, so they're depressed... They don't even take good care of themselves, because they don't know how to. It's just a matter of telling them or showing them the way that they can do something about it besides medication. And that's when they open their eyes and start doing small changes. But yes, in the ophthalmology world, not yet. We're starting. And more people will get in this.

Bret: Yes, I hope so. Well, I think there are a number of take-home messages from this podcast and one of them is like you started with saying, get your eyes checked. If you have type 2 diabetes, get your eyes checked, because you may not know that you have retinopathy unless someone takes a detailed look.

Also, even before you have type 2 diabetes, is still important to get your eyes checked, because

like you said, you've been able to pick it up on people who haven't even had a diagnosis. And the same for high blood pressure; high blood pressure causes other problems that you can see in the back of the eyes. So, I think that was a great take-home message. And what other messages or thoughts do you want to leave our listeners with today?

Ana: I'd like them to be their own advocates. To advocate from their health. Because here in Mexico is very prevalent that people trust their doctors 100% and they want like a magic pill. For example, they get their diagnosis, even diabetic retinopathy, and they think that with laser or intravitreal injections they are going to get better.

And they don't want to do any changes. And I want them to know that they-- I mean, it's good to trust your doctors, but I want them to do their own research, to know that this is reversible, that they can ask their doctors about other options they have. And I think it's very important for them to know that there are options, that they can do something about it and not just taking the medications or do exactly as the doctor said.

Bret: Yeah, that's a great take-home message. We really have to be our own advocates, our own best advocates as patients. And fortunately now with the Internet we can find other sources of information. Now, hopefully they are credible sources of information. But there are other ways out there to educate yourself and hopefully help educate your doctor.

And as you were explaining that, also the obvious point that you can treat the diabetic retinopathy with lasers, with injections, but that does nothing for your kidneys, for your heart, for your peripheral vascular disease, for the whole metabolic system in your whole body.

So, it's a local problem to a systemic issue... Sorry, a local solution to a systemic problem in a systemic issue. So, advocating for yourself to get treatment that's going to help your entire body, not just the one local problem, is definitely a great take-home message as well.

Well, thank you so much for taking the time to join me. I really appreciate your information. And you mentioned a YouTube channel and some other sources that you have. So, where can you direct people to go to, to kind of learn more about you?

Bret: Sure, Bret. Our webpage is inedia.mx and we're also on Facebook and Instagram, so they can look me up. Right now for ophthalmologists since Covid-19 I'm only doing consultations... Well, for ophthalmology I can't do it online. But for metabolic health I'm doing it online. So, people can reach me there and if they want more information they can look in social media. **Bret:** Great, now spell that website for us, just so that everybody can--

Ana: It's I-N-E-D-I-A...

Bret: Very good.

Ana: .mx

Bret: Dot mx, great, great. I'm sure a wonderful resource and we can put a link down in the description below of the podcast. So, thank you very much and I wish you luck and I'll look forward to seeing a lot more from you in the future with all your advocacy... so, thank you.

Ana: Thank you and excuse my English. It was a little rusty.