"Medicine: time for a change": review of a mind-changing webinar

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"Medicine, Time for a Change" is the title of a webinar Dr. Attilio Cavezzi presented on line on May 26thth [1], but it's also the cry of a medicine that, today more than ever, is showing the limits of its own paradigm. The video in question, inspired by a scientific article published in the Journal of Clinical Medicine by Dr. Attilio Cavezzi[2], is a powerful and bold synthesis that questions the very core of contemporary biomedicine science. The thesis is clear: while average lifespan has increased, healthy lifespan has not. Increasing lifespan was easy, so to speak; extending healthspan, however, requires a re-foundation of medical thought.

In the webinar it is highlighted with scientific rigor that approximately 75% of chronic degenerative diseases (CDD) stem from epigenetic factors - and therefore modifiable ones - while only 25% are genetic. In several high-level scientific publications, wrong nutrition, sedentary lifestyle, altered management of chronic stress (and lack of psycho-biological resilience), altered/reduced sleep and low sunlight exposure have been linked to chronic low-grade cellular inflammation and to deregulated cell senescence (the so-called "inflammaging").

The criticism becomes even more trenchant when analyzing the consequences of hyper-medicalization (diagnostic and therapeutic procedures) of the patients, and of drug abuse/misuse; thus, drugs like statins are widely prescribed for primary cardiovascular prevention with marginal benefits and ascertained relevant adverse effects, proton pump inhibitors are associated with an increased risk of several CDD, and mass screening (e.g. mammography) may result in more overdiagnosis than lives saved.

Among the most emblematic examples cited in the video and paper are statins, treated as a sort of "cure-all" for cardiovascular prevention. The message is simple (too simple): the lower the LDL cholesterol levels, the better. But the actual evidence is much more nuanced. Independent systematic reviews, Cochrane reviews and meta-analyses have repeatedly shown that in people with no prior history of cardiovascular events (i.e., primary prevention), stains bring a reduction in absolute cardiovascular mortality risk of less than 1%. The relative risk is exaggerated for communication purposes-for example, a "36% reduction" is mentioned, when in reality it goes from 3 events in 100 to 2 in 100. This is statistically correct, but clinically misleading.

The video also highlights an often-overlooked fact: lowering LDL cholesterol does not automatically equate to a reduction in overall mortality, but mostly it is true the opposite: the lower the cholesterol level the higher the all-cause mortality risk. Many industry-sponsored studies present surrogate outcomes (e.g., changes in biomarkers) instead of real clinical endpoints (e.g., survival rate, well-being, functional capacity). Furthermore, statin side effects, such as muscle pain, increased risk of type 2 diabetes, neurodegeneration, etc. (al linked especially to the mitochondrial impairment induced by statins), are underreported in publications. Cavezzi's contribution emphasizes that the benefits of statins do not justify extensive, long-term treatment, much less the clinical inertia that accompanies this drug-oriented approach.

It's clear that it's not a matter of "being against statins," but of knowing if and where they're truly needed and where they have instead become an automatic response to a cholesterol "perceived" as the enemy, rather than to a real, personalized risk, if not to a friend molecule.

During the webinar many more drugs and diagnostic/therapeutic interventions have been questioned in terms of cost/benefit, appropriateness, side effects, defining a panorama of evidence-based need for a reappraisal of the current biomedical approach to CDD and to aging in general. Furthermore, the author invites us to reflect on a medicine increasingly governed by marketing, conflicts of interest, and a performance-based approach that rewards costly interventions over useful ones.

Interestingly, literature data clearly report the suboptimal reliability of the outcomes generated by the industry-sponsored scientific studies[3], together with the low level of evidence for the safety/efficacy ratio of many pharmaceutical/technological interventions employed within the current medical approach. Beyond the critical review of several negative aspects of current scientific research, educational processes and clinical approach in biomedical science, the author proposes a series of intriguing themes which should be taken into consideration in the future health management, in the

framework of a less reductionist view and of a mind-body bi-directional interaction which significantly impacts human health.

One of the most disruptive aspects of the vision proposed in the webinar is the recognition that thoughts, beliefs, and emotions are not merely psychological phenomena, but actual biological signals. Modern neuroscience and PNEI (psycho-neuro-endocrine-immunology) medicine show that every thought activates brain and (mainly autonomic) nervous system patterns that reverberate along biological axes, from chronic stress-mediated to the hormonal regulation of the hypothalamic-pituitary-adrenal (HPA) axis and immune responses; a recurring thought-positive or negative-is a structural input for our biology.

It's documented that pessimistic beliefs, fear of illness, and a chronic sense of helplessness activate persistent pro-inflammatory signals (via IL-6, TNF-α, and other inflammatory pathways) that promote cardiovascular dysfunction, insulin resistance, and neurodegeneration. Conversely, a sense of control, realistic optimism, and faith in the possibility of recovery activate dopaminergic, serotonergic, and parasympathetic circuits, lowering cortisol and systemic inflammation. In this sense, thought becomes a drug or a toxin, depending on its quality, coherence, and meaning.

This mental plasticity, however, does not develop by chance. This is where the first 1,000 days of life come into play, a critical epigenetic window in which the neurobiological set points of adult behavior are formed. The type of birth (vaginal vs. cesarean), breastfeeding, quality of attachment with the care-giver (mother primarily), exposure to environmental positive/negative inputs, sleep-wake rhythm, and early stress can modulate gene expression in a lasting way, through mechanisms such as DNA methylation and histone modifications.

In other words, psychological resilience is not merely an educational or temperamental quality: it is a biological trajectory formed in early childhood. Interestingly, it has been definitely proven that psycho-physical resilience is primed especially in the first 1000 days of life, following to the possible early life adversities; from these intrauterine and infancy-linked factors finally derives the so-called conserved transcriptional response to adversity which lifelong influences our stress management.

In this context, adult mental health, including the ability to adhere to therapeutic changes, make wise decisions, and face a diagnosis without collapsing, is the long-term fruit of biological soil planted in the early years of life. Those born into a predictable, affectionate, and nurturing environment are more likely to develop a flexible mindset, open to novelty, and capable of tolerating uncertainty and therefore illness, thanks to a better stress-coping. Those who experience early instability, on the other hand, tend to develop rigid defense strategies, vulnerable to panic, somatization, and greater passive medicalization in adulthood.

This means that adherence to treatment plans, the effectiveness of lifestyle changes, and even the success of doctor-patient communication partly depend on early neuroplasticity, that is, "who we become before we can even choose."

This evidence leads us to an uncomfortable but necessary conclusion: medicine that deals only with the adult organism, neglecting its prenatal and perinatal psycho-social and physical terrain, is not only incomplete, it is blind. Longevity medicine, to be true, must invest in the first 1,000 days, just as it invests in cancer prevention. Because it is there, in that seemingly silent time, that the foundations of healthy thinking and the body that will host it for life are built or broken.

The critical review proposed throughout the webinar and in other articles of the author[2,4] thus also becomes an invitation to reflect upon the role of the physician, who can no longer be limited to being a technician of illness, but must become an interpreter of health as a process. The medicine of the future, Cavezzi suggests, will have to embrace education, the co-construction of therapeutic pathways, and deep listening. And it will have to do so against the logic of profit, against reimbursement-based medicine, and against marketing disguised as science (the disease mongering issue…). Because if it's true that "illness pays," as the current system cynically suggests, it's equally true that regenerated health, true health, is priceless. And, for this reason, it doesn't generate revenue.

The merit of this work, therefore, lies not only in the criticism of several medicine issues, but in the proposal: a radical proposal, in the noblest sense of the term, that goes to the root. It doesn't reject pharmacological medicine, but integrates it. It doesn't reject technology, but subordinates it to clinical common sense. It doesn't absolve the patients of responsibility, but considers them co-author of their own health.

Hence, a medicine centered on the person, on the biography, on adaptive biology is not utopia, it's a necessity to sustain the otherwise nearly-to-collapse health system in industrialized countries especially. And this review can only conclude with the echo of a hope: that the medicine of the future will truly be able to change. Because, as the author suggests, we don't need more medicine, we need more health.

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