®

Adequate Treatment for Fighting Back Against Arthritis

Robert Bingham, M.D.

First National Seminar
The Rheumatoid Disease Foundation
Birmingham, AL July 18-20, 1985
(Formerly published in The Journal of the Rheumatoid Disease Foundation, *Volume 1, Number 1)*
The Roger Wyburn-Mason and Jack M. Blount Foundation
for the Eradication of Rheumatoid Disease
AKA The Arthritis Trust of America ®
7376 Walker Road, Fairview, Tn 37062

Robert Bingham, M.D. (deceased)

Summary: The "A, B, Cs" of Arthritis Diseases must be considered and adequately treated for successful management of the patient.

"A" is the type of arthritis which must be accurately diagnosed.

"B" is the body of the patient, whose personal health , nutrition, and resistance to illness must be evaluated and improved.

"C" is for "control" of the disease, which rarely follows the use of any single method or drug, and challenges the skill and knowledge of the physician and needs the cooperation of the patient to secure improvement and "permanent relief of symptoms."

A = Arthritis

Adequate control of arthritis depends, first, on accurate diagnosis. Do not overlook the importance of a careful history and physical examination. These often reveal more than the laboratory tests and x-rays, although every helpful aid should be employed. For practical office use, we have some simple classifications:

1. Infectious arthritis due to viruses and bacteria.
2. Metabolic arthritis, including gout and dietary deficiencies.
3. Rheumatoid disease, including arthritis caused by protozoa.
4. Degenerative arthritis, including osteoporosis.
5. Mixed arthritis = patients with two or more types of diseases.

Of the more than 120 varieties of arthritis, it is rare to find a patient who does not fit in one of these five groups.

The more specific a diagnosis is made the more successful will be the treatment of the patient. Let us review each category.

Infectious Arthritis

Virus and bacterial infections are usually self-evident, and the arthritis phenomena are secondary. Treatment of the primary source will halt the process leaving few residuals. Foci of chronic infection in teeth, nose and throat, lungs, intestines, kidneys and pelvis must always be sought and eliminated when found.

Metabolic Arthritis

Careful studies of the body chemistry, diet, hormone balance and metabolism of patients at our clinic show that more than 60% show disorders or deficiencies that either are the *causes* of their arthritis or *contribute* to the severity of other forms of arthritis.

Gout signs and symptoms are classic. And the blood uric acid levels are confirmatory evidence.

Protein deficiencies are often found in association with carbohydrate and fat excesses, obesity, arteriosclerosis and lack of important minerals and vitamins. Osteoarthritis may truly be caused by these factors rather than to "old age" and degenerative changes" in the bones and joints.

Hormone problems, such as menopausal osteoporosis, are so very common, and yet are pre-existing conditions in most hip fractures and compression fracture of the spine.

Calcium deficiency and lack of **vitamin D** in the diet are usually found together in the same patient, causing "soft bones" which in x-rays are frequently interpreted as "hypertrophic arthritis" because of the spurs and exostoses which they produce.

Excess calcium deposits in the body particularly in the cartilage of the ribs, indicate a *lack of calcium intake* rather than a surplus, and the bones are more atrophic than normal.

Rheumatoid Disease and **Rheumatoid Arthritis** have always been the "mystery disease" of the medical practice. They are also the "stars" of our program here today. If we are to conclude that pathogenic protozoa are the etiological agents of many of these conditions, we should develop critical diagnostic criteria for those forms of **collagen** and **auto-immune diseases** which respond to the use of anti-protozoal drugs.

Continuing studies are necessary, but here are listed the clinical and laboratory findings of patients in this category:

1. Two or more inflammatory joints, usually symmetrical.
2. Synovial swelling and thickening, with or without an increase in joint fluid.
3. Pain is always present, and is the last symptom to respond to treatment.
4. X-ray: bone atrophy and marginal joint erosions.
5. Laboratory: elevated sedimentation rate, positive rheumatoid fact (in 90% of cases), mild anemia, increased eosinophils (in 60% of cases), moderately elevated white blood count.

Medical History:

1. Temporary relief with aspirin or the NSAIDS, the non-steroidal anti-inflammatory drugs.
2. Improvement with corticosteroids followed by spread of the disease to joints previously not involved.

Physical Examination:

1. Limitation of motion associated with discomfort. Weakness and muscle atrophy.

Degenerative Arthritis

A medical history of one or more of the following:

1. Joint injuries, sprains, fractures, falls, etc.
2. Repeated trauma, such as heavy work, lifting, carrying.
3. Micro-trauma, of fingers and hands, with machine work or housework.

4. Past infectious diseases in the vicinity, such as tonsil and throat infections, which may be the cause of intervertebral disc degeneration in the cervical spine.

5. Systemic infections, currently, or in the past.

6. Chronic gastro-intestinal problems.

7. Signs of premature aging in other systems.

8. X-ray: Either sclerosis or osteoporosis, but with loss of joint cartilage space, hypertrophic margins, ligamentous calcification.

Laboratory:

1. No characteristic findings. Usually normal.

Mixed Arthritis: Forty percent of our clinic patients exhibit signs and symptoms which can be found in more than one of the above classes.

1. **Degenerative arthritis** frequently follows the joint damage done initially by infectious or rheumatoid arthritis.

2. **Osteoarthritis and osteoporosis** are often seen together, particularly in elderly women.

3. **Some osteoarthritis joints** become inflammatory.

4. Hypertrophic changes occur in **infectious and rheumatoid arthritis** after the diseases have been arrested.

5. **Ankylosing arthritis** of the spine may follow infectious arthritis of the genito-urinary tract, malaria, etc.

An accurate diagnosis and a comprehensive history, physical examination and complete laboratory and x-ray studies will often indicate the treatment which will be successful for that patient.

"B" = The BODY of the Patient

Do you treat the patient? — the disease? — or both?

"Holistic medicine" has captured the interest of many people because of the concept, "treat the whole patient!"

While this may be difficult for the average practitioner, consultations with specialties are usually available. And the initial evaluation by the primary physician of the physical, mental, emotional, and even spiritual problems of the patient will be guides for a complete program of care.

Some forms of arthritis, particularly rheumatoid disease, are so serious and disabling that only cancer has more disastrous consequences. So the treating doctor is justified, even responsible, to use every aid, diagnosis, and every modality of healing within his knowledge and capability.

Factors in the body which affect treatment and recovery:

Age. Sex. Height. Weight? Blood pressure. Body temperatures of the extremities, at the hands and feet. Susceptibility to heat and cold. Thickness of body fat. General nutrition. Condition of the teeth. Digestion. Elimination. Food habits. Allergies, particularly to essential foods. Use of alcohol, tobacco, excess tea or coffee. And chronic illnesses. Patterns in use of drugs, particularly for arthritis, pain, sleep, anxiety, "nervousness."

The use of food supplements, vitamins, minerals and herbs. Any chronic or other systemic diseases. A history of injuries.

Stress, work history, recreations, exercise, occupation. A list of surgical operations. Marital status. Prior treatment for arthritis. (Obtain the previous medical records for study and comparison whenever possible.) The more you learn about the patient, the more effective will be your treatment.

Predisposing Factors in Arthritis

Age? Rheumatoid arthritis can occur at any age. This is true also of infectious arthritis and post-traumatic arthritis.

Degenerative arthritis is more common in each older age group.

Sex? Gout is more prevalent in males, osteoporosis in females. Virus arthritis is seen most often in children.

Weight? Obesity is closely associated with osteoarthritis, particularly of the weight bearing joints — hips and knees.

Stress? Commonly found to be a factor in the onset of rheumatoid arthritis, probably related to adrenal depletion.

Diet and Nutrition? Now being recognized as important keys in the solution of resistance to disease, susceptibility to infections, and tools for the physician to use in treatment.

Other associations between arthritis and the excesses or deficiencies in the lifestyle of the patients may be evident. Each one is an opportunity for the conscientious and caring physician to develop a plan of treatment based on the particular findings and needs in that patient.

"Cellular immunity" may be a new phrase in medical lexicon, but keep it in mind. It relates to the "natural immunity" of the tissues of the body, or to the "acquired immunity" bestowed by the patients' reaction to a vaccine, or developed in the recovery process of an illness.

"Auto-immune disease" will probably become a discarded theory and an obsolete term for rheumatoid disease as we learn more about infectious arthritis and the role of pathogenic protozoa. Immunity to these organisms is a field for research.

"C" = Control

THE GOAL OF TREATMENT OF ANY CHRONIC SYSTEMIC DISEASE IS ITS **CONTROL.** IN THE MANAGEMENT OF ARTHRITIS, THE OBJECT IS TO OBTAIN **PERMANENT RELIEF OF SYMPTOMS.**

Every physician who treats the rheumatoid diseases has probably developed his own routine. At the Desert Arthritis Medical Clinic in Desert Hot Springs, California, we have had sixteen years of experience in setting up a program to examine and treat patients from all parts of the United States and Canada.

The dry warm desert climate and the natural hot mineral waters are the main attraction to this health resort town. Many patients need more than this, so our clinic — which was originally a community medical center and crippled children's clinic — became more specialized for the treatment of arthritis.

We took the first two pages from our children's program, improvement in nutrition and the prescribing of vitamin and mineral supplements. Compared with seventy percent of physically handicapped children who were under-nourished, about sixty percent of adults with arthritis were found to have diet deficiencies.

Control Number One — Control the Diet

Each patient completes a "Diet Analysis." A record is kept or recalled to memory of every meal and all foods eaten, amounts, beverages, food supplements of minerals and vitamins, and the demographic data on the patient — age, height, weight, sex, health, and physical activity. This is sent for computer analysis along with a specimen of hair for mineral analysis. Since the "turn-around-time" is 10 to 12 days, it gives the clinic about two weeks to accomplish the other aspects of the program.

Control Number Two — "Physical Therapy"

At their hotels, motels, mobile home parks and public pools, the guests indulge themselves in the hot mineral water pools and swimming pools several times a day. In addition, the clinic treats each patient from three to five times a week with hot packs, ultrasound, paraffin baths for the hands and feet, remedial exercises under the therapists and learns home exercise programs to be continued on their return to their permanent homes. This occupies two or three weeks, giving adequate time for diagnostic work, examinations by more than one doctor if necessary, and a general physical check-up, chest x-ray, electrocardiogram and treatment or recommendations for care of any general health problems.

Control Number Three — "Educate the Patient"

A "Free Lecture on Arthritis" for our patients and the public is

given every Monday at the clinic from 4:30 to 5:30 P.M. Between 20 and 30 people attend. Five or six are visitors, and an equal number are new patients each week. Since it takes about eight hours to cover all aspects of these diseases, some printed literature must be distributed and used to get the cooperation and understanding which is so important between physician and patient.

We use publications of this foundation. Cost of eductionan is "less than the cost of a visit to the doctor." The value to the patient in securing cooperation and compliance with continued care cannot be underestimated.

Control Four — "Furnish Supplies"

In our program, the patients also require vitamins and mineral supplements. We find that to be certain of quality and quantity we must furnish them to the patients rather than to permit them to take their own previous preferences. "A month's supply of food supplements costs less than a follow-up visit to the doctor."

Control Number Five — INNOVATIONS IN TREATMENT
Arthritis Vaccines

Almost ten years ago, a physician in our clinic noticed the when patients received their "flu vaccines" or "cold shots" that their arthritis symptoms frequently subsided, "sometimes permanently." We combined three commercial and FDA approved vaccines into a therapeutic formula which we call an "Arthritis Vaccine."

It is given as a "test dose" for any allergy or sensitivity, then in a series of four therapeutic injections, from 3 days to a week apart. Then, one month later and three months later, the patient is given a "booster shot" to maintain the "non-specific immunity" that this vaccine seems to provoke in many patients. We have given over three thousand injections without any complications or ill effects.

Besides the effect on the patient's arthritis, they receive some protection from influenza, upper respiratory infections, skin and virus infections. Patient compliance and control is also required, as when they return for their "booster shots" we obtain a record of their progress and improvement and have the opportunity to bring their "arthritis program up-to-date."

Yucca Food Supplement

About ten years ago, a company manufacturing supplies for the agriculture industry of the western states came to our clinic with an extract from the yucca cactus that they had been selling as a water purifier. It contained saponin, the agent which causes water and oils to mix, and a vegetable steroid, which encourages the growth of normal bacteria and inhibits parasites in water and soils.

They had noticed that horses drinking water so treated seemed to improve or recover from joint stiffness. Further investigation showed that the Indians of the Southwest had used the yucca juices for many generations for the treatment of "rheumatism."

Since it was a natural and non-toxic substance, they tried it on themselves and friends. They reported "less pain and joint and muscle stiffness and tightness." Some migraine type headaches seemed to be relieved. And many digestive problems of people seemed diminished or abolished.

We ran double-blind controlled studies with yucca extract and were able to verify these health benefits of the "herbal" substance but also found that it often lowered abnormal blood pressure and higher than normal levels of blood cholesterol and triglycerides.

It is now available in almost every health food store as a "food supplement" (not an "herbal medicine"). And it may be safely recommended to your patients as an "aid to digestion and to lessen joint and muscle stiffness." It is also available to veterinarians for arthritis symptoms in dogs. And large quantities are being used by farmers and ranchers raising cattle and chickens, if that can be considered a recommendation as to its safety and usefulness.

Unproven Remedies

Do not disparage your patients from trying other remedies and modes of treatment. Some will tell you of the benefits of bee venom, aloe vera, alfalfa tea, DMSO, garlic, green mussels, chiropractic, certain foods or vitamins, copper bracelets, etc. You do not encourage or promote methods of which you know very little or which are probably useless.

But the tests are:

1. Is it harmful?
2. Is it being "exploited" or "promoted"?
3. Does it prevent the patient from following your treatment?

If it is one or more of these three, "Do not approve."

If the patient **"thinks" or "believes"** it is helping him allow him to continue until you have proved that you have given him a better plan and get superior results with your treatments. [Ed. Note: other logical possibilities exist; the patient may have discovered something that works, & it is the doctor who should keep equally open to the possibilities. S.C]

Encourage a state of mind of optimism, hope, encouragement, faith in the treatment and in you as a physician. His **belief** that he will improve any may recover from some of most of his pain and other symptoms and delay or halt the downhill course of arthritis is a valuable asset to his progress and health.

SYMPTOM RELIEVING DRUGS
Salicylates Are Number One

But not "aspirin" alone. Recent studies have shown that the "anemia of arthritis" is really not due to the effects of the disease on the bone marrow or the blood, but is the result of gastric and intestinal blood loss from the irritation of drugs used in treatment of the disease.

Plain aspirin is the chief culprit, and if any is prescribed, it must be *buffered, coated, time release* or otherwise treated and compounded to prevent micro-hemorrhage.

The *acetyl* radical is the problem. Other combinations of salicylate are better, safer, slower, but equally effective.

"NSAIDS" — The Non-Steroidal
Anti-Inflammatory Drugs

They all have an effect on arthritis symptoms about equal to aspirin. They all cause side-effects and seem to gradually lose their usefulness in most patients in three months to a year, and then another in this chemical category may be tried.

Watch for anemia and leukopenia. They all have about fifty percent of the tendency of aspirin to cause gastro-intestinal irritation, bleeding and discomfort. [Ed. Note: Pfeiffer, in *Zinc & other Micro-Nutrients* points out that NSAIDS are chelators, removing bivalent trace minerals, such as iron, from the system. S.C.]

One of their chief advantages is *patient compliance*. It is much easier to request the patient to "take one, or take two of these a day" than for him to remember to take four or six, and even "twelve aspirin a day."

Then, we are talking about *patient control.* When you are trying to help a patient, you must see him at regular intervals, usually at least monthly. The writing of prescription drugs, which must be refilled on your order, is one good way of keeping informed of the patient's progress under your care.

Conclusions

The "A, B, Cs" of adequate treatment for arthritis may be the most difficult alphabet you have ever learned in the field of medicine. But there are no easy solutions or certain remedies when you're **"fighting back"** at this **"Dragon of All Diseases — Arthritis."**

Conquest of the Amoebae

Robert Bingham, M.D.

When a mountain climber reaches the top of a tall ridge, he sees a higher one ahead. Medical science faces the same challenge. Now

that bacteria have been mastered, and viruses are for the most part understood and subject to some control — only the human parasites, of which amoeba constitute a large part — remain a field of mystery in the infectious diseases, yet to be conquered.

They are complex living creatures, organisms responsible for several human illnesses, and probably are the causes of some chronic diseases whose origins are as yet unknown. These are complicated one cell "animals," clever at invading our bodies and evading our defenses. Their very strange life cycles make them scientifically intriguing, but medically difficult to diagnose and treat.

Amoebae are far more complex than viruses and bacteria. They are microscopic creatures which live as parasites in the human body. They cannot survive for very long on their own, being killed by drying, sunlight, chemicals of many sorts, and by the large white blood cells of the body, the macrophages — for which they may easily be mistaken under the microscope. (Unless isolated by the thermotropic technique described by the late Dr. Roger Wyburn-Mason.)

Amoebae very often invade the body of another life-form to survive. From that host, they take food and shelter, in return they add nothing of which we are aware. Because they depend on their human hosts, they must not cause death until their own life cycles are complete, and their "feasts" on the tissues of the patient are exhausted.

For this reason, the diseases they cause produce chronic, long-term and debilitating effects. The characteristic signs of these infirmities are pain, swelling, inflammation, weakness and anemia — because they live in soft structures such as synovial linings and the fluids of the joints, and release toxic substances which may cause gradual destruction to adjacent tissues.

Most varieties of amoebae are relatively harmless. With improved sanitation, effective hygiene and safe water supply, we have little to fear from them. But the person who is weak, ill, in great stress, or poorly nourished is at greater risk of infection. The fact that they are destroyed by bile and bile salts indicates the role of the liver and the gall bladder in the defense of the healthy individual to amoeba which enter the gastro-intestinal tract.

While the living parasites cause the active disease and the spread of the infection from one part of the body to another, killing the parasites may release toxins which produce symptoms which make the disease temporarily seem worse. This is a cause of the Jarisch Herxheimer reaction. (Herxheimer reaction is a clinical confirmation of the cause of the disease and an indicator of the therapeutic benefit of the drug. The correlation is close.)

Though the Rheumatoid Diseases are of fairly recent origin in medical history and recognition of the pathology, dating back to not more than 200 years or less, their spread parallels the advances of modern civilization. These are the most common in the most civilized countries, where diets are richest in fats and proteins and high in processed white flour foods and refined sugar. These organisms "eat well," to begin with at least, on their well-nourished hosts, and are rarely found in lands where almost all foods are "natural and unprocessed," and the "natives have a lean and hungry look."

Some of these amoebae have a voracious appetite; they can practically eat their weight in blood in seconds. Then, when one joint has gone through the acute phase and suffered all the damage from the infection and inflammation, and the amoebae are "feeding less well"; then, the amoebae travel around in the patient's body looking for "other joints to conquer," often aided by the administration of cortico-steroid drugs, prescribed by a well-meaning physician who is "treating the symptoms but not the disease."

But the doctor's dilemma can be understood and appreciated. How are you going to treat a patient who has rheumatoid arthritis, said to "have no known cause and no known cure?"

With many parasites, there are known animal, insect and human vectors and carriers. These are not known or identified for the specific amoebae we are accusing as the cause of the rheumatoid disease.

We do not know how they are transmitted; they do not seem to spread from man to man. But they have been found in many water and food supplies and in the intestines of apparently healthy persons, as well as in "all tissues of the patients with the acute active forms of Rheumatoid Disease"(R. Wyburn-Mason.)

In many persons, there is probably natural immunity to the amoebae believed to cause "inflammatory rheumatism," as rheumatoid arthritis is often called around the world. That they do contain antigens is shown by the antibodies and "immune complexes" against amoebae which they develop in affected patients. Resistance is dependent upon the good health and natural immunity of the patient (This may be from birth, and the transmission of immunity from the nursing mother to an infant occurs in the early "colostrum milk," and may be weak or absent in the "bottle-fed" baby.)

The treatment goal of the future may well be a specific vaccine for the amoebae, developed from the blood (human sera) of "recovered" patients with high antibody titers.

But why should the physician feel discouraged when a patient does not seem to respond to treatment with one of the anti-protozoal drugs?

There are some good biological reasons to consider:

1. The amoebae are capable of some very clever immunological tricks. When they penetrate the body, they may live in the tissues for months, perhaps years, before producing symptomatic rheumatoid disease. They can live, not only in the synovia of the joints but in the connective tissues of the muscles, blood vessels, lymphatics, bursae, liver, eyes, and lungs, and perhaps in the brain and spinal cord. They conceal themselves by coating with the protein of the host.

2. Some masquerade as large histocytes, eosinophils or macrophages, and can only be identified by teasing them out into warm saline by Dr. Wyburn-Mason's methods where their identifying "tails," pseudopodia or flagella, can be seen under the microscope — a most difficult process.

3. The amoeba may cover itself with surface antigens from the body's own immune system. It has "disappeared." The body cannot see it, so it won't reject it. Any vaccine, therefore, would have to be given to PREVENT rheumatoid disease and would have no value in treatment.

4. The amoeba may vary its surface to prevent capture or destruction, coating itself with a membrane, with antigen molecules, or change into a trophozoite form (although this has not been demonstrated *in vivo*).

5. The amoeba may even resemble the same cells that set out to destroy them, the macrophages, or the (histocytes), eosinophils — thus accounting for the higher count of some of these cells in cases of active rheumatoid disease.

Plasmopherisi — filtering the blood to remove macrophages — may result in removing most of the amoebae.

The amoebae seem to find a hiding place where the body's immune system would never think of looking.

6. Amoebae can also manufacture enzymes, which reduce the effectiveness of the body's immune system, breaking up the antibodies so they have little effect. This neutralizes the patients' natural defenses against these organisms.

7. And finally, the amoebae can generate chemicals which resist the very drugs which in the beginning may kill them. A few may survive the initial drug therapy. Then, by a process of mutation, the remainder acquire a resistance to the medicine intended to destroy

them.

As a result, the physician searches for more different and more powerful anti-protozoal drugs, while all the time the few surviving amoeba are lying-in-wait to resist the next attack.

How do we know so much about the rheumatoid disease amoebae which we have not seen, not proved, or have not yet identified?

We know these tricks because amoebae resemble the families of other and more familiar parasites associated with other chronic diseases such as malaria, tuberculosis, syphilis, and the larger parasites of tropical diseases.

The problems presented here should not discourage the dedicated and intelligent physicians who are trying to treat their rheumatoid disease patients with these new methods.

Rather, these difficulties demonstrate the very great field which has been opened up for medical research and the very great need for the work of The Rheumatoid Disease Foundation to raise funds for supporting clinical and laboratory investigations at the present time.