THE RHEUMATOID DISEASE FOUNDATION
NEWSLETTER

Volume 1, Number 1 *Published Quarterly* *April 1984*

BOWMAN GRAY SCHOOL OF MEDICINE TO REVIEW SCIENTIFIC DATA

President John R.A. Simoons, Ph.D., working with Dr. Robert Turner (Professor of Medicine, Chief Section on Rheumatology of Bowman Gray School of Medicine) has paved the way for *The Rheumatoid Disease Foundation* to begin double-blind studies.

According to Dr. Simoons, "We have contacted Dr. Turner and requested his participation for the clinical evaluation of Clotrimazole or another Imidazole Compound in the treatment of rheumatoid arthritis.

"Dr. Turner was requested to review the scientific data required for filing the proper forms with the Food and Drug Administration and to prepare the protocol for a double-blind clinical trial with Clotrimazole versus placebo in 30 patients with rheumatoid arthritis.

"These 30 patients, when approved, will be treated for six months on a base of either optimal aspirin therapy or Ibuprofen."

John Simoons has also asked the manufacturer of Clotrimazole to make all of its literature available to the FD & A and to agree to make up both the requisite medicines and the placebos.

Clotrimazole and Tinidazole are available outside of the United States, and both are more potent antiamoebics than metronidazole.

If all goes well we arthritics may soon have a much more powerful medicine available to us!

LECTURE

by
Dr. Paul K. Pybus
(November 19, 1983)

Part I: Rheumatoid Disease

It is with great pleasure that I am able to give this talk to you all here today.

This talk is a summary of the work done by the late Professor Roger Wyburn-Mason in part I of the lecture, and describes his researches in the cause and treatment of Rheumatoid arthritis as well as some other autoimmune diseases.

Part II is a description of my own development of the basic principles taught me by the Professor many years ago.

The Roger Wyburn-Mason & Jack M. Blount Foundation for the Eradication of Rheumatoid Disease is founded on the discovery that Rheumatoid disease is a condition that affects every organ of the body and it is an allergic reaction to the presence of the free living *Limax amoeba* as shown in slide I. [See our premium book *Rheumatoid Diseases Cured at Last,* pp. 36-38]. These amoebae take many forms and are universal in distribution. They can be recovered from every organ in the body by the process of thermotrophism by means of an apparatus as shown in slide 2. It will be seen

(Continued page 7)

The Rheumatoid Disease Foundation

The Rheumatoid Disease Foundation was chartered as a non-profit, charitable organization in the State of Tennessee October 13, 1982, and received its retroactive tax-exempt status from IRS March 29, 1983.

Goals

Goals of **The Rheumatoid Disease Foundation** are:

1. To disseminate the scientific findings of Professor Roger Wyburn-Mason, that the *Limax ameoba* is the source cause of most forms of Rheumatoid Disease;
2. To contract with professional scientific and medical organizations for research and developmental studies related to the cure and/or remisssion of Rheumatoid Diseases;
3. To fund basic research with such professional organizations;
4. To provide free and/or contributory treatment to those who have Rheumatoid Diseases and in need;
5. To solicit funds from the general public in support of the above objectives.

LETTERS TO THE EDITOR

From A.M.B., M.D. to Dr. Jack M. Blount, Jr., M.D.

It was with great delight that I received your package containing the work of Roger Wyburn-Mason. It is indeed impressive and although I have just begun to read it I look forward to pouring over it. Many, many thanks and I plan to make a donation to the Foundation and will tender a check to you this summer when I am home for six months . . . .

Since the middle of November of 1983 I have been placing patients on this new treatment and have been so encouraged and pleased with their response. I currently have 84 patients on it and hardly a day goes by that I don't place another one on it. Our Korean doctor is also very anxious to begin using it and he has put on two patients this month, both showed a strong positive RA factor. I have an assortment of patients everything from collective RA to those with joint pain and negative RA factors and those with stubborn skin conditions, some diabetics non insulin dependent ones with joint pain or dermatological problems, a man with alopecia and one with viteligo. Also have about four Parkinsons on it. I should have more than 100 patients on this kind of treatment by the time I [return to the United States].

Blessings on you and your wonderful work. We must strive together to make this way of treatment known and put the option in the hands of the patients.

Blessings on you, too, Dr. A.M.B. You are a genuine searcher-after-truth in the service of God. We are all anxious to get a summary of results!

Readers who want access to Roger Wybur-Mason's basic work may write The Foundation for location of a book that may be loaned.

From Mr. A.T.O. to Jack M. Blount, Jr., M.D.

I read a newspaper article about your treatment of arthritis and was very impressed, so I discussed it with my [doctor]. He had been to a seminar, where it was discussed. [He] decided to try the treatment on me. Last April I took the first series and in October I took the second, I haven't taken pain medication since. I thought you would like to know.

Congratulations A.T.O.!

From W.E.C., Sc.D. to Dr. Gus J. Prosch, Jr., M.D.

I am enclosing a recent article showing another approach to RD which is remarkably analogous to that of Wyburn-Mason. Investigators at the Arthritis Institute of the National Hospital consider that RD is caused by Mycoplasma. Drugs that kill Mycoplasma *in vitro* (especially tetracycline) produce Jarsch-Herxheimer reactions *in vivo*. Tetracycline and related drugs have been given experimentally both orally and . . . . to gorillas and humans for many years. The approach has been very beneficial but slow, taking about 5 years for full effect!

It is possible that tetracycline could have some value as an adjunct to azoles, and that these investigators could become quite excited about azole drugs as a variant in their own approach to RD as an infection.

Your editor went off of antiamoebics during a week at the Veteran's Administration Hospital, having been given a week's supply of tetracylcine. Later, back on antiamoebics, the Herxheimer effect occurred with more severity than ever before. On reporting the phenomenon to Roger Wyburn-Mason, he stated "I've never heard of such before, but perhaps the tetracycline damages the outer walls of the Limax *amoeba* permitting the azole better access."

Later correspondence revealed that one physician who habitually gave doses of tetracycline to arthritics eventually found the antibiotic inefective, and resorted to more and

(Continued Next Page)

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We are glad to receive article contributions from physicians and readers, and will give consideration to whatever you send. Please place your name and address on each page, and keep copies of all of your work, as we are not responsible for return of manuscripts and letters. [Editor.]

LETTERS TO THE EDITOR

(Continued From Page 2)

more cortisone, until his patients were exactly like those attending standard rheumatology clinics.

It is clear that the synergistic relationship between various medicines needs much research, for which funds are needed — and funds need to be placed in the correct direction, not down the standard research rathole!

For those who wish to read more of the Antimycoplasma theory, see "Antimycoplasma Approach to the Mechanism and the Control of Rheumatoid Disease" in Inflammatory Disease and Copper, *Ed. J.R.J. Sorenson, pp. 391-407, Clifton, N.J.: Humana, 1982 (Supplied by W.E.C., Sc.D.)*

From Roger Wyburn-Mason (June 11, 1983) to Editor:

I do not propose to enter into an argument of the unproven virus or mycoplasmal theory of RA causation. I have dealt with that in my book and a viral causation remains without proven scientific basis and slow viruses are the refuge of the destitute.

Briefly my argument is —

1. I found free-living amoebae of the genus *Naegleria* in all humans and in all tissues as later confirmed by others.
2. All human sera, including that from cord blood, contains antibodies to the same organism (Cursons) as would be expected from 1, [above].
3. All free-living amoebae, pathogenic or non-pathogenic, are sensitive to a range of antiamoebic drugs and *in vitro* and specifically to bile salts.
4. All untreated cases of RD exhibit an Herxheimer reaction to the same antiamoebic drugs, indicating free-living amoebae are present in affected tissues.
5. Cases treated adequately by antiamoebic drugs result in cure or disappearance of disease activity and no longer give the Herxheimer reaction on further administration of these drugs, indicating no live amoebae are present in the body at this time.
6. No viruses are affected by antiamoebic drugs and the only known anti-viral agents, amantidine, vidarabine, acyclovir and inteferon have not been reported as benefiting RD and its related conditions. Mycoplasms are destroyed by antibiotics which have no effect on RD. Therefore pathogenic free-living amoebae are the cause of RD and there is no evidence that viruses or mycoplasms are involved.

Q.E.D. Fault this if you can.

This is all in my original book and in the *Addendum*.

In any case it is easy . . . to give armchair criticism to any new idea but the proper scientific method is to repeat the work and prove or disprove it.

The Editor has repeatedly challenged in the same manner. The proper scientific answer is to prove or disprove. It has never been up to Roger Wyburn-Mason, or his followers, to constantly prove what has already been done, but rather up to those who challenge to follow experimental design and to repeat experiments.

Science is not the art of political criticism, and neither is it a spectator's sport!

What Can You Do to Help?

Anything and everything!

Tell people about us!

and

Contribute!

Funds
Property
Services!

What If You Have Further Questions?

Then write or call:

The Rheumatoid Disease Foundation
Rt. 4, Box 137, Franklin, TN 37064.
(615) 646-3757

FREE PAMPHLET

We can supply any number of free pamphlets describing our background, goals, and Roger Wyburn-Mason's medical history. You can help the cause by sending a self-addressed, stamped envelope — and especially if you want large quantities — donations to defray costs. Editor.

From Dr. K.A.S. to T.C. and Editor:

At last I have managed to go through my results with the antiamoebic therapy which I have been using over the last ten months. All in all I have treated 64 patients with amoebacidal drugs; 46 of these have rheumatoid arthritis and the other 18 have several different ailments.

The treatment procedure which I have followed is basically that which is laid down in the "Red Book" [Rheumatoid Diseases Cured at Last]. If I fail to get a response with Allopurinol and Metronidazole then I use Tinidazole. I have tried using bile salts and copper sulphate in a few cases with limited success.

Of the 46 patients with rheumatoid arthritis 6 were not followed up, 16 got no better or became worse, 15 had significant improvement and 9 were totally freed of their symptoms. Invariably the patients who improved were those who had the disease for the shortest duration and who had had the least number of drugs in the past.

The other conditions I treated with this regime were: Ulcerative colitis (slight improvement), Intrinsic asthma (markedimprovement in 3 cases), Synovitis (no change), Psoriasis (some improvement), Myositis (marked improvement), Osteo-arthritis (no change), Sarcoidosis (no change), and motor neurone disease (some improvement in one out of 4 cases).

I think that the results with rheumatoid arthritis demonstrate that the treatment certainly works but that these patients should be put on these drugs first and not as a last resort.

I hope that you find these "statistics" encouraging — I do.

Since the criteria for determining improvement was not included, and neither was the initial condition of the patients, the Editor asked Dr. K.A.S. questions which he answered as follows:

The results quoted in my letter referred to patients who had varying degrees of RD. Some had been given gold or penicillamine in the past and some were taking or had taken cortisone.

I always take the patients off gold or pencillamine but leave them on the cortisone, reducing gradually as they improve. Most of the patients carry on with their non-steroidal anti-inflammatory drugs during the treatment. On the whole patients who have been on gold, penicillamine and long term steroids do not do very well.

I measure the success of the treatment in terms of pain, inflammation, stiffness, muscular power and deformity. I usually do an E.S.R. check every two months as well.

Extrinisic asthma usually follows a typical atopic pattern and with a family history of allergies and positive skin testing. A diagnosis of intrinsic asthma is often difficult to make but patients thus affected are not influenced by the same factors as those in the extrinsic group.

A few patients who have had psoriasis associated with their RD have noticed a marked reduction in the thickness and scarring of the lesions although the discolouration remained. One patient had badly affected finger nails which responded to topical tinidazole cream without any systemic amoebacide. Skin lesions also benefit from local applications to a certain extent.

I cannot readly differentiate between the pains of RD and OA.

I usually accept the patient's word that he is getting worse — this usually coincides with a persistently raised E.S.R. which is a more objective way of assessing the deterioration.

Many of my patients prefer not to have a depot steroid injection but I find that those who do have it tend to do better in the long run than those who do not.

My Lupus patients are not doing very well.

I am using the intraneural injections with good results on the whole. I have been using accupuncture for several years and find that the injections are an advantage in that the patient needs fewer visits to my rooms.

From J.P.M, D.O. to Editor:

Received your information from the Dreyfus Medical Foundation. Thank you very much.

I have had a great response to the antiamoebic treatment of Rheumatoid Diseases. I have worked out a protocol vitamin therapy (including Bromelain 300 mg, 3X/day).

I do metabolic treatment for cancer and have put one of my leukemia patients on BHT 250 mg, 3X/day.

Dilantin is a very *interesting* drug. The Rheumatoid Disease Foundation may some day become active in other alternative forms of treatment. This is a very new approach to medicine.

Thank you once again. If I can ever do anything for the Foundation, please let me know.

Dr. J.P.M. is the first doctor to utilize his access to radio and TV to publicize our Foundation. *We've had numerous responses*

from his geographical region asking for treatment protocols and books.

Letters to this column will be carefully considered. Names and addresses will be revealed only on query and after permission of each writer. As a general rule, your query will be forwarded on to the writer when stamped, self-addressed envelope enclosed.

EDITORIAL
Osteoporosis

Scientists and Physicians (Anthony A. Albanese, A. Herbert Edelson, Edward J. Lorenze, Jr., Maurice L. Woodhull, and Evelyn H. Wein) writing in the *New York State Journal of Medicine* (Feb. 1975, pp. 326, 327) state that "osteoporosis is one of the most common and yet poorly understood debilitating disorders of middle age. Various surveys in the past few years in homes for the aged and of ambulatory individuals (aged forty-five to ninety-five years) requiring medical care disclosed bone-loss incidence ranging from 15 to 50 per cent of these populations. Other estimates indicate that a minimum of 10 per cent of the population over fifty years of age suffers from senile osteoporosis severe enough to cause vertebral, hip, or long-limb fractures."

A number of Physicians and Scientists working with *The Rheumatoid Disease Foundation* suggest that anyone suffering from arthritis also suffers to some extent form osteoporosis.

Look at your fingernails: Do they have ridges? Are they extremely thin? Easy to break? Off color?

The condition of your fingernails can often be a mirror into your bone structures. Bones are living tissues, and cells must be built up at least as often as bone cells break down.

The editor received advice to take Calcium Orotate (a calcium compound found in vegetables) after a year's failure of dolomite and/or bone meal. The Calcium Orotate was coupled with Deca-Durabolin® (1 ml. IM/month, for six months).

The results were striking and the improved appearance of fingernails amazing!

Where fingernails had been so fragile that they would break with the slightest touch, they are now sturdy enough to survive most uses. Ridges have disappeared, and the surface appears as shiny as if coated with lady's nail lacquer.

If this same result has occurred in bone structures, the danger of breaking hip joints and other bones has decreased markedly.

In the article quoted above, authors reach the conclusion that ". . . beyond any doubt that a daily minimum intake of 1 Gm. of calcium, and perhaps more from whatever source throughout the human life-span is needed to maintain normal, if not optimal, bone density. Furthermore, the findings do not support claims that the human body, especially that of the elderly, can adopt to suboptimal levels of calcium intake without the jeopardy of bone loss and the greater risks of disabling fractures of that adaptation to low intakes and probably [is] undesirable at any age."

Even with vast quantities of Calcium intake, your body may not be able to utilize the Calcium in the form you are taking it because of various other problems related to your Rheumatoid Disease, as was the editor's case.

The Rheumatoid Disease Foundation's treatment protocol advises increasing intake of Vitamins A and D and Calcium. Without the vitamins, your body cannot benefit by your increased intake in Calcium, and without some limited sunshine each week (15 minutes) your body cannot utilize the Vitamin D.

One of our advisors cautions that Calcium Orotate may be stronger [more of a medicine] than we want, and suggests use of Calcium Lactate, the mineral found in milk. We don't know the validity of his statement but the editor is now trying the Lactate along with the Deca-Durabolin®.

[Vitamin A, D and Calcium therapy was pioneered by Dr. Carl J. Reich of Calgary Canada. Ed.]

How Can We Fight Rheumatoid Disease Now?

Did you know that about $52.00 worth of medicine available at any drug store will bring the progression of Rheumatoid Disease (RD) to a halt?

Did you know that your family physician, following our protocol, can treat and probably cure or bring about a remission of the disease?

Did you know that *The Rheumatoid Disease Foundation* has cooperating physicians world-wide, who will be delighted to assist your family doctor and/or treat victims of this terrible disease.

Did you know that we have publications that were written for both victims and their family physician? That we have a treatment protocol (procedure) that is free to anyone who requests it?

Who Was Roger Wyburn-Mason?

Professor Roger Wyburn-Mason was born in Monmouthsire, England October 2, 1911 and died June 16, 1983. At the end of his first schooling he attained the top marks of the whole of Great Britain, and was awarded a State Scholarship and an Open Scholarship to Christ's College, Cambridge where he obtained double first class honors in the final Batchelor of Arts exam. As a Batchelor Fellow of the College, he did research in pathology, particularly protozoology, and afterwards was awarded the Master of Arts degree as well as the only University scholarship awarded to graduates completing their clinical studies at a London hospital where he obtained his Batchelor of Medicine and Batchelor of Chirurgerie. He held the post of Instructor in the foremost hospitals in London: Middlesex Hospital, Brompton Hospital for Chest Diseases, National Heart Hospital, National Hospital for Nervous Diseases, the Royal Marsden Hospital for Cancer.

He took part in the first clinical trials of Sulphonamide Antibiotics.

He received his M.D. degree (a higher degree than in the United States), and also sat for the Member of the Royal College of Physicians (M.R.C.P.) examination where he again obtained top marks of all candidates. His M.D. degree was on vasculor tumors and abnormalities of the spinal cord and its membranes, the first description of these matters.

He also published papers on two nervous system diseases, both being named after him. (Wyburn-Mason Syndromes I and II).

He was elected Research Fellow at the Royal Mardsen Hospital for research into cancer and later Research Fellow at the Royal College of Surgeons of England whence he continued research into the nature of cancer and first isolated from all human malignant tumors and from cases of rheumatoid arthritis an hitherto unknown, very small, free-living amoeba (*Limax amoeba*), for which work he received the Ph.D. degree.

He was first to identify and describe a viral causation of cancer; he worked at Yale University and later at the Mayo clinic in neuropathology.

For his many papers and works he was awarded the Doctor of Science degree at Cambridge (a rare honor), and elected a Fellow of his old college.

After twenty years work on the *Limax amoeba* he was able to show that it was the cause of rheumatoid arthritis, and that infection with species of this organism in susceptible subjects seemed to be the cause of a large proportion of human cancer, which can be prevented by taking appropriate substances which will kill the organism.

Professor Roger Wyburn-Mason died while helping us to build **The Rheumatoid Disease Foundation**.

FOREIGN RHEUMATOID DISEASE FOUNDATIONS

At the regular Board Meeting of *The Rheumatoid Disease Foundation* (November 19, 1983), a resolution was passed that will enable all foreign branches to operate independently, and to nontheless coordinate research, educational, and treatment goals.

All countries have legal and constitutional provisions which prevent another country from controlling non-profit, charitable, tax-exempt organizations.

England, for example, must have its own charter and own board members independent from the United States. South Africa, we presume, is the same, with added legal problems.

At the suggestion of Executive Director/ Secretary Kay D. Hitchen of England, the United States Foundation approved the motion that the Executive Directors of each country's Foundations be on the voting Board of the other, and that whenever the numbers become excessive, that all Executive Directors shall vote-in representative members who shall represent the Committee of Executive Directors.

It is hoped that this device will permit each country's Foundation to coordinate in a unified manner with all others in preserving the initial charter goals, and that the 35% funding expected from each country shall go into a pool to support commonly agreed upon goals.

ENGLAND'S NEWSLETTER

Dynamic Kay Hitchen, Executive Director/ Secretary of the English Foundation, produces an excellent Newsletter that brings information to English citizens about activities of the *Rheumatoid Disease Foundation*.

Two interesting features are her chatty, personable presentation and also her many creative ideas about ways and means of raising funds for our joint charitable work.

I'm sure that non-English citizens could find some way of subscribing to her NEWS if interested, and if they would inquire at 2 Wylye Close, Chartwell Green, West End, Southhampton, S03, 3LF, England

that after sterilization and careful cleaning of the apparatus the specimen is placed on a filter with pores of 0.5μ and this is placed on a zinc filter (not copper as this kills the amoeba). This is in direct contact with warmed Ringer's solution which is kept at this temperature by means of a water bath. On top of the tissue is a clean sterile beaker filled with ice which is replaced as it melts. Under these conditions the amoebae will migrate through the pores of the filter and can be recovered from the Ringer's solution. These amoebae are mainly members of the *Naegleria* or *Acanthamoeba* genus. Most patients live in symbiosis with these amoebae which have been recovered from almost all tissues in the body, but some are allergic to their presence, and these people develop Rheumatoid diseases amongst which is Rheumatoid arthritis, which concerns us today.

It is found clinically that if certain anti-amoebic drugs such as Metronidazole are given in a *large* dose of 2 gms to normal people, no reaction occurs. If however, this same dose is given to a patient with Rheumatoid arthritis the patient reacts with an Herxheimer reaction. This comes on approximately half an hour after administration, with feeling of fever, drenching sweats, rigors, headache, nausea and other "flu-like" symptoms. These symptoms quickly subside, but the next evening the process is repeated and a further reaction occurs. The patient is left for a week without treatment and at first he feels greatly relieved of symptoms, but after two days the pain may get temporarily worse, and pain may even increase and appear in joints not previously involved. This is due to the absorption of toxic products of the dying amoebae. However, by the next week, the patient returns to normal and the process is repeated. This is done for six weeks in all and during this time the patient will show progressive improvement, and the Herxheimer reaction gets progressively less.

The main drugs given by our *Foundation* are:

1. Metronidazole 2 gms daily for 2 successive days, weekly for 6 weeks. (Flagyl). [Divided into 4 equal doses. Ed.]
2. Tinidazole (Fasigyn). 2gms on 2 successive days. [Divided into 4 equal doses. Ed.]
3. Allopurinol (Zyloprim) 300 mg tds for 7 days.
4. Furazolidone (Furoxone) 100 mg tds for 7 days. (This drug produces a bright orange urine, so warn the patient of this. Asthmatic attacks may also occur.)
5. Nitrozoline (Nicene) 2 tablets 3 times a day.
6. Diodoquin 100 mgs 3 times a day. [Not for children. Ed.]
7. Rifmapicin 100 mgs twice a day.
8. Chloroquin 100 mgs 3 times a day.

Results are almost universally good and a Herxheimer occurs in 80% of cases, with a remission of symptoms. At the completion of the course the patient is kept under observation and should symptoms recur, either the same antiamoebic drug can be repeated or a different one used at the discretion of the Physician.

This treatment is often criticized as there is no double blind trial to show its efficacy. This particular investigation is, however, almost impossible with a drug that gives a Herxheimer reaction, as both the patient and the doctor know immediately which is receiving the antiamoebic and which the placebo. A few trials have been carried out but with totally inadequate doses, not great enough to produce an Herxheimer.

Part II: Osteoarthritis will appear in the next issue.

The Scope of "Rheumatoid Disease"

"Rheumatoid Disease" no longer means just "arthritis" but a whole cluster of diseases that are caused by the same germ (*Limax amoeba*) on invasion of various tissues. Since each tissue containing this organism responds with different symptoms, it has appeared to physicians that more than one kind of disease was involved: Lupus, Psoriasis, Bursitis, Tunnel Carpal Syndrome, Rheumatic Heart, Rheumatoid Arthritis — all of these and many more are now called "Rheumatoid Diseases" or RD.

Thousands of people have been cured or their Rheumatoid Disease (RD) brought under remission by physicians world-wide who've applied Wyburn-Mason's findings.

Fifteen billion dollars per year is spent in the United States by the sick and the lonely, chiefly for aspirin substitutes that simply treat symptoms, and not causes. Unfortunatley there is always a great conservatism in the acceptance of scientific findings so earth-shaking, and one must remember that other great pioneers — Semmelweis, Jenner, Koch, Harvey, Ross, Lister, Pasteur, Ehrlich, Sister Kenny, Roentgen — fought the same silent battle, often having their reputations tarnished, and without the aid of modern communications facilities such as available to this Foundation.

FLAGYL TRIALS

Our Chief Medical Advisor, Dr. Paul K. Pybus, of the Republic of South Africa, sends his latest trial statistics on the use of Metronidazole (Flagyl) with arthritics. Since there is no standardized evaluation of degree of severity of disease in each patient, nor other pertinent factors, the cold figures are difficult to interpret. Nontheless, taking the most pessimistic approach, they are quite striking. Note, that the severity of reaction to the killing of the *Limax amoeba* seems to correlate well with improvement; i.e., the more severe the reaction, often the more recovery — but not always true:

Table I

Total number of cases treated with Flagyl	*156*
Degree of Herxheimer reaction:	
1. Absent	15%
2. Mild (blushing only)	26%
3. Good (fever and other 'flu-like' symptoms)	31%
4. Severe (rigors and other severe symptoms)	28%
Clinical results	
1. Poor (i.e. no change)	7%
2. Fair (i.e. slightly improved)	22%
3. Good (i.e. one joint only still troublesome)	38%
4. Excellent (i.e. symptomless)	33%

What Dr. Pybus is telling us is that, according to his stringent criteria, 71% of those treated received Good or Excellent recovery, while an additional 22% received relatively poor improvement.

Compared to the traditional methods, where perhaps 27% will show some "improvement" (and placebo treatment will also show about 27% improvement), Dr. Pybus' figures are excellent.

Dr. Robert Bingham's experience (*Rheumatoid Diseases Cured at Last*, pp. 68-69) showed that increasing the dosage of metronidazole (Flagyl) also increased the cure/remission rate above 88%. Since, at this time, we do not know Dr. Pybus' methodology, criteria, nor his dosage level, (he's submitting them to a professional medical journal for publication) these figures must stand alone.

STRENGTH OF ANTIAMOEBICS

by

John R.A. Simoons, Ph.D.

In trying to establish the relationship between chemical structure and pharmacological action of various Imidazoles, we observed that "in vitro" [in test tube; in laboratory. Ed.] antiprotozoal activity was linked to certain substitutions at the ONE position of the Imidazole nucleus. Compounds with substitutions at the TWO position, such as Mebendzoline and Flumizole and those substituted at the THREE position, such as Miconazole, were almost inactive against the strain of protozoa in our tests. The dose related antiprotozoal activity for compounds substituted at the ONE position was the highest for CLOTRIMAZOLE and TINIDAZOLE, followed by NIMORAZOLE, ORNIDAZOLE and METRONIDAZOLE in this order.

METRONIDAZOLE is at the bottom of antiamoebic activity list but the only one approved by the F & DA. All the other azoles are available in foreign countries. This will explain why it is so necessary for us to get funds to pay for studies, so that the F & DA will permit us to buy CLOTRIMAZOLE and TINIDAZOLE at our own drugstores. Ed.

So What Is Left?

What remains is a great deal of education, research, and treatment for perhaps as many as 2 out of 3 people on earth who are or will be affected by this terrible scourge.

Further, **The Rheumatoid Disease Foundation** (through development and application of Professor Roger Wyburn-Mason's theories by its Chief Medical Advisor, Dr. Paul K. Pybus) has developed a new treatment for both the sciatica pains of RD and for osteoarthritis. As many as 9 out of 10 folks either do or will suffer osteoarthritis before they die.

But more, much, much more. We must:

- spread the word faster and wider;
- find more and better antiamoebics
- study the basic characteristics of the *Limax amoebae*;
- find out what determines "genetic susceptibility" (Why are some affected and some not affected?)"
- eventually research for immunization;
- get more and more folks well.