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Anti-amoebic Treatment for Rheumatoid Disease

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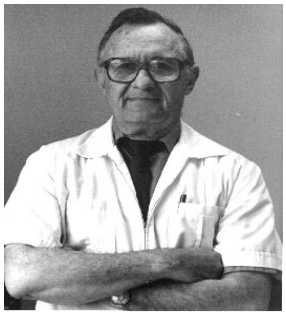

Gus J. Prosch, Jr., M.D.

Introduction

Good morning, to all you visitors, friends and supporters of The Rheumatoid Disease Foundation. I'm honored to have been asked by The Rheumatoid Disease Foundation to speak to you and share with you some of the exciting new developments and advances that are being made concerning the treatment of Rheumatoid Arthritis and other Rheumatoid Diseases. I would like to personally thank each and every one of you who have supported The Rheumatoid Disease Foundation and want you to know that if it had not been for the personal help and financial support of many of you and thousands of other supporters across the entire United States, our progress would have been very minimal, but thanks to you and all our supporters, our knowledge and research is moving and progressing at a very rapid rate.

I was asked to speak on the anti-amoebic treatment of Rheumatoid Disease and this is a very broad subject. I know that there are some people here who are not familiar with our work so I will give a rapid background review of our work, what has been done, and then go into the actual treatments and support methods being recommended at the present time.

Brief History of Development of this Treatment in the United States

As a physician, I have over the years specialized in treating overweight problems, and I've had an intense interest in seeking means to treat Rheumatoid Arthritis and other chronic degenerative diseases. Work done by Dr. Jack M. Blount, Jr., of Philadelphia MS, came to my attention about three years ago. Although I was very skeptical, my subsequent interviews with several of Dr. Blount's successfully treated arthritic patients made me curious enough to seek out and review the medical literature on advances and treatment of Rheumatoid Diseases. What I found convinced me that Dr. Blount's theory and treatment mode made a good deal of sense.

The treatment advocated by Dr. Blount was based primarily on the published research of Professor Roger Wyburn-Mason of England. Dr. Blount, a victim of Rheumatoid Arthritis, had by early 1974 been nearly totally disabled. He had undergone replacement of his right hip joint, but the pain and disability had gotten worse. All the usual treatments had failed to alleviate his pain or slow the progress of his disease. In early 1976, Dr. Blount read an article in *Modern Medicine* entitled "Has One man Found the Cause and Cure of Rheumatoid Disease." According to that article, Dr. Wyburn-Mason claimed that Rheumatoid Arthritis is caused by a germ, a protozoan, not unlike the lettuce bug amoebae.

Dr. Blount decided to try Wyburn-Mason's treatment, but the suggested drug, Clotrimazole, was not available in the U.S. However, investigation led him to compare *Clotrimazole* with another drug called Flagyl (produced by G.D. Searle and Co.), and known generically as *Metronidazole*. He found the two drugs to be nearly identical. The American drug has been used since 1962 to treat Amebiasis and Tricomonas Vaginitis.

Dr. Blount knew the standard dosage for treating Amebiasis or Trichomonas would not be strong enough since it would have been noticed by other researchers to relieve Arthritis if the drug was effective as Dr. Wyburn-Mason suggested. Dr. Blount increased the dosage and during the next two weeks he found the soreness, stiffness and swelling in his joints started going away. Repeating the course of treatment every two weeks, he found his condition was improving. After treating himself for three months, he asked several of his former patients if they would be interested in trying the treatment for their arthritic conditions. Some 30 patients received the treatment during the summer of 1977. Most of them had the same good experience as Dr. Blount. Since that time, Dr. Blount has treated over 16,000 patients [eventually 17,000: Ed.], most of whom have been significantly relieved.

After learning about Dr. Blount's work, I spent several months thoroughly investigating this theory in order to determine if there was any truth or substance to his claims. I took the following steps to thoroughly check out and investigate his work.

1. I reviewed the available but scanty literature in the medical library and concluded that not only was the theory of a type of germ causing Rheumatoid Arthritis possible but it was probable.

2. I then sent several Rheumatoid Arthritis patients to Dr. Blount to be treated and was quite impressed with their results.

3. I then visited Dr. Blount to study the theory and treatment in more detail. I was tremendously impressed with his knowledge, his sincerity and his dedication. He willingly shared everything he knew with me and offered to help me in any way possible. I learned from him that his work and treatment was based on previous research by Dr. Roger Wyburn-Mason in London, England, who claimed that the cause of Rheumatoid Arthritis and other auto-immune or collagen diseases was due to a certain pathogenic, free-living amoebae of which every living person is infected to some degree. I learned that Dr. Wyburn-Mason's credentials and background were impeccable and of the highest caliber and obviously he was of genius status. He was a protozoologist, a pharmacologist and rheumatologist and had researched this amoeba theory for 26 years. He had published numerous articles in the medical literature as well as writing several books about his work.

4. I then contacted Dr. Roger Wyburn-Mason and made arrangements to get a copy of his book entitled *The Causation of Rheumatoid Disease and Many Human Cancers — A New Concept in Medicine*. I studied this book in detail.

5. I spent hundreds of hours in the medical library studying

references found in his book which convinced me that he was on the right track and his work could mean a major breakthrough in treating Rheumatoid Diseases.

6. I secured a list of patients previously treated by Dr. Blount and was tremendously impressed with the results they obtained from their treatment.

7. I contacted two physicians and another scientist who had used this treatment in their work and received very favorable reports about their results.

8. I then treated my own Rheumatoid Disease problem and received total and immediate relief from the severe debilitating leg pain I had had for 15 years. Incidentally, there has been no recurrence of pain since that treatment.

9. I then began treating patients at my office clinic and have treated over 500 since that time.

10. I then helped Perry Chapdelaine and Dr. Jack Blount and a few others to get The Rheumatoid Disease Foundation organized and functioning. I gave Dr. Roger Wyburn-Mason's book to the University of Alabama Medical Library and wrote rheumatologists in the area to tell them about the book and where it was available. I was invited by the University of Alabama — Birmingham Department of Rheumatology to speak to the Department and various rheumatologists about this work and unfortunately was given a fairly hostile reception which at that time I could not understand as my only interest was to help these physicians relieve the pain and suffering of their arthritic patients. The only legitimate complaint these physicians could make was that we had not completed double-blind studies on the medications we were using to kill amoebae even though The Rheumatoid Disease Foundation was raising funds at that time to get these double-blind studies completed. We felt that if we were successful, this would leave the entire medical community of the world no excuse for not using this treatment on their Rheumatoid Disease patients. It was like the attitude of the person who says that you can't play a piano because I tried it, and it can't be done.

You know in the past history of man, I've noticed that practically every time a new idea or method and especially in medicine, a new treatment comes along, it always passes through three stages of development:

1. Stage 1 is the stage of criticism and condemnation.
2. Stage 2 is a stage of testing and trying.
3. Stage 3 is a stage of acceptance and utilization.

Our work is presently in stage 2 in its development and for any idea, method or treatment to finally prevail, it must stand the test of time in passing through these three stages. We've had tremendous opposition, criticism and condemnation in getting through stage 1, but we are extremely confident that we will be in stage 3 in the next 2-3 years.

Now unfortunately Dr. Wyburn-Mason died in June of 1983 and The Rheumatoid Disease Foundation is presently raising funds to duplicate and reproduce all of his findings by a major medical university in the United States. This work, after it is published, we believe will pave the way for acceptance of this treatment for the various Rheumatoid Diseases.

Rheumatoid Diseases

Now you have heard me refer to the term Rheumatoid Diseases and let me clarify this term. Dr. Wyburn-Mason was able to isolate and identify heavy concentrations of free-living amoebae which he called the *Limax Amoebae* in the involved tissues of most of the so-called auto-immune or collagen diseases as well as several types of cancers that primarily involved the lymphatic system as lymphomas. Auto-immune diseases are those in which the white blood cells are tying to fight some agent (such as a germ or chemical) in the tissues and they are not able to tell the difference between the agent and normal tisssues so they attack normal tissues as well as the agent and this results in severe tissue destruction in the tissues involved. Dr. Wyburn-Mason found the amoebae in all these tissues and learned that the amoebae can attack any tissue in the body. Rheumatoid Disease is not simply a disease of the joints but a generalized condition and every tissue of the body at some time has been reported to be affected. The same tissue changes seen under a microscope as are found in the joint tissues can be seen in other body tissues and consist of invasion by certain white blood cells as lymphocytes and plasmacytes along with inflamed small arteries. If they attack the joints, the disease is called Rheumatoid Arthritis.

If they attack the colon, the condition is called Ulcerative Colitis. Small intestine, Crohn's Disease; arteries: Periarteritis Nodosum; blood: [hemolytic disease]; [connective tissue, skin, organs]: Lupus Erythematosis; thyroid: Hasimoto's Thyroiditis; nerves: Multiple Sclerosis; salivary glands: Sjorgrens Syndrome; muscle: Dermatomyositis; skin: Psoriasis or Scleroderma.

These are just a few of the various diseases that Dr. Wyburn-Mason has been able to isolate the amoebae from. He therefore calls these diseases where the limax amoebae are found "the Rheumatoid Diseases" and many of these diseases have gone into remission after being treated by anti-amoebic medications. As examples, I have had about 2 out 3 Psoriasis and Lupus Erythematosis patients go into remission after trying the anti-amoebic treatment. I've had about 50% of Ulcerative Colitis or Crohn's Disease patients go into remission.

Of the Rheumatoid Arthritis patients treated with various anti-amoebic medications, I have found about 80%, 8 out of 10 patients are very significantly relieved or they go into remission. Dr. Robert Bingham of Desert Hot Springs, California, has treated hundreds of Rheumatoid Arthritis patients and his results are very close to my own. Dr. Paul Pybus, The Foundation's Chief Medical Advisor, also has had results that fairly closely parallel those of my own. Some physicians have gotten even better results and some have even reported poor results. We haven't determined as yet why this is so, but we are working on those factors that play a part in influencing treatment medications.

1. Methods of administering the anti-amoebic medications.
2. The diet followed by the patients and nutritional supplements provided.
3. The amounts and types of exercise recommended.
4. The mental attitude and hope instilled into the patients by various physicians.
5. The geographic areas of the country involved.
6. Possibly other types of germs that may be involved or different species of the amoebae that may be resistant to the present available medications.
7. The presence of allergies or co-existing infections that play a part in weakening the immune system.
8. Digestive disturbances and faulty absorption of necessary nutrients, foods and supplements. *Candida albicans*.

Anyhow, several physicians are working on these factors, and we believe with time that we will be able to solve to a great extent the unanswered questions that remain. We are tremendously excited and enthused about our progress so far and are anxiously awaiting the results of presently on-going studies that have been made possible because of the loyal support of the thousands of concerned members of the Rheumatoid Disease Foundation that are helping us.

Are Rheumatoid Diseases an Infection?

In the past few years, it appears that most researchers now believe that the Rheumatoid Diseases are due to an infectious etiology, or they are caused by some type of germ. Dr. Wyburn-Mason in his book clearly summarizes the medical literature with his ex-

haustive work proving how the research and findings of multitudes of investigators only serve to confirm his own findings. Dr. Wyburn-Mason discusses, compares, explains and analyzes many answers to numerous unanswered questions relating to the Rheumatoid Diseases. He presents documented evidence which demonstrates significant improvement and in many cases, complete remission when treated by anti-amoebic drugs of all the Rheumatoid Diseases. He lists in his book comparison after comparison proving that the Rheumatoid Diseases are infective in their cause or that they are caused by an invading germ organism. Time does not permit a detailed discussion of these events; but in a very short summary, let me list some comparing factors he demonstrated to prove this infection etiology or cause. The following symptoms and signs are very often seen in infections of one type or another as well as the various Rheumatoid Diseases:

Fever, loss of appetite, weight loss, increased sedimentation rate in blood, enlarged lymph glands, increased gammaglobulin in blood, enlarged spleen, granulomas, anemias, increase or decrease of white blood cells, increased plasmocytes, decrease of blood platelets, increased paraproteins, increased cryoglobulins in blood, evidence of amyloidosis, increased eosinophils in blood, allergic reactions, Jarisch Herxheimer reaction, atrophy of stomach and small intestine lining, presence of rheumatoid and antinuclear factor in blood, return to normal of most of preceding abnormalities following treatment with anti-amoebic drugs.

I believe all those listed factors are very important in proving an infectious cause of the Rheumatoid Diseases, but they seem insignificant when we consider a phenomenon called the Jarisch Herxheimer reaction. In 1902, while treating syphilis patients with arsenic and mercury compounds, Dr. Herxheimer noticed that patients got worse before getting better and they all developed "flu-like" symptoms. Also Dr. Lucio in treating patients with Leprosy, noticed that when the *M. leprae* germs were killed the patients had fairly severe "flu-like" symptoms. The same was found when the complex germs of African Sleeping sickness was killed. It is now known that when patients who are infected with the higher schistosomiasis and trypanosomiasis germs, *M. leprae* of leprosy and protozoans, as the amoebae are killed, these patients develop the "flu-like" symptoms called a Herxheimer reaction.

Most patients, while being treated undergo this reaction, the severity of which depends on how badly they are infected with the amoebae. Those that are not too severely affected may notice nothing at all to possibly a mild fever, nausea and aching feelings like a mild case of "flu." Those severely affected may notice fairly severe "flu" symptoms with headache, aching bones and skin, nausea, fever and chills, flushing of the skin and the joint swelling and pain may even increase in severity at first. Therefore, the patient may seem to get worse before getting better. These symptoms are similar to symptoms seen when there is a foreign protein in the body.

It seems that some people following treatment, may be allergic to the proteins and/or toxins of the rapidly dying amoebae that swarm throughout the body, and this reaction is closely related to that allergy. These symptoms may persist for several days and even four or five weeks in those rare patients who have many tissues infected with the amoebae. Even though this reaction is uncomfortable, it denotes a good sign that the amoebae are being killed and the body is ridding itself of the dead germs. This is a good indication that the Rheumatoid Diseases are caused by a form of germ (amoebic) and the reaction only verifies the fact that the body is getting rid of the dead germs.

Within days to a few weeks at most, the "flu-like" reaction subsides and the swelling, pain and tenderness of the joints usually go away. Ironic as it may seem, it has been my experience that patients who experience the Herxheimer reaction the strongest, seem to receive the most relief from the treatment. Conversely, those patients who experience no reaction whatsoever "usually" do not have Rheumatoid Disease or amoebic origin or that the germs are not sensitive to the particular anti-amoebic drug prescribed (as often seen with anti-amoebics) and it may be necessary to prescribe another type of amoebaecidal drug. Those patients who still experience the Herxheimer reaction during their sixth week of treatment may require a few additional weeks of treatment or until all Herxheimer symptoms have subsided.

Treatment does not correct any damage that has already been done by the amoebae to the tissues, but the progress of the disease is usually arrested. Therefore, any arthritic deformities remain but the pain, swelling, stiffness and redness all gradually go away. Some patients may become reinfected and depending upon the severity, they may have to return for re-treatment. Dr. Blount advises patients that one way to prevent re-infection is to make certain all water pipes in one's house are copper, since copper kills the amoebae very effectively. Also, since chlorine doesn't kill amoebae [efficiently] and they grow rapidly in swimming pools, especially in warm water, he advises placing plates of copper in the pool itself. [Further research has shown that the more effective treatment is the use of a copper algaecide, as suggested by William E. Catterall, Sc.D. Bio-Guard™ MSA Algicide (Bio-Lab, Decatur, Georgia) contains 7% copper in the form of a soluble triethanolamine complex. Recommended treatment is 4oz./5000 gal, or 0.4 ppm copper added. Ed.]

Anti-amoebic Treatment of Rheumatoid Disease

We have found that the majority of patients with Rheumatoid Arthritis respond well to treatment by using Metronidazole and Allopurinol. The Allopurinol, according to Dr. Wyburn-Mason interferes with the enzyme systems of the amoebae and this is the reason for its effectiveness. The Metronidazole itself or its metabolites seem to actually kill the amoebae and are primarily responsible for causing the Herxheimer reaction if given in the proper dosage. I usually routinely begin treatment of my Rheumatoid Arthritis patients by giving 3 primary medications.

1. One cc of Depot Medrol is given on the day the patient comes to my office. This is a cortisone-like medication that prevents a severe Herxheimer reaction. As more amoebae are killed at first, the "flu-like" symptoms can be quite severe and the Depot Medrol lasts about 7-10 days. Because of this, many patients notice fairly severe flu-symptoms the second and third week of treatment after the Depot Medrol has worn off. I don't like to use cortisone-like medications for any condition normally, but I find it very appropriate in this treatment.

2. Secondly, I give a prescription for Allopurinol or Zyloprim™, 300 mg. tablets. The patient takes 1 tablet 3 times daily for 1 week then stops this medication.

3. I also give a prescription for Metronidazole, 250 mg. tablets, to be taken in divided doses, two days in a row each week for 6 weeks. For a patient who weighs around 200 pounds, I recommend 2000 mg. daily or 2 tablets with meals and 2 at bedtime two at bedtime two days in a row, each week for six weeks. For a 150 pound patient, I give 1,500 mg. daily or 2 tablets with each meal and none at bedtime. For a person who weighs over 225 pounds, I prescribe 3 tablets with each meal or 2,360 mg. daily. I have the patient begin both medications the next day after the Depot Medrol injection.

In addition to the above medications, I prescribe a special diet and various supplements that I will mention later. Also, I check each involved joint to determine if any of the nerves are inflamed and inject the affected nerves when appropriate. I will also go into detail tomorrow concerning the techniques and theory involved with intra-

neural injections. I have the patient make an appointment to return for evaluation in 6 or 7 weeks.

When the patient returns for the second or follow-up visit, I usually see one of three things that have happened:

1. The patient has no more arthritic pains and the involved joints are not inflamed anymore even though the patient may have had no Herxheimer reaction, or a moderate or a severe reaction. I do not give any further medication to these patients but advise continuing the diet along with continuing the supplements for another 2-3 months.

2. Some patients returning may be no better at all and have had no Herxheimer reaction at all. With these patients, I re-evaluate the previous diagnosis and if the original diagnosis was wrong, I change the treatment accordingly. With this situation, one of two things has happened: The diagnosis is wrong and the patient doesn't have Rheumatoid Arthritis or the patient's particular amoebae are not sensitive or responsive to the medication given and with these patients I will usually change to another anti-amoebic medication.

3. The third thing I may see on the second return visit is a patient who has had a mild, moderate or severe Herxheimer reaction and usually is somewhat to greatly improved but still has arthritic pains and symptoms and some evidence of inflammation in the involved joints. Should they seem to be reacting to medication, I may prescribe an additional 4 weeks of Metronidazole. If they have had only a mild Herxheimer reaction, I may change the medication to a different anti-amoebic drug. It really depends on the particular patient response.

Another thing I have seen on a few patients after a few weeks or months, is that they may be in total remission initially and then the arthritis symptoms gradually begin to recur again. If this happens, I have to conclude that either the patient's original amoebae turned to the cyst stage where the medication couldn't kill them or maybe the original amoebae found some place to hide in the body tissues that had a very poor blood supply and the medication couldn't get to the amoebae. If these patients responded well to the Metronidazole, I may give them another 4 to 6 weeks treatment and have them take the Metronidazole the first 2 days of each month thereafter, or I may change to another anti-amoebic drug, depending on the patient.

For the past two years, I have strongly suspected that in some patients, the amoebae may hide in body tissues or areas where there is poor blood supply such as in cartilage or fascial (connective tissue covering the muscles) tissues or even inside the colon where there is an abundance of *E. coli* germs that is a favorite food of the amoebae. I've even given some patients high colonics and enemas to try to clean out the entire colon, but so far the results are not spectacular, but I am still working on this aspect. I am becoming more convinced each day that amoebae do hide in the fascial or connective tissues which have a very poor blood supply.

Dr. Seldon Nelson of Lansing, Michigan, and myself are working on this aspect and Dr. Nelson is an Osteopathic Physician and has developed various techniques of stretch and counter-stretch actions which increase the blood supply of these tissues, and we are seeing some very good results in some patients who have been unresponsive to the regular anti-amoebic treatment. Dr. Nelson has been visiting my clinic 3-4 days each month, and we are developing and improving these techniques that he originally discovered and perfected and he has done a magnificent job in his research. We hope to develop techniques to improve the healing as well as the functioning of the deformed joints of patients with even long-standing arthritis. One exciting breakthrough is that some patients with multiple sclerosis are getting better and improving, but let me emphasize to any physician here that he should never treat a patient with multiple sclerosis with the anti-amoebic protocol as the patient can be made worse. I hope to discuss this a little further tomorrow when I talk to you about the intraneural injections.

Other Anti-Amoebic Medications

One of the major problems that we are faced with today is the scarcity of medications or effective drugs that are able to kill the different strains of the limax amoebae. We do have some moderately effective drugs available in America, but those drugs that are known to be the most effective for killing the amoebae are not available in the U.S. The following slide lists the drugs that are known to be anti-amoebic, and they are listed according to what we believe to be the most potent anti-amoebic listed first, and the least potent listed last. Those that are available in the U.S. will have a double star or asterisk typed after the generic name.

Anti-Amoebic Medications

Listed in order of potency and United States availability denoted by **:

Generic Name	Chemical Name	Brand Name
Clotrimazole	Imidazole	Myceliex, Lotrimin
Tinidazole	Nitroimidazole	Fasigyn
Nimorazole	Nitroimidazole	Emtryl, Naxogin
Ornidazole	Nitroimidazole	Tiberal
Metronidazole**	Nitroimidazole	Flagyl
Furazolidone**	Nitrofuran	Furoxone
Rifampicin**	Rifamycin B	Rimactane
Allopurinol**	Pyrimidine	Zyloprim
Diiodohydroxyquinon**	Oxyquinoline	Yodoxin
Copper ions**	Inorganic Copper	Copper Sulfate
Dehydrocholic Acid**	Bile Salts	Decholin
Cimetidine**		Tagamet
PABA**		Potaba

Of the medications avaible in the United States, I have received the best results in treating patients with a combination of Metronidazole and Allopurinol. I seem to get fair results with Yodoxin, Furoxone and Rimactane. The copper works very well in some patients, but there are some problems encountered with absorption and delivery of the copper ions to the actual site of infestations of the amoebae. Dr. Seldon Nelson and myself are presently working on various techniques of administration of several drugs to improve this as well as methods to increase blood circulation to affected areas which should deliver better concentrations of the copper and other medications to the infected tissues. The Rheumatoid Disease Foundation is presently supporting double-blind studies by Bowman Gray School of Medicine on Clotrimazole and hopefully these studies will make available to our physicians this drug which we believe is the most potent anti-amoebic.

Supportive Measures in Treating Rheumatoid Arthritis

To achieve the best results in treating any chronic degenerative disease it is important to remember that simply giving a drug to kill a disease causing germ is not enough. In the first place, these patients have been ill for many months to years and their entire body chemistry, digestion, nutrition, and immune system has been continually stressed and damaged over this period of time. The next slide will list the supporting facets of treatment which first not be overlooked if a physician wants to give his patients the very best opportunities to achieve the most successful improvement.

Supportive Evaluations for Better Results in Treating Any Chronic Degenerative Disease

1. Diet and proper nutrition.
2. Correction of any Nutritional Deficiency or imbalance.
3. Correction of any digestive malfunctions.
4. Elimination of contributing factors that may be suppressing the patient's immune system:

a. Food, inhalant, and chemical allergies.

b. Concomitant infections such as yeast, virus, foci of infections.

c. Exposure to toxins such as heavy metals and petrochemicals.

5. Exercise.
6. Rest and relaxation.
7. Removal of physical or mental stress factors.
8. Instill hope and positive mental attitude in patients.
9. Intraneural injections for arthritis patients.

Intraneural Injections

Most patients with Rheumatoid and Osteoarthritis have developed inflammation in various nerves that go to the joints. These areas of inflammation in the nerves may be caused by calcium deposits in the nerve areas, trauma or injury to the nerves or even invasion of the nerves by germs like the amoebae or Candida-yeast infections. Our Foundation's Medical Director, Dr. Paul K. Pybus, has been working with this problem for several years and has developed various techniques of intra-neural injections that have caused remarkable improvement in many patients. I will be speaking tomorrow concerning these injections and will go into detail to explain the theories involved, the preparation of solutions for injection and the actual techniques of injection, but I just wanted to mention here that this is a supportive measure I use in treating all arthritic patients. I would now like to go into a little more detail on a couple of the other very important supportive measures.

Diet

There are more incidents of the chronic degenerative diseases in our land today than has ever been known in the history of mankind. These diseases include all the forms of arthritis and auto-immune diseases but also obesity, diabetes, and cardiovascular diseases which include heart disease, arteriosclerosis, and peripherial vascular disease. Today, with the processing of most our foods, many important vitamins, minerals, amino acids, and fatty acids are removed so the foods will last longer on the shelves. Many soils which are used to grow our foods are becoming depleted of essential nutrient substances, especially minerals.

Also thousands of chemicals are added to soils in the growing process and also preservatives and other chemicals are added to our processed foods. Because of all of this, we are finding that our entire society is suffering from a diet that is plagued with over-consumption and under-nutrition and the incidence of chronic degenerative diseases can only increase in severity. Most Americans are now conditioned to follow this "S.A.D." or Standard American Diet and our diet plays a very important factor in treating all arthritic patients. It can spell the difference in getting poor, fair, good, or excellent results in the treatment of our arthritic patients.

Whereas normal body fluids are nearly always slightly alkaline, as opposed to acid, I constantly find those patients with arthritis disease have body fluids that are more acid in nature than normal. This is partly due to a deficiency in free (ionic) calcium, which itself is very alkaline in nature. But the primary cause of this acid-alkaline reversal can be found in the diet and nutritional habits of those with arthritis disease. Most cellular mechanisms of the body and particularly those involving the use of ionized (free) minerals such as the secretory (all glands) processes, nerve function processes, and muscle contraction, etc., proceed best in a mildly alkaline state. For this reason, a diet consisting of high alkaline forming foods should be consumed, combined with avoidance of acid forming foods. Acid forming foods are those which are high in one or more of three elements: phosphorus, sulfur, and chlorine. Alkaline forming foods are those which are high in one or more of four othe elements: potassium, calcium, magnesium, and sodium. The following diet has proven to be effective in treating those with Rheumatoid Diseases, but also seems to strengthen and fortify any individual's immune system and body defenses, especially when combined with other adequate vitamin and mineral supplements.

The following slide is a summary of the type of diet I recommend for all arthritic patients. I will explain the reason and rationale for each of the foods listed.

Summary of Diet for Rheumatoid Disease Patients

Avoid These Foods

1. Processed foods (foods in box or can).
2. Alcohol, caffeine, nicotine.
3. Processed cereals, white rice, and corn products.
4. Four vegetables — Irish potatoes [white potatoes], tomatoes, eggplant, and peppers.
5. All forms of pork.
6. Peanuts, walnuts.
7. Skim milk or low fat milk.
8. Any known allergenic foods.
9. All sweets, deserts, sugars, candy, soft drinks, ice cream, pies, cakes, pastries, etc.
10. All white flour such as white breads, crackers, biscuits, spaghetti, macaroni, pasta.
11. All "hydrogenated" or "hardened" cooking oils or fats, and especially margarine.
12. Excessive diet drinks (2 per day permitted).

Eat These Foods

1. Fish, fowl, eggs, cheeses, lamb, and beef (up to 3 times weekly), yogurt, venison, shrimp.
2. All vegetables, preferably raw or "wok" cooked, (avoid potatoes, tomatoes, eggplant, and peppers).
3. All vegetable juices except tomato.
4. All salad vegetables.
5. Whole wheat or whole grain breads (if 100%).
6. Whole grain cereals — non-processed.
7. All nuts except peanuts and walnuts.
8. Home canned foods without sugar added.
9. All fruits and juices including dried fruits. (The whole fruits are preferable to the juices.)
10. Decaffeinated coffee, herbal teas, whole milk, buttermilk, spring or mineral water, juices.
11. Butter, olive oil, cooking oils that are "cold-pressed."
12. Adequate vitamin, mineral supplements with cod liver oil.

Calcium Imbalance

During the physical examination and after studying the history of patients with Rheumatoid Arthritis and Osteoarthritis, I very frequently find strong evidence of calcium deficiency. There are two main types of calcium in the body. These are free or ionic calcium and the calcium bound to proteins. Blood calcium measurements measure the total of free and protein bound calcium, and it seems to be the free-ionic calcium that arthritic patients are deficient in, and the blood calcium measurements are usually in the normal range and do not show up the deficiency of free calcium. Previous research by another physician in Canada, Dr. Carl Reich, has shown that arthritic patients are quite deficient in this free calcium and this problem must be addressed to get better results in treatment.

Dr. Hans Nieper of West Germany has done much research on the use of various calcium preparations, and he has shown that there are two forms of calcium that occur naturally in our vegetables and the body uses these forms of calcium much better than regular calcium supplements. These two forms are Calcium Orotate and Calcium Aspartate, and ideally the patients should get about 400-500 mg of calcium daily from one or both of these forms of calcium. Some health stores carry calcium daily from one or both of these forms of

calcium. Some health food stores carry calcium orotate since many people have learned that the orotate form is the very best type that helps osteoporosis. The FDA is trying to make it a prescription item, so I usually furnish this to the patients since they may not be able to find it in health food stores.

In order for our bodies to use the calcium properly, we must have available adequate vitamin D3 or natural vitamin D. Most supplements contain the D2 form as well as the D2 form that is added to milk and other foods, and this form is synthetic. This synthetic D2 causes the body to absorb the calcium all right but does not regulate how the calcium is used. The natural D3 causes the calcium to be absorbed from the small intestine and regulates and promotes the excretion of any excess calcium which helps protect the body from the development of kidney stones. I also advise patients to try to get about 30 minutes of exposure to the sun each week which activates the vitamin D. The natural vitamin D3 is found in fish liver oils, so arthritic patients must take cod liver oil. I recommend that they go to health food stores and purchase the Norwegian cod liver oil that contains 10,000 units of vitamin A and 1,000 units of vitamin D3 per teaspoon and recommend 2 teaspoons morning and night.

Fatty Acid Deficiency

Another nutrient that I find all arthritic patients deficient in and I estimate that about 80% of our entire population also are deficient in fatty acids. This is the fault of our food companies who take out all the fatty acids when they process our foods to prevent the foods from turning rancid. In my opinion, this is the primary reason that we are having so much arteriosclerosis with heart attacks and strokes today, and we are seeing these diseases occurring earlier in life, even men in their twenties. There are two primary reasons for this: One reason is the cholesterol scare that has been thrown at us from all angles. Cholesterol intake, in my opinion, is not the cause of any cholesterol buildup in our arteries, but the inability of our bodies to use the cholesterol manufactured by the body itself is the cause.

The cholesterol we take in as food is digested and broken down into its component parts in the stomach and is not cholesterol anymore. We manufacture our own cholesterol, and how our bodies use this manufactured cholesterol determines whether we get arteriosclerosis or not.

Besides, if cholesterol intake caused atherosclerosis, the Greenland Eskimos would be dying like flies from atherosclerosis since their diets are tremendously high in cholesterol, yet they have much fewer deaths from heart and blood vessel disease than we do. The diet of the Eskimos also is very high in the fatty acids that our food companies take out of our foods, and also their diets contain very small amounts, if any at all, of the hydrogenated oils as found in margarines and our hardened cooking oils.

So the two reasons, in my opinion, for the near epidemic state of arteriosclerosis in America is due to number one, the excess of hydrogenated oils in our diet; and number two, the deficiency of fatty acids in our diets.

The excess hydrogenated oils block the chemical pathways by which the few fatty acids that do get in our diets are utilized. Therefore, our bodies cannot use our cholesterol properly. Then, the actual deficiency of the natural fatty acids our bodies must have to manufacture other hormone-like substances called prostaglandins play an important role in [not] allowing our bodies to use the cholesterol and triglycerides manufactured by our own bodies.

I've been treating my patients who have high cholesterol and triglycerides by simply adding the fatty acid supplements to their diets, and I'm seeing amazing results.

Now all these arthritic patients are severely deficient in these fatty acids that are used to manufacture the hormone-like prostaglandins. It's the prostaglandins that our systems must have to resist and overcome any inflammatory reactions. Some prostaglandins cause inflammation; and to fight any inflammation, we must have adequate prostaglandins of which, for our consideration, there four primary ones, prostaglandin 1, 2, 3, and 4:

Prostaglandin 2 is a bad guy, and we get loads of it in our red meats, seafoods, and diary products.

Prostaglandins 1, 3, and 4 are good guys and the ones that are removed from our foods.

Prostaglandin 1 is very important, and the hydrogenated oils block its production; the fatty acid it is made from is gamma linolenic acid. It is found in high concentrations in Oil of the Evening Primrose and can be purchased at health food stores. I recommend 6-8 capsules daily.

Prostaglandins 3 and 4 are also important, and their precursors are Eicosapentanoic Acid and Docosahexanoic Acid; both of these are removed from our foods.

Salmon oil is rich in both of these fatty acids and can be found in the health food stores under the name Maxepa, and I recommend 6-8 capsules of this daily.

I have seen definite improvements and faster improvements in all arthritic patients when I give them these fatty acid supplements.

I realize I have only hit some of the high points in this talk, but I hope that I have been able to enlighten you more about the work of The Foundation and what we are trying to accomplish. I would like to spend these last few minutes of time in answering any questions you may have.