To: Dr. T. Koba April 12, 1979

It was indeed a pleasure to receive your letter dated March 29, 1979. I appreciated your profound interest in the rheumatoid diseases. Yes, I was a victim, myself, for many years. A brief summary of my case is found on page 205 of your book, (*The Causation of Rheumatoid Disease . . .* . by Prof. Wyburn-Mason). When you read it please notice that I am in Mississippi and not Missouri. I have now been back at work for almost 20 months, and I am going strong, especially in the treatment of rheumatoid diseases. I have a feeling that I was sent back by God to do just this. As you know He has some hard-headed people in our profession. We simply won't listen to Him.

In the U.S.A. the Imidazole Derivative that we have that is nearest to Clotrimazole and Tinidazole is Metronidazole (or Flagyl), It is approved here for the treatment of protozoal infections of ameba and trichomonas. In my experience it works better than any of the others, and with fewer untoward effects. I haven't found a contraindication to it. During the past 2 years I have prescribed it for more than 400 people. [*Dr. Blount treated more than 17,000 by the time he retired. Ed.*]

With Prof. Wyburn-Mason's advice and help the treatment regimen has been quite simplified. I treat the rheumatoid diseases as infectious diseases, mostly on an out-patient basis using Flagyl in the place of the other well known antibiotics. The routine is 2 grams after supper two successive days each week. For example, if the patient is seen on Monday his prescription will read ". . . after supper each Monday and Tuesday." This automatically requires it to be taken after a meal, and just before going to bed. This minimizes drug interference.

As you know there is a tendency toward the Herxheimer reaction during the first treatment and this can be distressing. To avoid or minimize this I give an injection of repository corticosteriod (Depo Medrel 40 mgm I.M.) the first day. Clinoril can be given concommitantly. Patients who are in acute distress also appreciate a 5 or 10 mgm dose of Prednisone or Prednisolone each morning -- Note! One small dose, once a day, at a specific time.

Those who have joint effusions require aspirations. I deposit a corticosteroid at the time. Also acute foci are injected with a combination of a local anesthetic + a corticosteroid.

Among the diseases that have been treated successfully with this routine are: rheumatoid arthritis, lupus erythematosis, sarcoidosis, periarteritis, erythema multiforme and nodosa, psoriasis, phlebetis, etc. The worst case of psoriasis I ever saw completely cleared up after oral and topical use of Flagyl.

The practice of medicine is now a pleasure every day. I used to dread seeing these patients. I had nothing really useful for them. I thank God for letting me be a part of this new relief of agonizing distress, which we so recently considered incurable.

I will be looking forward to hearing of your successes, too.

Yours truly
J.M. Blount, Jr., M.D.

[*Editor's Note: This is a very early letter in the development of a standard treatment by a committee of doctors on behalf of The Arthritis Trust of America/The Rheumatoid Disease Foundation. The standard treatment now recommended includes use of the Wyburn-Mason/Pybus/Prosch Intraneural Injections in lieu of cortisone, as described in many places on our website at* http://www.arthritistrust.org.]