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for your info
Carl

Bob Owen Box 1100 Cannon Beach, OR 97110.

Dear Bob.

I guess I've previously send a Schedule of Dosages. Together, with the Alkaline Producing diet and exercise to the level of Aerobic Exertion should "do it"!

But it appears that some "acidics" have been deficient for so long that their functional-reversible cellular mechanisms have been replaced with physical-irreversible ones. So these remain "locked in" and all the nutritional therapy of the deficiency will not alter them, so that the pH can't revert to normal.

Countless individuals are acidic to the level of 6.0 and functioning well with hardly a symptom except they've lost stamina and don't go biking et cetera. I say that they are deficient and their acidifying adaptive mechanisms of lung, intestine, and carbohydrate metabolism retaining CO_2 or evacuating base are working fine to effect biochemical compensation by facilitating the ionization of residual cellular molecular calcium. But they are in the "symptom and disease prone state" for the ionic =Ca++ deficiency may eventually induce <u>direct</u> symptoms, <u>direct</u> disease arising from these symptoms, or <u>indirect</u> disease from the ner e excited adaptive mechanisms

I gather you were "laboring through" my concept of adaption giving way to "mal-adaption"! For this reason I will give a "bit of a run-down" on it. Please copy and refer to Dr. Priestly for, if she is to integrate "my thing" into her practice and research, it is vital that she understand it.

Regarding adaption versus ionic -Ca++ deficiency it is most important to realize that this was produced by the evolutionary process providing protection against deficiency of vitamin D that <u>would not last longer than a winter season.</u> "Advances" of civilization in the form of indoor occupation and recreation, clothing, and diet made it possible that a large percentage of the population may experience a level of this deficiency, for decades or a lifetime, that our primitive ancestors would experience at the end of a winter season. The mothers of a civilized population could therefore give birth to several children while they were so ionic calcium deficient and experiencing adaption to the deficiency. This deficiency, and this biochemical defect, will be reflected on these children, particularly the later born, as "biochemically inherited defects". Examples of these are chronic asthma, a diarrhoeal disease, and rheumatoid arthritis in infants and young children.

Bob Barefoot refers to the "laws of chemistry" which dictate the adoption of a different pH by the cell if the cell is to have its requirement of ionic calcium =Ca++ in calcium deficiency environment. But he doesn't propose how such "chemical force" is acquired! I propose it reflects the autonomic or automatic excitation of those adaptive functions that involved the transduction of chemical energy of glucose and oxygen within smooth muscle and secretory cells of the lungs and intestines into motion and secretion. As those functions increased acidic retention and alkaline excretion these in turn were transduced into the required acidity. So the sequence it is chemical change into function into chemical change.

Asthma and diarrhoeal disease which may result from the breakdown of such function represent two of the "smooth muscle adaptive acidifying and indirect mal-adaptive diseases".

Hypertension is another such "smooth muscle spastic disease" but I propose that its "adaptive device" is not acidity but the transduction, by the same sequence, of kinetic energy exerted on a blood constituent for reason of increased cardiac contraction plus arteriolar spasm, into the appropriate chemical change.

Other classes of "mal-adaptive disease " are the calcium demineralization diseases of the skeleton and the metabolic diseases.

The two major forms of arthritis and osteoporosis represent variant autonomically stimulated adaptive devices involving the calcium demineralization of the skeleton.

Diabetes represents a metabolic form of adaption in which the CHO metabolism is interrupted at a point where it will result in the increased production of organic acids.

While the above represent organ or tissue-based adaption and mal-adaption, cancer represents cell-based adaption to the same deficiency. It is the creation by "reverse mutation" of a primitive cell type which has no need for oxidation of glucose which is conducted in the mitochondria, and an ionic calcium energy transport mechanism. Instead, even foregoing oxygen, it can acquire all the energy it needs, and more, through the uncontrolled anaerobic fermentation of glucose that occurs throughout the cell.

I believe that, for reason of the evolution of mammals including man in an environment that contained ultra-violet radiation, ionic calcium became intimately involved in the control of the oxidative system. This may have been a point of contact between oxygen and glucose catalyst effect or control by the promotion or negation of an energy transport system carrying the released solar bonding energy to sites in the cell where it was to be used. Whatever, a deficiency of ionic calcium will lead to "cell energy starvation".

The coincided or sequential occurrence the above diseases indicates that multiple "calls" for adaption versus threatening "cell energy starvation" may be made by the autonomic nervous system. Most likely a second, third, or more such "call" will be made only when for reason that advancing physical changes caused the exhaustion of the adaptive potential of the previously excited adaptive function.

I have little doubt that Dr.Priestly will have little trouble in establishing that, prior to contacting the HIV virus, most of her AIDS patient were deficient and experiencing some of the effects of the deficiency in the form of functional or physical stigma of the "ionic calcium deficiency syndrome". Moreover, as she has already studied advanced cases of the disease, she has noted that some may exhibit several of the above mal-adaptive diseases with or without cancer.

The point in therapy will not just be a means of alkalinization, like that applied by the Korean author you mentioned, of taking a lot of MATOL for its high potassium content, or by taking rubidium and cesium as advocated by Barefoot, but also the provision of the D vitamins and calcium. They, far more than the others, represent that evolutionary factor.

I guess that's all Bob, or enough "pondering" for a while! Thanks for the stimulus to present this again which compels me to "hone the concept down into shape", or at least into different form!

As for your daily supplements I'll mention mine! I am 76 tomorrow and hike the mountains. My pH is 7.0 to 7.5 but after such a week end is "off the alk. end of the paper" to possibly be 8.0 Two week ends ago I hiked 2,000 feet up and several miles back with two F-18 student pilots (friends of my sons) to get to the level of a herd of mountain sheep! And I didn't get the least muscle ache!

Several time a week, when I remember, I take:

500 mg calcium + 300 mg Mg + 25 of Zn
six halibut liver oil caps
each 400 of D (mainly D-3)
5,000 of A natural
4 to 6 brewers yeast tabs
4 to 6 alfalfa "
400 of E

Possibly you should do something the equivalent aiming to get between 7,000 to 10,000 IU of D <u>weekly.</u> That is until the sun gets an ultra-violet "punch" again and you expose more skin to it! I'm sure that you are OK in all others, but possibly low in D.

Sincerely,

Carl C.

SCHEDULE OF DOSAGES - THE AVERAGE INITIAL AND MAINTENANCE DOSAGES GIVEN TO THREE AGE CATEGORIES.

AVERAGE MAINTENANCE DOSAGE

Depending on response to therapy the following initial dosages are maintained for several weeks or months. Usually they are reduced to 1/2 to 1/3 this initial dosage within that time.

THE AVERAGE INITIAL QUANTITIES AND DOSAGES OF VITAMINS

PRODUCTS USED	QUANTITY PRESCRIBED	TOTAL DAILY DOSAGES VITAMIN A	D2 & D3	CALCIUM DAILY DOSAGE OF CAL-MAG DOLOMITE BONE MEAL ET CETERA TO PROVIDE
	Three Year old Child			250 Mg. to 1/2 Gram
Aquasol A & D	2-3 drops b.i.d.-t.i.d	5,000 to 12,000 iu	1,000 to 2,400 iu	
	Fifteen year old Adolescent			500 Mg. to 1.0 Gram
Aquasol A & D	5 drops t.i.d.	20,000 iu	4,000 iu	
Halibut liver oil capsules	1 b.i.d.	10,000 iu	800 iu	
	TOTAL	30,000 iu	4,800 iu	
	150 - 175 Pound Adult			1,000 Mg. to 1.5 Gram.
Aquasol A & D	6 drops t.i.d.	24,000 iu	4,800 iu	
Halibut liver oil capsules	2 t.i.d.	30,000 iu	2,400 iu	
	TOTAL	54,000 iu	7,200 iu	

THE VITAMIN PREPARATIONS

"Aquasol A and D" is mfgd. by Rorer Can.Inc. 130 East Dr.Bramlea Ont. Can. L6T 1C3, (416) 792-1212. In 50cc bottles. Each 3 drops contains 800IU of Vit.D-2 and 4,000 of Vit A. In the USA this may be substituted with Twin Lab's water soluble "Allergy D Caps. 400 IU", containing a preferred Vit. D-3, and " Allergy A Caps. 1,000 IU".

Halibut liver oil capsules 400 IU Vit. D-2 + D-3 and 5,000 IU natural A are mfgd. by R.P. Scherer of Ont. (519) 253 2405.

MONITORING OF DOSAGES

SMA serum blood tests are done prior to therapy for hypercalcaemia due to hyperparathyroidism, pre existing vitamin D therapy or other causes