# The Journal Of The Rheumatoid Disease Medical Association

*Volume 1, Number 1*




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## Editorial

*Volume One, Number One*

As members of the Rheumatoid Disease Medical Association, we are the physicians who realize, more than any others of our profession, the seriousness of the arthritis problems which we see every day in our practices of medicine.

In line following heart disease and cancer, the **Rheumatoid Diseases** have become the **third** greatest cause of serious illnesses and disabilities in the 1980s.

The origin of these rheumatoid diseases is still an enigma. But the pioneer work of the late Dr. Roger Wyburn-Mason brought us closer to the solution and has afforded us new approaches in diagnosis and treatment. This has been of great help to the practicing physician who must deal with this family of diseases in his clinical practice.

The *Rheumatoid Disease Foundation* is now going through a metamorphosis from an organization promoting one theory — the origin of rheumatoid arthritis caused by amoebae — and one treatment — a protozoal drug — to a non-profit corporation supporting medical research and dedicated to finding the causes and treatment of all types of rheumatoid diseases, whatever their origins may be and whatever method of management will benefit or cure the patient.

We have abundant clinical evidence that the rheumatoid diseases are infectious in etiology. And the collected reports from our members furnish more data and proof that the use of a variety of medicines, which have an anti-protozoal action, are more effective in producing improvement and remissions than drugs which are commonly used for the signs and symptoms of these diseases. And these are much safer and better tolerated by most patients.

Very many years ago, I had the privilege to work with the Nobel prize winner, Rene Dubos, at the Rockefeller Institute for Medical research in New York City. We used his discoveries of the pioneer antibiotics, gramacidin and tyrocidin on some patients of mine with osteomyelitis at the New York Orthopedic Hospital. It turned out that we were the first to find out and demonstrate that bacteria could develop an immunity to antibiotics.

Protozoa, being more complex because they are one celled "animals" (often having more complex DNA) can be expected to acquire immunity to antibiotics more quickly than lower forms of pathogens. This may explain why such a drug as metronidazole may lose its effect. This may require the physician to change medications from time to time, particularly in chronic cases where the disease has been treated with many types of anti-arthritic remedies. [Metronidazole is not metabolized by the human enzyme system. When good-guys micro-flora is knocked out — often by metronidazole on the first usage — the next time with an overgrowth of *Candida albicans* or other organisms, the human body simply does not metabolize the medicine thoroughly. On taking a goodly supply of viable *Lactobacillus acidophilus* before, during, and after ingestion of metronidazole, the medicine, the medicine gets metabolized. This fact is not true of tinidazole or clotrimazole, as the human enzyme system does metabolize the medicine. In the case of metronidazole, the metabolites are the active ingredients, not the metronidazole.]

Clinical information as simple as this may help the member of the Rheumatoid Disease Medical Association in understanding the drug problems of his patients and to manage them more successfully.

It is the hope and intent of your editor to select and publish articles and clinical reports on new and better methods of therapy so that this *Journal* will be of practical use to the physician who is treating arthritis patients.

Since only about 15% of arthritis patients are treated by rheumatologists — the other 85% by physicians in general practice, by specialists in internal medicine, by orthopedic surgeons and by physical therapists and chiropractors — this *Journal* should have a strong appeal and a wide circulation. Membership in our new Association will be an honor as well as a source of valuable clinical information. Your Case Reports, Reviews of Books and articles and questions to our Scientific and Medical Advisory Committee will be welcome. This is your medical journal. Pass along any news and clinical information which may be of interest to our members.

No advertising can appear until we have a considerable number of paid subscribers. If you have not sent your dues or subscriptions, please do so soon, so this new *Journal* can continue to grow in size and in service to our membership, and through them to our

patients, who trust and depend on us for their care.

This "Volume One, Number One" is the first of a series of journals which we hope and expect will continue until the rheumatoid diseases are conquered and the specific treatments for them are accepted and published in every medical textbook. Until then, your cooperation and support will be needed, by the *Rheumatoid Disease Foundation* and the officers and directors of your new *Rheumatoid Disease Medical Association*.[Now The Arthritis Trust of America, Ed.]

ROBERT BINGHAM, M.D.

## Historical Note

*An unpublished letter from Professor Roger Wyburn-Mason*

Rheumatoid Disease is a generalized condition, not just one of joints and muscle spasm. The occurrence of rheumatoid granulomatous nodules subcutaneously, at the sites of pressure or even on the meninges or sclera or of rheumatoid lung, heart, liver, and kidney lesions or of involvement of the parotid and lacrimal glands and skin lesions can only be found in a systemic pathology.

The autonomic neurogenic cause of the disease was exploded many years ago by the fact that complete sympathectomy was repeatedly found to have no effect on the disease. This is not a "one-of" finding, but has been repeatedly confirmed. The nervous system may be involved in producing the inflammatory changes in rheumatoid disease.

Years ago I showed that inflammation in a tissue is dependent on the integrity of the unmyelinated C fibers of the posterior nerve roots and mixed peripheral nerves. If these are destroyed, as in gunshot wounds, leprosy, tabes or syringomyelia then injury to the part normally supplied by these nerve fibers results not in inflammation but in necrosis. While in the condition of causalagia resulting from injury to the median or sciatic nerves, mild trauma in the painful area may result in an exaggerated inflammatory response as compared with that in normal tissues of the patient. Inflammation depends on antidromic impulses passing down from the spinal cord to the inflamed area through these special nerve fibers, in the case of rheumatoid arthritis, to the region of the joints.

Such cases as the following:

All were fit middle-aged men, ploughing the dry fields on windy days — one in the Middle West of USA, one in Ontario and one in Rhodesia. During the ploughing, there was a great deal of dust being blown about from the dry surface soil and this was inhaled by the subjects. During the next night, all three were wakened by drenching night sweats, general malaise and next morning were found to have temperatures of 105° F. Every joint in the body was painful, swollen and immobilized even including the cryoarytenoids and temporo-mandibular. They had a cough, sputum, severe headache and muscular aching. All were admitted to the hospital and eventually found to be suffering from acute rheumatoid disease. In spite of intensive treatment, their symptoms only very gradually diminished over the next 3-4 months, but they were left at this time with severe pain and swelling of the joints which did not respond to any treatment over the next year or more. These cases are typical of severe infection and ***NOT*** of a disturbance of the autonomic nervous system. The origin of their infection would seem to lie in something inhaled from the copious surface soil dust (which contains free living amoeba).

I isolated free-living amoebae from all the body tissues in cases of active rheumatoid disease, cultured them from the laboratory, found that antiamoebic substances killed them and then treated cases of active rheumatoid disease with various antiamoebic substances.

Incidentally, the eminent protozoologists Kofoid and Swezy, working in their laboratory at the University of California (LA) in 1922 found the same organism in the bone marrow of cases of rheumatoid arthritis and suggested its aetiological relationship to the disease some 40 years before my work. They reported this in a zoological journal which never reached the medical profession.

Furthermore, any substance which in vitro kills the organism when given to active cases of rheumatoid arthritis often produces a transient Herxheimer reaction, that is an exaggeration of the inflammatory changes of rheumatoid arthritis and often the appearance of lesions in previously unaffected tissues, just like mercury exaggerated the symptoms of syphilis. When given to healthy subjects,

these antiamoebic drugs have no such effect, and Herxheimer reactions do not occur when antibiotics or antiviral substances are used against sufferers from bacterial or virus diseases. This observation alone shows the presence in rheumatoid arthritic lesions of an organism more complex than a bacterium, namely an amoeba. This is the complete proof of the amoebic causation of rheumatoid arthritis. [Subsequent studies were unable to confirm this amoeba theory, but strongly suggested that the treatment worked to normalize or stop auto-immune activity of macrophages which happened to resemble amoebae. Ed. S.C.]

Local anesthetics have two effects — they are anti-protozoal and also paralyze the unmyelinated C fibers, the discharge of which is responsible for inflammation. Both these effects could explain some of the benefits from procaine therapy in rheumatoid disease.

## Free-Living Amoeba

The Cause of Rheumatoid and Autoimmune Diseases?

by ROGER WYBURN-MASON
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[Reprinted by permission of *Arthritis News Today*, Yorba Linda, CA August 1981; from a paper presented at the 15th International Congress of Rheumatology in Paris this June]

Numerous species of the universally-found free-living amoeba are known. Most fall into two genera — *Acanthamoeba* and *Naegleria* — and some are pathogenic to man and animals. In inimical conditions, they form hollow spherical cysts, which are present in the air in most parts of the world and can readily be found on agar plates exposed to air. Free-living amoeba prefer warm surroundings and tend to migrate to an environment at body temperature (thermotropism).

All living beings are surrounded by many species of these free-living amoeba which pass into mammalian respiratory passages as cysts or trophozoites. These must also be present as trophozoites in the gastrointestinal tract of many animals, including man, since they are found in their feces. These organisms are motile and, once they enter an orifice, they migrate under thermotropic influences into body tissues.[20]

Recently it has been shown[3] that the blood contains antibodies against *Acanthamoebae* and *Naegleria*, indicating universal infection of man and the newborn with these organisms. Textbooks on protozoology state that unspecified types of amoebae have been isolated from every tissue in the body[6]; there is hardly an organ in the body from which somebody has not obtained amoebae.[2] Lesions due to species of such organisms have been described in a few cases of plants and man, namely amoebic meningo-encephalitis.[1,16]

In 1922, the eminent protozoologists, Kofoid and Swezy, reported the presence of free-living amoeba in the bone marrow of rheumatoid arthritis patients without dysentery or *E. histolytica* in the feces. These organisms were distinguished from human cells by mitotic processes and contained only 6 chromosomes rather than the normal 46 of human cells. They showed a single blunted pseudopodium and numerous vacuoles, suggesting a causal relationship between infection and the arthritic process.[5, 9-14]

### Anti-amoebic Substances

Recently I have shown[19, 21-23] that free-living pathogenic or non-pathogenic amoebae can be made to migrate out of human tissue, including those of the newborn and fetus, by using the property of thermotropism. Large numbers are found in the affected tissues of all patients with rheumatoid disease, in extra-articular tissues affected by autoimmune disease, in normal feces, in uncooked butcher's meat, and in surface soil. Smaller numbers may be recovered from some tissues of apparently healthy humans, when they are presumably of non-pathogenic nature; they appear identical with those found by Kofoid and Swezy. These findings have been confirmed in laboratories in various parts of the world.

In the laboratory, these organisms can be cultured in "amoeba saline," into which a culture of *E. coli* has been introduced. Various antiamoebic substances found effective in killing the organisms when added to the cultured cells include bile salts (1% solution), 4-aminoquinolines, copper sulfate (very dilute solutions), metallic copper, gold salts, emetine, dehydroemetine, pentamidine, and levamisole (which contains an imidazole group). Particularly effective are the 5-nitroimidazole group of drugs — including metronidazole, tinidazole, ornidazole and nimorazole — which possess a wide spectrum of antiprotozoal as well as antiamoebic activity.

Since the organisms are not numerous and look like macrophages or lymphocytes, they can be recovered in spite of the fact that they are not usually observed in affected tissues stained by ordinary methods. This is a feature repeatedly observed in laboratory animals experimentally infected with free-living amoebae and recalls the situation with syphilitic lesions before stains for *Treponema pallidum* were discovered. The organisms in rheumatoid arthritis, however, can be demonstrated in tissue sections by immunofluorescent staining using sera containing appropriate antibodies to the organisms and by studying their mitosis and chromosome content in marrow biopsy material.

### The Effect of Anti-amoebic Drugs on Active Rheumatoid Disease

Rheumatoid disease is not limited to joints but may involve any tissue of the body. The same histological changes in joint capsules are found in extra-articular lesions and consist of lymphocytic infiltration, formation of germinal follicles, and often plasmocytosis accompanied by arteritis, arteriolitis, or endarteritis. Many of the extra-articular lesions constitute so-called autoimmune diseases but also include Sjogren's Syndrome, bone marrow infiltrations, thymic lesions, and granulomatous nodules. Symptoms typical of an infection — fever up to 40° C, sweating and raised ESR — may be present. Any of the extra-articular or autoimmune lesions may occur in any combination with or without arthropathy.

I have shown that any substance which kills the free-living amoebae *in vitro,* when administered to cases of active rheumatoid disease, may cause a rapid disappearance of the inflammatory changes around the joints and elsewhere in the body. Complete cure is obtained in early cases. But more commonly these drugs may induce a transient exaggeration of the inflammatory changes around the joints and elsewhere; and often, inflammatory lesions in a part of the body not previously affected will appear. This may be accompanied by influenzal symptoms, sweating, pyrexia, lymphadenopathy rise in ESR, and eosinophilia. This reaction is also seen in cases of active rheumatoid disease treated with gold salts[18] and levamisole.[15] Various countries — notably the U.K., United States, Holland, and New Zealand — have confirmed this reaction in cases of active rheumatoid disease treated with anti-protozoal substances.

### The Herxheimer Reaction

This phenomenon, first described by Herxheimer[8] in cases of syphilis treated with mercury, also occurs in diseases due to organisms more complex than bacteria when drugs that kill the causative organism in the tissues are administered. This "Herxheimer reaction" is due to the liberation of irritant and antigenic substances from the dying organisms and is not observed in healthy persons or in rheumatoid patients given antibiotics. Its occurrence in rheumatoid disease (including those of autoimmune lesions) treated with

various antiamoebic drugs proves that a causative pathogenic amoeba is present in the affected tissues. [Since anti-amoebic medication is also known to kill friendly bacteria, increased accumulations of acetaldehyde byproducts from population explosions of *Candida albicans* could also account for what was thought to be a Herxheimer reaction. Ed. S.C.] After administration of antiamoebic drugs (especially 5-nitroimidazoles), evidence of rheumatoid disease activity usually completely disappears in both joints and extra-articular tissues within 3 to 6 months. Therefore, autoimmune lymphocytic and humoral reactions are not the primary disturbance in rheumatoid and autoimmune diseases; they are the cellular-antibody response to infection and its antigens and contribute to the tissue damage.

The whole syndrome resembles syphilis. Indeed, Waldenstrom and others[17] state that "if the spirochaete had not been discovered, syphilis could be taken to be the ideal model of an autoimmune disease. The variety of tissue reaction antibodies, the widespread lymphocytic damage, and the vasculitis are characteristic features."

Rheumatoid disease also closely resembles the rheumatic manifestations in leprosy.[4] This disease may present with acute arthritis affecting one or a number of joints, polymyositis, skin lesions, fever, raised ESR, and other signs; there will also be an increase in circulating gammaglobulins and positive serological tests for autoantibodies RF and ANF, as in rheumatoid disease. This is an immune complex syndrome with antigens provided by disintegrating *M. Leprae*. The reaction known as Lucio's phenomenon, which is identical to the Herxheimer reaction, may be precipitated by antileprosy drugs.

The syndrome confirms deductions made regarding rheumatoid disease, proving that every tissue in the body may contain unsuspected free-living amoebae. If pathogenic, they may cause tissue infiltration by lymphocytes with germinal centers and often plasma cells in genetically susceptible subjects (as governed by their tissue types). They are also the source of unknown chronic antigenic stimulation previously postulated by Glynn[7] as the cause of rheumatoid disease.

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## Criteria and Treatment Methods Using Anti-Protozoal Drugs

**Selection of Patients**

There must be verification of some form of ACTIVE Rheumatoid Disease.

The patient should have four out of nine of these indications.

1. History of a rheumatoid disease syndrome.
2. Physical findings diagnostic of the condition.
3. Positive serology.
4. Elevated sedimentation rate.
5. 2% or more eosinophilia.
6. Secondary anemia.
7. Two or more inflamed joints.
8. Atropic joints by x-ray.
9. Morning pain and stiffness.

**Drugs of Choice (May be Limited by Local Availability)**

This dosage based on 70 Kg. (150 lb.) man:

**Flagyl. (Metronidazole)** 2 Gm./day for 2 days a week, for six weeks.

Or 2 Gm./day for 10 days. Then, for 3 days a month for 3 months. Then, repeat laboratory tests before continuing treatment. A change of drugs may be indicated if substantial improvement or a remission has not been obtained.

**Lomotrin. (Clotrimazole)** 1.0 mg. per 10 Kg. body weight per day for 8 weeks. Then, repeat lab. etc.

**Diodoquin. Yodoxin. (Di-Iodohydroxiquin)** 650 mg. three times a day with meals for 10 days. Then, for 3 days a month for 3 months. Recheck lab. work.

**Fasigyn. Tinidex. (Tinidazole)** 500 mg. in a single dose for the first week, increasing to twice a week for 10 weeks.

**Pentamidine** 200 mg. day by injection 3 days a week for three weeks. Then, recheck laboratory findings.

The total course of treatment may be from 3 to 6 months in the average patient. Those previously treated with drugs affecting the immune systems, such as gold, penicillamine and the cortico-steroids, are more resistant to anti-protozoal drugs.

A nutritional diet, adequate vitamin and mineral supplementation, exercise with appropriate rest periods and avoidance of stress are necessary factors in care of the rheumatoid disease patient.

This is a personal protocol: ROBERT BINGHAM, M.D.

# Anti-amoebic Treatment for Rheumatoid Disease

Gus J. Prosch, Jr.



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## 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, 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 exhaustive 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 intraneural 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 autoimmune 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 overconsumption 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.

## Natural Treatment and Cure for Arthritis

Raymond F. Peat, Ph.D.

A very healthy 71-year-old man was under his house repairing the foundation, when a support slipped and let the house fall far enough to break some facial bones. During his recovery, he developed inflammatory arthritis in his hands. It is fairly common for arthritis to appear shortly after an accident, a shock, or surgery, and Hans Selye's famous work with rats shows that when stress exhausts the adrenal glands (so they are unable to produce normal amounts of cortisone and related steroid hormones), osteoarthritis and other "degenerative" diseases are likely to develop. But when this man went to his doctor to "get something for his arthritis," he was annoyed that the doctor insisted on giving him a complete physical exam, and wouldn't give him a shot of cortisone. The laboratory examination showed low thyroid function, and the doctor prescribed a supplement of thyroid extract, explaining that arthritis is one of the many symptoms of hypothyroidism. The patient agreed to take the thyroid, but for several days he grumbled about the doctor "fixing something that wasn't wrong" with him, and ignoring his arthritis. But in less than two weeks, the arthritis had entirely disappeared. He lived to be 88, but without a recurrence of arthritis.

Selye's work with the diseases of stress, and the anti-stress hormones of the adrenal cortex, helped many scientists to think more clearly about the interaction of the organism with its environment, but it has led others to focus too narrowly on hormones of the adrenal cortex (such as cortisol and cortisone), and to forget the older knowledge about natural resistance. There are probably only a few physicians now practicing who would remember to check for hypothyroidism in an arthritis patient, or in other stress-related conditions. Hypothyroidism is a common cause of adrenal insufficiency, but it also has some direct effects on the joint tissues. In chronic hypothyroidism (myxedema and cretinism), knees and elbows are often bent abnormally.

By the 1930s, it was well established that the resistance of the organism depended on the energy produced by respiration under the influence of the thyroid gland, as well as on the adrenal hormones, and that the hormones or pregnancy (especially progesterone) could substitute for the adrenal hormones. In a sense, the thyroid hormone is the basic anti-stress hormone, since it is required for the production of the adrenal and pregnancy hormones. A contemporary researcher, F.Z. Meerson[1], is putting together a picture of the biological processes involved in adapting to stress, including energy production, nutrition, hormones, and changes in cell structure.

While one of Selye's earliest observations related gastro-intestinal bleeding to stress, Meerson's work has revealed in a detailed way how the usually beneficial hormone of adaptation, cortisone, can cause so many other harmful effects when its action is too prolonged or too intense.

Some of the harmful effects of the cortisone class of drugs (other than gastro-intestinal bleeding) are: Hypertension, Osteoporosis, delayed healing, atrophy of the skin, convulsions, cataracts, glaucoma, protruding eyes, psychic derangements, menstrual irregularities, and loss of immunity allowing infections or cancer to spread.

While normal thyroid function is required for the secretion of the adrenal hormones, the basic signal which causes cortisone to be formed is a drop in the blood glucose level. The increased energy requirement of any stress tends to cause the blood sugar to fall slightly, but hypothyroidism itself tends to depress blood sugar. The person with low thyroid function is more likely than a normal person to require cortisone to cope with a certain amount of stress.

However, if large amounts of cortisone are produced for a long time, the toxic effects of the hormone begin to appear. According to Meerson, heart attacks are provoked and aggravated by cortisone produced during stress. (Meerson and his colleagues have demonstrated that the progress of a heart attack can be halted by a treatment including natural substances such as vitamin E and magnesium.)

While hypothyroidism makes the body require more cortisone to sustain blood sugar and energy production, it also limits the ability to produce cortisone, so in some cases stress produces symptoms resulting from a deficiency of cortisone, including various forms of arthritis and more generalized types of chronic inflammation. Since cortisol is formed as one of the last steps in a series of reactions, glandular exhaustion means that a whole group of other steroids is depleted, before cortisol or cortisone. I believe that the safest way to handle a steroid deficiency is to supplement the precursors of the raw materials, so that a normal balance of the various substances is preserved.

Often, a small physiological dose of natural hydrocortisone can help the patient meet the stress, without causing harmful side effects. While treating the symptoms with cortisone for a short time, it is important to try to learn the basic cause of the problem, by checking for hypothyroidism, vitamin A deficiency, protein deficiency, a lack of sunlight, etc. (I suspect that ultraviolet light on the skin directly increases the skin's production of steroids, without depending on other organs.) Using cortisone physiologically, rather than pharmacologically, it is not likely to cause the serious problems mentioned above.

Stress-induced cortisone deficiency is thought to be a factor in a great variety of unpleasant conditions, from allergies to ulcerative colitis, and in some forms of arthritis. The stress which can cause a cortisone deficiency is even more likely to disturb formation of progesterone and thyroid hormone, so the fact that cortisone can relieve symptoms does not mean that it has corrected the problem.

Besides the thyroid, the other class of adaptive hormones which are often out of balance in the diseases of stress, is the group of hormones produced mainly by the gonads: the "reproductive hormones." During pregnancy, these hormones serve to protect the developing baby from the stresses suffered by the mother, but the same hormones function as a part of the protective anti-stress system in the non-pregnant individual, though as a lower level.

Some forms of arthritis are known to improve or even to disappear during pregnancy. As mentioned above, the hormones of pregnancy can make up for a lack of adrenal cortex hormones. During a healthy pregnancy, many hormones are present in increased amounts, including the thyroid hormones. Progesterone, which is the most abundant hormone of pregnancy, has both anti-inflammatory and anesthetic actions, which would be of obvious benefit in arthritis. There are other naturally anesthetic hormones which are increased during pregnancy, including DHEA, which is being studied for its anti-aging, anti-cancer, and anti-obesity effects. (One of the reasons that is frequently given for the fact that this hormone hasn't been studied more widely is that, as a natural substance, it has not been monopolized by a drug patent, and so no drug company has been willing to invest money in studying its medical uses.) These hormones also have the ability to control cell division, which would be important in forms of arthritis that involve invasive tissue growth.

While these substances, so abundant in pregnancy, have the ability to substitute for cortisone, they can also be used by the adrenal glands to produce cortisol and related hormones. But probably the most surprising property of these natural steroids is that they protect against the toxic side-effects of excessive adrenal hormones. And they seem to have no side-effects of their own; after fifty years of medical use, no toxic side effects have been found for progesterone or pregnenolone. Pregnenolone is the material the body uses to form either progesterone or DHEA. Others, including DHEA, haven't been studied for so long, but the high levels which are normally present in healthy people would suggest that replacement doses, to restore those normal levels, would not be likely to produce toxic side effects. And, considering the terrible side effects of the drugs that are now widely used, these drugs would be justifiable simply to prevent some of the toxic effects of conventional treatment. It takes a new way of thinking to understand that these protective substances protect against an excess of the adrenal steroids, as well as making up for a deficiency. Several of these natural hormones also have a protective action against various poisons — Selye called this their "catatoxic" effect. (If a toxin, for example a bacterial product, is involved in a sickness, such as arthritis or colitis, these catatoxic steroids might be helping by blocking the toxin and strengthening the patient.)

Besides many people whose arthritis improved with only thyroid supplementation, I have seen people use one or more of these other natural hormones for various types of arthritis, usually with a topical application, and I know of several other people who used progesterone topically for inflamed tendons or other inflammations. Only one of these, a woman with rheumatoid arthritis in many joints, had no significant improvement. An hour after she had applied it to her hands and feet, she enthusiastically reported that her ankle had stopped hurting. But after this, she said she had no noticeable improvement.

The first time I saw arthritis disappear after treatment with progesterone was accidental. A woman who began using progesterone for her epilepsy decided to dip her arthritic fingers in the oily solution, and a few days later proudly demonstrated that she could bend them without pain.

About a year later, a friend in Mexico City complained about a knee that had been increasingly stiff and painful for about a year. Twenty minutes after applying progesterone the pain was gone, and when I asked him about it a few years later, he said it never hurt again. Knowing that those "raw material" steroids, pregnenolone, progesterone, and DHEA, could be converted into anything the body needs, such as cortisone and sex hormones, but that they protect against the toxic effects of other hormones, many other people (including physicians and researchers) were interested in trying them on their own joint problems.

Some typical cases are described below:

1. A 72-year-old woman. She was considered to have mild rheumatoid arthritis which was degenerating into porosis, with her fingers being the most seriously affected joints. A 3% solution of DHEA in olive oil was applied to one index finger, and a 10% solution of progesterone in mixed tocopherols was applied to the other index finger. All of her fingers had been rigid for over a year, with the result that she was extremely disabled. Forty minutes after the DHEA solution had been applied, the finger treated with that solution could be bent enough to touch the base of her thumb, without significant pain, but none of her other fingers showed any improvement. Several days later, the DHEA solution was applied to all of her fingers, with similarly good results. After about 6 months, stiffness and pain returned in spite of her use of DHEA. Although thyroid was suggested, she had been taught to be afraid of that hormone, as have millions of other women.

2. A 60-year-old woman with a long history of rheumatoid arthritis had serious degeneration of many joints. She had undergone surgery several times, for implantation of two artificial joints and for repair of joint cartilage. She walked a little as possible and

experienced pain, inflammation and fatigue with excessive walking. She applied a solution containing 7% DHEA and 3% progesterone in a solvent consisting of olive oil and tocopherol. She applied the solution several times one afternoon and the next morning to all affected joints, including hands, wrists, elbows, knees, and ankles. She experienced what she said was "complete relief," and spent the next two days walking around the town sightseeing, without any of the after-effects she had previously experienced from walking.

3. A 62-year-old man. His knees had been stiff, painful, and inflamed for over two years, following an accidental fall onto his knees. Arthroscopic examination revealed damaged cartilage in his right knee, and surgery was recommended to restore function. The patient refused surgery, even though he walked with difficulty and had to use his left leg (which was also affected) to lift himself slowly up steps. He said he had not slept well since he had developed the arthritis, because he pain woke him repeatedly during the night, and only the use of an analgesic would allow him to go back to sleep. He coated his knees and the skin around them, about four inches above and below, with a total of nearly an ounce of a solution similar to that used in case number two. Within 30 minutes, he appeared to able to walk more normally, and about 45 minutes after applying the solution, he remarked that he believed he was able to walk more easily. He repeated the application that night before going to sleep. Around 10 o'clock the next morning, he returned and laughingly demonstrated his knees by running up the stairs, and said that he had been able to sleep through the night for the first time in years, and had not taken his usual analgesic. Topical treatment was discontinued after a few days, and he remained free of symptoms while taking 60 mg of pregnenolone orally, daily.

4. A 61-year-old woman. Painful and stiff joints in her hands had interfered with her work as a musician, and had made it impossible to sleep through the night, since the pain woke her two or three times during the night. A solution similar to that used in cases three and four was applied to the painful joints early in the evening, and a few hours later she was able to go to sleep without taking aspirin and slept through the night. She occasionally uses the same solution preventatively, and has not had a recurrence of the joint pain or stiffness.

We often hear that "there is no cure for arthritis, because the causes are not known." If the cause is an imbalance in the normal hormones of adaptation and resistance, then eliminating the cause by restoring this balance will produce a true cure.

Informed patients who suspect that their health problems are related to stress should encourage their physicians to investigate the use of thyroid hormone, progesterone, pregnenolone, DHEA, and the anti-stress nutrients, especially magnesium and vitamins A and E.

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# 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.

# Adequate Treatment for Fighting Back Against Arthritis

Robert Bingham, M.D.

*First National Seminar*
*The Rheumatoid Disease Foundation*
*Birmingham, AL July 18-20, 1985*

**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 nonsteroidal 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 wa-

ters 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:

1. *Rheumatoid Diseases Cured at Last,* Anthony di Fabio
2. *Fight Back Against Arthritis,* Robert Bingham
3. *Patient Nutrition Handbook,* Nellie F. Strauss
4. *Arthritis Program,* Robert Bingham.
5. *Arthritis and Health News,* Desert Arthritis Clinic.

The cost of all three of these 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."**