

My Rheumatoid Arthritis Protocol

Posted by: Dr. Mercola

Introduction

Rheumatoid arthritis affects about 1 percent of our population and at least two million Americans have definite or classical rheumatoid arthritis. It is a much more devastating illness than previously appreciated. Most patients with rheumatoid arthritis have a progressive disability. More than 50% of patients who were working at the start of their disease are disabled after five years of rheumatoid arthritis. The annual cost of this disease in the U.S. is estimated to be over \$1 billion.

There is also an increased mortality rate. The five-year survival rate of patients with more than thirty joints involved is approximately 50%. This is similar to severe coronary artery disease or stage IV

Hodgkin's disease. Thirty years ago, one researcher concluded that there was an average loss of eighteen years of life in patients who developed rheumatoid arthritis before the age of 50. Most authorities believe that remissions rarely occur. Some experts feel that the term "remission-inducing" should not be used to describe ANY current rheumatoid arthritis treatment. A review of contemporary treatment methods shows that medical science has not been able to significantly improve the long-term outcome of this disease.

My Experience with the Dr. Brown's Protocol

I first became aware of Doctor Brown's protocol in 1989 when I saw him on *20/20* on ABC. This was shortly after the introduction of his first edition of *The Road Back*. The newest version is *The New Arthritis Breakthrough* that is written by Henry Scammel. Unfortunately, Dr. Brown died from prostate cancer

shortly after the *20/20* program so I never had a chance to meet him. By the year 2000, I will have treated over 1,500 patients with rheumatic illnesses, including SLE, scleroderma, polymyositis and

dermatomyositis. My application of Dr. Brown's protocol has changed significantly since I first started implementing it. Initially, I followed Dr. Brown's work rigidly with very little modification other than shifting the tetracycline choice to Minocin. I believe I was one of the first people who recommended the shift to Minocin, which seems to have been widely adopted at this time.

In the early 90s, I started to integrate the **nutritional model** into the program and noticed a significant improvement in the treatment response. I cannot emphasize strongly enough the importance of this aspect of the program. It is absolutely an essential component of the revised Dr. Brown protocol. One may achieve remission without it, but the chances are much improved with its implementation. The additional benefit of the dietary changes is that they severely reduce the risk of the two to six month worsening of symptoms that Dr. Brown described in his book.

In the late 80s, the common retort from other physicians was that there was "no scientific proof" that this treatment works. Well, that is certainly not true today. If one peeks ahead at the bibliography, one will find over 200 references in the peer-reviewed medical literature that supports the application of Minocin in the use of rheumatic illnesses.

The definitive scientific support for minocycline

in the treatment of rheumatoid arthritis came with the MIRA trial in the United States. This was a double blind randomized placebo controlled trial done at six university centers involving 200 patients for nearly one year. The dosage they used (100 mg twice daily) was much higher and likely less effective than what most clinicians currently use.

They also did not employ any additional antibiotics or nutritional regimens, yet 55% of the patients improved. This study finally provided the "proof" that many traditional clinicians demanded before seriously considering this treatment as an alternative regimen for rheumatoid arthritis.

Dr. Thomas Brown's effort to treat the chronic mycoplasma infections believed to cause rheumatoid arthritis is the basis for this therapy. Dr. Brown believed that most rheumatic illnesses respond to this treatment. He and others used this therapy for SLE, ankylosing spondylitis, scleroderma, dermatomyositis and polymyositis.

Dr. Osler was also a preeminent figure of his time (1849- 1919). Many regard him as the consummate physician of modern times. An excerpt from a commentary on Dr. William Osler provides a useful perspective on application of alternative medical paradigms:

Osler would be receptive to the cautious exploration of nontraditional methods of treatment, particularly in situations in which our present science has little to offer. From his reading of medical history, he would know that many pharmacologic agents were originally derived from folk medicine. He would also remember that in the 19th century physicians no less intelligent than those in our own day initially ridiculed the unconventional practices of Semmelweis and Lister.

Osler would caution us against the arrogance of believing that only our current medical practices can benefit the patient. He would realize that new scientific insights might emerge from as yet unproved beliefs. Although he would fight vigorously to protect the public against frauds and charlatans, he would encourage critical study of whatever therapeutic approaches were reliably reported to be beneficial to patients.

Revised Antibiotic-Free Approach

Although the antibiotics frequently worked and the six-month period of worsening that was part of Dr. Brown's protocol was virtually eliminated, I always felt like I had failed because I had to resort to the use of antibiotics.

This has now changed, as I have been able to implement a major change in my revision of the protocol that allows for **a completely drug-free treatment of RA**. The major change seems to be the use of nutritional typing, along with energy techniques. Since we have integrated nutritional typing with full use of EFT to address the stressors that seem to be universally present in RA, **we have been able to cause RA to routinely go into remission without the use of antibiotics**.

To say I am excited is a serious understatement.

nutritional typing allows each patient to get a unique diet that is right for their body. It is very easy to understand how a physician who successfully treats one patient with a particular diet would come to the conclusion that the diet that person was on was the "cure" for RA, when in fact nothing could be further from the truth. Another person with the same disease could quite possibly need an entirely different diet to receive any benefits, that is how powerful nutritional typing can be.

If you haven't yet read the book *The nutritional typing Diet*, I would strongly encourage you to do so as it reviews these topics extensively (it is definitely a book that belongs on the shelf of anyone with any interest in nutrition).

There are some general principles that seem to hold true for all nutritional types and these include:

- 95 Eliminating sugar and grains (you can read more about this below)
- 95 Having unprocessed, high-quality foods, organic if possible

Eating your food as close to raw as possible

Having omega-3 fish oil

I am overjoyed beyond belief that after 14 years of treating RA I can finally offer a drug-free, effective and rapid solution for most of those with RA with the aid of nutritional typing. However, it is clear that a perfect diet alone will rarely cause the RA to go into remission.

This is because RA is an autoimmune illness. It does indeed appear to be caused by an infection, as Dr. Brown speculated. But the central issue is why did the person acquire the infection in the first place? It is my experience that this infection is usually acquired when a person has a stressful event that causes a disruption in their bioelectrical circuits, which causes an impairment in their immune system. This impairment predisposes them to developing the initial infection and also contributes to their relative inability to effectively defeat the infection .

The antibiotics clearly seem to help most people fight the infection, but, as I mention above, there are better ways that address the underlying foundational cause of the illness.

I am quite convinced that energy techniques are required to resolve this energetic disruption. Prayer can certainly be one of them. However, in my experience, most have not utilized prayer in a way that rallies their body's resources to resolve the problem.

In my experience, energy psychology techniques are very helpful in this area and can be easily integrated with prayer. I happen to use EFT in my practice and you can download my free **25-page report** to find out more about this technique

However, the emotional trauma that causes RA is nearly universally quite severe and is best treated by a professional. Trying to treat this trauma by yourself is somewhat similar to a general surgeon trying to perform an appendectomy on him or herself. Although it is possible, it is not generally recommended (Interesting aside : I read an article in JAMA about 10 years ago in which a surgeon in the late 1800s actually did this. Unfortunately, he died from complications .)

Dr. Partirica Carrington has actually compiled some guidelines on how you can find an EFT practitioner. In the following sections I have included information about the antibiotic therapy for RA for anyone who is interested . However, I now recommend my drug-free approach for anyone fighting this illness.

Nutritional Considerations

Limiting sugar is a critical element of the treatment program. Sugar has multiple significant negative influences on a person's biochemistry . Its major mode of action is through elevation of insulin levels. However, it has a similarly severe impairment of intestinal microflora. Patients who are unable to decrease their sugar intake are far less likely improve.

One of the major benefits of implementing the dietary changes is that one does not seem to develop worsening of symptoms the first three to six months that is described in Dr. Brown's book. Most of my patients tend to not worsen once they start the antibiotics. I believe this is due to the beneficial effects that the diet has on the immune response.

Antibiotic Therapy With Minocin

There are three different tetracyclines available: simple tetracycline, doxycycline, or Minocin (minocycline). Minocin has a distinct and clear advantage over tetracycline and doxycycline in three important areas.

1. Extended spectrum of activity
2. Greater tissue penetrability
3. Higher and more sustained serum levels

Bacterial cell membranes contain a lipid layer. One mechanism of building up a resistance to an antibiotic is to produce a thicker lipid layer. This layer makes it difficult for an antibiotic to penetrate. Minocin's chemical structure makes it the most lipid soluble of all the tetracyclines

This difference can clearly be demonstrated when one compares the drugs in the treatment of two common clinical conditions . Minocin gives consistently superior clinical results in the treatment of chronic prostatitis. In other studies, Minocin was used to improve between 75-85% of patients whose acne had become resistant to tetracycline. Strep is also believed to be a contributing cause to many patients with rheumatoid arthritis . Minocin has shown significant activity against treatment of this organism.

There are several important factors to consider when using Minocin.

Unlike the other tetracyclines, it tends not to cause yeast infections. Some infectious disease experts even believe that it even has a mild anti-yeast activity . Women can be on this medication for several years and not have any vaginal yeast infections. Nevertheless, it would be prudent to have patients on prophylactic oral Lactobacillus acidophilus and bifidus preparations. This will help to replace the normal intestinal flora that is killed with the Minocin.

Another advantage of Minocin is that it tends not to sensitize patients to the sun. This minimizes the risk of sunburn and increased risk of skin cancer. However, one must incorporate several precautions with the use of Minocin. Like other tetracyclines, food impairs its absorption. However, the absorption is much less impaired than with other tetracyclines . This is fortunate because some patients cannot tolerate Minocin on an empty stomach. They must take it with a meal to avoid GI side effects . If they need to take it with a meal, they will still absorb 85% of the medication, whereas tetracycline is only 50% absorbed. In June of 1990, a pelletized version of Minocin became available. This improved absorption when taken with meals. This form is only available in the non-generic Lederle brand and is a more than reasonable justification to not substitute for the generic version. Clinical experience has shown that many patients will relapse when they switch from the brand name to the generic. In February 2006 Wyeth sold manufacturing rights of Minocin to Triax Pharmaceuticals (866-488-7429).

Clinically it has been documented that it is important to take Lederle brand M inocin. **Most all generic minocycline is clearly not as effective.** A large percentage of patients will not respond at all or not do as well with generic non-Lederle minocycline.

Traditionally it was recommended to only receive the brand name Lederle Minocin. However, there is one generic brand that is acceptable and that is the brand made by Lederle. The only difference between Lederle generic Minocin and brand name Minocin is the label and the price.

The problem is finding the Lederle brand generic. Some of my patients have been able to find it at Wal Mart. Since Wal Mart is one of the largest drug chains in the US, this should make the treatment more widely available for a reduced charge .

Many patients are on NSAID"s which contribute to microulcerations of the stomach which cause chronic blood loss. It is certainly possible they can develop a peptic ulceration contributing to their blood loss. In either event, patients frequently receive iron supplements to correct their blood counts.

IT IS IMPERATIVE THAT MINOCIN NOT BE GIVEN WITH IRON.

Over 85% of the dose will bind to the iron and pass through the colon unabsorbed. If iron is taken, it should be at least one hour before the minocin or two hours after. One recent uncommon complication of Minocin is a cell-mediated hypersensitivity pneumonitis .

Most patients can start on Minocin 100 mg . every Monday, Wednesday, and Friday evening . Doxycycline can be substituted for patients who cannot afford the more expensive Minocin . It is important to not give either medication daily, as this does not seem to provide as great a clinical benefit.

Tetracycline type drugs can cause a permanent yellow- grayish brown discoloration of the teeth .

This can occur in the last half of pregnancy and in children up to eight years old. One should not routinely use tetracycline in children. If patients have severe disease, one can consider increasing the dose to as high as 200 mg three times a week. Aside from the cost of this approach, several problems result may result from the higher doses. Minocin can cause quite severe nausea and vertigo. Taking the dose at night does tend to decrease this problem considerably.

However, if one takes the dose at bedtime, one must tell the patient to swallow the medication with TWO glasses of water. This is to insure that the capsule doesn't get stuck in the throat. If that occurs, a severe chemical esophagitis can result which can send the patient to the emergency room

For those physicians who elect to use tetracycline or doxycycline for cost or sensitivity reasons, several methods may help lessen the inevitable secondary yeast overgrowth . Lactobacillus acidophilus will help maintain normal bowel flora and decrease the risk of fungal overgrowth .

Aggressive avoidance of all sugars, especially those found in non-diet sodas will also decrease the substrate for the yeast's growth. Macrolide antibiotics like Biaxin or Zithromax may be used if tetracyclines are contraindicated. They would also be used in the three pills a week regimen .

Clindamycin

The other drug used to treat rheumatoid arthritis is clindamycin. Dr. Brown's book discusses the uses of intravenous clindamycin. It is important to use the IV form of treatment if the disease is severe . Nearly all scleroderma patients should take an aggressive stance and use IV treatment. Scleroderma is a particularly dangerous form of rheumatic illness that should receive aggressive intervention. A major problem with the IV form is the cost. The price ranges from \$100 to \$300 per dose if administered by a home health care agency. However, if purchased directly from Upjohn, significant savings will be appreciated.

For patients with milder illness, the oral form is preferable. If the patient has a mild rheumatic illness (the minority of cases), it is even possible to exclude this from their regimen. Initial starting doses for an adult would be a 1200 mg dose once a week.

Patients do not seem to tolerate this medication as well as Minocin . The major complaint seems to be a bitter metallic type taste, which lasts about 24 hours after the dose. Taking the dose after dinner does seem to help modify this complaint somewhat. If this is a problem, one can lower the dose and gradually increase the dose over a few weeks .

Concern about the development of C. difficile pseudomembranous enterocolitis as a result of the clindamycin is appropriate. This complication is quite rare at this dosage regimen, but it certainly can occur. It is important to warn all patients about the possibility of developing a severe uncontrollable diarrhea. Administration of the acidophilus seems to limit this complication by promoting the growth of the healthy gutflora .

If one encounters a resistant form of rheumatic illness, intravenous administration should be considered. Generally, weekly doses of 900 mg are administered until clinical improvement is observed. This generally occurs within the first ten doses. At that time, the regimen can be decreased to every two weeks with the oral form substituted on the weeks where the IV is not taken.

What To Do If Severe Patients Fail To Respond

The most frequent reason for failure to respond to the protocol is lack of adherence to the dietary guidelines. Most patients will be eating too many grains and sugars, which disturb insulin physiology. It is important that patients adhere as strictly as possible to the guidelines. A small minority, generally under 15%, of patients will fail to respond to the protocol described above despite rigid adherence to the diet. These individuals should already be on the IV Clindamycin.

It appears that the hyaluronic acid, which is a potentiating agent commonly used in the treatment of cancer may be quite useful. It seems that hyaluronic acid has very little to no direct toxicity but works in a highly synergistic fashion when administered directly in the IV bag with the Clindamycin .

Hyaluronic acid is also used in orthopedic procedures . The dose is generally from 2 to 10 cc into the IV bag. Hyaluronic acid is not inexpensive as the cost may range up to \$10 per cc. One does need to exert some caution with its use as it may precipitate a significant Herxheimer flare reaction .

Patients will frequently have emotional traumas that worsen their illness. Severe emotional traumas can seriously impair the immune response to this treatment.

New Drug Therapy for Rheumatoid Arthritis

Posted by: Dr. Mercola

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In the latest issue of the New England Journal of Medicine, two studies are published on a new class of drugs for the treatment of Rheumatoid Arthritis. Also included was an accompanying editorial, written by John H. Klippel, MD of the Arthritis Foundation, which is summarized below.

Dr. Klippel notes that:

Until now, nothing has even begun to approach the dramatic effect glucocorticoids have had in improving the care of patients with rheumatoid arthritis and other systemic inflammatory diseases ... Products devised by the biotechnology industry for the treatment of rheumatoid arthritis have now been introduced into the clinic and appear to have ushered in a new era of scientifically based therapy for arthritis.

The first of these new biotechnology treatments are products that inhibit tumor necrosis factor (alpha) (TNF-(alpha)) and other biologic therapies are expected to follow .

He notes that the FDA has now approved two such drugs (etanercept and infliximab) for the treatment of rheumatoid arthritis . Etanercept is sold under the brand name of Enbrel™'99 and infliximab is sold under the name Remicade™'99

The theory is that since TNF-(alpha) has a major role in both inflammation and bone resorption in rheumatoid arthritis, blocking the interaction between TNF-(alpha) and its receptor can provide benefit. In addition to being approved for use in patients with rheumatoid arthritis, Enbrel has been approved for the treatment of children with polyarticular juvenile rheumatoid arthritis and infliximab for use in patients with Crohn's disease.

However, these 2 drugs are now being used "off-label" in patients with other types of chronic inflammatory and immune disorders on the assumption that TNF-(alpha) has a similar key role in those diseases as well.

As compared with methotrexate, which is considered to be the standard treatment for rheumatoid arthritis in the United States, these 2 drugs are associated with greater improvements in the symptoms and signs of arthritis and a lower risk of joint damage.

Dr. Klippel makes the assertion that "on the basis of this evidence, that TNF-(alpha) inhibitors should be used as early as possible in all patients who have documented rheumatoid arthritis," despite the fact that he acknowledges that there is no data on the long-term efficacy and safety of TNF(alpha) inhibitors.

The drugs are also tremendously expensive at about \$10,000 to \$12,000 per patient per year, and the treatment must be continued for life.

Dr. Klippel also notes the apparent lack of side effects with these drugs:

TNF-(alpha) inhibitors have surprisingly few side effects. The most common are reactions at the injection site (in the case of etanercept) and hypersensitivity reactions (in the case of infliximab) and minor upper respiratory tract infections. Serious, life-threatening infections have occurred, although the exclusion of patients with chronic, recurrent, or active infections from randomized trials has markedly diminished the risk.

However, he notes that just this past month, physicians were notified that development of pancytopenia, including several cases of fatal aplastic anemia, as well as

demyelinating syndromes had occurred in a small number of patients who were treated with etanercept.

"The finding of demyelinating syndromes is of interest, and perhaps not totally unexpected, since inhibition of TNF-(beta) has been associated with worsening in patients with multiple sclerosis," notes Dr. Klippel, adding that these newly surfacing risks "serve as a reminder that our understanding of the risks of inhibiting TNF-(alpha) remains incomplete."

Rheumatoid Arthritis Has Been Around for Centuries -- How Best to Treat It?

Posted by: Dr. Mercola

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Rheumatoid arthritis (RA) is an **ancient** disease, although the condition was not recognized by European "official medicine" until the 1800s. Studying the fossil remains of people with the disease, along with their environmental surroundings, could help investigators learn more about the development of RA and other immune-system-related conditions, the authors note.

RA, in which the joints become inflamed and painful, is an often-disabling condition that occurs when the immune system turns against the body. The cause of RA, which may actually be several different diseases, is unknown, and there is no effective treatment.

The researchers reviewed medical literature, art, and archeological evidence and found many reports of a disease that is probably RA.

For example, the Roman emperor Constantine IX, who lived from **980 to 1055**, appears to have had RA, according to a detailed contemporary description. An Icelandic doctor described RA in **1782**, noting that it was more common in women and most often struck people around the age of 40.

And abnormalities identical to those seen in RA have been found in skeletons of Native Americans living along the Tennessee River dating from **6500 to 450 BC**. Another 21 skeletons found in Mexico, dating from **1400 BC to 1550 AD**, also were found to have RA-like deformities.

One reason why RA was considered a "new disease" in the 1800s, the researchers suggest, was that people rarely lived beyond their 40s, when the disease generally first develops.

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Dr. Mercola's

Rheumatoid arthritis can be a terribly crippling disease causing huge amounts of pain and suffering in those who are afflicted with it. This is particularly sad as most who are afflicted with it seek the help of traditional rheumatologists who have absolutely no clue how the body is designed to operate.

Additionally, they continue to mostly ignore Dr. Brown's work on the use of antibiotics to treat the mycoplasma infection that is believed to be a major factor in this illness. This is in spite of

the fact that it has been "proven" scientifically with double-blind, placebo controlled, randomized trials in some of the largest and most prestigious medical centers in the world. The cost of the trial was over ten million dollars (funded by the US Congress) and the results were also published in the most prestigious journals.

Yet most rheumatologists continue to ignore the results.

This experience has been very enlightening. Even though most doctors demand to see the proof, most will not act on it.

Clearly the most effective and efficient way to pursue natural medicine research are outcomebased trials which require far less resources to compile.

I have used my revision of Dr. Brown's protocol for over a decade and have helped over 2,000 patients with rheumatoid arthritis. Dr. Brown helped over 10,000 in his career.

My revision of his work includes two major breakthroughs.

The first I have been using for many years and that involves the food choice program.

However, for the last six months we have been using NST in our office with incredible results. It has improved our results quite dramatically. Prior to NST our success rate was about 80%, and now it has improved to 95%.

At this time NST is an essential and necessary element of my rheumatoid arthritis protocol. I am recommending EVERYONE with rheumatoid arthritis receive this care as the results are so amazing and profound.

But what is really exciting is that the 80% who improved before took 1-2 years to obtain remission. With NST, the remission rate has dropped down by 50-75%.

This is really amazing work