



# The Arthritis Trust

*Dedicated To Eradicating Rheumatoid Disease From The Earth*

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## A Key Treatment for Unriddling Rheumatoid Disease

by Anthony di Fabio  
Part 3

### Introduction

Wasn't it Adolf Hitler's *Mein Kampf* that pointed to a sad fact, that if one repeatedly tells an untruth, it becomes known as a truth?

We hear the refrain -- like the slow drip of water in a metal bucket -- again and again -- that Rheumatoid Disease is incurable. "One need only provide enough money for research and we'll soon find its cure!"

There are several untruths in the hearing, but in the telling, truth is that Roger Wyburn-Mason, M.D., Ph.D. was routinely curing folks with Rheumatoid Disease in the 1960's, more than forty years ago!

Another truth is that this untruth -- told about inability to cure Rheumatoid Arthritis -- is also deceptively repeated about quite a number of other health problems! Other newsletters -- as we've recommended on our website at <http://www.arthritis-trust.org>, "Links" tab, adequately cover many of those deceptions; and, since the truth about the falsity of "incurable" arthritis is huge enough to keep this foundation busy, we defer to those fine publications.

### Summary of Prior Two Articles

Roger Wyburn-Mason, M.D., Ph.D. was the first to routinely cure rheumatoid arthritis using a variety of drugs to kill what he presumed to be a finding of amoebic infestation. The amoeba he thought he found was such that victims of rheumatoid arthritis developed a tissue sensitivity, so that the body's internal struggle between the microorganism's toxins or dead protein products (antigens) and the individual's reaction to the toxins, produced compounds that resulted in apparent tissue self-destruction.

Well, of course, on formally making the announcement of his discovery, this world-famed nerve specialist was suddenly cast into the mold of con artist!

Fortunately, before his death, a few other physicians braved ostracism and did listen to Dr. Wyburn-Mason. This writer, among thousands of others, was treated and brought into a cured state from otherwise "incurable" and certainly crippling Rheumatoid Arthritis.

What have we learned since 1982 about the causes of Rheumatoid Arthritis?

Well, first of all, the causes are usually multiple, not via a single organism -- although sometimes a single organism of some sort might be the main culprit.

This means that normally there's more than one cause at play -- which is also true for most other so-called "degenerative" diseases, such as cancer, diabetes, and so on.

While some folks will get well through the path of a single treatment modality, most folks would be wise to investigate all the

common causes -- not in a literal-minded manner, but in a reasoning, investigational approach.

The main fields to investigate are now well known, consisting of nutritional, anti-candida, anti-food allergy, anti-microorganism (not just amoebas), root canal infections, mercury toxicity, herbicide and pesticide accumulation, hormonal rebalancing. Depending upon the individual, there could be additional stressors in need of investigation, but the principle is clear. Check these possibilities thoroughly -- usually with the help of a knowledgeable health professional.

Meanwhile, during your investigation, your pain and joint destruction seems non-ending. So, what do you do?

Doctors Pybus, Prosch and others found that Intraneural Injections (called Specific Injection Therapy by Philbert) immediately halted joint pain as well as the on-going joint destruction.

And, while the use of Intraneural Injections might provide only temporary relief -- up to 3 weeks or longer -- at least during that period the patient could more easily face the seemingly long, sober, investigational period determining what role the other aforementioned factors played.

But even after the initial 3 week period -- if that's as long as the Intraneural Injection relief lasted -- another set of injections could safely be completed which would then extend the relief period.

Most arthritics (including osteoarthritis) will find but three weeks of relief, because there is often something awry causing the malfunctioning of certain nerve ganglia leading to the joint. Many factors could be causing disturbance of the controlling nerve ganglia. Over a twenty year period of development, Dr. Paul K. Pybus found the use of Intraneural Injections indispensable.

Here's a summary of patient relief results over the period of his recordation:

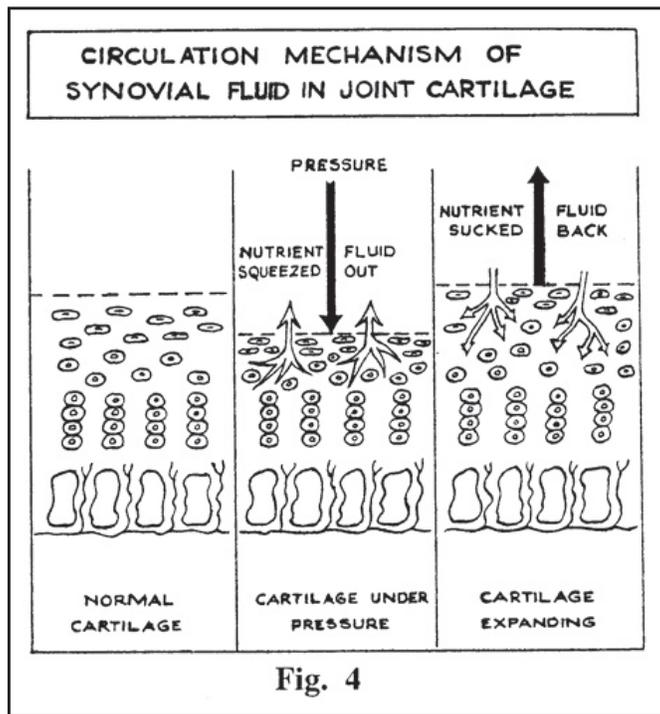
*Patients Who were Followed Up by Dr. Paul K. Pybus<sup>25</sup>  
Over a 4 year Period. (Lost Patients are Unknown.)*

Type of Joint	Numbers	Numbers of Failures	Months of Relief	Average Relief of Joint Pain (Months)
Hips	37	3	385	10.40
Knees	124	7	1421	11.45
Ankles	44	5	491	11.15
Shoulders	44	1	716	16.27
Elbows	19	0	339	7.30
Hands	56	7	549	9.30
Sciatica	49	1	496	10.12
Neck	20	2	283	14.20
<b>Totals</b>	<b>393</b>	<b>26</b>	<b>4680</b>	<b>11.27</b>

KEY TREATMENT continued on 2

The above patient population includes any kind of joint pain complaint, not just Rheumatoid Arthritis.

In the past two issues of this newsletter we laid out Dr. Pybus' theory on how the nerve signals, from a disturbed nerve ganglia, led to two types of nerve impulses along what is known as the "C" fibers, those uninsulated nerves usually found close to the surface of the body. One set of impulses produced the heat, pain and swelling, whereas the other set -- really a stimulus-response circuit to the spinal chord



and back to the affected joint -- producing the tension or clamping together of the joint thru the surrounding joint muscles. This latter set of signals -- those causing the tension at the joint -- are really the "source" of joint damage. Note, again we repeat that "source" is not necessarily the "cause." (See <http://www.arthritis-trust.org>, "Newsletters" tab for past issues.)

Dr. Pybus was able to relate this phenomena to the "unbalancing" or "rebalancing" of electric potential at key nerve ganglia, most of which corresponded to well known acupuncture points.

This treatment of "Intraneural Injections," (or "Specific Injection Therapy" as named by Dr. Philbert) (1) is important in immediately and safely reducing joint pain without the damage of traditional drugs, (2) halts joint damage temporarily, (3) provides time for the patient to explore the other well-known causes of Rheumatoid Disease.

### Joint Cartilage Circulation and The Charnley Clamp

For whatever reason, when key nerve ganglia become disturbed, nerve signals come back from the spine in a spinal arc that causes more tension than expansion in the joint controlled by that nerve ganglia. Here is the source (not necessarily the cause) of joint degeneration. Dr. Pybus has schematically explained the sponge-like requirements for nutrients for healthy tissue in his Figure 4. Pybus' diagram also clearly explains why Dr. William Kaufman's (MD) unique and important discovery in 1941 that arthritis -- particularly osteoarthritis

-- would drastically improve if niacinamide were to be ingested at intervals during the day. Niacinamide, like Niacin, improves blood circulation which then improves joint cartilage nutrition. (Kaufman's book, *The Common Form of Niacin Amide Deficiency Disease: ANIACINAMIDOSIS*, Yale Press, 1943). See <http://www.arthritis-trust.org>, "Articles Tab".

Dr. Pybus says, "There are no blood vessels in healthy cartilage. The hyaline cartilage of joint surface consists of large cells arranged in palisades and suspended in a semi-fluid, resilient matrix which is compressible and expandable. The synovial fluid circulates in this semi-solid matrix and its circulation is maintained by alternate compression and reactive expansion of the cartilage. Thus as pressure is increased, as in weight bearing, the fluid is expressed out of the cartilage and the waste products of cellular activity are removed, and as the weight is taken off the joint surface the cartilage absorbs the fluid, bringing oxygen and nutriment to the cartilage. The cartilage acts like a sponge; this was described by McCutchen in his classical description in 1962 [McCutchen CE, "Animal joints and weeping lubrication," *New Scientist* 1962;15:928-930] and is shown diagrammatically in Figure 4. The only other source of nutrition for these cells is direct diffusion from the blood vessels of the vascularised bone marrow at the base of the cartilage which is inadequate.

"Thus nutriment and oxygen are received and waste products removed mainly by the process of alternate expression and soakage of fluid as described, apart from the small amount that diffuses directly from the blood vessels at the base of the cartilage."

In short, joint cartilage acts like a sponge, squeezing out and soaking up blood which carries life-sustaining nutriment and gathers up waste!

If there is more squeezing than expansion, cartilage decomposes, and that, in turn, creates secondary and tertiary free radical damage, further eroding the joint cartilage!

To support his explanation, Dr. Pybus refers in his Figure 5 to the "Charnley Clamp," a long-ago experimental procedure used on monkeys to induce osteoarthritis.

According to Pybus: Osteoarthritis, or degenerative joint disease, has been produced experimentally in the knees of rhesus monkeys and rabbits by a number of workers . . . Salter and Field,<sup>12</sup> [Salter RS, Field P, *The Effects of continuous compression of living articular cartilage: an experimental investigation*. Bone and Joint Surgery 1960;42A:31-45] Trias,<sup>13</sup> [Trias A, *Effect of persistent pressure on the articular cartilage.- an experimental study*. Bone and Joint Surgery 1961;43B:376-386] Crelin and Southwick<sup>14</sup> [Crelin EX, Southwick WD, *Changes induced by sustained pressure in the knee joint articular cartilage of adult rabbits*. Anat Rec 1964;149:113-134] all performed experiments that were similar in their approach in applying continuous joint fixation and compression of the cartilaginous surface of the knees of these animals by means of the use of a Charnley clamp. Figure 5. An osteoarthritic-type lesion, including prominent cartilage degeneration, was produced in the joint following as few as three days of continuous fixation compression, and by the end of 14 days the condition was well established.

After six weeks the joint degeneration was in its final stages, the cartilaginous joint surface being worn away with eburnation of the underlying bony layers. It was also shown by Callandruccio and Gilmer,<sup>15</sup> [Callandruccio RA, Scott GW, *Proliferation, regeneration and repair of articular cartilage of immature animals*. Surg

1962;44A:431-455] that if experimental fixation and compression is released, the condition is reversible and the cartilage shows signs of regeneration. These workers postulated that constant fixation

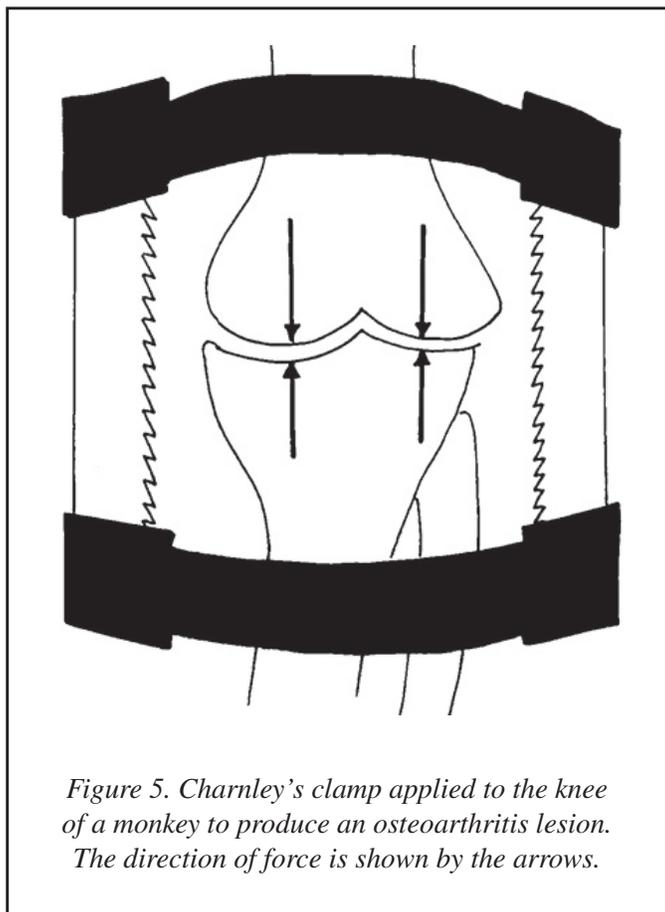


Figure 5. Charnley's clamp applied to the knee of a monkey to produce an osteoarthritis lesion. The direction of force is shown by the arrows.

compression of the joint surfaces acts by impairing the nutrition of the cartilage cells. This can be readily understood when it is realised that the circulation of the synovial fluid can no longer take place. The cartilage now solely depends on the nutrition brought in from diffusion from the vascularised bone marrow at the cartilage's base, and, this being insufficient, the result is death and disillusionment of the most superficial cells. Thus it can be seen that [persistent] compression is a powerful factor in the production of osteoarthritis by virtue of its curtailment of the oxygen supply to the cartilage.

If we accept this explanation it will be seen that the treatment for osteoarthritis or osteoarthritis now becomes obvious. The root cause of the trouble is, therefore, not in the joint as previously presumed, but in the damaged destabilised nerve, and for relief of this condition treatment must be directed at this nerve.

As described previously, this area is negatively charged due to the constant leak of electrons, and for the nerve impulses to be stopped these excessive electrons have to be eliminated. This can be done in three main ways:

1. **Physical.** Use of acupuncture needles. These needles are made of resilient metal with a good conductivity of electricity. They are pointed, and when inserted into the body near an area of electrical charge will act as a miniature lightning conductor, the electrons being attracted to the

point of the needle, and then distributed to the exterior via the hands of the operator, and thence to the earth, Figure 6. For three thousand years this principle of acupuncture has been practised in China, and for some time now western medicine has sought an explanation for its undoubted efficacy. The author, for one, has witnessed the efficiency of this method on numerous occasions when performed by others, and has also obtained similar results himself. He has also observed that the results are superior when the needles are deliberately earthed, as can be done by the simple method of removing the shoe of the operator.

Acupuncture, however, shows no great permanency

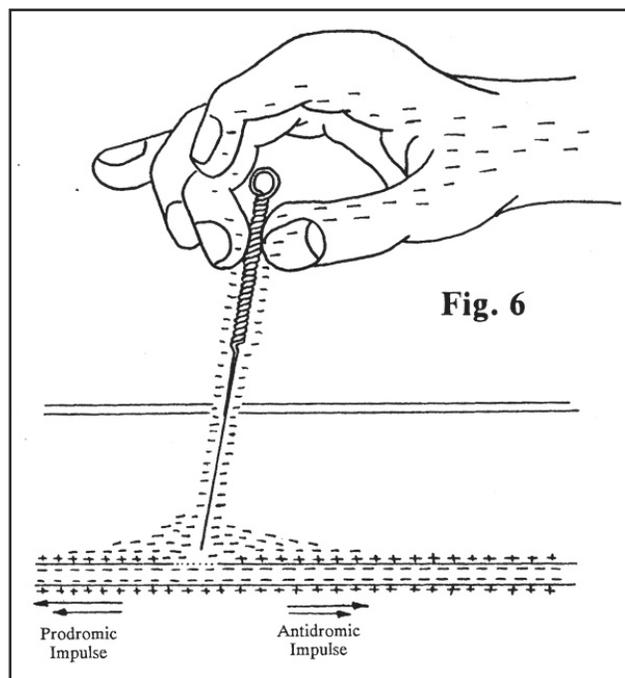


Fig. 6

in the relief afforded just by one treatment, as when the needle is removed the membrane is still destabilised and the condition reverts to the status quo ante.

2. **Chemical.** Local anaesthetic. Local anaesthetic is a well-known nerve stabiliser and its action is described in numerous textbooks of anaesthesia<sup>16</sup> -- all nervous impulses are blocked and none can be propagated. In the case of the C-type fibres or trophic nerves, this blockage of impulses takes a matter of two seconds due to the lack of a myelin sheath (with the A fibres it takes a matter of minutes for the local to penetrate the thick myelin sheath). These two facts are well-known to anyone who has both performed regional anaesthesia by means of nerve block and injected so-called 'trigger points' with a local anaesthetic agent. However, it is also well-known that neither the regional anaesthesia nor the relief of pain by local anaesthetics only is permanent; they last just as long as the anaesthetic stays in relation to the nerve or 'trigger point'. A further substance is required in order to stabilise the nerve more permanently.

### 3. Healing agents. Corticosteroids or other anti-inflammatory agents.

The breach in the nerve sheath has to be stabilised permanently by the healing process and the inflammation eliminated. The most efficient of the anti-inflammatory agents is still cortisone. This has not been satisfactory in the past due to the undesirable effects when given by mouth. However, if this substance could be delivered at the site of inflammation in such a manner as to be permanently static in that position, then the desired effect would be achieved. Depo-steroid preparations are the present best solution to this problem. There are at least three of these available at the present time.

- a. Triamcinolone hexacetonide (Lederspan or Aristospan). This has the advantage of slow absorbability and rapid action in producing diminution of inflammation in three to four hours. It is the ideal preparation at the present time.
- b. Betamethasone acetate (Celestone-Soluspan). This is also effective in two to three hours, but, unfortunately, the commercial preparation has the disodium phosphate salt also included, and as the latter moiety is rapidly absorbed there are dangers of resultant side-effects.
- c. Methylprednisolone acetate (Depo-Medrol or Depomedrone). This also has a Depo effect but has the disadvantage that it takes six to eight hours for its anti-inflammatory action to take place. Thus there is a two to three-hour time lag between the action of the local and that of the steroid and therefore a period when the pain seems to recur with the fading of the local anaesthetic action; this period may be unduly prolonged.

It is possible that if a non-steroidal anti-inflammatory drug could be made in a depot form suitable for injection intraneurally, then the steroids could be eliminated completely in treatment. Unfortunately, to date no such preparation has been developed. (1984) [Practitioners eventually learned that Depot-Medrol and related depositions were unnecessary for equally good results.]

The peripheral nerves themselves, in all parts of the body, are supplied by small unmyelinated nerve fibres which pierce the perineurium with the blood vessels and are distributed to the nerve fibres within (nervinervorum). When these minute nerves are stimulated by trauma it will produce an inflammatory reaction in the nerve, which in turn stimulates the fibres in the main nerve, and it is then obvious that suppression of inflammation in this area will reduce all trophic activity in that nerve, with the consequent abolition of excess nervous impulses, thus breaking the vicious circle.

All the various joints have definite points where nerves tend to be damaged around them. These points, if inflamed, have the properties of a neuroma, namely:

1. They are tender to the touch,
2. They are all in the anatomical line of a known nerve,
3. They are painful on distortion,
4. They are rapidly eliminated by a number of physical means, via:

- a. Insertion and grounding of an acupuncture needle<sup>18</sup> [Pybus PK, *Nerve membrane stabilisation*. Brit Med Acupuncture Soc J 1984;16],
- b. Local application of various physical agents such as cold, heat, massage, short wave, ultrasound, etc.,
- c. Injection of local anaesthetic.

Rheumatoid disease is not primarily present in the joints but in certain local peripheral nerves, and the arthritis is only a secondary but painful manifestation of the condition. Each arthritic joint involved has situated around it several local areas of destabilized nerves, and these points will be described later as to their location. This can be done by the use of steroids, which are the most powerful anti-inflammatories on the market today. And it would explain their early success in the treatment of rheumatoid arthritis, even if the mechanism was not at the time fully understood. Later, due to the complications of this therapy, and to the large doses that were administered to get any result, it fell into serious disrepute, where it has rightly remained, even if it is still given, with definite indications, by some rheumatologists.

The collapse of the cortisone charisma, which was to cure all cases of rheumatoid arthritis, was followed by the development of non-steroidal anti-inflammatory drugs which acted by suppressing all inflammation throughout the body but had no steroid effect. These drugs, after an initial success, were also found not to be without their complications, causing a great deal of gastric upset with ulceration, gastric hemorrhage which was sometimes fatal, leucopenia and even cases of agranulocytosis which were often fatal. They were, however, more acceptable than cortisone, as they did not cause the serious hormonal and electrolyte disturbances produced by the latter, and so now are largely the standard treatment (1984) [now methotrexate, even more dangerous].

However, both of these treatments have the same radical disadvantage, namely, their generalised action, when in point of fact the drug action is only required at the damaged site in the nerve.

During the dispute that was going on over the use of corticosteroids and of non-steroidal anti-inflammatory drugs, a number of very excellent products were produced for injecting into the joints with the idea of introducing the steroid where required, namely, the joint surface, and with the general absorption being kept to the bare minimum. These have had a variable success rate. Hollander<sup>17</sup> in the United States claims excellent results, but this treatment is by no means universally successful in other hands. Furthermore, it does not treat the root causes of trouble but merely the symptoms, namely, the inflammation of the joint; it ignores the primary nerve involvement.

The author has developed the idea of introducing an anti-inflammatory drug at the damaged nerve site. This anti-inflammatory would have to be slowly absorbed, and the only such injectable depot forms available at present are steroidal in nature. These are:

1. Triamcinolone hexacetonide (Aristospan or Lederspan)
2. Methylprednisolone acetate (Depo-Medrol or Depomedrone)
3. Betamethasone acetate (Celestone-Soluspan)

At present, as previously noted, no non-steroidal anti-inflammatory drugs are made in depot form, but such a drug, if available, would be extremely useful.

It will be seen that the local anaesthetic stabilises the nerve in

the first five hours, and meanwhile the depot steroid is healing the traumatised breach in the nerve membrane. Thus, when the local has worn off the membrane is largely healed and normality is restored.

We will also show in future issues how to use these intraneural injections.

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## Food Sensitivity and Knee Arthritis

Several years ago I noticed I was developing arthritis in both knees. One day while walking, I heard a sharp "snap" and felt extreme pain in my right knee. An appointment with an orthopedic clinic revealed that the cartilage in my knee had experienced abnormal growth. Doctors at the clinic recommended I give the knee a rest to see if the problem would resolve itself over time. Otherwise, they said, surgery would probably be necessary. During this same period, I had developed some digestive problems of gas and bloating.

Over the next two years, I tried to resolve these issues with various nutritional regimens, including digestive enzymes, hydrochloric acid tablets, vitamins C and E, glucosamine with chondroitin sulfate, fish oil, and even unflavored gelatin. None of these measures resolved or significantly improved either the knee arthritis or digestive symptoms. If anything, the arthritis seemed to be getting worse.

In 2003, my digestive problems reached a crisis when I tore and perforated the bowel while helping lift a heavy outboard motor. The doctor diagnosed diverticulitis and peritonitis, and I was scheduled for emergency surgery within the hour. I was fitted with a colostomy bag for 20 weeks to let the bowel heal, then a second surgery was performed to remove the colostomy and reconnect the bowel.

During my recovery, I eliminated all dietary supplements. When I was able to eat normally again, I began to reintroduce the supplements one at a time. I soon discovered that vitamin C in amounts as low as 60 mg, even as pure crystalline ascorbic acid or calcium ascorbate, reactivated the digestive problems. I also found that caffeine, even as 97% caffeine-free green tea or coffee, did the same thing. Not only did these two dietary substances result in digestive disturbances, they also dramatically aggravated the knee arthritis. Over time, I learned that foods containing vitamin C were well tolerated, but vitamin C in supplement form or any amount of caffeine would reactivate the bloating problems for days and the knee arthritis for weeks. By strictly avoiding these two offending substances, my bowel function once again became normal, and my knee arthritis virtually disappeared.

This experience taught me that nutritional balance is unique to the individual and dietary sensitivities can make even an apparently balanced diet deleterious. Nutritional imbalance can cause diverse symptoms of ill health, symptoms that may be effectively resolved if the cause of malnutrition is identified and addressed.

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Permission to publish granted.

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Send a legal size, self-addressed, stamped envelope to The Arthritis Trust of America®, 7376 Walker Road, Fairview, TN 37062-8104, and ask for our latest Physician and Scientist Advisory list. Or, go to our [website at www.arthritis-trust.org](http://www.arthritis-trust.org).

When requesting our Physician and Scientist Advisory list, while it is not necessary to donate \$2, a donation of that size or greater would help us defray the cost of this service.

## Is Hyperbaric Oxygen Good for Treatment of Rheumatoid Arthritis\*

### *Basic Considerations*

Rheumatoid arthritis is a systemic inflammatory disease of a chronic nature that is characterized primarily by a pattern of involvement of the synovial joints. The inflammatory process may involve soft tissues such as tendons, ligaments, and muscle, and may invade the bone. The etiology (cause) of the disease remains uncertain among traditional medical practitioners.<sup>1</sup> Researchers suspect immunological disturbances and/or infectious agents. However, virtually 100% of research funding is spent on treating the symptoms -- pain, swelling, heated joints -- as opposed to searching for causes. This swells the bank account of those with pharmacological interests and does absolutely nothing for those suffering from this painful condition.

Medical school textbooks describing rheumatoid arthritis accept two hypotheses: (1) possible immunological problem, or (2) sensitivity to antigens from dead protein products or dead microorganisms. Research funding normally extends only toward the failed hypothesis, that something is aklter regarding the patient's immune system. Whereas, since the advent of Professor Roger Wyburn-Mason's work from the 1960s, thousands have been treated and cured following hypothesis number two, that of sensitivity to antigens formed by invasive microorganisms.

In searching for relief from this terrible condition, many avenues have and are being explored both by complementary physicians as well as by arthritic victims themselves.

Hyperbaric oxygen -- oxygen under pressure -- is one of those avenues that has been explored, but perhaps insufficiently.

McCarty (1981)<sup>1</sup> reviewed the available evidence in search of a rationale for hyperbaric oxygen in the management of rheumatoid arthritis. Hypoxia of the arthritic patient is evidenced by low synovial pO<sub>2</sub> [partial oxygen pressure] levels but these are not specific to rheumatoid arthritis. The causes of hypoxia [too little oxygen] are:

Increased metabolic demand for oxygen by an inflamed joint.

Decrease of blood flow to the joint by raised intraarticular pressure.

There is a fall in the synovial fluid of a rheumatoid knee joint after exercise. The hypoxic condition of many inflamed joints may be responsible for microinfarction of particulate collagens [dead collagen tissue] in joint fluid that are qualitatively and quantitatively identical to the collagens of synovial membrane.

Hyperbaric oxygen can suppress sterile inflammation due either to immunologic factors or microbial infection. Thus, arthritis induced in rats by injections of adjuvant [synergistic or assisting irritant] is suppressed if hyperbaric oxygen is started within 2 days after injection. Moreover, daily hyperbaric oxygen therapy suppresses the inflammatory response even if given when the arthritis is fully developed (Warren *et al* 1979). Shakhbazyan *et al* (1988) studied the effect of hyperbaric oxygen [1.5 ATA and 3 ATA; 1-1/2 to 3 times the pressure of atmosphere at sea level] on the development of clinical, immunological, and morphological manifestations of adjuvant arthritis in a type of mice bred to respond to the adjuvant, or irritant, by creating a simulated rheumatoid arthritis. In comparison with the control group, hyperbaric oxygen was found to inhibit the development of clinico-morphological manifestations of adjuvant arthritis and hindered the development of the process. The treatment was more effective in the early stages of the disease. Pressure of 3

ATA was more effective than 1.5 ATA, but toxic manifestations were seen with 3 ATA in the pulmonary vessels. 1.5 ATA is approximately the same as the pressure 7 feet below water, when swimming, and is most often quoted as the safest application of hyperbaric oxygen.

### *Clinical Applications*

Kamada (1985) carried out laboratory examination of patients with rheumatoid arthritis undergoing hyperbaric oxygen therapy. Under hyperbaric oxygen therapy, serum superoxide dismutase values increased and lipid peroxidase activity decreased. At the same time ESR [erythrocyte sedimentation rate] and Lansbury's index showed a remarkable recovery. From these results, the authors suggested that hyperbaric oxygen therapy may be an effective treatment for patients with rheumatoid arthritis.

Saikovsky *et al* (1986) have used hyperbaric oxygen in treatment of 20 patients with rheumatoid arthritis and recommend it as an appropriate therapy when systemic symptoms such as ischemic neuropathy, arteritis, or Raynaud's phenomenon are present.

Davis *et al* (1988) conducted a pilot study in 10 patients with rheumatoid arthritis of which 8 received hyperbaric oxygen HBO treatments (100% oxygen at 2.5 ATA, ten 90-min sessions once a day on alternate days) and 2 sham treatments (breathing air at normal pressure). There was no remission of the disease during treatment period and authors concluded that further large scale double-blind trials to assess efficacy of hyperbaric oxygen in rheumatoid arthritis were not worthwhile.

Lukich *et al* (1991) treated 35 patients with rheumatoid arthritis by hyperbaric oxygen. Each patient received 21 sessions of hyperbaric oxygen under 1.7 ATA for 40 min. Good clinical results, both immediate and late, were obtained. The effect of hyperbaric oxygen on the immune system of the patients intensified the suppressive function of T-lymphocytes (especially in those with systemic manifestations of the disease), normalized cell-bound immunity and decreased the serum concentration in immune complexes.

Rui-Chang (1994) reported on the results of hyperbaric oxygen treatment of 37 patients with rheumatoid arthritis using relief of pain and swelling with improved mobility as criteria of success. Nine patients (24.3%) recovered completely, 19 (51.4%) improved markedly, and 6 (16.2%) showed slight improvement. Only 3 (8.1%) patients failed to respond.

### *Conclusions*

Hyperbaric oxygen has proven to be a useful adjunct to surgery in the treatment of trauma to the extremities, particularly crush injuries. Most of the benefit is obtained by counteracting the effects of ischemia and anoxia commonly found in such injuries. Plainly hyperbaric oxygen would have an even more important role to play in patients with multiple trauma. There is already evidence for the beneficial effects of hyperbaric oxygen in head injuries (cerebral edema) and acute spinal cord injuries. Every large trauma center should have a hyperbaric facility, as it is vital to institute hyperbaric oxygen therapy as soon as possible.<sup>1</sup>

It's clear that hyperbaric oxygen treatment can improve and possibly halt the progress of rheumatoid arthritis, but even clearer that more research needs to be performed following the use of hyperbaric oxygen on active, inflamed rheumatoid disease.

1. Abstracted from *Textbook of Hyperbaric Medicine*, 4th revised and expanded edition, K.K. Jain, M.D., Hogrefe & Huber, 2004



**In Memoriam:**  
**Wayne E. Martin, B.S.**

†† June 17, 1911 ☞☞ May 13, 2006 ††

by Perry A. Chapdelaine, Sr.  
The Roger Wyburn-Mason and Jack M. Blount Foundation  
for the Eradication of Rheumatoid Disease  
aka The Arthritis Trust of America/  
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**Wayne E. Martin, B.S.**

During the past twenty four years we've been fortunate to have Wayne Martin as one of our most esteemed advisors. Wayne was not just a knowledgeable advisor, but also a fine friend, one who unstintedly gave of his medical knowledge to whomever inquired.

Wayne Martin graduated from Purdue University with a BS in Chemical Engineering in 1933 with major emphasis on biochemistry and bacteriology. Depression years prevented him from obtaining a medical degree, his first love, but did not stop him from a lifetime of interesting synthesis of the world's medical literature, often resulting in discoveries of interesting treatments used today by many complementary/alternative medical practitioners.

His professional work in Chemical Engineering also resulted in remarkable findings results of which are still used by people everywhere. Ninety percent of the beryllium copper alloys used worldwide contain 1.80% of beryllium instead of the more expensive form of 2.2 to 2.5% beryllium set by Germans at the Siemens and Halske Company. Working at the Beryllium Corporation, Wayne Martin in 1935 discovered that the 1.80% beryllium to copper alloy (Berylco 180) was superior in many ways and less expensive. For more than fifty years automobiles -- and you -- have used Wayne Martin's beryllium alloy.

Early in World War II, at the Sperry Gyroscope Company, and also as a "dollar-a-year" consultant with The War Production Board (WPB), Wayne Martin developed two National Emergency (N.E.) aluminum casting alloys (319, 380). Ninety-five percent of today's aluminum castings are made of these two alloys. Sixty million pounds

monthly of this aluminum alloy is currently used to produce the modern automobile.

At the end of World War II, the Beryllium Corporation was stuck with a plant owned by the Atomic Energy Commission for which they wanted a peace-time use. Wayne suggested that it be used to make potassium titanium fluoride. The entire aluminum industry uses it to grain-refine aluminum. After it's return to the Atomic Energy Commission, Henry Kawecki, Wayne's friend, formed the Kawecki Chemical Company to manufacture potassium fluoride, becoming a multimillion dollar firm, all on Wayne's ideas.

In 1950, Wayne Martin helped to place aluminum/magnesium alloy (AL MG 35) for which there was a large market. In 1960, he developed another aluminum alloy (Precedent 71) which, over a period of 20 years, made his employer, U.S. Reduction Company, a great deal of money. (Think of airplanes, among other uses.)

Wayne retired in 1979, becoming a salesman with The Southern Aluminum Casting Company of Bay Minette, Alabama. Thereafter each retirement has led to further consulting jobs, so he never truly retired.

So why was a Chemical Engineer who invented important metal alloys featured as a consultant in medicine?

Although the great American depression had steered him elsewhere for survival's sake, he never lost touch with medicine. His enquiring mind synthesized many medical articles and research papers to bring to light remarkable treatments in heart, cancer, and other medical problems.

In one example from years' gone by, in 1963 Wayne organized the Nutrition Research Products Company dedicated to doing something about the 600,000 deaths each year from heart attacks. His idea was carried to The Royal College of Surgeons and The National Heart Hospital in London, England, where Nutrition Research Products Company spent \$200,000, and proved that his ideas were effective in preventing heart disease.

Wayne periodically gave himself weak hydrochloric acid shots because he'd learned -- long before the advent of antibiotics -- that administration of these weakened solutions stimulated macrophage and leucocyte activity, thus killing and/or warding off invasive infections. (See *Three Years of Hydrochloric Acid Therapy*, <http://www.arthritis-trust.org>, "Books and Pamphlets" tab.) His story about the Harvard medical school graduate who became wealthy by specializing in this treatment in Las Vegas, NV was very educational as well as hilarious.

Wayne had a lifetime love affair with study of problems related to the heart and circulation and also with various types of cancers.

Many years before the expenditure of billions of dollars to "find the cure for cancer," Coley's toxin was bringing about remarkable "permanent remissions." This so aggravated the medical monetary and power structure that the simple mixture was forbidden. Having seen at first hand cures brought about by this mixture in his early adulthood, Wayne could never cease telling about it. Several years ago he invested a good sum of his own money to have the product made in Brazil, thus making it available to any patient who wished to use it.

Again, alas! The long arm of "forbidden medicine" reached into Brazil, and the US supply was again halted.

Nonetheless, Wayne found another way to help cancer patients by publishing the formula for Coley's toxin so that any patient or doctor can make up their own supply, if desired. (Coley's Toxin formula is

Martin continued on next page

now found at our website at <http://arthritistrust.org>, "Research and Letters" tab, under Wayne Martin's name.)

But even prior to his publication of Coley's toxin, certain doctor friends began manufacturing their own Coley's toxin and are having great success in bringing about "permanent remissions," among some of their patients!

Wayne Martin's thinking about medical treatment has been frequently reported in *Townsend Letter for Doctors & Patients* (911 Tyler St., Port Townsend, WA 98368-6541; <http://www.townsendletter.com>). It is there one should go for the articles.

In his youth, Martin's motorcycle accident resulted in loss of a leg. Phantom pain haunted him for years until he discovered that it could easily and safely be diminished thru the use of ginger.

Martin's recommendations for the safe easing of pain through the use of ginger can be found in our The Arthritis Trust of America Summer 2001 Newsletter at <http://www.arthritistrust.org>, "Newsletters" tab.

Martin was a remarkable human being, one who cared greatly for his fellow man, who gave without concern for rewards, who loved life, and who made each hour, each minute count toward bettering his fellow man.

We are so glad that he passed away peacefully -- not in pain or suffering from degenerative disease -- just a few months before his 95th birthday! But, we are not at all happy that he passed so early in his life -- and we shall sorely miss this intelligent, generous, kind scientific advisor!

## Bequests

### Plan Us Into Your Future

A good way to make your contribution live for years onward is to plan us into your will.

A bequest such as those provided by others provides that a specific amount of money, property, or a percentage of your estate be given to *The Arthritis Trust of America*.

A general guideline for making such a provision is this: "I give, devise, and bequeath to *The Arthritis Trust of America* the sum of \$ ----" (or describe the real or personal property).

*All contributions to The Arthritis Trust of America® are tax-deductible to the full extent allowed by law.*

While easy to write, best that you work this provision out with your attorney or CPA -- and again, many thanks!

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