CARL J. REICH M.D., FRCP(C) - retired -

MEMBER MEDICAL ADVISORY COMMITTEE CALGARY CHAPTER
ALBERTA EDTA CHELATION ASSOCIATION

4039 Comanche Road N.W.
Calgary Alberta T2L 0N9
29 December 1992.

X X X X X X X X X X X X X X X X X X X X X X X X X X X X X X X

RENEE PELLERIN
PRODUCER, MARKET PLACE CBC
Toronto M5W 2A2

Dear Ms. Pellerin.

I thank you for the program on chelation therapy that was shown on CBC Market Place, on the 15th. I will not respond to that program but will give an impression of this therapy that is based on clinical research carried out during 33 years of practice, and an appeal for research on chelation therapy that is based on that study and practice.

A copy of this letter, and of that impression and proposal of research titled "Chelation Therapy and Ionic Calcium Deficiency" will be directed to the following: to the approximate dozen physicians in British Coumbia and to several American physicians who are currently prescribing the therapy; to four physicians in Alberta who are prepared to prescribe it; and to those others shown on the program who were either in favor or against the therapy.

Yours sincerely,

Carl J. Reich.

X X X X X X X X X X X X X X X X X X X X X X X X X X X X X X X

TO PHYSICIANS IDENTIFIED IN THE ABOVE LETTER

Dear Doctor.

As the above CBC program unquestionable heightened public interst in EDTA chelation I trust the enclosure will arouse interest in research on this form of therapy along lines I propose.

Yours sincerely,

Carl J. Reich.

CHELATION THERAPY AND IONIC CALCIUM DEFICIENCY.

THE PURPOSE

The purpose of this writing is to propose an integration of the clinical research I have conducted on chronic ionic calcium deficiency into the practice and research that is currently being conducted by physicians prescribing chelation therapy. As well those physicians may make other application of my research in their daily practices.

THE APPLICATION OF MY CLINICAL RESEARCH

Chelation therapy concerns an excess of molecular calcium that, for reasons not yet known, is principally metastatically deposited in arteries. In contrast, my research and practice concerns a deficiency of biologically active ionized calcium in the entire body, involving each of its trillions of cells, that I propose is the consequence of specific lifestyle defects. Despite such difference I propose that the practice and research that I have conducted may be applied to research on chelation therapy. To this purpose I present a brief summary of this research and of such proposals.

In summary I propose that the lifestyle defects which I have associated with certain diseases and symptoms may also be responsible for the arterial disease that chelation therapy is primarily prescribed for. This proposition largely arises from the fact that these symptoms and diseases are those that are found to be loosely related to arterial disease, and are found to be relieved by chelation therapy as it relieves the arterial defect. Therfore, when the symptoms and diseases that I have long treated as arising due to chronic ionic calcium deficiency are relieved by chelation therapy they may also be defined as "the fringe benefits of chelation". The relief of these symptoms and disease has therefore been wrongly attributed to circulatory improvement.

This overview of my research also pertains to the biochemical mechanisms that possibly are responsible for those circulatory and other illnesses, and also pertains to the clinical means by which all of those illnesses may be prevented.

THE BEGINNING WITH ASTHMA

In 1950 I began clinical research in practice which four years later led me to recognize that chronic asthmatic patients were experiencing lifestyle defects which gave rise to deficiency of dietary calcium and of dietary and sun-on-skin vitamin D. Consequently in 1954 I treated a nine year old boy who had suffered chronic asthma for seven years with one bone meal tablet and one halibut liver oil capsule three times a day. Within several days he had experienced 75% resolution of his disease.

APPLICATION TO OTHER DISEASES

As I applied this experience to other types of cases such as to forms of ileitis-colitis, hypertension, and arthritis, I became known as a "crank on calcium". Despite such criticism, and arbitrary restriction of hospital practice and specialist licence, over the ensuing 30 years I treated between 10 to 12 thousand cases of chronic asthma and an equal number of other cases in this fashion, or with only minor variations of therapy.

CELL ENERGY STARVATION AND THE "DISEASES OF CIVILIZATION"

This research led me to believe that the "culprit" responsible for these diseases, and a variety of symptoms and physical changes, was chronic cellular ionic calcium deficiency. This deficiency may be the product of the isolated single deficiency of either the synergistic calcium and vitamin D substances, or more readily by a combination of these deficiencies. Years later I was led to believe that this ion was intimately related to the ADP-ATP process transferring the solar bonding energy of glucose and oxygen that was released in the oxidative process in "the furnaces of the cell", to the 1,000 or more sites of biochemical processes in the cytoplasm that are responsible for cell function. I, therefore, proposed that chronic deficiency of this ion led to "cell energy starvation".

For reason that most of the diseases I was interested in had already been defied as "the diseases of civilization", and because I observed that most of the symptoms and diseases I had treated with the above named nutritional and sun-on-skin factors arose because of commonly experienced defects of the modern lifestyle, I defined them as "the symptoms diseases of civilization".

THE IONIC CALCIUM DEFICIENCY SYNDROME AND DISEASES

My application of this research in practice led me to organize symptoms and physical changes complained of or seen in patients experiencing these deficiencies, that were also relieved by this therapy, into an "ionic calcium deficiency syndrome". Three of the prominent physical findings of this syndrome are: (i) increased irritability of skeletal muscle on percussion, (ii) pain on firm palpation of this muscle, and (iii) an acidic state of the saliva. The most common functional findings of this syndrome are those arising for reason of: increased activity of muscle and nerve tissue. These included symptoms arising for reason of intestinal and other smooth muscle spasm, skeletal muscle spasm, and increased central and peripheral nerve tissue activity. Examples of these are constipation, pain due to intestinal and uterine muscle, cardiac irritability, skeletal muscle pain, cramping, and myositis.

This research also led me to organize most of the diseases that I related to the deficiencies and successfully treated into a genus of "ionic calcium deficiency diseases" comprised of two divisions, a minor "direct" and major "indirect" division. The "direct ionic calcium diseases" are those which represented the accentuation of one of the above mentioned symptoms to acquire the proportion of a disease. Examples of these are disabling myositis, disabling dysmennorhea, and migraine. The "indirect-mal-adaptive" diseases are those which represent the breakdown of an autonomically excited adaptive function of an organ or tissue which was designed to effect biochemical compensation for the ionic calcium deficiency. Examples of these are chronic asthma, ileitis-colitis, hypertension, both major form of arthritis, and diabetes.

A BOOK, "THE CALCIUM FACTOR" AND A PENDING BOOK

My studies on the biochemistry of calcium have led me to co-author a book on that subject with a research chemist, titled "The Calcium Factor". This book, described in the enclosed brochure, is 90% biochemistry and only 10% clinical.

In contrast, another book in manuscript form titled "The Ionic Calcium Deficiency Symptoms and Diseases", is 90% clinical and 10% or less biochemical. This book may be ready for presentation to publishers sometime in '93.

A POSSIBLE MECHANISM RESPONSIBLE FOR ARTERIOSCLEROSIS AND THE ASSOCIATION WITH IT OF CERTAIN CLINICAL FINDINGS.

This clinical experience revolving about the availability of calcium that has been adequately ionized by vitamin D has led to the following clinical-biochemical explanation for calcific arteriosclerosis. The deterioration of the tissues of the arterial wall and the ultimate deposition in them of gross metastatic molecular calcium may represents the effect of chronic cellular deficiency of vitamin D. Since I believe that ionic calcium is intimately related to the energy transfer processes of the cell, this deficiency which was of the degree that calcium could no longer be maintained in its ionized state in the cell, led to "cell energy starvation". This starvation, in turn, first created dysfunction, then physical changes, disrepair, death of cells, and microscopic and then the macroscopic deposition of molecular calcium.

As this deposition perpetuated the ionic calcium deficiency state more calcium which was ingested in the diet, or taken from the skeletal store, was transported to the arterial tissue to also be deposited in molecular form.

It is reasonable to expect that such calcification of tissue due to chronic cellular deficiency of vitamin D will be associated with other clinical findings that have been attributed to this deficiency. I refer to the symptoms and physical changes of the ionic calcium deficiency syndrome and to the ionic calcium deficiency diseases. The presence of these symptoms and diseases in varied combination with calcific arteriosclerosis, and their relief as the EDTA "chelates out" the molecular calcium forces the definition of such relief as the "fringe benefits" of EDTA chelation.

THE POTENTIAL OF IONIC CALCIUM DEFICIENCY TO CREATE ILLNESS AND THE VARIATION IN PRESENTATION OF THIS ILLNESS

A basic concept produced by this study is that, for evolutionary reasons, ionic calcium is by far the most important factor in cell function. For this reason chronic deficiency of this ion, arising for reason of lifestyle defects and creating cell energy starvation and the adaptive acidity of body fluids, has produced a "pool" in the general population out of which most body ills, including arteriosclerosis, arise. The vast variety of the ills which may arise singly or in varied combination from this pool is due to an equally vast number of secondary factors which may affect it. Examples of these are genetic faults, stress, other deficiencies, and toxins, and their varied combination.

The clinical conditions found associated with calcific arteriosclerosis may also be varied for reason of the differences which individuals may have in their potential to adapt to the ionic calcium deficiency state. Individuals with a lesser degree of such potential will experience more

deficiency symptoms and fewer adaptive diseases while those with high adaptive potential will be inclined to experience fewer symptoms but more "mal-adaptive" disease.

The dictum arising from this concept concerning this deficiency and adaptive potential is "First test the salivary pH of the patient and if acidic then first treat their cell energy starvation with calcium and vitamin D".

RESEARCH PROPOSAL

The clinical observations I have made, and the concepts which naturally evolved from them, compel me to make the following recommendations of research to physicians who are prescribing EDTA chelation therapy.

I propose that patients presenting for this therapy are studied as I have studied and treated approximately 25,000 patients over the years of 1954 to 1983, to identify if they are suffering the effects of chronic ionic calcium deficiency. This means that, prior to and following a course of EDTA chelation therapy that does or does not include the nutritional dietary and supplemental therapy which I have prescribed to asthmatic and other patients, that these patients are studied as follows:

(A) QUESTIONED IN REFERENCE TO THE PRESENCE OF:

i) lifestyle defects creating deficiency of dietary calcium, and of dietary and sun-on-skin vitamin D.

ii) the functional stigma of this syndrome due to:

(a) spasm of smooth vascular, intestinal, uterine and ocular muscle, and spasm of skeletal muscle, the outstanding of which are headaches, abdominal pain due to intestinal and uterine spasm, blurring of vision, skeletal muscle aches and pains,

(b) heightened central and peripheral nerve function, such as hyper-activity and irritability, and

(c) a combination of the above effects which is the "hypochondriac-chronic fatigue-anxiety-depression state".

iii) the "direct" ionic calcium deficiency diseases that largely represent accentuation of the above symptoms, such as migraine, disabling myositis, and disabling dysmennorhea

iv) the "indirect-adaptive" such diseases examples of which are asthma, ileitis-colitis, osteo and rheumatoid arthritis, hypertension, and diabetes.

(B) EXAMINED IN REFERENCE TO THE PRESENCE OF:

The physical stigma of the ionic calcium deficiency syndrome of which the outstanding are:

i) cracking or layering of finger nails and tongue coatings

ii) increased myotatic irritability of skeletal muscle on percussion, and increased pain of this muscle on firm palpation

iii) increased tendon reflexes

iv) an acidic state of saliva when tested with litmus paper

ANALYSIS OF THE ACCRUED DATA

The above data will be prepared for, and subjected to computer analysis.

This analysis will prove or disprove that :

i) much disease is related to particular lifestyle defects giving rise to a deficiency of calcium and vitamin D and to an acidic state of the saliva.

ii) as chelation therapy or nutritional therapy alone, or a combination of these therapies, normalize the acid-base balance of the saliva, disease is resolved.

iii) calcific arteriosclerosis is related etiologically and biochemically to the ionic calcium deficiency syndrome, and diseases.

THE RESEARCH PROJECT

This may be entered into in three stages with stage #2 and #3 not contemplated until either stage #1 or #2 produces positive results.

STAGE #1

This largely involves the physician becoming acquainted with the salivary pH test and seeing that his staff performs the litmus paper test on patients prior to, during, and after therapy.

Physicians will soon note that patients requiring chelation therapy have an acidic state of their saliva while that of controls (highly proficient and non deficient athletes) is in the neutral to slightly alkaline range.

Physicians will also note that patients experiencing symptoms and disease other than those arising because of arterial disease, will also show an acidic saliva.

While making these preliminary observations physicians will "look ahead" in the study to observe that the pH of the above classes of arteriosclerotic and other patients will increase by an average of 1.5 logarithmic points as their clinical condition resolves on either chelation therapy, nutritional therapy, or a combination of these therapies.

If the above preliminary observations are verified, and some of the "look ahead" findings made, the physician may proceed to stage #2.

STAGE #2

Analysis of the above patients in reference to:
(i) lifestyle, (ii) the deficiency syndrome, and (iii) the deficiency diseases.

If an analysis of this date indicates a firm relationship of those clinical findings stage #3 may be contemplated.

STAGE #3

Increase the number of patients analyzed.
Subject all data to computer analysis.

OTHER ASPECTS OF THE RESEARCH

REQUIREMENTS FOR THE STUDY PROVIDED

Protocols defining:
i) lifestyle defects, ii) the deficiency syndrome
iii) the deficiency diseases,
iv) the salivary test,
v) alkaline producing dietary therapy, and supplemental vitamin A and D plus calcium therapy,
vi) chelation therapy.

Description of the method of physical examination particularly to the examination of skeletal muscle.

Analysis forms, and a supply of litmus paper.

COOPERATION AND CENTRALIZATION

It is hoped that between 1,000 to 5,000 patients will ultimately be analyzed in keeping with the prescribed protocols.

Physicians will be invited to submit such data on cases they have treated with EDTA chelation therapy to the agency promoting the study. This agency will prepare the data for computer analysis and produce such analysis.

You are invited to offer suggestions as which associations may be approached to assist in gaining physician cooperation, financial backing, and other assistance. Advice from "computer experts" and statisticians is welcomed and expected.

IN CLOSING

I have little doubt that the above proposal of research will raise many questions, and possibly concern. Regardless, for the following reasons, I offer it for what it is worth.

i) Despite that up to one million patients may have been treated with EDTA chelation the "community of chelating physicians" has done relatively little research to forward the acceptance of this therapy.

ii) It is obvious that the therapy is inducing profound clinical effects which must arise for reasons other than the mere improvment of circulation.

iii) What I propose may not only present a unique opportunity to identify a major cause of arteriosclerosis but to also to identify the cause of an array of other symptoms and other obscure "allergic", "auto-immune", and "metabolic" diseases.

"GETTING ACQUAINTED"

Physicians wishing to "become acquainted with the salivary pH test", not only in reference to its use in patients with circulatory problems but in other types of patients, are invited to write and ask for a vial of 100 strips of the litmus paper plus detail of the test. Charge of this vial suitable for 300 or more tests if used economically, and directions on how to do the test is $10.00

I offer the assurance that this test will "open a door" to an entirely new perspective of medicine involving the diagnosis, therapy, and prevention of illnesses arising for reason of common but heretofor unidentified lifestyle defects.

Carl J. Reich.