

# Rheumatoid Diseases Cured at Last

BY  
ANTHONY DI FABIO



®

## **A Simple Plea to Sincere Physicians**

On Behalf of all Board Members of the The Arthritis Trust/Rheumatoid Disease Foundation

by

Gus J. Prosch, Jr., M.D.

"If you are sincere and truly desire to relieve the agony and suffering of your arthritic patients, I beg of you to give these recommended treatments a trial on your rheumatoid and osteoarthritis patients. I promise you that you will receive far superior results in relieving your patients' pain, suffering and disability than anything you have ever used before. You will be treating the cause of the rheumatoid disease and not simply the symptoms. You can now offer these severely neglected patients far more than a simple 'hope' of finding relief which conventional methods of treatment cannot even offer. You will be offering them total relief which will literally change the entire lives of these patients and their families. You will never find the satisfaction and pleasure of helping your fellowman any greater than by using these techniques to treat arthritic sufferers. You will completely and thoroughly understand what I mean when certain patients come to you in a wheelchair and, after receiving your treatment and injections by the above recommended techniques, they refuse to use the wheelchair to leave your office.

"What a joy! What contentment! What satisfaction!

"Good luck and God be with you!!!"

Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.

**This book is no longer available except in computer print-out form. Since it's initial publication, we've learned that many microorganisms, not just the amoeba reported herein, or mycoplasmas reported elsewhere, can be a cause of rheumatoid disease -- and that many other factors are now identified, and can be investigated for the purpose of solving the disease.**

**See our later publications containing up-dated information, please!**

A SIMPLE AND INEXPENSIVE CURE/REMISSION FOR RHEUMATOID DISEASES IS SET OUT IN **CHAPT. IV: Recommended Treatments**. IF YOU ARE A SUFFERER (OR KNOW SOMEONE WHO IS) SHOW THE PAGES TO YOUR FAMILY DOCTOR, DRAWING HIS/HER ATTENTION TO THE LIST OF COOPERATING PHYSICIANS SIGNED UP WITH THIS FOUNDATION WHO USE THIS TREATMENT AND WHO ARE WILLING TO BE CONSULTED. PHYSICIAN REFERRALS AND INFORMATION IS AVAILABLE THROUGH THE RHEUMATOID DISEASE FOUNDATION, Now The Arthritis Trust of America.

The Arthritis Trust of America, 7111 Sweetgum Drive SW, Suite A, Fairview, TN 37062-9384, (615) 799-1002; Phone and Fax are the same.

---

## RHEUMATOID

## DISEASES

## CURED AT LAST

*The Original "Amoebae Theory" of Arthritic Diseases, an hypothesis that Serendipitously Developed The Arthritis Trust of America's Presently Successful Medical Treatments*

by

Anthony di Fabio

A Publication of the The Arthritis Trust of America®

---

### A Publication of the Arthritis Trust of America

*Publisher certifies that this is an independent news report made as accurately as possible, and further certifies that no drug company, medical doctor, or medically related institution has any financial interest in the sale and proceeds of this publication or the medicines recommended. Publisher further advises that all treatment should be through a licensed physician, and that we cannot be responsible for mal-application or mis-application or inappropriate treatment of any kind. Voluntary contributions to the tax-exempt, charitable The Roger Wyburn-Mason and Jack M. Blount Foun-*

*...ation for Eradication of Rheumatoid Disease, Inc., (The Rheumatoid disease Foundation/The Arthritis Trust of America, 7376 Walker Road, Fairview, TN 37062-8141), will be used for the purpose of furthering research and in communicating discoveries.*

---

*All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopy, recording, or otherwise, except for brief reviews, where credit is given to author, artist, and publisher, without prior written permission of the publisher.*

Library of Congress Cataloging Number 82-73215

ISBN 0-931150-12-4

©1982 by Anthony di Fabio

©1983, 1984, 1985 revised editions by Anthony di Fabio  
revised 1994 by Stephan Cooter, Ph.D.

"Louis Pasteur, Medical Quack," John W. Campbell, Jr.  
Copyright by the Condé Nast Publications, Inc.  
first published in Analog Science Fiction/Science Fact.

Published by The Arthritis Trust of America  
7376 Walker Road, Fairview, TN 37062-8141

Originally Printed in Washington, DC, USA  
Second Printing in Franklin, TN

---



Roger Wyburn-Mason, M.D., Ph.D. and Jack M. Blount, Jr., M.D.

### Dedication and Acknowledgment

*This book is dedicated to two brilliant and brave men, Professor Roger Wyburn-Mason, who one day should receive the Nobel Prize in Medicine, and Dr. Jack M. Blount, who should at least receive the Congressional Medal of Honor for bravery in the face of hostile forces; with special mention also for Dr. Robert Bingham whose open-mindedness and foresight brought Professor Roger Wyburn-Mason's work overseas, John R.A. Simoons, Ph. D., for persistence in bringing this work to attention of academia and drug manufacturers, Dr. Archimedes A. Concon, for vision in*

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.** applications, and Dr. Eugene S. Wolcott who knows why; and an additional personal thanks to L. Ron Hubbard and John W. Campbell, Jr. for providing the author with vision on the coin's other side.

Physicians and Scientists Advisory Committee of *The Roger Wyburn-Mason and Jack M. Blount Foundation for Eradication of Rheumatoid Disease, The Rheumatoid Disease Foundation*, now *The Arthritis Fund* have been particularly helpful in creating new medical protocol and in dissemination rheumatoid disease information, for which a deep, heartfelt thanks — .

This book is a report of the life-time work of Professor Roger Wyburn-Mason, who had for more than twenty-six years researched the roles of pathogenic protozoa in human disease as a protozoologist, pharmacologist and rheumatologist.

In collaboration with his wife, and over twelve years, he wrote a monumental work, which may revolutionize the diagnosis and treatment of many chronic and dangerous illnesses. The work is titled *The Causation of Rheumatoid Disease and Many Human Cancers — A New Concept in Medicine*.<sup>1</sup>

The material that follows in this book for the most part is taken from Professor Roger Wyburn-Mason's primary book and/or his Addenda. (*The Causation of Rheumatoid Disease and Many Human Cancers — A New Concept in Medicine — A Précis and Addenda, Including the Nature of Multiple Sclerosis*) with his permission. The Memoriam below is from the new cover of Roger's Addenda, his last book to be published.

*We also wish to acknowledge and to share with the reader our appreciation for the more than generous cooperation of the many people who helped us. They are: Branch Owen Adkerson (Franklin, TN, USA), Stan J. Bardo (Pietermaritzburg, Republic of South Africa), Frederick H. Binford (Nashville, TN, USA), Warren B. Causey (San Antonio, TX, USA), E. Harrison Clark (Alexandria, VA, USA), Terry Crommelin (Perth, Western Australia), Robert Edmonds (Hollywood, CA, USA), George Hay (London, England), Kay Hitchen (Southampton, Hampshire, England), Carl Hosch, Jr. (Atlanta, GA, USA), Bob Kemp (Beebe, AR, USA), John Kern, (Brentwood, TN, USA), Jean Lancaster (Philadelphia, MS, USA), Gus and Patty J. Prosch, Jr. (Birmingham, AL, USA), Paul K. Pybus (Pietermaritzburg, South Africa), Carl J. Reich (Calgary, Alberta, Canada), Larry L. Roberts (Nashville, TN, USA), Don and Nancy Vansant (Nashville, TN, USA), Joan Wyburn-Mason (London, England), Vaughn Young (Hollywood, CA, USA), and many others, some of whom prefer anonymity.*

### **In Memoriam**

Roger Wyburn-Mason Oct. 2, 1911 - June 16, 1983

When I was at last cured of the dreaded, crippling rheumatoid arthritis, I never dreamed of embarking on a world-wide challenge to professional rheumatologists, the gigantic and ineffective Arthritis Foundation, and the American petrochemical industry that siphons \$15,000,000,000 a year in the United States of America from the sick and the lonely, chiefly for aspirin substitutes that simply treat symptoms, and not causes.

Somehow the Good Lord has seen fit to successfully guide my path — along with other determined, sincere people — to bring the good message to all: there is a cure! it is simple! it is cheap! it is available everywhere!

My book *Rheumatoid Diseases Cured at Last* (1982) was monitored by professor Roger Wyburn-Mason, and based on his original work, *The Causation of Rheumatoid Disease and Many Human Cancers* (1978). My book was designed for the ailing to find hope, to convince them, to be carried to their family physician for further interpretation where they would be treated.

My small book also launched The Roger Wyburn-Mason & Jack M. Blount Foundation for Eradication of Rheumatoid Disease, The Rheumatoid Disease Foundation, now The Arthritis Fund, which is now successfully off and running, millions of messages spreading the word. Many fine humanity-conscious physicians and non-physicians are now members, and working toward common goals set by Professor Roger Wyburn-Mason.

Some six weeks ago I wrote to Roger, asking that he please include a summary of his professional life and writings. I argued that while his work ought to stand on its own two feet, professional humans, like other humans, simply were more impressed with the number of "brownie points" and "merit badges" than with whether or not the work was "scientifically valid" — not meaning, of course, to disparage either the Boy or Girl Scouts, (I was an active Boy Scout) but rather to emphasize the sad state in which the so-called professional scientific community finds itself — where "altitude" and "prestige" is of more consequence than scientific validity.

Reluctantly, Professor Roger Wyburn-Mason sent this, his last letter before the Good Lord called him on June 16, 1983.

"I was born in Monmouthshire, England. On my mother's side I am a descendent of Bishop Stephen Gardiner, who was Lord Chancellor of England, that is the most powerful person in the country after the Monarch in the reign of King Henry VIII, King Edward VI, Queen Mary and first and Queen Elizabeth the first. He conducted the marriage of King Philip II of Spain to Queen Mary the first of England in Winchester Cathedral, where he is buried in a magnificent tomb. My mother's cousin was the former Prime Minister of New Zealand, Mr. Nash. My godfathers were the greatest English Composer, Dr. Ralph Vaughn Williams of Cambridge University and now buried in Westminster Abbey, and the historian H.A.L. Fisher, the head of New College Oxford both of whom held the decoration of Order of Merit (O.M.), the highest honour that can be bestowed by the Monarch.

"I attended a public school (a public school in England is the opposite of one in the United States, being privately as opposed to state owned and includes such distinguished Institutions at Eton, Harrow and Winchester Colleges). At the end of school years I took the necessary final examinations and gained the top marks in the whole of Great Britain and was awarded a State Scholarship and an Open Scholarship to Christ's College, Cambridge (founded in 1405 A.D.), where the poet John Milton and the great scientist Charles Darwin were also students. Here I occupied the same rooms as those of Darwin himself.

"At Cambridge I obtained double first class honours in the final examinations for the B.A. (Bachelor of Arts) degree. I also represented my University at Rugby football and Athletics. At the end of my period as an Undergraduate, I remained in Cambridge as a Bachelor Fellow of the College and did research in pathology and particularly protozoology. I afterwards was awarded the degree of M.A. (Master of Arts) a higher degree and the only University scholarship awarded to graduates completing their clinical studies at a London Hospital where I finally obtained my M.B. (Bachelor of Medicine) and B. Chir. (Bachelor of Chirurgie [British archaic spelling of Surgery]). I afterwards held the posts of Registrar (the equivalent of Instructor in America) in the foremost hospitals in London, namely the Middlesex Hospital, the Brompton Hospital for Chest Diseases, the National Heart Hospital, the National Hospital for Nervous Diseases and the Royal Marsden Hospital for Cancer. While at the Middlesex Hospital, I took part in the first Clinical Trials of the first sulfonamide antibiotics. While working at the National Hospital for Nervous Diseases I wrote my thesis for the M.D. (Cambridge Degree — This is a

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

higher degree unlike it is in the United States and other countries). I also sat for M.R.C.P. (Member of the Royal College of Physicians) examination in which I obtained the top marks of all the candidates. My M.D. thesis was entitled "The vascular tumours and abnormalities of the spinal cord and its membranes" and received with acclaim as it was the first description of these matters. It was published as a monograph and has remained the standard work on this subject. While working at the National Hospital for Nervous Diseases, I published a number of papers in medical journals and two of these described new diseases which have since been named after me, and I am the only living doctor who has such a distinction. One of these conditions describes the presentation of cancer as a peripheral neuropathy, that is a disturbance of the nerves of the limbs before any other evidence of cancer is present. The other describes a congenital blood vessel disease of the skin of the forehead, the fundus of the eye, the optic nerve and the brain.

"I later was elected Research Fellow at the Royal Marsden Hospital for research into cancer and later Research Fellow at the Royal College of Surgeons of England, where I continued my research into the nature of cancer and first isolated from all human malignant tumours and from cases of rheumatoid arthritis an hitherto unknown, very small free-living amoebae. For this I received the Ph. D. degree.

"While Working at the Royal Marsden Hospital, I discovered that human tissues affected by *herpes zoster* (shingles) and by *herpes simplex* (cold sores) which are both due to virus infections were liable to develop cancer of the skin at a later date. This was the first description of human cancer caused by a virus, and it resulted in my invitation by the late Professor Duran-Reynals, who was working at Yale University on the viral cause of human cancer, to Yale to work with him his assistant where I continued after his death. I later transferred to the Mayo Clinic and worked with the late Dr. J.W. Kernohan, the neuropathologist.

"I became convinced that while viruses cause cancer in animals, they rarely do so in man. During these years, I published many papers and monographs (books) on my researches, and as a result of these I was awarded the degree of Doctor of Science of Cambridge University (a rare honour) and elected a Fellow of my old College.

"After twenty years work on the new organism which I had discovered, I was able to show that this was the cause of rheumatoid arthritis. Furthermore, infection with species of this organism in susceptible subjects seemed to be the cause of a large proportion of cases of human cancer, which can be prevented by taking appropriate substances which kill the organism. This work has all been described in a book entitled *The Causation of Rheumatoid Disease and Many Human Cancers — A New Concept in Medicine*, and it has caused worldwide interest.

"After a time, it became necessary for me to return to England where I continued my work in the laboratories and wards of the National Health Service.

"Among my publications are the following -

### Books

*The Vascular Tumours and Abnormalities of the Spinal cord and its Membranes.* Henry Kimpton, London, 1943.

*Trophic Nerves.* Henry Kimpton, London, 1950.

*Reticulo-endothelial System in Growth and Tumour Formation.* Henry Kimpton, London, 1958.

*A New Protozoan, Its Relation to Malignant and Other Diseases.* Henry Kimpton, London, 1964.

*The Causation of Rheumatoid Disease and Many Human Cancers — a New Concept in Medicine.* Iji Publishing Co. Tokyo, Japan, 1978.

*A Précis and Addendum* to the above. AC Publishing Co., The Arthritis Fund, Franklin, TN 37064, 1983.

### Some Papers

"On some anomalous forms of amaurotic idiocy and their bearing on the relationship of various types." *Brit. Journ. Ophthalmol.*, April/May 1943, p. 145-187.

"Arterio-venous aneurysm of midbrain and retina, facial naevi and mental changes." *Brain*, 1943, 66, 163-203. (This is known as Wyburn-Mason Syndrome I).

"On some pressure effects associated with cervical and the rudimentary and 'normal' first ribs and the factors entering into their causation." *Brain*, 1944, 67, 141-177.

"A new conception of angina pectoris." *Brit. Med. J.*, 1948, i, 972.

"Bronchial carcinoma presenting as polyneuritis." (Wyburn-Mason's Syndrome II). *Lancet*, 1948, i, 203.

"The significance of the reference of angular pain to the right or left side of the body." *Amer. Heart J.*, 1950, 39, 325-335.

"The nature of tic douloureux." *Brit. Med. J.*, 1954, iii, 119.

"Costo-clavicular compression of the subclavian vein and its significance in relation to post operative oedema in carcinoma of the breast." *Brit. Med. J.*, 1953, iv, 1106-1109.

"Malignant change following herpes simplex." *Brit. Med. J.*, 1957, ii, 615-161.

"Visceral lesions in herpes zoster." *Brit. Med. J.*, 1957, i, 678-681.

**These last three articles are the first reports of a viral cause of human cancer.**

"Association of gastroduodenal lesions with Menière's syndrome." *Brit. Med. J.*, 1959, i, 78-83.

"Clotrimazole and rheumatoid arthritis." *Lancet*, 1976, i, 489.

"The free-living amoebic causation of rheumatoid and auto-immune diseases." *International Medicine*, 1979, i, 20-25.

"New views on the aetiology of rheumatoid arthritis." *British Medicine*, August 21st, p. 12-14.

"The Naeglerial causation of rheumatoid disease and many human cancers - A new concept in medicine." *Medical Hypotheses*, 1979, 5, 1237-1249.

"SLE and lymphoma." *Lancet*, January 20th, 1979.

Roger Wyburn-Mason June 10th, 1983

Professor Roger Wyburn-Mason solved the riddle of one of man's oldest curses, and in so doing, discovered a vast panorama of formerly, and so-called, incurable diseases. He strived with every ounce of his great, God-given intellect to bring to all humanity his discoveries. We prayed to be there when he walked across the stage to receive his Nobel Prize, and other prizes that were his due — but God, in his great wisdom, decided otherwise for us, and we must accept.

To the famous names of Semmelweis, Jenner, Koch, Harvey, Ross, Lister, Pasteur, Ehrlich, Sister Kenny, and Roentgen add Wyburn-Mason — a most brilliant, brave, humanity-loving man who pursued evil forces causing them to acknowledge that humanity need not always feel pain, suffering, depression, disillusionment —.

The simple anti-amoebic cures developed by Professor Roger Wyburn-Mason, M.D., Jack M. Blount, M.D., and Robert Bingham, M.D. are described herein; and corroboratory case histories are also included.

### In Memoriam

Mrs. Joan Wyburn-Mason, the beautiful lady who patiently supported and worked with Roger Wyburn-Mason through his many brilliant medical discoveries, died March 1, 1985.

Her last work, in support of her former husband, is entitled *Dedication, Love and Humour*, a brief biography of their life together, as told through Joan's loving eyes.

This well-written booklet is published by The Rheumatoid Disease Foundation, now The Arthritis Trust of America.

1. Professor Roger Wyburn-Mason's book *The Causation of Rheumatoid Disease and Many Human Cancers*, was originally only available in Japan at \$125 each. Limited numbers have been placed in various hospital and university medical libraries, at Dr. Jack M. Blount's expense. A summary of the 479-page book, with a *Précis and Addendum* has been republished by The Rheumatoid Disease Foundation, now The Arthritis Society of America, for \$10.

#### Table of Contents

*Dedication and Acknowledgment*.....

**Table of Contents**.....

**Preface**.....

**Chapter I: You and Your So-Called Hopeless Disease**.....

*For the Rest of Your Life?*.....

*The Ordinary Made Hard*.....

*Stiffness, Pain, Heat and Cold*.....

*Hopelessness*.....

*Traditional Treatments*.....

*Non-traditional Treatments*.....

*So Where From Here?*.....

**Chapter II: Dr. Jack M. Blount's "Miracle"**.....

*Dr. Jack M. Blount's Gift to Mankind*.....

*Dr. Blount's Story: Rheumatoid Disease is of the Entire Body*.....

*Despair*.....

*Why Was I Saved?*.....

*"The Miracle of Professor Roger Wyburn-Mason"*.....

*I Experiment on Myself*.....

*More Successful Patients*.....

*Well Again!*.....

*Prayer For the Entire World*.....

**Chapter III: The Author is Also Cured**.....

*The Beginning of Arthritis*.....

*Fatigue and Depression*.....

*Pains Increase*.....

*The Discovery*.....

*The Cure*.....

**Chapter IV: The "Miracle" Treatment**.....

*Recommended Treatments*.....

**The Rheumatoid Disease Foundation Protocol - Rheumatoid**.....

*Herxheimer reaction signs and symptoms*.....

**Chapter V: Cooperating Physicians and Scientists**.....

*How to Contact Them*.....

*Table of Medicines*.....

*A Simple Plea to Sincere Physicians — Gus Prosch, Jr. M.D.*.....

**Chapter VI: Professor Wyburn-Mason's Theory of Protozoal Cause of Many Hitherto Unrelated Diseases**.....

*The Prevailing Medical Theory*.....

*Wyburn-Mason's Findings*.....

*State of Art in Medicine*.....

*Primary Source of Rheumatic Diseases*.....

*Roger Wyburn-Mason Letter June 1983*.....

**Chapter VII: Amazing Implications of the Protozoon Discovery**.....

*Broad-spectrum Antibiotics*.....

*Broad-spectrum Antiamoebics*.....

*Isolation of the Amoeba*.....

*Collagen Diseases*.....

*Susceptibility*.....

*Present Rheumatology Practices Unscientific*.....

*Important Note*.....

**Chapter VIII: Case Histories**.....

*Based on Wyburn-Mason's Work —*.....

*Introduction*.....

*Successive cases treated with furazolidone*.....

*Successive cases treated with allopurinol*.....

*Conclusion*.....

*Based on Madden's and Mendel's work --*.....

*Introduction*.....

*Successive cases treated with tinidazole*.....

*Conclusion*.....

*Based on Concon's Work --*.....

*Introduction*.....

*Successive cases treated with metronidazole*.....

*Conclusion*.....

*Based on Bingham's Report --*.....

*Introduction*.....

*Effects of treatment with clotrimazole*.....

*The Treatment of Rheumatoid Disease With*.....

*Anti-Protozoal Drugs - A preliminary Report*.....

*Comparative Results of Treatment With Other Drugs*.....

*Conclusion*.....

*Irony*.....

*Roger Wyburn-Mason Letter May 1983*.....

**Chapter IX: Correspondence, Testimonials, and Book Report**.....

*From Dr. Paul K. Pybus*.....

*From Bob Kemp*.....

*From A.W. Hamilton*.....

*From E.H.C.*.....

*Interviews*.....

*Letters to and on File with Dr. Jack M. Blount*.....

*Book Report by Dr. Robert Bingham*.....

*Adequate Treatment by Dr. Robert Bingham*.....

*Letter by Dr. Jack M. Blount*.....

*More Letters*.....

**Chapter X: Is it Ethical to Deny the Sick?**.....

*Children Sick Forever --*.....

*The Right to Try!*.....

*Vested Interests*.....

*Definition of a Quack*.....

*I Pray That You Will Be Healed, Too!*.....

**Chapter XI: Treatment of Osteoarthritis, Osteoporosis Rheumatoid**.....

*Arthritis Pains and Element of Proper Nutrition*.....

*The "Aging" Disease*.....

*The Rheumatoid Disease Foundation Protocol -- Osteoarthritis*.....

*Injection Points for Intraneural Injections*.....

**Chapter XII: The Past and the Future**.....

*The BCF Syndrome*.....

*The Rheumatoid Disease Foundation [The Arthritis Trust of America]*.....

*Donations*.....

**Chapter XIII: Dr. Jack M. Blount's Suspended Sentence**.....

*The Board Hearing*.....

**References**.....

Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.

Physician & Scientist Advisory List.....	
Donation and /or Order	
Blanks.....	last page
The Roger Wyburn-Mason and Jack M. Blount Foundation	
.....	Back Cover

### Photographs and Drawings

Professor Roger Wyburn-Mason and Dr. Jack M. Blount.....	
Left hip of Jack M. Blount, M.D., December 11, 1975.....	
Right hip of Jack M. Blount, M.D., December 11, 1975.....	
Right Hip of Jack M. Blount, M.D., after prosthetic implant, March 21, 1976.....	
Photograph of a <i>Limax amoeba</i> .....	
ozoite.....	
Cysts of <i>Limax amoebae</i> after migration.....	
Drawing of apparatus used to separate <i>Limax amoebae</i> .....	
Schematic Drawing I: Probable Cause of Sciatica Pain in Osteoarthritis.....	
Schematic Drawing II: Nerve Sites for Intra-neural Injection.....	
Schematic Drawing III: Nerve Sites for Intra-neural Injection.....	
Schematic Drawing IV: Nerve Sites for Intra-neural Injection.....	

### Preface

Cooperating physicians have successfully treated tens of thousands of patients afflicted with so-called incurable rheumatoid diseases using a low-cost, simple medical procedure.

The American Medical Association estimates some 13 million Americans seek relief from rheumatoid arthritis. Three million are restricted in their daily activities. Seven hundred thousand cannot do useful work, keep house, attend school or enjoy recreational activities.

The April 24, 1983 Arthritis Foundation National Telethon (out of Nashville, TN) stated that one out of every three people will suffer from some form of arthritis, that one person contracts the disease every 33 seconds.

Dr. Carolyn K. Davis<sup>1</sup> of the U.S. Department of Health and Human Services stated that the U.S. Medicare program costs the U.S. Government about one billion dollars annually for rheumatoid diseases; and that probably an equal annual amount is spent through State Medicaid programs, totaling U.S. Citizens about two billion dollars per year for treatment and care of those afflicted with the dreaded disease.

At least one-half billion per year in lost wages is reported by *The Meridian Star*.<sup>2</sup>

Others<sup>3</sup> estimate that 31 million Americans of all ages suffer from arthritis, that it attacks a million new patients a year, and costs the national economy about \$15 billion annually.<sup>4</sup>

For each male who suffers, there are three females. The symptoms often appear between ages of 20 and 35 with weakness, fever, loss of appetite and weight loss. One or more of the smaller joints becomes inflamed and swollen. Acute, painful inflammation migrates from one joint to another. Mental depression is common.

Attacks may develop gradually, or suddenly with dramatic seizure. Pain and inflammation may come and go for no apparent reason. The disease may affect children and produce stunting of growth and gross deformities.

Considering the insidious nature of rheumatoid diseases, its many forms of symptoms and its long-term degenerative activity on your body, sometimes extending from birth onward, apparently this book is for you, your relatives and your friends!

1. Davis, K. Carolyn, Letter to Senator James Sasser, September 1, 1982, transmitted by letter to author by Senator James Sasser September 23, 1982.

2. *The Meridian Star*, "The Arthritis Foundation — Distributing Information to Those with the Affliction," Meridian, MS, February 24, 1983.

3. *The Scanner*, Volume 1, Number 4, Fall 1981, The Arthritis Institute of the National Hospital for Orthopaedics and Rehabilitation, 2455 Army Navy Drive, Arlington, VA 22206, p. 1.

4. E. Harrison Clark reports that *Barron's* and *Wall Street Journal* report a figure of \$1.5 billion, or a little less for pain-killers.

## Chapter I

### You and Your So-called Hopeless Disease

#### *For the Rest of Your Life?*

So, you've been told you have rheumatic arthritis, and there is no cure! For the rest of your life, you must watch your fingers and toes and arms and legs twist and turn and torture themselves into grotesque shapes that offend each eye and spirit!

When you awake each morning, your fingers and other joints are swollen, red and they burn as if held to a slow-roasting fire. You flex them and sharp pains make you grimace. Stiffened and puffy, your fingers feel like *not you*, like some burning, sausage-like appendages that were fastened on by instant glue during the night.

Gingerly protecting each joint, you slide carefully from your over-soft mattress. Oh, how it hurts to reach for clothing! Easy now! Not too fast, not too hard! Ouch! How that hurts! You wince, but go on dressing, though slowly. What else can you do?

#### *The Ordinary Made Hard*

Someone has tightened the coffee jar lid too much. A flash of resentment stirs as you wonder why others cannot understand, and why they cannot help you more by anticipating your weakness. Again pain forces your immediate attention. It's everywhere, at each joint -- the terrible, long-lasting, daily increasing pain....

Dare you risk injury to finger joints by fighting the coffee jar top this morning.

But you *need* the stimulation, the black, warm brew, something --anything -- to lighten depression, to sway your outlook...

So you struggle with the cap, gripping down on it, squeezing it and grimacing again, while sharp pains make you want to scream aloud -- and then -- at last -- the jar cap moves ever so slightly. Relaxing your fingers permits pain to diminish somewhat, and then you staunchly tackle the lid again.

You pour the steaming coffee ever so carefully and you hold it ever more gingerly. You must not place your fingers about the warm cup, for every finger joint will burn with a fury as though a small, hot laser beam were focused in them. And so it is with cold items as well. Are you one of those who wisely insulates all cups and glasses?

Such are the once easy chores that now loom larger than life itself!

Perhaps you use special tools designed just for invalids with *incurable* arthritis: A wide-band holder for jar caps that multiplies weakened muscles and applies increased friction about the cap; a bathtub grip-bar (what a terrifying experience, that old-fashioned bathtub); an elevated toilet set; buttoning devices for shirts, coats, blouses; a special device for turning on and off faucets at kitchen or shower (what an absurdly simple act that was once); long handles designed to reach clothing on the floor, and to permit ease in hanging them; special hooks and handles for special eye and needle affairs for tying shoe-laces — the mechanical

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

devices are endless as the disease works into every muscle-fiber and joint.

#### *Stiffness, Pain, Heat and Cold*

How people comment about your hyperactivity! What they don't understand is that you sit or stand or lay in one position overlong, you become stiff and your joints ache excruciatingly. So you move -- here, there, everywhere -- all the time!

Do your hands and feet feel cold? Do you sweat night after night, with a terrible burning?

Your walking gait is changing; your skin bruises more easily and it has an increased fragility. Nodules have appeared in skin tissue, especially over points of pressure or friction. If you're bedridden the nodules will be found at the posterior portions of head, trunk and spine.

You might have developed skin ulcers or difficulties of another kind inside your lungs, or any of a dozen other physical problems that at first glance do not appear to be related to arthritis.

But you're probably one of the lucky ones, one of those who can still function, still determine your own physical course daily, still decide for yourself. What of those whose disease has progressed beyond, and now must lie bedridden, or rely on a wheelchair, and must be lifted and towed everywhere, must be dependent upon others, not daily, but hourly, for every little need, every little change, every little pleasure -- if any?

Are you still free and financially able to go to a warm climate where blessed relief may temporarily be yours? Oh, how cold rains and winds shrivel us and compress pain upon pain!

#### *Hopelessness*

Must you lie and stare, and hopelessly dream of the blessings of suicide, the relief of drugs, the wonderful numbness of alcohol.... remembering that first visit to your doctor?

"You've rheumatic arthritis and there is no cure. Oh, we know that within the first year you may have a spontaneous remission, that perhaps as much as ten to twenty percent of our patients get better. Although sometimes even those have it come and go again.

"Remember, it isn't true that nothing can be done for this disease. Aspirin will kill the pain, and when your system can no longer tolerate aspirin, we've indomethacin, phenylbutazone and many other drugs all designed very nicely to ease inflammation and your pain; we've antimalarial drugs like chloroquine and hydroxychloroquine, and sometimes we use gold compounds, [gold compounds are now believed to interfere with and diminish the effectiveness of The Arthritis Fund treatment protocols] although I wouldn't advise it personally; and there are several others, like propionic acid derivatives and tolmetin....

"Then later, if you do not get better, we may give you cortisone shots -- adrenocorticosteroids. I'd not advise that either unless very urgent, as there are dangerous side-effects....

"Don't fret because the majority of patients with rheumatic arthritis can continue to lead active lives with varying degrees of restrictions. We must not seek a short-term solution, but plan for long-range management of your problem.

"There are no specific dietary recommendations,<sup>1</sup> but you should maintain a good balanced diet, and there are no indications of vitamin supplementation, unless, of course, you just happen to have a special vitamin problem, which I don't believe is true for you. [Nutritional support, vitamin-mineral supplementation is now known to be vital to altering the course of arthritic problems and returning the patient to health. Specific recommendations are available from The Arthritis Fund. S.C. editor] Weight reduction -- and keeping it off -- should have a high priority.

"You must have rest, and we must determine a program

of maintenance of joint function by physical measures, and also we don't want your muscles to atrophy. In other words, some kinds of exercises are a must, so long as you don't over-stress your joints.

"Then there is the inevitable depression and fatigue..."

"Depression?" you ask. "Fatigue?"

Do you need a lecture on depression and fatigue?

Sharp and dull pains bombard your each waking moment, until there is nothing left but for your analytical mind to attenuate, to close down, to push you into a state of emotional apathy that is beyond words.

Nothing, absolutely nothing on earth or beyond earth, can have meaning when you are at lowest ebb. Loved ones speak, and you groan, or turn-over, or at the very best you growl out, "I just don't give a damn!" and you mean it with every cell, every fiber of your being. Your spouse could move out at that instance, and you'd care not! Your beautiful children could be crying of ache and loneliness, and you'd care not! You could be told of inheriting a million dollars, and you'd care not! A flying saucer could land beside your bedroom window emitting five little green men, each carrying strange weapons that will evaporate anything they touch, and you'd care not!

You could die at that instant, and you'd care not!

Please physician, tell us about apathy and fatigue...

#### *Traditional Treatments*

But the body recovers with rest, although with lessened vigor at each interval, and morning comes again. You struggle to dress, to remove the coffee jar lid, to move about, and to bathe and go through the motions or easing your daily load.

Time passes. Another trip to the doctor, and another. Your medicine closet bulges: besides aspirin there is now Indocin®, Butazolidin®, Motrin®, Clinoril®, Tolectin®, Naprosyn®, Feldene®. Each day you take one or another with increased frequency.

You may be one of those whose system rebels further, and you may suffer eternal diarrhea, or you may have developed stomach ulcers, or some other insidious problem - just when you thought your body withstood all the problems it could bear...!

Little by little, over weeks and months, you watch fingers and toes turn and bend, despite rigorous exercises, and you constantly fight pain. There is absolutely nothing that can be done, except now and then expensive physical therapy might slow the terrible deformation if conducted under proper professional conditions, -- but eventually nothing helps when the very joints and cartilage and tendons themselves have been eaten alive.

Now you've become a ranking candidate for prosthesis, those wonderful steel and plastic devices that are transplanted into joints.

Terrible you say?

Not so! Not if your life consists of unmoving, continuous staring at a colorless, lifeless ceiling above your bed, and a terrible moment by moment waiting for someone to come and move you from hither to thither.

Joint by joint is destroyed by the raging inferno of your own immunological system, your life eating up yourself, and joint by joint can, perhaps, be replaced, until there is little you left at all, or until you finally, blessedly, succumb to the greatest depression of all -- death!

You are probably intelligent enough to know your future - you've seen so many others with this terrifying sickness. You've got choices. You can fight, do all the things your family doctor tells you to do: keep down inflammation and pain; exercise, but also rest frequently.

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

### *Non-traditional Treatments*

Or, like so many of us, you can ignore medical science and technical knowledge and react to hearsay, superstition, panaceas. You know! Copper bracelets;<sup>2</sup> cactus juice;<sup>3</sup> special diets; [these treatments have been clinically tested by The Arthritis Fund now, and have been shown to be helpful] faith healers; mumbo-jumbo of one kind or another.

Who can blame us?

There is no hope, because there is no known cause, we've been told; and every day the depression and pain and fatigue and weakness increases, as does the bending and twisting and distortion of ourselves.

You look in the faces of loved ones, spouses and children and grandchildren, who move with gay abandon and carry on life with zest that was once yours -- and you wonder - can you impose this frightful crippling burden on their wonderful future? Do you have the right? Do they have the obligation to suffer with you?

What kind of terrible sin have you committed, you secretly wonder, that the Lord put this on...

Somewhere secretly deep inside you've committed yourself to ending it all at just the right time if you can find a way to do so without hurting them.

Meanwhile, any hope, something is better than nothing at all, even if that something is simply fantasized hope! Who would take that away also?

So there is nothing you can do!

Live with it, and search for relief anywhere, everywhere, and hope or give up life completely -- that's our choice!

So we search in national newspapers for special arthritis cures -- if you don't like this week's, there's always another coming along next week just to keep our fantasies alive; we look into fancy diet books and magazines and organic health journals; we carefully listen to positive sounding, authoritarian faith healers, those men who are so sure that if we will just believe a higher power will reach out with a mystical touch and lo! we are healed; oh, how we donate to their favorite causes; and we drink this briny juice, or eat that tasteless herb, or we go on special diets that would normally make us very happy if we were herbivores; or we spend time and much money getting ourselves analyzed and explained away by one school of head-shrinks or another....

No matter, all the time the terrible fires rage, our joints puff and shriek with pain, and the inexorable horrible twisting and turning marches onward!

So Where From Here?

So here you are now, with this publication, with just another claim to cure. You're pessimistic, aren't you? You have a right to be. So, keep your pessimism.

If what follows makes sense, you'll try it, like you've tried so many other things that didn't work, even when they didn't make sense. If it is science, if it is proper medical practice, it'll work. If it works, you'll be well. If it doesn't work, you're no worse off, especially since the time and cost involved in this alleged "real cure" is relatively tiny, and especially since your own family doctor can be party to the cure.

What have you to lose? A six weeks trial at very little cost under your own family physician?

That's not much compared to an endless lifetime draining cacti of their sap, or eating alfalfa, or doing some other silly thing, is it? [Distrust of these traditional medicine approaches has now turned into appreciation of these approaches for many good reasons]

Read on, if you dare, if you can stand one more hope.

And God be good to you as he has already been good to so

many others....

1. Advice from some physicians differ. Dr. Robert Bingham, for example, states that 60% of rheumatoid arthritis patients have dietary deficiencies, and 80% have vitamin and mineral deficiencies. [This is now the consensus of most doctors associated with The Arthritis Fund.]

2. According to Professor Roger Wyburn-Mason, copper ions from a copper bracelet, on invading the bloodstream, can in fact weaken an amoebic infection which is the primary source cause of rheumatoid arthritis; but that the copper ion concentration from a bracelet source is not usually sufficient to reduce the infective population in the drastic numbers necessary. [Later, Professor Wyburn-Mason was able to demonstrate with others that pure metallic copper ions in stronger concentrations did constitute an effective treatment for many people. See *The Journal of the Academy of Rheumatoid Diseases, Vol 1, No 3. S.C.*]

3. According to Dr. Robert Bingham, Yucca juice is helpful for some rheumatoid arthritis patients. Its usefulness seems to come from its two most important chemical components: saponin, which facilitates the combination of oil and water aiding digestion and elimination, the other a vegetable steroid related to the cortisone family of drugs, thereby relieving symptoms. [Yucca has also been shown to have broad-spectrum antimicrobial effects in water treatment and has reversed arthritis in horses. S.C.]

## **Chapter II**

### ***Dr. Jack M. Blount's "Miracle"***

Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.



(On left) Left hip joint of Jack M. Blount, M.D., which shows normal head and acetabulum (socket).  
(On right) Right hip joint of Jack M. Blount, M.D., which shows abnormal (fragmented) head and acetabulum (socket) caused by rheumatoid disease (aseptic necrosis). X-rays taken December 11, 1975.



Right hip joint of Jack M. Blount, M.D., showing Charney's prosthesis and acrylic socket, March 21, 1976.

Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.

### *Dr. Jack M. Blount's Gift to Humankind*

Dr. Jack M. Blount's story is an emotionally gripping account of a man who has been to the very depths of hell and has come back to tell us how he escaped the fires. He tells his story simply, without any attempt to embellish, and it is told with a genuineness that makes you believe in his continued concern for your health and welfare. In this chapter Dr. Blount will tell his own story in his own words. Keep in mind that he is cured of the ravages of rheumatoid arthritis, that he has since treated better than 16,000 patients successfully, and that he freely gives of his knowledge to any who ask. He is a man who was active physically in his youth although his symptoms began as a systemic illness in his teens with muscle pain, metatarsalgia (pain in the foot), lumbago (pain in the back), intercostal (between ribs) pains, iridocyclitis (inflammation of eye), psoriasis (skin lesions) and that eventually he got pains in the joints, generalized arthritis with effusions (fluids into joints), carpal tunnel syndrome (compression of nerve in wrist), paresthesia (loss of feeling or perverted sensation), ulcerative colitis (sore or inflammation of colon), aseptic necrosis (death) of a femoral head for which a prosthesis (steel and plastic joint) was inserted, etc. He was reduced to total invalidism and took to alcohol, morphine-containing drugs, barbiturates and was a terminal case. He had to give up his medical practice in March 1974 and had taken steroids for more than twenty years.

#### *Dr. Blount's Story: Rheumatoid Disease is of the Entire Body*

I cured myself and more than 16,000 others of an incurable illness. RHEUMATOID DISEASE. I call it a MIRACLE.

I had rheumatoid disease. Rheumatoid disease is a disease of the entire body, not of just the joints although most of the pain and destruction seems to be in and around the joints. I was hopelessly ill.

In the Spring of 1974, I had developed aseptic necrosis (complete destruction) of my right hip socket and femoral head. I had to quit work (private medical practice) and take to the bed. The only thing that would help was a hip replacement with a prosthesis. The orthopedic surgeon that I went to said at first he would do the operation but then changed his mind giving the excuse that because I was only fifty-two years old at the time I was ineligible. They didn't know, yet, how much dependence to put on the procedure.

#### *Despair*

Despair set in; I could only lie in bed and stare at the ceiling. The cure of my illness was hopeless. No one knew the cause. No one knew anything useful to do for it. The usual advice was to take a lot of aspirin and learn to live with it. Pharmaceutical companies tried to improve on aspirin and gave us Butazolidin®, Indocin®, Motrin®, Tolectin®, Nalfon®, Naprosyn®, Clinoril®, Meclomen®, etc. They called these "nonsteroidal anti-inflammatory" agents: all were useless except for some analgesic effect.

"Cortisone" was introduced in 1949 and was hailed for a while as the long awaited answer. It was, and still is, the quickest relief of arthritis symptoms, but it causes devastation worse than the disease. These adverse effects included hyperadrenalism (Cushing's Disease) diabetes, ulcers, weakened bone, (decalcification) etc. I took a form of this for about twenty years.

While lying in bed, my arthritis became complicated by colitis, with diarrhea of sometimes up to twenty times a day, kidney stones, alcohol, and drugs. I was in and out of hospitals repeatedly. I thought I would surely die. Friends kept sending word that they were praying for me. I often thought of committing

suicide. The pain and agony were unbearable. One morning after I had accumulated about forty Seconal® capsules (sleeping pills) I swallowed them all. Four have been known to kill. I didn't want to kill myself, but I couldn't endure such perpetual agony. After some hours, my wife found me unconscious; and on finding the empty bottle, she knew what I had done. I awoke very groggy and tied to a hospital bed. After regaining enough sense to know anything at all, I wanted to know if I had been apneic. (Had I been deprived of oxygen long enough to cause permanent brain damage?) I was assured the answer was "no." Despite such an overwhelming dose of sleeping pills, I had continued to breathe adequately without supplemental oxygen or assisted breathing. This was a miracle in itself. "Somebody up There" was not ready for me.

#### *Why Was I Saved?*

Back home I kept breathing but hardly living. Why was I still here at all? I had been waiting for some earthly savior and none came. Was there some "learned University professor or researcher" somewhere who knew something to do?

#### *The Miracle of Professor Roger Wyburn-Mason*

One day in the spring of 1976, I came across an article in *Modern Medicine*<sup>1</sup> entitled "Rheumatoid Disease: Has One Man Found the Cause and Cure of Rheumatoid Disease? Arthritis?," written by Robert Bingham, M.D., practicing in Riverside County, California. Dr. Bingham, orthopedic surgeon, had heard of work done by Professor Roger Wyburn-Mason, Richard Hill, Surrey, England, and had gone to England to interview the Professor. His article told about how the English researcher, practitioner, microbiologist, had determined that the etiological agent (cause) of rheumatoid disease is actually a germ, a protozoan, an amoeba, similar to the "lettuce bug" amoeba that causes dysentery. He also reported that a chemical (in fact, several chemicals) had been found that would kill the "bug" in patients without killing the patient.

He was curing people who had the disease that was killing me. The chemical (medicine) that the Professor was using successfully was called clotrimazole.

That's wonderful, but how could I get some for myself? It was not and still is not on the market anywhere in the world for systemic use.

Finally, in the Spring of 1976, my orthopedic surgeon decided to operate. They removed the upper part of the right femur with the femoral head and reamed out the acetabulum (socket). The socket was filled in with plastic to make a new one and the bone was replaced with a "comma-shaped" steel rod with the pointed end inserted down into the marrow, distally, of the remaining femur.

Now, I thought I would recover. But recovery was terrible. I still needed my pain medicine and booze. My brother became disgusted with me and had me sent to an alcoholic ward and "detox" center at the State Hospital. After a month there, I was off everything addicting except my daily early morning "Cortisone." I still had my rheumatoid disease -- my germs, the amoeba. I still had to rid my body of them. The operation seemed to give them new life.

Somehow, I remembered that clotrimazole is the active ingredient in a preparation used to treat yeast and fungus infections of the skin but it was just one part clotrimazole plus ninety-nine parts propylene glycol, car antifreeze - Prestone®. This is poisonous to man if taken internally.

I decided to telephone Delbay, the company that puts the mixture together, and see if I could get clotrimazole that hadn't been mixed. The answer was "no." They were afraid of the U.S. Food

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.** and Drug Administration.

Failing with that endeavor, I started wondering if there might be something else almost the same that would work. I looked at the word clotrimazole and focused on the azole. I looked that up in the medical dictionary and found that the parent of this is Imidazole. Somehow I remembered that I had heard that word somewhere before. I kept repeating it. Then I remembered that this is the chemical name of the medicine metronidazole, or Flagyl®. I compared the formulas of the two and they looked close enough alike that I thought it was worth a trial. We had had Flagyl® since 1962 and used it to cure amebiasis (intestinal) and vaginal Tricomonas infections. It was known to be able to kill both of these protozoa. I decided to try it. Later I pulled out a drawer in my bath room, and there was a bottle of one hundred Flagyl® tablets. A MIRACLE! God had put the answer to my illness that close to me.

How should I take it? I realized that the small dosages that were recommended for Tricomonas and intestinal amebiasis would not do any good. If it would have, someone would have discovered it accidentally. I checked the medical text books and saw that it had been given in doses as high as three tablets, 250 mg, three times daily. That is the amount I started to take.

#### *Experiment On Myself*

I didn't know how long to continue taking it. I didn't know if it would kill me. I realized I didn't have much to lose; therefore, I took all I had which lasted eleven days. On the morning of the eleventh day, I got nauseated while brushing my teeth -- and emptied my stomach. Then I knew I couldn't take anymore even if I had had more readily available, so I stopped.

But during these eleven days, a miracle had begun to happen. My arthritis started getting better. I awoke in the middle of the night and realized that the soreness, stiffness, and swelling had started subsiding. I looked at my hands which had been so bad and now were so much better. I couldn't hold back the tears. I started praying and thanking God.

After that, I didn't know how much was enough. I knew that I was still sick. I still had sweats and felt cold. I was bound to still have the infection. After two weeks, I decided that I needed more. I restarted taking three 250 mg tablets three times a day. I took it for eleven days more; and on the eleventh day, I got nauseated again. But I was surely improving by the day. I decided to continue this pattern.

#### *More Successful Patients*

I decided to find out if some of my former arthritis patients were brave enough to try it.

I telephoned them and invited several of them to my home, one at a time. To each I explained what it was all about. Every single one was eager to try it; nothing else had ever helped. Why not? During the Summer of 1977, about thirty of them were treated and most of them had the same good experience that I had. Some got nauseated from the start and decided to quit.

Among the thirty, was a Reverend Ethel Beall. Brother Beall not only had arthritis, but had lost a leg due to an automobile accident. The bone in the stump of the leg had gotten infected and drained constantly and was always painful. During this treatment period with Flagyl®, his arthritis got better and his leg got well and stopped hurting. (Several months later he died suddenly of embolus [blood clot] while recovering from a prostate operation).

#### *Well Again!*

After 8 months, I was able to return to my private medical practice on a limited basis. I had been out three and one-half years. On September 1st 1977, I was back in the office seeing patients by appointments.

I decided to write Professor Roger Wyburn-Mason in England and tell him of my experiences. I owed him my life. He answered immediately and said that he had decided to include my case in a book he was writing. *The Causation of Rheumatoid Disease and Many Human Cancers -- A new Concept in Medicine*. My story appears on page 205 in the book, which was published in Japan in March 1978 by a Professor T. Koba, who obtained the original manuscript from Professor Wyburn-Mason.

We continued to correspond, and I visited with him during the Summer of 1978. He told me that he tried metronidazole at one time and it didn't work. His dosage was not adequate; he had tried giving only 250 mg three times daily. However, later he gave 750 mg three times daily, and it did work about equally as well as clotrimazole. He found other nitroimidazoles that would do the job, also.

Lately he has found three commonly used medications that are amoebicidal when used in high doses: furazolidone, allopurinol and rifampicin.

His experiments proved that Flagyl® and the other nitroimidazoles are excreted slowly from the body and it is not necessary to give them on a daily basis. After giving a loading dose for two days there is an effective blood level (for killing the amoebae) for several days more. During the past six years, I have treated more than 16,000 arthritic people with very gratifying results. Some are cured of the disease while in others it has been arrested. People are now coming from all over to share in the miracle.

Professor Roger Wyburn-Mason should be nominated for the Nobel Prize in medicine.

#### *Prayer for the Entire World*

I pray that the entire world will soon know and people every where can receive the same relief that I have. What a joy I know now!

I thank God!

This information is free to whomever will take and use it. I need no wealth and seek no fame.

---

1. *Modern Medicine*, "Rheumatoid Disease: Has One Investigator Found Its Cause and Its Cure?" Robert Bingham, M.D., Feb. 15, 1976, pp. 38-47.

2. Published by Iji Publishing Co., Ltd., Japan (\$125). Out of print. Limited number have been donated to medical libraries (USA) by Jack M. Blount, Jr., M.D. Addenda (precis and summary) available from The Arthritis Fund (\$10); also write for information on loan copies of basic work.

---

#### **Important Note**

William Renforth, M.D. (Connersville, IN, USA) deserves respectful praise for research of nitroimidazoles prior to 1977, distributing information and pioneering in the use of metronidazole for treatment of Rheumatoid Disease. Dr. Archimedes Concon (Memphis, TN) following a non-amoebic theory, also effectively used metronidazole for RD prior to 1976. [From time to time historically important papers will be published by The Rheumatoid Disease Foundation, now The Arthritis Fund.]

---

#### **Chapter III**

##### ***The Author is Also Cured***

##### ***The Beginning of Arthritis***

In 1978, the author, at age 53, began suffering from the first pangs of rheumatoid arthritis, although at the time it was passed off as simply unimportant, transitory pains in toes and

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**  
fingers and groin of unknown origin.

By choice, the author slept on a hard, cotton-pad, but slowly shoulder pains became so great that foam padding had to be overlaid.

Later visits to medical specialists brought out that the pains were from “degenerative arthritis.” This diagnosis was confirmed by medical doctors at the Veteran’s Administration Hospital.

#### *Fatigue and Depression*

During the following year, the author began experiencing a kind of fatigue that sapped strength and made for a hopeless despair at times which was never part of his former life. Considering the fact that the author had normally worked more than one job or position, had stayed busy seven days a week writing or teaching, or working about the yard and house, and now he had listless and suffering periodic bouts of almost complete apathy, it became clear early that something more serious was wrong. During one of these severe periods, when apathy was deepest, a misunderstanding with spouse triggered off a divorce after thirty years of marriage and ten children.

Since there seemed to be a medically defined distinction between rheumatoid arthritis and degenerative arthritis, and the writer was told (wrongly) that the former required considerable more rest and the second required active exercise of a moderate nature, this writer undertook to begin learning to play the piano and to also dance.

There’s little question that the various physical exercises kept joints fluid,<sup>1</sup> although painfully so at times, but the greatest puzzle was in the fact that within two years of the initial diagnosis of “degenerative” arthritis, the small finger on the right hand began to turn sidewise, and a typical rheumatoid arthritis and hard nodule had begun to form at this joint.

#### *Pains Increase*

Pains continued to increase at various joints; and finally, about three years into the disease, the hands began to flush red and hot and to swell, especially on arising early mornings. A great number of like symptoms lasted throughout the day.

It became almost impossible to type on the author’s regular manual typewriter, because of pain kick-back to the joints.

Now the little finger on the left hand began to twist also, and all the joints at the hands began to almost glow a fiery red.

The author was having difficulty opening ordinary bottles; catsup, pickle jars, soft drinks; and the problem of opening sacks of peanuts became a procedure of first cutting the celluloid wrappings with a knife, instead of gripping and tearing with fingers.

Lifting pots and pans became an exceedingly painful chore.

Changing a tire without help was excruciatingly difficult.

His children could not understand why the author’s habits had changed so drastically. Once there was nothing he would ask them to do in the way of farm or house maintenance that he, himself, would not chip in to do.

Hopelessness extended from self to family to friends, and finally even to passing acquaintances who could instinctively sense the unhappiness carried about by this rapidly aging man.

How could one make fast friends when daily his body was changing, and daily one became weaker and more ineffective with everything touched?

How could long-range commitments be kept, or strong personal relations be acknowledged? How fair is it to impose on those you love such burdens: future helplessness and twisted grotesqueness?

The author was sufficiently imaginative to know where it would end, and frankly did not want to burden anyone with what

was coming. He would rather be dead than crippled and helpless and apathetic and sapping the youth and vitality of his children.

Still, the author, having had an extensive scientific background (mathematics, chemistry, physics, psychology) and also a very wide-ranging background in many different disciplines, started searching through technical literature (just as did Dr. Blount) and talking to people. Only by fortuitous accident did he come to be helped by Dr. Jack M. Blount, and it came about through this series of connections:

#### *The Discovery*

A daughter-in-law knew of the author’s terrible pains and his search in the literature. She mentioned the author’s search to parents. They had a friend who’d been to Dr. Blount and had been cured. They suggested to her that her father-in-law write to Dr. Blount.

Like so many others in like predicament, the author sent out the letter, not with great anticipation -- frankly, he thought he’d be fluffed off to his family doctor -- but because by now (as those with the condition know) one cannot afford to overlook anything.

Lo! A most amazing answer came back, consisting of three pages, that described Dr. Blount’s own search and cure, as told in Chapter II above; and in that correspondence was embedded the name and amount of the drug necessary to produce the cure -- *at no expense to the author.*

#### *The Cure*

The author tried Dr. Blount’s treatment, which lasted six weeks. Here’s what happened:

- After two weeks, the puffiness and redness of fingers disappeared for the first time in a half year.
- After four weeks, the pain, depression and fatigue ended.
- After seven weeks, the redness of finger joints nearly disappeared.
- After seven weeks the author’s attitude toward life and people changed remarkably, and again he feels like life is worth the effort, and so are people and personal relations.

There are still problems. The twisted little fingers are still distorted, and they still hurt when used. Damaged joints may never heal, but where capillaries exist, over time, healing may again proceed faster than self-destruction. There is some redness of the other finger joints from time to time, especially when used for long periods at the typewriter. There is still some pain of other joints here and there. Dr. Blount says that experience shows most of these residual pains will settle out in time.

But, the author can daily turn more bottle tops, and lift heavier loads, and wrestle playfully with another without screaming bloody murder!

And best of all, extreme apathy is gone, as is middle-of-day fatigue!

Can there be a better gift from one human to another, than this, that health and happiness is restored, and at no cost, except that of minor medicines?

Need the author state: I love Dr. Jack Blount and Professor Roger Wyburn-Mason, the first for courage, fortitude and charity, the second for wisdom, persistence and intelligence!

---

1. According to Professor Roger Wyburn-Mason, all forms of arthritis should be rested, as joint activity increases inflammation and pain and prevents healing.

## **Chapter IV**

### **The “MIRACLE” Treatment Recommended Treatments**

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

To your family doctor, we say: *Antiamoebics have never been considered for use against rheumatoid diseases because the various arthritis associations have not yet*

*investigated Professor Roger Wyburn-Mason's brilliant scientific work, published now since 1964.*

*You must decide if the prescriptions that follow are harmful to your patient. If not, is the cost involved worth a trial, considering the hopeless and insidious nature of the diseases?*

*Many cooperating physicians are using the protocol that follows:*

**The Roger Wyburn-Mason**

**&**

**Jack M. Blount Foundation**

**for Eradication of Rheumatoid Disease**

7111 Sweetgum Drive SW, Suite A, Fairview, Tn 37062-9384;  
(615) 799-1002

**The Rheumatoid Disease Foundation,  
now The Arthritis Trust of America**

A non-profit, charitable, tax-exempt organization

The Rheumatoid Disease Foundation through its cooperating physicians in a committee chaired by Robert Johnson, M.D. (Charleston, SC) has established the following standards of practice when treating rheumatoid disease. These are suggested standards. Many physicians will exceed these basic standards. What follows is an outline developed through research and experience of cooperating physicians. A SIMPLE AND INEXPENSIVE CURE/REMISSION FOR RHEUMATOID DISEASES IS SET OUT IN WHAT FOLLOWS. DRAW YOUR DOCTOR'S ATTENTION TO THE MEDICATIONS THAT OTHER PHYSICIANS ARE ALREADY USING EFFECTIVELY. IF YOU DO NOT HAVE A FAMILY DOCTOR, WRITE FOR OUR LIST OF COOPERATING PHYSICIANS.

Your family physician should know that there are at least two genus of *limax amoebae* (one-celled animal life) that cause Rheumatoid Disease if you are genetically susceptible to it, or its products: *Acanthamoeba* and/or *Naegleria*.

Within these two genus, are many species, and strains within species, and they vary considerably in their ability to adapt to various antiprotozoal agents. Where one antiamoebic will kill one organism inside they body, another will not, and which organism affects you can only be learned by trial and error. Success rates from the first application of the treatment program listed below varies from 78% to 95% depending on which physician and which group of patients is being treated. The success rate is higher whenever further applications of the appropriate antiamoebic is used.

If the first treatment does not bring about a Herxheimer reaction, the physician is advised to move to another antiamoebic, and in any case, both this Foundation as well as any of the cooperating physicians will be more than happy to share their experiences.

The Foundation cannot, of course, be responsible for mal-application, mis-application, or inappropriate treatment of any kind, and again suggests that all treatment, if possible, be through your family physician.

#### **Rheumatoid Disease Protocol**

The central theme of treatment is based on the preliminary work of Professor Roger Wyburn-Mason and Jack M. Blount, M.D., and later findings or Robert Bingham, M.D.; it also seeks to introduce physicians to alternative or extended courses of treatment that have been found to be useful by other physicians in the

organization, the goals being to: (1) arrest rheumatoid disease, (2) repair damage caused by rheumatoid disease, (3) further the maintenance for wellness.

This protocol is intended as an outline, and cannot serve as a "course in treatment" for rheumatoid disease. It is necessary for each physician to pursue his/her own intricacies of modalities mentioned.

#### **I. Diagnosis: Shall be made on the basis of**

##### **A. Patient History - to include**

1. Time of onset
2. Degree of disability
3. Family history
4. Remissions and exacerbations
5. Contributing factors
6. Previous treatment modalities and results thereof
7. Activity pattern
8. Medications being taken

##### **B. Physical Examination**

1. General appearance
2. Weight and height
3. Blood pressure and pulse
4. Head and neck
5. Cardio-vascular system
6. Abdomen
7. Musculo-skeletal system (to include evaluation of

joints)

##### **C. Laboratory testing**

1. Urinalysis
2. SMAC -24
3. Rheumatoid pane (to include sedimentation rate and CPR)
4. Analysis of synovial fluid (when present)
5. Other (as indicated)
6. Electrocardiogram
7. X-rays of affected joints (if indicated)
8. Any of the above that have been performed by another physician within the past 60 days may be utilized at the discretion of the treating physician.

#### **II. Treatment: (several treatment regimens are available)**

##### **A. Oral Medications**

1. Nitroimidazoles
  - (a). Metronidazole
  - (b). Tinidazole
  - (c). Clotrimazole

Whichever nitroimidazole is used, the dosage (modified by weight) is the same: 2 grams for two (2) days each week X6 weeks. (Children 250mg/25 pounds body weight).

2. Furazolidone (Furoxone) 100 mg q.i.d. X1 week
3. Iodoquinol 650 mg t.i.d. X3 weeks
4. POTABA 2 grams 6 times daily X2 weeks
5. Allopurinol 300 mg t.i.d. X1 week (this in conjunction with one of the above 5 antiamoebics - 1.(a), 1.(b), 1.(c),2,3. --used together acts as broad spectrum antiamoebic).
6. Rifampin or Rimactane 600 mg daily X1 month (If reactions are severe, stop treatment immediately).

##### **B. Injections**

1. Intraneural Injections (technique of Dr. Paul K. Pybus, Dr. I.H.J. Bourne)
2. Cleveland Clinic treatment (method of Jack M. Blount, M.D.: Lumbar subarachnoid injection of 2.5 cc of 0.3% procaine with 20mg Depo-Medrol)

##### **C. Nutrition** (to include vitamin and mineral supplements)

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.** as well as counseling relative to diet. [Updated guidelines are now available through The Arthritis Trust of America for this nutritional support. Ed. S.C.).

**D. Steroids** -- the use of Prednisone 20 mg daily X5 days or Depo-Medrol 40 mg injection X1 will reduce considerably the Jarisch-Herxheimer reaction often seen when initiating therapy (See *General Information*).

**E. Ancillary treatment modalities** (as used by various advisory committee members).

1. Mega vitamin dosage (Prosch, Reich, Bingham)
2. Chelation therapy (American Academy of Medical Preventics -- AAMPS)
3. Hot mineral baths (Bingham)

**F. Return visits**

1. Return visits should probably be in 1 week, 3 weeks, 6 weeks, then every 3 months thereafter.

2. Preventive maintenance: It usually helps to prevent the recurrence of rheumatoid disease if the patient is given a round of treatment with Allopurinol at 6 months post-original treatment and every 6 months thereafter. If symptoms are present, the entire original treatment regimen should be repeated. Allopurinol can cause a very severe reaction on the second round of treatment -- Wyburn-Mason).

**G. General Information**

1. Most patients will need counseling about diet and nutrition.

2. Explanation of the Jarisch-Herxheimer reaction often will prevent patient drop-out in many cases.

3. Since Metronidazole is the only nitroimidazole currently available in the United States, it is probably the drug of choice for beginning treatment.

4. Utilization of the "Cleveland Clinic" injection and intraneural injections should probably be reserved until the individual physician has had the opportunity to learn the technique from a physician already using it.

5. Most of the foregoing treatment is directed toward rheumatoid disease. Osteoarthritis has been found to respond much less dramatically, although it does often show some degree of improvement. (Best results seem to be achieved with intraneural injections.)

6. Rationale for treatment with antiamoebics: Based on Dr. Roger Wyburn-Mason's work which demonstrated free-living *limax amoebae* to be the causative agent in rheumatoid disease, amoebicidal drugs have been postulated as a treatment of choice. When these drugs kill the organism, the release of foreign proteins usually results in a Jarisch-Herxheimer reaction (similar to the old arsenic treatment for syphilis). This results in a temporary generalized increase of rheumatoid symptoms with the administration of an antirheumatic drug.

7. Drug reactions

(a). *Rifampicin* -- violent Herxheimer. In this event, discontinue treatment with rifampicin at once.

(b). *Allopurinol* -- leg pain, temperature spike, chills, sweating, rash on body and face.

**This protocol is subject to revisions (additions, deletions, changes) as The Rheumatoid Disease Foundation, now The Arthritis Trust of America completes relevant research.**

Perry A. Chapdelaine, Sr.

*Executive Director/Secretary*

Revised 1985: Physicians & Scientists Committee

Since alcohol in presence of antiamoebic (*metronida-*

*zole, Allopurinol*) (or antibiotics) makes some people sick, it may be best not to take any alcohol during period of treatment of six weeks. (The medicine will stay in the body during the first four weeks. Also sometimes alcohol destroys certain chemical compounds and, in the case of several antiamoebics, alcohol is definitely not a good idea.

If you are taking other medicines, such as anti-inflammatory drugs for arthritis, and other than cortisone compounds, you may continue taking them. There will be no conflicting side-effects. However, for the most part, it is best if you *check with your family physician when determining possible contra-indications of other medicines.*

Cost of these medicines may vary from \$37 to several hundred dollars depending upon your treatment, the pharmacy with which you trade, and the length of the treatment.

Please keep in mind that every physician including your own will have additional treatment modalities in mind: nutritional guidance, exercise, strengthening of the immunological system by various techniques, chelation therapy, hot baths, and so on. You should understand what your treatment will consist of in advance, and why, before rejecting your physicians directions out of hand.

**However, in no case should you permit the use of gold shots or penicillamine at the same time you are taking antiamoebics.**

**The response of patients to the above medicines is often inhibited by long-continued, previous treatment with gold injections, penicillamine or corticosteroids.**<sup>3</sup> East patient must be considered and studied independently, for the most effective treatment.

And while the former use of gold shots and/or penicillamine does not necessarily mean that you will not respond (many do), it may mean that you must find a way to chelate out the residual gold prior to having effective antiamoebic treatment.

F.M. Logsdon, M.D. (TX: deceased) developed a technique that seemed effective using the American Academy of Medical Preventics (AAMPS) treatment protocol for chelating out residual gold, following the progress through several chelations via laboratory tests.

*On the Herxheimer*

From experience, your primary rheumatoid arthritic symptoms should begin to be alleviated within a day or so, although it is not unusual for several weeks to go by before changes are observed.

In particular, *one should know that the fever and swollen feeling and swollen appearance of joints may be increased at first.* The symptoms may appear very similar to flu symptoms: flushing of skin, sweating, aching bones, fever, headache, sometimes running nose . . . like a foreign protein reaction. This is the Jarisch-Herxheimer reaction which is a "transiently increased discomfort in skin lesions and temperature elevations occurring . . . after start of antiamoebic treatment . . .," according to a medical dictionary.

You may also be quite allergic to the proteins (and /or the toxic products) of the rapidly dying protozoa that swarm in your body, and the Jarisch-Herxheimer reaction is related to that "allergy," a phenomenon very similar to a serum reaction.

However, despair not! Within days to weeks at most, this reaction (if you have it) will be lessened, and you will be pleasantly surprised!

---

The use of antiamoebics for treatment of Rheumatoid Disease was introduced by Roger Wyburn-Mason in 1964 in the Henry Kimpton/Charles C. Thomas publication, *A New Proto-*

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

zoan and also at the IXth International Conference of Chemotherapy held in London, England in July 1975.

Chief antiameobics recommended by The Rheumatoid Disease Foundation, now The Arthritis Fund, are imidazoles where substitution has been made in the ONE position (Dr. John R.A. Simoons, Pharmacology).

These compounds are amoebicidal *in vitro* against species of *Naegleria* and *Acanthamoeba*.

Metronidazole does not fit in the above classification, and is not amoebicidal *in vitro* against the named genus. Since Metronidazole works *in vivo* we speculate that one of its two chief metabolites, both azoles, and resulting from intestinal bacterial action, may be the active substance(s). [And some of these related compounds may also be effective against *Candida albicans*, Cell Wall deficient candida, Cell Wall Deficient bacteria, and macrophages believed to be responsible for autoimmune activity, which may have been what Wyburn-Mason had identified as amoebae. The appearance of all these single celled forms are nearly identical. See *The Journal of the Academy of Rheumatoid Diseases*, vol 1, no 3. Ed. S.C.] (Metronidazole is the only Nitroimidazole available in the United States). Antibiotics, of course, can knock out desirable microflora. [Acidophilus supplementation was later recommended partly to help the body metabolize Metronidazole into its effective metabolites, and partly to make up for the destruction of desirable microflora important in digestion. Ed. S.C.]

Wojtulewski evaluated clotrimazole in a double-blind study, finding that compound "effective in the treatment of Rheumatoid Arthritis and superior to Ketoprofen." ("Clotrimazole in Rheumatoid Arthritis," *Annals of the Rheumatic Diseases*, 39: 469-472; 1980.)

The Rheumatoid Disease Foundation, now The Arthritis Trust of America, is funding placebo controlled, double-blind studies at Bowman Gray School of Medicine, Wake Forest University, Winston-Salem, ND (Chief Investigator, Robert A. Turner, M.D., Chief, Rheumatology Section).

The Rheumatoid Disease Foundation, now The Arthritis Trust of America, following the life-time work of Professor Roger Wyburn-Mason, views Rheumatoid Disease as consisting of perhaps more than 100 different presenting symptoms, depending upon which tissues are affected by which genus, species, or strain of *limax amoebae* [abnormal macrophage, Cell Wall Deficient bacteria, candida strain, etc. Ed. S.C.]. Key to understanding the treatment protocol is observing the Jarisch-Herxheimer effect (flu-like-symptoms) accompanying the use of antiameobics. When treating Leprosy, the phenomenon is known as Lucio's Phenomenon. Treatment of tuberculosis, and the historical arsenic treatment of syphilis creates the same phenomenon.

While The Rheumatoid Disease Foundation, now The Arthritis Fund, views the *limax amoeba* theory as being the most probable (and workable) hypothesis in explaining and bringing about cure/remission of Rheumatoid Diseases, it recognizes that a multiplicity of factors are at work, including genetic susceptibility, nutrition and other good health rules; and it does not view free-radical explanations as being inconsistent with the *limax amoeba* hypothesis.

One difficulty seen in hindsight has been in distinguishing between the disease as an on-going process and the damage done by the disease.

The disease can be stopped but many of the symptoms having resulted from the disease -- the damage done -- may prevail, requiring other treatment protocols: nutrition, chelation, exercise, surgery, et. al.

Open studies, using various antiameobics in the treat-

ment of Rheumatoid Diseases by Drs. Robert Bingham, Gus J. Prosch, Jr., Paul K. Pybus depict results varying from 78% to 95%. [Anna Boland's, M.D. (Korea) figures are less successful while Sheldon Nelson's, D.O. (Michigan) are more successful.]

Traditional, anticipated placebo effects in an open study would not be greater than about 33%. Results showing 78-95% are considerably beyond placebo expectation.

[Wyburn-Mason/Pybus intraneural injection studies show excellent results when treating pains of Rheumatoid Disease and Osteoarthritis. Additional independently conceived and developed intraneural injection studies are available from Dr. I.H.J. Bourne (Richmond, Thorndon Approach, Herongate, Brentwood CM 13 3PA, England).]

In a letter to Dr. John R.A. Simoons, July 7, 1984, Gus J. Prosch, Jr., M.D. says;

Let me make some general statements concerning past observations and studies that I have concluded to be the truth in treating Rheumatoid Disease with antiameobic drugs.

1. I recently completed a research project concerning the treating of 200 patients with Rheumatoid Disease with antiameobic medication. The primary antiameobic used was Metronidazole, and when the desired response was not forthcoming, I used other

antiameobics such as Allopurinol, Furazolidone or Rimactane. Final analysis demonstrated 78% good to excellent (cured or in remission) results and 22% showing poor to no result. All patients having a favorable response had some Herxheimer

reaction and those showing poor to no response demonstrated very mild to no Herxheimer reaction. Incidentally, no serious side effects were observed from the medication.

2. The amoeba (or offending agent) can involve (or infect) any body tissue, organ or system.

3. If involved (or infected), that tissue, organ or system can demonstrate some form of a Herxheimer reaction when antiameobic medication is introduced into the body.

4. With the initial introduction (1st week) of the antiameobic medication, the Herxheimer reaction can be so severe that patients become fearful that the medication is doing them great harm and may want to stop the treatment. For this reason, a single initial injection of 20-40 mg of Depot Medrol is usually given to lessen the severity of the reaction.

5. After the second week of medication, the reaction gradually begins to subside, as fewer amoebae (or offending germ or agent) are killed and less antigen is released in the body.

6. If a patient has any Herxheimer reaction following the sixth week of medication, the patient is still infected and further treatment is indicated.

7. Long standing or chronic Rheumatoid Disease responds slower than acute disease.

8. If a patient being treated with antiameobics does not have a Herxheimer reaction, the patient simply does not have Rheumatoid Disease or the particular amoebae (or offending agents) are resistant to the particular antiameobic medication being given. [There is also a possibility of lack of appropriate stomach bacterial flora to metabolize the imidazoles and/or enzyme deficiencies in the patient. Ed.]

9. Herxheimer reaction signs and symptoms:

a. General and usual: Sweating and especially night sweats, diarrhea, nausea, vomiting, headache, fever, general malaise, flushing of skin, anorexia, aching bones and "flu" symptoms resembling a serum reaction.

b. The inflamed and affected tissues become more in-

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

flamed and tissues previously unknown to be involved become inflamed.

c. If the urinary bladder tissues are infected, patients may develop signs of full blown cystitis.

d. If the heart, pericardium or cardiac tissue is infected, the patient may develop some paroxysmal auricular tachycardia, premature ventricular contractions or ectopic beats.

e. If the brain or meninges are infected the patient may develop severe (temporary) depression, lethargy, generalized weakness, temporary memory loss (personal experience), irritability along with headaches.

f. If the mouth tissues are infected, a bitter and/or metallic taste may be noted along with mild shedding or peeling of the mucosal tissues. This has also been noted in the rectal tissues.

g. When the periosteal tissues and skeletal muscle tissues are involved, fairly severe bone pain usually accompanied by severe muscle pains and spasms may be observed, usually at night.

h. When the lungs and bronchial tissues are infected, the patients may develop bronchitis symptoms and occasionally pneumonitis (resembling viral) has been observed.

From the above, one can easily see that most all of the previously observed side effects of [antiamoebics] may also be simply manifestations of the Herxheimer reaction. Therefore, a clinician that is not totally knowledgeable concerning these possible signs and symptoms could easily mistake the Herxheimer reaction for possible side effects of the [antiamoebic]. Should this information not be taken into consideration, a misleading and false evaluation of any adverse experiences by various patients caused by the [antiamoebics] will be inevitable . . . the medicine could be labeled more dangerous than it actually may be, and the aggravated symptoms could be misconstrued as an intensification of the disease being treated. The information and the above facts *must be considered* in evaluating [antiamoebic] effectiveness and side effects [when treating [patients].

1. Herxheimer, K., *Dtsch. Mewd. Wschr.*, 1902, Vol. 28, p. 895.

2. From Phil Gunby, *JAMA*, "Allopurinol Treatment for Protozoan Infections?" Vol. 240, No. 18, Oct. 27, 1978, p. 1941-1942; The *Limax amoeba* has a fatal flaw -- a unique enzyme system that transforms Allopurinol into a toxic (to the amoeba) adenine analog, 4-amino pyrazolopyrimidine. This analogue then is incorporated into their nucleic acid, with fatal results for the protozoan.

3. *The Causation of Rheumatoid disease and Many Human Cancers — A New Concept in Medicine - A précis and Addenda Including the Nature of Multiple Sclerosis*, The Arthritis Trust of America, 7111 Sweetgum Drive SW, Suite A, Fairview, TN 37062-9384, 1983, p. 3.

Prior to F.M. Logsdon's (M.D.) recent death, he suggested that residual gold could be chelated from the patient by means of several EDTA treatments, using American Academy of Medical Preventics protocols. Following up the residual gold measurements by means of sera tests, he was apparently successful with several patients who thereafter responded to antiamoebics. Whether or not this will work for all, most, or many is unknown.

## Chapter V Cooperating Physicians and Scientists How to Contact Them

The Rheumatoid Disease Foundation, now The Arthritis Fund, recommends that you take this book and its described

treatment to your family physician. He/she will be given every cooperation, without charge, to help you get well.

If your family physician is unwilling to learn this treatment, then we suggest that you search your city for a physician who is open-minded. After all, it is your file — not the physician's — and you have a right to the treatment of your choice.

Try, first, those physicians who are involved with preventive medicine as they are often more open-minded than the strict allopathic physician, who wants to prescribe standard drugs according to standard practices, whether you get well or not.

And do not be afraid to try osteopathic physicians, [chiropractic physicians, and naturopaths], the D.O., D.C., and N.D., after their names being just as significant as an M.D.

If all else fails, then you may write to The Arthritis Trust of America, 7111 Sweetgum Drive SW, Suite A, Fairview, TN 37062-9384, [(615) 799-1002] for a current list of physicians who've agreed to use these procedures.

There are many physicians scattered across the United States who use similar or equivalent procedures. How many are to be found in other countries is unknown, but The Rheumatoid Disease Foundation, now The Arthritis Fund, will refer where it can.

A list of physicians who've agreed to use The Rheumatoid Disease Foundation's treatment protocols — as of the printing date of this edition — may be found in the rear of this book.

### Table of Medicines

Robert Bingham, M.D., Jack M. Blount, M.D., Archimedes A. Concon, M.D., John R.A. Simoons, Ph. D., and Professor Roger Wyburn-Mason have kindly included the following table of medicines for physicians and other readers. All but one B vitamin are anti-free-living amoebic drugs, the prednisone being given temporarily to counter the Jarisch-Herxheimer reaction if the physician and patient desire: [the therapeutic uses of the supplements or herbs, boron, copper, protein digestive enzymes, Yucca extract, and bile salts as alternatives or adjuncts to the following medications are also available through The Arthritis Fund library of articles, books and journals]

[Note: The following table was prepared in 1982]

Generic Name	Chemical Compound Group	Brand Name	Manufacturer
allopurinol	pyrimidine	Zyloprim®	Burroughs-Wellcome
Clotrimazole*	imidazole	Mycellex®	Dome
clotrimazole	imidazole	Lotrimin®	Delbay
diiodohydro-oxyquinon	oxyquinoline	Yodoxin®	Vitarine
furazolidone	nitrofurans	Furoxone®	Eaton
metronidazole	nitroimidazole	Flagyl®	Searle
nimorazole	nitroimidazole	Emtryl®	Salsbury
nimorazole	nitroimidazole	Naxogin®	Erba
ornidazole	nitroimidazole	Tiberall®	Roche
prednisone***	glucocorticoids	Deltasone®	Upjohn
rifampin	rifamycin B	Rifadin®	Dow
rifampicin	rifamycin B	Rimactane®	Ciba
tinidazole	nitroimidazole	Fasigyn®	Pfizer
potassium para amino benzoate	vitamin B	POTABA®	Glenwood

\*Available in USA only as vaginal tablets and cream.

\*\* Not yet released by FDA for use in USA. (Tinidazole, for example, is available in Australia as Fasigyn® 500; but known as Tinidex® in Mexico without prescription; Most nitroimidazoles can be obtained through a compounding pharmacy in the United States)

\*\*\*Prednisone is not an antiamoebic.

Tony Chapdelaine, working under Dr. Jack Neff (protozoologist) at Vanderbilt University, conducted extensive *in vitro* chemosensitivity tests on *Acanthamoeba culbertsoni*, *Acanthamoeba castellanii*, and *Naegleri gruberi*, finding a great variation in response to the drugs listed above, and others not listed. This variation begins to explain why some will respond immediately to treatment, while others must go through a course of several antiamoebics before acquiring a Herxheimer, and subsequent health. One medicine will kill one *limax amoeba*, but not another, will encyst one, but ignore another . . . Considering

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**  
that there are more than 300 different species and strains within the above two classifications, each with a different sensitivity to various chemicals, one begins to understand the variable human responses to antiamoebics.

If the amoeba is killed *in vitro*, it is likely to be killed *in vivo*. But if it is not killed *in vitro*, it may or may not be killed *in vivo*.

A classic example, is metronidazole, which does not affect any of the above species *in vitro*. It must be, therefore, that one or both of the two metabolites (both azoles) of Metronidazole -- (1-acetic-2methyl-d-nitroimidazole) and (1-[2-hydroxyethyl]-2-hydroxymethyl-5-nitroimidazole) -- kill the organisms *in vivo*. Possibly the small number who do not respond to metronidazole (when given protocol quantities) do not have the appropriate microflora that are necessary for producing the two active metabolites. If this is true, then physicians should consider supplementing their patient's treatment with the restoration of the necessary intestinal bacteria [with *L. acidophilus*].

Diiodohydroxyquinon (Iodoquinol or Yodoxin), a recent addition by Robert Bingham, M.D., was found to kill *Naegleria*, but not *Acanthamoeba*. Clotrimazole, on the other hand, was effective in killing both genus *in vitro*, and is known to be effective *in vivo*, thus the reason for starting Rheumatoid Disease Foundation double-blind studies with clotrimazole.

Consider also that the *Limax amoeba*, like bacterial pathogens, is capable of losing sensitivity to one antiamoebic, and therefore each physician must consider the prospect of switching from one antiamoebic to another, especially for those who prove to be especially sensitive to the amoeba (or its products), and especially when considering the six-month anti-reinfection treatment.

*Some physician do not believe that prednisone should be used to mask the Jarisch-Herxheimer reaction, that it is better to discontinue treatment until the "allergy" reaction dies down, and then to begin antiamoebic treatment again.*

Keep in mind that while physicians' experiences and opinions may vary, results are what's important!

#### **A Simple Plea To Sincere Physicians**

On Behalf of all Board Members  
of The Rheumatoid Disease Foundation  
now *The Arthritis Trust of America*  
by  
Gus J. Prosch, Jr., M.D.

"If you are sincere and truly desire to relieve the agony and suffering of your arthritic patients, I beg of you to give the previously recommended treatments a trial on your rheumatoid and osteoarthritis patients. I promise you that you will receive far superior results in relieving your patients' pain, suffering and disability than anything you have ever used before. You will be treating the cause of the rheumatoid disease and not simply the symptoms. You can now offer these severely neglected patients far more than a simple 'hope' of finding relief which conventional methods of treatment cannot even offer. You will be offering them total relief which will literally change the entire lives of these patients and their families. You will never find the satisfaction and pleasure of helping your fellowman any greater than by using these techniques to treat arthritic sufferers. You will completely and thoroughly understand what I mean when certain patients come to you in a wheelchair and, after receiving your treatment and injections by the above recommended techniques, they refuse to use the wheelchair to leave your office.

What joy What contentment! What satisfaction!

Good luck and God be with you!!!"

## **Chapter VI**

### ***Professor Wyburn-Mason's Theory of Protozoal Cause of Many Hitherto Unrelated Diseases***

#### *The Prevailing Medical Theory*

Are you surprised that a simple thing, like an amoeba, is the basis, the primary cause of all your "incurable" rheumatic disease problems?

The author was, so much so that he visited Vanderbilt University Medical Library to consult with two current books of internal medicine. The following is quoted:

**Internal medicine book 1<sup>1</sup>:** "On the basis of current evidence, it is more likely that rheumatoid factors are products of the host response to a primary event. The nature of this postulated primary event is still unknown, but there is renewed interest in an old concept that microbial disease may underlie the development of rheumatoid arthritis."

**Internal medicine book 2<sup>2</sup>:** "The etiologic factor(s) [causes] that set into motion the above immunological events is not known. An infectious agent, viral or bacterial, may will initiate the immunologic and subsequent inflammatory process in rheumatoid arthritis, but this hypothesis needs experimental proof."

#### *Wyburn-Mason's Findings*

Professor Roger Wyburn-Mason's 479 page book *The Causation of Rheumatoid Disease and Many Human Cancers — A New Concept In Medicine* (1978) and his *Addenda* (1983), upon which this book is based, are textbooks written for medical doctors and researchers in micro-biology, and cannot be read easily without a medical dictionary.

Wyburn-Mason's proofs, arguments, and case-histories are exceedingly well done and lead the reader to but one conclusion: Protozoa that have been with man since his earliest evolution are still with him, and, like the bacterial theory of the origin of various diseases, these same amoebae can be cited as being the primary cause of many otherwise and hitherto unexplained diseases.

Indeed, since arthritic deformities are found in fossilized bones of animals that preceded man's evolution, his *Homo Sapiens* structure, it must follow that this protozoan or one of a similar genus followed man's every evolutionary step.

#### *State of Art in Medicine*

By way of placing what follows in context, the author would take the liberty of itemizing some fundamental principles that the reader should consider:

1. Clinical applications in medicine always lag behind research, sometimes by as much as a generation or more. The U.S. Food and Drug Administration tightly — sometimes too conservatively — controls the use of various drugs for experimental purposes, thus inhibiting your family physician from taking advantage of early work done by others, often overseas. State medical boards, rightly or wrongly, inhibit medical practices not approved by peer review.

2. The increase in malpractice suits against physicians has brought about an almost sterile inclination to practice any kind of medicine except that which is "acceptable" by text-book peer review. If the text-book says that something cannot be cured, and that one should, however, treat symptoms, then that is what your doctor will tell his patient, and what he will do, respectively. It keeps him out of trouble, although it has virtually no chance of

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.** curing you.

3. The theory of protozoa as sources of disease in the human body has only recently been opened by the general medical profession, and the theory has only now been fully developed by the research of Professor Wyburn-Mason and shown in the above named book.

4. There is already a well-developed theory of *bacteria* as primary source of disease, a well-developed theory of *fungus* and *yeasts* as cause of disease, a growing development of *viral* cause of disease, a new theory of *viroids* and *prions* (stripped-down virus), and a very sporadically developed theory of *protozoan* (amoeboid) cause of disease, until now.

5. Consider the original, historical impact of the theory of bacteria as primary source of disease. Once you get the idea that there are many different species and strains of bacteria and that, when they invade humans, they each affect different systems and organs in different ways, one can begin to understand the parallel protozoal theory. Broad-spectrum antibiotics can be used interchangeably against microbial caused diseases thereby demonstrating many different symptoms and bringing about a cure of each. So it is with the protozoan theory of disease. There are over 300 species of amoebae identified to date, some of which are pathogenic, and certain broad-spectrum anti-protozoal medicines will knock them out, no matter what the ultimate symptoms may appear to be and no matter how those symptoms are currently classified in medical literature. Remember, *symptoms classifications are only that, not descriptions of primary causes!*

6. According to Professor Roger Wyburn-Mason's work, there are certain protozoa that are called *Limax* (*Limax amoeba*: meaning slug-like amoeba) that are found in virtually all human and animal tissue from birth onward. Similar to the ever-present bacteria, these *Limax amoebae* may be pathogenic and may affect different parts of the human body in different ways, depending upon their species, your genetic heritage, and upon which systems or organs they invade. Their hostile invasions are apparently triggered off within the body in the same manner and for the same reasons that multiplication of hostile bacteria begins.

7. These *Limax amoebae* were not found in many diseases previously because (a) it was thought to take special staining techniques to find them, (b) when they are found they are often mistaken for the body's own macrophages or poorly stained leukocytes, (c) even when animals are inoculated with them and similar diseases produced in the animals, the amoebae are difficult to find in the lesions, although *the live protozoa can be separated from tissue by special techniques*.

8. In Chapter IV of Professor Wyburn-Mason's book (pages 120-1) it is stated that the *Limax amoebae* were isolated from:

a. all the tissues of all cases of collagen and auto-immune diseases examined, including cases of rheumatoid arthritis, systemic lupus erythematosus (disease producing symptoms on skin), lymphocytic thyroid lesions (infection of thyroid), salivary glands affected by Sjögren's syndrome (inflammation of parotid glands; arthritis; dryness of mouth from lack of secretion) etc. In these cases, it was found not only in the region of the affected joints, muscles, thyroid and salivary glands, but also in the spleen, lymph nodes and central nervous system, and, in fact, in all apparently normal tissues.

b. all body tissues in all cases of human leukemia (disease of blood-forming organs) and lymphoma (disease of lymphoid tissue) examined.

c. all of a large number of human and animal malignant tumors examined, when it occurred in large numbers in

the tumor itself, but in lesser numbers in all the unaffected tissues of the body.

d. all aborted material exhibiting congenital growth anomalies examined and in many normal placentas.

e. hypertrophied tonsils and adenoids removed at operation.

f. the normal tissues in many healthy subjects killed in accidents.

g. human and mammalian fecal material.

h. uncooked beef, mutton, pork, and eggs and unsterilized milk.

i. some specimens of surface soil.

j. certain plant tumors growing at the site where the stem passes through the soil.

9. The *Limax amoeba* was not found in laboratory mice and rat cancers.

#### *Primary Source of Rheumatic Diseases*

The protozoan theory as the primary source of rheumatoid diseases is simply this:

1. The *Limax amoebae* are found virtually everywhere in the world, and inhabit virtually all animal bodies, including man's. Encysted forms (spheres filled with reproductive material and holes through which this can escape) are taken into the body through air, water and food and adult forms are found in the feces of most animals, including man. We are constantly infected and re-infected with both pathogenic (disease producing) and nonpathogenic forms. *Such protozoa form part of our natural environment* and are quite unlike and unrelated to those forms of parasitic amoebae which cause amoebic dysentery in man.

2. In certain individuals, stress, or the taking into their body of certain pathogenic species of amoebae, causes the body tissues containing the organisms to react to their presence and become inflamed, providing the organism is pathogenic and the patient's individual cells contain certain genes which make them react to the presence in the tissues of these organisms, where its products are recognized as antigens<sup>3</sup> by our bodily defenses. This reaction to the presence of the organism is genetically controlled, so the disease may run in families.

3. The reaction to the presence of these foreign and pathogenic organisms consists of the proliferation of certain cells called lymphocytes and their derivative plasma cells, which produce antibodies against the antigens of the organism. These antibodies are present in the blood plasma forming immunoglobulins. Both the blood cells and chemicals attempt to destroy the foreign bodies and in so doing fail to discriminate between them and many normal tissues in the body. As Dr. Jack M. Blount explains, "like innocent bystanders, they get hit by bullets aimed at an invader; our own immune system attacks both the invader and our own tissues, thus the name 'autoimmune disease.'" However, though these blood changes are undoubtedly present, no one until now has been able to find their cause, though it has frequently been suggested that they are due to some unknown infection. These inflammatory changes may involve any tissue in the body.

4. Many other micro and macro events abound, but simply stated, it appears as though the inflammatory changes and destruction of joints is partially due to the presence of the amoeba and partially due to the blood. This is true of all the tissues of the body.

5. Two physicians have confirmed Professor Roger Wyburn-Mason's findings of protozoa in the tissues<sup>4</sup>; and also by England's Air Vice Marshall Stamm<sup>5</sup>; and also by Raymond Cursons,<sup>6</sup> New Zealand, that the sera of all living humans and even

Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.

the cord blood, contains antibodies against free-living amoebae, whether pathogenic or non-pathogenic, indicating that everybody is infected by these protozoa. Craig and Faust<sup>7</sup> state that unspecified types of amoebae have been isolated from every tissue in the body, while C. Dobell<sup>8</sup> states there is hardly an organ in the body from which somebody has not obtained amoebae." Dr. Bradley, a microbiologist, has positively identified antibodies against *Naegleria fowleri* in the blood of his patients<sup>9</sup>!

6. Most amazing, after Roger Wyburn-Mason's discovery of the organism in human tissues, there is found a published report in 1922<sup>10</sup> and 1924 by the eminent protozoologists, Kofoid and Swezy, in the *University of California Publications of Zoology*, who describe their findings in the bone marrow of cases of rheumatoid arthritis and the lymph nodes of Hodgkin's disease (**Dr. Roger Wyburn-Mason's work was confirmed 50 years earlier!**) The two protozoologists suggested an aetiological relationship to the arthritic process, but they published this in a zoological journal, so that their findings never received the interest they deserved. (In 1969, Dr. S.L. Warren and Dr. Leonard Marmor<sup>1</sup> reported finding an agent in tissue drawn from patients with

rheumatoid arthritis which could be transmitted to mice producing inflammatory changes. Since then, the substance [which appears to be an infectious nucleic acid precipitate] has been found in synovial tissues removed from the joints of patients with classical symptoms of advanced acute rheumatoid arthritis. It appears to be present during the early and active stages of arthritis when the disease is spreading from joint to joint. The *Limax am*

researchers suspect that the *Limax amoebae* are the carriers of the rheumatoid arthritis ribonucleic acid infective agent.)

7. But even without confirmation of the *Limax amoeba*, the fact that antiprotozoal medicines bring about the Jarisch-

Herxheimer reaction in suffering arthritics, and healthy patients do not react in like manner, proves the presence in the lesions of rheumatoid arthritis of an amoeba<sup>12</sup> [or other single celled organism such as a macrophage, Cell Wall Deficient bacteria, or Cell Wall Deficient candida, that is responsive to the same antiprotozoal chemicals. Ed. S.C.].

8. The organisms have been demonstrated in tissues by immunofluorescent staining of sections to which antisera to the organisms have been added.<sup>13</sup>

9. A condition almost identical with rheumatoid arthritis may complicate amoebic dysentery; but in this case, the organisms are not in the tissues, and patients do not exhibit the Herxheimer reaction with antiamoebic drugs.

10. Thus, if the protozoal theory is correct, when we seek to cut down inflammation and pain in rheumatoid arthritis with anti-inflammatory drugs (as with aspirin and aspirin substitutes), we are simply decreasing symptomatic responses, and leaving the protozoa free to continue proliferating and causing further damage.

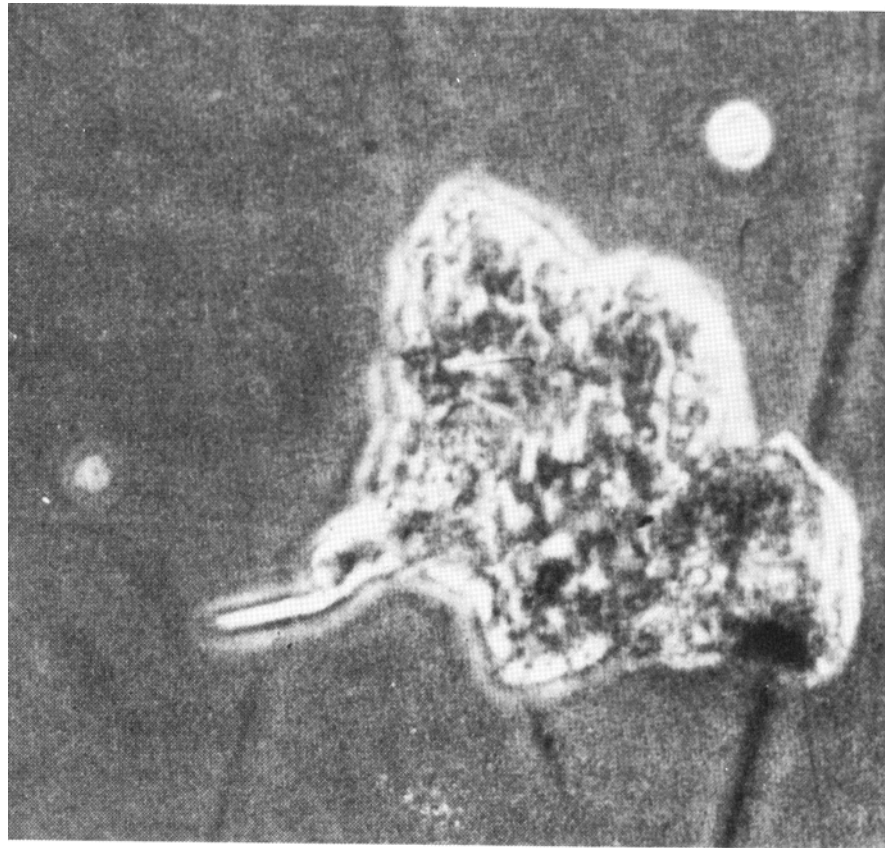
11. A- gain, if the protozoal theory is correct, when we seek to knock out the immunological system (as with imuran treatment)

we are simply freeing the protozoa from any check and balance, and so it can be expected to continue proliferating and causing further damage.

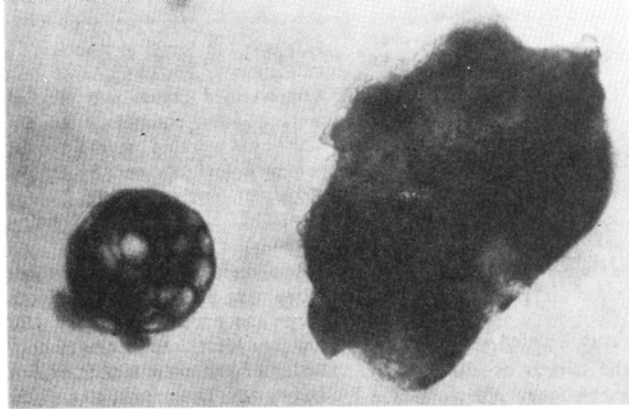
12. If the protozoal theory is correct, when we seek to block the interaction between antigen and anti-body (as with cortisone treatment), we are simply freeing the protozoa for further action.

13. If the protozoal theory is correct, then some weeks of the

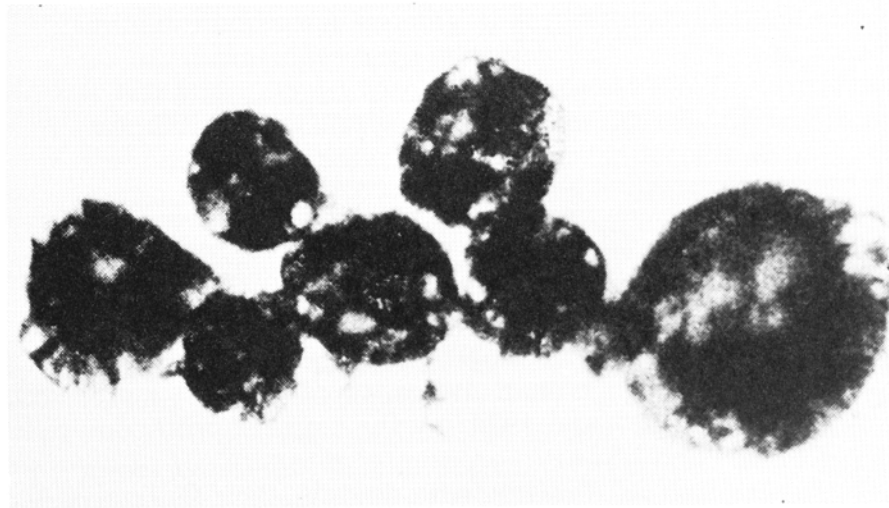
mediate relief in most symptoms, especially as the body no longer finds need to react against the invader, and the immunological system can then settle down -- and this is exactly what Professor Roger Wyburn-Mason<sup>14</sup> and Dr. Jack M. Blount and other researchers have



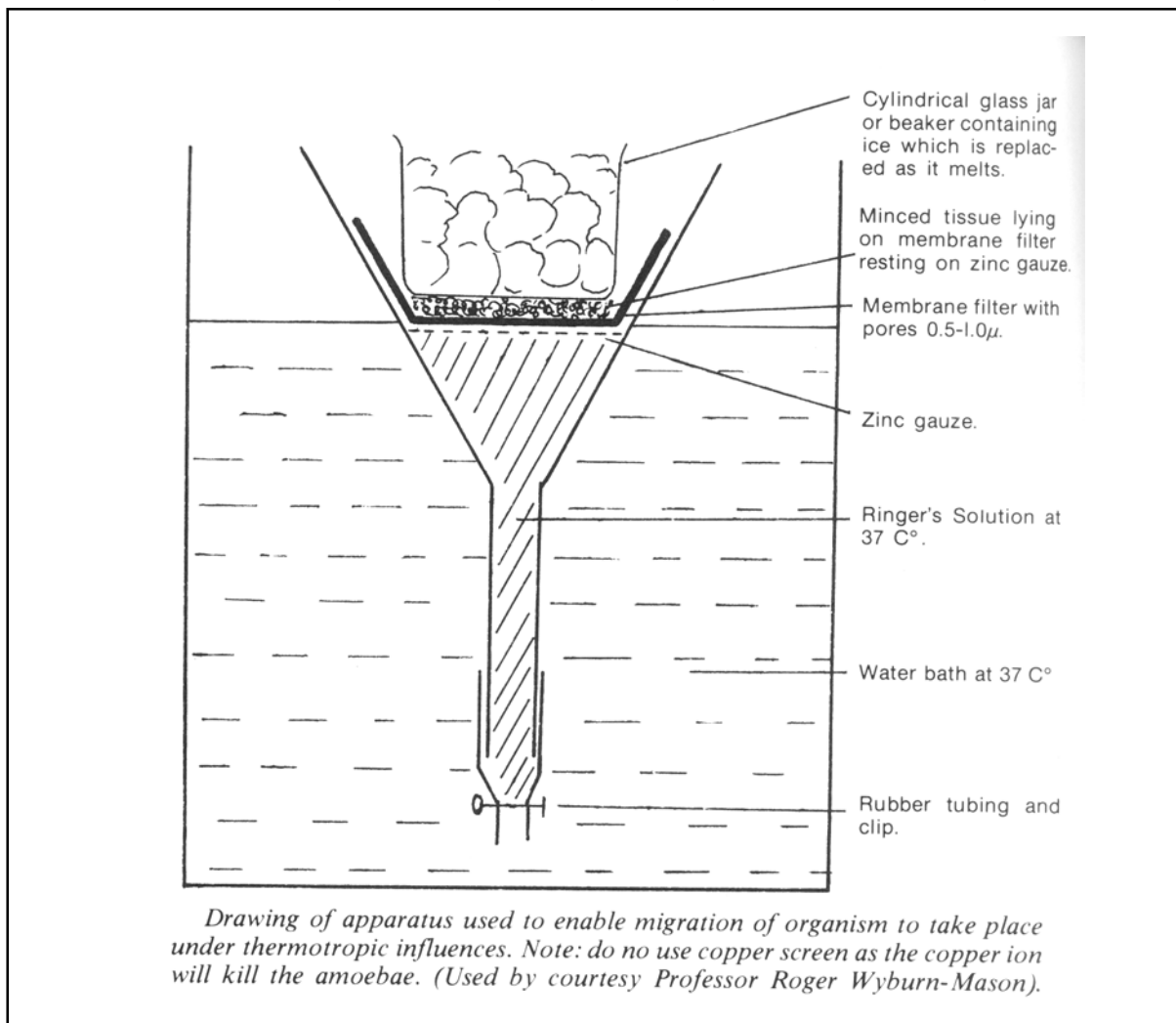
*Photograph of a Limax amoeba which emigrated from the malignant tissue in a case of carcinoma of the bronchus (unstained). (X1500). Note single spike-like pseudopodium, typical of many species of Naegleria\*.*



*A cyst of Limax amoeba beside a trophozoite heavily pigmented as recovered from human malignant tissue. The pigmentation is presumably due to phagocytosis of debris from the minced-up tumor tissue (unstained) (X2000)\*. [Compare with Figure 2 in Jager and Stamm (1972).]*



*Cysts of Limax amoeba formed after migration from malignant tumors under the influence of thermotropism (unstained). Shows simultaneous cyst formation from a cluster of trophozoites (X950)\*.*



found happens.

1. *Fifteenth Edition of the Cecil Textbook of Medicine*, Vol. I, W.B. Saunders Co., Philadelphia 1979, p. 187.

2. *Harrison's Principles of Internal Medicine*, 9th Edition, Vol. II, McGraw-Hill Book Co., New York, 1980, p. 1873.

3. From "The Genetics of Antibody Diversity," by Philip Leder, *Scientific American*, Vol. 246, Number 5, May 1982, p. 102, we learn: "[Our] immune system has a virtually unlimited capacity to generate different antibodies, which recognize and bind to many millions of potential antigens, or 'nonself' molecules. . . . An antibody is an assembly of protein chains, and the structure of a protein chain is specified by a unit of genetic information: a gene. . . . Antibodies, like other proteins, are made up of the subunits called amino acids. There are 20 kinds of amino acid, which can be linked together in any combination to form a protein chain. The amino acid composition of a chain and the sequence in which the amino acids are arrayed along the chain determine how the chain folds in three dimensions and perhaps combines with other chains. . . . The amino acid composition and sequence of a protein chain are prescribed by [the] gene."

4. James W. Overstreet III was in the Microbiology Department, Vanderbilt University, Nashville, Tennessee, USA in 1965, according to a personal letter from Professor Roger Wyburn-

Mason to author. In a letter dated February 1, 1983 to Wyburn-Mason, James W. Overstreet, M.D., Ph.D., now Associate Professor of Human Anatomy and Obstetrics and Gynecology at University of California, Davis, states: "Thank you for your letter of January 22, 1983. I am the same individual who corresponded with you in 1965. At that time, I was a second year undergraduate student and the work on protozoa recovered from human tissue was my first independent research project. I thought you might be interested in my curriculum vitae since it details my subsequent professional career. As you see, I spent several years in Cambridge where my research interests became focused on the area of Reproductive Biology. Although I never pursued the work on protozoa, I believe that project and your encouragement were significant factors in my decision to pursue a career in medical research"; and Magda Uhrinova, Oncological Research institute, Bratislavia, Czechoslovakia [from Professor Roger Wyburn-Mason, who states, "Dr. Magda Uhrinova and Dr. A. Kwasnicka working together also isolated the organism in the same way as I had done and, when I visited them in 1965, they showed me photographs of beautiful examples of the organism which I understand was reported to the House Journal of the Institute in that year; I have since lost touch with them"]

5. The doyen of amoebologists [personal letter from Professor Roger Wyburn-Mason who states: "Air Vice Marshall Stamm has long ago retired. He worked at the Institute of

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

Amoebology which was then part of the royal Free Hospital, London. Since his retirement the Institute has closed and this work is largely taken over by the London School of Hygiene and Tropical Medicine. I sent a number of slides to Air Vice Marshall Stamm apparently containing no amoebae visible by ordinary stains, but out of which I had obtained them. The slides consisted of tissue taken from the enlarged salivary glands in cases of rheumatoid disease, Hodgkin's disease, knee joint tissue and muscle taken from cases of rheumatoid disease and in addition various cancers. I asked him to test them by immunological staining using antibodies to various species of *Naegleria amoebae* for evidence of amoebae and in a number of phone calls and a letter he was highly enthusiastic and had confirmed by his very selective method of staining that certain cells in the tissues gave the typical stains for *Naegleria* though in ordinary circumstances they did not resemble them, but looked like macrophages. He did not, however, publish his findings as those were going to be included in my book. His findings are those cited by me in my book and were taken from his letter.]"

6. Cursons, R.T.M., T.J. Brown and E.A. Keys, *Lancet*, 1977, ii, 875.

7. Craig and Faust, *Clinical Parasitology*, 6th ed. Henry Kimpton, London, 1957, p. 211.

8. Dobell, C., *The Amoebae Living in Man*, John Bell Sons and Dainelsson, London, 1919, p. 90.

9. Personal correspondence from John R.A. Simoons, Ph.D. to Dr. J.M. Blount, November 5, 1981

10. Kofoid, C.A., Swezy, O., "Amebiasis of the Bones," *JAMA*, 78: 1602-1604, 1922a; also "Mitosis in Endamoeba Dysenteriae in the Bone Marrow in Arthritis Deformans," *Univ. Calif. Publ. Zool.* 20: 301-307, 1922b; also "On the Occurrence of Endamoeba Dysenteriae in the Bone Lesions of Arthritis Deformans," *Calif. State J. Med.* 20:59; 1922x Kodois, X.A.; Boyers, L.M.; Swezy, O. "Endamoeba Dysenteriae in the Lymph Glands of Man in Hodgkin's Disease," *Univ. Calif. Publ. Zool.* 20: 309-312; 1922a; also "Occurrence of Endamoeba Dysenteriae in the Lesions of Hodgkin's Disease," *JAMA* 78: 1604-1607; 1922b; and Kofoid, C.A., Swezy, O., Boyers, L.M., "The Coexistence of Hodgkin's Disease and Amoebiasis," *JAMA* 78: 1602-1604, 1922; [from Professor Roger Wyburn-Mason: Also "later publication in 1925 in the *Univ. Calif. Publ. Zool.* where they changed the name of the organism to that of *Vahlkampfia*, which is free-living amoeba. The organism that they found in the bone marrow differed from normal cells in that it contained only 6 chromosomes as compared with the normal 46 of humans and its method of mitosis (multiplying) and possessed one pseudopodium which is identical with the organism as found by "Professor Wyburn-Mason].

11. *Arthritis News Today*, Vol. 1, No. 10, "Progress on the Cause and Treatment of Rheumatoid Arthritis," P.O. Box 730, Yorba Linda, California 92686, July 1979, pp. 1-2.

12. P.K. Pybus, *SA Mediese Tydskrif*, "Metronidazole in Rheumatoid Arthritis," February 20, 1982, p. 261-262.

13. According to one of Professor Roger Wyburn-Mason's latest communications, "Dr. P.K. Pybus and Dr. A.E. Davis, both of South Africa, have recently informed of a very simple method of isolating the organism and the cysts from the effusion fluids of actively inflamed rheumatoid knee joints. Using a sterile needle and syringe they withdrew all the fluid from inflamed knees and put this into a sterile screw top bottle. They allowed this to stand and cool for a few hours and then examined the deposit. In all cases the deposits contained groups of typical free-living amoebic cysts identical in appearance with those in Figure 1 of the article by Jager and Stamm (*Lancet* 1972, ii, 1943)

featuring the cysts of an organism of the Naegerial genus. The size, the fenestrated holes allowing the cytoplasm of the cysts to escape and the varying colouration of the cysts from dark brown to light brown, dark blue to light blue, are typical of the same cysts photographed by the present author as being found with their trophozoites in rheumatoid disease and cancers and photographed at Figure 7, page 123 in the original monograph. The variation in colour found by both Pybus and Davis and the author caused the latter to christen the organism, *amoeba chromatosa* (colored amoeba). In addition Pybus and Davis sometimes found the motile amoebae apparently attempting ingestion of red blood cells and sometimes in the process of encystment. These workers remarked that these objects one would normally dismiss as cell debris or 'gubbins,' but in view of their features they are undoubtedly small amoebae."

14. Professor Roger Wyburn-Mason had spent 27 years in the field of protozoology, pharmacology and rheumatology.

"Of Course one does meet brilliant men but they are isolated. The fashion nowadays is all for groups and societies of every sort. It is always a sign of mediocrity in people when they herd together . . . The truth is only sought by individuals, and they break with those who do not love it enough . . ." -- *Dr. Zhivago* By Boris Pasternak.

#### **Roger Wyburn-Mason**

Letter received, June 1983

I have been thinking over the significance of the discovery of the cause and cure of rheumatoid disease in all parts of the world.

To begin with the treatment and cure of the early disease prevents patients becoming chair-bound and bed-ridden and eventually taking up beds in hospitals for the physically handicapped, which in your country and my own and in all countries of the civilized world is an enormous drain on financial resources.

In addition while the patient is gradually developing the disease over the course of years he has with the so-called orthodox treatment long periods off work in which he is paid for by the state either at home or in hospital absorbing enormous amounts of expensive anti-inflammatory or immunodepressant drugs very often paid for by the state and requiring medical and nursing attention throughout the active period of the diseases. In spite of this the disease makes its inevitable painful progress.

In children the disease causes painful deformity often treated with cortisone derivatives which stunt growth and do not kill the cause of the disease. They end in homes for the incurable provided by the state.

From these observations it is obvious that treatment of RD by anti-free-living amoebic drugs will result in the saving of enormous amounts of money by the state in providing hospital accommodation, doctors, nurses, drugs and apparatus, while if the patient is not hospitalized he remains ill at home where he has to be nursed and doctored and the Government pay his unemployment benefit.

The discovery of the cause of the disease and its cure will have an important financial bearing on the state and country providing all the above mentioned aids in the commonest disease affecting mankind and the one causing more suffering and disability than any other.

Within ten years the disease could probably be eliminated from civilized countries setting free enormous amounts of

Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment. money to be used for other purposes.

## Chapter VII

### *Amazing Implications of the Protozoan Discovery*

#### *Broad-spectrum Antibiotics*

As has been already stated, when the germ theory of disease was at last accepted, many disease symptoms could be seen to respond to similar or identical medicines. In later years, particularly stemming from the development of sulfa-like and penicillin-like drugs, we have seen many apparently dissimilar diseases respond to identical drugs, now called *broad-spectrum* medicines because of their ability to inhibit or kill a variety of species or genus within species of bacteria.

#### *Broad-spectrum Antiamoebics*

Professor Roger Wyburn-Mason asserts in his massive study that the same is true regarding protozoa as a primary cause of other diseases.

#### *Isolation of the Amoeba*

He was able to recover the free-living amoebae (to be distinguished from parasitic amoebae) from human tissues in certain conditions by using the property of these organisms to migrate from cold to body tissues to fluid at body temperature (37°). When this is done, the organisms can be grown in the laboratory and various substances can be tested on them to see which kill them. Among the latter are drugs containing the 5-nitroimidazole nucleus of which one is the metronidazole or Flagyl®, but numerous others exist, such as allopurinol. In addition furazolidone, clotrimazole, and other substances are effective in killing the organisms, but are unavailable in the USA.

#### *Collagen Diseases*

Closely related to rheumatoid arthritis are the so-called collagen diseases. These include systemic lupus erythematosus (SLE), dermatomyositis, scleroderma (systemic sclerosis) and polyarteritis nodosa, and every gradation to or combination of these various conditions with rheumatoid arthritis exists and these diseases may be associated with internal manifestations of the same process as affects the joints.

In SLE, the presence of the causative organism in the body produces changes in the proteins of the blood which may deposit in the walls of blood vessels which then cut off the blood supply to parts of the brain or kidney especially. When these changes have occurred, treatment with antiamoebics cannot cure the disease completely, but can halt its progress. The same applies to advanced cases of rheumatoid disease, though the cause of the disease may be killed and damaged joints may be treated by other means such as surgical or chelation therapy.

The other diseases mentioned above can be cured in early cases in the same way as rheumatoid arthritis.

Some cases of rheumatoid arthritis or any of the collagen diseases may be associated with mild diabetes or the rare muscular disease known as myasthenia gravis.

Myasthenia gravis appears to be due to liberation from infecting amoebae of substances which combine with the chemical substances normally liberated at the nerve endings in muscles thus inactivating and preventing muscle contraction and producing weakness.

Diabetes is not due to failure of the cells of the pancreas to produce sufficient insulin to enable the muscle and liver cells to store sugar in them. This was the theory until some years ago when a United States Professor<sup>1</sup> received the Nobel Prize for medicine by showing that in diabetes the pancreas produces either normal or excessive amounts of insulin in diabetics.

Diabetes is, in fact, due to inactivation of the normally

formed insulin by some substance in the body. If a patient suffering from diabetes is treated with the antiamoebic drugs, the mild diabetes will disappear unless the patient becomes reinfected with the organism. Until the recovery of the free-living amoebae from the tissues of cases of rheumatoid disease, the generally held idea was that the disease was due to a chronic antigenic stimulation though the source of this antigen was unknown. We now know that the amoeba is the [one] source of this antigen which induces the production by lymphocytes and plasma cells of antibodies in the blood.

#### *Susceptibility*

The presence in all bodies, including the newborn, of the organisms (transmitted across the placenta to the fetus) may produce no damage or signs of its presence unless the species is of a pathogenic type and even then it may not produce disease in humans unless the cells of the human's body possess certain genes which are inherited from the parents which enable them to become inflamed in the presence of the organisms. In this way, whole families may be affected by rheumatoid disease.

Rheumatoid disease may affect any tissue in the body and produce what are known as precancerous lesions, i.e. changes in tissues which may develop into cancer.

Treatment with antiamoebics can cure those precancerous lesions and the tendency for them to become cancerous, but this requires a course of treatment repeated perhaps yearly or so.

If no reaction to the antiamoebic medicines occurs, then the individual is free of pathogenic infection. If a reaction does occur, the individual is infected and even if there is no evidence of active rheumatoid disease, such an individual may have internal changes due to the organism, which may develop into cancer.

The Rheumatoid Disease Foundation, now The Arthritis Fund, recommends that allopurinol be taken at six month intervals to prevent reinfections. Whenever the patient appears highly susceptible, and/or the geographical region appears to offer maximum opportunities for reinfection, antiamoebics could be taken every two months. Public water systems, swimming pools, dust farming, meat handling. . . are often excellent sources of reinfection.

The copper ion seems to be rather deadly to the amoebae but chlorine, as used for purifying our drinking water, is not.

William Catterall, Sc.D., recommends a copper algicide for swimming pools; and while the *Limax amoebae* are very sensitive to small amounts of copper ion -- such as placing a copper wire in refrigerator drinking water -- he cautions against intake of too much copper, as this can upset the mineral ratios or even be dangerous.

Small doses of antiamoebics taken at semi-annual intervals may also prevent mild but obvious joint aches and pains, a sign that fluid movement is being inhibited and also an early sign of rheumatoid arthritis. If allopurinol is taken, then 3 tablets (300 mg) a day each day for seven days should be sufficient to remove reinfections, and the resulting Herxheimer, if any, will probably be much less than the first full treatment; if a different antiamoebic is used, then a different number of tablets may be required.

In both cases, the number of tablets will also depend upon body weight. Obviously children, or people of above average or below average weight, should be given differing dosages, usually determined in terms of 20# increments.

Regular doses will avoid cancerous change in some cases. Quite apart from the prospect of being able to prevent the appalling suffering and deformities of long-standing cases of rheumatoid arthritis and its internal lesions, one can cure the disease in children and eventually the prospect of wiping out probably the commonest disease in the world opens up.

In addition to this, there is the possibility of preventing the

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

development of many cancers by curing the pre-malignant diseases, which are part of rheumatoid arthritis. As stated, the presence in the body of the organisms with their antigens stimulates the appropriate cells (lymphocytes and plasma cells) found in the bone marrow to produce antibodies against these cells. If long continued, the bone marrow cells proliferate and change into cancerous cells called myeloma or lymphoma, so that the chronic infection with the amoebae is a very important cause of cancer. These growths can be prevented by taking yearly treatment with anti-amoebic drugs only some of which are available in the United States, but all of which are harmless, as opposed to the present anti-inflammatory drugs and cortisone.

#### *Present Rheumatology Practices Unscientific<sup>2</sup>*

From the discovery that rheumatoid arthritis is due to an organism around the lesions certain practices commonly found in rheumatology are seen to be unscientific:

Firstly, *all present anti-inflammatory drugs, gold salts and penicillamine have side effects which may be so dangerous as to kill the patient either by damage to the bone marrow, and thus failure to produce the essential blood corpuscles, damage to the kidney resulting in kidney failure, or to the skin which may peel off the whole body giving rise to severe and uncontrollable infection resulting in death, as in the case of the film actress Rosalind Russell. This group of drugs has never cured a patient. Whereas the drugs used to kill the amoeba have all been used for twenty or more years without causing ill effects. These anti-amoebic medicines are frequently successful in completely curing the disease.* Like bacteria, different amoebae show different susceptibilities to different anti-amoebic drugs. It may be necessary to switch from one to another to obtain the best results. (Alcohol should not be taken during treatment.)

Secondly, massage and exercising affected joints are guaranteed to spread the organism about and make the condition worse. Affected joints should be rested and cooled with water (not ice) and never massaged.

It is quite clear from the amazing list covered by Professor Wyburn-Mason's work, that he has opened a realm of medical applications that is strikingly unusual to say the least.<sup>3</sup> Causes for some diseases are unknown, some are classified as hereditary, and some are flatly blamed on viral infections, while others are diseases of behavior or thought. Yet anti-protozoan drugs seem to affect cures, with exceptions noted in Wyburn-Mason's book (such as arthritis caused by bacteria or physical shock, et. al.)

Keep in mind that symptom descriptions are only that, descriptions, and not necessarily indicative of the causes. When the *Limax amoeba* [or Cell Wall Deficient bacteria, Cell Wall Deficient *candida*, or autoimmune macrophage] attacks one kind of tissue, and depending upon your particular inherited body chemistry, you may have a set of symptoms totally different than would another from the same amoeba.

Since application of anti-amoebic drugs is novel in the treatment of most of the diseases listed, you should work with your family physician in seeking treatment, or, failing that, contact any of the medical doctors already working with this treatment.

1. Rosalyn S. Yalow, 1977, who shared one half the prize with two others, Roger C.L. Guillemin and Andrew V. Schally.

2. For analysis of the unscientific nature of present rheumatology practices, see *Clinics in Rheumatic Diseases*, December 1983, W.B. Saunders, Ltd., West Washington Square, Philadelphia, PA 19105. Especially read the chapters on gold shots and penicillamine, and the lack of scientific basis, as described by leading rheumatologists.

3. In the second edition, Crohn's disease was added to the list below by Dr. Gus J. Prosch; trigeminal neuralgia and multiple sclerosis has been added by further research of Roger Wyburn-Mason, with precautionary statements given on applying anti-amoebics to multiple sclerosis footnoted below the list. [See his *Addenda, The Causation of Rheumatoid Disease and Many Human Cancers -- A New Concept in Medicine: A Précis and Addenda, Including the Nature of Multiple Sclerosis*, The Arthritis Fund, 5106 Old Harding Road, Franklin, TN 37064, \$10.]

Dr. Jack M. Blount, states that manifestations of infection vary with the anatomy involved, the genetic composition of tissue affected, and the nature of the infestation. To your family doctor he says, "Compare to *Treponema pallidum* (Syphilis spirochete) symptoms -- may involve any organ or tissue . . . relapses frequent, may exist without symptoms for years."

Roger Wyburn-Mason, in his *Addenda*, [p.7] adds the following: "AI [autoimmune] lymphocytic and humoral reactions are thus not the primary disturbance in RD and AI diseases, but are the response to the tissue damage. The whole syndrome resembles syphilis. Waldenstrom (1963) and others state that 'if the spirochete had not been discovered, syphilis could be taken to be the ideal model of an AI disease. The variety of tissue reaction antibodies, the widespread lymphocytic tissue damage and the vasculitis are characteristic features. "RD closely resembles the rheumatoid manifestations in leprosy (*Lancet* Editorial 1981), which may present with an acute arthritis affecting one or a number of joints, polymyositis, skin lesions, fever, raised ESR, etc. with increase in circulating gamma-globulins and positive serological tests for autoantibodies, RF and ANF, as in RD. This is an immune complex syndrome with antigen provided by disintegrating *M. leprae*. The reaction may be precipitated by anti-leprosy drugs, a reaction known as Lucio's phenomenon, **which is identical with the Herxheimer reaction.**" [Emphasis author's]

#### *Tissues affected are:*

**Arteries:** Periarthritis

**Bone:** Paget's Disease, cysts, myelomas

**Brain and Cord:** Tremors, seizures

**Bronchi:** Bronchitis, intrinsic asthma

**Cardiac:** Dysrhythmias, myocardial disease, pericardial disease

**Cecum:** Appendicitis, mesenteric adenitis

**Colon:** Ulcerative colitis

**Endocrine:** Thyroid, parathyroid, thymus, pituitary, adrenal, gonads

**Esophagus and Stomach:** Atropic mucosa (pernicious anemia), webs

**Eyes:** Iridocyclitis, exophthalmias

**Fascial Planes:** Bursitis

**Female Genitals:** Ovarian cysts, fibroids, salpingitis-sterility, tubal pregnancies

**Functional CNS:** Neuroses, psychoses senility

**Hemopoetic:** Systemic lupus erythematosus, polycythemia, purpura

**Joints:** Arthritis

**Kidneys:** Pyelonephritis, calculi

**Liver:** Hepatitis, cholangitis, gallbladder disease

**Lower Small Gut:** Regional enteritis, Crohn's disease

**Lungs:** Alveolitis

**Lymphatics:** Lymphomas, splenomegaly

**Meninges:** Headache, meningomas

**Muscles:** Myositis

**Nerves\*:** Trigeminal neuralgia\*, [multiple sclerosis\*]

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

**Nose and Throat:** Rhinitis, eustachian salpingitis, enlarged tonsils, & adenoids, etc.

**Ovum:** Fetal deformities, abortions

**Pancreas:** Pancreatitis, maturity diabetes, noninsulin dependent diabetes

**Salivary & Tear Glands:** SICCA syndrome

**Skin:** Psoriasis, alopecia, erythemas, urticaria

**Tendons:** Tendonitis, ganglion

**Upper Gut:** Celiac disease

#### **Important Note**

\* From Addenda [Roger Wyburn-Mason, p. 26, 28-29]: “. . . The makers of 5-nitroimidazole drugs warn against administration to patients suffering from neurological disease, but none of them on close inquiry can give the reason for this warning. . . MS is due to the presence in the CNS [central nervous system] of pathogenic free-living amoebae in a sensitive subject as evidenced by the tissue antigens and the sudden destruction of the organisms by anti-free living amoebic substances can cause a sudden and violent exaggeration of symptoms due to the action of drugs on the organisms within the CNS. Can such drugs be used in the treatment of MS without running the risk of exaggeration of symptoms? . . . [It is possible that] antiamoebic drugs [that do not produce] an Herxheimer reaction might. . . be used to prevent the progress of MS by killing the causative agent and preventing the formation of new plaques..”

[also see “Candidiasis: Scourge of Arthritics,” Gus Prosch, MD; *The Missing Diagnosis*, Orian Truss, MD, about candida treatment causing a similar reaction in MS and other conditions; “Molybdenum for *Candida albicans* Patients and Other Problems,” Walter Schmitt, DC; “Sunshine Deficiency Diseases,” S. Cooter, and Chapters 10, 11, 12, in *Beating Chronic Illness*, Stephan Cooter, PhD, about the possibility of metabolizing the byproducts of candida, and possibly the byproducts of dead Cell Wall Deficient bacteria, candida, or macrophages, with molybdenum and other compounds in the ammonia, aldehyde, and sulfite biochemical pathways: supplying the minerals and vitamins necessary for the catabolism of sulfur containing proteins might lessen the severity of the Herxheimer reaction from “foreign” proteins decaying in the tissues or bloodstream.]

## **Chapter VIII**

### **Case Histories**

*(Based on Professor Roger Wyburn-Mason, Surrey, England, in which two new anti-protozoan compounds furazolidone and allopurinol were used in the treatment of rheumatoid arthritis. These compounds have been safely in use for many years for other diseases.)*

#### *Introduction*

Furazolidone is an antibacterial and antiprotozoan drug effective against a wide range of common enteric infections, both bacterial and protozoan, such as *Giardia lamblia* and *Entamoeba histolytica*.

It was found that *in vitro* a dilute solution rapidly killed the organisms in a culture of the free-living amoebae isolated from the tissues of rheumatoid and related diseases being equally or more potent in this respect to the 5-nitroimidazoles.

Allopurinol has been reported as being effective treatment of the protozoan diseases Leishmaniasis and Trypanosomiasis and it shows promising results in the treatment of *Trypanosoma cruzi* infections and diseases due to other haemoflagellates<sup>1</sup>.

Free-living amoebae of the genus *Naegleria* assume a flagellate form in distilled water and [Wyburn-Mason] found that *in vitro* the drug killed the cells of a culture of amoebae obtained from the

tissues of patients with rheumatoid disease in very dilute solution, being equally or more effective in this respect than the 5-nitroimidazoles.

Antiamoebic substances without anti-inflammatory properties, which kill free-living amoebae in cases of active, rheumatoid disease<sup>2</sup> often produce a Jarisch-Herxheimer reaction, indicative of the presence of such a causative organism in this disease.

It was decided to test the effect of these safe and long-established substances (furazolidone and allopurinol) in case of active rheumatoid disease, in view of [Wyburn-Mason's] previous findings of the curative effect of many antiamoebic substances.

When taking furazolidone, patients have occasionally been reported as having nausea or headache and facial flushing if they take alcohol. Both substances tend to cause dark yellow coloration of the urine and this prevents their use in a double blind trial.

The following are the details of successive cases of active rheumatoid disease treated in a rheumatology practice with furazolidone in doses of 100 mg four times a day for 7 days or with allopurinol 300 mg three times daily for 10 days.

#### **Successive cases treated with furazolidone**

*Case 1:* Female, aged 62 years. Family History: Mother, one brother and two sisters all suffered from rheumatoid arthritis while one brother and one sister are free of the disease. A nephew and one sister suffered from diabetes.

Past history: Her periods ceased at the age of 40 years. Ten years previously she noticed painless thickening and stiffness of all joints of the fingers and thumbs gradually increasing in degree and eleven months previously she woke up one morning with painful and swollen fingers and wrist joints, increasing in severity over the next two months. Her knees were also affected and her symptoms became so severe that she was unable to use her hands. Four months later the right knee and both elbows became painful and swollen, movements were restricted, and she developed bursitis of both elbows followed by pain and restricted movements of the right shoulder. She was treated with numerous anti-inflammatory drugs, including steroid injections into the shoulder joints and olecranon bursae. Five months previous to being seen, she developed bilateral carpal tunnel compression of the median nerve for which operation was undertaken successfully. X-rays showed some slight loss of disc space in the first carpo-metacarpal joints, but otherwise the appearances were within normal limits.

The serum RF was strongly positive. Blood sedimentation rate was 30 mm/hour, RBC was  $3.9 \times 10^{12}/\text{dl}$ , serum albumin 2.8, globulin 3.8g/dl, WBC  $4.8 \times 10^9/\text{dl}$ , Hb 10.9 g/dl.

She was at present taking 3 Naprosyn® tablets a day with little relief. There was morning stiffness and stiffness after sitting. Examination showed marked rheumatoid deformity of hands and thumbs and of the metacarpophalangeal joints. She could not make a fist. The changes of rheumatoid arthritis with heat and swelling were present in both wrists. Restriction of the shoulders, neck and midtarsal joint movements, and some swelling of the feet was present.

She was treated with furazolidone, which produced dark yellow coloration of the urine, stiffness and swelling of the affected joints on waking, but less pain in the shoulder joints. On the fifth day, the symptoms had all increased in severity with increased swelling and pain in the knees with limitation of flexion, but no free fluid. The symptoms persisted for the next week when they gradually subsided and after one month had completely disappeared. She was now able to make a fist on both sides, but there was no tenderness of any joint.

Two months after beginning treatment she had been able to

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

give up taking Naprosyn®, and all joint movements were full, free and painless. There was only minimal bony swelling in the proximal interphalangeal joints of the fingers which had been present for 10 years. Blood examination now showed ESR 10 mms/hour, RBC  $5.0 \times 10^{12}/\text{dl}$ , WBC  $5.6 \times 10^9/\text{dl}$ , serum albumin 4.6, globulin 3.2 g/dl, Hb 14.2 g/dl. She remained well for the next eight months of observation.

*Case 2:* Female, aged 63 years. Family history: nil revenant.

Past history, hysterectomy for fibroids and bilateral ovarian cysts aged 49 years. Three years previously, she developed pain, heat, hotness and restricted movements of the fingers, wrists, neck, elbows, shoulders, hips, knees and ankles. There was pain under the balls of the feet on weight bearing. There were posterior headaches and nocturnal sweating. In addition she had all the symptoms and signs of proven ulcerative colitis. She also had considerable weight loss though her appetite was good. She had been treated elsewhere with Indocid®, Feldene®, brufen, penicillamine, myocrisin, and salazoprin for diarrhea.

Examination showed a high color in the cheeks, mildly pale mucosae, pain and swelling of the fingers and wrist joints with deformities of the wrists, left olecranon bursitis, pain and restricted movements of the shoulders making it impossible for her to feed herself or to raise her arms above 45° from the body. Both knees showed lipomata below the patella, though the movements were reasonable and full, but painful on the left side. There was slight pain on extreme movements of the left ankle with midtarsal movements painful and restricted. She was tender on pressure under the balls of the feet.

Hb 9.0g/dl, WBC  $5 \times 10^9/\text{dl}$ , RBC  $4.0 \times 10^{12}/\text{dl}$ , ESR 44 mms/hour, serum uric acid 4.8 mg/dl, serum albumin 2.8, globulin 4.6 g/dl.

She was treated with furazolidone as above. On the fourth day, the joints of the upper limbs were stiff and painful. There was pain in the neck and head. The left hip was painful and movement restricted. The left knee became swollen and stiff, but not hot. These symptoms persisted for six weeks and then suddenly disappeared and on examination six weeks later the only abnormal physical sign to be made out was some slight fluid in the supra patellar bursa above the right knee; otherwise she was without evidence of rheumatoid disease.

She was given prednisolone (enteric coated) 2.5 mg's twice daily for a week when the signs of bursitis had completely disappeared. A blood count now showed Hb 14g/dl, WBC  $6 \times 10^9/\text{dl}$ , RCB  $4.8 \times 10^{12}/\text{dl}$ , ESR 19 mms/hour, serum albumin 5.0, globulin 3.2g/dl. She has been on a journey to Australia and New Zealand and back lasting six months without any recurrence of symptoms and remains well.

*Case 3:* Female, aged 68 years.

Past history: cholecystectomy for cholecystitis without gall stones. Ten years history of pains in the neck and shoulders with moderately restricted movements of the neck and shoulder joints. The neck pain tended to be severe on waking and occurred especially on the left side. Later it extended down the medial border of both scapulae, along the course of the suprascapular nerves. The joints of both middle fingers became hot, swollen, painful and the movements restricted, especially of the middle interphalangeal joints.

Examination showed moderate restriction of all movements of the neck with pain at extremities, tenderness on pressure over the cervical spine. There was audible crepitus on the neck movements and tenderness on pressure over the shoulder joints with some slight restriction and pain on movements in all directions. The

interphalangeal and metacarpal-phalangeal joints of both middle fingers were hot swollen and flexion restricted, so that the tips could not voluntarily reach the palms which showed palmar erythema. X-rays of the fingers and shoulder joints were normal, but those of the neck showed mild narrowing of the disc space between C4 and C5 vertebrae.

The blood count showed an Hb 14.2g/dl, RBC  $4.8 \times 10^{12}/\text{dl}$ , WBC  $6 \times 10^9/\text{dl}$ , differential count normal, ESR 25 mms/hour, serum uric acid 4.8 mg/dl, RF (latex) positive 1 in 160, serum albumin 2.6, globulin 8.4 g/dl.

She was given furazolidone in the above dose with no effect for 4 days when she began to develop influenza-like symptoms with general malaise and aching pains in most of her joints and increased pain in the neck and shoulders and increased signs of inflammatory changes in her middle fingers, which became markedly painful and movements further restricted and the joints more swollen. She sweated slightly and ran a temperature of 39° for 4 days. The urine became dark yellow in color. The exaggeration of symptoms of rheumatoid disease persisted for two days after cessation of treatment, at the end of which the ESR had risen to 40 mms/hour. There was no lymphadenopathy or eosinophilia. The exaggeration of symptoms then rapidly died down and within a week all symptoms and signs of rheumatoid disease had disappeared and remained absent over the next six months of observation, at the end of which time the ESR had fallen to 10 mms/hour, serum albumin 4.2, globulin 2.8 g/dl. She now feels extremely well.

*Case 4:* Female, aged 43 years. Her mother suffers from rheumatoid arthritis and diabetes. Past history: nil revenant.

Rheumatoid disease began some 5 months before being seen with pain in the balls of the feet on weight bearing, the feet swelling and the midtarsal joints becoming painful. The toes were painful on flexion and the ankles painful on any movement. Two years previously, she had pains across the lower abdomen and lumbar spine, which have persisted. In the last three months pains and swelling had spread to the fingers, thumbs, wrists, shoulders and neck, which was stiff. She suffered from night sweats. There was marked morning stiffness. RF was positive. She had been treated elsewhere with aspirin, Indocid® and exercise with some relief.

Examination showed warmth, tenderness, swelling and restricted movements of the wrists, finger joints, thumb joints and both midtarsal joints with tenderness on pressure under the metatarsals. X-rays showed no bony changes.

She was treated with metronidazole 2 gm on two successive evenings which was followed by generalized joint pains after 24 hours with sweating, headache, and a temperature of 38.6°C. Seven weeks later, there was marked improvement in her symptoms, but the thumb and first finger joint on both sides remained hot and swollen and the tips could not be flexed into the palms. Otherwise there were no abnormal physical signs. ESR was 45 mm hour, Hb 10g/dl, serum albumin 2.6, globulin 8.2 g/dl, serum uric acid 4.8 mg/dl.

The symptoms persisted over the next two month when the dose of metronidazole was repeated with a similar result. After a further two months, her only symptoms were pains on the dorsum of the fingers and tenderness of the right sternoclavicular joint. Five months later she noticed some return of pains and swelling to the fingers and wrists and hotness and tenderness of the right sternoclavicular joint, and hotness and tenderness on the inner side of the left foot, which could not be inverted fully without pain. The symptoms remained unchanged requiring treatment with aspirin for the next year. At this time, the ESR was 25 mms/hour.

She was treated with furazolidone as above. After three

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

days, this caused aching in the fingers, elbows and shoulders and the midtarsal joints with generalized influenza-like symptoms and tenderness in most of the other joints. She sweated and her temperature rose to 38.2°C for 3 days. The ESR rose to 80 mms/hour. Her symptoms rapidly disappeared three days after cessation of treatment when she complained of only occasional sharp pains in various joints, but there were no physical signs of rheumatoid disease to be made out. Four months after being treated with furazolidone, the ESR had fallen to 12 mms/hour, blood count showed Hb 15 g/dl. Over the course of the next three months, she became completely symptomless and has remained so for eight months since the course of furazolidone, with serum albumin 4.0, globulin 3.0g/dl.

*Case 5:* Male, age 53 years. Grandmother and mother both suffered from rheumatoid arthritis. Nil significant in the past history.

For 15 years, he had suffered from pain in the back of the right wrist with swelling, hotness and difficulty in dorsiflexion. There was occasional similar pain in the left wrist. RF was positive. A blood count and ESR were completely normal and serum uric acid was 4.2 mg/dl. X-rays of the wrists and hands showed no bony changes. He was treated with Inocid® 25 mg twice daily which controlled the swelling, but did not completely relieve the pain and had no effect on the restriction of writ movement. He had also been treated by acupuncture and some kind of electrical stimulation of the area without benefit and various herbal remedies without effect. A notable feature was that the pain and swelling were worse in the morning after taking alcohol of any sort.

On examination of the dorsum of the right wrist and neighboring region of the hand was markedly swollen, hot and tender in one small area. No dorsiflexion of the wrist was possible and palmar flexion and lateral deviation of the wrists was somewhat limited. No rheumatoid changes were found elsewhere in the body.

He was treated with furazolidone as above and this was followed by a marked increase in the swelling in the dorsum of the right wrist lasting 14 days. He also had slight symptoms affecting the left wrist. Three weeks after taking the tablets, pain and swelling had ceased and the movements of the wrists had returned to normal for the first time in 15 years. He has been followed for six months without return of symptoms or signs. The ESR and RF have not yet been retested.

*Case 6:* Male, aged 59 years. Family and past history nil relevant.

Two months before being seen, he noticed an onset of marked weakness of the arms with stiffness of the wrists and fingers, which could not be extend fully, and an inability to make a fist on either side. He also had tingling in the inner side of the thumb, index and middle fingers and the outer side of the ring finger on both hands. The neck was somewhat stiff, and there was marked pain and restricted movements of both shoulders and in the elbows, especially the left, and these could not be extended fully. There was also some pain and restricted flexion of the right knee. There was marked sweating of the palms of the hands, especially on the right. All the symptoms were worse after sitting. X-rays at another hospital showed no abnormalities in the joints. The weakness of the upper limbs were so severe that he was unable to carry on his work as a pianist. RF in the serum was mildly positive.

A blood count showed Hb 13.0 gm/dl, WBC  $6 \times 10^4$ /dl, RBC  $3.8 \times 10^6$ /dl, ESR 44 mms/hours, serum uric acid 5.8 mg/dl, serum albumin 3.0, globulin 4.8g/dl. He had been treated at another hospital for four months with indomethacin 25 mg three times daily

without benefit.

Examination showed marked weakness of all muscles of the arms and of movements of the wrists and fingers with inability to lift his arms above an angle of 75° of the body at the shoulders. He was unable to dress or undress because of this weakness. The palms were sweating profusely and on both sides there was evidence of median nerve dysfunction. The finger joints and wrists were swollen, hot and marked restricted. He was unable to flex the index and ring fingers into the palms. Both elbow joints were hot and tender and the movements restricted and there was marked tenderness and pain on attempted movement of the shoulder joints. Movements were partly restricted by severe weakness and pain. There were no abnormalities in the lower limbs. The CNS was normal, but a tensilon test was positive indicating the presence of myasthenia gravis in addition to bilateral median nerve dysfunction evidently associated with the rheumatoid condition.

He was treated with furazolidone as above. This produced a headache on the second day when all his joints became painful and there was general malaise, aching and morning stiffness. He sweated during sleep, but nine days after commencing treatment here was a rapid improvement in the joint pains and weakness of his upper limbs, though three weeks later he was still unable to close his fingers fully and full extension of the right wrist was not completely possible. There was also slight weakness of extension of the right elbow.

Two months after treatment, he still complained of stiffness on waking and after sitting with occasional pain in the right shoulder, both elbows and the middle interphalangeal joint of the right index finger. He was not quite able to make a fist and the medial nerve disturbances were still present. The middle interphalangeal joints of both index fingers were slightly swollen and tender with restricted flexion. The course of furazolidone was then repeated for 7 days again with mild increase in pains in the upper limb joints with hotness and swelling of the wrists and elbows and increased pain in the right shoulder joint lasting for 5 days, after which the myasthenic symptoms had completely disappeared and the symptoms of medial nerve dysfunction were absent. All joint pain and swelling had now ceased. He has been followed for a further six months and has remained symptomless. The ESR now had fallen to 9mms/hour, serum Hb 15gm/dl, WBC  $5 \times 10^9$ /dl, RBC  $5.5 \times 10^{12}$ /dl, serum albumin 6.8, globulin 2.8 gm/dl.

#### ***Successive cases treated with allopurinol***

*Case 1:* Male, aged 66 years. Fifteen year history of pain, swelling and restricted movements, particularly of knees, but also of hips, ankles, wrists and hands. He had been treated by many anti-inflammatory drugs including aspirin, Naprosyn®, indomethacin, Motril®, brufen and others. None of these helped the pain and swelling of the joints.

On examination, there was heat, swelling and restricted movements, especially affecting the knees but also the ankles, mid-tarsal joints, elbows, wrists, both shoulder joints and the neck. The finger joints were swollen, hot and tender and he could not make a fist on either side. RF in the serum was strongly positive, the ESR was 40 mms/hour, Hb 11 gm/dl, RBC  $4.0 \times 10^{12}$ /dl, WBC  $6 \times 10^9$ /dl, serum uric acid 5.6mg/dl, serum albumin 3.0, globulin 4.2 gm/dl. Differential count was normal.

He was treated with allopurinol 300 mg, three times daily for 7 days without any reaction until the 4th day when he began to get shooting pains in most of his joints. The temperature rose to 39.2-39.4°C for 5 days accompanied by shivering chills and on the 6th day by profuse sweating, severe stabbing pains affected the whole lower limbs, but also in various other parts of the body. This

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

lasted for 9 days when his temperature settled and remained normal.

Five weeks after the initial rise in temperature his symptoms and signs of disease had completely disappeared according to him "in a most extraordinary way."

He has been followed for eight months during which time he has had no return of rheumatoid symptoms. He is playing golf, tennis, squash racquets and swimming. His ESR is not 5 mm/hour, HB 15.2/dl, RBC  $5.3 \times 10^{12}$ /dl, WBC  $6.5 \times 10^9$ /dl, RF negative, serum uric acid 4.6 mg/dl, serum albumin 6.2, globulin 3.2 gm/dl.

*Case 2:* Male, aged 22 years. Family history — Grandfather suffered from rheumatoid arthritis. Three years previously the patient's right knee became painful and swollen and left knee, both ankles and left elbow followed within the next six weeks. These symptoms were relieved by brufen and paracetamol during the next six months; but after two years, he developed pain in the lumbar region and pain, swelling, hotness and restricted movements of the right elbow and wrist, and then other joints became affected on the left. Iridocyclitis appeared. This had varied in severity over the next year during which time the left shoulder and neck became painful with restricted movements and then the hips and the heels and insteps were also painful. He sweated excessively and the back of the neck was stiff. He had been treated with seven (7) 25 mg tablets of Indocid® and 6 paracetamol a day. The London Hospital had informed him that he had ankylosing spondylitis.

Examination showed some slight painful restriction movements to right and left. All movements of the left shoulder were moderately restricted by pain. Extension of the right elbow was limited to 15° with pain. The right wrist was hot, swollen and all movements restricted. Other joints were not affected. There was no evidence of iritis at the time.

He was treated with metronidazole 2 gm on two successive evenings which resulted in influenza-like symptoms on the first two days and on the second day exaggeration of the pain and swelling by pain in both shoulder joints, right toes, balls of the feet and heels on weight bearing. After this, the elbows were less painful and their movements less restricted. Other joints, however, were not infected. He had continued to take Indocid® and paracetamol during this time.

One month after taking metronidazole, there was slight pain at the back of the neck on flexion, but movements were full. The shoulder joints were normal. The elbows were painless and would now straighten almost completely. The right wrist was cold and not tender and the movements were now full.

The treatment was repeated and six weeks later the only symptom was slight pain in the ball of the right foot when walking.

He remained well during the next two years without taking any anti-inflammatory drugs when he reported that for the last two weeks his left shoulder had begun to ache and both knees gave him some pain on walking. The right elbow became painful and could not be extended fully. His neck was stiff on waking. There was generalized morning stiffness.

Examination showed the right elbow could not be fully extended by 10°. The blood count was normal, but the ESR was 30 mm/hour. RF was negative, serum uric acid was 5.2 mg/dl, serum albumin 4.1, globulin 5.2 gm/dl.

He was treated with allopurinol 300 mg three times daily for 7 days. This produced mild influenza-like symptoms, slight pyrexia of 38.2° C and some generalized joint pains especially for the right elbow and left shoulder joints and swelling of both wrists lasting for two days.

Following this, the symptoms rapidly disappeared and

within two weeks of beginning treatment he was completely symptoms without any physical signs of disease. The ESR had fallen to 9 mms/hour one month after beginning treatment with allopurinol.

He has remained completely well over the last nine months. Serum albumin 5.0, globulin 2.8gm/dl now.

*Case 3:* Female, aged 64 years. White inhabitant of Barbados. Family history, mother suffered from cholecystitis and mild rheumatoid arthritis and half-sister from thyrotoxicosis and a sister died of gastro-intestinal cancer.

In 1967, she had several attacks of cystitis and in June 1969 mild pains and swelling of the finger joints, wrists and pains and restricted movements of the shoulder and ankles. She was treated with aspirin without benefit; and in 1970, she began to suffer from severe weakness and arthropathy of almost all the joints and an anemia requiring blood transfusions. She was treated by repeated courses of gold injections until 1972 when this was changed to prednisolone and indomethacin suppositories. In 1974, she had a replacement of the right hip carried out. In 1974, both knees had become severely affected with the disease. In 1978 the pain and restricted movements of the neck became so severe that an x-ray was taken and showed severe involvement of the whole cervical spine with subluxation of C1 on C2 vertebra, for which she was treated with a collar. The movements of the shoulders became remarkably painful and restricted with nodules round the elbow. In 1979, there was severe pain under the balls of the feet, and she developed nasal blocking at this time. There was a slight chest cough with brown sputum. There was pain in the right chest on deep breathing. She also complained of considerable generalized pruritus.

Examination in 1979 showed bilateral nasal congestion, severe thinness; the chest exhibited crepitations in the right mid-zone, movements of the neck were impossible and the elbows and wrists were severely painful with all movements restricted with nodules round the elbow. The fingers and thumbs were completely useless with ankylosed joints. The right hip movements were free and painless (the site of the prosthesis) and the left hip movements were markedly painful and restricted. The knees were knobby without free fluid, but with severe crepitus and full movements accompanied by pain. The midtarsal joints were fixed. The toes were markedly involved with over-riding. She was unable to stand. X-rays of the chest showed diffuse shadowing in the right lung. The serum Hb was 10gm/dl, RBC  $11 \times 10^6$ /dl, WBC  $7.0 \times 10^4$ /dl, differential count normal, serum uric acid 5.5 mg/dl, ESR 88 mms/hr, serum albumin 1.8, globulin 5.8gm/dl. X-rays showed gross destruction of the knees, left hip joint, fingers, wrists and elbows and of the midtarsal joints with gross deformities of the toes. The RF was strongly positive. An ophthalmological opinion showed a positive Shirmer's test on both sides with evidence of scleritis and conjunctivitis.

In four days, she began to run an evening pyrexia of 39.2-39.4°C and complained of pain, hotness and swelling of most joints and pain in the neck. In addition, she developed rheumatoid nodules over the sacrum and on the dorsa of both feet. The increase in symptoms lasted for two weeks when the pyrexia settled and the rheumatoid nodules began to disappear slowly. The pain in the neck gradually lessened, and the hotness of the joints died down. By this time, the movements of the neck showed marked improvement in all directions, and those of the shoulders improved to such an extent she was able to do her hair and feed herself again. She was able to walk round the room, but this produced aching in the knee joints after five minutes. There was, however, no joint swelling and her temperature had fallen to normal.

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

This improvement was maintained over the next eight months; and at the end of this time, the serum Hb was 13.8 gm/dl, the ESR had fallen to 19 mms/hour, RBC was  $4.6 \times 10^6$ /dl, serum uric acid 4.6 mg/dl, serum albumin 5.8, globulin 3.6gm/dl. The eyes were markedly less dry as confirmed by Shirmer's test and there was no evidence of active rheumatoid disease, though the previous articular damage, of course, persisted.

*Case 4:* Female, aged 63 years. Family history nil relevant.

Past history, hysterectomy for fibroids and bilateral ovarian cystectomy age 49 years. Ten years later, she fell and injured the right ankle and immediately developed pain, hotness, swelling and restricted movements of the fingers, thumbs, wrists, knees, elbows, shoulders, hips and ankles, pain and stiffness and restricted movements of the neck and pain under the balls of the feet when weight bearing. This was accompanied by occipital headaches, sweating and loss of weight.

In addition, she later developed symptoms of ulcerative colitis proven by sigmoidoscopy, radiological appearances and mucosal biopsy. She was treated by numerous anti-inflammatory substances, including indomethacin, Naprosyn®, Feldene® by prednisolone and salazopyrin for the colitis. None of these produced appreciable improvement in her condition.

Her blood showed Hb 10.0 gm/dl, WBC  $7500 \times 10^4$ /dl, ESR 55 mms/hour, RF strongly positive, serum uric acid 5.3 mg/dl, albumin 4.2 gm/dl, globulin 6.3gm/dl.

Examination showed high facial color with mild mucosal pallor, mild rheumatoid deformities of wrists and fingers, left olecranon bursitis, pain and restricted movements of the shoulders, elbows, wrists, neck, marked crepitus during movements of both knee joints and restricted flexion and the presence of free fluid. Movements were painful at the extremes. The left ankle showed pain on extension, and she was tender on pressure under the balls of the feet. Walking was painful at the knees and under the balls of the feet. She was tender over the large intestine.

She was treated with allopurinol as above. After 4 days, this produced an increase in the symptoms of arthropathy with pain in the hips, knees, and ankles, the two latter becoming hot and swollen and her neck painful on movement. Her temperature rose on the 4th day to 38.5°C, and there was general malaise and influenza-like symptoms. The muscles were tender to the touch, and she sweated profusely.

These symptoms continued until two days after cessation of the drug administration when the temperature suddenly fell to normal; and within 5 days, there was a complete cessation of all joint swelling, hotness and pain and cessation of symptoms and signs of ulcerative colitis.

One month later, the serum Hb had risen to 13.8 gm/dl, ESR had fallen to 22 mms/hour, serum uric acid 5. mg/dl.

The temperature remained completely normal, and she has remained symptomless without taking any drugs over the last ten months and without any visual evidence of arthritis, bursitis, or deformities. No intestinal symptoms and barium enema normal. Serum albumin 6.4 gm/dl, globulin 4.0 gm/dl.

*Case 5:* Female, aged 60 years. Family history — no rheumatoid disease. Eighteen months previously she began to notice pain, swelling, hotness and restricted movements of the fingers and wrists later spreading to the elbows, shoulders and neck and to the knees, ankles and midtarsal joints with pain under the balls of the feet on weight bearing. She had been previously treated with indomethacin and aspirin without relief. On examination there was evidence of acute active inflammation in the fingers, thumbs, wrists,

elbows and shoulder joints with pain, tenderness, heat and restricted movements. The neck movements were painful and restricted. She was unable to extend her elbows fully or to do up or undo her brassiere. She could not feed herself. The wrists, fingers and thumb joints were markedly swollen, hot and tender, and she was unable to make a fist on either side. The knees were hot, swollen with free fluid and restricted flexion and this also applied to the ankles and metatarsal joints.

Hb was 10.2 gm/dl, WBC  $8 \times 10^9$ /dl, RBC  $4.0 \times 10^{12}$ /dl, ESR 42 mms/hour, serum uric acid 4.4 mg/dl, serum albumin 4.9 gm/dl, globulin 6.2 gm/dl, RF positive.

She was treated with allopurinol as above which produced on the third day a marked rise in temperature to 39.5°C, sweating and generalized pains in the muscles and joints which became swollen and hot and included the temporo-mandibular joints. The symptoms were severe enough to interfere with sleep in spite of continuing with the Naprosyn® as before treatment.

Ten days after beginning treatment, there was a sudden fall in temperature and evidence of active rheumatoid arthritis rapidly disappeared, so that after ten days she was completely free of pain, stiffness on waking and one month after beginning treatment she showed no abnormal physical signs whatsoever.

After three months, repetition of blood tests showed Hb 14.6gm/dl, RBC  $4.8 \times 10^{12}$ , ESR 16 mms/hour, serum uric acid 5.6 mg/dl, serum albumin 6.4 gm/dl, globulin 5.6 gm/dl.

She has been followed for a further six months without return of symptoms or recourse to pain killing drugs.

*Case 6:* Female, aged 54 years, Brazilian. Family history — mother suffered from rheumatoid arthritis. Eight years previous to being seen, she began to complain of pain, hotness, swelling and restricted movements of the fingers, wrists, elbows and shoulders, both knees, especially the right, left ankle and midtarsal joints. This had been treated in Brazil by hot wax baths to the fingers and wrists, by massage, exercising of the upper limbs, hands and lower limbs and by various anti-inflammatory drugs, including prednisolone 5 mg twice daily, none of which have controlled the symptoms.

On examination, there were typical rheumatoid arthritic changes in the above mentioned joints with swelling and heat, marked palmar erythema with restricted extension of the right knee. There was tenderness on pressure under the balls of the feet and bilateral olecranon bursitis. Neck movements were restricted with tenderness on pressure over the cervical spine at the side of the neck. She was unable to raise her arms above the shoulder; walking was only possible with a stick.

X-rays showed a minimal loss of disc space between C5-6 vertebrae in the neck, but were otherwise normal. Blood showed strongly positive RF, ESR 104mms/hour, Hb 10 gm/dl, WBC  $5 \times 10^9$ /dl, RBC  $4 \times 10^{12}$ /dl, serum uric acid 4.6 mg/dl, serum albumin 2.0 gm/dl, globulin 5.8 gm/dl. The temperature was 38.0°C and there was palmar erythema and sweating.

Treatment consisted of gradually tapering off the prednisolone and substituting with Feldene® 2 tablets in the morning. This, however, did not control the symptoms. She was therefore treated with a course of allopurinol.

Within three days, she had a violent joint reaction with pain, swelling, hotness and restricted movements of all her joints, profuse sweating and considerable pain requiring morphine injections to control it. The temperature reached 40.0°C for several days.

After ten days, there was a sudden cessation of her joint symptoms, pain and sweating and a fall in her temperature.

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

Within a week, she was free of any joint symptoms and was able to walk normally. At the height of her symptoms the ESR had risen to 1450 mms/hour, WBC  $9 \times 10^9$ /dl and 8% eosinophilia.

She was observed for the next six months during which time the symptoms did not return, even after giving up anti-inflammatory drugs.

The serum uric acid was at that time 4.6 mg/dl, Hb 14.5 gm/dl and the ESR was 18 mms/hour, serum albumin 6.8 gm/dl, globulin 5 gm/dl.

#### *Conclusion*

The above findings show that when the antiamoebic substances *furazolidone* and *allopurinol* are administered to patients suffering from active rheumatoid disease, within a few days they cause an exaggeration of the disease symptoms, which may be severe and accompanied by a rise in ESR, eosinophilia, sweating, pyrexia, all of which begin to die down after about ten days. This may be sudden and is followed by rapid and complete relief of disease symptoms, providing there has not been destruction of joint cartilage or bone or deformities have been present. Myasthenia gravis and ulcerative colitis likewise disappear.

In the next six months, all serological signs of infection disappear and the patient returns to health and normalization of the ESR and Hb and in the course of time the RF becomes negative. The exaggeration of symptoms is an example of the Jarisch-Herxheimer reaction. This is in accord with the previous demonstration of the presence of a free-living amoeba in the region of the joints and elsewhere in the body and of the curative effect of other antiamoebic substances, such as 5-nitronimidazoles.

*(Based on Madden, J.E., B.M., B. Ch. [Oxford], and Mendel D., M.D., B.S. Hounslow Health Centre, Middlesex, England) The effect of tinidazole on cases of active rheumatoid arthritis<sup>2,3,4</sup>.*

#### *Introduction*

Wyburn-Mason (1978) first reported the effect of 5-nitroimidazole drugs on cases of active rheumatoid arthritis. He found that in almost all cases, on first administration, they caused an immediate transient exaggeration of the manifestations of the disease often with influenza-like symptoms and in the appearance of lesions in tissues not previously affected. These symptoms gradually disappeared over the course of the next 2-3 months and in many cases all signs of disease activity were lost both clinically and serologically in the course of 8-12 months. The exaggeration of the symptoms of the disease could be lessened by the concomitant administration of an anti-inflammatory substance.

The authors undertook a trial in an attempt to confirm this report, using the most potent antiprotozoal drug of the 5-nitroimidazole series, namely tinidazole. The case of rheumatoid arthritis used in the trial were successive ones fulfilling the features of probable, definite or classical examples according to the American Rheumatism Association classification encountered in a general medical practice. In most cases, those which were already taking anti-inflammatory drugs continued on this regime and the tinidazole was given as 2 gram doses on 2 successive days. An attempt at a double blind crossover trial with a placebo was unsuccessful, since in all cases taking tinidazole within 24 hours there occurred generalized malaise with influenza-like symptoms, profuse nocturnal sweating and a marked increase in the arthropathy by the second or third day so that the trial was no longer blind to the observer. Instead of

this, an open trial was used. Full investigations of each case were carried out immediately before and throughout the trial and continued for 12 months or more after the administration of the tinidazole. All patients were advised not to take alcohol during the next month and not to exercise the joints and more than was essential and to avoid massage and heating the joints.

#### *Successive cases treated with tinidazole*

*Case 1:* Female, aged 54 years. Family history nil relevant. Acute onset of painful joint swelling in October 1979 involving the fingers, wrists, shoulders, knees and feet. Treated with aspirin without improvement.

Examination showed painful, tender, hot swelling of the wrists, finger and thumb joints, knees and ankles. Serum ANF positive, RF negative, ESR 20 mms per hour. HB 14.6 Gm per cent. RBC  $4.4 \times 10^{12}$ /dl, WBC  $5.8 \times 10^9$ /dl, no LE cells, albumin 2.4 mm per cent, globulin 2.4 mms per cent. Radiographs of wrists, fingers, knees, ankles normal.

On January 15th and 16th, 1980 she was treated with 2 grams of tinidazole on both days. This resulted in influenza-like symptoms and lasted 36 hours with severe nocturnal sweats and some increase in the severity of the arthropathy lasting for 10 days following which there was a rapid disappearance of the joint swelling, pain and heat and return of the movements to normal during the next 12 months.

After six months, she was completely symptomless. The ESR was 14 mm per hour. ANF and RF were still positive. Hb was 14.8 Gm/dl, RBC  $4.8 \times 10^{12}$ /dl, WBC  $5.5 \times 10^9$ /dl, serum albumin 3.0 Gm per cent, globulin 1.8 Gm per cent. Eighteen months after treatment apart from occasional joint pains varying with the climate and controlled by aspirin, she has remained well. The ESR is now 6 mm/hour, ANF and RF negative.

*Case 2:* Male, aged 43 years. Family history, nil relevant. Twelve year history of progressive seropositive rheumatoid arthritis beginning in the wrist and gradually spreading to involve the fingers, ankles, knees, elbows, shoulders, neck at midtarsal joints. He had been treated with indomethacin and prednisolone throughout.

Examination showed typical rheumatoid changes in all the above joints with signs of activity as evidenced by heat and pain. All the joint movements were restricted, especially wrists, fingers and knees, which exhibited free fluid in the joint cavities. The arms could not be raised about 45° at the shoulders, and he was unable to shave, feed himself, do up his tie or put on his coat. Walking was painful and limited and movements of the knees, and ankles were restricted and of the midtarsal joints nonexistent. He could not make a fist and dorsiflexion and palmar flexion of the wrists was impossible. The fingers and thumbs could not be fully extended. X-rays showed loss of joint space in both knees and fingers. Serum ANF negative, latex test positive 1 in 20, RAHA positive 1 in 2560, ESR 64 mm per hour, Hb 11.0 Gm per cent, RBC  $4.2 \times 10^{12}$ /l, WBC  $10^9 \times 10^9$ /l, neutrophils 59 per cent, lymphocytes 33 per cent, albumin 1.8 Gm per cent, globulin 3.8 Gm per cent, IgG 2000mg/dl, IgA 500/dl, IgM 200 mg/dl.

On 2nd and 3rd of February 1980, he was treated with tinidazole 2 grams on both days. He continued on indomethacin and prednisolone. This resulted in some exaggeration of his symptoms over the first week followed by a definite lessening of the pain and hotness of the joints; and after two months, the ESR had fallen to 19 mms per hour, RAHA was positive 1 in 640, latex test positive 1 in 20, and the ANF was negative.

Because of the improvement, the patient requested another course of treatment three months after the first. This was given as

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

2 grams tinidazole on the 1st and 2nd April 1980 and was followed by headache, general malaise and an increase in the joint pains a week later. He was tapered off steroids.

Six months later there was a remarkable improvement, and all signs of activity of the disease were absent, the joints being cold and mostly painless, not swollen and with full movements, except for the knees which were still painful with marked crepitus on movements due to secondary osteoarthritic changes, and some pain and swelling of the finger joints.

One year after the first treatment with tinidazole, the ANF was negative, the RF latex test was less than 1 in 20, and the RAHA was now 1 in 80, albumin as 3.6 Gm per cent, globulin 2.8 Gm per cent, ESR was 19 mms per hour, Hb 14.8 g per cent. RBC  $4.6 \times 10^{12}/l$ , WBC  $7.8 \times 10^9/l$ . He has remained symptomless apart from his knees and fingers and is still under observation.

*Case 3:* Female, aged 50 years. Family history, nil relevant. Three year history of gradual increase in pain, swelling, hotness and restricted movements of fingers, wrists, elbows, shoulders, neck, temporo-mandibular joints, knees, ankles, midtarsal joints and metatarso-phalangeal joints in spite of treatment with aspirin, gold injections, levamisole, indomethacin and opren.

On examination, there was typical rheumatoid arthritis affecting the fingers and thumb joints, wrists, elbows, shoulders, knee joints with effusions, ankles and midtarsal joints with edema of the feet and inability to move either the ankles or midtarsal joints. Joint x-rays showed no cartilage or bony damage. Serum ANF negative, RF latex positive 1 in 640, Rose Waaler test positive 1 in 64, ESR 34 mms per hour, serum albumin 2.8 Gm per 100 ml, globulin 3.8 g per 100 ml, IgG 2000mg/dl, IgA 400 mg/dl, IgM 200 mg/dl, Hb 12.0 Gm/d, RBC  $3.5 \times 10^{12}/l$ .

She continued to take opren, but on January 9 and 10, 1980, she took 2 gm tinidazole each evening. This was followed by influenza-like symptoms and general exaggeration of arthropathy over the next three weeks followed by gradual general improvement.

After two months, evidence of active joint disease had disappeared, and she began to put on weight and the muscle power to improve. After six months the ESR was 18 mms per hour.

She had given up treatment with opren; and after one year was completely symptomless except for occasional joint pain after twisting or wrenching or with changes in the weather. At this time, serum albumin was 4.0 Gm per cent, globulin 2.5 Gm per cent, IgG 800 mg/dl, IgA 60 mg/dl, IgM 140 mg/dl, ESR 6 mm/hour.

She has remained symptomless while still being followed two years after initial treatment.

*Case 4:* Female aged 73 years. Family history, a sister suffered from severe rheumatoid arthritis. The patient gave a ten year history of progressive pain, swelling, hotness of fingers, wrists, elbows, shoulders, neck, knees, ankles and midtarsal joints with considerable pain on the balls of the feet when weight bearing. There was pain in the region of the temporo-mandibular joints when chewing. She had been taking brufen over the last year with no appreciable relief of symptoms.

Examination showed tenderness on pressure over the temporo-mandibular joints, restricted painful movements of the head on the neck in all directions with pain on pressure over the cervical spine, marked restriction and pain of the shoulder movements bilaterally with tenderness on pressure over joint spaces. The elbows were swollen, hot and tender and could not be fully extended or flexed. Both wrists were swollen, very tender with marked restriction of all movements with swelling of the metacarpophalangeal joints of all fingers. She was unable to make a fist

or to extend the fingers fully. Palmar erythema was present; marked weakness of all movements of the upper limbs. The knee joints were swollen, hot and tender at the joint spaces with crepitus more marked on the left. Both ankle joints showed with bony thickening and restricted movements, midtarsal joints were swollen, hot and tender with absent movements. There was tenderness on pressure under the heads of all the metatarsals, some general edema of the feet and ankles. Blood examination — ANF, RF strongly positive. ESR 62 mm/hr, Hb 11.4 Gm/dl, RBC  $4.3 \times 10^{12}/l$ , WBC  $30 \times 10^9/l$ , 67 per cent neutrophils, 25 per cent lymphocytes, 4 per cent monocytes, 4 per cent eosinophils, albumin 2.1 Gm per cent, globulin 4.3 Gm per cent. X-rays showed losses of joint spaces in the knees and interphalangeal joints of the fingers. IgG 3000 mg/dl, IgA 550 mg/dl, IgM 200 mg/dl.

On January 11th and 12th, 1980, she was given tinidazole 2 grams on two successive evenings. Brufen was continued, but the tinidazole produced an influenza-like reaction with sweating and pyrexia of 38.8°C on the next two days and some exaggeration of joint pain and swelling.

She was seen again on May 20th, 1980, when there was a remarkable improvement in her general condition. The hotness and swelling of all the joints had disappeared. The neck and jaw ache were no longer present. The shoulder, neck and elbow movements were full and painless. The wrist swelling had disappeared. The joints were no longer hot and movements were almost normal, the finger movements were no longer painful, and swelling almost disappeared. Flexion and extension of metacarpophalangeal and interphalangeal joints were full with normal grip. The hip joints were normal. The knee joints were no longer swollen or hot, but movements were still painful. The swelling of the feet was no longer present, and movements of the ankles and midtarsal joints were full, free, and painless. There was still tenderness on pressure over the heads of the metatarsals.

On May 7th, 1980, the blood showed ANF and RF negative, ESR 3 mm/hr, Hb 14.6 gm/l, RBC  $4.8 \times 10^{12}/dl$ , WBC  $4.1 \times 10^9/l$ , 46 per cent neutrophils, 46 per cent lymphocytes, 5 per cent monocytes, 3 per cent eosinophils, albumin 4.5 Gm per cent, globulin 2.3 Gm per cent.

On December 5th, 1981, she remained symptomless apart from secondary osteoarthritic symptoms in both knees. The serum protein showed albumin 4.6 Gm per cent, globulin 2.4 Gm per cent, IgG 1000 mg/dl, IgA 300 mg/dl, IgM 110 mg/dl. She remains under observation and symptomless except for some pains in both knees.

*Case 5:* Male aged 69 years. Family history — mother suffered from asthma. At the age of 35 years, the patient developed nocturnal asthma. Ten years previous to being seen, he developed pains in the upper arms after exercise and drenching night sweats to be followed by calf pains on exertion and eventually generalized pains in the muscles which became tender and wasted. These symptoms became much worse two years before being seen. He also noticed painful lumps under the skin lasting 24 hours, morning stiffness, pains, hotness, swelling and restricted movements of the elbows and knees and pain and stiffness of the back of the neck. The shoulders became stiff, and their movements painful and greatly restricted as were the wrists, fingers, and thumbs. Also, pain was present in both joints and pain, swelling, hotness, and restricted movements of both ankles, midtarsal joints, and pains under the balls of both feet. The left toes became deformed. He also suffered recurrent left painful parotid swelling. He had been treated by recurrent courses of gold injections over 8 years without control of the pain and progress of the disease. He was now completely

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.** helpless.

Examination showed blood pressure 100/120, left parotid gland markedly swollen, and tender. All movements of the neck grossly restricted and painful and there was marked tenderness over the cervical vertebrae. All the shoulder joint movements grossly restricted and painful. He was unable to get his hand to his mouth to feed himself, shave, or comb his hair, or to take his shirt or coat on or off. All elbow movements were grossly restricted by pain and tenderness of joints which were hot. The wrists were swollen, hot and all movements impossible because of pain. Finger and thumb joints were thickened, cold; and movements slight and restricted. He was unable to write, cut up his food, dress himself, or go to the toilet. The knees were normal. Both ankles and midtarsal joints were thickened, hot and movements were impossible. The left toes showed outward deviation with tenderness under the balls of the feet on pressure. The palms were red. He was unable to walk more than a few paces. Serum RF positive 1 in 640, ESR 102 mm/hr, ANF positive, Hb 9.4 Gm per 100 ml, globulin 4.6 Gm per 100, diarrhea with passage of mucus and blood. Sigmoidoscopy and rectal biopsy and a barium enema showed typical ulcerative colitis. The indomethacin and aspirin were continued.

On April 6th and 7th, 1980, he was given tinidazole 2 gm on each occasion. This resulted in a violent reaction with further swelling and pain in the left parotid gland and pyrexia of 39°C, drenching night sweats, headache, severe neck pain and stiffness, and a generalized increase in pain, swelling, and stiffness in all the joints in the body. The shoulders were so markedly affected, he was unable to move his arms at the shoulders as though paralyzed. Within a week, the pyrexia and sweating had ceased, and the pain, swelling and hotness of the joints began to decrease.

After four weeks, there was considerable improvement in all his symptoms; and at that time, the ESR was 140 mm per hour. The parotid swelling had disappeared.

Over the next twelve months, there was a gradual disappearance of all signs of active disease. His diarrhea and abdominal pain ceased. Power returned to his limbs, and the muscle wasting lessened until he was left with only some bony thickening of the left ankle. He was now able to look after himself in the normal fashion, eat, feed, shave, and dress himself and to walk normally. He began to gain weight, and the ESR now was 19 mm per hour. The blood pressure had fallen to 140/80. He had been able to give up taking aspirin, indomethacin and some five months previously the ANF and RF were negative, Hb 15.2 Gm/dl, RBC  $4.8 \times 10^{12}/l$ , WBC  $6.8 \times 10^9/l$ , differential count normal, albumin 3.2 Gm per cent, globulin 2.8 Gm per cent, IgG 1200 mg/dl, IgA 280 mg/dl, IgM 80 mg/dl, barium enema was normal.

He has remained symptomless and under continued observation without further treatment during 2 years.

*Case 6:* Female, aged 45 years. Six months history of progressive pain, hotness, swelling, and restricted movements of wrists and knees, night sweats, morning stiffness, and occipital headaches.

Examination showed palmar erythema, swelling, tenderness, heat and restricted movements of wrists and knees with free fluid in the latter. Blood count showed Hb 12.6 Gm per cent, ESR 42 mm per hour, RF positive 1 in 320, serum albumin 1.8 Gm/dl, IgG 2000 mg/dl, IgA 350 mg/dl, IgM 200 mg/dl, LE cells negative, Rose Waaler 1 in 32. She was treated with brufen tablets, 2 three times daily after meals during six months with some lessening of the pain and heat, but no obvious regression of arthropathy. Fluid persisted in the knee joints.

On January 8th, 1980, she was treated with tinidazole, 2

gm on 2 successive evenings. After three hours, she noticed influenza-like symptoms with exaggeration of the heat, pain and swelling of the wrists and knees and the appearance of similar symptoms in the fingers and ankles. There was marked sweating during sleep. Brufen was continued.

The exaggeration of symptoms was maximal on the third day after tinidazole was given and thereafter gradual improvement over the next two months when the arthropathy had disappeared and the patient felt well. The ESR was now 68 mm per hour. Six months later, she still remained symptomless in spite of giving up brufen, and the ESR had fallen to 9 mm per hour, the RF was now negative, and the blood Hb had risen to 14.8 Gm/dl. A year after treatment, the serum IgG was 1400 mg/dl, IgA 330 mg/dl, IgM 100 mg/dl.

She is still under observation and symptomless and requires no treatment.

*Case 7:* Male, aged 49 years. Onset of swelling, pain, and restricted movements of the left metacarpo-carpal joint of the thumb persisting for six months followed by acute onset of intense pain and restricted movements of the left shoulder joint making it impossible for him to dress himself. This persisted for five months and was followed by pain in the right shoulder and in the right metacarpo-carpal joint of the thumb.

Examination showed signs of gross pain on attempted movement of both shoulder joints which could not be raised forward or laterally more than 45°. The metacarpo-carpal joints of the thumbs were severely tender and movements impossible. X-rays of the shoulder joints and thumbs were normal. ESR 36 mm/hr, RF positive, albumin 2 Gm/dl, globulin 2 Gm/dl. He was treated with 2 gm tinidazole on two successive evenings with violent sweating on each night and increased pain in the affected joints making it impossible for him to look after himself.

Within 4 days, all symptoms had disappeared and movements of the affected joints were completely normal and painless.

Three months later, blood ESR was 6 mm/hr, albumin 2.8 gm/dl, globulin 1.8 gm/dl. He has had no recurrence of symptoms during a year follow-up.

*Case 8:* Female, aged 29 years. Ten year history of severe rheumatoid arthritis affecting almost every joint in the body at times, but especially the left knee. She had received every form of treatment, including gold injections, penicillamine, cortico-steroids, and many anti-inflammatory tablets and had recently had a synovectomy of the left knee, which left it swollen and still containing large amounts of free fluid. She was confined to bed and emotionally extremely depressed.

Examination showed very active arthropathy affecting the neck, shoulders, elbows, wrists, fingers, temporomandibular joints, especially both knees with large amounts of free fluid, ankles, mid-tarsal, and metatarsophalangeal joints. She was totally bedbound, sweating and had a temperature of 37.5-39°C. X-rays showed surprisingly little damage to cartilage and this only partial in the left knee joint. Blood showed strongly positive RF, ESR 100 mm/hr, Hb 9.8 gm/dl, RBC  $3.6 \times 10^{12}/l$ , WBC  $4.8 \times 10^9/l$ , albumin 1.6 gm per cent, globulin 2.8 gm per cent.

She was treated with tinidazole, 2 grams on two successive evenings, followed by violent sweating, further pyrexia, and increased pain and swelling of all her joints gradually dying down during the last two weeks.

Within four weeks, she was able to walk and within three months, apart from the operated left knee, all the joints were cool, unswollen and movements normal and painless. The fluid in the

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

left knee had absorbed, but walking was still painful to some extent.

During the next two years, her life has become completely normal except for some pain in the left knee after prolonged walking. She is able to look after her house and husband and do a full time job and take a degree at the Open University. Blood count now is completely normal, ESR 4 mm/hour, RF negative, albumin 2.9 gm/dl, globulin 1.8 gm/dl.

She requires no further treatment.

*Case 9:* Girl, aged 18 years, born with juvenile arthritis with marked deformities and had received prednisolone treatment almost since birth. She complained of pain in the back, in feet and hands, and her growth was stunted.

On examination, she showed the typical changes of Still's disease affecting the spine, wrists, fingers, knees, ankles and feet. The child was in continuous pain and tearful with severe growth stunting. Blood showed ESR 60 mm/hr, positive RF, Hb 5.0/dl, RBC  $2.5 \times 10^{12}/l$ , albumin 1.2 gm percent, globulin 3.0 gm percent. X-rays showed gross kyphoscoliosis of the spine and marked deformities of the wrists, fingers, ankles, feet, and toes.

She was treated with one gram tinidazole on two successive evenings which produced a short lived Herxheimer reaction; but within four weeks, the patient was obviously in much less pain and in two months was completely free of pain, and the joint movements were markedly freer.

The prednisolone was gradually tapered off. She gradually began to grow in the next year and grew two inches in height and was able to walk about though the deformities remained. She has been able to play games with school friends; and after 1-1/2 years, all the blood parameters are within normal limits.

*Case 10:* Male, aged 65 years. Slow onset of pain in the left shoulder and left side of the neck and tingling down the outside of the arm, forearm and into the fingers followed by pain and swelling of the right wrist and right index finger making work impossible.

Examination showed a painful, fixed left shoulder, tenderness on pressure over the cervical spine and pain, hotness, swelling and tenderness of all joints of the right middle finger. X-rays of the shoulders were normal; of the neck showed some degree of spondylitis, and of the right middle finger were normal. Blood showed doubtful positive RF, but was otherwise normal.

He was treated with 2 grams of tinidazole on each of two successive evenings which resulted in violent night sweats and a pyrexia with further swelling of the finger.

On the third day, the movements of the shoulders were completely painless and free; and three weeks later, the finger was completely normal.

He has remained well over the next two years and is now able to play golf.

Disease activity was assessed clinically before, during, and at the end of observations. Pain and stiffness was scored subjectively according to an arbitrary scale, severe (3), moderate (2), mild (1), and absent (0).

A Ritchie articular index was used to assess joint tenderness, and grip strengths were measured with a sphygmomanometer bag inflated to 30mm of mercury. Laboratory measurements included C-reactive protein by single radial immuno-defusion, immuno complexes by liquid-phase Clq-binding assay and IgM rheumatoid factor by an enzyme-linked immuno-assay and red and white blood cell counts by the standard methods. The ESR was carried out in the normal manner.

*Conclusion*

In all ten cases, tinidazole induced sweating, pyrexia, and exaggeration of the symptoms of active disease both in the affected tissues and the appearance of inflammation in other joints, not previously affected. This exaggeration of symptoms is typical of an Herxheimer reaction.

These phenomena gradually settled down during the next few months; and after one year, joints in which no radiological damage was present were normal clinically.

The accompanying parotid swelling and ulcerative colitis cleared permanently. In joints with erosion of cartilage or bone deformities, symptoms persisted.

After a year, the blood changes returned to normal.

*(Based on Archimedes A. Concon, M.D., Memphis, Tennessee)*

#### *Introduction*

Dr. Archimedes A. Concon is a Memphis physician who has apparently had the experience of trying antiameobic drugs on a wide variety of ailments. From among the variety submitted for publication, the author has chosen the following, which includes the effect of metronidazole on psoriasis, lupus erythematosus, and rheumatoid arthritis, all diseases which are supposedly incurable with the present state of art of medical treatments.

#### **Successive cases treated with metronidazole**

*Case 1:* A 33-year-old white male patient came to see me with a history of psoriasis involving the hands and fingers of 12 years duration. Patient was put on metronidazole, 500 mg, 4 tablets (2 gm) after supper daily for 2 days, rest 5 days, and repeat course indefinitely until well. At the end of 4 months, the skin on the hands were largely clear. Most of the fingernails were normal looking. At the end of 6 months, patient was clinically free.

*Case 2:* A 61-year-old white female came in with complaints of rheumatoid arthritis involving the hands, left hip, and knees of 14 years duration. She was barely able to use her hands or walk at the time I saw her because of stiffness and pain of joints involved. She was put on metronidazole, 500 mg, 4 tablets (2 gm) after supper daily for 2 days, rest 5 days, and repeat course indefinitely until well. At the end of 3 months from the start of treatment, stiffness and pain in joints were hardly noticeable. At the end of 6 months from start of treatment, patient was clinically free. During course of treatment, patient complained of chronic nausea which was bearable. The chronic nausea disappeared after termination of treatment.

*Case 3:* A 29-year-old white male patient came in with a history of systemic lupus erythematosus, of 7 years duration with recent kidneys involvement. His albuminuria (urinary protein) was 2+. Urinary output was adequate at start of treatment. Patient was put on metronidazole, 500 mg, 4 tablets (2 gm) after supper daily for 2 days, rest 5 days, repeat course indefinitely until well. After 1 month of treatment, his albuminuria was 1+. His urinary output was adequate. At the end of 5 months of treatment, his albuminuria was negative, and his urinary output was adequate. Patient could tolerate exposure to sunlight where before he could not. Patient was clinically free.

#### *Conclusion*

The above findings apparently show that the *Limax amoeba* [abnormal macrophage, Cell Wall Deficient bacteria, Cell Wall Deficient *Candida albicans*, or other organisms susceptible to the treatment that behave like the *Limax amoeba*] is responsible (as reported by Professor Roger Wyburn-Mason) for more than limited forms of rheumatoid diseases.

Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.

*(Based on Robert Bingham [Report],  
Desert Hot Springs, California)*

#### *Introduction*

Robert Bingham, M.D., was Chief of Orthopaedic Surgery of the Surgical Section, Esperanza Inter-Community Hospital, Yorba Linda, CA, and is Medical Administrator of the Desert Arthritis Medical Clinic in Desert Hot Springs, CA. He's had a special interest in arthritis for more than 30 years, which began when he was an intern at the University of Pennsylvania Hospital, and continued under several renown specialists over the years. In August 1976, Dr. Bingham visited Professor Roger Wyburn-Mason in England, and followed up the visit with the article, "Rheumatoid Disease: Has One Investigator Found its Cause and its Cure?" This is the same article credited by Jack M. Blount, M.D., in Chapter 2, which led to the vital clues that saved his life.

According to a second article<sup>5</sup> by Robert Bingham, the first medical information on clotrimazole to be published in Britain appeared in *Lancet*, Feb. 28, 1976 as a medical letter from Professor Wyburn-Mason. Therein, Wyburn-Mason reported the first ten patients treated whose signs and symptoms of active rheumatoid disease disappeared in from 3 to 28 days and showed no return of the disease in a one year follow-up.

In his article, Dr. Bingham describes results of over two hundred patients treated by Professor Wyburn-Mason, and includes the following case histories based on interviewing Roger Wyburn-Mason and reviewing case reports and letters from patients who had been treated with clotrimazole.

#### **Effects of treatment with clotrimazole**

*Case 1:* ... He was suffering from painful and complete ankylosis of the spine and other joints of the limbs. The disease had lasted 33 years. He could not move his neck or back at all, and the joints of his extremities were swollen, tender and painful. His spine, hips and knees were flexed and fixed so that his eyes were directed toward the floor when he was standing. In 12 weeks on clotrimazole, 2 gm per day, he was able to move his spine almost normally and to stand erect. The swelling in his hands and feet subsided, and he was able to walk with a normal gait. He is now decorating his house, digging the garden and driving an automobile again for the first time in 30 years.

*Case 2:* ... a physician's 5-year-old daughter, had very acute painful and tender joints and night sweats with elevated temperatures continually up to 106°F. She was taking prednisone 80 mg per day. Her temperature fell to normal in 12 hours after beginning clotrimazole and remained down, enabling prednisone to be stopped without return of symptoms.

*Case 3:* Another child — 13 years of age — had the disease since she was 1 year old. Symptoms included a low hemoglobin. Her spleen was huge and the sedimentation rate elevated to 60 mm/hr. Her hands, knees, ankles, and feet were swollen, and she was in constant pain. She had been taking prednisone, 5mg and Indocin®, 50mg per day, with only partial relief of pain. Within 2 days of clotrimazole treatment, her temperature dropped to normal for the first time in months. By the end of 3 weeks, the corticosteroid and pain-relieving drugs could be stopped, and she was walking comfortably. Her hemoglobin increased from 50% normal to 80% normal in just a few weeks. At the end of 12 weeks, all signs of active rheumatoid arthritis had subsided.

*Case 4:* ... a boy age 5, proved that the most dramatic results with clotrimazole occur in juvenile arthritis. He was completely handicapped by pain, swelling and joint deformities from onset of the disease. He had been taking prednisone, 30mg per day. He was 9 inches too short and 20 pounds overweight for his age. In 3 or 4 days after the start of clotrimazole (500mg once a day), he had so much relief of pain and swelling that his actions were "lively and comfortable." He became almost uncontrollable ... The cortisone was decreased at the rate of 5mg each week, and he continued to improve. Clotrimazole was given at 500 mg/day for 5 weeks and then decreased to 250 mg/day for 7 more weeks. After 12 weeks, it appeared that he had made a "full recovery." After a year, he has remained well and is now of normal weight and height for his age.

#### *The Treatment of Rheumatoid Disease With Anti-Protozoal Drugs*

##### **A Preliminary Report** by Robert Bingham, M.D.

On a clinical basis...treatment of rheumatoid arthritis and its related forms of disease with anti-Protozoal drugs has proven very successful. This infectious origin of rheumatoid arthritis explains the success in the use of chloroquine which has anti-Protozoal properties as well as anti-malarial action.

Over the last six years, our clinic has used various anti-Protozoal drugs for the treatment of active rheumatoid arthritis in over 500 cases. We have not done double-blind placebo studies for lack of research funding. However, we have used two groups of patients, one not treated at all, the second group treated by conventional methods such as with gold, penicillamine, and anti-inflammatory drugs, and we have compared our results with six medications which have anti-Protozoal properties.

Dr. Roger Wyburn-Mason recommends tinidazole (Fasign®) which is available in Great Britain but not the United States. He believes it is more effective and has less side-effects than any of the drugs used in this study. We have found di-hydroxyquin (Diodoquin®) and metronidazole (Flagyl®) to be very effective and adequate in our series. If a patient shows any side-effects to one of these, such as nausea or loss of appetite, or if the particular case shows some resistance to treatment, then a change to the other of these two drugs has often been effective in relieving acute symptoms. The failure rate of patients with active rheumatoid arthritis treated with anti-Protozoal drugs has been about 6%.

Flagyl® (metronidazole) is given as follows: for a 150 pound male (70 kg), three tablets of 250 mg each, three times a day for ten days, a total of ninety tablets. With women patients weighing approximately 120 pounds (50 kg), two tablets of 250 mg three times a day for ten days, a total of sixty tablets. Then the medicine is stopped from one to five months. If there is a recurrence of symptoms or a continued activity, then the medicine is repeated for three days, one tablet (250 mg) three times a day, a total of nine tablets.

In using Diodoquin® (di-iodohydroxyquin), the dosage is two tablets (650 mg per tablet), three times a day for ten days, a total of sixty tablets. If the medicine has to be repeated in one to five months, then one tablet is given three times a day for 3 days, a total of nine tablets. These medications should be given with food or milk, preferably at the beginning or in the middle of a meal. Except for occasional nausea or anorexia, we have found no side-effects. We have had no drug reactions or complications with these medicines in the dosages mentioned.

*Results:* 500 patients have been treated with anti-Protozoal drugs. All had active rheumatoid arthritis with elevated sedimentation rates and positive rheumatoid serology. Of these, 278 patients showed improvement, 137 showed complete remission

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.** and 85 had no improvement with the first drug used; 30 of these responded to the second course of treatment or the second drug used.

#### Comparative Results of Treatment With Other Drugs

	Patients Treated	Improved or Remissions	% Change
Controls	22	7	30
Conventional Care	30	8	27
Copper Sulfate	12	8	66
Bile Salts	12	9	75
Clotrimazole	9	7	78
Diodoquin®	204	189	93
Chloroquine	12	6	50
Flagyl®	221	181	82*

\*Recent cases have done better on increased dosages.

#### Conclusions

The discovery of Dr. Roger Wyburn-Mason that many cases of rheumatoid arthritis are infectious in origin with either *Limax* or amoeba *Naegleria* seems confirmed by success with treatment of acute active cases using anti-protozoal drugs. Diodoquin® and Flagyl® have been the most successful. Further clinical and pathological studies are recommended to verify these results and determine the pathological relationships between the protozoa and the rheumatoid diseases.

#### Conclusion

Apparently, there is a wide range of antiamoebics that will kill the *Limax amoeba*. Clotrimazole was one of the very first, and it was no less effective than those that are in general use now.

5. *Orthopedic Review*, "Dr. Wyburn-Mason is Alive and Back at Work, The Protozoal Theory of Rheumatoid Disease, A Progress Report and a Drug for Treating It," Robert Bingham, M.D., 1977, pp. 23-26.

#### Irony

In America, much is made out of the idea of double-blind experiments, which are quite costly, and perhaps can help discriminate between one aspirin substitute and another. Rheumatologists have insisted on double-blind experiments which are supposed to be the ultimate in "scientific" proof, — although their own routine usage of gold shots and penicillamine have no scientific basis — the lack of such studies kept Wyburn-Mason's findings from the general public for six years.

According to my recent letter, "Roger Wyburn-Mason told the story of his student who originally wrote up the double-blind trial method in the *Lancet* and the Editor gave a glowing appraisal of the method. It was then seized on as the perfect proof of all new therapies and was adopted. The first one done was on the use of cortisone in asthma and the result of this trial was that it showed quite conclusively that cortisone had no effect on asthma! It is well known that the most effective therapy for asthma is cortisone. So where do we go from here?"

[Name withheld by author]

"Chance only favours the mind that is prepared." —Louis Pasteur

ROGER WYBURN-MASON  
Letter received, May 1993

Many substances having in common the fact that they kill free-living amoebae have been found when administered to sufferers from active rheumatoid disease to cause a transient but rapid

increase in the symptoms of the latter followed by marked improvement or complete disappearance of disability and pain. Deformities are, however, not usually affected. These substances have no effect in healthy subjects. Because of this property of first increasing the symptoms of the disease before lessening or abolishing them, it is impossible to carry out a double-blind trial with them on rheumatoid patients. Rheumatologists have seized on this as a reason for not accepting the idea that these drugs are of benefit to such patients, whereas, in fact, if given correctly, they invariably cause the activity of the disease to cease and, in early cases, result in complete cure. Rheumatologists refuse to try the treatment on patients to see if they get similar results, which is the true test of a scientific discovery. Instead, unscientifically, they dismiss anti-amoebic treatment out of hand simply because no double-blind trial has been carried out owing to the impossibility of doing them. They ignore the fact that if a substance has already been found to be curative, then no double-blind trial is necessary. None was carried out in humans in proving the benefit of salvarsan in cases of syphilis, of the original sulphonamides in many human bacterial infections [Professor Roger Wyburn-Mason took part in the original trials of sulfonamides], or the first human trials of penicillin on infections.

Eminent [ethical] doctors maintain that once a drug treatment has been shown to be superior in treating any disease, other drugs should be abandoned. This applies to rheumatoid disease when the pain and suffering can be rapidly brought to a halt with the giving of anti-amoebic drugs. Only this group of drugs should be continued to be used in the treatment of rheumatoid disease. Failure to do so could be unethical and amount to malpractice or negligence.

#### Chapter IX

##### Correspondence, Testimonials, and Book Report

From Dr. Paul K. Pybus,<sup>1</sup>

Pietermaritzburg, South Africa

(To *The Beebe News*, Beebe, Arkansas) "Other doctors in South Africa are also using metronidazole with equally good results. It really works. I also know Professor Wyburn-Mason who first advised its use to me. Many years ago I was his House Physician.

"Dr. Blount is doing wonderful work ... The whole world must know what has been discovered ..."

(To Dr. Jack M. Blount) "... one must promote a cure if we have one. If the medical profession will not accept it, then it must be stated elsewhere. Neither of us wish to keep our secrets for our own monetary gain. The Hippocratic oath tells us to teach our colleagues. If any doctor is man enough, and there are many of them, to bring a patient to me, I will not only treat the patient but give the doctor details of how to do it. I have myself not only done this but also even given the doctor materials with which I work. My methods are open for all to see and for those who wish to learn so that all may benefit. I know that yours are also."

From Bob Kemp, Beebe, Arkansas

(From Bob Kemp, editor of *The Beebe News*, Beebe, Arkansas) "I took the first dose of Flagyl® at 5 p.m. on Thursday, Oct. 29. Eight tablets, 250 milligrams each, were swallowed following a supper meal. Two hours earlier — at about 3 p.m. — I took a 400 milligram Motrin® tablet, a medication which had been in use several months. This was the final Motrin® tablet. Within just a few hours — before bedtime — I began experiencing less pain.

"During the early morning hours — some 7 hours after the initial Flagyl® dosage — a headache developed, but nothing else. The patient took three aspirin tablets, went back to bed and

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

the headache quit. Less and less body pain was experienced Friday morning and a previously severe pain in the right knee — the most troublesome pain in the past — was completely gone. This remains so at the writing of these comments on Tuesday morning. The second dose of Flagyl® — another 2000 mg or two gm — was taken at 4 p.m. Friday. This dose — taken on a partially empty stomach, not recommended by Dr. Blount — produced nausea but not severe enough to vomit. Also a headache developed a few hours after the second dose. Three aspirin tablets (5 grains each) ended the headache rather quickly. On arising from bed Saturday morning, all arthritic pain — and all other pain — had vanished. It seemed like a miracle had happened. This general feeling of well-being continues.”

(Reprint from *The Beebe News*, Beebe, Arkansas) On Wednesday, Nov. 25, Dr. Blount flew to Chattanooga, TN, to appear on a morning television show on Channel 12, with the show host: Harry Thornton, and a woman colleague.

Several of Dr. Blount’s patients from the Chattanooga area were at the studio to give results of his treatment. What they said was almost unbelievable. Dr. Blount provided *The Beebe News* with an audio tape of the program. The following information is from that audio tape:

A woman that identified herself as Louise Searcy said:

“I was almost in a wheel chair. I was just dragging my feet and could not hardly go any steps or anything. And I went down there to Philadelphia, [Mississippi] that morning and got up the next morning after driving, and I was almost crying with my knees hurting so bad. On the way home, they relieved me. After my first treatment, I felt better all the way home. That was the first day of October. I’m doing square dancing now.”

And the woman invited the TV audience to come and see her square dance at a nearby center that day.

A man who identified himself as W. M. Hill gave this account:

“I had osteoarthritis. Not the crippling kind. I’ve had it 36 years, 6 month and 6 days before going to Dr. Blount. I took so much pain pills in those amount of years that I came up with heart trouble. But I haven’t had any pain since I left Dr. Blount’s office at Philadelphia two weeks ago today. I haven’t took any pain killers since then and haven’t needed any pain killers. I was living off pain killers. I was living off pain killers for 36 years, 6 months and 6 days.”

Others in the studio audience gave testimonials of benefits and the TV hosts told of hearing similar glowing reports from other persons in the area. A woman who said she is Helen Erwin told of breaking-out and having some swelling after her first dose of Flagyl®. She commented that the druggist, because of this, would not refill her Flagyl® prescription.

Dr. Blount commented: “The druggist was right in not refilling the prescription *under the circumstances*.” But Dr. Blount explained that such reaction “does happen — even though it is rare.” However, he told the woman that a short course of cortisone-like injections (Depo Medrol) “usually takes care of that all right.” “Most such patients,” he said, “are able to take the medicine (Flagyl®) eventually.”

At this point in the TV show, Dr. Blount was told by the TV woman hostess: “I have talked to people who have gone down to see you who were just about carried into your office and by the time they got back to Chattanooga, they were walking and doing well.”

TV host Thornton commented: “Dr. Blount, do you fell your treatment is a cure for arthritis or just a pain reliever? Replied

Dr. Blount: “I think it is a cure.” Dr. Blount explained that the patient’s diagnosis has to be right.

“I have patients brought in with broken hips and told at the door they have arthritis.”

“Can the treatment do anything about deformity?”

“Not much,” answered Dr. Blount.

Dr. Blount was asked what percentage of success had he accomplished in arthritis: “Almost universal,” was his reply.

A TV studio question to Dr. Blount by a TV watcher asked: “Do you treat arthritis and bursitis the same way?”

“We treat them the same. It is the same germ that is the troublemaker,” said Dr. Blount.

“Is the Flagyl® treatment employed by you for fibrositis?”

“It is,” said Dr. Blount.

“Can a person with a heart condition or a diabetic take this treatment?”

“Yes, sir. Many such are taking it already.”

Regarding backaches and those who have had back surgery: “We treat those people.” Dr. Blount explained that if the original cause was the germ, the germ is still there after the operation and in those cases Flagyl® is the treatment he has found effective.

“We treat those people and they get well of their backaches ... even those who have had several operations on their backs.”

Asked about gout, Dr. Blount said that condition is caused by buildup of uric acid caused by faulty metabolism. Flagyl®, he said, is not the treatment for gout.

“One reason I am here is to tell people who have arthritis that there *is* hope. Up until now, they have been told there is nothing that can be done constructively about it. But to say there is no hope to a patient, *that is hell*. There is hope. Almost all can improve. New cases can get well,” declared Dr. Blount.

During the TV appearance, Dr. Blount was told by the TV woman reporter: “I know of people who could not do their own work or comb their own hair. They are now doing their own work ... and this just a week later after treatment.”

The TV hostess further commented on Dr. Blount’s remarkable results.

“That’s a gift of God,” commented Dr. Blount.

“What has been the reaction of organized medicine?”

“It has been hard for them to accept it right now, because they have been taught the orthodox, and fear of litigation ... and errors,” replied Dr. Blount.

“A gift of God we cannot hide. We must pass it on,” commented the TV woman hostess.

“Right,” said Dr. Blount.

In closing the TV program, TV host Thornton gave these kind words to Dr. Blount: “I wish I could say how much I appreciate this man. Coming at his own expense, getting a plane, having a pilot with him and flying up here. I wish I could say how much I appreciate him going to all that trouble and expense. He did it because of his interest in reaching people and helping people. I just wish we covered the entire United States, so the people everywhere might know that there is hope for them.”

### *From A. W. Hamilton,<sup>2</sup> Salisbury, Rhodesia*

(To Dr. John R. A. Simoons) “It seems to me that Roger Wyburn-Mason has been the first man to make a positive suggestion in the cause and treatment of rheumatoid arthritis. The announcement appeared remotely in one of our Rhodesian papers, and my wife latched on to it smartly. Se lost no time and I simply wrote to Wyburn-Mason.

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

"Fan me with a plate of soup if I don't get a reply by return of post.

"My own case history goes back over 16 years, and I can genuinely trace it to a fall on the polo field at the time, complicated by an onset of 'Tick-bite-fever.' The name of the fever may, in fact, be a bit of a misnomer. Suffice it to say that the fever ran to a very high temperature, days in bed, and profuse sweating.

"Subsequently my left knee began to swell, and cartilage trouble was diagnosed. Out came one cartilage. No improvement whatsoever. The following year, a second surgeon diagnosed the trouble as coming from my groin and wanted to operate. I put a stop to that, smartly. On the third year, the inner cartilage was removed with much ado. No improvement whatsoever, although I was beginning to know the nurses by their first names. It's an ill wind ...

"Tiring of the sight of knives and hospital food in Rhodesia, I took myself off to Scotland in the hope that, if the worst came to worst, I could die on my native soil. With the abandon which comes from experience, I struck myself into the Royal Infirmary in Glasgow, under Professor Watson-Buchanan, head of arthritic research at the Royal Infirmary. Three months and 36 X-rays later, I am advised by Professor Watson-Buchanan that I have nothing more romantic than Rheumatoid Arthritis. Steroids and aspirin until the end of my days were prescribed. I prescribed for 12 further pain-racked years.

"In the interval, the R.A. seemed to spread, first to my toes, then to the other knee, and, as you know, I've only got two, my thumbs and my right shoulder. By this stage, I began to look like a cross between a mouse with dysentery, and a camel with glandular fever.

"I spent my time going about saying ... 'Oh, Death, where is thy sting.'

"Enter the article by Dr. Wyburn-Mason.

"Mind you, in the interval, I had been cheered. I had been cheered by people reminding me of the man who had NO legs.

"Orthodox medicine seemed to have failed. In Africa, I had an alternative which I even considered. A witch Doctor! Certain it was that his results could not have been less negative. However, I am a bit scared of witch Doctors in case they ask me to eat my young. I did not want to commit three gorgeous daughters to the frying pan. One daughter, incidentally, having spent a year in Hollywood [California], a fully qualified nursing sister, looking after the brat of ... It should have been me.

"Cautiously I hoped that Wyburn-Mason might JUST have the answer. An arthritic ship will, perforce, seek any port in a storm.

"The books ... *There IS a Cure for Arthritis, Arthritis and Common Sense*, ... line my shelves. I must consign them to the flame and the lazy. Boiled elephant dung has even been suggested. I have been trying for some time to catch an elephant. They are non-cooperative. In addition, I do not run fast enough.

"Little is left, except Wyburn-Mason. It made sense. A bug, eating away at the tissues between the joints, bone against bone, distortion and infinite pain. Let's have a crack at Doc Roger.

"With all the will in the world, it is difficult to sit down, when invited, on a seat laced with a pin. Remove the pin, and I shall be happy to sit down. Thus it was with the 'experts' screaming at me to keep movement going. Remove the pin, or the pain, and I'll sit down happily. None had removed the pin.

"I must correct you here. After 14 days, I began to FEEL that something was happening with clotrimazole. After 16 years, there seems little hope for the apparently hopelessly distorted joints from assuming the appearance of those given to a new

born babe, but hope does still spring Eternal after clotrimazole. In the event, I was able to get off steroids for the first time in 11 years, and the masses of aspirin with which I alternated, — up to 15 aspirin per day at times.

"Now, weather does seem to have an effect, and if it is cold and wet, Bob's-your-Uncle, pain. Diet too, I consider most important, without being a faddist... After 7 years of being denied the fairways, I am back on the links, not yet down to the old scratch golf club standard, but shaping. When I re-started last year, the Captain of the local golf club picked me out for playing the ball from the Ladies' tee. I told him to get out of my road and let me hit my third shot.

"The degree of morning stiffness has been improved by, I would say, 75%.

"All in all, I personally feel, after 16 odd years, that Wyburn-Mason HAS found the answer and daily my mobility is improved. However, now in my fifties, do not expect me to break any track records, play golf again for the Royal Air Force, or play polo for Rhodesia."

**From E. H.C., Ph.D., Chevy Chase, MD**

(To John R.A. Simoons, 1979) "I am a male, 67, who still likes to engage in vigorous physical activities. I was under treatment by Dr. \_\_\_\_\_ for chronic rheumatoid arthritis from late 1973 or early 1974 until January 1977.

"My medical history indicates I showed evidence of the infection prior to 1974: Various forms of bursitis (1961-1973), gout (1964), and periodontal disease (1971).

"Aside from aspirin, the drugs which Dr. \_\_\_\_\_ prescribed were Motrin® and Tandearil® (1974-5), Indocin®, Ilosone®, Naprosyn®, Butzoladin® and Tolectin® in 1976. (Tolectin® gave me the most unpleasant side reactions I ever had from a drug.) I was given Plaquenil® in 1976 and 1977. In addition, when the pains were too great, Dr. \_\_\_\_\_ injected cortisone in the knees. There was never any improvement and indeed I fully expected to be crippled. I gave up almost all exercise and sports; even stair climbing often required going up on hands and knees.

"The 1975 report on rheumatoid arthritis, and its successful cure, by Prof. Roger Wyburn-Mason to the International Conference on Chemotherapy in London received extensive but garbled coverage in the *Washington Star*. This I clipped for reference. In 1976, the National Institute of Arthritis published *How to Cope with Arthritis* which stated that neither the cause of nor a cure for arthritis was known. This was confirmed by other authoritative sources. It was obvious I was spreading a great deal of money with no hope for improvement.

"When my wife and I went to Switzerland in the winter of 1977, I flew to London to see Wyburn-Mason. I saw him again before we left Switzerland. I have had his constant advice and assistance since that time.

"On my first visit, he gave me an imidazole compound not otherwise identified. I was scarce prepared, back in Switzerland, for the violence of the reaction and pain which I began to experience some 46 hours after taking the first dose. It reached over a period of days to every part of my body below the neck. It was almost like a lesson in anatomy and physiology as the stabbing pains spread; they confirmed Prof. Wyburn-Mason's statement that the infection was universal in my body. The second dose of tablets produced nearly as strong a reaction. Thereafter, the pains became less intense. When I went again to London, I was told to take imidazole tablets only when the preceding pain had virtually disappeared.

"In May 1977, I attended a dance where, without thinking about it, I was on the floor for three hours. This was the point

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

where I realized how effective the antiprotozoal drugs had been. I subsequently and quickly returned to tennis, squash, golf, swimming, etc. There was a noticeable change in my appearance, remarked upon by many people to my wife. Rheumatoid disease is depressing and debilitating, as well as painful.

"I had not informed my Washington physician of my new treatment, prior to going to London, since Prof. Wyburn-Mason could give me no advance assurance of success. Some time later when I was sure the treatment had worked, I sent him a written report. In September and October 1977, he gave me a complete physical, with further checkups thereafter. He found no trace of rheumatic pains in any of the joints, which he had unsuccessfully treated for several years previously. My RF was negative; my ESR which was 40mms per hour soon dropped to 30. It has not been checked since that time. Dr. \_\_\_\_\_ was sufficiently impressed with the results to phone them to Dr. \_\_\_\_\_, a leading Washington-area rheumatologist. The latter asked me for a sample of the drugs to analyze. I have heard nothing further on this. Subsequently I lent Prof. Wyburn-Mason's book to Dr. \_\_\_\_\_. Prof. Wyburn-Mason later assured me my ESR was not unusually high after a course of potent antiprotozoan drugs.

"In September 1977, Prof. Wyburn-Mason provided me, through a friend, a supply of tinidazole tablets from Switzerland. Although I had no arthritic pain, I still had lingering reactions to the drugs, indicating I might still have some *Limax amoebae* in the system. In the winter of 1977-78, when I was again in Switzerland and Italy, I replenished, with Prof. Wyburn-Mason's prescription, the supply of tinidazole and added Naxogin®. I was advised to continue to use them from time to time as a safeguard. By then, I had little or no reaction to the drugs. Although I felt I should not resume alpine skiing, I was able to take lessons in Swiss cross-country skiing, which is a vigorous enough exercise."

The insidious nature of reinfection is shown by the follow-up letter received recently (1982) by the author from E.H.C., Ph.D.:

"I have had, since then, serious relapses, as I seem to be genetically highly sensitive to the amoeba involved. Most likely I was being reinfected by our swimming pool which we keep heated all winter. After conferring with Prof. Wyburn-Mason, I have now added copper plates and copper sulfate to the pool, to kill the infective organisms.

"I have also been under an intensive course of treatments, this winter and spring, with allopurinol, felden, and furazolidone. I am greatly improved, but I cannot yet say I have had a complete cure."

On making further queries of Professor Wyburn-Mason regarding a situation in Tennessee (USA), where perhaps eighty percent of the well and spring water contains coliform bacteria — implying that the protozoa must also be present — the Professor replied as follows:

"As regards sterilizing of your water supply — the protozoan is killed not only by copper sulfate, but also by metallic copper,<sup>3</sup> but not by chlorine. The simplest way to get over the problem of the organism in the drinking water is to have pipes from the reservoir changed to copper ones. However, while you can take reasonable precautions not to take the organism into the body, one is always left with the fact that the cysts float in the air and can be taken in by breathing or talking. There is no way of preventing this unless you are one of the lucky ones and the organisms you inhale

are not pathogenic."

#### *Interviews*

The author interviewed patients as they entered Dr. Blount's office, finding that most were there, from scattered parts of the country, because of what they had seen happen to friends, neighbors, and relatives ... Their responses were overwhelmingly enthusiastic. They told of those they'd personally witnessed, who'd not been able to work, or to walk, or were suffering considerably, and now could work, or walk, or were free of pain. The author, of course, could not collect statistics on such short notice; and, in any case, such numbers would not have satisfied the more stringent requirements of scientific "double-blind" experiments. Nonetheless, having had personal experience with anti-amoebic treatment, having read Professor Roger Wyburn-Mason's technical research findings, having interviewed patients — and having had some technical knowledge of biostatistical requirements — its problems and pitfalls — there was little the author could do but be impressed.

#### *Letters to and on File with Dr. Jack M. Blount*

(From Mrs. A.B.M., Chattanooga, Tennessee) "Just a note to let you know how we are feeling. Mrs. G. is better than she has been in over 6 years. She is having *no pains hardly*, and planning a trip to New Orleans to visit her grand-daughter, when she hasn't been able to even go to the grocery store. She's driving her car, going where she needs to go now. My sister, M.H., was feeling much better while she was at my apartment, but she left on Wednesday after we were to see you on a Monday. She was awful sick vomiting. She said her stomach was full of gas, and she was so sick, but I haven't heard anything else. Myself I feel much better. I think the treatment has helped my headaches as much as arthritis pains. My pains in my fingers I still have. I have a breaking out on my bottom, but I don't believe the medicine I am taking has anything to do with it. Enjoyed your appearance on H's show and it was nice seeing you again."

(From Mrs. E.K., Trenton, Tennessee) "I was in your office Thursday of last week. I began my medicine on Friday. Today I am free of pain for the first time. I really feel as if I want to do things, and to go somewhere. It is unbelievable."

(From B.D. Killen, Alabama) "I am writing you to let you know that my father is doing great since he seen you the 23rd of November. He has not missed any work and is dressing himself now. We all want to thank you so much."

(From E.H. Florence, Alabama) "Hello. I am feeling fine. Thanks to Dr. Blount."

(From A.S.B., Rogersville, Alabama) "I am sure you will be glad to know that I am doing very well following my visit and treatment."

"I was down there December 18, 1981."

"I finished my medication two weeks ago. The last two weeks of Flagyl made me feel sick to the stomach but vomited only twice."

"Some mornings I feel a little stiff but the severe pain is gone. Sometimes I feel a weakness in the lower back but not the pain I once had. Other joints of the body have some soreness but very little."

(From G.H., Savannah, Tennessee) "I was down there and had a treatment October 26. I have not had a pain since. Since I was there it has helped my husband and Mrs. W. too... I think you will be getting some calls from Savannah for treatments as I am just fine."

(From an English physician who prefers to remain anonymous; [Note that this physician had been corresponding with Dr.

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

Jack M. Blount from time to time and especially arguing that Dr. Blount could not help the long-term arthritic in the manner reported, and that he, personally, had not seen the same results from such patients that Dr. Jack Blount had reported]) “He was a 63 year old man from Georgia, USA, who insisted on coming to see me although I tried to advise him that he was really so bad it would be a waste of time. He was the worst case of rheumatoid arthritis I had ever seen. Every joint in his body, including cryo-arytenoids, was completely ankylosed. He could only speak in a whisper, could not move his bowed head and was brought in in a wheel chair. I treated him much against my will because I thought he would be wasting his time and money, but he implored me to do so as I was his last hope. He had traveled all over the world including going to Taiwan for acupuncture. Curiously, his condition was quite painless, since all joint movement was prevented by adhesions. The disease had begun 33 years before at which time he had had to give up driving his car. I gave him metronidazole at four weekly intervals. He had only a mild Jarisch-Herxheimer reaction, but then the most astonishing things began to happen. Normally, his wife used to put him to bed, and he lay on one side quite immovable until she turned him in the middle of the night. About five days after the first dose of tablets, while lying in bed, he suddenly threw his right arm out and found he could extend it fully at the elbow after a loud cracking of the adhesions. This process went on over the next few months and five months after returning to the USA, he wrote to me in his own hand (previously impossible) to say that he was now symptomless, had just dug his garden, planted flowers, painted and decorated his house inside and out, bought a new car, and he and his wife were going for their first holiday in 33 years. This is a remarkable case.”

#### **Book Report by Dr. Robert Bingham<sup>4</sup>**

Each generation of man develops a few independent medical investigators whose recognition may be long delayed. This is true as well of inventors, geniuses, and original thinkers in other fields. But confirmation and proof of a discovery in medicine may be controversial for many years.

This may be the fate of the author of this new book by Professor Roger Wyburn-Mason. He has for more than twenty years researched the roles of pathogenic protozoa in human diseases. For twelve years, he has been writing a monumental work, in collaboration with his wife, which may revolutionize the diagnosis and treatment of many chronic and dangerous illnesses.

After taking his degrees at Christ’s College, Cambridge, England, where he was also a Fellow, he was an associate professor and lecturer at Yale in the United States. He then returned to London as a research fellow in Royal Marsden Hospital, London, Proffit Research, in microbiology.

While serving as a physician in the Ealing-Hammersmith and Hounslow Health Authority in hospitals and laboratories, he discovered pathogenic protozoa in arthritis patients from all tissues of the body. He was amazed to find these in cases of rheumatoid arthritis and in some forms of cancer and degenerative diseases — all conditions considered by most doctors to be of “unknown etiology” and generally incurable as well.

The Preface states: “What is required in the search for the causes of rheumatoid disease and human cancer are not just increasing expenditures of money for traditional research but new ideas. This book puts forward such new ideas and shows how clinically and pathologically they fit the known facts about both rheumatoid disease and many cases of human cancer.”

He discovered that the organisms responsible for rheumatoid arthritis are *Limax amoebae*. They are found in brackish

waters and affect certain susceptible individuals, migrating from the gastrointestinal tract into the blood and then into the joints and other body tissues.

These are thermotropic, or “heat-seeking,” organisms and can be isolated by chilling the laboratory specimen, whereby the amoebae migrate through a fine membrane into warmed saline solution where they can be identified.

His next problem led to exploration and experimentation to find chemicals and drugs which would destroy these amoebae and control these diseases.

Several chemical compounds have proved useful, as he announced in July 1975 at the International Congress of Chemotherapy in London. One was *clotrimazole*, manufactured by Bayer in Germany. It is now undergoing further clinical tests in Germany and England and has been tested at the National Arthritis [now Desert] Medical Clinic in California.

Professor Wyburn-Mason further writes: “It seems highly probable that various species of free-living *Limax amoebae* are the etiological agents of collagen-auto-immune diseases. In general, these diseases show every gradation and combination with one another. They are not due to a single organism but to a number of similar organisms. Such a parasitic infection would explain the urticaria [hives], asthma [intrinsic], and eosinophilia observed in many cases of collagen or auto-immune diseases.

“The failure to find such organisms in ordinary sections of tissue is due to the fact that they appear like macrophages. They may be shown up, however, by immunofluorescent techniques.”

This list of chronic and degenerative diseases, in which pathogenic protozoa have been found by Professor Wyburn-Mason and the investigators who have been studying his work, reads like a list of the unknown maladies of mankind: Paget’s disease of bone, ulcerative colitis, myasthenia gravis, arteritis, chronic pyelonephritis, some cases of diabetes, pericarditis, some cases of hepatitis and cirrhosis of the liver, uterine fibroids, ovarian cysts, and in some types of malignancies such as lymphoma, leukemia and Hodgkin’s disease. These organisms may also cause scleroderma, alopecia, vitiligo, melanoderma, eczema, psoriasis and dermatitis herpetiformis of the skin. In the mouth, they are associated with gingivitis, pyorrhea, and dental caries may occur. Asthma and chronic bronchitis may appear in the lungs. Parkinson’s disease of the central nervous system, psychoses, and gliomas may result from such protozoal infections.<sup>5</sup>

They may cause many pre-malignant conditions and thus play a role in causing many human malignancies. Severe physical and nervous stress, injuries and other illnesses may precipitate these diseases by lowering local and general tissue resistance and permit the spread or localization of protozoa which under other circumstances might not cause symptoms.

#### **Adequate Treatment<sup>6</sup> by Dr. Robert Bingham**

A young woman patient with an early case of rheumatoid arthritis presented herself at the Desert Arthritis Medical Clinic in Desert Hot Springs for treatment. She brought with her a five-page consultation from a famous medical center. It was well written, contained an excellent medical history, a complete physical examination, many x-ray reports, and three pages of laboratory tests. The clinical diagnosis was correct: “active rheumatoid arthritis.” But the treatment of her disease had failed completely. Her physician, a well-known rheumatologist, had advised her as follows: “*You have an active case of rheumatoid arthritis. I don’t know whether it will get better, get worse, or become chronic. Take twelve aspirin tablets a day. Come to see me in three months’ time.*” She had not improved on the “aspirin alone” therapy.

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

(This is not an isolated example. It is wrong only because it is inadequate. Aspirin relieves pain. It causes an increased flow of blood to the joints and has some anti-inflammatory effect. The omission of other medical advice regarding her health, diet, rest, exercise, physical therapy, and vitamins handicapped her in making any improvement or recovery.)

Further evaluation of this patient showed that she was in a high stress occupation, teaching school in a neighborhood where disciplinary problems were almost out of hand, leaving her exhausted at night. She smoked too many cigarettes. She didn't get enough sleep. She was "dieting" to avoid getting fat. She was not taking any regular exercises. Her arthritis was worsening, and her impending mental and physical breakdown was feared by the school principal. He gave her a month's "sick leave." She came to the desert to recuperate in a change of environment and the dry warm desert climate. Fortunately, she had not been started on corticosteroid drugs or gold therapy. Her arthritis was early and acute and limited mostly to the metacarpal-phalangeal and proximal interphalangeal joints of her hands and feet and her wrists and elbows and knees. These joints were hot, tender, swollen, and painful. On twelve aspirin a day, she was capable of walking and of self care, but she had been getting worse during the past few months.

In reviewing her x-ray and laboratory findings, I found a sedimentation rate of 56, a positive rheumatoid arthritis factor in the latex fixation test, a positive C-reactive protein test, a white blood count elevation of 11,000 with a slight shift to the left and 5% eosinophils. Her other blood chemistries, serological tests, and urine findings were normal.

A dietary analysis was obtained, typical of one week's meals prior to her coming to the desert. This showed an inadequate protein intake for her height, weight, age, sex, and physical activity. It was only 62% of normal. Her fat intake surprised her very much, because she was dieting to lose weight. It was 120% of normal. Her caloric intake was 80% of normal. She was deficient in every single vitamin and mineral. Her acid base balance was strongly to the acid side.

Since she is somewhat typical of the rheumatoid patients which we examined and treated during the past year, I will mention the features of her care.

1. She was placed on a *high protein, high vitamin diet* eliminating refined carbohydrate, high fat, processed and preserved foods. An important part of this diet is certified raw milk, fresh fruit, fresh vegetables, and emphasis on nuts and grains.

2. Vitamin supplements were used therapeutically, giving her about four times the minimum daily requirements to build her vitamin reserves and improve her metabolism.

3. A hair analysis showed mineral deficiencies which were treated with chelated minerals, especially chelated magnesium.

4. She was given "*Yucca extract*" tablets as a food supplement to correct any lower bowel malfunctions and to help relieve her arthritis symptoms.

5. She was started on the *arthritis vaccine* program.

6. Female *hormones* were first given by injection, later by mouth.

7. *Physical therapy* was started, hot wax baths for her hands and wrists, and hot packs and ultra sound for her knees.

8. She took deep hot *natural mineral water therapy* two or three times a day in the pools of the motel in which she stayed in Desert Hot Springs.

9. She started a gradual program of *sunbathing* and light tanning.

10. *Exercise* was started by swimming twice a day and

short walks of gradually increasing distance.

11. She was started on one of the new *anti-protozoal drugs* (Flagyl®) for a three-week period of medical care, gradually reducing her aspirin intake from forty to about ten grains a day.

This might be called an "eleven point program" for the treatment of rheumatoid arthritis.

On this regime, by the end of only four weeks, she was greatly improved. All heat and swelling had disappeared from her joints. Stiffness and limitation of motion was greatly reduced. The constant pain was relieved, permitting her to sleep without drugs. Fortunately, she had an early and fairly mild case of the disease. By six months, a follow-up examination revealed only a slight amount of stiffness in her wrists. She was considered to be "recovered" without significant permanent joint damage.

(From Terry Crommelin, Perth, Western Australia to the author) "Perhaps you are aware of the fact that one of my close friends on holiday in America saw Dr. Robert Bingham's article at the same time as Dr. Jack M. Blount did. I immediately telephoned Dr. Bingham, recalling his amazement on hearing someone from Perth, as he passed through here during the war for one day. His words were 'By all means, bring your daughter Jenny to see me, but I am not the number one man. I have commenced practicing the works of Roger Wyburn-Mason.' His charming wife respected the long distance call advising me that Professor Wyburn-Mason was recovering from a heart attack, but would speak to me.

It is history that I visited him a month or so later and arranged for my wife and my 13 year old daughter to go to London for treatment. She started on clotrimazole, then moved to Flagyl®. She had been on cortisone for 10 years or more. She is now 19 years old, only 4'8" high and weights approximately 32 kg and has recently been diagnosed as a celiac, as my 23 year old daughter is also.

The genetic history of our family was of great interest to Professor Wyburn-Mason, particularly my wife's father being diabetic and her mother suffering from rheumatoid arthritis. The genetic build-up of the family has affected the three living children. One died after birth. Whilst crippled, Jenny has no joint pain. She takes Fasigyn regularly in small doses.

My friends with minor joint aches and pains that disturb their golf and gardening take Fasigyn with immediate results, usually four tablets every six months.

#### **Letter by Dr. Jack M. Blount**

(To Professor Wyburn-Mason) The practice of medicine is much more rewarding and satisfying since your wonderful revelations. I used to dread seeing people with rheumatoid — collagen — auto-immune — disease. I had nothing that would help appreciably. Now it's a pleasure to see them. The thrill really comes when they return and tell how grateful they are that they have finally found something that really helps.

I have continued to refine and simplify the treatment....

#### **More Letters**

Between the first and second editions of this book, more success letters have been received from patients and physicians, world-wide. I wanted very much to include all of them in the second edition, especially those heart-rending successes from Dr. Paul K. Pybus of the Republic of South Africa.

Unfortunately, space and time precluded satisfaction of my desires; also it is unlikely that either physicians or the afflicted will be convinced by several tons of testimonials and letters — only by trying it, and observing successful results will complete acceptance of *The Rheumatoid Disease Foundation*, now *The Arthritis Fund*, protocol be accepted everywhere.

Dr. Paul K. Pybus has contributed in other ways most significantly to the solution of the residual pains of rheumatoid

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.** disease, known as pains of sciatica, and also in giving us an approach to handling osteoarthritis — an for that important, precious knowledge, additional book space is indeed devoted, and presented beginning with Chapter XI.

1. Also see “Metronidazole in rheumatoid arthritis” **To the Editor:** *Sa Mediese Tydskrif*, 20 Februarie 1982, pp. 261-2, P.K. Pybus, advocating further investigations. Also see *S. Afr. Med. J. Journal*, Roger Wyburn-Mason, “Metronidazole in Rheumatoid Arthritis,” May 1982, Vol. 61, pp. 648-649. [In personal letter to author (June 17, 1982), Paul K. Pybus, M.D., further states: “I have subsidized my treatment of this antiamebic therapy. My intraneural treatment (developed from what was taught to me by Professor Wyburn-Mason many years ago) gives the patient immediate relief from the pain and stiffness of the disease. Metronidazole keeps them that way.”

2. Alec Hamilton died of “uncontrollable bleeding from gastric ulcers,” as a result of the side-effects of corticosteroids as reported to John R. Simoons, Ph.D. via letter by A.E. Strover, M.D., of Cape Town, South Africa.

3. According to Dr. Jack M. Blount, demographic studies ought to demonstrate a statistically significant relationship between the use or exposure to copper and lessened incidence of rheumatoid diseases, as with certain primitive tribes that use copper bowls for cooking and eating, exclusively. William E. Catterall, Sc.D., and Nutritionist, in a March 23, 1983, letter to Professor Roger Wyburn-Mason, says: “I remain skeptical about your treatment of swimming pools. Concerning your evidence, many pools would be toxic to amoebae under filling conditions. I have typical water analyses around the U.S. East Coast (typically soft, acid water) with copper contents up to 5 ppm. Excess copper is likely to precipitate a typical pool pH of 7.4-7.6 and no more could dissolve. In any case, dissolution of oxide-coated copper at this pH must be nil, as suggested by non-corrosion of copper water systems at this pH. The copper algicide I mentioned is readily available in the U.S.: BioGuard® MSA Algicide (Bio-Lab, Decatur, Georgia). This contains 7% copper in the form of a soluble triethanolamine complex. The recommended treatment is 4 oz/5000 gal., or 0.4 ppm copper added.”

4. Bingham, Robert, M.D., **Book Review**, *Arthritis News Today*, “The Causation of Rheumatoid Disease and Many Human Cancers, A New Concept in Medicine by Roger Wyburn-Mason, M.A., M.D.,” pp.5-6.

5. Professor Wyburn-Mason does not state that all of the aforementioned diseases are solely caused by the amoeba, nor that solid, unmoveable, scientific proof has been proffered in all named diseases, certain specified rheumatoid diseases certainly being an exception, in that solid scientific evidence has been presented.

6. *Arthritis News Today*, “What is Adequate Treatment for Rheumatoid Arthritis,” Vol. 1, No. 8, May 1979, p. 7. (It should be noted that in the view of Professor Roger Wyburn-Mason, unless the amoeba is absent from the system, rheumatologist’s routine more or less standard treatments involving heat and exercise may need to be re-evaluated.)

## Chapter X

### *Is It Ethical to Deny the Sick?*

#### *Children Sick Forever—*

Why haven’t the various rheumatology associations and foundations and the rheumatology organizations of professional medical practitioners studied Professor Roger Wyburn-Mason’s findings, now nearly a generation old?

Why does The Arthritis Foundation still conduct televi-

sion telethons, using the names of music celebrities, *for the purpose of finding a cure for rheumatoid diseases*, when the primary cure is already known?

Why are Professor Roger Wyburn-Mason’s findings made known only in a book of this kind? Why isn’t the whole medical profession aware of Professor Wyburn-Mason’s astounding discovery?

On television recently, I [di Fabio] watched three lovely children limping through playground activities. Beside them was a young handsome, learned rheumatologist, who nicely explained to us, his audience, that these children suffered from an *incurable* disease, and that their only hope lie in aspirin substitutes.

I restrained hot tears.

Suppose you *knew* for certain that these children could be cured, that the method was simple, inexpensive, eminently safe, and took but six or seven weeks? What would you do? Would you immediately pick up the telephone and try to contact that professional specialist? Would he listen if you did? What credentials do you have to make him listen? The fact *you* are cured is *not* a credential, but perhaps nothing more than a “spontaneous remission” — the modern world’s name for miracle.

Or perhaps you never had the disease. Someone who was not a specialist undoubtedly diagnosed it wrongly to begin with — the proof, you understand, lies in the definition of “incurable.” If the disease is incurable, then how can it possibly have been cured? And if the expert, the specialist, has pronounced it as such, i.e., incurable, then who are you to say otherwise?

#### *The Right to Try!*

Dr. Jack M. Blount records all of his telephone conversations, and one such I listened to with great dismay and shame. A specialist in rheumatology called Dr. Blount and proceeded to lecture him with great vituperation. Was Dr. Blount *trained* in this specialty of rheumatology? If not, then what *right* did Dr. Blount have to *practice* in this field? —and so it went, until at last the caller stated, “I hope someone gets you!”

The rheumatology specialist had not heard of the brilliant medical detective work of Professor Roger Wyburn-Mason, nor had he read that the *Limax amoeba* was the source cause of rheumatoid diseases, nor had he talked to patients who claimed to be cured, nor had he conducted laboratory examinations on them, nor had he asked for an explanation from Dr. Blount, nor had he ever tried the simple medications the knowledge of which is given away so freely — free of charge — by all participants.

Was this specialist ethical? “Is it ethical for a group of men who can offer ... no hope whatever, to deny ... the right to *try* a remedy of which they do not approve?”<sup>1</sup>

I am *not* implying that all young, learned specialists in rheumatology are so hostile, so unthinking, so unscientific, but I have been terribly amazed at the lack of response in the so-called objective field of medicine and science to Professor Roger Wyburn-Mason’s nearly life-time work.

#### *Vested Interests*

We all suffer from vested interests: In the case of this brash, young, learned specialist in rheumatology, he suffered from an insufferable ego, an identification of his own personality with cookbook truisms taught him by the elite and also those who could and did decree upon him a symbol of his great value to society, his medical certificate. Can one who has studied so long, and so hard, and who is so conscientious have overlooked a genuine cure for rheumatoid diseases? In his mind, hardly! Anyone who says otherwise, therefore, must be a quack, a real danger to society!

It takes a genuinely humble, self-knowing individual to acknowledge that lessons long-learned are in error, that life is for

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

learning, each and every day, until the very end, that we must continue to learn and unlearn.

Then there is the vested interest of State Medical Boards, each member presuming to judge peers according to standards established by state legislatures (also pressured by special interest minority groups called medical associations).

Any doctor who does not prescribe according to the current peer-group dictates of the times risks being censured by such boards, and at the very least will be embarrassingly, summarily brought before them to explain his/her peculiar behavior in treating someone in a non-standard, non-accepted, non-peer-group manner. The fact that no member of these boards has a cure to the problem is not pertinent to their hearing. In their minds, the important thing is that one treats patients according to accustomed norms.

The doctor who persists in curing people with non-standard, non-accepted, non-peer-group fashion also risks legal liability suits which are not covered by medical mal-practice insurance. Apparently insurance companies also have a vested interest in covering only standard, accepted, peer-group medicine. Why should they take risks? Their job is to make money for stockholders, not to cure people. If they accept current standard, accepted, peer-group treatment procedures approved by minority groups called medical associations, then they are legally safe from law-suits, and they can maximize their profit accordingly. On the other hand, they *will* finance small pamphlets to encourage people to drive safely, to look out for household accidents, etc., such activities not requiring them to take any kind of risk at all.

Do not forget the attorney who can make a contingency fee for filing and winning a suit against a medical doctor who treats with a non-standard, non-accepted, non-peer-group procedure, and, along with him, the patient who, rather than blame God, or the devil, or his environment, or his genes, finds it more convenience to blame the one person who genuinely strives to help. It looks awfully good to a naive jury for the attorney to ask “Dr. So and So, is this procedure approved by your peers who are specialists in the field?” It is so easy to second-guess the physician, especially in the artificial environment induced by courts of law, so far removed from the problem. The fact that you have *cured* is not pertinent, apparently.

Washington bureaucrats also have their little niche to protect. More and more decision-making has descended on petty tyrants who must blindly follow rules laid down by Congressmen who also responded to special interest groups. While the U.S. Food and Drug Administration has undoubtedly saved thousands of lives by their over-protectiveness in medical applications, they have also lost thousands of lives by the same guidelines. No one counts lives lost, and no one loses jobs for it, and so ultra-conservatism is the norm when deciding to release or not to release a particular medicine for use on a particular disease. Many foreign countries have leaped ahead of the United States in medical application, and we, the mighty and forward thinking American union of states have fallen ten to twenty years behind in certain applications.

Drug companies may apply to the U.S. Food and Drug Administration for permission to run limited tests on certain approved drugs. Treatment of arthritis by means of antiamebic medicines should be pronounced entirely safe and easily approved — many of the indicated medicines have been in use since the sixties in the United States, for other purposes, without contraindications. Yet this writer has read numerous letters about efforts to get various drug manufacturers off their duff, to treat arthritis with these procedures under Federal guidelines. Well, *fifteen billion dollars* returned to them annually for repetitive sales of ineffective aspirin substitutes is a larger financial stake than the

total national budget of many countries. Why should drug manufacturers take the lead in cutting down their own share of the medical pie? Besides, drug manufacturers contribute a great deal of money to arthritis foundations dedicated to “finding the cure” to arthritis, and to rheumatology groups. By this means, their consciences are salvaged.

This author has also read numerous letters written to foundations by the esteemed participants. The foundations claim to have a vested interest in treatment and potential cure of arthritis. Letters to the foundations itemize in detail the source cause of arthritis, the nature of the amoeba involved, how to isolate it, grow it, identify it, and how to inoculate animals with it to create similar diseases as humans have, human cases cured and how they were cured, and how long were follow-ups, as well as scientific source data. These foundations generally send out a nicely printed form letter that is so insulting they don't bear repeating in detail. In essence, they say thank you for being interested in arthritis and we will file your information in our files and perhaps some day some researcher will scour through them, and he will find your note, and it will help someone, somehow!

Lastly don't forget the patient — you and I — we each have strong-binding vested interests in maintaining our sicknesses: for sympathy, for a talking subject, for bringing about presumed companionship and ending presumed loneliness, for excuses to ourselves and others on why we cannot do things, or are not successful, for continued collection of pensions and insurance monies ...

Knowing all of this, what can I do to help those small, beautiful children recently viewed on television, and pronounced as forever ill, forever to be crippled, forever to be stunted...?

#### *Definition of a Quack*

According to John W. Campbell,<sup>2</sup> “Back before Pasteur discovered germs, Semmelweis discovered a 99.9% successful method of stopping childbed fever. There was a hospital in Vienna, one half of which was run by nuns, and the other half by doctors. The incidence of childbed fever in the doctors' half of the hospital at times ran as high as 90% — [10% to 30% of the] young women who came in to have their babies died of infection. The nuns had a far better record.

“The doctors didn't observe the fact particularly; the women of Vienna were acutely aware of it, however. (The human tendency to count your hits, and forget your misses —while the women observed the misses a lot more actively.)

“Semmelweis, studying the situation, came to the conclusion that the difference was that the doctors, as part of their routine, performed autopsies on the dead women; the nuns did not. Semmelweis came to the completely false, crackpot notion that it was the odor of death on the doctors' hands that transmitted the disease. It just happened that he picked, as his deodorizer, chlorine water.<sup>3</sup> It did indeed deodorize the doctor's hands; also, quite unknown to Semmelweis, it was an extremely powerful antiseptic — the concentration he used would kill anything.

“At that time — about a century ago — it wasn't customary to wash the hospital sheets very often, either — until Semmelweis detected the ‘odor of death’ there, too. ‘Wash ‘em! And use chlorine water!’

“The death rate from childbed fever among Semmelweis's patients dropped from about [30% to 1.2%].

“For this, Semmelweis was thrown out of the hospital by the other doctors, and violently attacked and harassed by the medical profession of Europe.

“Why? Because of a certain emotional factor involved.

“His work — his absolutely unarguable and shocking success — said ‘Doctor — healer! — *you* killed those young women.

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

*You killed them with your dirty hands. They didn't just 'happen to die'; you killed them!*

"Semmelweis was, of course, a dedicated healer; he could not endure standing idly by, so he was very busily spreading the word of laymen — telling them not to let a doctor examine a woman unless he scrubbed his hands in chlorine water.

"There's the old saying, 'What you don't know won't hurt you.' With respect to objective factors, that's obviously false. With respect to emotional things, however — it's true. So long as a doctor could hold off from his own mind the realization that it truly *was* his unclean hands that did it — then he did not have the grinding agony of regret.

.....  
"... the modern attitude that the patient has a right to perfect security, puts the doctor under terrific pressure to refrain from *any* therapy.

"Now let's consider for a moment what's meant by a 'quack' in the medical field.

"The usual charge is that a quack is someone who uses an improper treatment, one which does not help, or actually injures the patient, while inducing the patient to pay for his mistreatment, and keeping the patient from going to a licensed doctor and getting the treatment he needs. That a quack is in the business solely to make money at the expense of suffering humanity.

"Now any time A disapproves of B emotionally, he'll attribute B's actions to some generally demeaned motivation — 'just for money' being the most common, with 'just for his own pleasure' being a runner-up.

"Let's be a bit objective about this business of what a quack does. Suppose a man, calling himself Dr. Jones, treats a patient who has a lethal disease, and uses a method he knows for a positive fact will not save the man's life. He charges fees, and sees to it that the patient doesn't go to any other therapist — just gives him some drugs that do not save him, but let him die slowly.

"That set of actions fulfills exactly what the AMA<sup>4</sup> accuses those awful, nasty, wicked quacks of doing.

"It is also precisely what an AMA doctor does when he treats [a certain arthritis] patient; he *knows* that the standard treatments for [arthritis] do not work, do not save lives. [Arthritis], treated by AMA methods, means [continuous pain, disfigurement and possibly] death.

"The AMA, moreover, does everything in its power to make it impossible for the victim to get treatment from any other therapist who *might* be able to do better, and most certainly couldn't be less effective.

"The patient [may], moreover, wind up broke, and his family in debt — a charge constantly leveled against those wicked quacks! — by the time he dies.

"But this is not quackery, of course.

"Why not? Because the doctors know they are doing their best, with the best of intentions — which is strictly an emotional statement.

"How about an unlicensed non-M.D. who does his best, with the best of intentions—despite the AMA's convictions that he *must* be evil—and actually does better than the AMA's best?

"Oh . . . I see. That never happens, huh. . . .?"

". . . how about that unlicensed non-M.D.—that charlatan, that fraud, who'd gotten crackpot ideas from studying silkworms and wineries, no less!—who started treating human being for rabies? That chemist, with only half a brain, Louis Pasteur?

"Or how about that licensed M.D. charlatan, expelled from the hospital and the medical society — Semmelweis?"

"Or take a few other notorious quacks like Lister — who

was most violently attacked for his temerity in opening the abdomens of living patients. (Ethical doctors of the time never opened the abdomen until the patient died.) And Ehrlich, another chemist, who invented the concept of chemotherapy.

"Every time someone outside — or even inside! — the field of medicine brings up a break-through discovery, he'll be labeled a quack. The field is too emotional.

"He'll be charged with being a fraud, a charlatan out after money, a blood-sucking leech.

.....  
"Actually, it's pretty clear, the definition of 'quack' is 'someone I believe to be dangerous, evil, destructive and unprincipled.'

"Trouble is — the term 'quack' was — in their own place and time -- violently hurled at many men we consider today among the greatest medical heroes. [Semmelweis], Jenner, Koch, Harvey, Ross, Lister, Pasteur, Ehrlich, Sister Kenny, even Roentgen, who didn't even try to practice medicine!

"One very certain thing about the field of medicine: it is not, and never will be a field of objective science. It's too deeply dominated by emotional factors."

Considering all of the above vested interests from which spring emotional factors that will blind the very best intentioned, how can one answer those who insist on clinging to old methods that are absolutely doomed to failure?

The answer, I think, is simple, indeed elegant!

Ask—

"Have you read Professor Roger Wyburn-Mason's research work?"

"Have you studied the many case histories that reflect 'cures' in the traditional medical sense?"

"Have you talked to people who claim to have been cured? Have you studied their medical histories? Before and after?"

"Have you looked into the technical, professional literature, beginning with C.A. Kofoid and O. Swezy in 1922, and terminating with Wyburn-Mason, today?"

"Have you attempted to isolate out the thermotropic, free-living *Limax amoebae*? Grown them in the laboratory? Inoculated animals, and observed their illnesses?"

"Have you reviewed the research and medical credentials of Professor Roger Wyburn- Mason?"

*"Do you have any better alternative to offer?"*

State, in short, that—

"Simple denial, quiet disclaimer, profound indifference, is no longer sufficient. That the means are at hand for your cure, for your neighbor's cure; and even though you, yourself, must also remain skeptical, you — the sick one — have an absolute right to try a remedy so safe and so economical."

*I Pray That You Will Be Healed, Too!*

While not in medicine, this writer does have a rather extensive life-time of readings and work in mathematics and general science, and believes himself somewhat familiar with the scientific method, bio-statistical procedures and requirements, the placebo effect and personal-emotional-involvements in one's own cures, and also the dangers of early pronouncements regarding cures.

I have taken the time to study the authorities in the field, to read Professor Roger Wyburn-Mason's massive research report, to look at his credentials, to interview Dr. Jack M. Blount's patients, to get to know and to study Dr. Blount, to correspond with

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

others using similar or the same techniques, and even to try the medical procedures on myself, to an almost instant and wonderfully good effect.

It is my considered opinion that Professor Roger Wyburn-Mason will one day stand with Semmelweis, Jenner, Koch, Harvey, Ross, Lister, Pasteur, Ehrlich, Sister Kenny, and Roentgen as one of the greats in medical history.

It is my considered opinion that Professor Roger Wyburn-Mason should have received the Nobel and Lasker Prizes in medicine.

It is my considered opinion and prayer that those lovely children I recently viewed on television will be given the opportunity to be healed, as have tens of thousands since 1974!

It is my prayer that you, too, will be healed, as have I!

1. Harrison, Harry, Editor, *John W. Campbell: Collected Editorials from Analog, "Louis Pasteur, Medical Quack"* (Reprint from John W. Campbell Editorial, *Analog Science Fact and Fiction*, Condé Nast Publications, Inc. and Davis Publications, Inc.

2. *Ibid.*, pp. 114-122.

3. There seems to be some historical conflict between references as to whether phenol (carbolic acid) or chlorine water was used. According to the *Encyclopedia Americana*, Vol. 24, Grolier Inc., Danbury, CT 1982, p. 545, Semmelweis required students to wash their hands in chlorinated lime.

4. Although John W. Campbell has used the AMA organization as a vehicle to embellish his article, more fitting for this purpose would be use of the various arthritis foundations and the rheumatology association which, so it is said, are heavily subsidized by the drug industry, and both having to date been unwilling to look at Professor Roger Wyburn-Mason's life-time scientific work, or the results of various practicing physicians such as those reported herein.

## Chapter XI

### ***Treatment of Osteoarthrosis, Osteoporosis, Rheumatoid Pains, and Elements of Proper Nutrition***

#### *The "Aging" Disease*

Somewhere in humankind's long history, we accepted the idea that there are diseases "caused by aging." Such diseases, of course, can not be halted. One gets old, and one "ages" and one degenerates slowly but quite surely, until at last other infectious diseases bring us to our maker; or we break our bones and become invalid and dependent upon others for a mere pittance of unhappy survival.

Among these "aging" diseases *that everyone knows* is that of osteoarthritis, a disease of the "aging" that affects approximately 90 percent of the population by the age of 40. Among the many symptoms, degenerative joint diseases is the most common cause of chronic disability.<sup>1</sup>

When the author wrote the first edition of this book to report on the wonderful news that rheumatoid disease can and is being cured by a simple, low-cost medicine, there was no intent to include osteoarthritis. *Everyone knew* that osteoarthritis is *completely* unrelated to rheumatoid disease: rheumatoid disease displays systemic infectious factors (although its agent was unknown until Roger Wyburn-Mason's research), whereas osteoarthritis was considered as simply a consequence of being human — and living long enough. One lived through time, and one *aged*, and one got

degenerative bone and joint diseases. The "wear and tear" disease, it was called, although no authority ever bothered to check the mechanical engineering of human joints with mechanical and materials engineers, who would have informed us that bones and joints should be good for 150 years or more, based on simply the mechanics.

So much for "wear and tear —."

We victims of rheumatoid disease often also have mingled with our systemic rheumatoid symptoms, osteoarthritic symptoms, as well as weakening of the bones, called osteoporosis, where the ratio of bone cell replacement to bone cell destruction has decreased, until the bones become brittle.<sup>2</sup>

In any one person, all three symptoms may present themselves — or one of the symptoms may dominate over others.

Some 30 years ago, in the fifties, Dr. Paul K. Pybus worked and studied under Professor Roger Wyburn-Mason who, you may keep in mind, was a specialist in several fields, including that of diseases of the nervous system.

Roger Wyburn-Mason developed a theory of the causation of osteoarthritis which apparently was laid to rest until Dr. Paul K. Pybus had a need for it in treating members of his South African retirement community, many of whom suffered from classical osteoarthritis, and many of whom had a mingling of rheumatoid disease and osteoarthritis.

Casting back in his mind to the teaching of his earlier mentor, he came upon Roger's theory, which was that *whatever the source, osteoarthritis was a disease caused by inflammation of certain nerves, at certain key junctions*, which caused joints to stay compressed, and thereby to deny cartilage nutrients required for health.

Many who have rheumatoid disease also have osteoarthritis, and since many with osteoarthritis also display the Herxheimer effect when given anti-amoebics even in the absence of rheumatoid disease factors — it appears as through some osteoarthritis is caused by the *Limax amoeba*. That is, with a certain affinity for nervous tissue, the *Limax amoeba* apparently also invades these key nervous tissue junction points, creating inflammation, and thereby bringing about some osteoarthritis.

Some osteoarthritis responds to treatment of anti-viral medicines, and therefore some osteo must be caused by viruses.

Some osteoarthritis responds to treatment of appropriate doses of vitamins A, D, and calcium, and therefore some osteo must be caused by improper nutrition, or utilization of nutrition (mal-absorption often accompanies effects of rheumatoid disease.)

Surely, some osteoarthritis must be caused by bacterial agents and mechanical shock or damage, also.

In any event, in addition to a metabolic imbalance, most all osteoarthritis seems to have a common underlying cause: that the nervous tissue at certain key junctions is disturbed, becomes inflamed, sends signals to affected joints, and creates a condition where the joint cartilage cannot any longer receive proper blood supply, and therefore the cartilage begins to die — thus, "osteoarthritis," *disease of the aging*.

Dr. Paul K. Pybus<sup>3</sup> developed a simple technique and used it on aging members of the retirement community under his care. His results were phenomenal. *To this date he's had great success — far, far greater than traditional treatment — in treating thousands of patients! Many reportedly now conduct handball and other hitherto forbidden exercises.*

After rheumatoid disease has been vanquished — the disease process — there is left-over damage to the tissues and joints that create great pain. Killing the *Limax amoeba* [aberrant macrophage, Cell Wall Deficient bacteria, or Cell Wall Deficient can-

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

dida, or other similarly behaving cell or organism] remember, does not straighten out joints, nor does it eliminate pain resulting from nerve damage done by genetic susceptibility to the amoeba.

**The pain left over from rheumatoid disease is virtually identical to that found in osteoarthritis, and may be treated exactly the same way with great success.**

Gus J. Prosch, Jr., M.D., was the first American to learn Dr. Paul K. Pybus's technique and to apply it to patients, including the author, with success equal to that of Pybus. Now many American Physicians have equal success. Dr. I.H.J. Bourne, General Practitioner, Hornchurch, Essex, reported *independent* development of identically the same technique as that developed by Dr. Pybus.<sup>4</sup>

What follows is a second protocol from *The Rheumatoid Disease Foundation*, relating to rheumatoid disease, osteoarthritis and osteoporosis.

It is included in this book because of the many letters and phone calls relating to osteoarthritis and the pain of rheumatoid arthritis, and is proffered here primarily for your family doctor. Gus J. Prosch, Jr., M.D., chaired the committee that wrote this portion of our treatment protocol.

***The Roger Wyburn-Mason & Jack M. Blount Foundation for Eradication of Rheumatoid Disease***

7111 Sweetgum Drive SW, Suite A, Fairview, TN 37062-9384

**The Arthritis Trust of America, formerly The Rheumatoid Disease Foundation**

A non-profit, charitable, tax-exempt organization

**The Arthritis Trust of America through its Board Member physicians**

**has established standards of practice in the treatment of rheumatoid disease**

**and hereby supplements with the following protocol when treating osteoarthritis disease.**

**Primary Osteoarthritic Disease & Secondary Arthritis from Rheumatoid Diseases**

This work and the various intraneural injection techniques were pioneered by Dr. Paul K. Pybus of Pietermaritzburg, South Africa, as a development of what was taught him by the late Professor Roger Wyburn-Mason.

He has been successfully using these techniques for over seven years for the treatment of any type of inflamed joint, and tender neuritic areas that are located near the joints. These areas are physiological disturbances in nerves. These neuromata, as they are called, affect C type fibers which are responsible for the severe deep pains so often experienced in arthritis. The C type nerve fibers are 0.5-0.2 mm in diameter, and have a slow conduction rate of 0.5-2.0 m/sec. When irritated, these axons generate impulses both in the normal or prodromic, and reverse or antidromic directions. Prodromic impulses, producing the sensation of slow pain, relay in the cells of the spinal cord, reflexly causing spasm or stiffness of the musculature near the joint. The antidromic impulses dilate the blood vessels in the region of the peripheral origin of the nerve fibers, causing an increase in blood supply and swelling that occurs in the distal end of the sensory nerve, and effusion into the joint.

Many of these unmyelinated fibers travel to the various joints of the body and are very susceptible to damage which produces:

1. Pain and tenderness at the site of injury to reflexly produce:
2. Spasm of the muscles around the joint causing stiffness to produce:
3. Compression of the joint to produce:

4. Arrest of circulation of the joint fluid in the cartilage to produce:

5. Death of the cartilage cells to produce:
6. Creaking of crepitus, inflammation, swelling, heat redness, and loss of function.

It must be remembered that cartilage has no capillaries or blood vessels in it at all. Circulation in the cartilage takes place by means of joint fluid. This joint fluid is alternately sucked in or squeezed out by the cartilage, which acts like a sponge, expressing from the cartilage the nutrient synovial fluid as pressure is applied to it, and re-absorbing it again when pressure is taken off. If the muscles are continually in spasm, fluid is constantly driven out of the cartilage and so prevents circulation of the nutrients from reaching the vital areas. This results in cell death, some deformity in the erosion of the joint surface, and osteoarthritis. It is the stiffness of the muscle spasm which is responsible for the destruction and not necessarily the pain.

Therefore, in summary, it will be noted that around the inflamed joints will be observed certain areas of tenderness.

These trigger points or neuromata correlate closely with the sites of various superficial peripheral nerves, and at these points, the nerves are liable to damage. Around these damaged nerves develop areas of electrical disturbance resulting in a barrage of both antidromic and prodromic impulses arising at these points. Prodromic impulses are relayed to the dorsal horn of the spinal cord to produce a reflex spasm of the muscles around the joints, causing compression of the joint cartilage, interfering with the cartilage's nutrition and resulting in arthrosis. The antidromic impulses are conducted peripherally to the plain nerve ending where they result in the release of histamine like substances and vaso-dilatation and swelling, producing arthritis. (See Schematic Drawing I of these nerve fibers affecting joints, suggested by Dr. Paul K. Pybus.)

If these inflamed nerves which give off so many abnormal impulses can be suppressed, there will be an immediate cessation of the pain as well as of the spasm and stiffness and a reduction in the creaking of the joints and crepitus. Blocking these impulses with local anesthetic results in just this, namely, the abolition of these impulses and the immediate cessation of their effects with restoration to normality. This, of course, only lasts as long as the local anesthetic actions persists. By adding a very small amount of depot steroid, *which remains primarily at the inflamed area*, the inflammation is finally relieved and the arthrosis and arthritis stopped, and usually permanently so.

The following table refers to schematic drawings II, III, and IV: [a video tape is also available through The Arthritis Fund showing the procedure]

**Technique of Intraneural Injections**

*The following intraneural recommendations are suggested by The Arthritis Trust of America.*

**[Note: The booklet *Intraneural Injections for Rheumatoid Arthritis and Osteoarthritis and The Control of Pain in Arthritis of the Knee is available through The Arthritis Trust of America. This brief section cannot do justice to the work, and therefore is not complete.*]**

1. Palpate with firm pressure by using fingers or a blunt instrument, (e.g., pencil eraser) over any expected points of tenderness, and if tender, mark with a skin pencil. **Only the tender points are marked for injection.**
2. Infiltrate a bleb of local anesthetic intradermally at each site of tenderness. A Dermajet® power gun is nearly painless and saves time. [Mada-jet®: Mada Medical Products, Inc., 60 Commerce

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

Rd., Carlstadt, NJ 07072 as per John Baron, D.O.]

3. To 10 ml 1/2% local anesthetic, add 0.25% ml (5mg) triamcinolone hexacetonide (Aristospan® or Lederspan®). This fluid should now have a milky appearance. Not more than a total of 30ml of the mixture should be injected at any one session into the various marked points. Should the patient complain of dizziness, the procedure should not be continued further, but the remaining points should be treated at a later date.

4. Introduce the needle through the local bleb and probe gently towards the expected situation of the nerve, until the patient feels pain. It is essential to watch the patient's face at this time.

5. As the patient experiences pain, (with a change of facial expression), start to inject the mixture 1-4cc.

6. **The patient will experience acute pain for about 2-3 seconds.**

7. All tender sites are injected in this manner, and the patient is told the numbness will last 4-5 hours and then return to normal. Explain that some bruising will occur and the sites will be sore for a day or two, but the arthritis pain will no longer be there. If the nerves are injected properly, relief of the pain usually lasts from 4 months to 5 years or longer, but the overall average is about one year.

8. The patient is seen after one week and any points still tender are injected again. This can be repeated at weekly intervals until all pain is gone. The patient is then seen at three-monthly intervals and any recurrence dealt with as necessary.

### Injection Points for Intra-neural Injections

Injection	Acupuncture	Nerve Root	Name of Nerve (1st line) Location of Tender and Injection Points & Details of Possible Variations (2nd, 3rd line)
#1	BL-9	C-2	Greater occipital Lateral aspect of upper margin of external occipital protuberance about 1" from midline
#2	GB-11	C-2	Lesser occipital On posterior aspect of mastoid process of temporal bone about 1-3/4" lateral to #1
#3	BL-10	C-3	Third occipital Approximately 2 inches inferior to #1 and 3/4 inch lateral to midline
#4	TH-23	Trigeminal	Zygomatico-temporal Two centimeters above zygomatic arch at the lateral tip of the eyebrow
#5	BL-2	Trigeminal	Supraorbital At the medial end of the eyebrow
#6	SI-17	C-2,3	Great Auricular Approximately 1-1/2" ventral to ear lobe
#7	HT-1	C-5,6	Axillary (lower branch) (Circumflex humeral) In mid-axilla on medial aspect of axillary artery
#8	Not Known	C-5,6	Axillary (upper branch) (Circumflex humeral) Not Known
#9	TH-13	C-5,6	Lateral cutaneous of arm Just dorsal to anterior axillary fold or crease On posterior surface of arm approximately 1-2 inches lateral to posterior axillary fold
#10	SI-9	C-5,6	Axillary bifurcation (Circumflex) One thumbbreadth superior to posterior axillary fold
#11	SI-10	Brachial Plexus	Suprascapular Passing through suprascapular notch sending filaments to all joints of shoulder
#12	CO-15	C-3,4	Supraclavicular (Posterior branch) Posterior-lateral and inferior to acromion where depression is formed with arm raised
#13	TH-15	C-3,4	Supraclavicular (Anterior branch) Posterior over trapezius muscle 2-3 inches lateral to midline at level of C-4
#14	BL-41	C-6, 7, 8	Thoracodorsal Four fingerwidths (of patients) of 3-1/2 inches lateral to inferior end of spinous process T2
#15	SI-12	C-5, 6	Superior subscapular In middle of supraspinatus fossa
#16	LU-5	C-5, 6, 7	Lateral cutaneous of forearm At cubital fossa on the radial aspect of biceps tendon
#17	SI-18	C-8, T-1	Medial cutaneous of forearm In fossa between ulnar olecranon and medial epicondyle of humerus with elbow flexed. (May be found as the nerve emerges through the deep fascia in front of medial epicondyle)
#18	HT-3	C-5, 6, 7, 8, T-1	Median At the medial end of the elbow crease when elbow is flexed
#19	LU-8, 9	C-5, 6, 7, 8, T-1	Anterior inter-osseous Approximately 1 to 1-3/4 inches proximal to wrist flexion crease just medial to the radial artery and flexor pollicis longus tendon

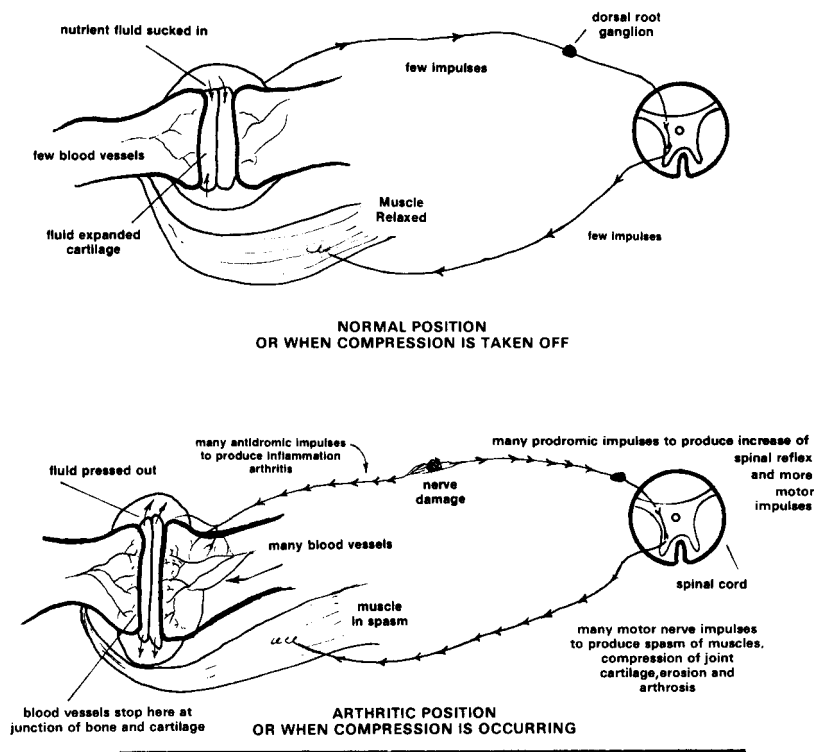
#20	TH-4	C-5, 6, 7, 8, T-1	Posterior inter-osseous ganglion On the dorsum of the wrist in the depression of the skin crease proximal to the 3rd and 4th metacarpals
#21	CO-4	C-5, 6, 7, 8, T-1	Radial terminal branches On dorsum of hand between 1st and 2nd metacarpals in anatomic snuff box
#22	SP-20	T-2, 3	Lateral cutaneous of thoracic Six inches lateral to mid-sternal line at a line even with the 2nd intercostal space
#23	SP-21	T-6	Lateral cutaneous In the mid-axillary line in the 6th intercostal space
#23	KI-27	T-1	Anterior cutaneous One and 3/4 inches lateral to mid-sternal line in the 1st intercostal space
#23	KI-26	T-2	Anterior cutaneous One and 3/4 inches lateral to mid-sternal line in the 2nd intercostal space
#23	KI-25	T-3	Anterior cutaneous One and 3/4 inches lateral to mid-sternal line in the 3rd intercostal space
#23	KI-24	T-4	Anterior cutaneous One and 3/4 inches lateral to mid-sternal line in the 4th intercostal space
#23	KI-23	T-5	Anterior cutaneous One and 3/4 inches lateral to mid-sternal line in the 5th intercostal space
#23	KI-22	T-6	Anterior cutaneous One and 3/4 inches lateral to mid-sternal line in the 6th intercostal space
#24	BL-27	S-1	Posterior rami S-1 One to 1-1/2 inches lateral to 1st sacral vertebra, superior to sacroiliac joint
#24	BL-28	S-2	Posterior rami S-2 One to two inches lateral to 2nd sacral vertebra to sacroiliac joint
#24	BL-29	S-3	Posterior rami S-3 One to 2 inches lateral to 3rd sacral vertebra, level with anterior superior crest of ilium
#25	BL-30	S-4	Posterior rami S-4 One to 2 inches lateral to sacral hiatus
#26	BL-35	S-5	Posterior rami S-5 One centimeter m lateral to the mid-line of spine, level with the superior border of the coccyx
#27	BL-37	S-1, 2, 3	Posterior femoral Trigger points can be anywhere in a 2 inch band running down the mid-posterior thigh from the gluteal region to the back of the knee
#28	GB-27,28	L-2, 3	Lateral femoral cutaneous Anterior and about one inch inferior to the anterior superior spine of the ilium
#29	LI-11	L-2, 3, 4	Accessory obturator (often not present) Approximately one inch inferior to medial end of Poupart's ligament
#30A	None known	L-2, 3, 4	Obturator A. Anterior area of greater trochanter; insert needle at X & penetrate to trochanter
B			Arterial branches B. Superior area of greater trochanter; insert needle at X and penetrate to trochanter
C			Nerve to quadratus femoris C. Posterior area of greater trochanter; insert needle at X & penetrate to trochanter
#31	GB-30		Joint capsule (hip) 2/3's of distance from midline on a line joining the greater trochanter with sacral hiatus
#32	ST-34	L-2, 3, 4	Intermediate femoral cutaneous 2 to 3 thumbbreadths superior to the patella along the lateral margin of the patella
#33	SP-10	L-2, 3, 4	Medial femoral cutaneous 2 thumbbreadths superior to the medial border of the patella on the medial aspect of the thigh with the knee flexed
#34	SP-11	L-2, 3, 4	Saphenous in femoral canal Approximately 6 inches superior to #33 on the medial aspect of Sartorius muscle & lateral to the femoral artery
#35	GB-31, 32	L-2, 3	Lateral femoral cutaneous On the lateral aspect of the thigh approximately 4 to 6 inches proximal to the superior border of the patella
#36	SP-9	L-2, 3, 4	Saphenous At attachment of median longitudinal ligament 1-2 cm inferior to medial condyle of tibia about 1 inch medial to patella; this point often relieves ankle pain
#37	?	L-2, 3, 4	Saphenous At origin of infrapatellar branch of the nerve
#38	?	L-2, 3, 4	Saphenous Immediately below the patella; there may be two or three points located here
#39	?	L-2, 3, 4	Saphenous At the apex of the curve in the nerve as it enters the subcutaneous tissues
#40	ST-36	L-4, 5	Musculocutaneous (Peroneal) Approximately 3 inches inferior to tibial tuberosity & one finger lateral to crest of tibia in the tibialis anterior muscle
#41	SP-6	L-2, 3, 4	Saphenous for foot At the junction of the mid & lower 1/3 of the shaft of the tibia approximately 4 inches superior to the apex of the medial malleolus & slightly medial to the tibial crest
#42	LI-4	L-2, 3, 4	Saphenous for foot At the lower 1/4 of the tibial shaft two thumbs superior to the medial malleolus & lying just medial to the tibial crest
#43	ST-41	L-4, 5	Anterior tibial (Deep perineal) On dorsum of foot in the center of the inferior extensor retinaculum & between the tendons of the extensor hallucis longus & extensor digitorum longus
#44	BL-59,60	L-4, 5	Sural In the depression anterior to the Achilles tendon & posterior to the lateral malleolus
		S-1, 2, 3	Also three inches superior to this point

### Recommendations, Rationale and Research

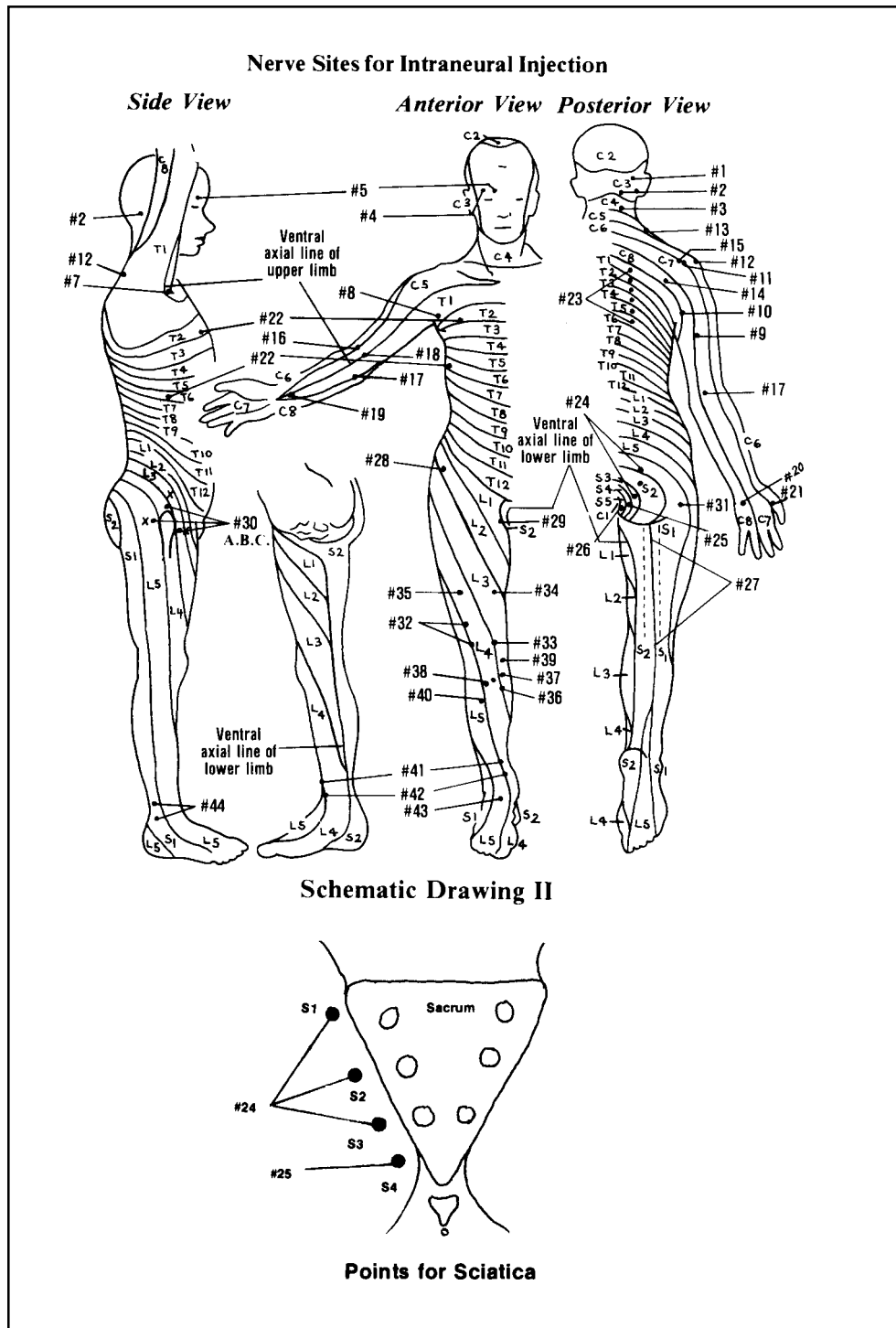
The majority of physicians working with *The Arthritis Fund*, formerly The Rheumatoid Disease Foundation, are realizing

Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.

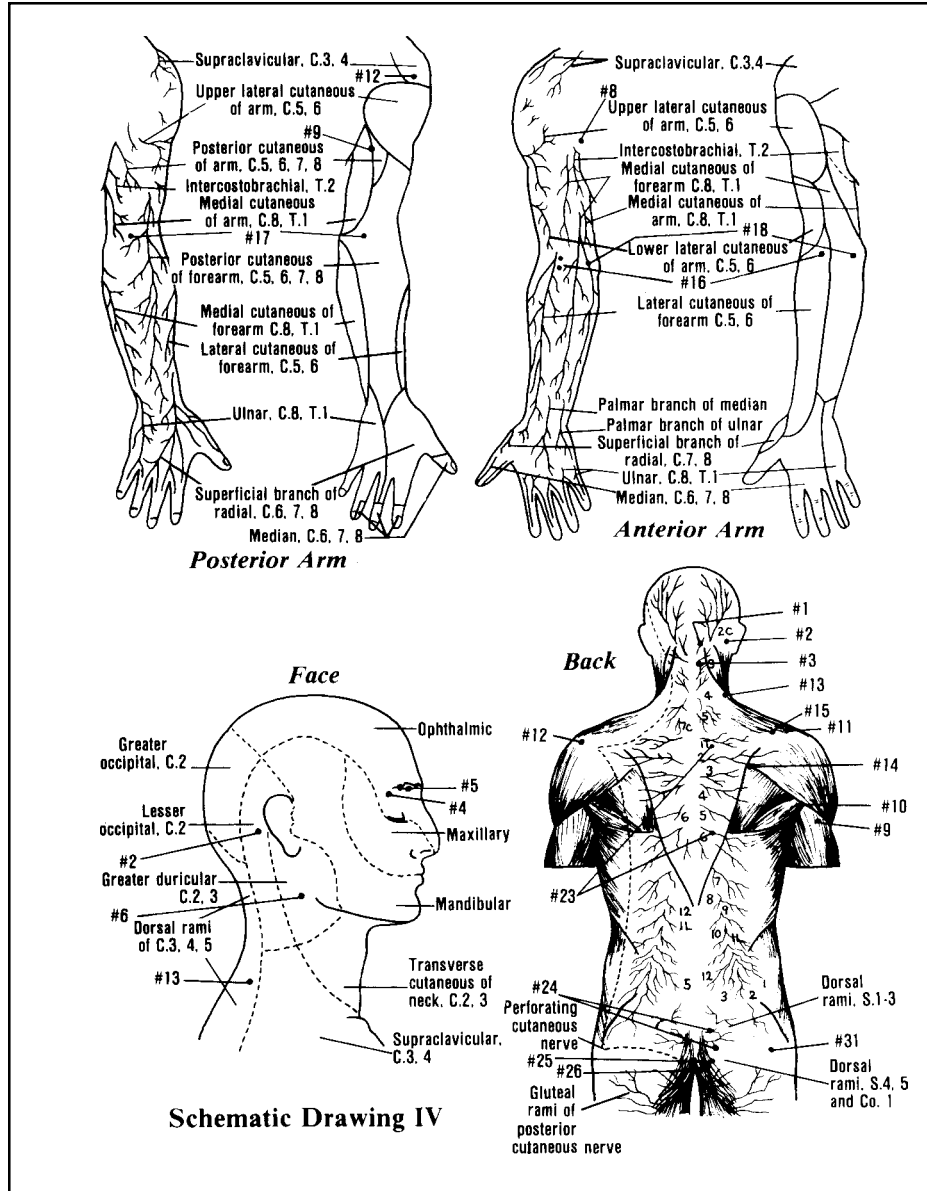
### Schematic Drawing I

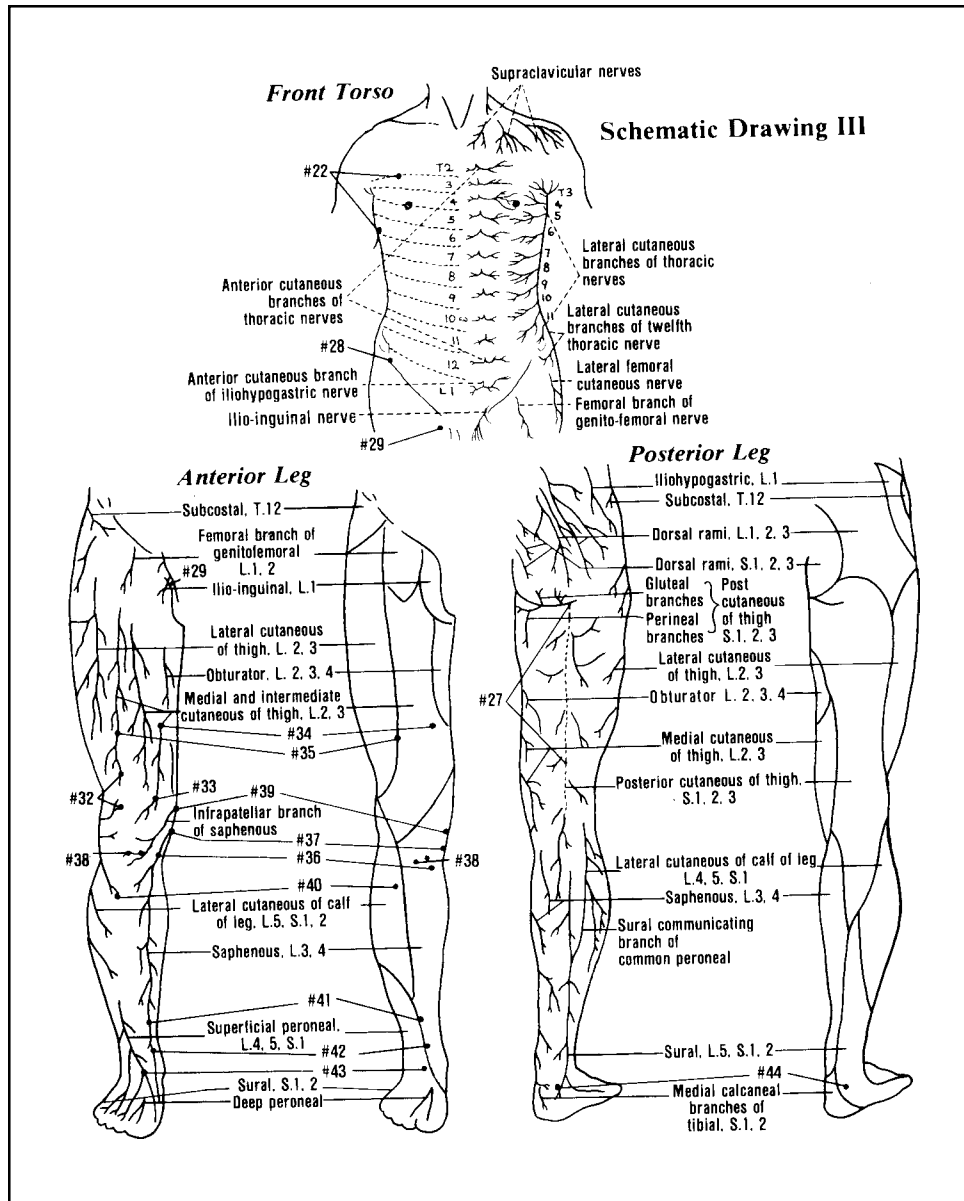


*Schematic Drawing I: Probable cause of sciatic pain in osteoarthritis according to Professor Roger Wyburn-Mason and Dr. Paul K. Pybus, who, along with Gus J. Prosch, Jr., M.D., also developed a successful remedy. These two pictures occur alternately when the patient is walking. However, when the nerve has been inflamed, as in the above picture, the cartilage stays pressed and nutrients do not provide for the cartilage, and it is destroyed.*



Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.





**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

the importance of good nutrition, adequate and proper diet with necessary vitamin and mineral supplementation. With the increasing number of patients being treated by these physicians daily, a few obvious facts are becoming clearer. Those of greater importance are the following:

1. Most all arthritic patients' body fluids are more acid than they should be.
2. Most all arthritic patients show numerous signs and symptoms of a deficiency in free or ionic calcium in the body.
3. Most arthritic patients drink 2% butterfat milk, eat margarine instead of butter, and demonstrate a lack of vitamins D and A along with other nutrients.
4. The diet of arthritic patients does play an important part in controlling the severity of their symptoms.
5. Vitamin and mineral supplementation does shorten recovery time; and by strengthening the immune system, these patients become less susceptible to reinfection by amoebae as well as other infections.

As opinions and conclusions tend to vary widely at the present time among most physicians concerning the use of diet, vitamin and mineral supplementation, and strengthening the immune response system, *The Arthritis Fund* makes no recommendation to any physician concerning these important factors. These decisions are left to the discretion of the attending physician. However, to those physicians [and consumers] who are sincerely interested in these important factors, a short summary of diagnostic signs and symptoms and our rationale concerning diet, vitamin, and mineral supplementation and strengthening of the immune system will be presented. [Many new articles are now available from The Arthritis Fund concerning dietary support for arthritic and related conditions including candidiasis, the roles of essential fatty acids, and enzymes].

Credit for much of the following information should be given to Carl Reich,<sup>5</sup> M.D., of Calgary, Alberta, Canada, who has studied much of the presented information for the past twenty years. Dr. Reich has noticed a strongly positive relationship between the various forms of arthritis and poor or inadequate nutrition. Numerous other physicians have observed similar findings along with a multitude of arthritic patients. One of our physicians has undertaken a continuing in-depth study of this subject, resulting in three primary observations:

1. Many patients who are blood-related to arthritic persons do not develop arthritis especially when different dietary habits are followed.
2. Oftentimes arthritic patients exhibit slight to significant improvement when self-administered home and folk remedies are taken, as alfalfa tablets, bone meal tablets, cod liver oil capsules, vinegar with honey, peanut oil, bee venom and cherries.
3. Some patients are more susceptible to becoming reinfected with amoebae than others, once the germs [or aberrant macrophages] have been destroyed in their bodies by antiamoebic drugs.

The same physician initiated a program to accomplish the following three proposals listed below. Space does not permit a detailed explanation of the technique and methods of study involved, and so only conclusions are presented.

#### **Studies Performed**

1. To determine any previously overlooked physical signs and symptoms exhibited primarily by arthritic patients.
2. To determine and correct any poor or inadequate eating habits along with any vitamin and mineral deficiencies present by using an in-depth and de-

tailed past history questionnaire.

3. To determine a successful method to strengthen the arthritic patient's immune system in an effort to prevent any reinfection by amoebae along with any simple and easy-to-follow techniques that will rid the patients drinking water of any pathogenic amoebae.

#### **Tentative Results of These Studies**

1. There are present with arthritic patients certain physical signs and symptoms which have been found to be much more prevalent than in normal persons not afflicted with arthritis. Of course, one must understand that not all arthritic patients exhibit every sign or symptom listed below, but some are seen in nearly every arthritic (rheumatoid and osteo) patient in one form or another:

- a. Longitudinal ridges in fingernails with an increase in opaqueness of the nails.
- b. Mild to moderate tenderness with strong palpation of the soleus and trapezius muscles.
- c. Generalized slight increase in deep tendon reflexes.
- d. Generalized irritability of skeletal muscles to percussion.
- e. Acid saliva on the average should be about pH 7. Arthritic patients' saliva usually ranges from 4.5 to 6.5 as determined by using Hydrion® paper which is manufactured by Micro Essential Laboratories of Brooklyn, N. Y.
- f. Slight to severe coating on the tongue.

2. An in-depth past history questionnaire which includes a past nutritional evaluation should be completed on arthritic patients. Most arthritics consume a diet that is strongly acid-forming in nature; and it is felt that these patients should be educated as to the proper foods they should eat along with foods they should avoid. It has been found that arthritic (rheumatoid and osteo) patients respond to treatment more rapidly and successfully when they follow the diet recommended below. The diet also helps prevent reinfection by amoebae when followed.

#### **Diet, Vitamins and Minerals**

One of our leading physicians says:

"In my practice, I have noticed that most arthritics avoid whole milk and butter and instead drink skim or low-fat milk and eat margarine. Their clinical symptoms and physical examination signs usually demonstrate strong evidence of a deficiency of "free" calcium in their system as well as a lack of vitamins A and D. Blood calcium studies are misleading since they measure the free calcium along with other forms as all the calcium bound to proteins. Whereas normal body fluids are nearly always slightly alkaline, as opposed to acid, I constantly find those patients with rheumatoid disease have body fluids that are more acid in nature than normal. This is partly due to a deficiency in free (ionic) calcium, which in 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 rheumatoid 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 body state. For this reason, a diet consisting of high alkaline forming foods should be consumed, combined with the 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 other elements: potassium, calcium, magnesium, sodium. The following diet has proven to be effective in preventing and treating those with rheumatoid diseases, but also seems to strengthen and fortify an individual's immune system and body defenses, especially when combined with adequate vitamin and mineral supple-

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.** ments.

“The diet used to treat and prevent development of rheumatoid diseases should definitely *avoid*, as much as possible, the following foods: All processed and most canned foods should be avoided along with caffeine, sugar in all its forms, as well as the simple carbohydrate foods that quickly upon digestion turn into sugar as white flour foods, crackers, many cereals, macaroni, (pasta foods), white rice and corn products. Ideally, nicotine and alcohol should be avoided, along with any sweets, candy, soft drinks, pastries, or desserts. The “nightshade plants” (foods containing solanines) such as white potatoes, tomatoes, egg plant and garden peppers should be avoided. Also avoid chocolates since they contain oxalates which interfere with calcium absorption. Most fruits are alkaline forming (contrary to public opinion) with the exception of cranberries, plums and prunes, which of course should be avoided.

“Concerning vitamin and mineral supplementation, the most important point to consider here is to correct the free calcium deficiency present in most arthritics. This requires much larger amounts of vitamins A and D in their natural form than what is usually recommended by the ‘recommended daily allowances’ tables. The synthetic vitamin A and D-2 preparations on the market simply do not work. Synthetic vitamin D-2 does increase the calcium absorption from the small intestine but seems to be totally inadequate in regulating the use of calcium and especially calcium excretion by the kidneys. The only preparation I have found that is adequate is the natural D-3 which is found in fish liver oils. Therefore, I recommend plain cod liver oil as the ideal which seems to be even better than cod liver oil capsules. It is easily taken when mixed with some orange juice and stirred rapidly. The preparation recommended is plain Norwegian cod liver oil liquid which contains 10,000 units of vitamin A and 1000 units of vitamin D per teaspoon. I recommend that patients take two teaspoons on arising each morning and two teaspoons at bedtime. This preparation can be found in most health food stores and should be taken for at least four months then the dosage should be cut in half. I explain to the patients to not fear any vitamin A or D toxicity with this dosage as it is less than 1/3 the toxicity level that has been reported in the literature. If the patient absolutely cannot take the liquid, they can usually find capsules at a health food store which will provide approximately 40,000 units of vitamin A and 400 units of D. I also explain that *exposure to the sunshine of at least 20 minutes weekly will activate the vitamin D.*

“Concerning calcium preparations, I have found that none of the available inorganic calcium preparations are effective. I discovered that organic bone meal tablets (3-4 per day) work better than other calcium preparations but I continue to have reservations. Recently, I located a calcium preparation that seems to work ideally. This compound is Calcium Orotate which is the naturally occurring calcium in plants. Miller Pharmacals of Chicago or Lanpar Corporation in Dallas, Texas carries this compound and I prescribe 500 mg Calcium Orotate (50 mg elemental calcium) three times daily with meals for two months, then 500 mg twice daily. This calcium preparation also seems to enhance the ability of the body to use and metabolize other forms of calcium ingested. I also prescribe 500 mg Magnesium Orotate once daily to balance the calcium-magnesium ratio. The above calcium preparation is also excellent for osteoporosis and it greatly strengthens the bone and cartilage structures in the body.”

“As a rule, most protein foods tend to be acid forming since they contain phosphorus and sulfur. Animal sources of protein — lean meat (beef, lamb, veal) poultry, fish and eggs — are definitely in this category. With the exception of shrimp, most sea food is extremely acid forming. These foods *must not* be avoided

however in the diet, as they provide the building blocks for all body functions and processes. Therefore one of these proteins should be eaten with each meal. Pork meats should be limited however. Just try not to eat an entire meal consisting of protein foods, but balance these foods with alkaline forming foods. Ideally your breakfast should always consist of some high protein foods, balanced with whole milk, fruit juices, etc. Also remember to cook protein foods at low temperatures, as enzymes and trace minerals are reduced when foods are heated above 120 degrees F.

“Avoid processed and hydrogenated, or “hardened” oils and fats. Most margarines, peanut butters, restaurant prepared French fries and potato or corn chips are prepared with hardened oils. Sweet cream butter is best and use “non hydrogenated” vegetable oils (like Pam®) for home cooking. Also watch those high calorie salad dressings. Most fats and fatty foods (butter, oils, sausages, bacon, etc.) are neutral in their acid-alkaline content, but they greatly contribute to excessive weight gain which severely complicates arthritis. Therefore, it would be wise to limit are oily, greasy, fried, fatty foods, if you tend to be overweight.

“Most all vegetables (except corn) are highly alkaline in nature and should be emphasized in your eating program. Salad vegetables are excellent and should be eaten daily. All other vegetables are very good and when “wok” cooked or stir-fried in “non-hydrogenated” vegetable oil, they are even better for you. Fresh vegetable juices (not canned) are nearly perfect and should be part of your diet. It is important to prepare and serve as many foods in their raw and natural state as possible. All fruits and fruit juices (excepting cranberries, plums and prunes) are very good alkaline forming foods and should be eaten daily. Most nuts (with the exception of peanuts, pecans and walnuts) are alkaline forming and are good to “munch” on. Whole milk is one of the best alkaline forming foods due to its high calcium content. Raw certified whole milk is much preferable if you can find it, and I would class it as the #1 choice of foods for arthritis patients. You should not drink skim milk or low fat milk in preference to whole milk. At least two glasses of whole milk should be taken each day and use butter instead of margarine. Plain yogurt is an excellent alkalinizing food and not only easy to digest but tastes great when mixed with fresh fruit. Certain dried fruits such as raisins, dates, dried figs and apricots are also good and make excellent munching foods. This diet will change your system to be more alkaline as it should be.

[It is also reported that the steroid, Decadurabolin® (nandrolone decanoate by Organon) injected intra-muscularly, 100 mg once each month for six months, also reverses the progress of osteoporosis—Editor]

“Concerning other vitamins for arthritic patients, I recommend as an ideal supplement program the following:

1. Vitamin B complex — two to three “Stress” B vitamins daily in divided doses.
2. Vitamin C — two to three grams daily in divided doses.
3. Zinc Orotate — 500 mg, one to two tablets daily.
4. Selenium, 250 mcg daily as yeast selenium.
5. Beta-Carotene — 25,000 units daily.
6. Vitamin E — 400 units daily.

“The above vitamin and mineral supplementation will not only help the patient’s arthritis by stimulating the immune response system but will play an important role in counteracting the aging process as well as acting as a deterrent to some forms of cancer since many of these preparations act as free radical and peroxide scavengers in the body. With painful hands and feet, I recommend in addition 100 mg vitamin B6 twice daily. this is also helpful for carpal tunnel syndrome. With neuralgia, I suggest 500

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**  
mg niacinamide twice daily.

"In treating rheumatoid disease patients who have recently been taking any cortisone preparations, gold injections, or penicillamine, the physicians working with The Arthritis Fund have discovered that these patients respond more slowly and less effectively with anti-amoebic medications. Professor Roger Wyburn-Mason believed that these medications produce some form of shield or coating around the amoebae which prevents the anti-amoebic drug from getting to the amoebae.

"In trying to prevent reinfection of the amoebae and realizing that drinking water is a primary source of reinfection with the fact that copper kills the amoebae effectively, the writer recommends to patients that they should either boil their drinking water 10-15 minutes before drinking or to place one half pound of clean "non-insulated" copper wire in each of two gallons of water which is allowed to stand at least 8 hours before drinking.

The Arthritis Fund recommended treatment for rheumatoid arthritis was previously presented in Chapter IV. Dr. Prosch's observations (which coincide with some Arthritis Fund members' observations) on osteoarthritis follow:

1. It has been observed that the majority of osteoarthritic patients are infected to some degree with amoebae. For this reason, all osteoarthritis patients are first given a "therapeutic trial" of anti-amoebic medication usually in the form of metronidazole and allopurinol as suggested under the recommended techniques of treating rheumatoid disease.

2. Location and injection of tender points of the nerves affecting the involved joints as shown under the prior table and schematics in this section under intraneural injections.

3. Prescribe amantidine hydrochloride (Symmetrel®) 100 mg three times daily for 2-3 months or until symptoms disappear. Along with this, colchicine 0.6 mg should be given once daily for 6 days of each week for 2-3 months or until well. These two together (without other treatment) have proven effective in about 55% of patients, according to Dr. Archimedes A. Concon.

4. Follow the recommended diet suggestions to "alkalinize" the body.

5. Follow the recommended vitamin and mineral supplementation mentioned previously with special emphasis on the proper dosage of cod liver oil and calcium, magnesium and zinc orotates.

**This protocol has been subject to revisions (additions [e.g. boron, essential fatty acids], deletions [amoebae may have been Cell Wall Deficient bacteria, or CWD candida albicans, or aberrant macrophages], changes) as Board Members have completed relevant research. New articles are now available from**

#### **The Arthritis Trust of America**

Perry A. Chapdelaine, Sr.  
Executive Director/Secretary  
March 1984;  
revised

1. *Fifteenth Edition of the Cecil Textbook of Medicine, Vol. 1*, W.B. Saunders Co., Philadelphia 1979, p. 202.

2. Deca-durabolin®, used in South Africa and Europe, seems to turn osteoporosis around. See The Arthritis Fund protocol, "Diets, Vitamins, and Minerals."

3. See *The Control of Pain in Arthritis of the Knee*, Paul Notrik, The Arthritis Fund, 5106 Old Harding Road, Franklin, TN \$4.50 plus \$1 postage and handling, 1984.

4. See "Treatment of Backache with Local Injections," 222: 708-711; "Treatment of Painful Conditions of the Abdominal Wall With Local Injections," 224:921-925; "A Controlled Trial to Compare the Effects of Local Injection of Cortiosteroid and Lignocaine into Painful Lesions of the Back"; "Treatment of the Painful Knee With Local Injections," all with *The Practitioner*; "Local Injection Therapy," *The Physician*, 185-188, 1984.

5. According to Carl J. Reich, M.D.: "In essence, I feel that calcium is intimately related with energy release mechanisms of the cell and deficiency of it enhances these processes to cause 'burn out' of cell function, whether it be of muscle cell, nerve cell, connective cell, etc.

"Likewise, I feel that calcium deficiency causes the autonomic nervous system to excite certain adaptive units, present in the lung, intestine, or skeleton to function in a different direction that may be compensatory for the encroaching calcium deficiency state.

"These combined influences of calcium ion deficiency, of course, may be heightened by any toxin which will depreciate the effectiveness of ionic calcium.

"Therefore, a calcium deficient patient may be asymptotically adapting to the calcium deficiency by some autonomically excited process of lung, intestine, and skeleton; and in such instances, this asymptomatic adaptive process may be broken down to pathological maladaptive disease by an infection which may aggravate the deficiency state.

"Most importantly, vitamin A which is the natural accompaniment of vitamin D and calcium in milk products, and vitamin A which accompanies vitamin D in fish oils, may be a natural anti-yeast or protozoal protective device, the deficiency of which will predispose the individual to infection with these agents. Because of the co-existence of these nutrient factors in milk products and fish oils, etc., the person who becomes infected for reason of vitamin A deficiency, naturally pays the penalty of experiencing the calcium disrupting effect of the toxin which the infection excretes.

"...Possibly the most important aspect ... [the] symptoms and signs due to the direct effect of deficiency on the individual, may constitute a warning that the person's deficiency is of a level that is exciting physiological adaptation. I now also interpret these symptoms and signs as a warning that the individual also is susceptible to infection, which infection may depreciate the asymptomatic adaptive device to pathological expression in acute fashion, whereas otherwise, if infection did not occur, the breakdown of this function to induce disease might not have occurred for years or decades later, or possibly not at all."

6. *Patient Nutrition Handbook*, Nettie F. Strauss, National [now Desert] Arthritis Medical Clinic, 13630 Mountain View Road, Desert Hot Springs, CA 92240; *1981 Arthritis Program*, Robert Bingham, M.D.

7. ANAVIT-F3, Chemical Consultants International, Inc., P.O. Box 88041, Honolulu, Hawaii 96815.

## **Chapter XII**

### ***The Past and the Future***

#### ***The BCF Syndrome***

For people like you and me, the future is again glistening. Not only do we perceive the living of useful, happy pain-free lives, but through forthcoming research of the tax-exempt, non-profit *Arthritis Fund*, we perceive discovery and development of new techniques and medicines that will prevent tissue and joint destruction before it begins. Before the tuberculosis bacillus was discovered, physicians had a hundred different names for what seemed to be a

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.** hundred different diseases. Once the tubercle bacillus was identified and isolated, it became apparent to all that what had come in a hundred different guises was in reality but one germ that affected a hundred different body tissues.

Thus it is also for Professor Roger Wyburn-Mason's discovery of the *Limax amoebae* — a hundred different symptoms disguised by discriminating medical nomenclature is found to have the same basis, and therefore, the same cure.

Since the first edition of this book, the author has repeatedly been asked: "Why don't the authorities — medical organizations, drug manufacturers, Arthritis Foundation, U.S. Government, et al — look into Professor Roger Wyburn-Mason's findings, and do something about all this? After all, they are in the business of helping the sick?"

I thought that Chapter X, "Is It Ethical to Deny the Sick?" with its inclusion of a description of vested interests, sufficient to answer the question in advance. It appears that something stronger is required.

There is a sickness among us which I've titled the *BCF Syndrome*:

This disease is characterized by a group of mental disorders affecting thinking, mood and behavior. There is an altered concept of reality, and in some cases, delusions and hallucinations. Mood changes include inappropriate emotional responses and loss of empathy. Withdrawn, regressive, and bizarre behavior may be noted. Whenever reality is addressed, i.e., whenever the person's attention is forcibly directed toward the real world, delusions of persecution may drive the individual to attack with unwarranted venom. Such attacks often take the form of Authoritarian statements of denunciation to the press, radio, and TV, the primary purpose of which is to restore the denouncer to a semblance of inner security in an inner world where all things are nicely predictable, thus also nicely controlled, and no thing is perceived as a threat.

I am writing, of course, of the dreaded **Bumblebees Can't Fly Syndrome**.

The **Bumblebees Can't Fly Syndrome** was named during the first part of this century in the 1920s or 1930s (I believe) by some unknown scientist who, when shown certain mathematical equations clearly demonstrating that Bumblebees Can't Fly, said, "But what of the one that has just flown to your shoulder?" He was summarily drummed from the Scientific Academy and thereafter attacked in the news media with great venom, many claiming that he was a fraud, a charlatan, not a true scientist at all: and at least one great organization, *The Foundation for the Preservation of the Mammoth Elephant*, proceeded forthwith to send out a stupendous number of requests for research funds to find the cure for why Bumblebees Can't Fly, at the same time warning all recipients not to listen to any quacks who claimed otherwise.

While the disease — **BCF Syndrome** — was named but recently, the symptoms were observed several hundred years ago, the most memorable occasion being when august French scientists at a famous museum threw out a valuable collection of meteorites, patiently collected over several hundred years, because "everyone knew that rocks can't come from the sky."

Of course, I'm being facetious!

But consider the same thought posed in a more restrained manner: Arthur Koestler in his *The Sleepwalkers*,<sup>1</sup> says:

"... the inertia of the human mind and its resistance to innovation are most clearly demonstrated not, as one might expect, by the ignorant mass — which is easily swayed once its imagination is caught — but by professionals with a vested interest in tradition and in the monopoly of learning. Innovation is a twofold

threat to academic mediocrities; it endangers their oracular authority, and it evokes the deeper fear that their whole laboriously constructed intellectual edifice may collapse."

Consider, for example, the Arthritis Foundation: It should have done something with Professor Roger Wyburn-Mason's research the moment it was published in 1964, but it did not. In the author's opinion, and to the author's personal knowledge, the Arthritis Foundation has impeded any attempt to spread the word, or to bring about proper scientific investigation of Professor Wyburn-Mason's work — and it still begs for money "for research to find the cure for arthritis!"

Most of the established Foundations use a code word that, among those not in the know, sounds erudite and conservative and proper; but in fact, to those who are in the know — the medical and scientific establishment — means "don't touch," we haven't approved. The code word is simply *not proved* or "an unproven remedy." The term "unproven remedy" is fostered on the public as being equivalent to quackery — this despite the fact that 80-90% of AMA-approved medical practices are also unproven, according to the *U.S. Office of Technology Assessment*, publication (1978), "Assessing the Efficacy and Safety of Medical Technology." Try calling the Arthritis Foundation and ask why they are not using and/or propagating the Roger Wyburn-Mason treatment which has been said to be scientifically proved over six years ago. The answer you will most probably receive from any of its many branches will be simply "not proved." This code word means "not invented here," "not approved by our FNR (friendly neighborhood rheumatologists) who run our organization," "boycott this treatment, because it's not part of our establishment," and so on. They will never once tell you that they are themselves investigating the claims — for they are not —, or that they've furnished funds for running "requisite" double-blind studies — for they have not —, or that they have looked into the claims, either through Professor Roger Wyburn-Mason's research, or through other physicians' cures and remissions — for they have not.

They will never tell you of the treatment research background, in many medical fields, or Professor Roger Wyburn-Mason, but rather seek to cast doubt on this wonderful person through innuendo and false statements taken out of context. And when they speak of Dr. Jack M. Blount, of course, they will use two modes: (1) On the record, this is an "unproven" remedy (the code word), and they will make fun of his heart-rending story as told herein in Chapter II. (2) Off the record, Dr. Blount is a [you fill in the blank].

The Arthritis Foundation has over many years used its IRS tax exempt base and its privilege of free radio and TV time to *condition* people into believing that their foundation is the sole authority on arthritis, that everyone else who has insight, knowledge, data, is a fraud and charlatan, that one should check with *them* before making any move whatsoever. They admittedly can do nothing for you, except teach you how to live with your pain and suffering and continuing and increasing disfigurement, but since they've set themselves up as being *The Authority*, they have the gall to also judge for you where to go for treatment — and they will protect your pocketbook from charlatans and con artists while steering you to your FNR (friendly neighborhood rheumatologist), who will, instead, take your money without any cure.

*The Arthritis Foundation has no greater legal basis for existing than does any other association of individuals; nor are they any greater authority than they can produce workable results — which is apparently none!*

As to the FNR (friendly neighborhood rheumatologist), he or she is a physician who has specialized in rheumatology. Con-

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

sciously or unconsciously, professional rheumatologists know that if Professor Roger Wyburn-Mason is correct, and that rheumatoid diseases can be easily and swiftly cured with a small amount of medicine (and they can), then *any general practitioner can cure the disease, and rheumatology as a specialty is doomed!* Some, I'm sure, have a severe mental conflict when they are told that all the procedures they use, for treatment and for alleviation of symptoms, are wrong! After all, *they* are the experts. They have a university degree to show for it, haven't they? The fact that they cannot get results is ignored by their own suffering from the **Bumblebees Can't Fly Syndrome**.

As to show the American petro-chemical industry, the American health systems, and some foundations, control virtually all practice of medicine for profit (as opposed to the chief aim of getting people well), I have only to refer the reader to a series of *Penthouse* articles wherein thorough investigative and objective reporting shreds the mysterious veil of direct and indirect control over the American public's right to health.<sup>2</sup>

And any serious student of these matters would do well to review problems encountered by The Dreyfus Medical Foundation,<sup>3</sup> wherein Jack Dreyfus, — who had access to Presidents, top Federal bureaucrats and the Army Surgeon General — was unable to effect a needed minor change in the *Physicians' Desk Reference*.<sup>4</sup>

One famous German physician describes Americans as "Stupid," because we conduct all the basic medical research, and then bury it. All the Europeans need to do is read our journals, and apply findings and lo!, they are ahead of us in medical applications by twenty years!

It is not the author alone and other now-cured rheumatoid victims who have reached the point of disgust on how our health and welfare is controlled by others with vested and narrow-viewed interests. The People's Medical Society<sup>TM5</sup> has recently been chartered with the stated goals of giving each of us more control over our own medical care and to reduce health-care costs. Robert Rodale says, "The medical confrontation is not just coming — it's here."<sup>6</sup>

#### *The Arthritis Trust of America*

The Roger Wyburn-Mason and Jack M. Blount Foundation for the Eradication of Rheumatoid Disease, IRS tax-exempt, non-profit, is dedicated to curing you, and everyone else who suffers from rheumatoid diseases: (1) stopping disease progress, (2) repairing damage, (3) maintaining health.

Professor Roger Wyburn-Mason spent many agonizing years suffering through skeptical rebuffs, when all anyone had to do was look at this proffered research. Jack M. Blount, Jr., M.D., likewise has charged ahead despite much ridicule and persecution to bring his knowledge to those who, like myself, also suffered.

Every member of *The Arthritis Trust of America* has sacrificed more or less in some manner to bring this valuable information to those who suffer needlessly.

With welcome assistance from many others, *The Arthritis Trust of America* is now sending out letters asking for research funds to bring Roger Wyburn-Mason's findings to fruition. There are many research, development, and application needs that can be satisfied through your donation — big or small — and these are:

1. First and foremost is the use of funds to conduct double-blind studies. We must demonstrate to the American medical and scientific establishment the correctness of Professor Roger Wyburn-Mason's treatment. In making double-blind studies, patients are divided into two groups, one to receive the medicines that are thought to cure or bring relief, and the other group that receives a known neutral ingredient, called a placebo. "Double-blind" studies mean that neither the patient nor the physician is aware of

which patient receives the anti-amoebic and which the placebo (inert ingredient without any medical value). In some parts of Europe, it is both unethical and illegal to perform double-blind studies when an agent is known to effect relief of pain and suffering. In the United States, double-blind studies are necessary to convince those who set the standards (medical establishment) of what shall constitute proper medical treatment, although neither the miraculous sulfa drugs nor penicillin went through such costly and extravagant studies. Perhaps double-blind studies can be effective in showing which of several anti-inflammatory substances, that treat symptoms only, is most effective, but of what use when the cause and cure are known? *The Arthritis Trust of America* has acquired funds through generous donors and is currently running double-blind studies with clotrimazole at Bowman Gray School of Medicine, Winston-Salem, NC, Department of Rheumatology under Robert Turner, M.D. These scientific studies will take 12 months, but as studies begin, it will be quickly shown that double-blind studies cannot be done, because each infected patient who receives anti-amoebics will have the Herxheimer effect, and the administering physician will at once know which patient is receiving the anti-amoebic and which is not, thus destroying the double-blind aspect. [The patient may not know what is happening or why, but the physician will know, thus only single-blind trials are possible.]

However, *The Arthritis Trust of America* must go through this expensive charade for the sake of getting information into the present hard-headed medical establishment.

There are another \$2,000,000 worth of studies of similar nature waiting to be funded.

2. There must be developed a better test to determine genetic susceptibility [or resistance] to the *Limax amoeba* [or other similar organisms or cells] in advance of tissue destruction, and awaiting the Jarisch-Herxheimer effect (after taking amoebics) for initial verification. Right now, it's like saying, "Yup! That guy over there who's almost dead *did* have the disease." Until now, the state of medical art has precluded such definitive tests — most expensive presently used laboratory tests and x-rays are non-definitive — but whole new fields of bio-genetic engineering are unfolding which give promise to solve this problem neatly.<sup>7</sup>

During 1985, with the help of generous donors, *The Arthritis Trust of America* funded one to three university centers to duplicate Roger Wyburn-Mason's initial work in isolating the *Limax amoeba*. With this step accomplished, we will then be able to fund monoclonal antibody studies that will provide the physician with a specific test to determine which amoeba, [Cell Wall Deficient bacteria, Cell Wall Deficient candida, or aberrant macrophage] must be killed [or normalized] with which anti-amoebic. No more guessing or shotgun approach!

3. Now that we know how insidiously dangerous is the *Limax amoeba* [and its look-alikes, aberrant macrophages, Cell Wall Deficient bacteria, or Cell Wall Deficient candida], we should have a catalog of all 300 or more species, with their characteristics, so that the basic and developmental research can be performed to safeguard people; such research would include knowledge on how they affect changes in tissues, their capacity to adapt to changing environments, including different anti-amoebics, their relationship to diets, including vitamins and minerals — and we must communicate to people on the proper procedure of treating the symptoms of rheumatoid disease. For example, for many years rheumatologists have told victims to exercise, and to use massage and warmth. It turns out that this standard advice has been causing the organism that causes rheumatoid disease to spread faster. Money must be spent to de-condition people, so that they will know the truth.

We must have definitive tests that can discriminate be-

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.** tween allergies, yeast infections, bacterial, viral, [autoimmune] and amoebic.

5. *The Arthritis Trust of America* has republished Professor Roger Wyburn-Mason's masterly publication, *The Causation of Rheumatoid Disease and Many Human Cancers*<sup>8</sup> and his *Addenda*.<sup>9</sup> These must be made more widely available so that all physicians and scientists can study in detail the massive amount of work Wyburn-Mason placed into them over a lifetime, and thereby convince themselves that merit lies therein.

6. Other rheumatoid diseases that have not, until now, been recognized as related to the rheumatoid condition need more studies and therefore also need funding. Many have been named in Chapter VII, but it would be well to cover here two important ones: cancer and multiple sclerosis.

In Wyburn-Mason's *Addenda*<sup>10</sup> is stated: "Certain human lesions are well recognized as premalignant and, if their cause could be elucidated and removed, the possibility of finding the aetiology and of prevention of some forms of cancer arises." Wyburn-Mason briefly reviews the statistical studies, and their implications, and it becomes easy to visualize that perhaps as much as 20% of cancer is now set up by the *Limax amoeba* [and/or other similar in appearance macrophages, Cell Wall Deficient bacteria, or Cell Wall Deficient candida] by establishing a changed environment around individual cells, which, when the cells adapt because of the changed environment, become precancerous, among which are the following: Exocrine glands (salivary and lacrimal glands, cystic mastitis, chronic lymphocytic pancreatitis, liver), Endocrine glands (lymphocytic or Hashimoto's thyroiditis, adrenal, parathyroid, thymus, ovary), Mucosa of the respiratory or gastrointestinal tract, Colon, Lungs, Gallbladder, Bone Marrow, Bones, Lymph Nodes, Macroglobulinaemia, etc. Wyburn-Mason further states, "In order to prevent certain malignant changes, it would seem that the premalignant lesions described above must be prevented. This can be accomplished in some cases by administration of anti-amoebic substances to all subjects at regular intervals as every person becomes reinfected with amoebae in the course of his life and these may be pathogenic or the subject sensitive to them. In this way, [the various syndromes] can be prevented."

Multiple sclerosis, the last disease researched by Wyburn-Mason before his death, also seems to be an invasion [in part] of the central nervous system by *Limax amoebae* [or its look-alikes]. However, those anti-amoebics now routinely used to cure other rheumatoid diseases are dangerous for victims of multiple sclerosis to use, because during the course of killing amoeba, there is a plaquing over of nervous tissue, causing the disease to progress faster. Obviously, now that the [cellular or microbic] cause of multiple sclerosis is known, research funds for assessing anti-amoebics which do not at the same time create a worsening condition would be very well spent. Since the [cellular or microbic] cause of multiple sclerosis is known, the disease can now be prevented by assuring that those who are susceptible to the *Limax amoebae* receive anti-amoebics before the disease progresses into the nervous structure; and perhaps the cure of multiple sclerosis is just around the horizon, as has already been experienced by other rheumatoid disease victims. As of this writing, one of our cooperating physicians may have the answer for MS! Perhaps by the book's next edition, we will be privileged to publish that answer.

7. Since the *Limax amoeba* is resistant to chlorine, the treatment of public water systems must be reevaluated, and public hygiene programs must be instituted for preventing reinfection through swimming pools, drinking water, mishandling of sewage, and so forth.

8. Perhaps one or more clinics for the indigent can be

established across the nation and the world in time. Cost is no longer a large factor in treating rheumatoid disease conditions.

9. Hundreds of thousands of anti-amoebics need to be screened to learn which are the most effective. Those given in this book, Chapter V, represent chiefly the results of discoveries by Prof. Roger Wyburn-Mason, Jack M. Blount, M.D., and Robert Bingham, M.D., none of whom have been in the business of searching and screening. Think of what can be found — and the good that will be forthcoming — when funds are at last available to search out the most effective, lowest cost anti-amoebics!

The above are only my suggestions. *The Arthritis Trust of America* Board members will make a determination of priorities as donations become available, and you can be quite sure that any further suggestions, whether or not accompanied by a donation to *The Arthritis Fund* will be seriously considered.

#### *Donations*

If you are concerned for yourself, your children and their children, and other loved ones, and if you want to help in this magnificent effort, your donation may be made to *The Arthritis Trust of America, 7111 Sweetgum Drive SW, Suite A, Fairview, TN 37062-9384*. Your gift will be tax-deductible to the full extent of the law, and will represent a first effort to lick a scourge that has been with humankind since its beginnings, and must, therefore, be an act of mercy heard by many sufferers and also by *He* who demands love and mercy for us all —.

1. Koestler, Arthur, *The Sleepwalkers*, McMillan Co., New York, NY, 1959.

2. Some of the articles are: "The Great Cancer Fraud," Gary Null and Robert Houston, *Penthouse*, September 1979; "The Suppression of Cancer Cures," Gary Null, *ibid.*, Oct. 1979; "Alternative Cancer Therapies," Gary Null with Anne Pitrone, *ibid.*, Nov. 1979; "Suppression of New Cancer Therapies: Dr. Joseph Gold and Hydrazine Sulfate," Gary Null with Anne Pitrone, *ibid.*, January 1980; "The Politics of Cancer, Part 5 — Suppression of New Cancer Therapies: Dr. Lawrence Burton," Gary Null and Leonard Steinman, *ibid.*, July 1980; "The Politics of Cancer, Part 6 — Suppression of Alternative Cancer Therapies: Dr. Josef Issels," Gary Null and Leonard Steinman with Kalev Pehme, *ibid.*, Aug. 1980; "The Politics of Cancer, Part 7 — Laetrile — The Drug that Never Was," David Rorvik, *ibid.*, Jan. 1981; "The Politics of Cancer, Part 9 — The Cancer Insurance Scam," Robert Sherrill, *ibid.*, Jan. 1982; "The Politics of Cancer, Part 10—Warning: The American Cancer Society May be Hazardous to Your Health," Allan Sonnenschein, *ibid.*, May 1982; "The Politics of Cancer — The Promise of Hydrazine Sulfate," Ralph W. Moss, *ibid.*, Jan. 1983.

3. *A Remarkable Medicine Has Been Overlooked*, Jack Dreyfus, Pocket Books, 1230 Avenue of the Americas, New York, NY 10020.

4. *Physicians' Desk Reference*, Medical Economics Co., Inc., Oradell, New Jersey, 1983.

5. People's Medical Society™, "Charter Invitation," Trieste Kennedy, 33 East Minor St., Emmaus, Pennsylvania 18049.

6. "Our New Alliance For Health, Robert Rhodale [with magazine editor], *Prevention*, May 1983.

7. "Antibodies for Sale," Julie Ann Miller, *Science News*, Vol. 123, No. 19, May 7, 1983, pp. 296-298, 302.

8. *The Causation of Rheumatoid Disease and Many Human Cancers — A New Concept in Medicine*, Roger Wyburn Mason, Iji Publishing Co., Tokyo, Japan, 1978.

9. *The Causation of Rheumatoid Disease and Many Human Cancers -- A New Concept in Medicine, A Précis and Addenda, Including the Nature of Multiple Sclerosis*, Roger Wyburn-Mason,

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

The Arthritis Trust of America, 7111 Sweetgum Drive SW, Suite A, Fairview, TN 37062-9384, 1983.

10. *Ibid.*, pp. 15-17.

### Chapter XIII

#### *Dr. Jack M. Blount's Suspended Sentence*

##### *The Board Hearing*

In 1983, Dr. Jack M. Blount received a suspended sentence of two years from the State Board of Medical Licensure of Jackson Mississippi. Dr. Blount's "crime" was as follows:

Following a hearing before the Board of Medical Licensure on May 19, 1983, and July 21, 1983, Dr. Blount was found guilty of unprofessional conduct, which included, but was not limited to, making or willfully causing to be made many flamboyant claims concerning his professional excellence and he was judged guilty of dishonorable or unethical conduct likely to deceive, defraud or harm the public...the Board suspended Dr. Blount's Mississippi medical license No. 2466 for a period of (two) 2 years. However, the period of suspension was stayed upon Dr. Blount's compliance with certain conditions:

Dr. Blount shall cease issuing papers extolling the particular virtues of the expected results of his treatment for arthritis.

Dr. Blount shall not prescribe by mail or in person to a patient unless he has conformed to the traditional ethical medical methods, including but not limited to, the taking of a medical history and performing a physical examination and suitable laboratory procedures.

Dr. Blount shall post conspicuously in his office a statement that the treatment he uses for arthritis is *experimental* and that there is no guarantee of any cure.

Dr. Blount shall verbally inform each patient he treats for arthritis that the treatment he uses for arthritis is *experimental* and that there is no guarantee of any cure.

Dr. Blount shall personally reappear before the board after a period of one (1) year has elapsed.

If Dr. Blount fails to comply with any of the conditions it will result in the immediate lifting of his license to practice medicine in Mississippi.

Dated July 25, 1983 — Mississippi State Board of Medical Licensure

As with most Board Hearings and court cases, the public seldom views behind scenes, they seldom sense or know the prejudicial power vectors that thrust a man like Dr. Jack M. Blount before a set of supposed peers for judgment. Fortunately, the author has personal and private knowledge that can shed some light on what took place, and by means of this book, you, the reader, can know something of those forces in our society that fight to keep us from getting well:

Prior to Blount's hearing of May 19, 1983, this writer got word from an independent source that the Arthritis Foundation had taken action to "get" Dr. Jack M. Blount, and next to go after another of The Arthritis Fund Board Members.

As reported in Chapter II and Chapter III of this book, Dr. Jack Blount was miraculously cured of arthritis himself, and he passed his good news on to this writer and to thousands of others. In perhaps 127 patients (including this writer), Dr. Jack Blount gave prescriptions away *free of charge*. When the prescriptions were used properly, sick people got well, or at least much, much better. It was perhaps unethical, by current medical practices, to give prescriptions away to those who had not been seen in his office, but how much more unethical would it have been for Dr. Blount to deny desperately ill people the same relief he had achieved?

His Hippocratic oath as a physician required that he ser-

vice suffering humankind — but his license as a Mississippi doctor required him to deny those same suffering people.

What would you do, knowing that you could easily lift your brother's burden by means of three scraps of paper: three prescriptions sent free of charge and with tons of love—?

During the hearing, Dr. Blount was repeatedly accused of making flamboyant claims. you, the reader, can judge Dr. Blount's judges: Read again Chapter II of this book, and ask yourself if Dr. Blount was making flamboyant claims. This chapter is a reprint of a speech Dr. Blount gave to a local business organization in Philadelphia, Mississippi, immediately on recovering from death's tolling, and it was later used to tell people about his swift recovery and what he'd discovered, using Professor Roger Wyburn-Mason's theory and recommendations. According to the prosecutor (and the Board), Dr. Blount must not use the words "miracle" and "cure." For him to use these words is the making of flamboyant claims. In retrospect, it seems quite obvious that had Dr. Blount told each and every patient: "Look! God is not involved in my sudden, new and wonderful knowledge, only science," and "There is no miracle, I cannot cure you of bring you relief," (a lie) then Dr. Blount, like all Friendly Neighborhood Rheumatologists, would not have been accused of the making of flamboyant claims.

There is an obvious constitutional question of whether or not any Board has the right to control another American's speech, writing, or religious convictions. I was taught that we were all guaranteed the right of freedom of worship, belief, and the right to freedom of speech and writing. Regardless of your convictions or mine, Dr. Blount's freedom of speech and religious convictions to be restricted, even in part, also decreases our own personal freedoms, and those of our loved ones.

It is the author's opinion, and hopefully the readers', that the Mississippi Board had no right to delve into Dr. Blount's religious expression or right to express his opinions — to patients or anyone else.

Dr. Jack M. Blount was brought before the Board by entrapment. Someone (probably the Arthritis Foundation) put the bug in one of the Mississippi investigative agencies, and told them to entrap Dr. Blount.

Of all the witnesses brought before the Board, only one was not a member or agent of the investigative agency set out to trap Dr. Blount. Each member but the one told essentially the same story to the Board: They were called on to lie to Dr. Blount about their desperate sickness and need for help, and they lied about their inability to pay. Thinking each to be a legitimate brother in sickness, Dr. Blount sent the same prescriptions that cured this writer, each free of charge.

The prescriptions were not used by these liars, of course, and were offered as part of the case against Dr. Blount.

The sole witness that was not (apparently) a direct agent of the Board, became one through intense fears placed in her by jealous rheumatologists or the Arthritis Foundation or the investigative agency or some combination of the three.

In her testimony on the stands, she said exactly the words that the Board's prosecutor had coached her to say, in the writer's opinion. But her words and emotional mannerisms told another story, that of a sickly woman who had been terrified by falsehoods, and she was stimulated to hostility and now wanted to get even.

She had been told by someone unknown that Dr. Blount's prescriptions were dangerous, and that she must not take them. She was obviously still ill with severe rheumatoid disease, and I introduced myself to her as a writer, and asked if I might talk to her for a short time. I had hopes of convincing her that she would be well if she tried those simple remedies.

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

The opposing attorney got wind of my plans and immediately ushered the lady away from me, and out of the hearing room — gone forevermore. This action, more than any other single action at the “trial,” gave the lie to the supposed ethics and purposes of the investigative agencies that performed the entrapment processes.

My final observation in the hearing is that the prosecutor at all times held two things on trial: (1) Dr. Jack M. Blount’s giving away of free prescriptions, and (2) Professor Roger Wyburn-Mason’s “unacceptable” theory of cause and treatment of rheumatoid disease.

While an equal amount of hearing time was spent on both portions, in all fairness to the Mississippi Board, they did not charge Dr. Blount with the requirement that he stop treating people according to the new methods and techniques, nor did they pronounce that the treatment and cure were fallacious.

They were wise to bear restraint —!

### Irony

In America much is made out of the idea of double-blind experiments, which are quite costly, and perhaps can help discriminate between one aspirin substitute and another. Rheumatologists have insisted on double-blind experiments which are supposed to be the ultimate in “scientific” proof. The lack of such studies has needlessly kept Wyburn-Mason’s findings from the general public for six years.

According to my recent letter, “Roger Wyburn-Mason told the story of his student who originally wrote up the double-blind trial method in the *Lancet* and the editor gave a glowing appraisal of the method. It was then seized on as the perfect proof of all new therapies and was adopted. The first one done was on the use of Cortisone in Asthma and the result of this trial was that it showed quite conclusively that Cortisone has no effect on Asthma! It is well known that the most effective therapy for asthma symptoms is Cortisone. So where do we go from here?”

[Name withheld by author]

### Additional General References

A medical doctor has so few course in protozoology that it is unlikely the average physician will know much about amoebic infection. The following references, for the most part, are tendered for those who would like to gain a better knowledge of amoebae characteristics, and some of its slow-growing research and clinical history.

Abd-Rabbo, H. “Dehydroemetine in Chronic Leukaemia.” *The Lancet*, 1161-1162, May 21, 1966.

\_\_\_\_\_. “Chemotherapy of Neoplasia (cancer) with Dehydroemetine.” *J. Trop. Med. Hyg.* 72: 287-290; 1969.

\_\_\_\_\_. “Is Flagyl Dangerous?” *The Medical Letter on Drugs and Therapeutics.* 17(13): 53; June 20, 1975.

Abd-Rabbo, H, H. Abaza, G. Hilial, M. Moghazy, L. Asser. “Nitro-imidazole in Rheumatoid Arthritis.” *Am. J. Trop. Med. Hyg.* 75: 64-66; 1972.

Adam, Katherine M.G. “A Comparative Study of Hartmannellid Amoebae.” *J. Protozool.* 11(3): 430-435; 1964.

Ahn, Tae L., Kwang W. Jeon. “Structural and Biochemical Characteristics of the Plasmalemma and Vacuole Membranes in Amoebae.” *Exp. Cell Res.* 137: 235-268; 1982.

Albanese, A., A. Antony, Herbert Edelson, Edward J. Lorenze, Jr., Maurice L. Woodhall, Evelyn H. Wein. “Problems of Bone Health in Elderly.” *New York State Journal of Medicine.* 326-336; Feb. 1975.

Anderson, Hamilton. “The Use of Fumagilina in Amoebiasis.” *Annals New York Academy Sciences.* 1118-1124; 1952.

Anderson, Kevin, Adele Jamieson. “Primary Amoebic Meningoencephalitis.” *The Lancet.* 902-903; April 22, 1972.

Anonymous. “Amoebic Meningo-encephalitis.” *The Medical Journal of Australia.* 1: 1036-1038; May 17, 1969.

\_\_\_\_\_. “Legionella and Amoebae.” *The Lancet.* 703-704; March 28, 1981.

\_\_\_\_\_. “Pathogenic Free-Living Amoebae.” *The Lancet.* 1165-1166; Dec. 3, 1977.

Anderson, K. and A. Jamieson. “Primary Amoebic Meningoencephalitis.” *The Lancet.* 902-903; April 22, 1972.

Apley, J., S.K.R. Clarke, A.P.C.H. Roome, S.A. Sandry, G. Saygi, B. Silk, D.C. Warhurst. “Primary Amoebic Meningoencephalitis in Britain.” *British Medical Journal.* 596-599; March 7, 1970.

Arehart-Treichel, Joan. “Boning Up on Osteoporosis.” *Science News.* 124: 140-141; Aug. 27, 1983.

Armstrong, J. & M. Pereira. “Identification of ‘Ryan Virus’ as an Amoeba of the Genus *Hartmannella*.” *British Medical Journal.* 212-214; Jan. 28, 1967.

Balamuth, William. “Action of Antibiotics Against Intestinal Amoebae *in vitro*.” *Annals New York Academy of Sciences.* 55: 1093-1103; 1952.

\_\_\_\_\_. “Comparative Action of Selected Amebicidal Agents and Antibiotics Against Several Species of Human Intestinal Amebae.” *The Am. J. Trop. Med. and Hyg.* 2: 191-205; 1953.

Beaver, Jung & Cupp. “Pathogenic Free-Living Amebae: *Naegleria* and *Acanthamoeba*.” *Clinical Parasitology.* Lea & Febiger, Philadelphia, 9th Ed., 135-148; 1984.

Bhaduri, K.P. “Endamoeba Histolytica in Leukorrhoea and Salpingitis.” *Am. J. Obst. & Gyn.* 74: 434; 1957.

Bhagwandeem, S., R.F. Carter, K.G. Naik, D. Levitt. “A Case of hartmannellid Amebic Meningoencephalitis in Zambia.” *Am. J. Clin. Path.* 63: 438-492; April 1975.

Bisno, Alan L. “Acute Rheumatic Fever: Current Concepts and Controversies.” *Current Clinical Topics in Infectious Diseases.* Eds. Jack S. Remington, Morton N. Swartz, McGraw Hill, 5: 316-341; 1984.

Blake, David R., Nicolas D. Hall, Paul A. Bacon, Barry Halliwell, John M.C. Gutteridge. “The Importance of Iron in Rheumatoid Disease.” *The Lancet.* 1142-1144; Nov. 21, 1981.

Bonnin, N. & Kay, H. “Dysenteric Arthritis: Case Reports and Comments.” *The Medical Journal of Australia.* 2: 380-382; 1943.

Borochovutz, Dennis, F.F. Paul, A. Julio Marinez, Gary T. Patterson. “Osteomyelitis of a Bone Graft of the Mandible with *Acanthamoeba castellanii* Infection.” *Human Pathology.* 12(6): 573-576; June 1981.

Bourne, I. H. J. “Local Injection Therapy.” *The Physician.* 185-188; Nov. 1984.

\_\_\_\_\_. “Treatment of Chronic Back Pain.” *The Practitioner.* 228: 333-338; March 1984.

\_\_\_\_\_. “The Treatment of Pain With Local Injections.” *The Practitioner.* 227: 1877-1883; Dec. 1983.

\_\_\_\_\_. “The Treatment of Painful Conditions of the Abdominal Wall With Local Injections.” *The Practitioner. Special Report.* Page 3, Vol. and date unknown.

Bos, H.J. “A Case of *Acanthamoeba* Keratitis in the Netherlands.” *Trans. Roy. Soc. Trop. Med. Hyg.* 75(1): 86-91; 1981.

Bossche, H., Van G. Willemsens, W. Cools, W.F.J. Lauwers, L. Le Jeune. “Biochemical Effects of Miconazole on Fungi. II. Inhibition of Ergosterol Biosynthesis in *Candida albicans*.” *Chem. Biol. Interactions.* 21: 59-78; 1978.

Boyle, A.J., R.E. Mosher, D.S. McCann. “Some *in vivo* Ef-

Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.

- fects of Chelation — I Rheumatoid Arthritis." *J. Chron. Dis.* 16: 325-328; 1963.
- Brewerton, E. Albert. "Rheumatology." *HLA and Disease*. Eds. Dauset, Jean & Anne Svejgaard. Williams & Wilkins Co., Baltimore, 94-107; 1977.
- Butt, Cecil. "Primary Amebic Meningoencephalitis." *The New England Journal of Medicine*. 274(26): 1473-1476; June 30, 1966.
- Butt, C., C. Baro & R. Knorr. "Naegleria Identified in Amebic Encephalitis." *Am. J. of Clinical Path.* 50(5): 568-574; 1968.
- Callicott, Jr., Joseph H., Clifford Nelson, Muriel M. Jones, Joao G. Santos, John P. Utz, Richard J. Dunn, Joseph V. Morrison, Jr. "Meningoencephalitis Due to Pathogenic Free-Living Amoebae." *JAMA*. 206(3): 579-582; Oct. 14, 1968.
- Cantwell, Alan R., Jr. "Histologic Forms Resembling 'Large Bodies' in Scleroderma and 'Pseudoscleroderma.'" *Speculations in Dermatopathology*. 2(3): 273-276; Fall 1980.
- Caplan, Arnold I. "Cartilage." *Scientific American*. 251(4): 84-94; Oct. 1984.
- Carter, Bayard, Thomas, Jones, Durham. "Invasion of Squamous-Cell Carcinoma of the Cervix Uteri by Endamoeba Histolytica." *Am. J. of Obst. & Gyn.* 68: 1607-1610; 1954.
- Carter, R. "Primary Amoebic Meningo-Encephalitis, An Appraisal of Present Knowledge." *Transactions of the Royal Society of Tropical Medicine and Hygiene*. 66(1): 193-213; 1972.
- \_\_\_\_\_. "Primary Amoebic Meningo-Encephalitis: Clinical Pathological and Epidemiological Features of Six Fatal Cases." *The Journal of Pathology and Bacteriology*. 96(1): 1-25; 1968.
- \_\_\_\_\_. "Sensitivity to Amphotericin B of a *Naegleria* Isolated from a Case of Primary Amoebic Meningoencephalitis." *Journal Clinical Pathology*. 22: 470-474; 1969.
- \_\_\_\_\_. "Description of a *Naegleria* Isolated from Two Cases of Primary Amoebic Meningoencephalitis and of the Experimental Pathological Changes Induced by It." *The Journal of Pathology*. 100(4): 217-244; 1970.
- Casemore, David. "Sensitivity of *Hartmanella (Acanthamoeba)* to 5-fluorocytosine, hydroxystilbamidine, and other substances." *Journal of Clinical Pathology*. 23: 649- 652; 1970.
- \_\_\_\_\_. "Free-living Amoebae in Home Dialysis Unit." *The Lancet*. 1078; Nov. 19, 1977.
- Cathcart, Robert F., III. "Vitamin C, Titrating to Bowel Tolerance, Anascorbemia, and Acute Induced Scurvy." *Medical Hypotheses*. 7: 1359-1376; 1981.
- Cerva, K. Novak, C.G. Culbertson. "An Outbreak of Acute, Fatal Amebic Meningoencephalitis." *Am. Journ. of Epidemiology*. 88(3): 436-444; 1968.
- Chapdelaine, Tony. "Preliminary Report on Drug Research Involving *Acanthamoeba* and *Naegleria*." Presented July 14, 1984, at 2nd Physicians and Scientists Meeting of The Arthritis Trust of America, 4 pages, 1984.
- Chandar, K., H. Mair, & N. Mair. "Case of Toxoplasma Polymositis." *Brit. Med. J.* 158-159; Jan. 20, 1968.
- Chang, R.S., & S. Owens. "Patterns of 'Lipovirus' Antibody in Human Populations." *J. Immun.* 92: 313-319; 1964.
- Chang, R. Shihman, I-Hung Pan, Barbara J. Rosenau. "On the Nature of the 'Lipovirus.'" *J. of Ex. Med.* 124: 1153-1166; 1966.
- Chari, M.V., B.N. Gadiyar. "A New Drug (MK-910) in the Therapy of Intestinal and Hepatic Amebiasis." *Am. J. of Trop. Med. Hyg.* 19(6): 926-928; 1970.
- Charoenlarp, P. Warren, L.G., R.E. Reeves. "Amoebiasis and Intestinal Protozoal Infections." *Trop. Dis. Bul.* 68(7): 814-819; July 1971.
- Chi, L. et al. "Selective Phagocytosis of Nucleated Erythrocytes by Cytotoxic Amebae in Cell Culture." *Science*. 130: 1763; 1959.
- Christ, Helmut W. *Personal Letter and Protocol on Use of Fumaric Acid in Treating Psoriasis*. 10 pages. Dec. 16, 1984.
- Chyrstal, Ewan J.T., Ronald L. Koch, Martha A. McLafferty, and Peter Goldman. "Relationship Between Metronidazole Metabolism and Bactericidal Activity." *Antimicrobial Agents and Chemotherapy*. 566-573; 1980.
- Cline, F. Marciano-Cabral, S.G. Bradley. "Comparison of *Naegleria fowleri* and *Naegleria gruberi* Cultivated in the Same Nutrient Medium." *J. Protozool.* 30(2): 387-391; May 1983.
- Cox, Eugene C. "Amebic Meningoencephalitis Caused by *Acanthamoeba* Species in a Four Month Old Child." *Journ. S.C. Med. Assoc.* 76(10): 459-462; Oct. 1980.
- Coxon, A., C.A. Pallis. "Metronidazole Neuropathy." *J. Neurol. Neurosurg. Psychiat.* 39: 403-405; Apr. 1976.
- Craig, Charles. "Observations Upon the Endamebae of the Mouth." *Journ. Infect. Dis.* 18: 220-239; 1916.
- Cranton, E.M., J.P. Frackelton. "Free Radical Pathology in Age-Associated Diseases: Treatment with EDTA Chelation, Nutrition, and Antioxidants." *Journ. Holistic Med.* 6 ( 1 ) : 1 - 3 6 ; Spring/Summer 1984.
- Cuckler, A.C., C.M. Malanga, J. Conroy. "Therapeutic Efficacy of New Nitroimidazoles for Experimental Trichomoniasis, Amebiasis, and Trypanosomiasis." *Am. Journ. Trop. Med. Hyg.* 19(6): 916-925; 1970.
- Culbertson, Clyde. "Pathogenic *Acanthamoeba (Hartmanella)*." *The American J. of Clin. Path.* 35(3): 195-202; 1961.
- \_\_\_\_\_. "The Pathogenicity of Soil Amebas." *Ann. Rev. of Micr.* 25:231-254; 1971.
- \_\_\_\_\_. "Soil Ameba Infection." *Am. J. Clin. Path.* 63: 475-482; 1975.
- Culbertson, C., P. Ensminger, & W. Overton. "*Hartmanella (Acanthamoeba)*. Experimental, Chronic, Granulomatous Brain Infections, Produced by New Isolates of Low Virulence." *Am. J. Clin. Path.* 46: 305-314; 1966.
- \_\_\_\_\_. "Amebic Cellulocutaneous Invasion by *Naegleria aerobia* with Generalized Visceral Lesions after Subcutaneous Inoculation: An Experimental Study in Guinea Pigs." *Am. J. Clin. Path.* 57: 375-386; 1972.
- Culbertson, C., D. Holmes, & W. Overton. "*Hartmanella Castellani (Acanthamoeba)*. Preliminary Report on Experimental Chemotherapy." *Am. J. of Clin. Path.* 43(4): 361-364; 1965.
- Culbertson, C., J. Smith, H. Cohen, & J. Minner. "Experimental Infection of Mice and Monkeys by *Acanthamoeba*." *Am. J. of Clin. Path.* 35: 185-197; 1959.
- Cunningham, Bruce A. "The Structure and Function of Histocompatibility Antigens." *Scientific American*. 96-107; Oct. 1977.
- Cursons, R., T. Brown, E. Keys. "Immunity to Pathogenic Free-living Amoebae." *The Lancet*. 875-876; Oct. 22, 1977.
- Cursons, Ray T.M., Tim J. Brown, Elizabeth A. Keys, Kevin M. Moriarty, Desmond Till. "Immunity to Pathogenic Free-living Amoeba: Role of Cell-Mediated Immunity." *Infec. and Immunity*. 29(2): 408-410; Aug. 1980.
- Daggett, Pierre Marc, Thomas A. Nerad. "The Biochemical Identification of Vahkampfid Amoeba." *J. Protozool.* 30(1): 126-128; 1983.
- Danielson, David A., Marian T. Hannan, Hershel Jack. "Metronidazole and Cancer." *JAMA*. 247(18): 2498-2499; May 14, 1982.
- Das, S.R. "Chemotherapy of Experimental Amoebic Meningoencephalitis in Mice Infected with *Naegleria aerobia*." *Trans. Roy. Soc. Trop. Med. Hyg.* 65:106-107; 1971.
- Davies, A.H. "Metronidazole in Human Infections with Syphi-

- Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.
- lis." *Brit. J. Vener. Dis.* 43:197-199; 1967.
- Davies, A.H., J.A. McFadzean, S. Squires. "Treatment of Vincent's Stomatitis with Metronidazole." *Brit. Med. Journ.* i: 1149-1150; May 2, 1964.
- Derrick, E. "A Fatal Case of Generalized Amoebiasis Due to a Protozoan Closely Resembling, If not Identical with, *Iodamoeba Butschlii*." *Trans. Roy. Soc. of Trop. Med. & Hyg.* 42(2): 191-198; 1948.
- Dowdie, E.B. "The Immunology of Rheumatoid Arthritis—Role of the Macrophage." *Bylaetot die SA Mediese Tydskrif.* 14-16; Oct. 19, 1983.
- Duma, Richard. "In vitro Susceptibility of Pathogenic *Naegleria gruberi* to Amphotericin B." *Antimicro. Agents & Chemo.* 109-111; 1971.
- \_\_\_\_\_. "Primary Amoebic Meningoencephalitis." *Virg. Med. Month.* 96: 546-548; 1969.
- \_\_\_\_\_. "Primary Amoebic Meningoencephalitis." *CRC Crit. Rev. in Clin. Lab. Sci.* 3: 163-192; June 1972.
- Duma, Ferrell, et al. "Primary Amebic Meningoencephalitis." *New Eng. Journ. of Med.* 24: 1315-1323; Dec. 11, 1969.
- Duma, R. & R. Finley. "In vitro Susceptibility of Pathogenic *Naegleria* and *Acanthamoeba* Species to a Variety of Therapeutic Agents." *Antimicro. Agents & Chemo.* 10(2): 370-376; Aug. 1976.
- Duma, Helwig, & Martinez. "Meningoencephalitis and Brain Abscess Due to a Free-living Amoeba." *Ann. of Inter. Med.* 88: 468-473; 1978.
- Duma, R.J., W.I. Rosenblum, R.F. McGehee, M.M. Jones, E.C. Nelson. "Primary Amoebic Meningoencephalitis Caused by *Naegleria*." *Ann. of Inter. Med.* 74: 861-869; 1971.
- Dunnebacke, T.H., R.C. Williams. "A Reinterpretation of the Nature of 'Lipovirus' Cytopathogenicity." *Proced. Nat. Acad. of Sci.* 57: 1967.
- Edelman, Gerald M. "The Structure and Function of Antibodies." *Sci. Amer.* 34-42; 1970.
- Edwards, J.H., A.J. Griffiths, J. Mullins. "Protozoa as Sources of Antigen in 'Humidifier Fever.'" *Nature.* 264: 438-439; Dec. 2.
- Efron, E. "The Big Cancer Lie." *American Spectator.* 17(3): 10-17; March 1984.
- Eldridge, A. & J. Tobin. "Ryan Virus." *Brit. Med. J.* 299; Feb. 4, 1967.
- Evers, R. "Method and Composition for Treating Arteriosclerosis." *U.S. Patent 4,167,562.* Pages 4; Sept. 11, 1979.
- Eyles, D. et al. "A Study of *Endamoeba Histolytica* and Other Intestinal Parasites in a Rural West Tennessee Community." *Amer. J. of Trop. Med. & Hyg.* 2: 170-190; 1953.
- Ferguson, K. & R. Anderson. "Amebic Liver Abscess in Service Personnel." *Gastroenterol.* 8: 332-342; 1947.
- Ferrante, A.B., Rowan Kelly, Y.H. Thong. "In vitro Sensitivity of Virulent *Acanthamoeba culbertsoni* to a Variety of Drugs and Antibiotics." *Int. J. Parasi.* 14(1): 53-56; 1984.
- Forre, O., E. Kelly, E. Kass. "Side-Effects and Autoimmunogenicity of D-Penicillamine Treatment in Rheumatic Diseases." *Adv. in Inflamm. Res.* 6: 251-257; 1984.
- Fowler, M. & R.F. Carter. "Acute Pyogenic Meningitis Probably Due to *Acanthamoeba*: a Preliminary Report." *Brit. Med. J.* 740-742; Sept. 25, 1965.
- Frye, W. et al. "Antibiotics in the Treatment of Acute Amoebic Dysentery." *Ann. N.Y. Acad. Sci.* 1104-1113; 1952.
- Fulford, S.G., F. Bradley, F. Marciano-Cabral. "Cytopathogenicity of *Naegleria fowleri*, for Cultured Rat Neuroblastoma Cells." Unpublished paper, Dept. Microbiology and Immun., Virginia Commonwealth Univer., Richmond, VA 23298, 20 pages, no date.
- Garcia-Laverde, A. & L. De Bonilla. "Clinical Trials with Metronidazole in Human Balantidiasis." *Am. J. Trop. Med. & Hyg.* 24(5): 781-83; 1975.
- Goldman, P. "Metronidazole: Proven Benefits and Potential Risks." *J. Hopkins Med. J.* 147: 1-9; 1980.
- Goobar, J. "Joint Symptoms in Giardiasis." *Lancet.* 1010-1111; May 7, 1977.
- Griffin, J.L. "Temperature Tolerance of Pathogenic and Non-pathogenic Free-living Amoebas." *Science.* 178: n.g.; Nov.24, 1972.
- Grunnet, M.L., G.H. Cannon, J.P. Kushner. "Fulminant Amebic Meningoencephalitis due to *Acanthamoeba*." *Neurology.* 31: 174-177; Feb. 1981.
- Gunby, P. "Allopurinol Treatment for Protozoan Infections." *JAMA.* 240(18): 1941-1942; Oct. 27, 1978.
- Gullett, J., J. Mills, K. Hadley, B. Podemski, L. Pitts, R. Gelber. "Disseminated Granulomatous Infection Presenting as Unusual Skin Lesion." *Am. J. of Med.* 67: 891-896; Nov. 1979.
- Han, J. H., K.H. Jeon. "Isolation and Partial Characterization of Two Plasmid Deoxyribonucleic Acids from Endosymbiotic Bacteria of *Amoeba proteus*." *Journ. Bact.* 1466-1469; Mar. 1980.
- Hamilton, D.M.E. "Combined Activity of Amphotericin B and 5-Fluorocytosine Against *Cryptococcus neoformans* in vitro and in vivo in Mice." *J. of Infect. Dis.* 131(2):129-137; Feb. 1975.
- Harkness, J.A.L., A.J. Griffin, I. Heinrich, T. Gibson & R. Grahame. "A Double-Blind Comparative Study of Metronidazole and Placebo in Rheumatoid Arthritis." *Rheum. & Rehab.* 21: 231-234; 1982.
- Hines, L. "Endamoeba Histolytica in Seminal Fluid in a Case of Amoebic Dysentery." *JAMA.* 81(4): 274-275; 1923.
- Hoffman, E., C. Garcia, J. Lunseth, P. McGarry, J. Coover. "A Case of Primary Amebic Meningoencephalitis." *Am. J. Trop. Med. & Hyg.* 27(1): 29-38; 1978.
- Hunter, W. "Discussion on Oral Sepsis as a Cause of Disease in Relation to General Medicine." *Brit. Med. J.* 1358-1363; 1904.
- Husain, M., & M. Mohan Rao. "Aminotransferase Activity of Hartmanella (Culbertson strain A-1) Grown Asexually." *J. Gen. Microbio.* 56: 379-386; 1969.
- Iman, S.A., G.P. Dutta, S.C. Agarwala. "Inhibition of Excystation of *Schizyrenu russelli* Cysts in the Presence of Emetine and Its Cysticidal Effect in Conjunction with Sodium Lauryl Sulfate." *J. Gen. Microbio.* 51: 17-22; 1968.
- Jakovijevich, R., B. Talis. "Recovery of Hartmannelloid Ameba in the Purulent Discharge from a Human Ear." *J. Protozool.* 16: 36; 1969.
- Jahnes, W., H.M. Fullmer & C.P. Li et al. "Free-living Amoebae as Contaminants in Monkey Kidney Tissue Culture." *Proc. Soc. Exp. Biol. Med.* 96:484-488; 1957.
- Jeon, K.W. "Integration of Bacterial Endosymbionts in Amoebae." *Intern. Rev. of Cytol.* Supplement 14: 29-47; 1983.
- \_\_\_\_\_, I.J. Lorch. "The Formation of Vacuole Membranes in the Presence and Absence of Cell Nucleus in Amoebae." *Exp. Cell Res.* Reprint 141: 351-356; 1982.
- Johnstone, T. "Primary Amebic Meningoencephalitis." *Personal Letter: Swimming Pools*, From Johnstone to J.W. Shaw, Env. Hlth. Eng., Env. Hlth. Srv., Lcl. Brd. Hlth., Edmonton, Alberta, Canada, 2pp., Feb. 20, 1980.
- Jones, D., G. Visvesvara & N. Robinson. "*Acanthamoeba polyphaga* Keratitis and *Acanthamoeba* Uveitis Associated with Fatal Meningoencephalitis." *Trans. of the Ophthal. Soc. of the Unit. Kingdom.* 93: 221-232; 1975.
- Jubb, R. "Non-steroidal Anti-Inflammatory Drugs and Articular Cartilage." Publication unknown. 6-8.
- Kenney, M. "The Micro-Kolmer Complement Fixation Test in Routine Screening for Soil Ameba Infection." *Health Lab. Sci.*

Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.

- 8(1): 5-10; 1971.
- Kerkering, T.M., P.M. Schwartz, A. Espinel-Ingroff, P.J. Turek, R.B. Diasio. "5-Fluorocytosine Susceptibility of Pathogenic Fungi in the Presence of Allopurinol: Potential for Improving the Therapeutic Index of 5-Fluorocytosine." *Antimicrob. & Chemo.* 24(3): 448-449, Sept. 1983.
- Kernohan, J., T. Magath & G. Schloss. "Granuloma of Brain Probably Due to Endolimax Williamsi (Iodamoeba Butschlii)." *Arch. of Path.* 70: 576-580; 1960.
- Key, S. III, W. R. Green, E. Willaert, A.R. Stevens, S.N. Key, Jr. "Keratitis Due to *Acanthamoeba castellanii*." *Arch. of Ophthalmol.* 98: 475-479; March 1980.
- Kingston, D. & D. Warhurst. "Isolation of Ameba from the Air." *J. of Med. Micro.* 2: 27- 36; 1969.
- Kishore, V., D.W. Roberts, J.B. Barnett, J.R.J. Sorenson. "Effect of Nutritional Copper Deficiency on Adjuvant Arthritis and Immunocompetence in the Rat." *Agents & Actions.* 14(2): 275-282; 1984.
- Kishore, N. L., R.G. Dotson, J.R.J. Sorenson. "Effect of Nutritional Copper Deficiency on the Development of Adjuvant Arthritis in the Rat." *Trace Substances in Environmental Hlt.* XVI: 291-299; 1982.
- Klatskin, G. "Amebiasis of the Liver: Classification, Diagnosis and Treatment." *Ann. Inter. Med.* 25: 601-631; 1946.
- Koch, R.L., E.J.T. Chrystal, B.B. Beaulieu, Jr., P. Goldman. "Acetamide—A Metabolite of Metronidazol Formed by the Intestinal Flora." *Biochem. Pharm.* 28: 3611-3615; 1979.
- Martinez, A. J., R.J. Duma, E.C. Nelson, F.L. Moretta. "Experimental *Naegleria* Meningoencephalitis in Mice." *Lab. Investigation.* 29(2): 121-133; 1973.
- Martinez, A.J., C.A. Garcia, M. Halks-Miller, R. Arce-Vela. "Granulomatous Amebic Encephalitis Presenting as a Cerebral Mass Lesion." *Acta Neuropathol.* 51: 85-91; 1980.
- Martinez, A.J., S.M. Markowitz, R.J. Duma. "Experimental Pneumonitis and Encephalitis Caused by *Acanthamoeba* in Mice: Pathogenesis and Ultrasound Features." *J. Inf. Dis.* 131(6): 692-699; June 1975.
- Martinez, A.J., C. Sotelo-Avila, H. Acala, E. Willaert. "Granulomatous Encephalitis, Intracranial Arteritis, and Mycotic Aneurysm Due to a Free-living Ameba." *Acta Neuropathol.* 49: 7-12; 1980.
- Martinez, A.J., C. Sotelo-Avila, J. Garcia-Tamayo, J.T. Moron, E. Willaert, W.P. Stamm. "Meningoencephalitis Due to *Acanthamoeba*." *Acta Neuropathol.* 37: 183-191; 1977.
- McCowen, M. et al. "The Effects of Erythromycin (Illotycin, Lilly) Against Certain Parasitic Organisms." *Am. J. of Trop. Med. & Hyg.* 2: 211-218; 1953.
- McFadzean, et al. "The Interactions of Metronidazole and Micro-organisms." *The Indian Practitioner.* 623-624; Oct. 1968.
- McMillan, B. "The Inhibition of Leptomonads of the Genus *Leishmania* in Culture by Antifungal Antibiotics." *Ann. Trop. Med. & Parasit.* 54: 293-299; 1960.
- McNeil, R. & M. Moraes-Ruehsen. "Ameba Trophozoites in Cervico-Vaginal Smear of a Patient Using an Intrauterine Device." *Acta Cytologica.* 22(2): 91-92; 1978.
- Meleney, H., E. Bishop & W. Leathers. "Investigations of *Endamoeba Histolytica* and Other Intestinal Protozoa in Tennessee." *Am. J. Hyg.* 16: 523-539; 1932.
- Miller, J.A. "Antibodies for Sale." *Science News.* 123: 296-298; May 7, 1983.
- Mills, L. "Amoebic Iritis Occurring in the Course of Nondysenteric Amebiasis." *Arch. of Ophthalmol.* 52(6): 525-545; 1923.
- Mitelman, F. B. Strombeck, B. Ursing. "No Cytogenic Effect of Metronidazole." *Lancet.* 1249-50; June 7, 1980.
- Milstein, C. "Monoclonal Antibodies." *Scientific Am.* 66-74; Oct. 1980.
- Moore, A.E., J. Hinka. "Hartmanella (*Acanthamoeba*) as a Tissue Culture Contaminant." *J. of the Natl. Cancer Inst.* 40(3); March 1968.
- Morring, K.L., W.G. Sorenson, M.D. Attfield. "Sampling for Airborne Fungi: A Statistical Comparison of Media." *Am. Ind. Hyg. Assoc. J.* 449(9): 662-664; Sept. 1983.
- Moss, R.W. "The Politics of Cancer: The Promise of Hydrazine Sulfate." *Penthouse.* Jan. 1983.
- Most, H. & F. Assendelft. "Treatment of Amoebiasis with Terramycin." *Ann. N.Y. Acad. Sci.* 1114-1117; 1952.
- Nagington, J., P.G. Watson, T.J. Playfair, J. McGill, B.R. Jones, A.D. McG. Steel. "Amoebic Infection of the Eye." *Lancet.* 1537-1540; Dec. 28, 1974.
- Nagington, J. & D. Smith. "Pontiac Fever and Amoebae." *Lancet.* 1241; Dec. 6, 1980.
- Nakamura, M. et al. "Drug Effects on the Metabolism of *Endamoeba histolytica*: In vitro and in vivo Tests of Synergism." *Am. J. of Trop. Med. & Hyg.* 2: 206-211; 1953.
- Neff, R.J. "Purification, Axenic Cultivation, and Description of Soil Amoeba, *Acanthamoeba*." *J. Protozool.* 4: 176-182; 1957.
- Nerad, T.A., G. Visvesvara, P-M Daggett. "Chemically Defined Media for the Cultivation of *Naegleria*: Pathogenic and High Temperature Tolerant Species." *J. Protozool.* 30(2): 383-387; 1983.
- Notkins, A.L. & H. Koprowski. "How the Immune Response to a Virus Can Cause Disease." *Sci. Amer.* 22-31; 1973.
- Oser, B. & R. Hosler. "Amebiasis with Complicating Encephalitis Probably Due to *Entamoeba Histolytica*." *Ohio St. Med. J.* 56: 1502-1503; 1960.
- Otterness, I.G. "Clotrimazole and Rheumatoid Arthritis." *Lancet.* 148; Jan. 17, 1976.
- Oye, R.K. and M.F. Shapiro. "Reporting Results from Chemotherapy Trials." *JAMA.* 252(19): 2722-2724; Nov. 16, 1984.
- Page, F. "Taxonomic and Ecological Distribution of Potentially Pathogenic Free-living Amoebae." *J. of Parasit.* 54(4): Sec. II, Part I., 257-258; 1970.
- \_\_\_\_\_. "Taxonomic Criteria for *Limax amoebae*, with Descriptions of 3 New Species of *Hartmanella* and 3 of *Vahlkampfia*." *J. of Protozool.* 14(3): 499-521; 1967.
- \_\_\_\_\_. "Redefinition of the Genus *Acanthamoeba* with Descriptions of Three Species." *J. of Protozool.* 14(4): 709-724; 1967.
- \_\_\_\_\_. Résumés of Contributions. *J. of Protozool.* 56(4): Sec. II, part I, 257-258; Aug. 1970.
- Panuha, R.S., & R. Yonker. "Rheumatoid Arthritis: Disease Outside the Joints." *Diagn.* 103-108; May 1983.
- Patterson, T.W. & F.M. Woodworth. "Ultrastructure of *Naegleria fowleri* Enflagellation." *J. Bact.* 147(1): 217-226, July 1981.
- Parelkar, W.P. & K.R. Stamm. "Indirect Immunofluorescent Staining of *Entamoebae Histolytica* in Tissues." *Lancet.* 212-213; Jan. 30, 1971.
- Patras, D. & J. Andujar. "Meningoencephalitis due to *Hartmanella (Acanthamoeba)*." *Am. J. of Clin. Path.* 46(2): 226-233; 1966.
- Pennington, J., E. Block, & H. Reynolds. "5-Fluorocytosine and Amphotericin B in Bronchial Secretions." *Antimicrob. Agents & Chemo.* 6(3): 324-326; 1974.
- Pereira, M. et al. "Ryan Virus: A possible New Human Pathogen." *Brit. Med. J.*: 130-132; Jan 15, 1966.
- Platt, P.N. "Examination of Synovial Fluid." *Clinics in Rheu.*

- Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**
- Dis.* 9(1): 51-67; Apr. 1983.
- Powell, S.J., et al. "Metronidazole in Amoebic Dysentery and Amoebic Liver Abscess." *Lancet*: 1329-1331; Dec. 17, 1966.
- Prasad, B.N. "In vitro Effect of Drugs Against Pathogenic and Non-Pathogenic Free-living Amoebae and on Anaerobic Amoebae." *Indian J. of Exp. Bio.* 10: 43-45; Jan. 1972.
- Prata, A. "Treatment of Kala-azar with Amphotericin B." *Trans. of Roy. Soc. of Trop. Med. & Hyg.* 57(4): 266-268; July 1963.
- Pringle, H.L., S.G. Bradley, L.S. Harris. "Susceptibility of *Naegleria fowleri* to Delta9- Tetrahydrocannabinol." *Antimicrob. Agents & Chemo.* 16(5): 674-679; Nov. 1979.
- Pybus, P.K. "Anti-amoebic Drugs in Rheumatoid Arthritis." *SA Mediese Tydskrif.* 63; Jan. 8, 1983.
- \_\_\_\_\_. "Easy Control of the Painful and Stiff Hand." Unpublished Paper. March 27, 1984.
- \_\_\_\_\_. "Metronidazole in Rheumatoid Arthritis." *SA Med. J.* 65: 454; March 24, 1984.
- \_\_\_\_\_. "Metronidazole in Rheumatoid Arthritis." *SA Mediese Tydskrif.* 261-262; Feb. 20, 1982.
- \_\_\_\_\_. "Nerve Stabilization." *Brit. Med. Acupuncture Soc. J.* 16-17; June 1984.
- \_\_\_\_\_. "Tender Spots Around the Osteo-Arthritic Knee." *SA Med. J.* 64: 270; Aug. 20, 1983.
- Rappaport, E., A. Rossien, L. Rosenblum. "Arthritis Due to Intestinal Amebiasis." *Ann. Int. Med.* 34: 1224-1231; 1951.
- Reilly, M.F., M.K. Bradley, S.G. Bradley. "Agglutination of *Naegleria fowleri* by Human Serum." *Proc. Soc. for Exp. Bio. & Med.* 17: 209-212; 1982.
- Reilly, M.F., et al. "Agglutination of *Naegleria fowleri* and *Naegleria gruberi* by Antibodies in Human Serum." *J. Clin. Microb.* 17(4): 576-581; Apr. 1983.
- Renforth, W. "Metronidazole Cures Rheumatoid Arthritis." Unpublished Paper. Sept. 30, 1977.
- Ringsted, J.B., et al. "Probable *Acanthamoeba* Meningoencephalitis in a Korean Child." *Am. J. Clin. Path.* 66: 723-730; 1976.
- Robert, V. & L. Rorke. "Primary Amebic Encephalitis, Probably from *Acanthamoeba*." *Ann. of Inter. Med.* 79: 174-179; 1973.
- Robinson, H. "General Pharmacology of Antibiotics." *Ann. N.Y. Acad. of Sci.* 55: 970-982; 1952.
- Rollo, I.M. "Drugs Used in Chemotherapy of Amebiasis." Chap. 46, "Metronidazole, 8-Hydroxyquinolines, Emetine, Dehydroemetine, Chloroquine, Diloxanide Furoate." *Pharmacological Basis of Therapeutics.* Weinstein Pub., N.Y.; 1980.
- \_\_\_\_\_. "Miscellaneous Drugs Used in the Treatment of Protozoal Infections." Chap. 47, "Suramin, Pentamidine, Melarsoprol, Other Arsenicals, Sodium Stibogluconate, Metronidazole, Nifurtimox, Quinacrine." Ed. L.S. Goodman, *Ibid.*; 1980.
- Rothrock, J.F., H.W. Buchsbaum. "Primary Amebic Meningoencephalitis." *JAMA* 243(22): 2329-2330; June 13, 1980.
- Rowbotham, T. "Pontiac Fever Explained?" *Lancet*: 969; Nov. 1, 1980.
- \_\_\_\_\_. "Pontiac Fever, Amoebae, and Legionella." *Lancet.* Jan. 3, 1981.
- Rowland, L. & M. Greer. "Toxoplasmic Polymyositis." *Neur.* 11(5): 367-370; 1961.
- Salem, H.H. & H.A. Rabbo. "Clinical Trials with Dehydroemetine in the Treatment of Acute Amoebiasis." *J. Trop. Med. & Hyg.* 67: 137-141; June 1964.
- Sargeant, P. & W. Lumsden. "In vitro Sensitivity of *Entamoeba histolytica* to Furazolidone and iodochlorhydroquin, Separate and Combined." *Tran. Roy. Soc. Trop. Med. & Hyg.* 70(1): 54-56; 1976.
- Saltzstein, S. & L. Ackerman. "Lymphadenopathy Induced by Anticonvulsant Drugs and Mimicking Clinically and Pathologically Malignant Lymphomas." *Cancer N.Y.* 12: 164-182; 1959
- Sawyer, P.R. et al. "Clotrimazole: A Review of its Antifungal Activity and Therapeutic Efficacy." *Drugs* 9: 424-447; 1975.
- Schuster, F. & E. Rechthand. "In vitro Effects of Amphotericin B on Growth and Ultrastructure of the Amoeboflagellates *Naegleria gruberi* and *Naegleria fowleri*." *Antimicrob. Agents & Chemo.* 8(5): 591-605; 1975.
- Searle. "Tumorigenic of Metronidazole." *Searle Research and Development, Division of G.D. Searle & Co.*, Skokie, Ill. Personal Letter to Wayne Martin. Aug. 27, 1984; 2 pages.
- Searle. "Ineffectiveness of Metronidazole for RD." *Ibid.* Personal Letter to Edmund Talanda, M.D., Aug. 22, 1984; 2 pages.
- Shookhoff, H. & M. Sterman. "Treatment of Amoebiasis with Aureomycin and Bacitracin." *Ann. N.Y. Acad. Sci.* 1125-1132; 1952.
- Shumaker, J.B. et al. "*Naegleria gruberi*: Isolation from Nasal Swab of a Healthy Individual." *Lancet* 602-603; Sept. 11, 1971.
- Sigel, H. "Metal Ions in Biological Systems." *Inorgan. Drugs in Def. & Dis.* 14: 17-124; 1982.
- Simoons, J.R.A. "Product Development Under FDA Regulations in the USA." *Overdruk uit Pharm.* 18: 293-301; 1972.
- \_\_\_\_\_. "Selection of Clotrimazole for Clinical Evaluation." Person Letter to The Arthritis Trust of America Board Members and Scientific Advisory Committee. July 23, 1984.
- Simpson, R.W. et al. "Association of Parvoviruses with Rheumatoid Arthritis of Humans." *Science* 1425-1428; March 30, 1984.
- Smith, A., W. Middleton, M. Barrett. "The Tonsils as a Habitat of Oral Endamoebas." *JAMA* 63(20): 1746-1749; 1914.
- Soltys, M.A. & P.T.K. Woo. "An Amoeba-Agglutination Test with *Acanthamoeba* (*Hartmannella*)." *Trans. Roy. Soc. Trop. Med. & Hyg.* 63: 426; 1969.
- Soren, A. & T.R. Waugh. "The Giant Cells in the Synovial Membrane." *Ann. of Rheu. Dis.* 40: 496-500; 1981.
- Sorenson, J.R. "Copper Aspirinate, A More Potent Anti-inflammatory and Antiulcer Agent." Reprint: John R. Sorenson, *Col. of Pharm., Univ. of Ark. for Med. Sci.* 7-22; date unknown.
- \_\_\_\_\_. "Use of Copper Complexes Offers a Physiologic Approach to Treatment of Chronic Diseases." *In Press*, Depart. Med. Chem., Univ. of Ark. Coll. of Pharm., 4301 W. Markham, Little Rock, Ark. 72205.
- Sorenson, J.R., et al. "Pharmacologic Activities of Copper Compounds in Chronic Diseases." *Biolog. Trace Element Research* 5: 257-273; 1983.
- Sorenson, J.R. et al. "Copper Complexes: A Physiological Approach to the Treatment of Inflammatory Diseases." *Inorganica Chim. Acta* 91: 285-294; 1984.
- Sorenson, J.R., T.M. Rolniak, L.W. Chang. "Preliminary Toxicity Study of Copper Aspirinate." *Inorganica Chim. Acta* 91: 131-134; 1984.
- Sorenson, J.R. & V. Kishore. "Antirheumatic Activity of Copper Complexes." *Trace Elem. in Med.* In press. Presented Oslo Rheumatism Hospital, Oslo, Norway. 15 pages, Oct. 20, 1983.
- Sotelo-Avila, C., F. Taylor, C. Ewing. "Primary Amebic Meningoencephalitis in a Healthy 7-Year-Old Boy." *J. of Ped.* 85(1): 131-136; July 1974.
- Spellberg, M. & S. Zivin. "Amebiasis in Veterans of World War II with Special Emphasis on Extra-Intestinal Complications, Including a Case of Amebic Cerebellar Abscess." *Gastroint.* 10(3): 452-473; 1948.
- Stamm, W. Abstracts 1434, 1435. *Trop. Dis. Bulletin.* 68(7): 816-817; July 1971.
- Stamm, W., M. Ashley, K. Bell. "The Value of Amoebic Serology in an Area of Low Endemicity." *Trans. Roy. Soc. of Trop. Med.*

- Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**
- & Hyg. 70(1): 49-53; 1976.
- Steinberg, S. "Cancer and Cuisine." *Science News* 124(14): 217; Oct. 1, 1983.
- Stevens, A. & W. O'Dell. "In vitro and in vivo Activity of 5-fluorocytosine on *Acanthamoeba*." *Antimicrob. Agents & Chemo.* 6(3): 282-289; 1974.
- Stevens, S.T., et al. "Primary Amoebic Meningoencephalitis: A Report of Two Cases and Antibiotic and Immunologic Studies." *J. Infect. Dis.* 143(2): 193-199; Feb. 1981.
- Stevens, A.R. & E. Willaert. "Drug Sensitivity and Resistance of Four *Acanthamoeba* Species." *Trans. Roy. Soc. Trop. Med. Hyg.* 74(6): 806-808; 1980.
- Swezy, O. "Mitosis in the Encysted Stages of *Endamoeba Coli* (Loesch)." *Univ. of Calif. Pub. Zool.* 29(13): 313-332; 1922.
- Thong, Y. et al. "Growth Inhibition of *Naegleria Fowleri* by Tetracycline, Rifamycin, and Miconazole." *Lancet* 876; Oct. 22, 1977.
- Tongreen, J.H.M. "Rheumatoid-Factor-Like Globulins and Tropical Parasitic Infections." *Lancet* 1266; June 4, 1966.
- Torres, E.F. & L. Benitez-Bribiesca. "Cytologic Detection of Vaginal Parasitosis." *Acta Cytol.* 17(3): 252-257; 1973.
- Triggle, D.J. "Calcium, the Control of Smooth Muscle Function and Bronchial Hyperreactivity." *Allergy* 38: 1-9; 1983.
- Ursing, B., et al. "A comparative Study of Metronidazole and Sulfasalazine for Active Crohn's Disease: The Cooperative Crohn's Disease Study in Sweden. II. Result." *Gastroenterol.* 83: 550-562; 1982.
- Ursing, B. & C. Kamme. "Metronidazole for Crohn's Disease." *Lancet* 775-776; Apr 5, 1975.
- Vaitukaitis, J., J.B. Robbins, E. Nieschiag, G.T. Ross. "A Method for Producing Specific Antisera with Small Doses of Immogen." *J. Clin. Endocr.* 33:988-991; 1971.
- Vaughan, J.H. "Rheumatoid Arthritis: Evidence for a Defect in T-Cell Function." *Hospit. Pract.* 101-107; May 1984.
- Venkatesh, R. et al. "Recovery of Soil Amebas from the Nasal Passages of Children During the Dusty Harmattan Period in Zaria." *Am. J. Clin. Path.* 71: 201-203; 1979.
- Veys, E.M. et al. "Mechanism of Flu-like Syndrome Induced by Levamisole Can Be the Base of Its Mode of Action in Rheumatoid Arthritis." *Adv. in Inflam. Res.* 6: 239-249; 1984.
- Visvesvara, G.S. & W. Balamuth. "Comparative Studies on Related Free-living and Pathogenic Amebae with Special Reference to *Acanthamoeba*." *Protozool.* 22(2): 245-256; 1975.
- Visvesvara, G.S., D.B. Jones, N.M. Robinson. "Isolation, Identification, and Biological Characterization of *Acanthamoeba* Polyphaga from a Human Eye." *Am. J. Trop. Med. & Hyg.* 24(5): 784-790; 1975.
- Walker, J. "Relief from Chronic Pain by Low Power Laser Irradiation." *Neuroscience Let.* 43: 339-344; 1983.
- Wang, S. & H. Feldman. "Occurrence of *Acanthamoeba* in Tissue Culture Inoculated with Human Pharyngeal Swabs." *Antimicrob. Agents & Chemo.* 1:50-53; 1961.
- \_\_\_\_\_. "Isolation of *Hartmanella* Species from Human Throats." *New Eng. J. of Med.* 277(22): 1174-1179; 1967.
- Warhurst, D. & J. Armstrong. "Study of a Small Amoeba from Mammalian Cell Cultures Infected with Ryan Virus." *J. Gen. Microbiol.* 50: 207-215; 1968;
- Warhurst, D., W. Stamm, E. Phillips. "*Acanthamoeba* from a New Case of Corneal Ulcer." *Trans. Roy. Soc. Trop. Med. Hyg.* 20:279; 1976.
- Warthin, A.S. "The Excretion of Spirohaeta Palida Through the Kidneys." *Arch. Ophthalmol.* 52: 525-545; 1923.
- \_\_\_\_\_. "The Occurrence of *Entamoeba Histolytica* with Tissue Lesions in the Testes and Epididymis in Chronic Dysentery." *J. Infect. Dis.* 30: 559-568; 1922.
- Weiss, S., E.S. Kisch, B. Fischel. "Systemic Effects of Intraarticular Administration of Triamcinolone Hexacetonide." *Isr. J. Med. Sci.* 19: 83-84; 1983.
- Wellings, F. et al. "*Naegleria* and Water Sports." *Lancet* 199-200; Jan. 22, 1977.
- Wessel, H.B. et al. "Granulomatous Amebic Encephalitis (GAE) with Prolonged Clinical Course: CT Scan Findings, Diagnosis by Brain Biopsy, and Effect of Treatment." *Neurol.* 30(30): 442; Apr 1980.
- Wilkinson, A.E., P. Rodin, J.A. McFadzean, S. Squires. "A Note On the Effect of Metronidazole on the Nichols Strain of *Treponema pallidum* in vitro and in vivo." *Brit. J. of Ven. Dis.* 43: 201-203; 1967.
- Willaert, E. & A. Stevens. "Isolation of Pathogenic Amoeba from Thermal-Discharge Water." *Lancet* 741; Oct. 7, 1976.
- Willaert, E., A. Stevens, & G. Healy. "Retrospective Identification of *Acanthamoeba culbertsoni* in a Case of Amoebic Meningoencephalitis." *J. of Clin. Path.* 31: 717-720; 1978.
- Wilmot, A., S. Powell, E. Adams. "Chloroquine Compared with Chloroquine and Emetine Combined in Amebic Liver Abscess." *Am. J. Trop. Med. Hyg.* 8: 623-624; 1959.
- Wilson, D. et al. "Induction of Amebiasis in Tissues of White Mice & Rats by Subcutaneous Inoculation of Small, Free-living Inquilinic, and Parasitic Amoebas with Associated Coliform Bacteria." *Experiment. Parasit.* 21: 277-286; 1967.
- Wojtulewski, P.J. et al. "Clotrimazole in Rheumatoid Arthritis." *Ann. of the Rheu. Dis.* 39: 469-472; 1980.
- \_\_\_\_\_. "Clotrimazole in Rheumatoid Arthritis." Unpublished Addenda to the Above Report Showing Effectiveness at Higher Levels. Personal Correspondence from Wojtulewski to John R.A. Simoons, 6 pages, undated.
- Wolfe, M. "Giardiasis." *JAMA* 233(13): 1362-1365; 1975.
- Wyburn-Mason, Roger. "The Causation of Rheumatoid Disease and Many Human Cancers." Book Report. *Lancet* 758; Apr 7, 1979.
- \_\_\_\_\_. "Clotrimazole and Rheumatoid Arthritis." *Lancet* 489; Feb 28, 1976.
- \_\_\_\_\_. "Dehydroemetine in Chronic Leukaemia." *Lancet* 1266-1267; June 4, 1966.
- \_\_\_\_\_. "Metronidazole in Rheumatoid Arthritis." *SA Med. J.* 648-649; May 1, 1982.
- \_\_\_\_\_. "The *Naegleria* Causation of Rheumatoid Disease and Many Human Cancers. A New Concept in Medicine." *Med. Hypotheses* 5: 1237-1249; 1979.
- Yoshikawa, T. et al. "In vitro Resistance of *Neisseria Gonorrhoea* to Metronidazole." *Antimicrob. Agents & Chemo.* 6(3): 327-329; Sept. 1974.
- Zaman, V. "Studies with the Immobilization Reaction in the Genus *Entamoeba*." *Am. Trop. Med. & Parasit.* 54: 381-391; 1960.

**The Arthritis Trust of America provides a PHYSICIAN & SCIENTIST ADVISORY LIST. While no donation or fee is necessary to receive this list, it would be helpful if at least a \$2.00 donation were given to help defray costs.**

**Write to The Arthritis Trust of America/The Rheumatoid Disease Foundation, 7111 Sweetgum Drive, Suite A, Fairview, Tn 37062-9384**

---

**Important Note**

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

We recommend that you first go to your family doctor. If s/he refuses to treat you, then try the physicians in this list. Since new physicians are joining each week, you may also wish to write to *The Arthritis Arthritis Trust of America* for the latest list.

---

## Chapter XVI

### Where Else Does One Look?

One of our referral physicians, Archimedes A. Concon, M.D., Memphis, TN, contributed the following treatment protocol. As it is not otherwise available in our literature, I make it available here.

Dr. Concon states: "In those cases of heumatoid Arthritis and Osteoarthritis which are intractable to our therapeutic regimens, I suggest adding Germanium to stimulate the patient's immune system, to overcome the disease process. Also applicable to other multiple collagen tissue diseases (MCTD)."

"Rheumatoid Arthritis."

*Rx Dexamethasone 50 mg 1 tablet qd, pc supper X 4 days*  
*Metronidazole 500 mg 4 tablets (2 grams based on body weight of 170#) qd, pc supper X 2 days.*

*Allopurinal 300 mg 1 tablet qd, pc breakfast X 6 days.*

He suggests that we read *The Report on Germanium* by Karl Loren, Ph.D., a book that can be ordered toll-free by phone at 1-800-443-0100, ext 170SP7.

"For Osteoarthritis."

*RX Symmetrel 100 mg 1 capsule bid, pc breakfast and supper X 6 weeks.*

*Vitamin D 50,000 units 1 capsule every other day, pc breakfast X6 weeks.*

*Germanium 300 mg 1 tablet qd, pc breakfast X 6 weeks.*

Germanium, he says, is available in health food stores as Germanium 50 mg, 150 mg, 300 mg tablets or capsules.

If you have tried all else recommended in our treatment protocol, I suggest you give these prescriptions a try through your family doctor. (Note that Colchicine is again mentioned in a totally different context than control of gout.)

In addition to the intraneurals recommended by our treatment protocol, there is increasing interest in the clinical use of lasers for treating neuromata that have been injured. Laser application in much the same as our intraneural treatment except that the skin is not penetrated with a needle, the amplified infra-red providing its own healing effects as it "sees" through the skin.

Anthony Lazzarino D.P.M. of Lewiston, NY has worked with "cold" laser applications to good effect. As a podiatrist he limits himself to lower extremities and the hands, but by the theory of intraneurals he finds himself quite often treating extensive neuromuscular skeletal systems to relieve patients of pain and symptoms.

A number of our referral physicians are familiar with laser treatments for these purposes.

Other devices, such as neural stimulators, are also in use by various physicians, and warrant investigation by you, if necessary.

Dimethylsulfoxide, known as DMSO, is a by-product of the paper-pulp industry. It is exceedingly cheap and is an extremely good, safe free-radical scavenger. DMSO has had many research papers covering its effects, and there are so many popularized books on the subject that I won't do other than sketch out its major importance to arthritics.

Most all of us who are arthritics have been exposed to the external (and sometimes internal) use of DMSO at one time or another in seeking pain relief.

It has been banned from easy access for out use because "it might

be unsafe," yet there is no proof of such unsafety on humans in any properly done research papers.

Arthritics sometimes purchase DMSO from veterinarian suppliers, where it is frequently used for animal pain. Food stores actively promote its sale, and I want to caution you on one deception I encountered.

When the store set on its shelves DMSO with a label stating that it was 90% DMSO "not for human use", I found that the way in which the "90%" was derived was by this means: they decanted DMSO from a large bottle marked as "90% DMSO" filling a small container 10% full of the 90% DMSO and the remainder of the container about 90% full of water.

I leave the first year algebra students the task of determining what the real percentage was!

DMSO when used for arthritis will surely relieve some pain at least temporarily - and in my opinion probably does so with much more safety than would be the taking of aspirin or SNAIDs (non-steroidal anti-inflammatories)

Two books that I recommend for your reading pleasure are: *The Persecuted Drug: The Story of DMSO* by Pat McGrady, Sr. The Nutri-books Corp., Box 5793, Denver, CO 80217; available also through many health food stores. And, Mildred Miller's *A Little Dab Will Do Ya! DMSO: The Drug of the 80's*, Quality Advertising, Degenerative Disease Medical Center, 1005 South Third, Las Vegas, NV, 89101.

Within these two books, and others on the market, are reports of so many positive features of DMSO that these pages are not adequate to report them all.

Besides being a very good anti-oxidant - free-radical scavenger - it "potentiates" (magnifies) the activity of other medicines, so that you do not need to take as much in order to produce the same results.

If a person who suffers from a very recent cerebral stroke is immediately injected with DMSO (in brain tissue near the hemorrhage) the stroke victim will most likely not be paralyzed or lose powers of speech. The reason: because leaking blood oxidizes to destroy brain neurons (nerve tissue), whereas the DMSO safely anti-oxidizes the leaking blood, thus protecting the neurons from damage. I have known two physicians who have used this method, and have succeeded in bringing about healthy post-stroke victims.

DMSO is also used intravenously for a multiplicity of reasons, very much like EDTA, but for different effects to some extent. It potentiates the use of EDTA in the veins while also contributing its own good effects, allowing one to use less EDTA - or to achieve "stronger" EDTA action over less time.

When used with and without EDTA it has brought about healing of kidney tissues in patients who've been on continuing dialysis.

DMSO when used intravenously, of course, must be quite pure, not laced with resins and by-products of the wood-pulp industry, and should be buffered with something like potassium carbonate.

There is also strong evidence that it will change rapidly, and safely the ratio of High Density Lipids (HDL) to Low Density Lipids (LDL). I've had one personal experience to verify this through laboratory tests, but I could not answer as to the effect's permanency. One of these lipids is responsible for carrying fats to the cells, and the other one for stuffing the fats in the cells, so to speak, and it always made good sense to me that the ratios ought to be close to one. Young people show an HDL to LDL ratio greater than one. Old folks show a ratio much less than one. My measured ratio was close to that of seventy year men, yet, at the time, I was but 58. After nine IV treatments of DMSO taken three times a week in increasingly stronger doseages, over increasingly long periods of time, my ratio reversed to that of twenty year olds. Multi-vitamins

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

and EDTA did not do this, as I also kept track of my ration through such treatments to determine exactly what would happen.

Was the treatment beneficial?

I believe it was, but I have no proof to offer, good or bad.

I've spoken of depression and lethargy that comes with arthritis and continual pain. These symptoms cause mood changes that can from time to time become virtually suicidal, as any arthritic will testify. That some of us do not suicide speaks to the tenacity of life, the love of supporting friends and relatives, and the often abiding faith we have in God.

One medicine that can help us ride through this period, and one that is normally quite safe, is Dilantin, also known as diphenylhydantoin.

Dilantin is also a potentiator of other medicines, but more importantly, it acts to stabilize brain cells into a normalcy of behavior. It is not a narcotic, not addictive, not a stimulant, not a barbiturate, nor is it a tranquilizer. It does little else but permit the brain cells to operate the way they were intended to do.

On taking it you will most probably find that your moods and ability to confront the emotional problems of life increase tremendously. Do not be dissuaded by those who argue that the *Physician's Desk Reference* lists Dilantin for use with epileptics and the brain damaged. There are many, many more uses for Dilantin than reported in that compendium of drug package inserts. Read the book *A Remarkable Medicine Has Been Overlooked* by Jack Dreyfus, Pocket Books (ISBN: 0-671-45607-5)>

Naturally this chapter is not complete, nor can it be. There are simply too many treatments of a beneficial or possibly beneficial nature, that exist "out there", and if you are to get well, you must take the bull by the horns, so to speak, and begin searching and applying them, preferably with your family physician's active support.

This book had the purpose of informing you, a victim of Rheumatoid Disease, alternative routes to recovering life without pain, and a future that you will want to live and to enjoy. I cannot promise you that all described will work for you, or that any of it will.

I have, I hope, shown you that establishment-type medicine, with its head-in-the-sand attitude will not accomplish wellness - but you already knew that or you wouldn't be searching still.

The fact that you search still is a very good sign, as it means that you, at least, are open to new and creative ideas - and that's the very first step toward wellness!

If nothing else, I hope you understand that "out there", in alternative medicine land, lies a tremendous number of procedures and techniques and treatment protocols, among which will be one or more that suit you perfectly. Eight out of ten will get well, or greatly improved through following The Rheumatoid Disease Foundation's suggestions. If your immunological system has already been permanently damaged by dangerous, ineffective establishment-type treatments, there is still hope, for at least 50% of such will be greatly improved or cured. The balance who are not helped should concentrate even harder on those other adjunctive and alternative remedies in this book, and perhaps search for some not as heartily recommended.

I can think, for example, of a number of treatments that we do not have room to describe, such as hydrogen peroxide therapy, taken both orally and by IV drip. You will probably need to go to a foreign country for it, however, and there you must consider the consequences if you fall into unscrupulous hands.

Macrophages kill invading organisms. With the weakening of the immunological system comes invaders: viral, bacterial, fungus and yeast and mycoplasmas. Your body loses its ability to destroy

these invaders by means of peroxides and superoxides produced by macrophages. Apparently hydrogen peroxide therapy provides the missing killing ingredient, peroxides, so that these organisms can be killed in large masses.

Many claims are and have been made about the dangers of this approach, but those who've tried to assure me that it was beneficial to them, and not dangerous at all.

One of our referral scientists, J. Rinse, Ph.D., suggests that arthritics check into the use of "natural" (unpasteurized, unstrained) honey. He reports on an article by Charles Mraz in *Health Freedom News*, August 1987 (212 W. Foothill Boulevard, P.O. Box 688, Monrovia, CA 91016). Mraz states that natural honey contains dextrose and levulose in about equal proportions.

According to Mraz: *Levulose in honey is hydroscopic, it has a great affinity for water so that it can absorb moisture from bacteria in contact with honey and dehydrate them. However, this is not its main bacterial action. Natural honey, also contains an enzyme, 'glucose oxidase'. This enzyme has the interesting activity to take the energy from the honey to produce about 35 parts per million hydrogen peroxide when the honey is diluted.*

*If honey is heated above the 100 degrees F. this will destroy the action of the enzyme, as will filtering of the honey. This enzyme action of the honey is preserved in that it is not activated until the honey is diluted. As long as the honey is stored in the honey combs, or stored in jars or other containers without any destructive processing this glucose oxidase enzyme remains ready to produce the health giving H<sub>2</sub>O<sub>2</sub> just as soon as it is consumed by the bees, and humans that add moisture to it as it is eaten. The interesting beneficial action of H<sub>2</sub>O<sub>2</sub> in honey is, that this action is carried out all through the digestive system of the body. Ordinary 'commercial' hydrogen peroxide would be active when first consumed, but the nascent oxygen is released long before it reaches the lower intestines. The enzyme in the honey will continue to produce hydrogen peroxide all through the intestines as long as moisture is added to the honey all during its travel through the digestive system.*

I have not investigated this approach, and I would advise caution if you suffer from Candidiasis, as honey contains yeast nutrition: sugar. However, if the effects are what is reported from the peroxides, then it must be through the action of killing off various yeast/fungus, mycoplasmas and other non-natural intestinal microflora. It may be worth a long-term trial.

Oxygen in the form of ozone is provided through IVs in some clinics. Ozone therapy, treating blood externally or internally through complex IV procedures, is used in some foreign countries, also to good effects on various diseases. One of our referral physicians in West Germany, Helmut Christ, M.D. spoke at our Second National Medical Seminar telling us both of his use of ozone therapy as well as a new treatment for Psoriasis that he has found 100% successful on every patient. Such a huge success percentage is unheard of (and almost unbelievable) in medical treatments.

The story is told that Christ's physician friend with Psoriasis himself, tried many different treatments until he stumbled on the use of fumaric acid. Apparently the Psoriasis victim's skin lacks fumaric acid, or the products with fumaric acid. When Helmut Christ obtained the knowledge he was a general practitioner, and had no desire to specialize in Psoriasis. He used the fumaric acid "recipes" on several of his patients, and lo! they were healed. Through word of mouth his patients were sending more and more Psoriasis patients to him, and he woke up one morning finding himself, really against his ambition, a specialist in Psoriasis.

A light case of Psoriasis is treated with fumaric acid salve, and provided with certain vitamins and minerals. A moderate case may be given fumaric capsules, and a heavy case of fumaric capsules,

**Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment.**

salves and fumaric acid soaks, all with various vitamins and minerals.

If you have an interest in this treatment, send a self-addressed, stamped large envelope to The Rheumatoid Disease Foundation along with \$5.00 or more donation to defray our costs. We will also provide the name and address of a pharmacy that has taken the trouble to prepare the ingredients according to Christ's treatment protocol. One caution: while many in the U.S. have had similar results to Christ's patients, I did talk to one lady who could not get these results. Was she treated incorrectly? Did she really have Psoriasis? Were there complicating factors consisting of other metabolic and/or nutritional and/or disease factors? Is the treatment less than 100% effective?

Live cell therapy is also administered in foreign countries. The theory is that as we age, or sicken, or the endocrine system no longer furnished us with appropriate substances from embryos of certain animals, our organs can be revitalized, thus restore the ability to better fight off stress and disease.

True?

I don't know, but I'd love to be able to try it.

Some physicians specialize in the rebalancing of hormones, and seem to have great success in eliminating various diseases, including Rheumatoid Disease. There is no special protocol, but rather an evaluation from day to day of patient needs - and these must be coupled with other good health rules.

A number of good alternative medicine periodicals will keep you abreast of various alternative treatments, and they will often discuss the pros and cons of these treatments so that you are free to form an independent judgment, unbiased by Authority or prejudice, or the strappings of past customs.

Among them is *Medical Hypothesis* available through various libraries, but can also be ordered at 1-3 Baxter's Place, Leigh Walk, Edinburgh EH1 3AF, Scotland. Warning: it is written for physicians and scientists, but otherwise very excellent for new ideas.

*Health Freedom News* is available by writing 212 W. Foothill Boulevard, P.O. Box 688, Monrovia, CA 91016.

*Townsend Letter for Doctors* can be ordered by writing 911 Tyler Street, Port Townsend, WA 98368.

*Health Consciousness*, P.O. Box 550, Oviedo, FL 32765.

While it is somewhat off the subject, two pamphlets perhaps of interest to you for general information available at The Rheumatoid Disease Foundation: are *Historical Documents In Search of the Cure for Rheumatoid Disease* (ISBN: 0-93150-18-3) with articles by Jack M. Blount, M.D., Archimedes Concon, M.D., James Rowland, D.O., William Renforth, M.D., Paul Williamson, M.D. and Roger Wyburn-Mason, M.D. Available for \$5.50 donation or greater; *Dedication, Love and Humour* written by Roger Wyburn-Mason's loving wife, Joan (ISBN: 0-931150-18-3-) who describes briefly her life with Professor Roger Wyburn-Mason, the genius who first discovered the effects of medicines in our treatment protocol on Rheumatoid Disease. Available for donation of \$5.50 or greater.

The Rheumatoid Disease Foundation is not bound by any treatment, including its own. We do not stand or fall on particular treatments, but rather on accomplishing the goal or eradicating Rheumatoid Diseases.

When a new treatment comes along that is superior in accomplishing this goal, we expect to be in the forefront of its acceptance.

Our present research, which is paid by donations by yourself and friends, not pharmaceutical companies, involves three aspects:

1. Untangling the biochemical reasons why our present treatment protocol works so effectively, when all others have failed so drastically.

2. Conducting double-blind studies on each of our recommended medicines to prove their safety and effectiveness in the eyes of the FDA, and the established medical community. Regardless of what we've said derogatorily about establishment-type medicine, it is the main thrust of generally accepted medical treatment, and we wish to convince, not destroy.

3. Continue to search out the cause or causes of Rheumatoid Disease, wherever that may take us in our studies.

No other organization has these three combined goals coupled with the self interest of eradicating your disease and all others who have been afflicted. No other organization has already done so much toward that goal, and with so little.

Together you and I have embarked upon a great, if not grand, adventure, and we want everyone to participate. There are a multitude of ways by which each can contribute, whether by personal services, the setting up of chapters, educating the public and news media, or contributing generously with your limited funds.

One of the most exciting concepts yet unresearched for clinical applications of medicine lies in the field of cell-wall deficient bacteria. Whenever antibiotics are used, various species of bacteria have their walls striped off in whole or in part. Some of these organisms, instead of dying, revert to a form that can live in body tissue (blood cells) without a wall. It happens that the way in which our immunological system recognizes a foreign invader is through sensing the molecules of the invader's walls. Without a wall, the bacteria cannot be sensed by our immunological system and has protected itself, and it continues to survive. Some bacteria can revert to a viral size and appear to be gone entirely. Later, it can reconstruct itself into common and well known bacteria, and again create the disease. Cell-wall deficient organisms have been known for ten years, but very little is known about treating them, or how they affect us.

It is research on promising subjects like this that needs your interest and active, willing support. All arthritics will be most grateful - all arthritics worldwide - and all of their arthritic neighbors and relatives - and all of their friends, everywhere!

Please write to The Rheumatoid Disease Foundation/The Arthritis Trust of America if you have further questions or suggestions, or means of supporting this noble work further.

Meanwhile, please also remember our joint goal. First get yourself well, then our relatives and friends, and afterward help us to go out into the world and eliminate the great cripple!

With great appreciation, I remain,

Anthony di Fabio