

June 9, 1984 Dear

Perry,

I asked Wayne Martin to send you the material he had on the infamous Flagyl rat. Instead he sent me the enclosed two pages from same (which is Sen. Kennedy's 1975 hearings on the FDA etc.) (title page is upside down), with the following comment: "... over 200 rats were used. One male rat — Control No. CM21 - developed breast cancer. The FDA claimed that this rat was a female and also that it had gotten Flagyl. In the end Searle made their case. The one out of over 200 rats to turn up with breast cancer was indeed a male and a control. If you want to wade through the entire 1,350 pages, I will mail them to you."

I expect that you don't want Wayne to fork out for all that postage. But the two pages should give an adequate idea of what went on; and if not, the title page gives you the reference.

Thank you for the info copy of the Bingham-Chapdelaine correspondence. I note that acanthamoebae have slipped into the RD picture while I wasn't looking, so I await future enlightenment. As for the American College of Eclectic Physicians, surely the word is eclectic. "Eclectic" would have to be someone's neologism, and there would be no point in the coinage when simply adding a C produces a long-established word meaning exactly what they are trying to convey.

Your remarks on cortisone and on your own intraneural injections suggest that it is time for me to tell you about my left knee, so I will. I have had osteoarthritis (known, that is) for 23 years, manifesting itself in the following sequence: neck, hands, left hip, left knee. I lived on aspirin and Indocin until early 1978, when a piece in the Saturday Review by Norman Cousins prompted me to give high-dose Vitamin C a secret trial (I was a complete skeptic, and didn't want to look like a fool if the stuff didn't work). Reading between the lines, I picked 10 grams per day as a large dose; being a total neophyte and naive, I had to feel my way in the dark. On the 4th day the improvement was so marked that I experimentally dropped Indocin and did not miss it at all. In time I experimentally dropped aspirin for a week; it was a miserable week, and I went back on aspirin thankfully. Some time later I read (*Chemtech*, Feb. 1978) an interview with Robert F. Cathcart III, M.D., an orthopedic surgeon-turned-G.P. who had discovered the bowel-tolerance phenomenon: i.e., that instead of being a nuisance side effect encountered by some people taking larger-than-vitamin-like doses of ascorbic acid, diarrhea is a God-given indicator that any person has taken more than he can absorb, and therefore more than he needs, at any given time. Having learned how to establish my needed intake, I quickly found that on about 30 grams per day I was without pain and essentially without discomfort. That was in May of 1978. From that time I have never taken an aspirin or other pain killer and have needed none. (Which is not to say that I have never had discomfort since, but rather that when I have it, either more C will help or nothing will help.)

Wanting to know what was the rationale, if any, behind this dramatic relief (and freeing from synthetic drugs), and also why my doctor didn't know about it (I having previously been a leading exponent of the If-it's-any-good-my-doctor-will-tell-me-about-it school of thought), I began to read and correspond intensively. In the ensuing six years I have learned that there are at least two ways in which C encompasses the relief of arthritic (or any inflammatory) pain: (1) By competitively inhibiting the enzyme phosphodiesterase, it protects the cyclonucleotide cyclic AMP and thus makes more of the latter

available to mediate the production of cortisone — which being home-made, does not have the undesirable side effects of the synthetic steroids; and (2) by maximizing the conversion of dietary linoleic acid into prostaglandin E-1 it minimizes the alternate pathway of conversion into PGE-2, which among other things governs the inflammatory process. (Aspirin and the prescription anti-inflammatory drugs are prostaglandin blockers, but they do so rather indiscriminately, so that in suppressing the semi-Bad Guy E-2 they also tend to suppress the super Good Guy E-1. Since E-1, among other things, governs the production of T-lymphocytes, this accounts for the fact that these drugs depress the immune system.) (E-2 is by no means all bad, so it should not be suppressed totally. It is involved in protecting the stomach against ulceration, which explains why the PG blockers so often cause ulcers. One RD patient was — before I got to her — on Motrin, and had to have emergency surgery for a perforated ulcer. She later got the anti-amoebic treatment from Dr. Plagenhoef, and is now free of RD.)

And, of course, I learned about the essential role of ascorbic acid in the manufacture, maintenance, repair, and replacement of collagen. And this brings us to my left knee. In April of 1980 I read a piece (Greenwood, J., On Osteoarthritis, the "Wear and Tear" Disease: Can Vitamin C Help? *Executive Health* 16, 7, April 1980) by a Houston neurosurgeon who has used relatively high-dose C on his back patients since the early 1960s ("as much as 10 grams a day") and claims thereby to have saved many from back surgery by restoring disc integrity. In this paper he strongly hinted, without actually saying it, that OA patients in whom cartilage erosion and defensive calcification of the bone end had not progressed too far might look forward over the long haul to complete repair of cartilage. I was skeptical, because at this time I had been on C. 30g/day of C for two years, and as far as I could see there had been no change for the better in any of the affected joints. The test was simple: how did the joint respond to hot water? All of my affected joints were still responding very gratefully indeed, indicating the inflammation was still present, even though rarely painful. But a year and a half later, in the fall of 1981, I lowered myself into a hot tub one morning, sank low enough to immerse my neck, and then, as was my custom, rolled over on my left side to immerse my left knee. No response from the knee. Holy cow! thought I, what gives? That knee doesn't seem to care whether it's in hot water or not. So I rolled over on the right side to test the response of my non-arthritic right knee. Same as the left. My goodness, thought I, can Greenwood be right? As soon as I got out of the tub and dried off I tried some deep knee bends, of which I had previously been able to do, painfully, a maximum of one. I did 25, and only stopped because both knees were protesting equally. Well! I said nothing to anyone, not even my wife, for three months, to make sure that it had not been some sort of freak occurrence. Now 2-1/2 years later, I can say with absolute assurance that that knee has been restored to absolute normality. (Six months later I wrote to Greenwood, detailing my experience and suggesting that if he had used Cathcart's Indicator to establish dosage, which in some patients would have meant going beyond 10g/day, some of his "failures" might have been successes. He now uses Cathcart's Indicator.)

It is probably significant that my left knee was the last joint to become arthritic, and was the one that had bothered me least.

It appears to me that Pybus' treatment is designed to interrupt a source of stress on the knee long enough to allow nutri-

ents (essentially protein and ascorbic acid) access to the cartilage so that repair may proceed. It would then seem that the "other health-improvement programs" of which you speak in your letter should above all include a bowel-tolerance intake of C.

Not only for the repair aspects, but also for the relief of residual inflammation. (A recent paper states that L-arginine considerably speeds up the deposition of collagen in healing wounds in rats and might well do the same in humans, so perhaps adding L-arginine to the regimen might be prudent.)

You might want to look up Cathcart's paper summing up his clinical experience with more than 9,000 patients on high-intake C over the course of ten years: Cathcart, R.F. III, Vitamin C, Titrating to Bowel Tolerance, Anascorbemia, and Acute Induced Scurvy, *Medical Hypotheses* 7: 1359-1376, Nov. 1981. Blount was much impressed by it "I must increase my Vitamin C intake to bowel tolerance"). If you can't readily lay hands on it, I'll be glad to loan you a copy.

It was thanks to Cathcart that I learned about Wyburn-Mason. His paper asserts that while RA significantly increases bowel tolerance, OA doesn't. I wrote, about a year ago, to argue that point on the basis of my own high intake. He replied that he stood by his observation, and that if my allergies were not enough to account for my large need, then perhaps there was an unsuspected, rheumatoid component in my arthritis; and he referred me to Wyburn-Mason's *Medical Hypotheses* paper of 1979. So in time I went to Dr. Plagenhoef and said I wanted to be tested for RD. All tests were negative. I said I wanted the drug anyway. He resisted. I prevailed. In the 4th and 5th weeks I had an unmistakable Herxheimer reaction. After the 6th week my arthritis was significantly improved about 50%. More to the point, my —bowel tolerance for C plummeted by 40%, showing that a chronic source of stress had been removed from my body.

The "how-to" sheet which I sent you, incidentally, is of course based largely on Cathcart's work, plus that of Irwin Stone, Fred Klenner, Sherry Lewin, and Pauling. It has been seen and approved by both Cathcart and Linus Pauling.

While I was on the Flagyl treatment, incidentally, I used no prednisone. I simply increased my intake of C as necessary to control the discomfort, which meant going as high as 4 grams an hour on the Herxheimer days. No! Exogenous steroids are not necessary — not when C so well facilitates the endogenous stuff.

Having used "incidentally" twice in short order, I perceive that it is time to wrap this up. Keep me posted, and I will be most appreciative.

Loquaciously yours,

Bill Burk

P.S. In case you don't know about Bronson as source of vitamins, etc., I enclose an order form. Only good source of Vitamin C crystals.

The false information that Flagyl (metronidazole) might produce cancer has been repeated annually in the *Physicians Desk Reference* and other publications based on the FDA's arbitrary order to place a control rat with cancer in the experimental group imbibing Flagyl. The following page from a congressional hearing has corrected the record, but not the *Physicians Desk Reference* and other false articles. Ed.

**PRECLINICAL AND CLINICAL TESTING BY THE
PHARMACEUTICAL INDUSTRY, 1975**

JOINT HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE
AND THE
SUBCOMMITTEE ON
ADMINISTRATIVE PRACTICE AND PROCEDURE
OF THE
COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE
NINETY-FOURTH CONGRESS
FIRST SESSION
ON
EXAMINATION OF THE PROCESS OF DRUG TESTING AND
FDA'S ROLE IN THE REGULATION AND CONDITIONS
UNDER WHICH SUCH TESTING IS CARRIED OUT

JULY 10 AND 11, 1975

Printed for the use of the Committee on Labor and Public
Welfare

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FLAGYL

DESTRUCTION OF EVIDENCE OF CM 21

The charges that microscopic diagnoses were misrepresented and that evidence was destroyed are false. Both of these charges relate to one tissue of one rat out of the more than 200 rats in the study.

As came out in the oral testimony, the initial diagnosis on this slide was made by Dr. Sagartz. Dr. Sagartz himself changed his initial diagnosis based on his final review of this slide before submitting his draft report to Dr. McConnell. This slide has been repeatedly reanalyzed by others, including Dr. Cross, and Dr. Sagartz's final diagnosis as given to Searle is correct.

Dr. Gross tried to remove Searle's only remaining wet tissue sample for this slide. He never told Searle his purpose, although repeatedly asked, and did not object when Searle employees told him that they would prepare additional slides from this tissue in his presence. After the slides were prepared he refused them. Searle was never told of the intent of Dr. Gross to do a chromosomal analysis. There is no truth to the assertion that Searle deliberately embedded the wet tissue in order to prevent any test of which Dr. Gross ever advised Searle. Dr. Gross is scientifically incorrect in his assertion that embedding this tissue renders it "unanalysable." Upon learning of this assertion and Dr. Gross' purpose Searle ran a sex identification test and determined that, contrary to the assertion that the tumor was from a female, it came from a male as represented. Memoranda on the test method generally and as

applied to the tumor tissue from rat CM 21 are attached.

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FLAGYL

CONTROL RAT MALE 21

Dr. Gross has made four serious charges of impropriety concerning control male rat 21 in the Flagyl study. They are that raw data was changed to support a summary table in the report, records were not kept on this rat, Searle refused to furnish wet tissue to FDA, evidence was destroyed and that Searle fraudulently substituted microscopic slides or tissue from this rat. The charges are wholly false and can easily be disproved beyond a shadow of a doubt.

This control rat developed a tumor in the mammary gland.
(*Underlining added.*)

It was preliminarily diagnosed by Dr. Sagartz as a benign tumor and that diagnosis was recorded on the pathology sheet. As a part of his final review in preparing the report to FDA, Dr. Sagartz conscientiously re-read all tumor slides. He voluntarily changed his diagnosis from benign to malignant. He then corrected the tumor summary table in the report but forgot to correct the diagnosis on the pathology sheet. As a result, the raw data contained one diagnosis and the summary another. When this clerical discrepancy was called to Searle's attention it was corrected in the amended report. Dr. Sagartz has confirmed these facts to Searle.

Dr. Gross next charges that there are no records on this rat. This is wholly false. Dr. Gross has the feeding and body weight sheets and the detailed records that account for each and every tissue specimen and microscopic slide prepared from this animal. They are available to this Subcommittee or any-